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WORKERS' COMPENSATION

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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. <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 /her 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 as 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. Employers 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
   d. 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: 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 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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KANSAS WORKERS' COMPENSATION

Applies to injuries occurring on or after July 1, 2024.

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 July 1, 2024

1. Notice must be given by the earliest of the following days:
    a. 30 calendar days from the date of accident or the date of injury by repetitive trauma; or
    b. 20 days from last date of employment if no longer employed.

C. For accidents between April 26, 2013 and June 30, 2024:

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.

D. 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.

E. 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.

F. 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."

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

H. 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. 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 $800 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 healthcare provider within two years from the date of the award or the date the claimant last received medical treatment from an authorized healthcare provider, there is a rebuttable presumption no further medical care is needed. This presumption can be overcome by competent medical evidence.

C. K.S.A. 44-515

1. All benefits suspended if employee refuses to submit to exam at employer's request until the employee complies with the 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). The report requested must be identical to the report submitted to the employer.

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. If the employee did not work a total of 26 weeks before the accident, divide by the number of actual weeks worked before the accident.

1. If the employee worked less than the employee's expected weekly schedule during the first week of employment, that week shall not be included in the calculation of the employee's average weekly wage.
2. If employed for less than one calendar week immediately preceding the accident or injury, the average weekly wage shall be determined by the ALJ.

B. Wages = Money + Additional compensation

1. Money: gross remuneration, including sick, vacation, other paid time off, 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, any 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. At least 20 days before the date of the preliminary hearing both parties shall exchange all medical reports so that all parties may be informed of all medical findings and opinions. Failure to comply may result in the ALJ granting a party's request for additional time to present evidence.

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

F. 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.

G. The ALJ may only order one Court-Ordered Independent Medical Examination (COIME) without the agreement of the parties. Parties are still free to agree to a joint IME.
   1. If the ALJ does order a COIME, the COIME must be done prior to the Prehearing Settlement Conference.
   2. The COIME may not be used for the purpose of a rating, permanent restrictions, or opinions on permanent total disability.

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

I. 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”.

J. 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.

K. 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. Claimant cannot show good cause for delay
   2. Dismissal considered final disposition for fund reimbursement
      a. This will not affect any future benefits which have been left open upon proper application by an award or settlement.

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

A. Must occur at least 10 days 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 - $100,000 (increase from $75,000)
      a. Cap now applies even if temporary total or temporary partial disability benefits were paid.
      b. $100,000 cap shall apply whether temporary total disability or partial disabilities benefits were paid.
   2. Permanent Partial Disability - $225,000 (increase from $130,000)
      a. Cap includes temporary total or temporary partial disability benefits paid
   3. Permanent Total Disability - $400,000 (increase from $155,000)
      a. Cap includes temporary total or temporary partial disability benefits paid
   4. Death benefits - $500,000(increase from $300,000)
      a. Includes $1,000 for appointment of conservator, if required.
   5. Caps will remain fixed until July 1, 2027, at which time a cost-of-living adjustment will kick in to raise caps on a yearly basis. The annual percentage increase will be based on a 5-year average of the percentage increase in the State’s average weekly wage.

B. Reduction for Pre-existing Impairment
   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 $225,000.00 for an injury on July 1, 2024 or later, 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
    a. Based on the 6th edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained and;
    b. Suffers a percentage of functional impairment determined to be caused solely by the injury that is equal to or exceeds 10% to the body as a whole or the overall functional impairment is equal to or exceeds 15% if there is a preexisting functional impairment.
3. Can only be permanently and totally disabled once in a lifetime.

F. Death Cases – K.S.A. 44-510b
1. Burial Expenses:
    a. Employer shall pay the reasonable expense of burial not exceeding $10,000.00.
2. Upon determination of dependency an initial Lump sum payment of $60,000.00 to surviving legal spouse or a wholly dependent child or children or both.
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 until the dependent child becomes 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. $500,000.00 - For surviving spouse and wholly dependent children
    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.
    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.
        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. Upon receipt of notice from the Division of the setting of a Regular or Post-Award Hearing the parties shall exchange medical reports at least 30 days before the hearing.
    a. Upon receipt of the proposed complete medical report, a party has 10 days to file a written objection to the offering party stating the grounds for the objection.
    b. An ALJ shall conduct a hearing on the objections as to whether the proposal meets a complete medical report's requirements.
3. 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.
        i. The testimony of a treating or examining healthcare provider may be submitted into evidence without additional foundation by submission to the opposing side of a complete medical report that complies with procedural rules set forth in the statute.
4. 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. The authorized treating physician’s opinion as to the need for future medical is presumed determinative on the issue of whether future medical will be awarded in cases where there have been no invasive procedures. This presumption can be overcome with clear and convincing evidence.
    c. If the injured worked had invasive treatment due to the work injury, the authorized treater’s assessment that no future treatment will be needed is still presumed determinative of the issue. However, that presumption may be overcome if claimant proves it is more likely than not that future medical will be needed.
    d. 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. If the employee is represented by counsel, a settlement can be completed without the need for a settlement hearing.
   1. The Division is mandated to create the appropriate stipulations and Award documentation.
   2. The ALJ is given five days from receipt of the signed stipulation to approve the agreed award.

C. 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.

D. 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.
        a. An award of PPD or PTD shall be subject to an offset equal to 50% of the Claimant's Social Security retirement benefits.
        b. An award of TTD and TPD benefits shall not be subject to an offset for Social Security Retirement benefits.

B. Second Injury Fund
    1. The Kansas Second Injury Fund provides a procedure to implead a statutory employer in cases where the primary employer is determined to be uninsured and without ability to pay benefits.

C. 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. During preliminary hearings the judge decides payment of medical treatment and the payment of temporary total or temporary partial disability. We can put on evidence to dispute the payment amount.
   2. Witnesses
      a. Get written statements concerning the contested issue, signed and dated.
   3. Evidence
      a. Compile all documents concerning the contested issue
         i. Light duty offers paperwork
         ii. Employment documents
         iii. Termination paperwork
      b. Notice of accident paperwork

B. Most Common Issues
   1. Did the accident arise out of and in the course of employment?
      a. Job duties
         i. Was the injured worker doing an assigned task?
      b. What happened?
         i. Eyewitnesses
         ii. Take photos of the work area
         iii. Gather video footage of the incident
      c. Were there any witnesses?
         i. Find out who the witnesses are and get a signed statement from them.
      d. How and why did the accident occur?
         i. Safety violations
         ii. Policy violations with specificity
      e. When did the accident happen – date and time?
         i. 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?
        i. When?
        ii. To whom?
        iii. Where did this take place?
        iv. What was said?
        v. Was treatment authorized and provided?
3. Work status
    a. Was accommodated employment offered?
    b. Detail conversation:
        i. Date of offer?
        ii. Verbal or written?
        iii. Who was present?
        iv. Detail any conversation that occurred regarding employment after an accident.
    c. Was there a resignation?
        i. Written?
        ii. Verbal?
    d. Unemployment?
    e. Other employment?
    f. Termination?
    g. Personnel file?
        i. Date of hire?
        (a.) Is wage statement correct?
        (b.) Too short for repetitive motion?
        i. Reviews

B. Regular hearings
1. Witnesses
2. Evidence

II. Witnesses

A. Questions regarding accident:
1. Who was/is the supervisor on duty?
2. Who saw the accident itself?
3. Who was told of the accident?
    a. Was an accident report done? Was a written statement filled out?

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
            i. Able to accommodate restrictions?
            ii. Documented?
        b. Fired
            i. Occurred after workers' compensation claim filed?
            ii. Able to accommodate restrictions?
            iii. Documented?

III. Evidence

A. Personnel file
    1. Evaluations/ date of hire

B. Wages
    1. AWW calculated based on 26 weeks of pre-injury wages
    2. Temporary benefits

C. Other valuable information regarding employee

IV. Safety Violations

A. Basis for penalty and standard

B. Reckless disregard KSA 44-501(a): Compensation for an injury shall be disallowed if such injury to the employee results from:
    1. Employee's deliberate intention to cause such injury.
    2. Employee's willful failure to use a guard or protection against accident or injury required pursuant to statute and provided for the employee.
    3. The employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished to the employee by the employer.
    4. The employee's reckless violation of their employer's workplace safety rules or regulations.
    5. The employee's voluntary participation in fighting or horseplay with a co-employee for any reason.

C. If under the totality of the circumstances it is clear that the employer allowed the employee not to guard or protect against an accident or not use reasonable and proper guard and protection, then the employee may be able to recover.

D. Definition of reckless: The actor knows or has reason to know of facts that would create a high degree of risk of physical harm to another and deliberately proceeds to act, or to fail to act, in conscious disregard of, or indifference to, the risk.

1. For something to be reckless it must be more than negligent. Recklessness must involve an easily perceptible danger of death or substantial physical harm, and the probability that it will so result must be substantially greater than is required for ordinary negligence.

V. Case Examples of Reckless Safety Violations

A. *Gould v. Wright Tree Service*, 376 P.3d 94 (Kan. Ct. App. 2016) (unpublished opinion)

1. What happened: Claimant spilled gasoline on his clothing while refueling a chainsaw. Later, while on break he lit a cigarette which ignited with the gasoline on his shirt, severely burning his torso. Upon starting employment, Claimant was given a manual covering all work policies including fire prevention, but it was not required. Additionally, the Claimant attended weekly safety meetings, but the fire prevention policy was never covered.
2. Outcome: The court found that Claimant was not in reckless violation because he was no longer handling flammable materials when he lit his cigarette, and the Claimant did not know the employers fire prevention policy, therefore he was able to recover.

B. *Anderson v. PAR Electrical Contractors*, 430 P.3d 493 (Kan. Ct. App. 2018) (unpublished opinion):

1. What happened: Claimant worked as a journeyman lineman and was cutting PVC pipe from one electric pole to transfer the wires to a new pole. The journeyman believed the cables did not have electric currents. The employer enforced a rule that if anyone was within 5-feet of an energized source they were required to wear protective gear, including rubber gloves and sleeves. Claimant was not wearing rubber gloves but believed there was no electric current and that he was farther than 5-feet away from the source. While one journeyman was cutting the wire, Claimant was holding the cables he was electrocuted and burnt on both arms. When the Claimant was electrocuted, he believed he was farther than 5-feet from the electric source.
2. Outcome: The court found substantial evidence supporting that the Claimant did not recklessly violate a rule because he believed he was further than 5-feet from the electric source and could recover.

C. *Terence D. Mahathey v. American Cable and Telephone*, 2012 WL 5461478 (Kan. Work. Comp. App. Bd. 2012):

1. What happened: Claimant was employed as a cable technician. The claimant was climbing a ladder and was supposed to hook the ladder to suspension wires using safety hooks to secure the ladder. Employees were instructed if they could not see the suspension line hooked at the top of the suspension wires to call Cox for help. The day in question the Claimant thought he had it hooked on a suspension line using the safety hooks, but the top of the ladder was obscured by a tree. When Claimant reached the top of the ladder, he grabbed his safety harness to hook it to the suspension wire, he shifted his weight and fell 25 feet because the ladder was not hooked on the suspension line.
2. Outcome: The court ultimately found that the Claimant did not recklessly violate the employer's safety policy because he did not intentionally not hook the suspension wire, it wasn't until he fell that he realized it was not hooked.

VI. Alcohol and Drug Rule Violations (intoxication or impairment defenses)

A. The employer shall not be liable when the injury was contributed to by the employee's use or consumption of alcohol or any drugs

1. If the medication was prescribed by a healthcare provider, compensation shall not be denied if the employee can show that the drugs or medications were being taken or used in therapeutic doses and there have been no prior incidences because of impairment from the drugs or medications within the last 24 months.

B. It will be conclusively presumed that the employee was impaired due to alcohol or drugs if they exceed the listed amounts below:

Drug	Quantity test cutoff levels
Alcohol	.04 or more
Marijuana	15 ng/ml
Cocaine metabolite	150 ng/ml
Morphine	2000 ng/ml
Codeine	2000 ng/ml
6-Acetylmorphine	10 ng/ml
Phencyclidine	25 ng/ml
Amphetamine	500 ng/ml
Methamphetamine	500 ng/ml

C. The employee may overcome the presumption that their impairment caused the injury by clear and convincing evidence.

D. An employee's refusal to submit to a chemical test at the request of the employer shall result in the forfeiture of benefits if the employer had sufficient cause to suspect the

use of alcohol or drugs by the claimant or if the employer's policy clearly authorizes post-injury testing.

VII. Case Examples of Alcohol and Drug Violations

A. *Gary L. Woessner v. Labor Max Staffing and XL Specialty Insurance Company*, 312 Kan. 36 (Kan. 2020)

1. What happened: The claimant fell 15-feet from a jobsite catwalk for no apparent reason and died. When an autopsy was performed the Claimant had 189 ng/ml of marijuana metabolized in his system.
2. Outcome: The Court looked at evidence of others working with the Claimant that day who stated the Claimant did not seem to be impaired and was generally a good worker. Additionally, the employer's expert could only testify that there was marijuana in the Claimant's system, not the level of the impairment. With this evidence the Court found that it was likely the Claimant's impairment did not contribute to his accident.

B. *Gideon v. Yost Properties and FirstComp Insurance Company*, 322 P.3d 1026 (Kan. Ct. App. 2014) (unpublished opinion)

1. What happened: The Claimant was directed to repair the roof of one of Yost's buildings. While on the roof he fell through the roof and sustained injuries to his back and arm. At the hospital he tested positive for cocaine, THC and had a blood alcohol level of 0.095. Claimant admitted to drinking beer earlier in the day before the accident and the positive drug test indicated he had cocaine within the last three days and THC within the last seven days.
2. Outcome: The Court ultimately found that the Claimant did not fall through the roof because he was impaired but rather because it was a rotting roof. A sober person would have fallen through the roof just as an impaired person did. The Claimant's impairment did not contribute to the injury and therefore he could recover.

C. *Wiehe v. Kissick Construction Company and Builders Mutual Casualty*, 43 Kan. App.2d 732 (Kan. Ct. App. 2010):

1. What happened: The Claimant was operating a sheep's foot roller; he was trying to flatten a large mass of dirt and it tipped over and he was ejected out of it. A co-worker watched as the Claimant tried to flatten the dirt and thought the mass was too large for the machine and testified that a reasonable operator would not try to roll over that mass of dirt in a sheep's foot roller. Another worker noticed the claimant acting strange that day before the accident happened. The claimant suffered multiple injuries including pelvic injuries and was hospitalized. Claimant was tested for drugs and alcohol after the accident and had a level of 62 ng/ml of marijuana in his system and his preliminary testing indicated a presence of methamphetamine, but not the final test results.

2. Outcome: The Court ultimately found that the way the claimant behaved that day by trying to roll the machine over a large mass of dirt, when no other experienced operator would have behaved that way, showed that claimant lacked the proper judgment because of his marijuana impairment.

I. Medical Information

A. Temporary or Permanent Accommodations
   1. Restrictions
   2. Maximum medical improvement
   3. Ratings
      a. Make sure the correct standard for the rating was used
      b. 6th edition is used as a starting point and then medical examiner should consider all relevant medical material

B. Employee's performance and communication with Employer
   1. Different than what they are telling the doctor?

RECENTLY ASKED QUESTIONS IN KANSAS

FROM ISSUES ADDRESSED IN RECENT KANSAS CASES

Q: Should vacation and holiday pay be included in calculating an injured workers' Average Weekly Wage?

A*: It depends on the date of accident.*

Gricelda Navarette sustained injuries in October 2017 while working for Tyson Fresh Meats, Inc. When applying for workers compensation benefits, Navarette sought to have her vacation and holiday pay included in determining her average weekly wage (AWW).

The Court of Appeals determined vacation and holiday pay should not be included in AWW calculations. The Court cited *Bohanan* and *Fuller.* In *Bohanan*, the Court indicated that under the statutory definition of wages, vacation and sick leave do not constitute 'money.' The only way for vacation and sick leave to be included in the AWW is if they constitute 'additional compensation.' K.S.A. 44-511(a)(2) states that additional compensation 'shall include and mean only' the items listed in the statute. Vacation and sick leave are not listed in K.S.A. 44-511(a)(2) and do not constitute 'remuneration for services in any medium other than cash.' In *Fuller*, the court reiterated the holding of *Bohanan* and held "the terms 'wage', 'additional compensation', and 'money' as defined in 44-511(a) did not include pay for vacation and sick leave. Based on the foregoing, the court held that vacation and holiday pay should not be included in determining AWW.

It is worth noting that K.S.A. 44-511 has since been amended by 2024 changes to the Kansas Workers' Compensation Act. The statute now specifically states "money" shall be construed to mean the gross renumeration, on an hourly, output, salary, commission, or other cases while employed by the employer, <u>including sick, vacation or other paid time off</u>, bonuses and gratuities. Based on this revision of the statute, sick leave and vacation can now be included in the calculation of an employee's AWW for all injuries after July 1, 2024.

Navarrete v. Tyson Meats, 2024 WL 504076 (Kan. Ct. App. 2024)

Q. If the claimant is injured on the first day of the job, is the AWW determined by looking at the 26 weeks of preinjury wages of a similar employer?

A: No, the Court may consider pre- or post-injury wages to determine the worker's AWW.

Mark Farmer sustained injuries to his right arm while working for Southwind as an Evening Tower Hand on April 4, 2019. Farmer was injured on his second day on the job. A wage increase went into effect at Southwind on January 4, 2019, raising the hourly wage from $15.00 per hour to $21.00 per hour.

The ALJ determined the claimant's AWW was $634.16 based upon wages of similar employees in the 26 weeks preceding the work injury.

The Board disagreed with this finding and instead used the wages Farmer could have reasonably expected to earn in the week following his injury if he had not been injured. Based on this, the Board found Farmer's AWW was $1,092.00. The Court determined K.S.A. 44-511(b)(2) grants the finder of fact wide latitude to consider pre- or post-injury wages to determine the worker's AWW. Subsection (b)(2) only applies to cases where the worker was injured in the first week of employment. The ALJ is directed to consider "all of the evidence and circumstances" including "the usual wage for similar services paid by the same employer" not to exceed the wage the employee "was reasonably expected to earn." Despite the ALJ being granted wide latitude, the Board disagreed with the ALJ's analysis. The Court held that the evidence concerning what Farmer would have earned the week immediately following his injury, if he had not been injured, was "more representative" of what Farmer "could reasonably expect to earn" for an AWW.

Farmer v. Southwind Drilling, 539 P.3d 1056 (2023)

Q: Whether the AMA Guides, 6th Edition should be considered exclusively in determining impairment for scheduled injuries?

A: No. In *Weaver*, the ALJ declined to consider any ratings that were not based strictly on the *AMA Guides, 6th Edition*. The ALJ held that K.S.A. 44-510d(b)(23) requires the Court to apply the 6th Edition when determining impairment for a scheduled injury, thus "competent medical evidence" is not to be considered.

The Court of Appeals emphasized that "functional impairment" in the Workers' Compensation Act has always required that it be established by competent medical evidence. This logic applies for both scheduled injuries under K.S.A. 44-510(b)(23) and non-scheduled injuries under K.S.A. 44-510e(a)(2)(B). Therefore, in determining impairment for scheduled injuries, the fact-finder should begin with the 6th Edition as starting point and consider competent medical evidence to modify or confirm the rating.

Weaver v. Unified Govt. of Wyandotte Cnty., 539 P.3d 617 (Kan. App. 2023)

Q: May a Claimant modify an Award seeking PPD benefits when she failed to present any evidence of PPD at the Regular Hearing?

A: No, Kimberly Jackson testified during a Preliminary Hearing on May 23, 2018, her injury was not compensable under the Workers' Compensation Act because the injury was caused by an assault during an unpaid lunch hour. During a final hearing on January 29, 2019, the ALJ stated that the only issues to be decided were whether Jackson's injuries were compensable under the Act. Jackson presented no evidence about any dispute regarding benefits and her counsel indicated that they were simply asking the ALJ to find the case non-compensable. For that reason, they did not submit any medical evidence.

With the only evidence being a deposition from Jackson taken in 2018, the ALJ ruled that the injuries were compensable under the Act but awarded no PPD benefits or future medical because none were requested. Jackson appealed to the Board. However, the only issue Jackson appealed was whether the injury arose out of the course of employment. She did not appeal anything regarding benefits or a disability determination. The Board upheld the ALJ's Award. After denial by the Board, Jackson requested a review and modification of the Award under K.S.A. 44-528(a). She sought modification on the grounds that her Award was inadequate and that her PPD had increased.

The ALJ and Board denied her request for modification of her workers' compensation Award. The ALJ and Board held that Jackson failed to show "good cause" as a threshold requirement under K.S.A. 44-528(a) for modification of her award and denied her request.

The Court of Appeals agreed. The Cour stated modification of a workers' compensation award is governed by K.S.A. 44-528(a). The subsection provides that any award may be reviewed by the ALJ "for good cause shown" upon application of the employee. After review and a hearing, the ALJ may then modify the award. The provision was designed for the situation in which a worker gets considerably better or worse following an award. The Court held that Jackson had failed to present any evidence as to why good cause existed to review her appeal and that she was using the review and modification proceeding to present evidence that should have been presented at the regular hearing. The court stated that "to allow what amounts to a do-over here would both deviate from that rule and stray far from the purpose of K.S.A. 44-528(a) as a check on the vagaries of medical prognostication."

Jackson v. Johnson Cnty., No. 126,441, 2024 WL 3075674 (Kan. App. June 21, 2024)

Q: Whether a claimant's testimony alone that they received a functional impairment rating in a prior workers' compensation case is sufficient evidence to establish an offset under K.S.A. 44-501(e)?

A: No. On March 11, 2020, Cregger suffered a left tibial plateau fracture near the knee. He also complained of back and right knee pain after the accident. In a discovery deposition and hearing, Cregger testified that in 1996, he suffered bilateral fractures to both tibias in a work-related accident. Claimant settled the 1996 claim for 28% permanent partial impairment to the body as a whole. Following a Regular Hearing for the 2020 claim, the ALJ determined the claimant sustained 19% permanent partial impairment to the body as a whole. However, he found the award was subject to an offset under KSA 44-501(e)(1) given the prior finding of 28% permanent partial impairment to the body as a whole.

Claimant appealed arguing the offset was inappropriate because the 28% impairment from the 1996 injury was not based on substantial competent medical evidence. The Board reversed, finding that there was no evidence showing the 1996 and 2020 injuries were to the same body parts. More specifically, the only evidence of a pre-existing

condition was the claimant's testimony and there was no information provided as to what body parts were rated or how they were rated individually and converted to a 28% total body rating. The Fund appealed, arguing that Cregger's testimony was substantial competent evidence to support offset of his new award.

The Court of Appeals upheld the Board's decision finding a claimant's testimony alone that they received a functional impairment rating in a prior workers' compensation case is insufficient evidence to establish an offset under K.S.A. 44-501(e). Medical evidence must be furnished by the Respondent showing that the injuries are related.

Cregger v. CLW Farms, Inc., 548 P.3d 387 (Kan. App. 2024)

Q: If an injured worker refuses a drug test after an accident, and the employer's policy clearly states post-accident drug testing is required, does the claimant forfeit workers' compensation benefits?

A: Yes. Claimant, a truck driver, alleged repetitive injury to his back from driving.

A policy included in the Employer's Member Handbook stated, "future drug and alcohol tests are required if Members are injured on the job, are involved in an injury on the job, appear to be under the influence, or are involved in an accident where Company property is damaged."

Claimant was referred to Cotton O'Neil. He was advised he was not allowed to leave the building due to the need for a drug test. However, Claimant left the clinic prior to undergoing the drug test.

The Board indicated that the case hinged on whether the claimant refused drug testing under the parameters of K.S.A. 44-501(b)(1)(E). The statute states a worker's refusal to submit to a chemical test at the request of the employer results in forfeiture of benefits under the Workers' Compensation Act if the employer had sufficient cause to suspect the use of alcohol or drugs by the claimant or if the employer's policy clearly authorizes post-injury testing.

The Board concluded the claimant clearly refused a drug test which was authorized under the employer's policy. Therefore, Claimant forfeited all benefits available under the Kansas Workers' Compensation Act by willingly refusing to submit to a post-accident drug test clearly authorized by the respondent's policy.

Scott Suitter v. Johnsonville Sausage, 2024 WL 959458 (Kan. Work. Comp. App. Bd. 2024)

Q: Should Claimant's ongoing and future medical treatment be paid from the proceeds of settlement of a medical malpractice suit in accordance with K.S.A. 44-504?

A: Yes. Claimant sustained a compensable back injury on April 30, 2014. He underwent surgical intervention. On October 2, 2016, he presented to Geary Community Hospital

ER with urinary complaints. The evaluating physician felt the claimant's symptoms were the result of prostate issues and/or medication use. Claimant underwent surgery three days later to treat cauda equina syndrome or swelling around the nerve roots in the spinal column.

Claimant settled the underlying workers compensation on claim on April 17, 2018, leaving open future medical benefits. After settlement, claimant pursued a medical malpractice claim against the Geary Community Hospital ER physician alleging he was not properly diagnosed which led to delay in diagnosis and surgery three days later. The medical malpractice claim settled for $800,000.

Claimant later requested medical treatment to be paid by Respondent. The ALJ determined the claimant's treatment should be paid out of the settlement proceeds from his medical malpractice settlement until those proceeds have been exhausted.

"K.S.A. 44-504 states if there is an injury, payable under workers' compensation, caused by circumstances creating a legal liability from a third party, the injured worker has the right to pursue a remedy against the third party. If there is recovery from the third-party claim, the respondent in the workers' compensation case shall have subrogation rights for benefits already paid and a credit for future benefits, including additional medical treatment. There are no limits on what portion of recovery is subrogated or credited to respondent, except for loss of consortium or loss of services of a spouse and attorney fees and expenses."

The Board affirmed the ALJ's decision and found Respondent's subrogation lien was intact. As such, the Respondent was excused from paying any medical bills until the medical malpractice settlement proceeds were exhausted.

Justin Rumbaugh v. DIRECTV, 2023 WL 8440385 (Kan. Work. Comp. App. Bd. 2023)

Q: Can an injured worker who accepted a job in Kansas with an employer based in Montana establish Kansas jurisdiction?

A: Yes. Claimant who lived in Kansas was offered a job from a Montana employer. Claimant accepted the job in Kansas by signing a letter of acceptance and faxing the signed letter to the employer in Montana. She then relocated to Montana completing new hire paperwork in Montana.

On November 7, 2017, claimant fractured her right ankle. She received medical benefits in Montana. However, she relocated back to Kansas and sought benefits under the Kansas Workers' Compensation Act. The Kansas Workers' Compensation Fund argued there was no Kansas jurisdiction as the contract for employment was not complete until claimant completed the new hire paperwork in Montana.

The ALJ and Board disagreed and found jurisdiction under the Kansas Workers' Compensation Act pursuant to K.S.A. 44-506 which confers coverage under the Act

where the contract of employment was made within the state. The Board found Claimant's act of faxing the signed contract letter to Respondent from Kansas was the last act necessary for the formation of an employment contract. As such, the contract for employment was made in Kansas. Completing the new hire paperwork was a condition subsequent to the completion of the contract, not a condition precedent as was argued by the Fund. Therefore, Kansas had jurisdiction over claimant's workers' compensation claim.

Linda S. Henretty v. Health Center Northwest, 2023 WL 9106064 (Kan. Work. Comp. App. Bd. 2023)

Q: Did the claimant recklessly violate the employer's safety rules and regulations pursuant to K.S.A. 44-501(a)(1)(D) when he failed to remain at least an arm's length from a running machine?

A: Yes. The claimant knew he was supposed to remain an arm's length from running machinery but got too close and was injured. K.S.A. 44-501(a)(D) states compensation for an injury shall be disallowed if such injury results from: the employee's reckless violation of their employer's workplace safety rules or regulations." Recklessness contemplates something beyond ordinary negligence or carelessness. To show that a claimant acted with recklessness, the preponderance of the evidence must support conscious disregard of a known or obvious risk that exceeds negligence. "Recklessness is akin to gross, culpable or wanton negligence, but is a lesser standard than intentional conduct."

The ALJ found the claim compensable and ordered medical treatment and TTD benefits. Respondent appealed and the Board reversed the ALJ's ruling and found the claimant recklessly violated Respondent's workplace safety rule because his behavior was deliberate and indifferent to a high degree of harm. In coming to this conclusion, the Board cited several cases denying benefits to a claimant who reached into a running machine contrary to safety rules.

Pastran Garcia v. Packers Sanitation Services, 2024 WL 448559 (Kan. Work. Comp. App. Bd 2024)

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)

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ILLINOIS WORKERS' COMPENSATION

I. JURISDICTION

A. Illinois jurisdiction is appropriate when:

1. The petitioner is injured in Illinois, even if the contract for hire is made outside of Illinois;
2. 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
3. The last act necessary to complete the contract for hire was made in Illinois.

II. COMPENSABILITY STANDARD

A. Accident or accidental injury must arise out of and in the course of employment.

B. Accident arises out of the employment when there is a causal connection between the employment and the injury.

C. Three types of risks include: (1) an employment risk; (2) a personal risk; or a (3) neutral risk

1. *McAllister* Supreme Court decision held everyday activities can be considered an "employment risk" and therefore compensable without utilizing a "neutral risk" analysis.

D. Injury must be traceable to a definite time, place, and cause.

E. *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.

1. 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.

1. 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

A. Statute of Limitations

1. Petitioner must file within three years after the date of accident, or two years after the last compensation payment, whichever is later.
2. In cases where injury is caused by exposure to radiological materials or asbestos, the application must be filed within 25 years after the last day that the petitioner was exposed to the condition.

VI. AVERAGE WEEKLY WAGE (AWW)

A. General Rule: Divide the year's earnings (52 weeks) of the petitioner by the number of weeks worked during the year.

1. *e.g.*, Sum of wages for 52 weeks prior to the accident = $40,000.

   $40,000/52 = $769.23.

B. If petitioner lost five or more calendar days during a 52-week period prior to the accident, then divide the annual earnings by the number of weeks and portions of weeks the petitioner actually worked.

1. e.g., Sum of wages for 52 weeks prior to the accident = $30,000 but petitioner missed 10 days = $30,000/50 = $600.00.

C. If petitioner worked less than 52 weeks with the employer prior to the injury,divide amount earned during employment by number of weeks worked.

1. e.g., Petitioner worked 30 weeks and earned $20,000 during this time

   $20,000/30 = $666.66.

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

E. Overtime: Overtime is excluded from AWW computation unless it is regular or mandatory.

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

F. When calculating a truck driver's AWW, the only funds to be considered are those that represent a "real economic gain" for the driver. *Swearingen v. Industrial Commission*, 699 N.E.2d 237, 240 (Ill. App. 5th Dist. 1998).

1. Petitioner's gross earnings for the 52 weeks prior to the date of loss including all earnings made per mile are divided by 52 to determine the AWW. However, any monies that the driver uses to pay for taxes, fees, etc., are not included in the gross earnings, as they do not represent real economic gain.

VII. BENEFITS AND CALCULATIONS

A. Medical Treatment — Pre-2011 Amendments: Petitioner may choose the health care provider, and the employer/insurer is liable for payment of:

1. First Aid and emergency treatment.
2. Medical and surgical services provided by a physician initially chosen by the petitioner or any subsequent provider of medical services on the chain of referrals from the initial service provider.
3. Medical and surgical services provided by a second physician selected by the petitioner (2nd Chain of Referral).
4. If employee still feels as if they need 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.
   a. The PPP only applies in cases where the PPP was already approved and in place at the time of the injury. Petitioners must be notified of the program on a form promulgated by the Illinois Workers' Compensation Commission (IWCC).
2. Under the PPP, petitioners have 2 choices of treatment providers from within the employer's network. If the Commission finds that the second choice of physician within the network has not provided adequate treatment, then the petitioner may choose a physician from outside the network.
3. Petitioners may opt out of the PPP in writing, at any time, but this choice counts as one of the employee's two choices of physicians.
4. If a petitioner chooses non-emergency treatment prior to the report of an injury, that also constitutes one of the petitioner's two choices of physicians.

C. Medical Fee Schedule—Illinois Legislature created a Medical Fee Schedule that enumerates the maximum allowable payment for medical treatment and procedures.

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

D. Temporary Total Disability (TTD)

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

F. Permanent Partial Disability (PPD)

1. 60% of AWW
2. See rate card for value of body parts
3. Minimum PPD rate is 2/3 (subject to 10% increase for each dependent) of Illinois minimum wage or Federal minimum wage, whichever is higher—as of 01/01/24, the Illinois minimum wage is higher ($14/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, head, and mental/psych 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 to the pre-2006 level of 190 weeks. The maximum award for the loss of the use of a hand in carpal tunnel cases was previously 205 weeks. For all hand injuries not involving carpal tunnel syndrome (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 can prove greater disability by clear and convincing evidence.
2. If the petitioner can 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. Must be to hand, head, face, neck, arm, leg (only below knee), or chest above the armpit line.
2. Maximum amount is 150 weeks if the accident occurred before 07/20/05 or between 11/16/05 and 01/31/06.
3. Maximum amount is 162 weeks if accident occurred between 07/20/05 and 11/15/05 or on or after 02/01/06.
4. Disfigurement rate is calculated at 60% of AWW.
5. A petitioner is entitled to *either* disfigurement or permanent partial disability for a specific body part, not both.

K. Death

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

L. Permanent Total Disability

1. Only arises when the petitioner is completely disabled which means the petitioner is permanently incapable of work.
2. Statutory PTD
    a. Statutory PTD arises when: loss of both hands, arms, feet, legs, or eyes.
    b. Employee receives weekly compensation rate for life, or a lump sum (based on life expectancy)
    c. PTD payments are adjustable annually at the same percentage increase as that which the state's average weekly wage increased, but this is capped at the maximum rate.

3. Odd-Lot PTD
    a. A petitioner who has disability that is limited in nature such that he or she is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the petitioner may fall into the odd-lot category of permanent total disability.
    b. The petitioner must establish the unavailability of employment to a person in his or her circumstances.
    c. The petitioner must show diligent but unsuccessful attempts to find work, or that by virtue of the petitioner's medical condition, age, training, education, and experience the petitioner is unfit to perform any but the most menial task for which no stable labor market exists.
    d. Once the petitioner establishes that he or she falls into this odd-lot category, then the burden of proof shifts to the respondent to show the availability of suitable work.

M. Vocational Rehabilitation

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

N. Maintenance

1. Not technically TTD.
2. A component of vocational rehabilitation.
3. Maintenance is paid once claimant at MMI and undergoing vocational rehabilitation or a self-direct job search.
4. Two common situations:
    a. When petitioner is undergoing formal vocational rehabilitation or a self-directed job search) and has been placed at MMI, maintenance picks up (at the TTD rate) similar to a continuation of TTD.

b. When employee has completed a vocational rehabilitation program and has yet to be placed in the labor market.

O. Wage Differential

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

P. Ratings

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

VIII. PREFERRED PROVIDER PROGRAM

A. The 2011 Amendments to the Workers' Compensation Act amended Section 8(4)of the Act to allow employers to establish preferred provider programs (PPP) consisting of medical providers approved by the Department of Insurance.
   1. The PPP only applies in cases where the PPP was already approved and in place at the time of the injury.
   2. 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.
   1. 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(s) 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
   a. 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, meals, and wages from days of work missed
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 redline," 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.
    a. This request must be served on opposing counsel 15 days before the status call.
    b. At the status call, the attorneys will select a time to pre-try the case.
    c. 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.
    a. 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.
    b. 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.
    a. Future medical benefits can only be closed through a settlement agreement.

D. Appellate Procedure

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

X. PENALTIES RELATING TO ACTIONS OF EMPLOYER/INSURER

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

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

1. For accidents *before* September 1, 2011, if the court finds that accident occurred because of intoxication then injury is not compensable.
    a. Intoxication not per se bar to workers' compensation benefits.
    b. Intoxication will preclude recovery if it is the sole cause of the accident or is so excessive that it constitutes a departure from employment.
2. For accidents on or after September 1, 2011, the Amended Section 11 of the Act provides that no compensation shall be payable if:
    a. The petitioner's intoxication is the proximate cause of the petitioner's accidental injury.
    b. At the time of the accident, the petitioner was so intoxicated that the intoxication constituted a departure from the employment.
    c. 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.
    d. The petitioner can rebut the presumption by proving by a preponderance of the evidence that the intoxication was not the proximate cause of the accidental injuries.

B. Unreasonable/Unnecessary Risk

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

C. Fraud

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

XII. WORKERS' OCCUPATIONAL DISEASES ACT

A. Covers slowly developing diseasesthat do not arise out of an identifiable accident or occurrence but not repetitive trauma.

1. Occupational Disease – “A disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment.”
2. Exposure can be for any length of time (even if very brief).
3. 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).
4. Petitioner must prove he was exposed to a risk beyond that which the general public experiences.
5. Applies only to diseases that are “slow and insidious”
   a. e.g., kidney ailment cause from repetitive exposure to liquid coolant.
   b. 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 recover 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.

1. e.g., Waitresses arguing over tables and the argument turns physical when one waitress strikes the other—this is compensable.

XVI. MINORS (UNDER 16 YEARS OF AGE)

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

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

XVII. VOLUNTARY RECREATIONAL PROGRAMS

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

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

XVIII. SECOND INJURY FUND

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

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

ILLINOIS WORKERS' COMPENSATION 201

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

A. Case Numbers & Docket / Arbitrator Assignments

1. Once an Application for Adjustment of Claim (Application for Benefits) is filed with the Commission, the case is assigned a case number and to an arbitrator's docket location.
    a. The docket site is usually within the vicinity of where the injury occurred or where the petitioner resides.
2. Cases appear on the docket for status hearings on three-month intervals until the case has been on file for three years, at which time it is considered above the "redline."
    a. 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 docket call date.
    b. 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 between the three docket sites within that zone on a monthly basis.
    a. 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.
    b. A 19(b) hearing request must be electronically filed at least 15 days before the date of the docket call or status hearing.
    c. Parties must undergo a virtual Pre-Trial Conference prior to any case being set for hearing – including 19(b) hearings.

B. Pro Se's

1. Once the petitioner indicates a willingness to settle their case, the insurer/employer can request a case number to be assigned by the Commission.
2. The petitioner and insurer/employer will 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 amount of benefits due and payable.
3. A delay in payment of benefits greater than 14 days shall be considered "unreasonable," but 19(k) penalties are discretionary rather than mandatory.
4. 19(k) penalties will likely not be awarded against an employer for not paying bills deemed unreasonable or unnecessary by a qualified IME or Utilization Review recommending against that prospective medical treatment.

D. Section 19(l) Penalties

1. May be assessed when TTD benefits are withheld "without good and just cause."
2. The Commission can award $30-per-day up to $10,000 for nonpayment of TTD benefits.
3. When the petitioner makes a written demand for TTD benefits, the insurer/employer must respond in writing within 14 days, setting forth the reason for delay.
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 the bill and the basis for nonpayment or underpayment.
    a. 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.
    b. 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 Attorney's Fees
   1. May be assessed when there is an unreasonable or vexatious delay or intentional underpayment of TTD or PPD benefits or medical bills, or the insurer/employer engages in frivolous defenses which to not present a real controversy.
   2. The Commission can award all or any part of the attorney's fees and costs against the insurer/employer.
      a. However, typically the Commission will award 20% of the penalties awarded under Section 19(k) above.

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

III. Utilizing the Limited Discovery & Investigation Tools

A. Section 12 IMEs
   1. The IME doctor can ask about the history/mechanism of injury, review medical records, and provide opinions on causation, additional treatment,restrictions, etc.
      a. The IME doctor can also provide an impairment rating.
         i. The Act requires the impairment rating be based on the most recent (*e.g.,* Sixth Edition) AMA Guidelines.
         ii. An impairment rating will be one of several factors considered by an arbitrator and Commission when awarding compensation for permanent disability.
   2. Can be used to avoid penalties (see above).
   3. Can also be used to ask the petitioner about his prior treatment, diagnosis,current complaints, etc.
   4. The insurer/employer must provide reimbursement for travel or travel arrangements prior to the IME date, otherwise the petitioner can refuse to appear for the IME.
   5. The insurer/employer must provide missed work wages, food, and potentially lodging expenses as well.

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

C. Prior claims filed by Petitioner
   1. Research prior settlements and claims previously received and filed by the petitioner on the Commission website.
      a. Credits can generally be taken by the insurer/employer for prior work injuries to scheduled body parts but not 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
   1. 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.
      a. 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.
   2. Allows the parties to argue their positions and obtain the arbitrator's opinion about issues, including causation, nature and extent, additional medical treatment, etc.
   3. Pre-Trials occur in front of the arbitrator assigned to the case, who will preside at trial if the parties are unable to resolve the case before then.

E. Depositions
   1. Cannot take the petitioner's deposition in Illinois.
   2. Can take the deposition of the IME doctor to help explain and elaborate on his opinions provided in the IME report.
      a. 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.
      a. 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.

b. The Commission determined the petitioner was not entitled to TTD after his refusal to attend the transitional, light-duty work assignment because he 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 terminate TTD benefits when they can offer transitional, light-duty work within the petitioner’s restrictions at another employer so long as they remain an employee of the employer (*e.g.,* subject to the employer’s policies, is paid by the employer, etc.).

B. Loss of Occupation

1. If the petitioner is unable to return to their former line of work, the arbitrator and/or Commission will likely award an increased PPD percentage to account for that.
   a. 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.
   a. The insurer/employer is required to provide weekly payments totaling 2/3 of the difference between their pre- and post-injury earnings capacity until they are 67 years old or 5 years from the date of the award, whichever is greater.
   b. Example: The petitioner earned $1000/week before the work injury, but now the petitioner can only earn $700/week after the work injury. The petitioner is entitled to $200/week until they reach 67 years old or 5 years after the date of the award, whichever is greater.

D. PTD & Odd Lot PTD

1. Arises only when the petitioner is completely disabled and/or unable to find any suitable employment anywhere.
2. Petitioner is entitled to 2/3 of his AWW for the rest of their life.
3. Odd Lot PTD is different from PTD, as it only arises when the petitioner has a disability that is limited in nature such that they are not obviously employable but can prove employment is unavailable to a person in their circumstances.
   a. 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.
   b. The insurer/employer can overcome this situation by showing availability of suitable work.

E. Vocational Rehabilitation
   1. When there is no dispute that the petitioner is unable to return to his prior job because of the work injury or the period of total incapacity exceeds 120 continuous days, the employer must prepare a written vocational rehabilitation plan.
   2. If there is a dispute, the arbitrator and/or Commission will look at whether: the injury caused a reduction in earnings capacity; vocational rehabilitation will increase their earnings capacity and the likelihood the petitioner will find suitable employment; the petitioner has sufficient skills to obtain employment without further training or education or has undergone similar rehabilitation program(s) in the past; and the petitioner's work-life expectancy.
   3. The insurer/employer must pay maintenance benefits when the petitioner is engaged in vocational rehabilitation or undergoing a self-directed job search and cannot return to his prior job or the employer cannot accommodate their restrictions.
      a. Maintenance is similar to TTD benefits but is a component of vocational rehabilitation and paid after the petitioner reaches MMI.
      b. The petitioner is not automatically entitled to maintenance benefits in situations where they cannot return to their prior job but do not undergo a self-directed job search or vocational rehabilitation program.

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

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

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

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

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

The claimant, Mr. McAllister, injured his right knee while at work. Specifically, the Claimant was looking for a pan of carrots that may have been left in the walk-in cooler. In the cooler, he knelt on both knees to search the top, middle, and lower shelves. As he stood up, he felt his right knee pop. The knee then "locked up" and he was unable to straighten his leg. Soon after, he informed his boss of the incident and his boss then drove him to the emergency room. This wasn't the first time he injured his right knee, however. In August 2013 the Claimant injured his right knee and underwent surgery to repair his injury. The Claimant received workers' compensation benefits, and after he had recovered, returned to full-time work duties.

Initially the claimant was awarded benefits. The Arbitrator found "that claimant's act of looking for the misplaced pan of carrots in the walk-in cooler was an act the employer reasonably could have expected of claimant to perform in order to fulfill his duties as a sous-chef." However, the Illinois Workers' Compensation Commission found that the injury did not "arise out of the claimant's employment" and reversed the decision. The Cook County Circuit Court affirmed the Commission's decision, and the Appellate Court, Workers' Compensation Division similarly affirmed the judgment. The Illinois Supreme Court agreed to hear the case.

There are three categories of risk:

1. Risks distinctly associated with the employment;
2. Risks personal to the employee;
3. Neutral risks which have no particular employment or personal characteristics.

The Court followed through the first step of risk analysis in determining whether the claimant's injuries arose out of an employment related risk. The Court found that the Claimant's injury did arise out of an employment related risk because the acts that caused his injury "were risks incident to his employment because these were acts his employer might reasonably expect him to perform…" Because the employee was responsible for arranging the walk-in cooler, the Court stated that he had a duty to find misplaced food that would have been in the cooler.

The court affirmed the *Caterpillar Tractor* test for analyzing whether an injury "arises out of" a claimant's employment when the claimant is injured performing job duties that involve common bodily movements or routine "everyday activities." If the risk of injury falls

within one of the three categories of employment-related acts, then it is established that the injury "arose out of" the employment.

McAllister v. Illinois Workers' Compensation Commission, 181 N.E.3d (Ill. 2020)

Q: If a traveling employee falls downstairs while at work, does the injury arise out of and in the course of his or her employment?

***A:* Most likely, yes.**

The Claimant worked for the Town of Cicero. Every morning at 7:30 and throughout the day, he would visit the town hall to retrieve his work phone and download his assignments for the day. To access his office, he would use the south stairwell. On July 2, 2018, the Claimant was leaving his office after retrieving what he needed for the workday. As he exited the building to access his Cicero-provided vehicle, he began descending the south stairwell as usual when his right foot slipped off the edge of the second-floor landing, causing him to fall down the stairs. As he fell, the right side of his body, right side of his head, his right shoulder, neck, back and left shoulder became injured.

A traveling employee is one who is required to travel away from an employer's premises in order to perform their job, making travel an essential element of their job duties. Here, traveling to town hall to retrieve his work phone, download his assignments, and obtain his Cicero-provided vehicle were all part of his job duties as a traveling employee. On the day of the accident, the Claimant had already picked up his work phone and downloaded his assignments when the accident occurred. Ultimately, the Court explained the Commission's finding that the employee descending downstairs after retrieving the phone and downloading his assignments was reasonable and foreseeable and incidental to his job as a blight inspector. As such, the Commission's decision was affirmed and the employee's injuries were determined to arise out of and in the course of his employment.

Town of Cicero v. Illinois Workers' Compensation Comm'n (Michael Iniquez) 2024 IL App (1st) 230609WC (April 2024; unpublished)

Q: If a Claimant is injured at work and completes treatment for that injury, but alleges he remains in pain and waits months to seek additional treatment, is the amount of time Claimant waited to receive treatment given significant weight?

***A:* Yes, by delaying additional treatment after undergoing treatment sanctioned by the Employer, the Court explained that the temporal gaps significantly undermined Claimant's credibility.**

While working as a shipping and receiving clerk, Claimant was trying to pull orders and fell from a ladder. As he fell, his right foot became caught between a wall and two pallets, causing him to fall backwards with his foot trapped, injuring his right ankle. He was given crutches and an air cast by an urgent care center, which according to Claimant caused him to walk with his right foot "splayed to the right" which caused issues with his knees and then his hips. Claimant stated his right knee hurt first, and he compensated by putting more weight on his left leg. Eventually, his left knee began to hurt more. After a ligament

reconstruction of his right ankle and physical therapy, Claimant returned to work. Seven months later, he was prescribed a custom orthotic, and underwent injections for hip pain, which reportedly did not help. Soon he learned that both hips demonstrated labral tears. Of note, Claimant had surgery in 1997 for a herniated disc, which Dr. Chilelli (who had given him hip injections) believed was the cause of his symptoms. Claimant then saw Dr. Burgess for a second opinion on his ankle as he had been experiencing continuing pain. Dr. Burges found that Claimant had mild ankle arthritis, instability, and possibly an osteochondral lesion. A year later he returned to Dr. Burgess complaining of knee and hip pain and Dr. Burgess agreed that Claimant should continue using the brace he had been using for the last few years and that there was a compensatory mechanism given the altered gait he presented with, therefore opining that the condition of Claimant's knee and hip were causally related to his work accident. A Dr. Vora examined Claimant on behalf of Employer who diagnosed Claimant with anterior ankle impingement with osteophyte, medial gutter osteophyte, and early ankle arthritis. He explained that these were chronic degenerative conditions that could have been aggravated by the accident and that they were not caused by the accident. Dr. Vora also stated Claimant was not at MMI. Of note, Dr. Vora could not define what a reasonable degree of medical certainty was and described it as more than 51%. Dr. Nho, another doctor for Employer examined Claimant stating that there was no causal relationship between Claimant's reported knee and hip pain and his work injury because the pain began about five years after the original injury. He also opined that claimant was at MMI as of Feb. 25, 2019. The arbitrator awarded Claimant PPD benefits but denied his claim for medical expenses and prospective medical expenses.

After the Commission and Circuit Court of Kane County denied Claimant's claims for compensation for additional injuries and medical expenses, Claimant appealed to the Appellate Court of the Second District.

The Claimant asserted that the Commission created a new doctrine by finding the fact that Claimant did not seek treatment for 7 months following his full duty return to work is an unwarranted assault on his credibility. The Court indicated that this was in no way an act of creating a new doctrine, but simply drawing a factual inference. Ultimately, this understanding of the temporal gaps benefits defenses of claims in which the Claimant alleges continuing injury after returning to work full duty, as neither the Commission, nor the Court of Appeals, found the arguments of the claimant persuasive in any way.

Osman v. Illinois Workers' Compensation Comm'n 2024 IL App (2d) 230180WC

Q: If a Claimant's injury is considered a non-scheduled loss, does it preclude recovery in other cases per the statute?

A: No, recovery in other cases is not precluded.

Claimant was working as a longwall shear operator until November 5, 2016, the date of the accident. While working for his employer he became "caught in between the 20-ton chunk of steel equipment and the coal block, and it squished him in the stomach to the

point of passing out." His injuries included damage to his spine, hip, abdomen, permanent blindness in both eyes, and to his head (anxiety, depression, and PTSD). These injuries required Claimant to undergo numerous surgical procedures-many of which were very serious and invasive.

The decision of the Illinois Workers' Compensation Commission was affirmed by the Circuit Court of Franklin County, awarding the claimant benefits. Employer appeals.

The Court followed the reasoning of *Beelman Trucking* in which the Court held that the words "total" and "permanent" do not indicate a maximum benefit or a cap on benefits for injuries sustained in a single accident.

Ultimately, the court explained that it would be against Supreme Court precedent to leave additional losses uncompensated where the additional losses above and beyond the specific case of loss of two member increased the Claimant's actual disability and further impaired the Claimant's earning capacity. The Court held that the Act permits an employee to recover for the loss of two members under section 8€(18) as well as to recover additional non-scheduled losses under section 8(2)(d).

American Coal v. Illinois Workers' Compensation Comm'n 2024 IL App (5th) 230815WC

Q: If a Claimant has a bad back with previous known injuries and could have reinjured the back with normal daily activities, but presents evidence of new symptoms following a workplace injury, is the employer still liable to compensate?

A. Most likely, yes.

A police officer was responding to a domestic violence call where he was required to essentially wrestle a resident to the ground for roughly 3-5 minutes. During this altercation, the Officer alleged to have injured his back, reporting pain unlike any experienced previously. Of note, the Officer had long standing preexisting back pain and a softball injury that had occurred months before the accident date. In fact, he had been given an injection only weeks before the accident date. Employer presented conflicting medical opinions of Dr. Hsu and Dr. Racenstein. Hsu opined that the Officer sustained a temporary injury on the accident date which resolved shortly after and his need for surgery did not relate to the work accident. Dr. Hsu and Dr. Racenstein both opined that there were no significant changes to the MRIs taken of the Officers back before and after the accident. Following a softball injury he had received an MRI, and another after the accident in December. Alternatively, the Commission found more persuasive the opinions of Dr. Karahalios and Dr. Ghaly. Dr. Ghaly's records reflected his recommendation of surgery because of the Officer's increased disc herniation. Dr. Karahalios recommended surgery, in part, because of the Officers new left sided symptoms.

The Commission found claimant sustained an injury that arose out of his employment. The Circuit Court found claimant sustained an injury that arose out of his employment. Appellate Court (2 Dist.) Workers' Compensation Commission Division affirmed the Commission and the Circuit Court.

The Commission's ruling was affirmed. Even though evidence demonstrated that the Officer's back condition could be triggered by activities of normal daily living, the evidence demonstrated that the Officer's back condition was aggravated when he attempted to restrain an individual at work, and that his pain and symptoms worsened after the accident. "The evidence demonstrated that the claimant's low back condition was caused, in part, by his act of restraining an individual at work, not an activity of daily living."

Excerpt from:
Howard Ankin, City of Aurora v. Illinois Workers' Compensation Commission, Workers' Compensation Law Newsletter, Illinois State Bar Association, Vol. 61 No. 4 (April 2024).

> "Employer challenged the decision as a Sisbro exception, feeling it proved the officer's health was so deteriorated that any normal activity of his is an overexertion. Here, the employer showed its employee was actively treating for a softball injury and had just received two injections and was scheduled to be back to the pain doctor at the time of the work accident. Surgery was already prescribed. Strongly advocating that the employer was not responsible to pay for the surgery as related to a pre-existing condition and/or a pre-existing condition that was so symptomatic that any turn or twist would have caused the need for surgery. The employer retained two experts advocating this point. Thus, illustrating that this City of Auora case shows the limitation or exception to Sisbro as to causation is such a high-water mark to achieve that it is only theoretical and virtually impossible to prove as a defense under Illinois law."

City of Aurora v. Illinois Workers' Compensation Comm'n, 2024 WL 327214 (Ill. App. 2 Dist., 2024)

Q: Does a Claimant lose credibility if he waits until after being terminated to report a workplace injury.

A: Yes. Claimant was a truck driver who alleged two injuries. Claimant alleged first he was injured while lifting heavy equipment on May 1, 2021 causing hernia/abdomen injury. Second, Claimant alleged that he had injured his back when falling backwards while getting out of his truck on February 2, 2022. Neither of these incidents were reported, even though Claimant was informed of the processes and importance of reporting injuries during orientation and, he himself was a supervisor that others could report injuries to. Claimant did not seek treatment until February 25, 2022. He was terminated from the company on February 16, 2022 for theft from the company through the misuse of his company credit card.

Claimant was not credible because he did not report the injury until after he was retaliated.

Jason Coca v. B&P Enterprises, Inc.

Q: If a Claimant is injured at work but does not report it or seek treatment until after vacationing and spending a period of time off work, will their credibility remain?

A: Most likely, no, especially when the injury is serious.

On December 17, 2017, Claimant was a pilot required to conduct pre and post-flight inspection routines. While performing an inspection, she slipped on deicing fluid, causing her to fall and injure herself. She continued working through this shift and did not report the injury to her employer. She worked another couple of days before going on a holiday break. During her break she went on vacation with her family. The accident was first reported 19 days after it occurred, on January 5, 2018. She was eventually diagnosed with a fractured patella. When asked why she did not seek treatment on the day of the accident, Claimant testified that because it was a Sunday it would have been too difficult to find a provider that was open.

The arbitrator found that the Claimant suffered a compensable accident arising out of and in the course of her employment. The Commission reversed this decision, and the Court of Appeals affirmed the Commission. Given the seriousness of a fractured patella and the fact that the Claimant alleges to have continued working for two days and then vacationed with family, the Commission and appellate court were similarly unpersuaded by the Claimant's delay in notice and seeking treatment. The Commission made significant determinations about Claimant's credibility, and the appellate court gave great deference to those findings.

Masters v. Illinois Workers' Compensation Commission

Q: Does an idiopathic injury necessitate the application of the risk analysis assessment from McAllister?

A: No. Claimant was a machine operator. Claimant experienced two injuries while working for Employer, the second of which was on December 2, 2011. On this date, Claimant slipped and fell off the platform, suffering injuries to her head and ribs, causing her to immediately lose consciousness. Of note, Claimant was diabetic, and testified to not having taken her medicine on the day of the accident and also consumed a sugary drink. However, she also testified that she was not feeling dizzy, weak, or tired, prior to the fall. When paramedics arrived, they determined that Claimant was exhibiting diabetic symptoms including lethargy, confusion, and being unable to answer their questions. Paramedics also did not observe any signs of physical trauma and were told by a witness that the Claimant had mentioned feeling thirsty and laid on the floor earlier. Claimant's doctor, Dr. Leong, opined that the Claimant's work accident was not caused by her diabetes.

Arbitrator found that although the incident occurred at her work location during work hours, she had failed to prove the existence of any work-related risk that contributed to an injury. The Commission found similarly, stating that no "accident" had occurred at all. The circuit court found that after analyzing the facts of the case under *McAllister*, the injury arose out of the Claimant's employment. With that said, the circuit court agreed with the

Commission's findings regarding Claimant's lack of credibility. Appellate court affirmed the circuit court's judgment.

The appellate court referred to *Stapleton v. Industrial Comm'n* and stated that if a claimant is injured as a result of an idiopathic fall, that is a fall due to the risk personal to the claimant, then such injuries are not compensable. "The appellate court explained that if the injuries are idiopathic in nature and employment conditions did not significantly contribute to the injury by increasing the risk of falling then the 'arise out of' prong is not satisfied." Ultimately, "If the injury sustained by the Claimant was idiopathic in nature, this would qualify as a personal risk, and the injury is not compensable under the Act. "Given that it is a personal risk, no employment related analysis is required under the Caterpillar test (*Caterpillar Tractor Co. v. Industrial Comm'n*. 129 Ill. 2d 52 (1989).

Juarez v. Illinois Workers' Compensation Commission, 2023 IL App (1st) 220684WC-U

Q: When should a wage-differential be used as opposed to PPD benefits?

A: In this case, Claimant was entitled to a wage-differential award as it was determined his earning capacity was reduced.

Claimant worked as a truck driver for Austin Tyler Construction Company loading and delivering materials such as asphalt, dirt, and stone. He was required to prepare and inspect his truck, which required him to climb in and out of the cab numerous times. On October 18, 2014, Claimant slipped and his foot landed in a pothole, causing injury in his foot. An MRI demonstrated torn tendons in his foot, and although surgery was recommended, Claimant opted for physical therapy in an effort to avoid surgery. Eventually, due to continuing and worsening pain and swelling, Claimant underwent surgery on May 19, 2016. Post-operatively, Claimant demonstrated very little improvement.

In June 2017, Claimant underwent a functional capacity evaluation which he was found to perform within the medium physical demand category. Austin Tyler provided him with accommodations such as a truck without a clutch (automatic transmission) and assigned him a "dry haul" that required less physical activity. Still, Claimant continued to be in severe pain, and in November of 2017 Claimant's doctor modified his work restrictions to light duty only with no climbing or heavy lifting.

The appellate court made a few findings crucial to its decision: (1) the fact that Claimant operated a clutch during the 2015 season post-accident without reporting the issue held little weight because his current condition post-surgery was what was at issue; (2) Claimant continued to have swelling multiple years after surgery which should have ceased by then; (3) the FCE simulated Claimant entering the cab only four times per day but realistically he was entering and exiting many more times per day; and (4) Claimant's doctor eventually gave him restrictions that prevented him from climbing onto a truck/trailer.

Therefore, “the court found the evidence demonstrated that Walsh is partially incapacitated from pursuing his usual and customary line of employment and there is a difference between the average amount which he would have been able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is able to earn in some suitable employment or business after the accident. Thus, the court found that the Commission’s award of permanent partial disability instead of a wage-differential was against the manifest weight of the evidence.”

The arbitrator awarded TTD benefits from October 19, 2014-May 19, 2016 and PPD to the extent of 30% loss of use of his left foot. The Commission adopted and affirmed the arbitrator’s decision, but extended TTD benefits to June 23, 2017. Circuit court reversed the Commission’s decision and remanded it on issues of TTD and PPD. The circuit court found TTD should have been paid through October 31, 2017, the date Employer accommodated Claimant’s work restrictions and further found that Employer’s accommodation of an automatic truck was insufficient. “Thus, the circuit court found that Claimant was entitled to a wage-differential award as the evidence demonstrated that Claimant lost access to his usual and customary line of occupation based on the physical requirements.” The appellate court ultimately affirmed the circuit court’s decision.

Walsh v. Illinois Workers’ Compensation Commission, 2023 IL App (3d) 230174WC-U

Q: If a Claimant has volunteered to work for no monetary compensation or expectation for future employment, has an employer/employee relationship been created?

A: No.

On June 29, 2014, while flying a plane for QCS to bring sky divers up to 10,000 feet, Claimant’s plane crashed during a landing attempt. Claimant sustained blunt force trauma to her face, causing lacerations and a broken nose. Claimant testified that she agreed to fly for QCS without payment or monetary compensation so that she could accumulate the necessary flight hours for her to become certified to fly jets as a commercial airline pilot. Claimant admitted to volunteering to do something which gave her the incidental benefit of not having to pay for accumulating flight hours.

The arbitrator found there was an oral implied contract between the parties and that Claimant was an employee of QCS at the time of the accident, and therefore gave her benefits. Commission reversed, holding that Claimant didn’t prove she was an employee at the time of the accident. The circuit court reversed the Commission’s decision finding that Claimant proved by a preponderance of the evidence that there was an implied contract for hire at the time of the accident. The appellate court found against the Claimant, stating that neither party had mutually agreed to the formation of an employer/employee relationship.

The appellate court agreed with the Commission’s finding that there was no mutual consideration that would have created a contract for hire because Claimant testified that she agreed to fly for QCS without payment or monetary compensation. Moreover, the

owner/operator of QCS testified to understanding Claimant to be an unpaid volunteer. The appellate court found the case analogous to *Board of Education of the City of Chicago v. Industrial Comm'n*, 53 Ill. 167 (1972) where the Claimant was studying at DePaul University when she applied to do volunteer work in the Chicago public schools within a program sponsored by the Board of Education of Chicago. The Claimant alleged that she was injured and claimed to be an employee of the Board of Education. The Illinois Supreme Court found the elements of consideration and mutual assent lacking because neither the claimant nor the Board of Education considered Claimant as an employee while she participated in the volunteer program. Similarly, the appellate court found that Claimant was working on an entirely voluntary basis with no expectation of payment or future employment, supporting the reasonable inference that neither party mutually agreed to the formation of an employment relationship.

Larson v. Illinois Workers' Compensation Commission, 2023 IL App (4th) 220522WC-U

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.

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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 (6) months after first distinct manifestation of disease or cumulative trauma or within six (6) 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 – Not required to be submitted

VII. MEDICAL TREATMENT - (85A O.S. § 50):

A. The employer has the right to choose the treating physician or chiropractor.

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, chiropractor, 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 or chiropractor, the employer's insurance company shall pay the physician or chiropractor 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 it is appropriate for a claimant 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 (3) 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 (3) 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 termination 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% of 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 $360.00 per week for injuries on or after July 1, 2021 through December 31, 2024.
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 occupational 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 though 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 receives $25,000.00 and 50% of the average weekly wage goes to each child. If 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 party 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 or 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 any 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 (6) 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)).

   1. "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, law enforcement officer, paid or volunteer firefighter, or emergency technician who suffers PTSD while responding to an emergency.
   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 a first responder receives benefits for a mental injury or illness with no physical injury who, after reaching MMI, is unable to perform the essential functions of his employment position and who is not eligible to receive disability retirement through his pension or retirement system shall be eligible to be awarded permanent disability not to exceed $50,000.
5. In cases where death results directly from the mental injury or illness within a period of one (1) year, compensation shall be paid to 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 (1) year after the time of disablement and the disablement shall occur within three (3) 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 (2) years from the date of death.
4. If a claim for benefits has been timely filed 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. Does a co-employee receive protections under the Exclusive Remedy Provision if their conduct does not arise within the course and scope of employment?

A. No. In *Bayouth v. Dewberry*, the Oklahoma Supreme Court held that a coworker is entitled to the protections of the exclusive remedy provision in the Oklahoma Workers' Compensation Act when their conduct arises within the course and scope of employment.

In this case, Employee A went to the office of Employee B and shot Employee B with a gun. Employee A was not working that day, i.e. had a day off. Employee B was paid indemnity benefits from the carrier of his employer. Employee B then filed a petition for the negligence of Employee A and his actions in causing the injury. The estate of Employee A filed a motion for summary judgment stating that since Employee B received indemnity benefits from his employer, he was not entitled to bring a third-party negligence against a coworker. The motion further stated that no exceptions to the exclusive remedy provision applied. Employee B responded by alleging that the actions of a coworker must meet the "co-employee immunity test," and since Employee B was off duty that day, his actions did not meet this standard.

In writing the majority opinion, Justice Combs held that a coworker is entitled to the protections of the exclusive remedy provision only when their alleged hurtful conduct arises within the course and scope of employment. Further, the definition of course and scope of employment, 85A O.S. §2(13), does not provide protection to an employee 24/7, but instead has areas and times where the employee is not protected when their actions are for personal matters or for actions not under the guise of work or employment.

Although the court did not determine whether the specific actions of Employee A were within the course and scope of employment, the court did make a correction to the interpretation of law. Not only must the injured employee be within the course and scope of employment to receive benefits, but also the coworker must be within the course and scope of employment to receive protections under the exclusive remedy provision.

Bayouth v. Dewberry, 2024 OK 42

Q. Can an employer be liable for both a workers' compensation claim and a common-law negligence claim?

A. No. In a recent decision, the Oklahoma Supreme Court held that an employer or contractor cannot use an indemnity clause to move their liability to another employer that is already liable under a workers' compensation claim.

Plaintiff is the widow of decedent who was a contracted employee for BJ's Oilfield Construction, Inc. ("BJ's"). Oklahoma Gas and Electric ("OG&E") contracted with SunPower Corporation Systems ("SunPower") for a solar power facility. SunPower contracted with Moss & Associates ("Moss") who then subcontracted with BJ's. Decedent

died while working at the construction site due to a fellow employee's use of a machinery. Plaintiff filed for and received Oklahoma workers' compensation benefits. Plaintiff later filed a wrongful death claim in district court alleging SunPower, Moss, and OG&E were negligent in maintaining the construction site. BJ's was also included as a defendant in this action. SunPower created an indemnity agreement with Moss which would move liability from SunPower to Moss. This language was extended to the contract between Moss and BJ's. This in turn would create liability on behalf of BJ's in the place of SunPower if a claim were to arise. SunPower argued that this language protected it from any liability arising from this incident. BJ's moved to dismiss this claim because no right to or contractual language for indemnity existed. The trial court granted BJ's motion to dismiss without stating the grounds for the grant.

In the majority opinion, Justice Edmondson held that the liability of SunPower cannot be placed on BJ's through an indemnity clause because BJ's was already liable to the Plaintiff through worker's compensation claims. Justice Edmondson stated that the Legislature has the power to limit the scope of contractual agreements between parties and did so with respect to liability of multiple parties under 85A O.S. §5. Justice Edmondson held that the language of §5 does not allow one employer to be liable for both a worker's compensation claim and a third-party common-law negligence claim for the same physical injury. An indemnity clause within a contract fails if the party taking liability has already been held liable either under workers' compensation or under a common-law negligence claim for the same physical injury. This restricts the ability of claimants to double dip in awards from a single party and instead pushes them to bring claims against other parties involved for claims arising out of the same physical injury.

Justice Edmondson stated that the mandatory language of 85A O.S. §5 cannot be waived through a contract creating a new legal relationship between employees and employers in regard to liability under workers' compensation and common-law negligence claims for the same physical injury. Due to the liability of BJ's for workers' compensation benefits, it is not liable in any sense for the common-law negligence claim for the same physical injury.

Knox v. Oklahoma Gas and Electric Company, 2024 OK 37

Q. Is a Claimant restricted by the exclusive remedy provision in the Administrative Workers' Compensation Act when the PPD 350-week limit has been exceeded at the time of the latest injury?

A. Maybe (still pending). The Oklahoma Administrative Workers' Compensation Act limits lifetime awards to permanent partial disability (PPD) for an injured worker to 350 weeks. That provision is moving toward an Oklahoma Supreme Court decision on (1) the constitutionality of the limit on the number of weeks of PPD and (2) the loss of exclusive remedy for the employer if the 350-week limit has been exceeded at the time of the latest injury.

In *Cantwell v. Flex-N-Gate*, the claimant sustained numerous injuries while employed for Flex-N-Gate over a 28-year period. His employment spanned the 2014 law changes,

bringing up this challenge of whether a claimant is entitled to 100% impairment to any body part of body as a whole or if a claimant is only entitled to 350 weeks pre-February 1, 2014/ 360 weeks post February 1, 2014.

Justice Gurich of the Oklahoma Supreme Court, writing the majority opinion, stated that when conflicting measurements of awards are at issue, such as weeks and percentages in this case, the more consistent one should be relied on. In this case, Justice Gurich holds that the PPD percentages are more consistent and should be used to determine the eligibility of a claimant to receive PPD over weeks which change regularly through statutes.

Justice Gurich cited the case of *Rivas v. Parkland Manor*, 2000 OK 68, in which the Court held that a claimant does not get the option of the more liberal remedy when receiving PPD so long as the remedies are not arbitrary and apply "evenhandedly to all claimants." Justice Gurich stated that going against this ruling, even though the applicable statutes have changed, would be impermissible and unconstitutional due to the uneven cap placed on different claimants under the same statutes.

Justice Kuehn of the Oklahoma Supreme Court, writing the dissenting opinion, states that the percentages and week measurements can be read effectively together to create a fair representation of the benefits that an individual is eligible to receive. Further, she states that the Legislature accounted for this issue of previous PPD percentages in 85A O.S. §45(C)(6)(a) by stating these pre-existing percentages should be accounted for in calculations and eligibility of benefits.

This case has been remanded for further findings and holdings based on the ruling of the majority.

Cantwell v. Flex-N-Gate, 2023 OK 116

Q. What are the requirements to bring an occupational disease claim? What are the appellate review standards?

A. In Exterran Holdings v. Abonza, claimant Abonza was diagnosed with silicosis after working as a sandblaster. The timing of the filing of his occupational disease claim was disputed. The Commission reversed the ALJ's decision, denying compensation as it was against the clear weight of the evidence. After the Commission's decision, Exterran Holdings appealed. The Court then determined the standard of review as described in 85A O.S. §78(c), which states that a judgment of the Commission shall be final, and an appeal shall stay any decision and award until the appeal rights have bene waived or exhausted. The Supreme Court can modify, reverse, or remand the decision for any one of the 8 reasons listed such as for a violation of constitutional provisions, unlawful procedure, error of law, fraud, arbitrary, etc.

Mr. Abonza worked as a sandblaster and painter for eight years and quit working for the employer on September 24, 2015, due to fatigue and difficulty breathing. After being diagnosed with silicosis and interstitial lung disease, he filed two claims for compensation alleging occupational disease and cumulative trauma. Claimant filed the claims in the Court of Existing Claims, which were dismissed as the CEC did not have jurisdiction. The claims were then brought before the Workers' Compensation Commission, the appropriate venue.

Different occupational diseases named under Title 85A have different requirements for timely filing. Under 85A O.S. §69(A)(2)(a), an occupational disease or infection must be filed within two years from the date of the last "injurious exposure to the hazards of the disease or infection." Within this, claims for diseases such as silicosis or asbestosis must be filed within one year after disablement and the disablement must be within three years of the last injurious exposure. For radiation exposure the claim must be filed within two years from when the condition is made known to the employee after an examination by a doctor.

Exterran Holdings, Inc. v. Abonza, 2023 OK CIV APP 33

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. Is a Claimant who undergoes surgery for a compensable hernia injury also entitled to disfigurement benefits?

A. No. 85A O.S. §61(B)(1) states the specific hernia benefits, six weeks of TTD benefits, which control and supersede the benefits set for in Title 85A. In *Houck v. Oklahoma City Public Schools*, claimant Houck received a hernia after lifting a hood on a bus. He received 6 weeks of TTD pursuant to 85A O.S. §61. Claimant argued that he was entitled to disfigurement benefits due to the hernia repairment surgery, which was disputed by the Employer who stated that §61 precluded his ability to receive disfigurement under 85A O.S. §45(F)(1).

The court, using plain language of the 85A O.S. §61(B)(1), determined that the intent of the legislature was for §61 to preclude the ability of a claimant to receive benefits under both §61 and §45. The Court stated that "notwithstanding," which means "despite" or "in spite of" in Black's Law Dictionary, shows that the Legislature intended for hernias to be completely regulated under §61 whether a claimant received a surgery or not. The court cited to *Graham v. D & K Oilfield Services, Inc.,* 2017 OK 72, in which the court held the Legislature has the power to limit the ability of recovery for specific body parts and ailments. Further it stated, injuries such as hernias have been limited since workers' compensation was established in Oklahoma.

Houch v. Oklahoma City Public Schools, 2023 OK CIV APP 27

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. 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, 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, 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.

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*: 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 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. *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*: 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.

RECENTLY PASSED LEGISLATION

HB 1738

- Amends 85A O.S. §47
- Effective Date: January 1, 2021
  - Surviving Spouse and 1 Child
    - Child receives lump-sum of $25,000 and 15% of the lesser of deceased employee's AWW and State AWW
  - Surviving Spouse and 2, 3, or 4 Children
    - Each child receives lump-sum of $25,000 and pro rata share of 30% of the deceased employee's AWW
  - Surviving Spouse and 5 or more Children
    - Each child receives a pro rata share of $100,000 and a pro rata share of 30% of the deceased's AWW

HJR 1035

- Effective Date July 1, 2024
  - 85A O.S. §50(H)(14) requires the Workers' Compensation Commission to evaluate the Fee Schedule for maximum rates paid for reimbursement to medical providers.
  - This is an approval for the proposed Fee Schedule to be signed by the Governor and the Secretary of the State
  - Signed by Governor on May 8th

SB 1457

- Amends 85A O.S. §13
- Effective Date: January 1, 2025
  - Expands workers' compensation coverage to law enforcement offices, paid or volunteer firefighters, emergency medical technician employed on a full-time basis by a municipality, county, or state, or a volunteer firefighter who suffer from PTSD while responding to an emergency.
  - Does not have to be accompanied by a physical injury.
  - If the first responder is not able to temporarily resume their job function due to the mental injury or illness, they shall receive compensation of the greater of the weekly benefit provided for in a collective bargaining agreement or 70% of the workers' average weekly wage
  - The employer will also be responsible for maintaining health insurance coverage for the first responder, if the health insurance was in effect on the date of the injury

SB 1333

- Amends 85A O.S. §380 which relates to the Oklahoma Volunteer Firefighter Group Insurance Pool
  - The Volunteer Firefighter Group Insurance Pool shall be transferred to the Office of Management and Enterprise Services (“OMES”) Comprehensive Professional Risk Management Program
  - Claims shall be handled by the OMES
  - This is only for volunteer firefighters, not paid firefighters
  - State agencies, public trusts, and other instrumentalities of the state shall pay $120 per firefighter per year for workers’ compensation coverage
  - OMES shall electronically report the number of enrollees and amount of expected surplus or deficiency

SB 1456

- Amends 20 O.S. §30(14), 85A O.S. §122, and 85A O.S. §§ 400, 401, 401.1
- Effective July 1, 2024
  - Workers’ Compensation Court of Existing Claims
  - Establishes court of Existing Claims Division in the Court of Civil Appeals
  - Replaces the Workers’ Compensation Court of Existing Claims
  - All administrative duties shall transfer to the Oklahoma Workers' Compensation Commission

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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 <u>arise out of</u> and <u>in the course of</u> 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
                a) is the occurrence of an event or condition which causes the employee to become actually incapacitated from performing work or from earning equal wages and other suitable employment as a result of the occupational disease.
4. Compensation – IA § 85A.5
    a. Employees who become disabled because of an injurious exposure are entitled to receive “compensation” and reasonable medical treatment. § 85A.17
        i. Compensation is payable to all “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 periodic 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 1/50th of the total earnings which the employee has earned in the prior 12 calendar months, including premium pay, shift differential, and overtime pay from all employment.
   b. *Employees with indeterminate earnings*: In situations where the employee's earnings cannot 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;
            a) 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:*
         a) 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.
         b) Locate the interest multiplier from that line from the same table in column B.
         c) 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:*
         a) Interest rate is calculated at the Treasury rate plus 2%.
         b) Interest is calculated using the following formula:

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

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

   b. Step 2:
      i. Compute the interest from the end of the period during which benefits are payable until date benefits are actually paid using the following formula:

         $$I = P \times R \times T(1).$$

         - 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 than 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: Are injuries to the shoulder and arm classified as scheduled or unscheduled under Iowa Code Section 85.34(2)?

A: The Iowa Supreme Court held that injuries to the shoulder and arm are scheduled under Section 85.34(2), and thus do not fall under the unscheduled injury category governed by paragraph (v).

The Iowa Supreme Court reversed the Court of Appeals decision that injuries to the shoulder and arm were unscheduled injuries under Section 85.34(2)(v). This decision rested on the language of Section 85.34(2), which governs compensation for permanent partial disabilities. Scheduled injuries are those described or referred to in paragraphs (a) through (u) of Section 85.34(2), while unscheduled injuries are governed by paragraph (v) of Section 85.34(2). The court held "an injury can be unscheduled only if it fits in paragraph (v). Iowa Code § 85.34(2)(v). And by its plain terms, paragraph (v) can *only* apply to injuries "other than those... described or referred to in paragraphs 'a' through 'u.' but the claimant's injuries are not "other than those... described or referred to in paragraphs 'a' through 'u.' " Claimant's injuries were to his shoulder and arm, and both are "described or referred to" in the schedule composed of "paragraphs 'a' through 'u.' Further, the court specifically noted the claimant's shoulder injury is "described or referred to" in paragraph (n), which states: "n. For the loss of a shoulder, weekly compensation during [a percentage of] four hundred weeks." § 85.34(2)(n), and the claimant's arm injury is "described or referred to" in paragraph (m), which states "m. The loss of two-thirds of that part of an arm between the shoulder joint and the elbow joint shall equal the loss of an arm, and the compensation therefor shall be weekly compensation during [a percentage of] two hundred fifty weeks." § 85.34(2)(m). Therefore, because the claimant's injuries are described and referred to in paragraphs (m) and (n), paragraph (v) does not come into play, and the injuries are scheduled.

The court also addressed three of the claimant's counterarguments, stating they deserved discussion:

(1) Anderson's argument concerning the statute's use of the singular and plural,

(2) Anderson's argument concerning paragraph (t), and

(3) Anderson's argument that our interpretation affords no meaning to paragraph (v).

In regard to the first argument, the court reasoned that the singular use of "arm" and "shoulder" in the statute holds no bounds unless "otherwise specifically provided by law, the singular includes the plural," citing *Little v. Davis,* 974 N.W.2d 70, 75–76 (Iowa 2022) (applying Iowa Code Section 4.1(17)). Further, the court cautions against reading "too much into the presence of 'a' or 'an' in a statute depending on the context," noting that the distinction here was not relevant as paragraph (v) does not say that it only applies to one of the paragraphs identified (a-u) but rather only injuries other than those described in paragraphs (a-u).

Second, the court held that the claimant's argument that paragraph (t) does not mention shoulder, inferring that the legislature meant to extend two body part losses from the schedule if one of those injuries was the shoulder, was incorrect based on the plain language of the statute. The court reasoned paragraph (t) was not relevant to the claimant, as paragraph (t) only applies to injuries "caused by a single accident," and evidence showed the claimant's injuries were due to decades of work wear and tear and not a singular incident. The court also noted that paragraph (t) does not preclude workers who suffer other combinations of injuries, stating that a scheduled injury combined with a scheduled injury does not create an unscheduled injury; therefore, if the injuries fall under (a-u), the injury would not fall into paragraph (v). Thus, this argument fails, and the injuries to both the arm and shoulder are scheduled members, and paragraph (t) does not dislodge this in the eyes of the court.

Lastly, the court held claimant's third argument held no merit as paragraph (v) retained meaning as it still does not apply to injuries to fingers, arms, hands, shoulders, or other parts described or referred to in the schedule but does apply to injuries that are not described or referred to in the schedule, such as back and head injuries. The court further noted, under current case law, "when there is injury to some scheduled member and also to parts of the body not included in the schedule, the resulting disability is compensated on the basis of an unscheduled injury," which would require compensation under paragraph (v). Thus, paragraph (v) maintains importance.

In conclusion, the Iowa Supreme Court held that an injury is unscheduled if it is an injury "other than those... described or referred to in paragraphs 'a' through 'u' " of Section 85.34(2), and seeing as how the arm is scheduled under paragraph (m) and the shoulder is scheduled under paragraph (n), paragraph (v) held no relevance to this case and compensation should not be computed based on loss of earning capacity.

Bridgestone Americas, Inc. v. Anderson, No. 22-1328, 2024 WL 1334165 (Iowa 2024).

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: Are vascular injuries per se unscheduled injuries under Iowa Code § 85.64, affecting entitlement to Second Injury Fund benefits?

A: The Iowa Supreme Court held that whether an injury results in the loss of use of a scheduled member or extends to the body as a whole is a factual determination to be made on a case-by-case basis, and vascular injuries are not per se unscheduled injuries.

The Iowa Supreme Court interpreted Iowa Code § 65.64 with regard to vascular injuries and whether they are per se unscheduled injuries therefore affecting entitlement to second injury fund benefits. The claimant established a first qualifying injury that occurred in 1986 to her left leg. In 2019 she suffered an injury to her right knee that resulted in a total knee replacement. She was placed at maximum medical improvement and issued a 37% impairment rating to the right lower extremity by the treating physician. Claimant subsequently developed pain and swelling in her right calf and was diagnosed with postsurgical lymphedema, a vascular injury. Claimant then filed a petition and settled her claim against the employer but not the Second Injury Fund claim.

In an Independent Medical Examination, Claimant was assessed additional impairment for the diagnosed lymphedema. However, this impairment was to the whole person, rather than the right lower extremity. The parties proceeded to hearing on the issue of "whether Claimant sustained a second qualifying injury for purposes of the Fund."

Under Iowa Code § 85.64(1), for an employee is entitled to Fund benefits if the employee (1) "previously lost, or lost the use of, one hand, one arm, one foot, one leg, or one eye," (2) "becomes permanently disabled by a compensable injury," that (3) "resulted in the loss of or loss of use of another such member or organ." Therefore, the determination of whether Claimant's 2019 injury was scheduled or unscheduled to determine whether she qualified for Fund benefits.

Previously, the Agency has relied on *Blacksmith v. All-American Inc.*, to support the argument that all injuries to the vascular system are unscheduled. 290 N.W.2d 348 (Iowa 1980). The Iowa Supreme Court specifically found reliance on *Blacksmith* to support a per se rule was erred. The Court held that whether an injury results in loss of use to a scheduled member or extends to the body as a whole is a fact determination to be made on a case by case basis.

The Court expanded by analyzing cases where injuries to bodily systems were localized to only result in loss of use of a scheduled member. *See Second Injury Fund of Iowa v.*

Armstrong, No. 10-1689, 2011 WL 2090023 (Iowa Ct. App. May 25, 2011) and *Reichert v. John Deere Waterloo Works,* No. 21700141.01 (Dec. 19, 2022). Therefore, while an injury to a bodily system can lead to a body as a whole injury, it is not inevitable and may only constitute a scheduled injury.

Additionally, the Court restated that "loss of use of another such member or organ," as used in the statute, includes losses to members that subsequently cause impairment to an unscheduled member. Therefore, the case was remanded with directions to conduct further proceedings according to the new interpretations.

Delaney v. Second Injury Fund of Iowa, No. 23-0182 (Iowa 2024).

Q: Does Iowa Code § 85.39(2) allow for reimbursement of the full cost of an independent medical examination (IME), including diagnosis, maximum medical improvement (MMI), and causation, or only the portion relating to issuing an impairment rating?

A: The Supreme Court held that Iowa Code § 85.39(2) allows for reimbursement of the full cost of the IME, including diagnosis, MMI, and causation, and that the reasonableness of the fee is a question of fact for the Commissioner to determine.

The Supreme Court reversed the Court of Appeals decision reducing the reimbursable amount of Claimant's IME. Under Iowa Code § 85.39(2) claimants are entitled to reimbursement for the reasonable fee for an independent medical examination by a physician of their choosing if they believe the impairment rating issued by the employer retained physician to be too low. The Supreme Court decision turned on the interpretation of the 2017 amendment to Iowa Code § 85.39(2) which added that "a determination of the reasonableness of a fee for an examination… shall be based on the typical fee charged by a medical provider *to perform an impairment rating* where the examination is conducted."

The Defendant's argued that the amendment only allowed for reimbursement of the portion of the IME relating to issuing an impairment rating. The Court disagreed holding that the amendment only added a point of reference to determine the reasonability of the fee for an IME and that the statute still allows for reimbursement of the cost of the accompanying examination. In ruling on the meaning of "perform an impairment rating" the Court held that it includes determining a diagnosis, whether the claimant is at MMI, and causation, all of which typically require reviewing past medical records and conducting a physical examination. Therefore, each portion is reimbursable under the statute.

However, under the 2017 amendment, the Court found that the reasonableness of the fee is a question of fact for the Commissioner to make. The Commissioner must make a finding on the fees typically charged in the area that the examination was performed and the parties may offer evidence to support or challenge the fee charged. In this matter, the Court stated that the Commissioner failed to make such a determination and sent the case back to the Commissioner for further ruling on the reasonableness of the fee.

MidAmerican Construction LLC and Grinnell Mutual v. Sandlin, No. 22-0471 (Iowa 2024).

Q: Is an employer liable for a functional impairment increase from an initial injury that was compensated based on industrial consideration?

A: Yes. Under section 85.34(7), an employer is not entitled to a credit for previous benefits paid for a reduction in earning compacity to offset claimant's entitlement to any new permanent partial disability as computed by any increase in functional impairment from a subsequent injury.

In *Loew v. Menard*, the claimant initially suffered a low back injury in 2015, which resulted in a 20% functional impairment and ultimately resulted in a 30% award of industrial disability. The claimant then suffered a second work-related back injury in 2018, which was compensated functionally as he continued to work for the employer and earned wages in excess of those at the time of the injury. As a result of the second award, the claimant was found to have an 8% functional impairment, taking the total functional impairment from 20% from the prior injury to a combined total of 28%. The commissioner concluded that the employer was not required to pay additional benefits for the second injury, as the employer received a credit for the 30% award that had previously been paid, which was in excess of the 28% functional award. The district court affirmed the commissioner's decision. However, the Supreme Court reversed the district court's ruling and remanded the claim back to the commissioner for further review.

The Court briefly reviewed the difference between functional and industrial injuries, noting that under 85.34(2)(v), "unscheduled injuries are to be determined functionally if the employee continues to work for the employer at the same or greater compensation." According to the Court, under this statute, "an employer is only responsible for paying for an injury once - double recoveries are prohibited." Further, the Court concluded that the commissioner "erred in interpreting 85.34(7) to preclude compensation for this new permanent partial disability." The Court cited the text of 85.34(7), stating it "limits an employer's liability only to the extent that the employee's preexisting disability has already been compensated under this chapter." The Court further noted that the claimant did not seek to hold the employer liable for a preexisting disability but instead only the new permanent partial disability of the additional 8% functional impairment that occurred as a result of the second injury.

The Court then indicated that this was not a double recovery claim, as only 20% of the 28% impairment had previously been compensated. As the earlier recovery was based on an industrial consideration rather than on a functional consideration, the Court quoted the reasoning in *Rife v. P.M. Lattner Manufacturing Co.* that the two recovery systems are "incommensurable, and it makes no logical sense to use one award to offset the other." The Court followed this reasoning with the example, "a claimant's industrial disability can be lower than functional impairment if claimant's earlier industrial injury had been 10%, there would be no argument that claimant would be entitled to an 18% award (the difference between the 10% industrial award and 28% functional loss." The Court held that the determination of the credit is to be made based on the difference between the functional rating of the initial injury and the functional rating of the subsequent injury.

Loew v. Menard, Inc., No. 22-1894 (Iowa 2024).

Q: Is an employer entitled to apportionment of liability under Iowa Code section 85.34(7) for a second shoulder injury, and is the claimant entitled to full reimbursement for an independent medical examination (IME)?

A: The Iowa Supreme Court held that apportionment credit for a shoulder injury under section 85.34(7) is based on whether there is a difference in functional impairment between the two injuries, with the employer being liable only for the marginal increase in impairment caused by the second injury, and that a claimant is entitled to full reimbursement for an IME if the fee is reasonable and customary within the geographic location.

In *P.M. Lattner Manufacturing Co. v. Rife*, claimant suffered a right shoulder injury in 2009, when the shoulder was considered a non-scheduled member. Following this incident, claimant received industrial disability which was calculated using a loss of earning capacity. After receiving multiple impairment ratings, the commissioner never made a finding regarding the impairment rating because the parties entered into a commutation settlement agreement which stipulated that claimant sustained a permanent partial disability of 29.6% of the body as a whole.

In 2017, the general assembly changed the method of calculating permanent partial disability benefits for an injury to the shoulder and reclassified a permanent partial disability arising out of an injury to the shoulder as a scheduled disability. This modified how compensation was calculated and based it on the percentage of functional impairment to the scheduled member in relation to a set number of weeks.

Following the 2017 amendment, claimant sustained a second work-related injury to his right shoulder in 2018. Claimant sought an independent medical examination (IME) where he received a 19% impairment rating to the shoulder. The physician did not distinguish between the 2009 and 2018 shoulder injuries when assessing the claimant's permanent functional impairment. After the deputy commissioner found the claimant would be entitled to 19% functional impairment, the employer argued that it was entitled to an apportionment of liability under Iowa Code section 85.34(7) and sought a credit for its prior partial disability payment. This argument was rejected, and Lattner appealed. Additionally, claimant sought reimbursement for the costs of the IME, and the deputy commissioner determined the reimbursement was appropriate. On appeal, the commissioner agreed with the deputy's conclusions that apportionment was not appropriate in this situation and that Lattner was required to reimburse the claimant for the IME. Lattner appealed to the district court, who concluded that the commissioner's ruling on the apportionment issue was erroneous, and the relevant statutes and commutation settlement should have been addressed. Additionally, the district court found the claimant was not entitled to any reimbursement and reversed the agency's decision. The claimant appealed, arguing to the court of appeals that apportionment under section 85.34(7) was not applicable. The court of appeals concluded that under section 85.34(7), Lattner was entitled to some credit for its disability payments made under the prior commutation settlement. Furthermore, the court of appeals concluded that

the claimant was entitled to reimbursement for the IME, but only for the cost of the impairment rather than the cost for the entire examination.

The Iowa Supreme Court first addressed the apportionment issue pursuant to section 85.34(7). The Court noted that the legislature's stated purpose in enacting section 85.34(7) was to "prevent all double recoveries and all double reductions in worker's compensation benefits for permanent partial disability." Furthermore, the Court mentioned that the holding in *Loew v. Menard, Inc.* resolved this case at hand. In *Loew*, it was concluded that, "offsetting an award based on functional impairment against a prior award based on loss of earning capacity was an improper comparison of apples to oranges." Ultimately, section 85.34(7) requires that the employer can only be liable for the marginal increase in functional impairment caused by the second injury. The Court concluded that distinguishing marginal increases in functional impairment was a factual inquiry the agency would be able to determine. Therefore, the Court remanded the case for additional evidence and determined Lattner should be afforded the opportunity to present evidence under the correct standard set forth in *Loew* to determine whether the physician's 19% functional impairment rating was in addition to, or inclusive of, the claimant's preexisting functional impairment.

The Court then addressed issue of IME reimbursement. It was concluded that an employee is entitled to reimbursement of the reasonable cost of the examination, which is to be based upon the typical fee charged within the geographic area in which the IME is performed. Ultimately, the Court found the commissioner's finding that the physician's fee was customary within the area and supported by substantial evidence.

In conclusion, the Court held that apportionment credit for a shoulder injury under section 85.34(7) is based upon whether a difference in functional impairment exists between the two injuries. Section 85.34(7) then requires that the employer be held liable only for the marginal increase in functional impairment caused by the second injury. The Court also held that a claimant is entitled to reimbursement for an IME when it is determined the fee was reasonable and customary within the geographic location.

P.M. Lattner Manufacturing Co. v. Rife, No. 22-1421 (Iowa 2024).

Q: Can the Court overturn a timely notice finding when the record could have supported a contrary conclusion?

A: When the Court concludes the commissioner's determination of timely notice is supported by substantial evidence, the decision will stand, even if the record could have supported a contrary conclusion.

The Court of Appeals affirmed the decision of the Commissioner holding the Defendant failed to show substantial evidence to support their notice defense under Iowa Code § 85.23. Defendant argued that Claimant only mentioned that he was hurt, but not that an injury was work related. However, Defendant failed to introduce testimony or evidence to rebut the Claimant's testimony that his supervisors had been informed of his work-related injury within the 90-day period. Specifically, the court stated that although the record could have supported Defendant's argument that Claimant failed to give notice, the

Commissioner finding was still supported by substantial evidence. Therefore, the court affirmed the commissioner's finding.

Kraft Heinz Co. v. Ernest Bynum. No 23-0045 (Iowa Ct. App. Feb. 7, 2024).

Q: Does the discovery rule toll the notice period if a claimant does not know the nature of one's injury?

A: No. Following the 2017 amendments to chapter 85, the ninety-day notice period begins when the claimant knew or should have known the injury was work-related, with no regard to the claimant's knowledge of the nature, seriousness, or probable compensable character of the injury.

The Court of Appeals affirmed the decision of the Commissioner holding the Claimant failed to provide notice of an injury within 90 days of the injury's occurrence. Claimant sustained a cumulative injury and therefore argued that the notice period should have been tolled under the discovery rule claiming he did not discover the nature of his injury until September of 2019. However, since the inception of the claim, the Iowa Supreme Court interpreted the 2017 amendments to Iowa Code § 85.26(1) which, in short, held that the legislature changed the date of the occurrence of the injury to be tied to the date the claimant knew or should have known the injury was work related. Therefore, the realization of the nature of the injury was irrelevant for the purposes of the starting of the notice period. The Claimant in this case conceded that he knew his injury was work related in 2018. Notice was not given until October of 2019, well outside the 90 day period and section 85.23 operated to bar recovery.

Tyler v. Tyson Fresh Meats, Inc. No. 23-0393 (Iowa Ct. App. Feb. 2024).

Q: Does the settlement with the Second Injury Fund divest the agency of jurisdiction, and is the claimant's petition barred by the statute of limitations under Iowa Code § 85.26?

A: The Iowa Supreme Court held that the settlement with the Second Injury Fund did not divest the agency of jurisdiction because it involved separate subject matter jurisdiction, but the claimant's petition was untimely as it was filed outside of the two-year statute of limitations period from when the claimant knew or should have known that the injury was work-related.

The Iowa Supreme Court addressed two areas of the Iowa Code governing Workers' Compensation: section 85.35(9) regarding settlements and section 85.26 regarding the discovery rule.

The claimant sustained an injury in 2017 to his right arm while vacuuming a grain bin. Claimant sought medical treatment and was diagnosed with tennis elbow. He underwent some conservative management of his pain. Claimant's pain did not subside and he returned to treatment in January of 2018. He then underwent physical therapy without success. It was not until May of 2018 that an MRI revealed a deltoid tear which was opined to have been caused by overcompensation for the tennis elbow injury.

Claimant filed a petition on January 21, 2020 in which he also alleged entitlement to Second Injury Fund benefits. Claimant settled with the Second Injury Fund prior to the

hearing. At hearing, Defendants argued that the agency no longer had jurisdiction due to the settlement with the Second Injury Fund and that regardless, the petition was not filed within the two year statute of limitations. The Deputy disagreed holding that the settlement did not divest the agency of jurisdiction and that the discovery rule applied and was not operative until April of 2018. Therefore, the petition was timely.

The case was appealed and ultimately landed before the Supreme Court which held that the petition was not barred due to the settlement with the Second Injury Fund because it involved separate subject matter jurisdiction. The extent of any bar relies on the subject matter of the settlement. Here, the subject matter of the Second Injury Fund claim was separate and apart from the claim against the employer. Therefore, the claim was not barred on these grounds.

However, the Court also held that claimant's petition was untimely. While the Commissioner relied on the discovery rule to find that the claimant did not appreciate the seriousness of his injury until April of 2018, The Court held that the definition regarding the date of the occurrence of injury as applied to section 85.26 was operative. Therefore, the petition must be filed within two years of the date the employee knew or should have known that the injury was work related. While the discovery rule was the proper method prior to the legislature's addition of the definition of "date of the occurrence of the injury", the legislature expressly intended it to be for the purpose of 85.26. Therefore, the Court found that the legislature expressly intended to limit the discovery rule to the knowledge an injury is work related and not the nature of the injury. Applying the new interpretation, Claimant's petition was file outside of the two year period from the date of the occurrence of the injury and barred as untimely.

Tweeten v. Tweeten, 999 N.W.2d 270 (Iowa 2023).

Q: Does an injury resulting from a Covid-19 vaccine that the employer encouraged arise out of and in the course of employment?

A: No, if the vaccine was not required by the employer there is no actual risk of an adverse reaction to the Covid 19 vaccine as a result of employment and the vaccine was in no way connected to employment.

Driscoll v. City of Cedar Rapids was a case of first impression in Iowa concerning an employee who developed complications from the Covid-19 vaccination and sought to demonstrate that the injury arose out of and in the course of his employment. The deputy concluded that claimant's injury had arisen out of and in the course of employment (Cleereman). On appeal, the commissioner reverses and concludes that the injury did not arise out of and in the course of employment. Parties agreed that claimant's injury had resulted from the administration of the Covid-19 Johnson and Johnson vaccine. The employer "strongly encouraged" employees to obtain the vaccine but there was no requirement from the employer that an employee must obtain the vaccine.

In his decision, the commissioner notes that although the City encouraged its employees to obtain the vaccine, "defendant made it clear the vaccinations were only recommended and not mandatory." The employer provided no incentives to obtain the vaccine and no disciplinary action was imposed if an employee failed to obtain the vaccine. The commissioner found that the employer had encouraged employees to receive the vaccine but had not "strongly encouraged" the receipt of the vaccine, nor was it required. The

deputy had originally relied on Larson's treatise on workers' compensation, which noted that a claim might arise out of and in the course of employment "if there is a combination of strong urging by the employer and some element of mutual benefit in the form of lessened absenteeism and improved employee relations." The commissioner however rejected this, noting that Larson's treatise was not universally accepted or applied throughout the states.

The commissioner did conclude that the claimant was "in the course of employment" when he received his vaccination, since claimant was able to use work time to obtain the shot. However, he ruled the injury did not arise out of employment. Using the actual risk doctrine, the commissioner concluded “claimant had not proven that there was an actual risk of an adverse reaction to the Covid-19 vaccine as a result of his employment. The vaccine was in no way connected to employment according to the commissioner. Taking the Covid-19 vaccine was not a rational consequence or hazard connected with claimant's employment. Had the vaccine been required, claimant would have been able to make such a case, but the vaccine was not required by the City.” The commissioner also held Larson's "strongly urged" standard, "creates a disincentive for employers to assist their employees and to provide convenience for their employees." The commissioner also finds that the "strongly urged" standard was not universally accepted.

Driscoll v. City of Cedar Rapids, No. 22001119.01 (App. Dec. Jan. 5, 2024).

Q: Are employers required to obtain split sample drug tests in accordance with Iowa Code § 730.5 in order to be admissible in workers’ compensation proceedings?

A: No, failing to obtain a split sample drug test does not render the drug test inadmissible, as section 730.5 does not apply to workers' compensation proceedings.

In *Davis v. Gordon Food Service*, the claimant suffered an injury at work and took a drug test pursuant to their employer’s policy which was positive for methamphetamine. The test, however, was not performed in accordance with section 730.5, which requires that *two samples* be taken to allow the claimant to have the samples independently tested. At the hearing, the deputy concluded that the failure to obtain a split sample did not make the test inadmissible. The deputy further concluded that the claimant did not rebut the presumption that he was intoxicated under 85.16 of the Code despite the fact that the claimant testified that he had not taken drugs for four days before the injury and there was no testimony that the claimant was acting in an intoxicated manner and no evidence that intoxication led to the injury. The commissioner affirmed, as did the district court on judicial review.

The claimant appealed, arguing that the repeal of language under the old code section exempting testing for workers' compensation benefits under 730.5 and the silence of the 2017 revisions to the code on how to drug test meant that 730.5 applied to workers’ compensation proceeding. Therefore, they argued that the failure to obtain a split sample required the exclusion of the results of the testing if the testing in the workers’ compensation setting. The employer argued that the legislature was aware of 730.5 when the 2017 revisions occurred as 730.5 applies only to private employees, and applying the statute in workers' compensation cases would lead to disparate results between private and public employees. The court agreed with the employer and affirmed the decision of

the commissioner. The changes to 85.16 indicated that intoxication demonstrated by a positive test result led to a presumption of intoxication. No reference to specific drug-testing provisions were referenced in 85.16, and the court found that this was a "deliberate omission." The court further rejected the argument that the claimant rebutted the presumption of intoxication as the claimant's argument was based on his testimony that "a meth high would last for hours, not days, and that he drove and otherwise acted without incident prior to the injury." The court held that the deputy had found the claimant's testimony self-serving and that this was a credibility finding by the deputy as there was an absence of any expert testimony or independent witnesses. The court affirmed the district court's decision, concluding that section 730.5 does not apply to workers' compensation proceedings and that a failure to obtain a split sample drug test does not render the test inadmissible in workers' compensation proceedings.

Davis v. Gordon Food Service, Inc., No. 22-1944 (Iowa Ct. App. Feb. 21, 2024).

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 a layoff by an employer who had been accommodating a disability lead to a review and reopening of a settlement if the employee has suffered an economic change due to not being able to find work?

A: Yes. If an employee shows an economic change after a layoff was a proximate cause of the initial injury the settlement may be reopened.

In *Debra Stuart v. Dickten Masch Plastics*, the appeals court dealt with the interpretation of section 86.14 of the Iowa code. Section 86.14 authorizes the workers' compensation

commissioner “to reopen an award for payments or an agreement for settlement” if “the condition of the employee warrants an end to, diminishment of, or increase of compensation so awarded or agreed upon.” Iowa Code § 86.14(2). In a review-reopening proceeding to increase benefits, the injured worker must show a change in their condition that was “proximately caused by the original injury.” *E.N.T. Assocs. v. Collentine*, 525 N.W.2d 827, 829 (Iowa 1994). “A cause is proximate if it is a substantial factor in bringing about the result.” *Blacksmith v. All-Am., Inc.,* 290 N.W.2d 348, 354 (Iowa 1980). The court in *Stuart* held, no proof of a physical condition was necessary when a change in economic condition is alleged. The court also provided more light as to the supreme court’s decision in *U.S. West Communications, Inc. v. Overholser*, 566 N.W.2d 873 (Iowa 1997). The court in *Stuart* found that the *Overholser* decision did not exclude a change in economic condition caused by a general layoff as a qualifier for reopening but instead, demonstrated that the commissioner must look at the full record to determine whether the workers “inability to secure employment after a layoff was proximately caused by the initial injury.” In totality, when examining reopening the commissioner must examine if the original injury was another proximate cause of the inability for the employee to find work after the layoff, not the only cause. This is decided through the evidence surrounding, accommodations, transferability of job skills, and inability to find work following the layoff resulting in a credible economic change. The case was reversed and remanded back to the commissioner.

Debra Stuart v. Dickten Masch Plastics, LLC and Employers Preferred Ins. Co., No. 23-0018 (Iowa Ct. App. Oct. 25, 2023).

Q: Does the Workers’ Compensation Commissioner have discretion to exclude medical records?

A: Yes, under rule 876 IAC 4.19(3), evidence may be excluded "if the objecting party shows that receipt of the evidence would be unfairly prejudicial."

In *Hagen v. Serta/National Bedding*, the Claimant failed to timely certify her expert witnesses and also failed to produce the reports of the experts at least thirty days before hearing. The deputy found that the acceptance of the reports would be unduly prejudicial to the employer and excluded the reports. The commissioner affirmed this decision, but the district court reversed that decision. The Court of Appeals affirmed the decision of the district court on appeal and the Supreme Court accepted the case for further review in February.

The court of appeals held, under rule 876 IAC 4.19(3), claimant was required to certify experts within 120 days of hearing. The rule also provides that reports from experts were to be provided within 30 days of hearing. The rules note that evidence may be excluded "if the objecting party shows that receipt of the evidence would be unfairly prejudicial." The hearing in the case was set for September 25, 2020. Claimant was originally to have an IME on May 19, the IME was rescheduled to June 23 due to illness of the medical examiner. A vocational expert was certified by the claimant for the first time on August 19. Both the reports were completed on September 10, with the IME served on the employer on September 10 and the vocational report on September 11, both within 30 days of hearing. A week before the hearing, the employer objected to both reports,

arguing that the experts had not been identified in a timely manner and that the reports were untimely. The employer argued that both reports were prejudicial and further arguing that they did not have time to respond or rebut either the IME or the vocational report. At hearing, claimant argued that defendants should be given additional time to respond to the reports which would cure any prejudice that existed. The deputy excluded the reports, finding that allowing the record to remain open would only "delay final disposition of the matter."

The court found that the agency should be given deference in administering its rules. It rejected the district court's opinion that the agency had assumed prejudice by noting that the commissioner had specifically found that the reports had been filed in an untimely manner, that only the VE had concluded claimant was permanently and totally disabled and that there was "unfair surprise and prejudice by the untimely exchange of these reports." Further, the commissioner had noted that the reports were not from treating physicians but from hired experts. The Supreme Court found that the prejudice resulting from an untimely designation “need not be great to justify exclusion of the testimony.” Although the commissioner could have exercised his discretion by allowing the employer to respond, the exclusion of the testimony was not outside of that discretion. The Court of Appeals was reversed, and the commissioner's decision was affirmed.

Hagen v. Serta/National Bedding Co., LLC. No. 22-0684 (Iowa 2023)

Q: Did the claimant properly preserve error regarding the argument that his injury included both the shoulder and arm, which was raised for the first time during judicial review?

A: The Iowa Court of Appeals held that the claimant did not properly preserve error because the issue of the injury including both the shoulder and arm was not raised during the agency proceedings and was raised for the first time during judicial review, reversing the district court’s decision.

The Court of Appeals addressed whether the claimant properly preserved error in his judicial review petition to the district court. Claimant sustained injuries to his shoulder for which he sought benefits. However, at the time of his hearing, and on appeal to the Commissioner, the Supreme Court had not yet interpreted the 2017 amendment to the definition of “shoulder” as included in the schedule. Therefore, arguing only that the Commissioner had wrongly interpreted what constituted a shoulder, the claimant sought body as a whole benefits.

However, by the time the Commissioner was to issue his appeal decision, the Supreme Court issued a decision in *Chavez v. MS Technology, LLC*, 972 N.W.2d 662 (Iowa 2022). The Court held that the claimant’s injury was limited to a shoulder and therefore a scheduled member under the 2017 revision. So, the Commissioner followed the Supreme Court and held that Williams’ injury was limited to a shoulder as well.

Williams then filed a judicial review petition, changing his argument to state that he had suffered an injury to his shoulder and his arm. The Defendants argued that Claimant had

failed to preserve error given that he had not raised the issue before the agency. The district court found the Claimant had preserved error given that they had argued for a body as a whole claim.

The Court of Appeals reversed the decision of the district court holding, ""[J]udicial review of administrative action is limited to questions considered by the agency." *Pruss v. Cedar Rapids/Hiawatha Annexation Special Loc. Comm.,* 687 N.W.2d 275, 285 (Iowa 2004). To preserve error on an issue, Williams needed to raise the issue during the agency proceedings and not for the first time during judicial review." Stating that Williams was attempting to find an alternative way to make the case given the change in law, the court found that the issue was not properly preserved.

Archer Daniels Midland v. Williams, No. 22-2075 (Iowa Ct. App. Dec. 20, 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: Is third party tort recovery subject to reimbursement?

A: Yes, under Iowa Code 85.22(1), the entire third-party tort recovery is subject to reimbursement.

In *McKoy v. Twin City*, Claimant was paid workers' compensation benefits for medical care and disability in the amount of $148,501.60. She subsequently pursued a third party tort claim and settled with those parties for $175,000. The insurance carrier filed an action under 85.22, seeking reimbursement of the entire amount of the workers' compensation settlement less a pro rata share of attorney's fees. Claimant contested this action, arguing that the tort settlement represented a payment for pain and suffering and thus was not subject to reimbursement under 85.22. The deputy commissioner disagreed and awarded $116,666.67 to the employer. The commissioner affirmed this order. The Court noted *Sourbier v. State*, 498 N.W.2d 720, 723 (Iowa 1993), stating “the Supreme Court had squarely addressed this question and concluded that the "statute allows the employer or insurer to be reimbursed out of damages for pain and suffering because such construction furthers the purpose of the statute." The Court found no reason that *Sourbier* would not apply to this case and upholds the decision of the agency and district court. The Court specifically concluded that pain and suffering awards can be reimbursed under 85.22. The Court also rejected claimant's argument that the release precluded reimbursement and finds that since the insurance carrier on the workers' compensation claim had not signed the release, there was no way it could be bound by that document and is therefore entitled to reimbursement.

McKoy v. Twin City Fire Ins. Co. and ITA Group, Inc., No. 22-1787 (Iowa Ct. App. Dec. 20, 2023).

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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 employs 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, i.e. 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 detract 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.

1. The term "as soon as practicable" has been interpreted to mean as soon as it is feasible to report the injury given the circumstances

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.

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 the 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 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.
    i. Loss or loss of use of multiple parts of the same arm, including the hand and fingers, or loss or loss of use of multiple parts of the same leg, including the foot and toes, resulting from the same accident or illness does not entitle the employee to receive compensation based upon the employee's 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 $1,094.00.
        iii. Award would be $16,410.00 (150 wks X 10% X $1,094).
        iv. No credit for TTD paid.
    b. Body as a Whole:
        i. Claimant qualifies for maximum compensation rate for his date of accident of $1,094.00.
        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 $153,160.00 (280 wks X $1,094.00 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 $11,600 as of July 1, 2024.

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.

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.

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

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. No. 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 aimed to increase benefits for workers who suffered injuries to two or more extremities in a single accident. It specified 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."

Initially, this statutory language was applied as originally intended until the Supreme Court, in the case of *Espinoza*, interpreted it to allow employees with injuries to two or more parts of the same extremity in one accident (e.g., right elbow and right wrist) to qualify for permanent disability based on their loss of earning capacity. Attorneys sought to persuade the Supreme Court to interpret the statute in line with its original legislative intent, but the Court upheld its broader interpretation. In response, LB 1017 was drafted and became effective on July 18, 2024. The legislative change restricts eligibility for permanent disability benefits based on loss of earning capacity to employees who have sustained injuries to two or more parts of different extremities in a single accident (e.g., left wrist and right elbow). This amendment clarifies the eligibility criteria in accordance with the original legislative intent that was overridden by the Espinoza decision.

2023 Bill Text NE L.B. 1017

Q. ***How have recent amendments affected medical fee schedules and lump sum settlement applications in Nebraska?***

A. Nebraska Workers' Compensation Court recently implemented revisions to several rules and Addendum 2, which became effective January 24, 2024, following their adoption on December 28, 2023. Amendments to Rules 5, 13, 14, and 15 addressed updates such as interpreter usage, fax filings, exhibits, and records checked out. However, the most noteworthy changes are seen in Rules 26 and 47. Rule 26 now dictates a revised Medical Service Fee Schedule for services rendered from January 1, 2024, onward, available for reference on the Nebraska Workers' Compensation Court's official website at newcc.gov. Meanwhile, Rule 47 modified Lump Sum Settlement Applications by updating the table

within Addendum 2, replacing the 2019 U.S. Life expectancy Table with the updated 2020 version. The 2020 U.S. Life Expectancy Table introduces minor adjustments from its predecessor, yet these nuances can significantly impact calculations involving future and present values.

Q. *Should we focus on the period of exposure before contracting an illness, rather than the circumstances during the hearing, when determining if it qualifies as an 'ordinary disease of life'?*

A. Yes. In *Thiele v. Select Medical Corp.*, the Nebraska Supreme Court overturned the denial of Christine Thiele's workers' compensation claim for COVID-19 contracted while working as a nurse liaison in Omaha. Thiele claimed COVID-19 was an occupational disease under Nebraska law, unique to healthcare workers due to their work conditions, not an ordinary disease of life. Initially denied by the Workers' Compensation Board, Thiele appealed and won, arguing COVID-19 posed a specific risk to healthcare workers during the pandemic. The 4-3 split decision highlighted differing views on whether COVID-19 qualifies as an 'ordinary disease of life'. The majority opinion stressed focusing on the period of exposure prior to contraction or onset of symptoms, rather than circumstances at the time of the hearing to determine if COVID-19 qualifies as an 'ordinary disease of life'. Dissenting judges argued COVID-19 spread similarly in all settings and should not be classified differently based on timing or occupation. Although it did not settle the issue indefinitely, Thiele's case sets a precedent for future workers' compensation claims related to COVID-19 in Nebraska. The Court's opinion suggests that one must focus on the period of exposure when determining if an illness, specifically COVID-19, is an ordinary disease of life.

Thiele v. Select Med. Corp., 316 Neb. 338, 4 N.W.3d 858 (Apr. 19, 2024)

Q. *When workers' compensation serves as the exclusive remedy, can an employee assert tort theories of recovery against their employer in district court?*

A. No. *In Lopez v. Catholic Charities of the Archdiocese of Omaha*, an employee filed claims for assault and intentional infliction of emotional distress in district court following injuries she sustained during a training drill at work. The district court dismissed these claims, citing the Nebraska Workers' Compensation Act which provides the exclusive remedy for employees, thus preventing them from pursuing tort claims against their employers in district court.

The Nebraska Supreme Court recently upheld the dismissal of the employee's claims, affirming that under the Nebraska Workers' Compensation Act, the statutory benefits constitute the sole recourse for employees injured on the job. The Court's decision also addressed and rejected the employee's arguments seeking to limit the scope of the exclusivity rule and asserting that dismissing her claim violated public policy. This case law emphasizes the exclusivity of the workers' compensation remedy, which is derived from statute, and underscores the principle that employees surrender their rights to any other method, form, or amount of compensation when their injury is covered by the

Nebraska Workers' Compensation Act. This principle ensures that employees receive no-fault benefits quickly for most economic losses from work-related injuries, in exchange for giving up the potential for complete compensation under tort law.

Lopez v. Cath. Charities of Archdiocese of Omaha, 315 Neb. 617, 998 N.W.2d 31 (Dec. 15, 2023)

Q. What constitutes timely notice of an injury under Nebraska workers' compensation law when an employee experiences delayed onset of symptoms related to a workplace incident, as opposed to pre-existing conditions?

A. In *Candia v. Orchard Park Assisted Living*, the Nebraska Workers' Compensation Court decided that waiting for a period of 2 to 3 weeks before notifying the employer was reasonable. This delay was justified because it took the employee this long to determine that her current pain was caused by the workplace incident rather than her existing back issues.

An employee experienced a sudden "pop" in her back while lifting a patient who had fallen. Due to previous episodes of back pain, she initially treated the discomfort with over-the-counter medications. However, after enduring persistent pain for 2-3 weeks despite the medications, she concluded that this new pain resulting from the workplace incident was distinct from her previous issues, and promptly informed her employer.

According to Section 48-133, an injured party must notify their employer of the injury "as soon as practicable." The key question is whether the injury was reported as soon as it was feasible, considering the specifics of the case, rather than focusing solely on the time elapsed since the injury. The Court determined that the employee's notification was timely because it occurred as soon as she recognized her back pain was linked to the workplace incident rather than her pre-existing condition.

Therefore, in situations where an employee delays reporting an injury to differentiate it from previous instances of pain, each case must be examined based on its unique circumstances. Factors such as previously existing conditions, whether medical treatment was sought, timing of notification, and other relevant details will influence whether the notice was given "as soon as practicable."

Debra Candia, Plaintiff, No. Doc: 220 No: 0059, 2021 WL 3540227 (Neb. Work. Comp. Ct. Aug. 4, 2021)

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. ***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. ***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 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 employee unilaterally change their form 50 physician?*

A. No. According to Neb. Rev. Stat. Ann. § 48-120(2), an employee cannot unilaterally change their Form 50 physician without the agreement of the employer or an order from the compensation court. 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 Workers' 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.

The court in Rogers emphasized that a new Form 50 physician can be selected either through mutual agreement between the employee and employer or by seeking approval from the compensation court. This is particularly relevant when the original Form 50 physician is no longer available, such as in cases of death or the employee moving out of state. Additionally, the case clarifies that the compensation court has the authority to order a change of physician if it deems it necessary, ensuring that employees continue to receive appropriate medical care even when their circumstances change.

Rogers v. Jack's Supper Club, 308 Neb. 107, 953 N.W.2d 9 (2021).

Q. *(1) Determining whether an injured worker qualifies as an employee, entitling them to workers' compensation benefits, or as an independent contractor. (2) What is the key factor in distinguishing an employment relationship from that of an independent contractor?*

A. (1) The court will consider several factors to determine if an injured worker is an employee or an independent contractor, including: (1) the extent of control, as defined 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 claimed that the plaintiff was an employee of the defendant and sought workers' compensation benefits. The defendant denied the claim, arguing that the plaintiff was an independent contractor. They presented several factors to support their position. Evidence showed that the plaintiff owned his own company and performed jobs for defendant intermittently for several years. The defendant invoiced the plaintiff for completed jobs, paid him per job, and issued him 1099 tax forms instead of W2 forms. The plaintiff had the freedom to decline jobs from the defendant, which he had done periodically. Plaintiff operated his own checking account and filed tax returns where he deducted significant business expenses such as vehicles, contract labor, and insurance. Plaintiff indicated on his tax returns that 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).

A. (2) In *Cajiao*, the Nebraska Court of Appeals emphasized that the key factor distinguishing between an employment relationship and that of an independent contractor is the extent of control. The Court elaborated, stating, "It was important to distinguish control over the means and methods of the assignment from the control over the end product of the work to be performed."

Oscar Cajiao was injured in a motor vehicle accident while driving a semi-trailer tractor leased by Arga Transport, Inc. (Argo). Cajiao alleged he was an employee of Arga and thus entitled to workers' compensation. The Nebraska Workers' Compensation Court (WWC), however, held that Cajiao was an independent contractor. Cajiao appealed.

Cajiao's argument relied heavily on the lease agreement language between Cajiao and Arga, which provided Arga should have exclusive possession, control, and use of the equipment, and should assume responsibility for the operation of the equipment. The appellate court disagreed, noting that such provisions are required to be in every lease that an authorized carrier enters into for equipment. The court stated that this language alone does not show the degree of control a company exercised over the method and manner of performing the work. 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 was an independent contractor and therefore is not entitled to workers' compensation benefits.

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

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).

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KANSAS 2024 LEGISLATIVE UPDATES

Legislative Action Effective 2024

SB 430 was debated and passage recommended by the Senate Commerce Committee on February 7, 2024. On February 21, 2024, the Senate took final action on the bill, passing it 40-0. On February 29, 2024, the House Commerce, Labor and Economic Development Committee recommended passage of SB 430. The legislation was signed into law and is effective as of July 1, 2024.

The following is a summary of the changes carried out via SB 430

I. Reduction of Benefits Based on Pre-Existing Impairment

A. Clarifies that an award of compensation for work disability, PPD, PTD, shall be reduced by the amount of functional impairment determined to be preexisting "to the same physical structure as the body part injured." K.S.A. 44-501(e)

1. This is consistent with the opinion in *Weaver.*

II. Caps *(current caps in parentheses)*

A. Death benefit cap will increase to $500,000 *(previously $300,000)*

1. Benefits can exceed death benefit cap for dependent child(ren) until the later of
   i. age 18.
   ii. age 19 or graduation if still in high school at age 18; or
   iii. until age 23 if in vocational school or college. K.S.A. 44-510b(h).

B. Permanent Total Disability Cap will increase to $400,000 *(previously $155,000)*

1. To be eligible to pursue permanent total disability benefits, an injured worker must prove the work accident resulted in at least a 10% permanent partial impairment to the body as a whole or, if the injured worker has preexisting impairment, the injured workers total permanent partial impairment to the whole body must be at least 15%. K.S.A. 44.510c(a)(2)(A).
2. The injured worker must still prove they are realistically and essentially unemployable as a result of the accident.

C. Permanent Partial Disability Cap will increase to $225,000 *(previously $130,000*)

1. Injured worker must prove permanent partial impairment to the whole body from the work accident of at least 7.5% or, if the injured worker has preexisting impairment, the injured worker's combined permanent partial impairment to the whole body must be at least 10%. K.S.A. 44-510e(2)(C)
2. Work disability is still determined by the average of wage loss and task loss related to the work injury.

D. If the workers' compensation accident results in only permanent partial impairment, an injured worker's recovery is capped at $100,000. *($75,000)*. K.S.A. 44-510(a)(4).

E. Caps will remain fixed until July 1, 2027, at which time a cost-of-living adjustment will kick in to raise caps on a yearly basis. The annual percentage increase will be based on a 5-year average of the percentage increase in the State's average weekly wage. K.S.A. 44-510f(b).

III. Preliminary Hearings

A. Injured workers shall provide medical reports to opposing counsel at least 20 days before a preliminary hearing. If records are not provided at least 20 days before the preliminary hearing, the court is empowered to grant additional time for the employer to provide evidence that may contravene the employee's records. K.S.A. 44-534(a)(2).

IV. Future Medical

A. The authorized treating physician's opinion as to the need for future medical is presumed determinative on the issue of whether future medical will be awarded in cases where there have been no invasive procedures. This presumption can only be overcome with clear and convincing evidence. K.S.A. 44-510h(e)(2)-(3).

B. If the injured worker had invasive treatment as a result of the work injury, the authorized treater's assessment that no future treatment will be needed is still presumed determinative of the issue. However, that presumption may be overcome if claimant proves it is more likely than not that future medical will be needed.

V. Post Award Medical and Attorney Fees

A. The only procedure allowed to pursue post award medical treatment will be under the provisions of KSA 44-510k. An injured worker may not pursue post-award medical benefits under preliminary hearing procedures of K.S.A. 44-534a.

B. If post-award benefits are provided within 30 days after an application for post award medical is filed, no attorney fees should be awarded without showing, by clear and convincing evidence, that the attorney had significant legal effort. K.S.A. 44-510k(b)(2).

VI. Court-Ordered Independent Medical Examinations (COIME)

A. The Administrative Law Judge may only order one COIME without agreement of the parties.

1. Without agreement of the parties, the COIME doctor can only address diagnosis, treatment recommendation and temporary restrictions.
2. If the ALJ does order a COIME, the COIME must be done prior to Prehearing Settlement Conference. K.S.A. 44-516(a).
3. In addition, the COIME may not be used for the purposes of a rating, permanent restrictions, task or wage loss, or opinions on permanent total disability. K.S.A. 44-516(b).

B. Parties are still free to agree to a joint IME.

VII. Medical Records

A. Upon receipt of notice from the Division of the setting of a Regular or Post-Award Hearing, the parties shall exchange medical reports including those by examining and treating health care providers. The exchange shall be at least 30 days before the hearing. K.S.A. 44-519(b).

B. The testimony of a treating or examining health care provider may be submitted into evidence without additional foundation by submission to the opposing side of a complete medical report that complies with procedural rules set forth in the statute. K.S.A. 44-519(c).

C. Upon receipt of proposed complete medical report, a party has ten days to file a written objection to the offering party stating the grounds for the objection. The ALJ shall then conduct a hearing on the objections as to whether the proposal meets the requirements of a complete medical report. K.S.A. 44-519(d).

VIII. Notice of Injury

A. An injured worker must notify the employer of the accident within 30 days from date of accident or 20 days from last date of employment, whichever is earlier. K.S.A. 44-520(a)(1).

IX. Stipulated Awards

A. If the employee is represented by counsel, a settlement can be completed without the need for a settlement hearing. The Division is mandated to create the appropriate stipulations and Award documentation. The Administrative Law Judge is given five days from receipt of the signed stipulation to approve the agreed award. K.S.A. 44-531(d).

X. Second Injury Fund

A. The Kansas Second Injury Fund is provided a procedure to implead a statutory employer in cases where the primary employer is determined to be uninsured and without ability to pay benefits. K.S.A. 44-566a(c)(2).

XI. Social Security Offset

A. An award of permanent partial or permanent total disability shall be subject to an offset equal to 50% of the Claimant's Social Security retirement benefits.

B. An award of TTD and TPD benefits shall not be subject to an offset for Social Security Retirement benefits. K.S.A. 44-501(f)

XII. Wages

A. The calculation of average weekly wage shall include vacation, sick leave and PTO paid during 26 weeks before accident. K.S.A. 44-511(a)(1).

B. Calculation eliminates the first week of wages from calculations if the employee did not work a full week. K.S.A. 44-511(b)(2).

XIII. Unauthorized Medical

A. The allowance per case for unauthorized medical is raised to $800. K.S.A. 44-510h(b)(2).

XIV. Per Diem

A. If an employee is required to be away from home all day to obtain medical treatment, the employer shall pay the employee a $30 per diem. K.S.A. 44-515(a).

B. The employer shall be responsible for reimbursement of the reasonable expenses of overnight accommodations as needed to avoid undue hardship on the employee. K.S.A. 44-515(a).

XV. Transcription of Hearing

A. The Director may order hearings to be recorded by digital recording or other means and later transcribed by a certified shorthand reporter or notary public who shall attest to the transcription's accuracy. K.S.A. 44-552(a)-(b).

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THE INTERACTION OF OSHA AND WORKERS' COMPENSATION

I. WHAT IS OSHA?

A. Introduction

OSHA, the Occupational Safety and Health Administration, is the federal agency responsible for protecting the health and safety of workers in the United States. OSHA was created by Congress in 1971 after the signing of the 1970 Occupational Safety and Health Act. Since the passing of this act, OSHA standards have significantly reduced overall injuries and illness rates for workers. OSHA has extended coverage to almost all private-sector employers, and even some public sector employers.

B. OSHA's Role in the Workplace

1. OSHA sets requirements based on extensive research of specific workplaces to establish accurate and beneficial standards for employees.
    a. Provide training, equipment, and explanations of procedures to encourage compliance from employers
2. OSHA enforces misconduct in the workplace through issuing fines and even sometimes criminal prosecution referrals for serious violations

C. Most Frequently Violated OSHA Standards

1. Fall Protection, construction (29 CFR 1926.501)
2. Hazard Communication, general industry (29 CFR 1910.1200)
3. Ladders, construction (29 CFR 1926.1053)
4. Respiratory Protection, general industry (29 CFR 1910.134)
5. Scaffolding, construction (29 CFR 1926.451)
6. Control of Hazardous Energy (lockout/tagout), general industry (29 CFR 1910.147)
7. Powered Industrial Trucks, general industry (29 CFR 1910.178)
8. Fall Protection Training, construction (29 CFR 1926.503)
9. Eye and Face Protection, construction (29 CFR 1926.102)
10. Machinery and Machine Guarding, general industry (29 CFR 1910.212)

D. Employees' Rights Under OSHA

1. Ask OSHA to inspect the workplace
2. Receive information and training about hazards, methods to prevent harm, and the OSHA standards that apply to their workplace in a language they can understand
3. Obtain copies of test results done to find hazards in the workplace
4. Review records of work-related injuries and illnesses

5. Obtain copies of one's medical records
6. Report work-related injuries and illnesses
7. Inform employees about hazards through training, labels, alarms, color-coded systems, chemical information sheets, and other methods
8. Keep accurate records of work-related injuries and illnesses
9. Perform tests in the workplace, such as OSHA's air sampling requirements
10. Provide hearing exams or other medical tests required by OSHA standards
11. Post OSHA citations, injury and illness data, and the OSHA poster in the workplace where workers will see them
12. Notify OSHA of all work-related fatalities within eight hours, and all work-related inpatient hospitalizations, amputations, and losses of an eye within 24 hours
13. No discrimination or retaliation against a worker for using their rights under the law

II. EMPLOYER RESPONSIBILITIES UNDER OSHA LAW

A. Notice Requirement

1. Employers MUST report any work-related fatality within 8 hours of learning about it.
2. Employers MUST report any work-related hospitalization, amputation, or loss of an eye within 24 hours of learning about it.
    a. Injury, illness, or fatality must be work-related, meaning it occurred in the course of employment or was aggravated by it.
3. Reports can be made to OSHA by calling the nearest OSHA office, calling the OSHA 24-hour hotline, or through the online reporting system available on the OSHA website.

B. OSHA requires work-related injuries or illness to be recorded if it results in:

1. Day away from work
2. Restricted work or transfer to another job
3. Medical treatment beyond first aid
4. Loss of consciousness
5. Diagnosis of a serious injury or illness

C. Recordkeeping Requirements

In addition to reporting severe injuries and fatalities, OSHA requires employers to keep records of work-related injuries and illnesses using the OSHA 300 Log, 300A Summary, and 301 Incident Report forms. These records must be maintained for five years. Certain low-hazard industries are partially exempt from routine recordkeeping and reporting requirements, though they still must report fatalities and severe injuries.

Failure to comply with these reporting requirements can result in significant penalties from OSHA, including fines for each violation. OSHA requires that certain personal identifying information of employees involved in an incident be kept confidential when reporting or recording injuries and illnesses.

III. POST ACCIDENT INVESTIGATION

A. Steps to Incident/Accident Investigations:

1. Preserve/document scene
2. Collect information
3. Determine root causes
4. Implement corrective actions

B. Preserve/Document Scene

1. Preserve the scene to prevent material evidence from being removed or altered
   a. Investigators can use cones, tape, and/or guards.
2. Locate and preserve any videos or photographs, including those taken by witnesses
   a. Make sure to note who any witnesses work for (especially on construction sites)
3. Document the incident facts, such as the date of the investigation and who is investigating
   a. Injured employee's name
   b. Injury description
   c. Whether they are temporary or permanent
   d. Date and location of the incident
   e. Video recording, photographing and sketching

C. *Collect Information*

1. Incident information is collected through interviews, document reviews and other means, such as:
   a. Equipment manuals, industry guidance documents, company policies and records, maintenance schedules, records and logs, training records (including communication to employees), audit and follow-up reports, enforcement policies and records, previous corrective action recommendations
2. Interviews should be conducted as promptly as possible- the sooner a witness is interviewed, the more accurate and candid his/her statement
3. Carefully question witnesses to solicit as much information as possible related to the incident.

4. Let employee know that they can have an employee representative (e.g., labor representative), if available/appropriate

D. *Determine Root Causes*

1. Root cause: the underlying reasons why the incident occurred in a workplace
    a. Root causes generally reflect management, design, planning, organizational and/or operational failings
2. Determining the root cause is the result of persistently asking “why”
3. Determining the root cause is the most effective way to ensure the incident does not happen again
4. Successful incident investigation must always focus on discovering the root causes.

E. *Implement Corrective Actions*

1. The investigation is not complete until corrective actions are implemented that address the root causes of the incident
2. Sample global corrective actions to consider are:
    a. Strengthening/developing a written comprehensive safety and health management program
    b. Revising safety policies to clearly establish responsibility and accountability
    c. Revising purchasing and/or contracting policies to include safety considerations
    d. Changing safety inspection process to include line employees along with management representative

IV. IMPORTANT MISSOURI STATUTES

A. RSMo 287.120.5: Safety Violation Interplay

1. Where 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 rule adopted by the employer for the safety of employees, the compensation and death benefit provided for herein shall be reduced at least twenty-five but not more than fifty percent; provided, that it is shown that the employee had actual knowledge of the rule so adopted by the employer; and provided, further, that 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. RSMo 287.128: Failure to comply with benefit increase

1. It shall be unlawful for any person to knowingly present or cause to be presented any false or fraudulent claim for the payment of benefits pursuant to a workers' compensation claim.

V. OVERTURNING *CHEVRON*: LOPER BRIGHT ENTERPRISES V. RAIMONDO

A. Overturning Chevron

1. SCOTUS overturned *Chevron v. Natural Resources Defense Council* with the *Loper* decision, striking down a 40-year precedent.
   a. *Chevron*- mandated that courts defer to an agency's interpretation of its own statutes if Congress had not clearly addressed the issue.
   b. *Loper* (Now)- Courts themselves should interpret ambiguous statutes, not defer automatically to agency interpretations.
2. How does this decision affect how OSHA regulates safety and health in the future?

B. Implications of Loper

1. More unpredictable regulatory environment
   a. Agencies like OSHA may face more challenges and uncertainties in implementing regulations, as each interpretation may be subject to judicial scrutiny.
2. Concerns about Expertise and Technical Knowledge:
   a. OSHA often relies on technical and scientific expertise in setting standards. Without *Chevron*, there's a risk that courts lacking such expertise could undermine or delay important regulatory measures.

C. How Does this Decision Affect Employers?

Chevron has been pivotal in allowing agencies to expand the scope and interpretation of employment laws through regulations. Without *Chevron*, agencies may face more challenges in implementing expansive regulations. The decision is expected to impact pending challenges to various agency regulations, including those related to wage thresholds, joint employer rules, workplace safety standards (like OSHA's rules on walkarounds), and more. Employers will need to monitor court decisions closely and possibly navigate conflicting rulings in different jurisdictions. Employers should continue to adhere to existing agency regulations unless courts invalidate them. They may also need to consider potential legal arguments against agency interpretations in litigation scenarios.

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Notes Pages

COVID-19 AND OCCUPATIONAL DISEASE CLAIMS IN WORKERS' COMPENSATION

I. OVERVIEW

The continued existence of Covid-19 as a disease has bolstered changes across all geographical regions. Within those regions, it has established a new set of norms that impact all careers and workplaces. These Covid-related changes will likely remain prominent and alter the way that all jobs across all sectors are completed. As infections continue, there remains a concern in how to classify a Covid-related injury. Yet, across many states, there is minimal litigation involving Covid infections and Workers' Compensation.[1] The states that have made determinations on the compensability of Covid-19 claims will look to the unique facts of the employee's employment and exposures at work.

II. COMPENSABILITY OF COVID-19 CLAIMS

Determining compensability requires Covid-19 to be an occupational disease in some states or a specific injury in others. Of course, this requires that the injury occur within the scope of employment.

A. Kansas

The Jose Hernandez case provides an analysis related to a Covid-related death. After obtaining a Covid-19 test, the claimant passed away. Days later, the test was confirmed positive. Claimants' physician asked him to stay home due to body aches and coughing up blood, but he chose to continue working. There was disputed evidence about whether the deceased was exposed to Covid at work or whether he could have contracted Covid from outside of work.

Because the claimant did not allege whether he sustained an injury by accident, repetitive trauma, or occupational disease, the court did a three-part analysis. An accident is defined as an undesigned, sudden, and unexpected traumatic event. Repetitive trauma refers to cases where the injury is the result of repetitive use.

In this case, there was no evidence showing that the claimant experienced Covid symptoms at any identifiable time or place of occurrence during a single work shift. Of note, he did not work in proximity with others, and he was not exposed to other employees that had Covid prior to his symptom onset. There were also no diagnostic or clinical tests done to demonstrate a repetitive nature of claimant's Covid infection. Therefore, he did not meet the burden of physical injury or repetitive trauma.

[1] Insights-Research-Brief-Presumptive-Coverage.pdf (ncci.com)

As for occupational disease, the question is whether the nature of the claimant's employment as a floor worker at a meat packing facility caused Claimant to have a particular risk of contracting Covid-19 above and beyond the risks of other employments and more than the risk of contracting Covid in general. The court does not believe the evidence sustains that it did.[2]

Therefore, the court looked at the rapid spread of Covid within the community and considered the fact there was no evidence the claimant worked in proximity with Covid-positive employees.[3] It was therefore not compensable. The court equated this to the cold or flu as an ordinary disease of life. They did not hold that Covid is never compensable.[4]

B. Missouri

To be compensable, Covid must be determined to be an occupational disease. Under 287.067.1 RSMo, "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 [the] section. The disease . . . 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.

Gordon Johnson v. RBX Transportation, Injury No. 20-094915, was the first Missouri decision by an ALJ as to whether Covid-19 exposure is compensable. In that case, the claimant worked for RBX Transportation as a night dispatcher and a load coordinator. He worked at a desk he shared with an employee who worked the night shift. Their shifts would overlap by about 15 minutes. The night shift employee tested positive for Covid the day before the claimant tested positive. There was testimony that there were 12-15 employees at RBX that were out sick in October 2020 (the month that claimant contracted Covid). No witnesses could identify an RBX office employee who had Covid before the claimant and the employee who shared his desk. There was also disputed evidence that there was use of Covid-prevention strategies such as use of a mask in the building, use of a fogging machine to clean ductwork, and use of hand sanitizer.

Claimant also testified that whenever he was out in the community during the relevant period, he always wore a mask due to mask mandates.

The parties retained experts who both agreed that Covid is an ordinary disease of life. Claimant's expert, Dr. Koprivica, testified that he believed Employee's Covid was compensable because the exposure he described at RBX exposed him to a greater risk of getting Covid than that experienced in the general population. The employer's expert, an infectious disease physician, testified that he did not believe claimant contracted Covid

[2] Jose Hernandez v. Elkhorn Valley Case No. CS-00-0457-779 PACKING CO LLC
[3] *Id*.
[4] *Id*.

at work. He said simply going out in public in October 2020 would put a person at high risk of getting Covid, even if they were wearing a common surgical mask.

The court determined that the claimant did not sustain an occupational disease arising out of the course and scope of his employment. Under RSMo Section 287.067.1, an occupational disease is an identifiable disease arising with or without human fault out of and in the course and scope of employment. The court found that on the date of injury, Covid was an ordinary disease of life. That is because all three medical experts testified as such, including by analyzing how widespread Covid was in the area.

Since Covid is considered an ordinary disease of life to which the public is exposed, the only way it is compensable is if Covid had its origin in a risk connected with the employment. Additionally, the court finds a common thread to occupational disease compensability, finding that the risk need be inherent in the performance of the job that exposed the employee. This claimant was a night dispatcher, and there is nothing that would inherently increase the employee's risk of Covid.

In making this determination, the court relied upon two cases that demonstrated that there must be a risk inherent in the performance of the jobs that exposed the employee to the hazard of contracting the disease by the normal performance of their job duties. In *Vickers v. Missouri Department of Public Safety*, 283 S.W.3d 287,291 (Mo.App.W.D. 2009), the claimant was an employee doing laundry for residents at a Missouri Veterans' home when she contracted C-diff. The court concluded that her work was a sufficient hazard of the job to find that the disease arose out of the employment. Similarly, in *Smith v. Capital Region Medical Center*, 412 S.W.3d 252 (Mo.App.W.D. 2013), the claimant developed hepatitis while working as a lab technologist in a hospital drawing blood. The nature of the job duties was found to be an inherent risk for the development of hepatitis- C.

The court also rejected claimant's argument that we should compare the exposure to Covid at work against the exposure to Covid in claimant's activities away from work, contending that there was greater exposure at work which should make this a compensable case. However, the court noted that the consideration of comparing the exposure in and away from employment is only applicable to an accident under RSMo. §287.020.3(2), but not applicable to an occupational disease under RSMo. §287.067.1 & 2. *Lankford v. Newton County*, 517 S. W.3d 577, 582 (Mo.App.S.D. 2017).

The *Johnson* case is on appeal to the Labor and Industrial Relations Commission, and it remains to be seen whether the case will be upheld on appeal.

C. Nebraska

To show a compensable injury and recover under the Nebraska Workers' Compensation Act, a claimant must prove by a preponderance of the evidence that an accident or occupational disease arising out of and occurring in the course of employment caused an injury which resulted in disability compensable under the act. Moreover, in establishing a claim for occupational disease in Nebraska, a worker must show that the injury was a disease resulting from causes and conditions characteristic of and peculiar to the trade, occupation, process, or employment in which the worker was employed, and the disease is other than an ordinary disease of life to which the general public is exposed.[5] The statute does not require that an occupational disease be one that exists exclusively in the particular employment. The causes and conditions of the employment must result in a hazard that distinguishes it in character from employment generally.[6]

Compensability of Covid-19 claims for most jobs remains unclear in Nebraska. Yet, the State's Supreme Court made a ruling for nurses that allow compensability for their claims. *Thiele v. Selection Medical Corp*. determined that there must be a focus on the period of exposure prior to contraction or onset of symptoms, rather than the circumstances at the time of the hearing to determine if Covid-19 qualifies as an ordinary disease of life.

Thiele, a nurse liaison, worked at a critical care recovery hospital at the beginning of the pandemic. She did not have a designated workspace and therefore worked in various places on the premises. She worked in close quarters with three/four coworkers and was in constant contact with medical personnel. Outside of work, Thiele stayed home during the pandemic and utilized grocery delivery services. She was also the only person in her household to contract Covid-19.

Thiele alleged that she faced severe and disabling medical issues arising out of the course of her employment due to Covid-19. She was originally denied workers' compensation benefits but appealed to the Nebraska Supreme Court. The court noted in the record her treating physicians and medical expert opinions. The court focused on the period of exposure prior to contraction or onset of symptoms, rather than circumstances at the time of the hearing to determine if Covid-19 qualified as an ordinary disease of life. Occupational diseases need not be the type that is exclusive to the worker's employment, but the unique condition of the employment may result in a hazard that distinguishes it in character from employment generally.[7]

Therefore, the court did not determine that Covid-19 is not compensable under the Act as a matter of law.

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[5] Thiele v. Selection Medical Corporation, 316 Neb. 338 (4. N.W.3d 858) 2024
[6] *Id*.
[7] Thiele v. Selection Med. Corp., 316 Neb 338

Additional Examples of Occupational Diseases:

1. Nurse developing hypersensitivity to latex in examination gloves *(Ludwick v. TriWest Healthcare Alliance* 267 Neb. (2004).
2. Dishwasher developing contact dermatitis after exposure at work to cleaners (*Ritter v. Hawkeye-Security Inc. Co*., 178 Neb. (1965).

D. Iowa

A recent decision has been handed down involving adverse side effects to the Covid-19 vaccination in the state of Iowa.

In *Driscoll v. City of Cedar Rapids*, the city was strongly encouraging employees to obtain the Covid-19 vaccination but did not make it mandatory. The City made it clear vaccinations were only recommended and not mandatory, and they did not provide any incentive to obtain the vaccine. There would be no disciplinary action if an employee did not obtain vaccinated status. Therefore, the Commission concluded that the claimant was in the course of employment when he received his vaccination, because the claimant was able to use work time to obtain the shot. Both parties agreed that the injury was a result of the administration of the vaccine. Yet, the injury did not arise out of employment and the claimant did not prove that there was an actual risk of an adverse reaction to the Covid vaccine because of his employment.[8]

In sum, taking the vaccine was not a hazard connected with the employment. This would have likely ended differently had the vaccine been required by the employer.

Another decision*, Sican v. JBS S.A*., indicates that Covid could be compensable if it is determined to be a workplace injury within the meaning of the Iowa Workers' Compensation Act rather than occupational disease. This stems from the decision of *Perkins v. HEA of Iowa, Inc.*, 651 N.W.2d 40 (Iowa 2002), finding that contracting hepatitis C in the course of employment was an injury rather than occupational disease.

The Iowa Supreme Court indicates that an occupational disease is typically contracted through prolonged or passive exposure to conditions in the workplace. *Burress*, 779 N.W.2d at 215. Injuries are defined as unexpected or abnormal exposure to infection. Therefore, Covid-19 is an injury in Iowa that could be compensable. Though, this *Sican* case was dismissed for reasons unrelated to Covid.

[8] Driscoll v. City of Cedar Rapids, No. 22001119.01 (App. Dec. Jan. 5, 2024).

E. Other Jurisdictions

Other jurisdictions are tasked with the same difficult decision of determining compensability for Covid-19 infections.

1. New York: In New York, the courts have determined that, while Covid can be compensable under their workers' compensation law, the claimant must meet their burden to show either a specific exposure to Covid or a prevalence of Covid in the work environment, such as workers with significant contact with the public in communities with high rates of infection. *Holder v. Office for People with Developmental Disabilities,* 188 N.Y.S 3d 754 (App.Div. 3rd Dept. 2023). In *Holder,* the employee worked as a house manager at a group home. However, there was no evidence of residents or fellow employees who had been infected with Covid before him, leading to a decision that he failed to meet his burden of demonstrating that he contracted Covid-19 in the course of his employment. *Holder,* at 757.

   Another case from New York, *Pierre v. ABF Freight*, 211 A.D.3d 1284, 1285 N.Y.S.3d 337, involved a claim for compensation based on a diagnosis of Covid-19. The claimant, Pierre, was hospitalized for a Covid infection. This came roughly two weeks after his work facility was temporarily closed due to a major Covid-19 infection at the plant he worked at. Pierre did not leave the house for anything other than work. The judge found that the claimant met his burden of showing that the Covid-19 infection arose out of and in the course of his employment. *Id*. at 339.

2. West Virginia: In West Virginia, an employee of Raytheon Corporation alleged that Covid came from his work conditions. The employee worked in a plant of workers that were in close proximity to one another and he alleged he was exposed to and contracted Covid-19 during an outbreak among employees between October 2-12, 2020, when he and 8 others tested positive. He alleged it started when a shipping manager came to work after being exposed to Covid at home and then caused it to spread throughout the plant. The court found that Covid was a disease of life to which the public at large was exposed, and his work exposure was not "incidental to the character of the business, and that it did not have its origin in a risk connected with the employment." *Hutchison v. Raytheon Corporation,* 2023 W.L. 2568817 (W.Va. CT. App. March 20, 2023).

   The case *PrimeCare Medical of WV, Inc. v. Foster,* represents a denial of benefits for a Covid-19 claim regarding a Health Services Administrator at a jail in West Virginia. 247 W.Va. 590, 885 S.E.2d 171, 172 (Ct. App. 2023). Foster, the claimant, administered Covid tests to inmates and attended staff meetings in close proximity to coworkers. The staff members were quickly sent home to quarantine after many of them tested positive. Yet, during her quarantine, Foster engaged in non-work-related outings. She then caught Covid and was hospitalized for two weeks. In denying her

claim, the court made note that West Virginia code Section 23-4-1(f) states that no ordinary disease of life to which the general public is exposed outside of employment is compensable, except when it follows as an incident of occupational disease. The Court pointed to the six-factor analysis stated in the West Virginia Code to determine whether the injury is an occupational disease. The Court found that although there is no prohibition of claims arising from COVID-19, it is generally not compensable-as it is a disease of ordinary life-unless the six-factor analysis is met.

3. Ohio: In Ohio, the court held in *Yeager v. Arconic Inc.*, that a furnace operator did not satisfy the requirement of occupational disease because his employment in that position did not create a higher risk of contracting Covid than the public.[9] Therefore, the claimant was denied compensation.

4. Arizona: In Arizona, the court allowed compensation to be awarded on a Covid-19 workers' compensation claim. *W. Millwork v. Indus. Comm'n of Arizona*, 256 Ariz. 177, 536 P.3d 305 (Ct. App. 2023). There, Claimant's husband (Zerby) passed away from catching Covid-19. Zerby was immunocompromised due to a kidney transplant and being pre-diabetic. Zerby frequently wore a mask and limited his social time. At his workplace, there were guidelines in place related to the spread of Covid. Those guidelines included requiring face masks when not in one's office, promoting social distancing, and requiring employees to stay home if sick or exhibiting COVID-19 symptoms. If an employee was experiencing symptoms, the employer required them to get tested and stay home until they received those results. On October 12, 2020, a coworker went into Zerby's office to talk with him for no more than 10 minutes. For the next two days, that coworker called out sick. The coworker took a Covid test but returned to the office before obtaining results. The test result came back positive. By October 18, 2020, Zerby tested positive for Covid-19 as well. The court determined that "the evidence reasonably supports the ALJ's finding that Zerby contracted COVID-19 from an infected co-worker while in the office and on duty. Testimony also supports the ALJ's observation that Zerby's employment required him to 'have contact with project managers such as [the infected co-worker] from time to time.' The record does not adequately support that Zerby was exposed outside of work to any individual infected with COVID-19 during the relevant time when he could have become infected." *Id*. at 312-313.

5. Other States: Labor Commissions in other states have also had to rule on compensability of Covid cases with the majority of states finding Covid was not a compensable occupational disease. *Cheryl L. Rapp v. Chugach Elec Co*., 202128184, 2023 WL 341299 (Jan. 13, 2023) (Alaska); *Donna Geels v. Friendship Community Care, Inc*. WCC No H005785, 2023 WL 248995 (March 7, 2023) (Arkansas); *Maria Castillo v. LCL Food Services*, 2023 WL 3244874 (May 1, 2023)

[9] Yeager v. Arconic Inc., 168 Ohio St. 3d 1406, 195 N.E.3d 1046

(Florida); *Car'reyana Baker v. Sumpter Enterprises, Inc* 2022 WL 510195 (Feb. 15, 2022) (Florida); *John Nelson v. Nano LLC*, AP-00-0472-082, 2023 WL 1768566 (Jan. 4, 2023) (Kansas); *Misty Donohoe v. Newsouth Neurospine*, 2107300-R-4647, 2023 WL 3145633 (Apr. 17, 2023) (Mississippi); *Jonathan Gullo v. Brown's Monument LLC*, A22-0149, 2023 WL 2866275 (Mar. 8, 2023) (Pennsylvania); *Terri Lang v. Anderson County School District*, SCWCC File No: 2105707, 2022 WL 20211045 (June 10, 2022) (South Carolina); *Karen Franken v. Smithfield Foods Inc*, HF 84 2021/22, 2022 WL 3336624 (South Dakota); *Jason Ross v. Parkfairfax Condo*., VA02000037789, 2023 WL 3947692 (June 2, 2023) (Virginia); *Estate of Ernest Royal v. Georgia Pacific Wood Products*, VA 00001776694, 2022 WL 2190031 (June 2, 2022) (Virginia); *Latesha Holloman v. Sentara Healthcare*, VA 02000036565 (May 13, 2022) (Virginia).

III. POTENTIAL DEFENSES

A. Common defenses to Covid-19 compensability may include:
   1. Family and Friends with Covid
   2. PPE used by worker
   3. Employee handbook expectations regarding safety procedures and if they are commonly adhered
   4. Cross-Referencing Coworkers
   5. Contract Tracing
      a. Does the Claimant allege that the only possibility was contracting Covid at work vs where the Claimant was going outside of work
   6. Experts
      a. Medical
      b. Epidemiologists
      c. Statistics
         i. Including the likelihood of contracting the disease from work or outside work

IV. CONCLUSION

Covid remains present as a disease that can potentially cause long-term disabilities. Yet, states remain indecisive in their handling of Claims for Compensation. But there are things that all workplaces can do to mitigate their risks. OSHA provided recommendations for employers and workers that remain applicable as states continue to determine compensability. Those OSHA recommendations include:

A. Facilitate Employees getting vaccinated.
B. Instruct symptomatic employees or unvaccinated employees exposed to Covid to stay home.
C. Implement physical distancing in all communal work areas for unvaccinated and other at-risk employees.

D. Provide workers with surgical masks unless their work requires respirators.
E. Educate workers about Covid policies.
F. Suggest that unvaccinated visitors wear a mask and/or request that all visitors wear a mask in areas of high transmission.
G. Maintain ventilation systems.
H. Perform routine disinfection.
I. Record and report Covid infections.
J. Implement protections from retaliation.
K. Follow other Mandatory OSHA standards.[10]

V. THE MAIN POINTS

Handle each case individually because each case requires a fact intensive analysis. Therefore, perform an initial investigation and document all records.

Identify any risk which caused or may have caused the accident. With Covid claims, this may be more difficult to pinpoint as the virus is airborne. Some cases are clearer because many employees at a job site remain in proximity, and all report an infection. Other times, this may require a determination if the risk is actually employment related or manifested as a personal risk.

Consider whether the employee was exposed to the risks of Covid in their normal, everyday life. During the peak of the pandemic, many individuals rightly pointed out that they were not leaving the house to go anywhere except for work. Many of them were getting groceries delivered. Now, life looks a lot different and that is not the norm anymore. Therefore, consider if there was an equal non-employment risk to Covid infection. This may require an evaluation of statistics in the given community.

[10] Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace | Occupational Safety and Health Administration (osha.gov)

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WHAT'S IN A NAME? INDEPENDENT CONTRACTOR VS. EMPLOYEE VS. STATUTORY EMPLOYEE

I. WHY DOES THIS MATTER?

A. If the claimant is an independent contractor, they are not entitled to workers' compensation benefits.

B. If the claimant is an employee, they are entitled to workers' compensation benefits.

C. If the claimant is a statutory employee, they could possibly be entitled to workers' compensation benefits. However, if not, the employee could then pursue civil litigation.

II. DEFINITIONS

A. Definition of Employer

An employer is defined as every person, partnership, association, corporation, limited liability partnership or company, trustee, receiver, the legal representatives of a deceased employer, and every other person, including any person or corporation operating a railroad and any public service corporation, using the service of another for pay. *Section 287.030.1(1), RSMo 2020.*

B. Definition of Employee

An employee is defined as every person in the service of any employer under any contract of hire, whether express or implied, oral or written, or under any appointment or election, including executive officers of corporations. *Section 287.020.1, RSMo 2020.*

C. Definition of Independent Contractor

Chapter 287 does not define independent contractor. However, in the context of workers' compensation claims, the term has been defined as "one who, exercising an independent employment, contracts to do a piece of work according to his own methods, without being subject to the control of his employer, except as to the final result of his work." *DiMaggio v. Johnston Audio/D & M Sound*, *19 S.W.3d 185, 188 (Mo. Ct. App. W.D. 2000).* The primary factor in determining whether a worker is an independent contractor or employee is the amount of control exercised by the alleged employer. *Id*.

III. CONTROLLABLE SERVICES TEST

Courts and the Commission apply a two-step test referred to as either the control test or the controllable services test.

First, the worker must be "in the service" of the alleged employer; second, the services of the worker must be controllable by the alleged employer. *Howard v. Winebrenner*, *499 S.W.2d 389 (Mo. 1973); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).* For workers' compensation purposes, Missouri courts define "service" as the performance of labor for the benefit of another. *Id*.

The employment relationship contemplated by the law is characterized by the right vested in the employer to control the employee. *Howard, 499 S.W.2d 389; I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004)*

The following factors are considered by Courts and the Commission when attempting to determine whether there is a right of control:

A. The actual exercise of control
B. The extent of control
C. The duration of the employment
D. The method of payment for the services
E. The furnishing of equipment to the worker by the employer
F. The relationship of the services to the regular business of the employer
G. The contract of employment

I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004). This is a fact intensive analysis, and one factor is not more important than another.

IV. INDEPENDENT CONTRACTORS

An independent contractor is defined as someone who, exercising an independent employment, contracts to do work according to his or her own methods without being subject to the control of the other party to the contract except as to the ultimate result of the work being performed. *Vaseleou v. St. Louis Realty & Sec. Co.*, *130 S.W.2d 538 (Mo. 1939); White v. Dallas & Mavis Forwarding Co., 857 S.W.2d 278 (Mo. App. W.D. 1993); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).*

If the actual control or right of control of the work cannot be determined easily, the courts then proceed to examine the following factors:

A. Whether the work is part of the regular business of the employer.
B. Whether the employment is a distinctive occupation requiring special skills.

C. Whether the alleged employee may hire assistance.

D. Whether the work is usually done under supervision.

E. Whether the alleged employee must supply his or her own tools, equipment, supplies, and materials.

F. The existence of the contract for a specific piece of work at a fixed price.

G. The length of time the person is employed.

H. The method of payment, whether by time or by the job,

I. The extent to which the alleged employee may control the details of the work, except for the final results.

Maltz, 82 S.W.2d 909; Lawrence v. William Gebhardt, Jr. & Son, 311 S.W.2d 97 (Mo. App. E.D. 1958); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).

The one factor that appears to be the most persuasive to the courts is the power to summarily discharge the employee. *White*, *857 S.W.2d 278. I Mo. Workers' Compensation Law § 2.5 (MoBar 3rd ed. 2004).*

V. STATUTORY EMPLOYERS AND EMPLOYEES

Employers and workers not otherwise subject to the law nevertheless may be subjected to its jurisdiction if they qualify according to § 287.040, RSMo 2020. In most cases, an independent contractor is not considered an employee under the law. But by § 287.040, the law statutorily creates certain instances when an independent contractor will be deemed to be an employee for its purposes. *Staggs v. Venetian Harbor Co.*, *813 S.W.2d 8830 (Mo. App. E.D. 1991), overruled on other grounds by Hampton v. Big Boy Steel Erection, 121 S.W.3d 220 (Mo. banc 2003); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).*

The term "statutory employee" is not defined by the law. *Crain v. Webster Elec. Coop.*, *568 S.W.2d 781 (Mo. App. S.D. 1978); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).* However, § 287.040.1 defines a statutory employer as "any person who has work done under contract on or about his premises which is an operation of the usual business which he there carries on shall be deemed an employer and shall be liable under this chapter to such contractor, his subcontractors, and their employees, when injured or killed on or about the premises of the employer while doing work which is in the usual course of his business." *I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004)*

There is no universal test to determine statutory employment and each case must be determined on its own facts. *Schwandt v. Witt*, *346 S.W.2d 50 (Mo. 1961); Wilson v. Unistrut Serv. Co. of St. Louis, 858 S.W.2d 729 (Mo. Ct. App. W.D. 1993); I Mo. Workers' Compensation Law § 2.3 (MoBar 3rd ed. 2004).*

Pursuant to § 287.040.1, RSMo 2020, a claimant must establish the following in order to be classified as a statutory employee:

A. The work must be performed pursuant to a contract.

B. The injury occurred on or about the premises of the employer.

C. The injury occurred while performing work normally done in the usual course of business of the employer.

According to the Supreme Court of Missouri in *Bass v. National Super Markets, Inc.*, *911 S.W.2d 617 (Mo. banc 1995)*, an employer's usual business is limited to those activities:

A. That are performed routinely;

B. That take place in accordance with a schedule that requires them to be performed both regularly and frequently;

C. That are contemplated in the agreement between the independent contractor and the alleged statutory employer to be repeated over a relatively short span of time; and

D. The performance of which would require the alleged statutory employer to hire permanent employees absent the agreement with the independent contractor.

I Mo. Workers' Compensation Law § 2.28 (MoBar 3rd ed. 2004)

VI. CASE LAW

A. Hayes v. Ginger C, LLC, 582 S.W.3d 140 (Mo. Ct. App. W.D. 2019)

Facts: Asmar was the owner of Ginger C, a company owning houses and apartments available for rent to students, low-income residents, and veterans in Columbia, Missouri. Hayes began performing renovation, repair, and maintenance on Ginger C's rental properties. Asmar testified that Ginger C used independent contractors to perform this type of work and that he advised individuals hired to work on the rental properties that they were independent contractors working by the job. Ginger C issued 1099 forms to individuals hired to perform renovation, repair, or maintenance work on the rental properties and did not withhold taxes from checks paid for the work performed. The company also did not provide health insurance, vacation days, or sick time to any of the individuals hired for this type of work. Hayes would either submit a bid for work that needed to be performed or he would bill Ginger C at an hourly rate of $12 per hour, plus the cost of any materials provided. The company also reimbursed Hayes for the use of his personal truck. Asmar testified that Hayes always provided his own tools, and that if Hayes needed a tool to perform the work, it would be purchased for him, and the cost deducted from his check. Hayes's testimony conflicted with that of Asmar's in that Hayes alleged Asmar did not tell him he was an independent contractor or that he worked job to

job. Hayes was working on a concrete job that involved replacing the concrete flooring of a basement of one of the properties. After the job was complete, Hayes took off his work boots to find that he had concrete burns on his legs. He was admitted to the burn unit, where he was diagnosed with third-degree burns. Skin grafts were required on his legs, and he spent four days in the hospital. Hayes testified that he missed two to three weeks of work because of his injuries.

1. The issue was whether Claimant was an independent contractor or a statutory employee.
2. The Missouri Court of Appeals upheld the Commission's finding that Hayes was an independent contractor.

Reasoning: Asmar testified that everyone working for him in 2013 was an independent contractor, Ginger C had no employees in 2013 and did not issue any W2s. Asmar bought tools for Hayes to keep and deducted the cost from Hayes's check, Hayes was reimbursed if he bought materials himself, Asmar left the work hours up to Hayes, and Hayes could turn down any job requests from Asmar. The Court also held that Hayes did not sustain his burden to establish a statutory employment relationship with Ginger C because the activity that resulted in Hayes's injury was concrete work and there was no evidence that concrete work was routinely performed by Ginger C on its rental properties.

B. *Martinez v. Nationwide Paper*, 211 S.W.3d 111 (Mo. Ct. App. S.D. 2006)

Facts: Nationwide distributed paper products to regional customers. Its warehouse in Springfield, Missouri stored its paper products. Claimant was unloading a truck for the supplier he worked for at Nationwide's warehouse and sustained several fractures to his right foot when his foot became smashed between two floor jacks. Claimant alleged that Nationwide was his statutory employer.

1. The issue was whether Claimant was an independent contractor or a statutory employee.
2. The Missouri Court of Appeals upheld the Commission's final award denying compensation and stated that Nationwide was not Claimant's statutory employer.

Reasoning: The Court determined that Claimant failed to prove the first prong of the test used to analyze whether an individual is a statutory employee. The first prong that must be proven is whether the work was being performed pursuant to a contract. The Court found that Nationwide did not have a contractual duty to unload the paper products that it purchased and had delivered to its warehouse. The Court also noted that Nationwide had never voluntarily unloaded products before. Therefore, because Claimant was not injured while carrying out a duty routinely performed by Nationwide, the Court found Claimant's claim was non-compensable.

C. *Busselle v. Wal-Mart*, 37 S.W.3d 839 (Mo. Ct. App. S.D. 2001)

Facts: Claimant worked as an electrician and engaged in electrical contracting for a variety of customers. He first performed work for Wal-Mart at a store in Buffalo, Missouri to install electrical wiring at that store prior to its opening. Claimant then agreed to change ballasts in fluorescent lighting fixtures on an as needed basis in Wal-Mart's Buffalo, Missouri and Bolivar, Missouri stores. Wal-Mart employees previously changed the ballasts, but Wal-Mart's home office instructed store managers that only licensed electricians should perform that task. Claimant came to those two stores to change the ballasts when contacted directly by Wal-Mart. There was no set schedule. Wal-Mart provided the ballasts and light tubes, a ladder, and an employee to assist Claimant. Claimant used his own tools to change the lighting fixtures. Claimant was injured when trying to change a lighting fixture in the autobody area, which had ceilings higher than the rest of the store. Claimant tried to reach the fixture by standing on a concrete block that the Wal-Mart employee placed on top of the ladder. The block shifted, and Claimant fell from the ladder.

1. The issue was whether Claimant was an independent contractor or a statutory employee.
2. The Missouri Court of Appeals upheld the Commission's finding that Wal-Mart was Claimant's statutory employer.

Reasoning: The Court utilized the "usual business" test and analyzed whether Claimant's changing of the lighting fixtures was (1) routinely done, (2) on a regular and frequent schedule, (3) contemplated in an agreement, and (4) the performance of which would require the statutory employer to hire permanent employees without the agreement. Here, the Court decided that even though there was no set schedule for Claimant to change the lighting fixtures, his doing so still occurred routinely and frequently. The Court also held that there was a clear agreement between Wal-Mart and the Claimant. With regard to the last factor of the usual business test, the Court held that even after Wal-Mart hired Claimant to change the fixtures, Wal-Mart continued to use a regular Wal-Mart employee to assist Claimant. Therefore, the Court concluded that Wal-Mart was Claimant's statutory employer.

Notes Pages

Notes Pages

INTERPLAY OF THE ADA, FMLA & WORKERS' COMPENSATION

I. What is the ADA?

The Americans with Disabilities Act requires employers to accommodate disabled employees by finding other job positions in which the employee can perform with or without an accommodation, if those positions are vacant.

This Act applies to employers who have 15 or more employees, and those workers who have a disability.

- A disability is defined as: a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.
- The ADA does not specifically name all of the impairments that are covered.
- Major life activities include: seeing, hearing, eating, talking, sleeping, learning, standing, bending, lifting, communicating, reading, concentrating and thinking.

Not all situations involving an employee requesting a change at work for a medical purpose are classified as requesting accommodation. Employers should consider whether the ADA applies or not for each complaint or request. Further, employers can ask an employee, with a known disability, if they need accommodation when the employer reasonably believes the employee may need it.

When the employee requests accommodation, the employer and employee should have a general conversation to determine what would be reasonable and appropriate under the circumstances. In some instances, the disability and accommodations will be readily obvious. Under the ADA, employers must limit the scope of a medical inquiry if it is in response to a request for accommodations. Employers may request additional information, such as medical documentation that establishes the specific disability and need for accommodation. It can also be beneficial for learning more about a certain disability and the nature of the symptoms: predictability, frequency of occurrence, duration, etc.

The accommodation must be reasonable. Further, the employer does not need to create a new job to accommodate the now disabled employee, rather only place them in a vacant light duty job that is available. The employer is required to accommodate the disability unless it is considered unreasonable, or they would result in an undue burden. There are no specific procedures or policies the ADA dictates that employers must follow to accommodate disabilities, but it is recommended that employers create their own to be prepared and consistent. It can be useful to employers to document their compliance with the ADA and can also be beneficial to employees in their expectations.

Generally, light duty jobs refer to work that is physically or mentally less demanding than the duties of the normal job. Light duty also may refer to excusing certain job functions the employee cannot perform due to their disability. Further, light duty jobs are those that are created specifically for the purpose of providing other forms of work for those

employees who are unable to perform a portion of their normal duties. The ADA does not require light duty jobs be created, but the employer must provide some alternative forms of reasonable accommodation in their absence. Therefore, the existence of light duty jobs can force the employer to keep an employee that has been disabled who otherwise would not have been retained.

The employee must be given the vacant job even if other employees are more qualified, so long as the employee meets the job's minimum qualifications. The vacancy in that light duty job creates an obligation. However, permanent light duty is not required as indefinite accommodations are not reasonable. The Sixth Circuit Court confirmed that in *Meade v. AT&T Corporation*, No. 15-6362 (6th Cir. 2016).

The employer can still insist that the employee still be able to perform all the essential functions of the job even if they involve a variety of tasks in a wide range of environments. If that employee is unable to physically work for the employer with or without accommodation, they may be subject to termination.

II. What is FMLA?

FMLA is the Family and Medical Leave Act and requires employers to provide up to 12 weeks of unpaid leave during a 12-month period of birth or adoption. The Act also applies to a serious health condition of the employee or family member. At the culmination of the employee's leave covered under FMLA, the employer must reinstate the injured worker to the same job/position the employee had before. If that is not the case, a job that is substantially the same would qualify as well if the absences could be intermittent.

The Act's purpose is to either allow the parent to bond with their new child; to care for a spouse, child, or parent who has a serious health condition; or to deal with a serious health condition themselves.

FMLA applies to all government employees and private employers with more than 50 employees in a 75-mile radius. Prior to the start of leave, employees must have worked at least 12 months and 1,250 hours at a jobsite where 50 or more employees work within 75 miles. However, the 12-month requirement does not have to be consecutive. The 1,250-hour requirement must be within the preceding 12 months. Employees must also give the employer notice of leave, and medical certification may be required. Notice must be given 30 days prior to birth or adoption if it is "foreseeable," and for serious health conditions as well if it is practicable. To certify the leave of the employee, the employer can require other proof, such as other medical opinions. This additional proof is at the cost to the employer.

Rights of Employees on Leave:

- Group health benefits must be maintained as if the employee returned to work
- Once the employee returns, the position they left in must be available
- Up to 12 weeks of unpaid leave
- Protection from employer retaliation for exercising rights
- The highest paid 10% of salaried employees have limited rights to return to their position if there is a specific substantial and grievous economic injury to the operations of the employer due to the restoration of the employee.

Events that Qualify:

- Pregnancy
- Birth of a child
- The employee being placed with an adoptive child or foster child
- A spouse, child, or parent (not parent-in-law) of employee has a serious health condition
- Employee has a serious health condition
- Employee's spouse, child, or parent is on covered active duty or call to covered active duty status as a member of the National Guard, Reserves, or Regular Armed Forces

Childcare leave should be taken in one lump, unless the employer agrees otherwise. If the parents of a new child – born or adopted – share the same employer, the employer can dictate that the parents must split their leave, in essence each receiving half.

Routine medical care, part-time workers, care for pets, or care for elderly relatives other than parents are situations that do not apply.

III. Retaliation and Work Comp

No employer or agent shall discharge or discriminate against any employee for exercising any of his or her rights under this chapter when the exercising of such rights is the motivating factor in the discharge or discrimination. Any employee who has been discharged or discriminated against in such manner shall have a civil action for damages against his or her employer. For purposes of this section, "motivating factor" shall mean that the employee's exercise of his or her rights under this chapter actually played a role in the discharge or discrimination and had a determinative influence on the discharge or discrimination. Mo. Ann. Stat. § 287.780 (West)

Employees need only to prove that the filing of a workers' compensation claim was a "contributing factor" to the employees' discharge, termination, or discipline rather than the "sole, exclusive factor." *Templemire v. W & M Welding, Inc*., 433 S.W.3d 371 (Mo. Banc. 2014). This is a change from the old standard that required that the exercise of workers' compensation rights was the "sole, exclusive factor in the employee's termination." In line with this change, it allows an employer to potentially be held liable if the employer had a legitimate, non-discriminatory reason for the termination or discipline. If the employee can prove that the claim at least contributed in part to the adverse action against him, the employee may have a retaliation claim.

Suggestions on how Employers Can Handle the Change:

- Keep accurate records detailing specifically why an employee was disciplined or dismissed. The less precise the circumstances detailing the situation are, the more likely an employer may be subjected to a workers' compensation claim even when they have a legitimate, non-discriminatory reason.
- Be consistent in disciplinary actions against all employees. Employees being disciplined in various lengths or manners for the same wrongdoing can point to exterior variables playing a contributory role.
- Understand that all disciplinary actions are subject to review in subsequent proceedings should a particular employee claim retaliation.

- Strive to ensure fair, transparent, and appropriate disciplinary actions that would be found to be reasonable and upheld when examined by a neutral third party.

Federal law does not prohibit workers compensation retaliation specifically, but various other types of retaliation are covered. However, most states have some sort of protection for workers' compensation retaliation.

Retaliation can be shown in different ways, and while some forms are obvious, such as termination, others may be more subtle. Therefore, the circumstances of the situation and the employer's action must be examined. If the employer's adverse action would deter a reasonable person in the situation from making a complaint, then it likely constitutes illegal retaliation. Additionally, the law protects those who cooperate in Equal Employment Opportunity Commission (EEOC) investigations, or serve as a witness in EEOC litigation, as well as whistleblowers or those on FMLA leave.

For purposes of statute prohibiting employer from discriminating against employee in retaliation for exercising rights under workers' compensation law, discrimination may take various forms, including denying employee advancement, denying salary or hourly pay increases, or assignment to less desirous jobs or locations. *Palermo v. Tension Envelope Corp*. (App. E.D. 1997) 959 S.W.2d 825, rehearing and/or transfer denied.

IV. Health Insurance and Work Comp

In Missouri, employers generally are required to continue the health insurance of employees who are off work due to a work injury. However, employers can require the employee to pay their own premium while on leave. While most states prevent retaliation by employers regarding work comp claims, many states do not address the issues of whether benefits must be continued, and as such, some employers choose to cease payments for health coverage.

In response, there are two federal programs that mandate the continuation of health coverage benefits for those employees on leave. These programs aim to assist injured workers and allow for health coverage to go on, but the employee is still required to pay the cost, or their normal share of the premiums. In both situations, if the employee ceases to make the payments on the premiums as required, the employer can terminate the health insurance coverage.

- FMLA:
  - As mentioned prior, the Family and Medical Leave Act can provide employees with up to 12 weeks of unpaid leave per year if the employee and employer both qualify as candidates for the program. If FMLA is applicable, the employer must maintain the same level of health insurance benefits the worker had before taking the leave.
  - However, if the employee exceeds the 12 weeks allotted for leave, the employer can cancel those continuing health benefits.
- COBRA
  - The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) can be considered when either the employee or employer does not qualify for FMLA, or the employee has exhausted his allotted FMLA leave. This Act applies to private employers with 20 or more employees. This option allows for

continuation of health coverage (to the employee, spouses, former spouses, and dependent children) after a "qualifying event" causes an employee to lose health care coverage. The specific health care plan should be consulted to determine if there are standards, such as a minimum hour worked requirement, that would leave the employee ineligible for coverage. If so, a COBRA notice should be issued to the employee, as a "reduction of hours of the covered employee's employment" as one of the qualifying events that triggers COBRA.

- The failure to provide COBRA continuation notices can result in the risk of civil penalties imposed on the employer. Some other triggering events include death of employee, divorce, termination, or a child's loss of dependent status.

V. Return to Work /Fitness for Duty

Maximum medical improvement, or MMI, occurs when the employee who was injured reaches the stage where his condition is at full improvement, and the healing process has plateaued with treatment. No additional significant change in the injury condition is expected after MMI is reached. At this point, the condition is assessed, and the degree of partial or permanent impairment is determined.

The need for an exam to test for fitness for duty can be significant because the medical and temporary disability benefits end at maximum medical improvement and can do so without any mention from a treating physician about whether the employee is able to return to work. When an employee seeks to return to work following a work comp absence and has restrictions from a doctor, a functional capacity examination is suitable to determine the employee's capabilities.

Fitness for duty exams, or return to work exams, can be conducted and determinative regarding the employee's ability to work again even though the worker's doctor has given the full or partial release. Under the ADA, the employer cannot discriminate against a disabled worker when hiring, but if the worker is no longer able to perform the essential functions of his job or is posing a threat to the safety and health of himself or those around him, the ADA likely does not cover the prohibition of that employee working.

After taking FMLA leave, an employer may request a fitness for duty certification before the employee returns to work. The law provides the employer assurances that the employee is ready and able to do the previous job duties that they had prior.

VI. Earned Leave, FMLA, and Work Comp

Section 103(c) of the FMLA states that, as a general rule, the leave is unpaid. But there are certain circumstances in Section 102(d) when the employee may substitute accrued paid leave to run concurrently with the unpaid leave. Employees may elect the substitute, or employers may require it if they choose. When employees seek FMLA leave to care for a qualifying family member's serious health condition, accrued paid sick, medical, personal, or vacation leave may be substituted. 29 U.S.C. § 2612(d)(2)(B); 29 C.F.R. § 825.207(c).

Employers are not required to provide paid sick leave or paid medical leave in any situation in which such employer would not have normally provided any such paid leave. The circumstances are also dictated by the employer's specific leave plan. Employers

can limit the situations in which the paid leave can be substituted, such as FMLA leave to care for a child not qualifying for paid sick leave if the plan allows it only to be for the employee's own condition. Essentially, employers maintain medical or sick leave policies distinct and separate from FMLA and will not be required to provide paid leave where the reason is not covered by their policy.

The regulations provide that when employees are on leave under a short-term disability or work comp claim, the choice to substitute paid leave for unpaid FMLA leave is inapplicable because such benefit plans already provide compensation and thus the leave is "not unpaid." 29 C.F.R. §§ 825.207(d)(1)-(2). If the disability for which the employee is receiving workers' compensation benefits also qualifies as a serious health condition under FMLA, an employer may designate FMLA leave to run concurrently with the employee's work comp or disability leave.

If the requirements to qualify for disability plan payments are more stringent than those of FMLA, the employee may either satisfy the more stringent plan standards or instead choose not to receive disability plan payments and use unpaid FMLA leave or substitute available accrued paid leave.

VII. Privacy, Medical Records, and Work Comp

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects employee privacy and restricts how medical records may be distributed. However, the HIPAA Privacy Rule permits the disclosure of medical records and other health information without individual authorization in situations concerning workers' compensation. This extends to workers' compensation insurers, third-party administrators, and some employers to manage the workers' compensation claim at hand. The disclosure laws vary from state to state, and the Privacy Rule intends to provide only the minimally required information needed to manage the claim.

Though workers' compensation claims are generally exempt from HIPAA rules, covered entities are required "reasonably to limit the amount of protected health information disclosed under 45 CFR 164.512(l) to the minimum necessary to accomplish the workers' compensation program."

VIII. General Release and Resignation Agreements

For many years, employers have considered offering additional consideration for an injured worker to execute a General Release and Resignation Agreement at the time the offer is extended to resolve the workers' compensation claim. These release and resignation documents are negotiated separately, and separate consideration is paid by the employer for the release. The payments cannot be issued by the workers' compensation insurance carrier or self-insured as a work comp payment as they are not "workers' compensation" benefits. The respective state Division of Workers' Compensation has no jurisdiction over a Release and Resignation Agreement and will not sign off on such a document or weigh in on the reasonableness of such a document. The motivations for employers to propose a release and resignation for an employee who is in the process of resolving his or her workers' compensation claim vary and can include the following:

1. The workers' compensation settlement contemplates some aspect of either a temporary or permanent wage loss;
2. Where the employer has a legitimate concern that there is additional civil exposure under the ADA based upon their potential inability to accommodate the permanent work restrictions from the workers' compensation claim, even with reasonable accommodations. Litigation expenses on these types of cases can be expensive and sometimes it is preferred to deal with the issue pre-suit as opposed post-suit;
3. The claimant has already been separated from employment (voluntarily or involuntarily) and the employer wants a clean well-documented separation regarding former employees;
4. Standard corporate policy.

Workers' compensation benefits in Kansas, Missouri, Illinois, Iowa, Nebraska, and Oklahoma, are state entitlements. In other words, if a claimant sustains a compensable accident arising out of and in the course of his/her employment, the injured worker is guaranteed certain benefits per statute. Additionally, the worker does not have to resign to receive his/her workers' compensation benefits. In light thereof, the employer cannot force the claimant to quit his or her job in order to receive the workers' compensation benefit entitlement.

As noted above, employers have been offering additional consideration to entice employees to execute Release and Resignation Agreements for years. Recently, however, some employers have begun **insisting** that a claimant resign to receive his/her workers' compensation benefit entitlement. In some states, this is the norm and not looked upon unfavorably by the Division of Workers' Compensation or the claimant's bar. In our midwestern states listed above, however, it is not standard operating practice to demand that an employee resign and execute a general release in order to receive his/her workers' compensation benefits in every case.

The workers' compensation systems are designed to run smoothly with a vast percentage of compensable claims settling without requiring significant litigation. Refusing to pay permanent impairment or permanent disability benefits pursuant to the rating of the authorized treating physician or refusing to engage in reasonable settlement negotiations (absent a legitimate reason for doing so) between the rating of the treating physician and the rating of the claimant's attorney's rating physician is met with open hostility by our judges. This is viewed as an impediment to the appropriate functioning of the respective Workers' Compensation Act and, depending upon the respective state statute, could be viewed as a fraudulent or abusive act or expose the employer and/or carrier to additional penalties.

For example, in **Kansas**, K.S.A. 44-5,120 describes fraudulent or abusive acts or practices as including denying or attempting to deny payments of workers' compensation benefits for any person. The list of acts could be interpreted broadly to include not paying the treating doctor's impairment rating when there is no legitimate dispute for not paying it. K.S.A. 44-5,125 even provides potential criminal penalties depending upon the amount

of benefits in question. K.S.A. 44-512b provides an avenue for the Administrative Law Judge to award interest as a penalty if the judge finds that there was not just cause or excuse for the failure of the employer or insurance carrier to pay, prior to an award, the compensation due. The statute provides that such interest shall be assessed against the employer or insurance carrier and shall accrue from the date such compensation was due. The interest is considered a penalty and shall not be considered a loss or a loss adjustment expense by the insurance carrier regarding rates. Some lawyers will demand payment of the lowest rating and trigger the statute when there are no other issues in dispute.

In **Missouri**, R.S.M.O. section 287.128 provides that it is unlawful for any insurance company or self-insurer in the state to knowingly and intentionally refuse to comply with known and legally indisputable compensation obligations and provides criminal penalties for violation thereof. R.S.M.O. section 287.780 specifically provides that no employer or agent shall discharge or discriminate against any employee for exercising any of his/her rights under the Missouri Workers' Compensation Act when the exercising of such rights is the motivating factor in the discharge or discrimination. Any employee who has been discharged or discriminated against in such manner shall have a civil action for damages against his/her employer. The statute provides that for the purposes of this section, "motivating factor" shall mean that the employee's exercise of his/her rights under the Missouri Workers' Compensation Act actually played a role in the discharge or discrimination and had a determinative influence on the discharge or discrimination.

The **Illinois** Workers' Compensation Act provides that it shall be unlawful for any employer, insurance company, or adjustment company to interfere with, restrain, or coerce an employee in any manner whatsoever in the exercise of the rights or remedies granted to him or her by the Workers' Compensation Act or to discriminate, attempt to discriminate, or threaten to discriminate against an employee in any way because of his/her exercise of the rights or remedies granted to him/her by the Workers' Compensation Act. 820 ILCS 305/25.5(h).

Certainly, nothing mentioned above should be construed to mean that an employer cannot offer additional consideration to entice the claimant to sign the Resignation and Release Agreement. The key in negotiating these releases and resignations is communicating that it is a separate and independent offer from the workers' compensation settlement offer. Furthermore, such releases and resignations are more likely to be accepted, if not expected, when they are offered when the claimant is already no longer working for the employer or when there is a nexus between wage loss and the value of the workers' compensation claim.

In the sections below, we point out those circumstances where there would be a nexus between the workers compensation benefit settlement amount and an element of wage loss:

Kansas:

Certain types of benefits payable under the Kansas Workers' Compensation Act do contemplate the fact that the injured worker has either a partial or complete wage loss as a direct result of the work accident. These types of benefits are generally referred to as work disability benefits or permanent total disability benefits.

An injured worker in Kansas is entitled to work disability benefits if he/she has sustained a greater than 7.5% impairment to the body as a whole as a result of the work accident. An injured worker is also entitled to work disability benefits if their overall impairment exceeds 10% to the body as a whole in cases where there is preexisting functional impairment, and the injured worker sustains a post-injury wage loss attributable to the work accident of at least 10%. In these cases, the injured worker may have returned to work for the employer against whom the claim is being pursued but at a lower wage rate or may be alleging that there is no work available to him/her with that employer and that he/she will have a wage loss when seeking his/her next job.

In Kansas, there would also be a nexus between wage loss and the workers' compensation benefit entitlement when the injured worker claims they are permanently and totally disabled from any employment. In these circumstances, the claimant and the claimant's employer are more likely to agree to a release and resignation at a low consideration level. Of course, if the injured worker's attorney believes that the employee has valid claims against the employer outside of the workers' compensation system under the ADA, FMLA, or other state/federal action, then the abovementioned nexus alone will not be enough to encourage the release/resignation for a relatively low consideration.

Senate Bill 430, recent legislation in Kansas that took effect July 1, 2024, includes a reduction in the Social Security offset. Previously, this offset allowed employer's insurance carriers a dollar-to-dollar credit against temporary and permanent weekly disability payments. However, this new enactment states that an award of permanent partial or permanent total disability shall be subject to an offset equal to fifty percent of the Claimant's Social Security retirement benefits. This enactment aims to benefit working seniors injured on the job. Finally, an award of temporary total disability and temporary partial disability benefits shall not be subject to an offset for Social Security retirement benefits.

Missouri:

Missouri workers' compensation benefits are described in terms of overall disability rather than separated between impairment and work disability. Awards for the injured worker's disability consider both the nature of the injury and the impact of that injury on the person's ability to earn comparable wages. The Administrative Law Judges are more likely to nudge up the award of disability if the injury prevents the claimant from doing his/her former job and earning the same type of wages earned pre-accident. This procedure is not a mathematical formula based on a specific percentage of wage loss.

For permanent total disability cases, however, the injured worker formally alleges that he/she cannot engage in any substantial and gainful employment. In these situations, absent other civil liability concerns, the injured worker and his/her attorney would tend to be more agreeable to executing a general release and resignation at a lower level of consideration.

Illinois:

In Illinois, if a petitioner sustains a reduction in earnings capacity due to the work injury and is unable to return to their "usual and customary" line of employment, they could be entitled to wage differential benefits. Wage differential benefits are weekly benefits to be paid at two-thirds of the difference between the petitioner's pre-injury and post-injury earnings' capacity. These weekly payments are made to the petitioner for five years or until they are 67 years old, whichever is longer. Along with that, the petitioner could be entitled to formal vocational retraining or rehabilitation to be provided by the employer/insurer.

Additionally, if the work injury prevents the petitioner from returning to their "usual and customary" line of employment but does not reduce their earnings capacity, they could be entitled to a loss of occupation or loss of trade claim, which substantially increases the arbitrator's permanency award. Loss of occupation cases are valued as unscheduled, body as a whole (500 weeks), injuries rather than scheduled injuries. This, in turn, increases the value of the claim.

Permanent total disability means the petitioner is alleging he is permanently incapable of obtaining any type of gainful employment in the labor market. In all these situations, absent other civil liability concerns, the petitioner/petitioner's counsel, would tend to be more agreeable to executing a general release and resignation at a lower level of consideration, given that the petitioner already cannot return to work at their former employer.

Iowa:

Wage or job loss in Iowa comes into play primarily in a few scenarios. First, injured workers in Iowa who have suffered a body as a whole injury before July 2017 (including shoulder injuries) are entitled to industrial disability benefits regardless of their employment status with the employer for which they were employed at the time of the injury. Industrial disability is a determination of the injured worker's loss of earning capacity, and consideration may be given to several factors, including functional impairments, age, education, qualification. Experience, and inability to perform work that suits the worker. Not all pre-July 2017 injuries will result in higher industrial disability due to actual wage or job loss since the determination depends on the loss of earning *capacity*, not necessarily loss of actual earnings. The reason for the wage or job loss would be one factor in the overall determination of industrial disability.

Whole body injuries occurring after July 1, 2017, are handled differently, with no automatic right to industrial disability. Iowa Code Section 85.34 (2)(v) states that "if an employee

who is eligible for compensation under this paragraph returns to work or is offered work for which the employee receives or would receive the same or greater salary, wages, or earnings than the employee received at the time of the injury, the employee shall be compensated based only upon the employee's functional impairment resulting from the injury, and not in relation to the employee's earning capacity." However, if the employee returns to his job and is later terminated, a reopening proceeding may be commenced to determine a reduction of the employee's earning capacity. These new provisions in the Iowa Workers' Compensation laws have not yet been subject to any judicial interpretation.

When shoulders were removed from body as a whole injuries in the 2017 amendments, they received a separate section in the Iowa Workers' Compensation laws that states that if an injured worker suffers a shoulder injury after July 1, 2017, and is unable to return to work because of the disability, they may be entitled to extensive vocational rehabilitation benefits including evaluation for career opportunities in specific fields, specific education programs at community colleges, and financial support for participation in the education program up to $15,000 for tuition, fees, and supplies.

Finally, permanent total disability benefits are nearly always alleged and potentially in play for a whole-body injury if the injured worker is unable to return to work and can connect that to the work injury. In Iowa, no particular type of case would be more likely to result in a resignation and release. Generally, these agreements are included in the settlement discussions when it is apparent that the employment relationship has broken down in some capacity or if it is clear the injured worker already intends to resign. However, if there appears to be a potential valid claim under employment laws, the resignation and release may become a significant issue in the negotiations, requiring substantial participation and consideration, often at mediation, from the employer.

Nebraska:

Wage loss resulting from a non-scheduled injury in Nebraska is a factor in determining the extent of permanent partial disability (PPD) which is measured by Loss of Earning Power (LOEP).

There are four factors taken into consideration when determining LOEP, as follows:

1) Loss of ability procure employment generally;

2) Loss of ability to earn wages;

3) Loss of ability to perform the tasks of the work; and

4) Loss of ability to hold a job obtained.

It is possible for the injured worker to have a LOEP even if the worker returns to work for the same employer at the same or higher wage because of the other factors considered when determining LOEP. Thus, not every non-scheduled injury and finding of LOEP involves a wage loss, but often a wage loss is involved and due to permanent work restrictions assigned for the injury. A finding of a 100% LOEP is a finding of permanent total disability (PTD) and thus will always include an element of wage loss. Injured

workers in Nebraska are often willing to consider a release/resignation for a nominal amount in cases of PTD and in those cases of PPD where the injuries do not allow for return to work for the employer on date of accident.

Oklahoma:

In Oklahoma, like Missouri, permanent disability is not separated between physical impairment and loss of wage earning capacity. Under Title 85 Section 2 permanent disability is defined as, "permanent disability or loss of use after maximum medical improvement has been reached which prevents the injured employee, who has been released, to return to work by the treating physician, from returning to his or her pre-injury or equivalent job. All evaluations of permanent disability must be supported by objective findings."

Based on this definition, only physical impairment can be considered. However, also under Section 2 of Title 85A, disability is defined as, "incapacity because of compensable injury to earn, in the same or any other employment, substantially the same amount of wages the employee was receiving at the time of the compensable injury." Many claimant's attorneys are arguing that this gives a rise to damages in the nature of lost wages. To this date, that has not been successfully pled.

Additionally, Oklahoma can grant vocational training if the employer is unable to put the claimant back to work within a reasonable accommodation. Certainly, the Administrative Law Judges have some discretion on the permanent disability awarded. If the claimant was unable to return to work, we generally see the permanent disability a little higher, or even if they are able to return to work but have some permanent restrictions and require accommodation. For injuries resulting in permanent restrictions where the employer is not able to accommodate, claimants and attorneys are usually more open to a release and resignation generally for a bonus or additional funds for re-training or job placement

IX. Pitfalls of the Resignation and Release Offer:

If the injured worker accepts the additional consideration for the separate release and resignation, then the employer gets a full release of all potential outstanding claims against them and obtains a clean separation of employment. The claimant receives the additional consideration offered by the employer and formally executes the Release and Resignation Agreement document. In certain situations, however, the injured worker may not want to resign or execute a general release and the mere fact that the employer offered the release and resignation can be used against the employer later when an individual is terminated.

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MARIJUANA AND WORKERS' COMPENSATION

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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PARTNERING FOR EFFICIENCY: TIPS ON WORKING TOGETHER TO RESOLVE CLAIMS QUICKLY

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 to the employee 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 following an 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 can 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 for 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 during 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 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 mediation: some jurisdictions require mediation before a request for a 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 to proceed with an authorized medical procedure or not, that hesitancy 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 then 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.

V. Understanding Vendors and Their Effect on Settlement

A. A greater understanding of various vendors provides a valuable resource when attempting to participate in settlement negotiations. Insurance carriers and self-insured employers use vendors to outsource services to multiple organizations, such as third-party administrators, managed care organizations, and various medical providers, including network providers and specialized clinics. These services provide employers ample opportunity to focus their efforts on moving cases toward early resolution when appropriate. By understanding these vendors more deeply, one can fully prepare and outline various negotiation strategies that best suit their practice to move cases quickly and efficiently.

- Third Party Administrators (TPAs) provide services such as claims processing and employee benefits management under contract to another company. An example of a TPA includes Gallagher Bassett.
- Managed Care Organizations (MCOs) are used to control medical costs and ensure quality care for injured workers by coordinating medical services and providing case management resources. Coventry Workers' Comp Services is an example of an active MCO.
- Finally, states have multiple options for medical providers, including network providers and specialized clinics. Network providers, such as hospitals, clinics, and specialized medical practitioners, ensure quality care and cost control. Specialized clinics work closely in occupational health and workers' compensation cases.

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NAVIGATING THE SECOND INJURY FUND

AN OVERVIEW OF THE FUND AND ITS IMPACT ON OUR NEGOTIATIONS

I. What is the Second Injury Fund?

The Second Injury Fund compensates injured employees when a current work-related injury combines with a prior disability to create an increased combined disability. Fund law, governed by Section 287.220, changed significantly in 2014. The impact of those changes is still being flushed out as case law continues to shape the interpretation of the statutory requirements to obtain Fund benefits. Because of that ambiguity, claimants are now arguing that employers/insurers should be liable for total disability claims if the claimant cannot satisfy the requirements to recover from the Fund, even if the claimant is not totally disabled from the last injury alone.

II. Preexisting Condition Requirements for Permanent Total Fund claims

- □ Must be a medically documented preexisting condition;
- □ Equal to at least 50 weeks of permanent partial disability; and
- □ Fall into one of the four following categories:
  - □ A direct result of active military duty in any branch of the United States Armed Forces;
  - □ A direct result of a compensable injury;
  - □ A preexisting disability which is aggravated or accelerated by the subsequent injury; or
  - □ An injury which is to the opposite extremity of the primary injury.

This isn't as straightforward as it may seem. These requirements apply to each preexisting condition and several have not been examined by the courts.

III. What to Expect in Negotiations

- Claimants' attorneys will be more inclined to demand at least fifty weeks for each body part for which claimants treat in an effort to help preserve future Fund claims.
- Savvy claimants' attorneys won't want to settle possible total disability claims with employers/insurers if there is any ambiguity in the strength of their Fund claims.
- Claimants may demand a premium to let employers/insurers out of a case prior to hearing against the Fund. Factual circumstances can heavily influence the appropriateness of compromise on PPD in those situations. Be sure to discuss any such demands with counsel to ensure the benefits and risks are fully assessed.
- Depositions will be critical as expert testimony can largely make or break our ability to shift liability for total disability to the Fund, so they will likely be recommended to solidify our defenses.
- Prior medical records, relevant employment records, and any settlement stipulations will be essential when trying to assess our ability to shift liability to the Fund.
- There may be delays. As new cases go through the court system, claimants remain hesitant to try cases with Fund involvement when the case involves a component of

the requirements that has not been clearly defined by the courts. The ALJs have not been inclined to push claimants to try cases if they indicate they are awaiting guidance of case law before proceeding.

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INNOVATIONS IN WORKERS' COMPENSATION: HOW AI IS CHANGING THE GAME

I. ARTIFICIAL INTELLIGENCE: AN OVERVIEW

Artificial Intelligence (AI) is a branch of computer science focused on creating systems that can perform tasks that typically require human intelligence. These tasks include problem-solving, reasoning, learning, and understanding language. The development of AI has been a dynamic journey marked by pioneering theoretical ideas, groundbreaking technological advances, and evolving challenges.

A. Defining Artificial Intelligence

1. John McCarthy, the computer scientist who coined the phrase "Artificial Intelligence," defined it as "the science and engineering of making intelligent machines." Years later, Stanford University, where McCarthy taught, defined AI as "technology that enables computers and digital devices to learn, read, write, create, and analyze." The Oxford Language Dictionary defines AI as "the theory and development of computer systems able to perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision-making, and translation between languages."

B. Early Foundations

1. The concept of AI has roots that stretch back to ancient times. Early mechanical devices, such as the Antikythera mechanism from ancient Greece, displayed an early understanding of automated processes. Philosophers like Aristotle explored formal logic, which underpins computational reasoning. In the 19th century, figures like George Boole formalized logic further with Boolean algebra, laying the groundwork for computer science.

   Alan Turing, in the early 20th century, made crucial contributions to AI. His 1936 paper introduced the concept of the "universal machine," a theoretical construct that could simulate any computational process. This idea was fundamental in the development of modern computers. Turing's 1950 paper "Computing Machinery and Intelligence" proposed the Turing Test as a criterion for machine intelligence, assessing a machine's ability to exhibit intelligent behavior indistinguishable from that of a human.

II. THE BIRTH OF AI

The formal establishment of AI as a field occurred at the Dartmouth Conference in 1956, organized by John McCarthy, Marvin Minsky, Nathaniel Rochester, and Claude Shannon. This conference is often cited as the birth of AI as a distinct area of study. The attendees

hypothesized that "every aspect of learning or any other feature of intelligence can in principle be so precisely described that a machine can be made to simulate it." This period saw the creation of early AI programs such as the Logic Theorist, which could prove mathematical theorems, and ELIZA, an early natural language processing program.

A. Early Enthusiasm and the First AI Winter
    1. The optimism of the 1960s and 1970s saw significant advancements, including the development of early AI systems and the establishment of AI research centers. However, this period also faced significant challenges. The limitations of computer hardware, the complexity of real-world applications, and high expectations led to the first "AI winter" in the 1970s. Funding and interest in AI research declined as early AI systems failed to meet the lofty expectations set for them.

B. The Emergence of Machine Learning
    1. The 1980s marked a paradigm shift towards machine learning, a subset of AI focused on algorithms that improve through experience. Key developments included the revival of neural networks, particularly with the backpropagation algorithm, which enhanced the training of multilayered neural networks. During this period, expert systems gained prominence. These systems, such as MYCIN for diagnosing bacterial infections, used a set of rules to emulate the decision-making process of human experts. The 1980s also saw the development of decision trees and genetic algorithms, which contributed to the growing field of machine learning.

C. The Rise of Intelligent Systems
    1. The 1990s and early 2000s saw significant advancements in AI, driven by increased computational power and the availability of large datasets. This period is noted for the development of intelligent systems that could tackle more complex tasks. In 1997, IBM’s Deep Blue defeated world chess champion Garry Kasparov, demonstrating AI’s ability to perform at a high level in structured environments. This victory was a significant milestone in AI and highlighted the potential of computational approaches to complex problem-solving.

D. The AI Renaissance
    1. The 21st century marked the beginning of an AI renaissance characterized by breakthroughs in data availability, computational power, and algorithmic advances. The rise of deep learning, a subfield of machine learning involving neural networks with many layers, transformed AI research and applications. In 2011, IBM’s Watson won the quiz show "Jeopardy!" against human champions, showcasing its advanced natural language processing and information retrieval capabilities. Another landmark achievement was Google DeepMind’s AlphaGo, which defeated world champion Go player Lee Sedol in 2016. Go, a game with a

vast number of possible moves, presented a significant challenge for AI. AlphaGo's success demonstrated the power of deep learning and reinforcement learning techniques in handling complex strategic tasks. More recently, and relevant to this discussion, an AI program called Chat GPT took and passed the bar examination with a score in the 90th percentile and did so in just six minutes!

E. Advancements in Natural Language Processing

1. The 2010s and 2020s brought remarkable progress in natural language processing (NLP), driven by the development of large-scale language models. OpenAI's GPT-3, released in 2020, represented a significant leap in language generation and understanding. GPT-3, with its 175 billion parameters, was able to generate human-like text, translate languages, and even perform some degree of reasoning. Subsequent models, including GPT-4, further advanced the capabilities of NLP systems, enabling more sophisticated interactions and applications.

III. BENEFICIAL APPLICATIONS OF ARTIFICIAL INTELLIGENCE

A. Healthcare

AI has fundamentally transformed healthcare, leading to more accurate diagnoses, personalized treatments, and efficient drug discovery.

1. Medical Imaging
    a. AI has made significant strides in the field of medical imaging. For instance, the AI-powered diagnostic tool developed by PathAI assists pathologists in identifying cancerous tissues with greater accuracy. The system analyzes pathology slides and provides recommendations, helping pathologists diagnose conditions like breast cancer and melanoma more effectively. Similarly, Google's DeepMind has developed an AI model that can detect over 50 eye diseases by analyzing retinal scans, often achieving diagnostic accuracy comparable to or exceeding that of human specialists.
2. Personalized Medicine
    a. AI-driven platforms such as Tempus leverage vast amounts of genomic and clinical data to tailor treatment plans for cancer patients. By analyzing genetic mutations and their responses to different therapies, AI helps oncologists develop personalized treatment strategies that are more likely to be effective for each individual patient. This approach not only improves treatment outcomes but also minimizes the risk of adverse effects associated with less targeted therapies.
3. Drug Discovery
    a. The process of discovering new drugs can be time-consuming and costly. AI has accelerated this process through platforms like BenevolentAI, which uses

machine learning to identify potential drug candidates and predict their efficacy. For example, AI algorithms have been used to repurpose existing drugs for new therapeutic uses, such as identifying potential treatments for COVID-19, thus speeding up the development of life-saving medications.

B. Education

AI is reshaping the education sector by offering personalized learning experiences, automating administrative tasks, and enhancing language acquisition.

1. Personalized Learning
    a. AI-powered educational platforms such as DreamBox and Smart Sparrow adapt to students' learning styles and progress. DreamBox, an adaptive math program, uses AI to adjust lesson difficulty based on real-time assessments of students' understanding, providing targeted interventions and practice to address specific learning gaps. Similarly, Smart Sparrow offers adaptive e-learning experiences in various subjects, tailoring content to individual needs and enhancing student engagement.
2. Administrative Automation
    a. AI helps reduce the administrative burden on educators by automating routine tasks. Tools like Gradescope use machine learning to assist with grading assignments and exams, providing instant feedback and freeing up educators' time to focus on instructional activities. Additionally, AI-powered chatbots, such as those used by Carnegie Mellon University's CMU-Q, handle student inquiries about administrative procedures and academic resources, improving accessibility and efficiency.
3. Language Learning
    a. Language learning applications like Duolingo use AI to provide personalized language practice. By analyzing users' performance and adjusting the difficulty of exercises, Duolingo creates an engaging and effective learning environment. AI also enables speech recognition features that help users practice pronunciation and receive instant feedback, making language acquisition more interactive and enjoyable.

C. Environmental Sustainability

AI plays a crucial role in advancing environmental sustainability by optimizing resource use, monitoring ecosystems, and supporting renewable energy development.

1. Precision Agriculture
    a. AI-driven tools, such as those developed by Climate Corporation, analyze data from sensors, drones, and satellites to optimize crop management. By monitoring soil conditions, weather patterns, and crop health, these tools help

farmers make data-driven decisions about irrigation, fertilization, and pest control. For example, AI-powered systems like John Deere's See & Spray technology use computer vision to precisely target and apply herbicides, reducing chemical use and minimizing environmental impact.

2. Wildlife Conservation
    a. AI supports wildlife conservation efforts by monitoring animal populations and tracking endangered species. The Wildlife Conservation Society uses AI to analyze camera trap images, identifying and classifying animal species in remote areas. This technology helps researchers track population trends and assess the impact of conservation interventions. Additionally, AI algorithms are used to analyze acoustic data from environmental sensors to monitor biodiversity and detect the presence of endangered species.
3. Renewable Energy
    a. In the energy sector, AI enhances the efficiency of renewable energy systems. For example, Google's DeepMind has partnered with the energy provider ARM to optimize the operation of wind turbines. AI algorithms analyze weather data to predict wind patterns and adjust turbine settings for optimal energy production. Similarly, AI-driven smart grids manage energy distribution by predicting demand and balancing supply from renewable sources, contributing to a more sustainable and resilient energy infrastructure.

D. Business and Economy

AI is revolutionizing business operations by improving decision-making, enhancing customer service, and fostering innovation

1. Data Analytics
    a. AI-powered analytics platforms like Tableau and Power BI help businesses make data-driven decisions by analyzing large volumes of data and providing actionable insights. These tools enable organizations to identify market trends, optimize supply chains, and develop targeted marketing strategies. For example, Netflix uses AI to analyze viewing patterns and recommend personalized content to users, enhancing customer satisfaction and driving engagement.
2. Customer Service
    a. AI-driven chatbots and virtual assistants, such as those developed by IBM Watson and LivePerson, improve customer service by handling routine inquiries and providing instant support. These systems use natural language processing to understand and respond to customer requests, freeing up human agents to address more complex issues. For example, Sephora's chatbot offers

personalized beauty recommendations and assists with order tracking, providing a seamless shopping experience.

3. Innovation
    a. AI fosters innovation by enabling new business models and products. For instance, autonomous vehicles powered by AI have the potential to revolutionize transportation by improving safety and efficiency. Companies like Tesla and Waymo are developing self-driving cars that use AI to navigate and make real-time driving decisions. Additionally, AI-driven platforms like Canva democratize design by providing users with intuitive tools to create professional-quality graphics and marketing materials.

IV. POTENTIAL PROBLEMS WITH AI

1. Ethical Concerns
    1. One of the foremost challenges with AI is the ethical implications of its use. AI systems, particularly those involving autonomous decision-making, raise concerns about accountability and moral responsibility. For instance, autonomous vehicles must make split-second decisions in emergency situations. These decisions can have life-or-death consequences, leading to ethical dilemmas about how to program these systems. The "trolley problem," a philosophical thought experiment, exemplifies the difficulty in programming moral decisions into machines.

       Moreover, the development of AI for surveillance purposes has sparked debates about privacy and civil liberties. Governments and corporations increasingly use AI-powered surveillance tools to monitor public spaces and online activities. While such tools can enhance security, they also pose risks to individual privacy and can lead to a surveillance state where citizens are constantly monitored. Balancing security and privacy remain a significant ethical challenge.

2. Bias Discrimination
    1. Bias in AI systems is another critical issue that has garnered attention. AI algorithms often reflect the biases present in the data they are trained on. For example, facial recognition technologies have been shown to have higher error rates for people with darker skin tones compared to those with lighter skin tones. This discrepancy is primarily due to the lack of diversity in the training data. When AI systems are deployed without addressing these biases, they can perpetuate and even exacerbate existing social inequalities.

       Furthermore, biases can be introduced unintentionally by the designers of AI systems. Even with good intentions, developers may not fully recognize the biases embedded in their algorithms. For example, predictive policing algorithms, which use historical crime data to forecast future criminal activity, can disproportionately

target marginalized communities if the historical data reflects systemic biases in law enforcement practices.

a. Facial Recognition Bias - In 2018, the American Civil Liberties Union (ACLU) conducted a study using Amazon's facial recognition technology, Rekognition. The test revealed that the AI incorrectly identified 28 members of the U.S. Congress as individuals who had been arrested for criminal activity. The misidentifications disproportionately affected people of color, demonstrating how facial recognition technologies can perpetuate racial bias. This controversy raised concerns about the use of facial recognition by law enforcement and led to calls for stricter regulations and oversight.

b. Hiring Algorithms - Amazon faced backlash in 2018 when it was revealed that its AI- powered hiring tool was biased against female candidates. The algorithm was designed to screen resumes and recommend candidates, but it was found to favor male applicants over female ones. The bias emerged because the system was trained on resumes submitted over a decade, which reflected historical gender imbalances in tech roles. As a result, Amazon had to scrap the project and address the broader issue of bias in AI recruitment tools.

3. Privacy Implications

1. The collection and use of personal data by AI systems pose significant privacy concerns. Many AI applications, such as recommendation engines and personal assistants, rely on vast amounts of data to function effectively. This data often includes sensitive information about individuals' habits, preferences, and personal details. The challenge is ensuring that this data is collected, stored, and used in ways that respect individuals' privacy rights.

   In addition, the risk of data breaches and unauthorized access to personal information is a growing concern. AI systems can be targeted by cyberattacks, potentially exposing sensitive data to malicious actors. Ensuring robust security measures and transparent data practices is essential to protecting user privacy and maintaining trust in AI technologies.

   a. Cambridge Analytica Scandal - The 2018 Cambridge Analytica scandal highlighted the misuse of personal data by AI-driven political consulting. The firm harvested data from millions of Facebook users without their consent to build psychological profiles and target political ads. This case raised serious concerns about data privacy and the ethical implications of using AI for political manipulation. The scandal led to increased scrutiny of data practices and privacy regulations for tech companies.

b. Smart Home Devices - In 2019, a security flaw in Google Nest smart home devices was discovered, allowing unauthorized access to users' video feeds. The vulnerability exposed personal data and led to privacy concerns about the security of AI-driven home automation systems. The incident underscored the importance of robust security measures and transparency in the design and implementation of AI technologies.

4. Potential for Misuse
    1. AI technologies have the potential for misuse in various ways, ranging from the creation of deepfakes to the automation of harmful activities. Deepfakes, which use AI to create hyper- realistic but fake videos, pose significant risks to individuals and society. They can be used to spread misinformation, damage reputations, and influence public opinion. The ease with which deepfakes can be created and disseminated complicates efforts to combat their misuse.

       Additionally, AI-powered tools can be employed in malicious ways, such as developing autonomous weapons or conducting cyberattacks. The potential for AI to be used in warfare or criminal activities raises concerns about global security and the ethical implications of AI in military contexts. Further, even proposed beneficial uses – like autonomous vehicles – have risks that can cause harm. - Developing international regulations and norms for the use of AI in these sensitive areas is crucial to mitigating these risks.

       a. Deepfakes and Misinformation - The rise of deepfakes—AI-generated videos that manipulate reality—has led to issues of misinformation and defamation. In 2018, a deepfake video of President Obama, created by BuzzFeed and filmmaker Jordan Peele, demonstrated how AI could be used to fabricate realistic but false content. The technology poses risks of spreading fake news, damaging reputations, and influencing public opinion, raising ethical concerns about its responsible use and potential for abuse.
       b. AI in Warfare - The use of AI in military applications, such as autonomous weapons systems, has led to ethical and legal debates. In 2018, a letter signed by over 100 researchers and activists called for a ban on lethal autonomous weapons, citing concerns about the lack of accountability and the potential for misuse. The development and deployment of AI in warfare pose significant challenges regarding international law, ethics, and the potential for unintended consequences.
       c. Uber’s Fatal Self-Driving Accident - In 2018, an Uber self-driving car struck and killed a pedestrian in Tempe, Arizona. The incident was attributed to a combination of technological limitations and human error, as the vehicle's AI system failed to recognize the pedestrian in time. This tragedy raised questions about the safety and regulatory oversight of autonomous vehicles. Following

the accident, Uber halted its self-driving program and faced legal scrutiny over the technology's reliability and the company's safety protocols.

d. Tesla's Autopilot Accidents - Tesla's Autopilot system has been involved in several high- profile accidents, including fatal crashes. In 2016, a Tesla Model S in Autopilot mode collided with a semi-truck, resulting in the driver's death. Investigations revealed that the system did not detect the truck due to its white color blending with the sky. The incidents have sparked debates about the limitations of semi-autonomous driving systems and the need for clear guidelines on their use and safety.

V. PREDICTIVE VS. GENERATIVE AI

1. Predictive AI
    1. Purpose – Predictive AI focuses on forecasting future outcomes based on historical data. It analyzes patterns and trends to make informed predictions.
    2. Functionality – It uses statistical algorithms, machine learning models, and data analysis techniques to predict events, behaviors, or values. Examples include demand forecasting, risk assessment, and recommendation systems.
    3. Data Dependency – Relies heavily on large datasets to learn patterns and make accurate predictions.
2. Generative AI
    1. Purpose - Generative AI aims to create new content or data that mimics the characteristics of the input data it has been trained on. It generates new instances that are similar to its training examples.
    2. Functionality - It employs deep learning models such as Generative Adversarial Networks (GANs) and Variational Autoencoders (VAEs) to produce new images, text, music, or other content. Examples include creating realistic images, text generation, and content creation tools.
    3. Creativity - Focuses on creativity and innovation, producing outputs that can be novel and unique while maintaining coherence with he training data.

VI. HOW ARE INSURANCE COMPANIES USING AI?

1. State Farm

1. State Farm utilizes AI across multiple areas, including customer communications, contract processing, and fraud detection. They have integrated AI-driven customer relationship management (CRM) systems to enhance customer interactions and streamline processes. Additionally, State Farm employs AI to expedite the analysis and processing of contracts using natural language processing and machine learning, significantly improving productivity and reducing costs. The company

also uses predictive modeling to detect and combat insurance fraud, enhancing overall security and operational efficiency.

2. Allstate
    1. Allstate has developed an AI-driven virtual assistant named ABIE (Allstate Business Insurance Expert), which assists agents in providing accurate and timely information to customers. This virtual assistant uses natural language processing to guide agents through quoting and issuing policies. Allstate also employs machine learning algorithms to improve fraud detection and enhance customer service through automated data-driven insights. Additionally, Allstate's telematics program Drivewise uses AI to monitor driving behavior and offer personalized insurance discounts.
3. Nationwide
    1. Nationwide uses AI to personalize customer interactions and improve claims processing. The company has implemented AI-powered chatbots to handle routine customer queries and claims submissions, freeing up human agents to focus on more complex issues. Nationwide also leverages machine learning models to analyze data from various sources, such as wearables and IoT devices, to assess risk and tailor insurance products to individual customers' needs.
        a. Underwriting and Pricing – AI technology accelerates the underwriting process by automating data gathering and analysis, leading to more competitive and personalized pricing. This helps define the best rates and reduces the time required to implement new pricing strategies.
        b. Fraud Detection - AI tools at Nationwide quickly identify anomalies in claims data, flagging potential fraud much faster than human analysis could. This enhances the accuracy and efficiency of the claims process.
        c. Generative AI – The partnership aims to leverage DigitalOwl’s advanced platform, which transforms medical data into meaningful summaries. This initiative seeks to enhance the underwriting process for Nationwide, ensuring better, faster, and more accurate reviews of applicants’ medical histories.
    4. Farmers Insurance
        1. Farmers Insurance integrates AI in their claims processing and customer service operations. They use AI to automate the initial assessment of claims, reducing processing time and improving accuracy. Farmers also employ AI-driven chatbots to assist customers with policy information, claims status, and other inquiries. The company's AI initiatives aim to enhance customer experience and streamline internal processes.

5. Key Uses in Insurance
    1. Risk Assessment and Underwriting - AI enhances the accuracy of risk assessments and underwriting decisions by analyzing large datasets and identifying key risk factors, leading to more precise policy pricing.
    2. Claims Processing - AI automates and accelerates the traditionally manual claims process, improving efficiency and accuracy in handling claims.
    3. Fraud Detection – AI algorithms detect fraudulent claims by identifying patterns that may be missed by human analysts, helping to mitigate fraud risks.
    4. Customer Service – AI-powered chatbots provide 24/7 customer support, handling routine queries and improving customer satisfaction.
    5. Policy Pricing Optimization – AI analyzes extensive datasets to offer competitive and accurate policy pricing, reflecting the true risk associated with each policyholder.

VII. HOW ARE ATTORNEYS (AND PARTICULARLY WORKERS' COMPENSATION ATTORNEYS) USING AI?

1. Legal Research – Westlaw AI helps conduct quick and accurate legal research by generating responses based on a trusted database. Many firms and law schools have implemented Westlaw's new tool.
2. Administrative Tasks - AI tools like ChatGPT assist with drafting legal documents, writing emails, and conducting simple research, reducing time spent on these tasks.
3. Documenting Drafting – AI helps draft legal documents such as briefs and memos, summarizing large documents and freeing up time for other tasks.
4. Claim Analysis – AI is used to analyze claim data and predict high-risk cases in workers' comp and insurance law, allowing firms to allocate resources more effectively.
5. Virtual Assistants – AI Virtual assistants help with client inquiries, schedule meetings, and provide preliminary advice, allowing lawyers to focus on more complex issues.

Notes Pages

PTSD IN MISSOURI WORKERS' COMPENSATION

I. Types of Mental Stress Claims

A. **Physical Injury – Mental Stress**

1. Ex: Claimant is a truck driver who is in a MVA where the truck rolls over a guard rain and down into a river. He suffers multiple fractures and is now afraid to return to truck driving for fear of another accident.
2. Standard of causation**:** Was the work accident the prevailing factor in the development of the medical condition and disability?

B. **Mental Stress – Mental Stress**

1. Ex: Claimant alleges anxiety and depression from co-workers and supervisors constantly degrading him and yelling at work over a five-year period on a constant basis.
2. Standard of causation: is the mental stress caused by extraordinary or unusual stress?

C. **Mental Stress – Physical Injury**

1. Ex: Claimant works long hours at a high-pressure job with many deadlines as a surgeon, criminal attorney, WC claims rep, etc. and suffers a heart attack, rash, etc.
2. Standard of causation: Was the mental stress the PF in the development of the medical condition and disability?

II. Requirements of States Where MVP Attorneys Practice

1. **Missouri:** No physical injury is required for a mental stress claim, therefore allowing mental-mental claims.
2. **Nebraska:** Only allows mental-mental claims in the case of first responders.
3. **Illinois:** Must be able to be tied to a time, place, and cause; no physical injury is required therefore allowing mental-mental claims.
4. **Iowa:** Allows mental-mental claims; must be primarily caused by work.
5. **Kansas:** Must be associated with a physical injury.
6. **Oklahoma:** Mental-mental claims are not allowed unless it arises out of an act of violence.

III. New Missouri Statute 287.067(9)

Posttraumatic stress disorder (PTSD) in first responders is now statutorily recognized as a compensable occupational disease in Missouri. Generally, no physical injury must occur to the first responder, and it must be shown by clear and convincing evidence that the PTSD has resulted from acting within the course and scope of their employment. The first responder must be examined and diagnosed with PTSD by an authorized provider as a result of one of the following qualifying events:

A. Seeing for oneself a deceased minor;
B. Witnessing directly the death of a minor;
C. Witnessing directly the injury, participating in the physical treatment of, or manually transporting a minor who subsequently died before arriving at a hospital emergency department;
D. Seeing for oneself a person who has suffered serious physical injury of a nature that shocks the conscience;
E. Witnessing directly a death (including suicide), due to serious physical injury;
    a. This includes homicide, including murder, mass killings, manslaughter, self-defense, misadventure, and negligence;
F. Witnessing directly a person suffering serious physical injury that shocks the conscience which results in death;
G. Participating in the physical treatment of an injury (including attempted suicide) or manually transporting an injured person who has suffered serious physical injury and dies before arrival at a hospital emergency department;
H. Involvement in an event that caused, may have caused, or had the potential to cause the death of the first responder (whether by accidental or intentional acts of another)

The time for notice of injury or death in cases of compensable PTSD is fifty-two (52) weeks measured from either (1) exposure to one of the qualifying stressors listed above, or (2) the diagnosis of the disorder, whichever date is later.

IV. Missouri Case Law

***Linda Mantia v. Missouri Department of Transportation*, 2024 WL 2944136 (Mo. Lab. Ind. Rel. Com. 2024)**

On May 30, 2024, following a mandate from the Supreme Court of Missouri, the Labor and Industrial Relations Commission issued its final award allowing compensation. The Commission determined that in applying the proper objective standard for proof of extraordinary and unusual work-related stress, new evidence could be presented. The 2017 Supreme Court opinion quoted Black's Law Dictionary defining an objective standard as one "based on conduct and perceptions external to a particular person."

Evidentiary Issue

The new evidence, which was admitted during the remand hearing on December 20, 2023, was the deposition transcript of Mr. Larry Doelling for the employee, and the deposition transcript of Ms. Rebecca Allmeroth for the employer. During the deposition of Mr. Doelling, employer's counsel objected numerous times to leading questions, hearsay, and requiring the witness to form a legal opinion. The Commission found that the employer's attorney did not preserve his objections to the employees exhibit by failing to ask the ALJ to rule on the objections, and further by stipulating to the admission of the deposition.

Analysis With Additional Evidence

During his deposition, Mr. Doelling testified that he did not know of any other employee who had seen as many or more disturbing tragedies on highways as the Claimant. He continued, explaining that although her duties were no different than others in the same position, the number and type of tragedies she had experienced were unusual compared to those of other employees. He testified that he believed witnessing the events the claimant had encountered would cause a reasonable highway worker extraordinary and unusual stress. The Commission found this testimony very persuasive.

For the employer, the deposition of Ms. Allmeroth was less persuasive. She testified to also having experienced tragedies, although none of the same caliber and far fewer instances. She explained that MoDOT has safety trainings and access to counseling through the Employee Assistance Program. Of note, Ms. Allmeroth declined to testify as to what a reasonable highway workers response would be to those experienced by the claimant because she believed individuals respond differently to tragedy due to different personality types, sensitivity levels, and emotional reactions.

The Commission found Ms. Allmeroth's testimony to the individuality of reactions irrelevant because it ignored the Missouri Supreme Court's language that "individualized, subjective reasons to circumstances are irrelevant." Instead, the Commission found Mr. Doelling's testimony persuasive, showing that the Claimant had responded to a "greater-than-average number of unusually disturbing accidents involving fatalities." The Commission awarded the payment of $77,808.00 in PPD benefits to the Claimant in addition to future medical care.

City of Clinton v. Dahman 669 S.W.3d 142 (Mo. App. W.D. 2023)

Factual Background

Officer Dahman was diagnosed with PTSD following an incident in August of 2017. As a result, he filed a claim for compensation. On the night of the incident, he was responding to a crime scene where Officer Michael, a friend of his, had been fatally shot. Upon arriving, he found Officer Michael unconscious on the ground with no sign of the suspect. He soon learned that the suspect had crashed after fleeing the crime scene, and Officer Dahman responded to the scene of the crash. At this point, there was still no sign of the suspect, it was very dark outside, and he knew the suspect used a high-powered rifle to shoot Officer Michael. He also knew that the bulletproof vest he wore would not stop bullets fired from a high-powered rifle. Officer Dahman was alone for approximately 30 minutes until more officers arrived and he learned that Officer Michael had died from his injuries. This was the first officer killed in the line of duty in the City of Clinton.

Immediately after this incident, he began experiencing symptoms such as helplessness, anxiety, nightmares, and more. He also began drinking heavily. In October of 2017, Officer Dahman resigned from the Police Department, explaining that the death of Officer Michael and circumstances of the night he died were the primary reason that he felt he needed to leave the law enforcement and seek other employment.

Analysis and Discussion

The Court of Appeals for the Western District began their discussion by explaining the standard to be applied in a case like this is an objective one, as required by § 287.120.8 and explained in *Mantia v. Mo. Dep't. of Transp.* 529 S.W.3d 804, 809 (Mo. 2017). In sum, an employee "must show that the events they experienced would cause a reasonable person in the same profession extraordinary and unusual stress." *Id* at 810.

The court reasoned that the Claimant had met his burden of showing that the August 2017 incident was extraordinary and unusually stressful by objective standards. The court weighed factors such as the fact that he was the only officer exposed to the dangerous circumstances which left him highly vulnerable, and although officers encounter dangerous situations every day, Officer Michael's murder was the first time an officer had died in the line of duty in the City of Clinton. The fact that the Police Department had also brought in counselors, a crisis response team, and an employee assistance program for mental health issues was also considered to be proof of the extraordinary and unusual stress. In the end, the court affirmed the Commission's Final Award Allowing Compensation.

***Libby Boyer v. Taney County Animal Control,* 2024WL 2820785 (Mo. Lab. Ind. Rel. Com. 2024)**

Factual Background

While working for the Taney County Animal Control as a kennel technician on December 3, 2021, Ms. Boyer was asked by a co-worker (Ms. Koster) to assist her in moving a dog to a different location so that its kennel could be cleaned. As Ms. Boyer attempted to put a leash around the dog's neck, it began growling and attacked Ms. Koster. Ms. Koster was knocked down onto her back and the dog began "eating at Ms. Koster's arms." Ms. Boyer attempted to punch the dog in the face and pull it from behind off Ms. Koster, but when that did not work, she went to the office and called 911 where the dog followed Ms. Boyer. Of note, Ms. Boyer was not attacked by the dog and had no physical injuries.

Ms. Boyer testified that two days prior she had been attacked by a cat, and before that had been attacked by a dog. She continued, explaining that she had witnessed other employees become similarly injured. While unrelated to the workplace incident, Ms. Boyer testified that she had told co-workers she moved to Missouri after her ex-fiancé told her he was going to kill her and that he had a gun.

For Ms. Boyer, employee Sara Minter testified as a witness. She explained that she has flashbacks to the day of the incident, has sought psychological treatment and is on prescription medication. She further testified that she quit her job on the day of the incident, describing a combination of the attack and "other resentments" as her reasoning for leaving the Taney County Animal Control.

Ms. Boyer had two additional witnesses, Dr. Sky, a licensed psychiatrist, and Mr. Gary Behrman, PhD, who is a psychologist and social worker. Ultimately, Dr. Sky did not opine that the treatment he recommended was necessary as a result of extraordinary or unusual stress for a reasonable animal control employee. He also was unaware of the prior

incident involving the Employee's ex-fiancé's threats. Dr. Sky diagnosed the Employee with PTSD, mild-to-moderate depression, and mild mood disturbance, and he believed her chronic PTSD was causally related to the workplace incident occurring on December 3, 2021. Most importantly regarding Mr. Behrman, he had not been paid for his treatment nor had he charged the employee, even though she had undergone psychological counseling with him.

Analysis and Discussion

The Commission gave significant weight to the fact that both Ms. Minter and Ms. Boyer testified to having seen other employees be attacked by animals in the past. Through this, they found that no evidence was produced by Ms. Minter showing that the event was extraordinary and unusual. Although Ms. Minter testified that she quit her job following the attack at issue, she stated that the incident alone was not enough for her to have quit her job due to mental stress. It was the underlying resentment she held for the employer.

Moreover, the Commission found the testimony of both Dr. Sky and Mr. Behrman to be unpersuasive given the financial interest that Mr. Behrman maintained in the outcome of the trial and the testing procedures used by Dr. Sky. Ultimately, the Commission noted the lack of evidence showing impairment of attention, concentration, ability to relate and communicate socially, and ability to function socially and occupationally as insufficient to find for the employee. The experience was described as "an intrinsic risk of the job."

The Commission concluded that the employer/insurer were not responsible for benefits to the employee and that the employee failed to meet her burden by objective evidence that she sustained extraordinary and unusual stress due to the incidents that occurred on December 3, 2021.

***George v. City of St. Louis,* 162 S.W.3d 26 (Mo. Ct. App. E.D. 2005)**

Factual Background

Claimant had been placed on disability retirement from his Job as Battalion Fire Chief. He had previously served in the Army and deployed to Vietnam for one year. During his time in Vietnam, he experienced and was a participant in numerous events "that left indelible scars on his memory." After returning from his deployment, he was treated at the VA for PTSD. His symptoms at this time included shaking and having bad dreams as a result of combat. After his time in Vietnam, Claimant returned to his job with the Postal Service. Finding this job unfulfilling, in 1972 (around when he ended treatment with the VA) he started his career as a firefighter. He worked for the City fire department for twenty five years and achieved the rank of Battalion Fire Chief.

In 1984, while on duty, Claimant received a call that his home was on fire. His wife and son were both injured but recovered. Upon arriving at the scene, he saw his wife on a gurney and believed she was dead. After this, he began having nightmares and flashbacks to his time in Vietnam. Approximately eleven years later in 1995, the home of Claimant's daughter caught on fire, causing her second and third degree burns. During his time with the fire department, he experienced numerous other tragedies which exacerbated his PTSD and depression. Some of these tragedies involved children such

as hearing a mother scream for her child, only to find the child had died in the fire he was responding to. This reminded him of a memory from Vietnam where a fellow soldier was burning on the back of a tank, yelling for his mom, but Claimant could do nothing to help. Another incident involved a bus that had overturned, throwing children out around the interstate (some of whom were dead). This reminded him of another memory from Vietnam where he witnessed a motorized scooter overloaded with kids pass him and his group of soldiers, only to hit a tank mine. Claimant identified two additional memories that lingered, which included having to deal with the burned and dead bodies of a three-year-old girl, and an elderly man in a wheelchair.

Analysis and Discussion

Section 287.067.5 enumerates certain diseases which are normally non-compensable but are compensable for firefighters if they are shown to have been directly caused by a firefighters exposure to smoke, gases, carcinogens, inadequate oxygen, or psychological stress.

Here, the Court explained that PTSD "flowed" as a rational consequence of the employment. "Claimant's performance of his usual and customary duties as a firefighter was a substantial factor in causing his PTSD and exacerbating his depression." He did not need to show that his job stresses were extraordinary and unusual compared to other firefighters of equal rank.

Commission's Award of total disability benefits affirmed.

***Braswell v. Missouri State Highway Patrol,* 249 S.W.3d 293**

Factual Background

Claimant, while employed as a Missouri State Highway Patrol Trooper on February 1, 2004, witnessed other officers use a taser on a restrained individual. However, Claimant mistook the taser for a service revolver. Employer did not produce medical expert testimony, though the Claimant had 3 experts.

Analysis and Discussion

"The Commission determined that '[i]f [E]mployee's claim of mental injury can be proven to be based upon the traumatic [event], and not from work[-]related stress, the compensability of [E]mployee's claim must be determined under section 287.120.1.'" Because the mental injury experienced by Claimant was not the result of work-related stress, but a traumatic event on February 1, 2004, Sec. 287.120.8 was the incorrect standard to apply. The event was compensable, largely due to the Employer's failure to write a competent brief, produce expert testimony, and argue their case using legal precedent. One of the main arguments of Employer was that it was a "common sense determination," meaning that Employer felt it unnecessary to produce an expert witness. In fact, "Employer made a strategic decision not to hire an expert witness to refute medical causation."

***Jones v. Washington University,* 199 S.W.3d 793 (Mo. Ct. App. E.D. 2006)**

Factual Background

Claimant was a licensed practical nurse for twenty-one years primarily working in the outpatient dialysis department. On December 30, 2000, Claimant was working in the outpatient dialysis department treating a male patient. As Claimant bent over to prepare the patient for dialysis, the patient reached inside of Claimant's top and grabbed her breast. The Claimant removed the patient's hand and yelled at him, explaining he is not allowed to touch nurses. The patient looked at the Claimant, smiled, and said "I guess I'm in trouble because I'm a white man."

Claimant informed the charge nurse of this incident, and later emotionally "broke down" in her car. At the end of January, Claimant began psychiatric treatment and was diagnosed with depression and PTSD based on the incident. She received counseling and took medication, but ultimately resigned in April of 2001 because of the incident. Claimant's vocational expert determined that, based on her emotional problems, she was permanently and totally disabled.

Analysis and Discussion

On appeal, Claimant argued that the Commission erred in applying Sec. 287.120.8 to determine that Claimant did not sustain an accidental injury arising out of and in the course of her employment. The Court concluded that the Commission erred in applying Sec. 287.120.8 because the plain language of Sec. 287.120.8 indicates that it applies only to claims of mental injury resulting from work related stress. Here, Claimant's claim of mental injury was based on the physical assault she experienced at work. "Claimant's claim is for mental injury resulting from a traumatic incident, one which included the physical contact or impact of the patient grabbing Claimant's breast, not from work related stress." Therefore, because the mental injury was not alleged to have been caused by work related stress, Claimant was not required to prove that the stress was extraordinary and unusual, and Sec. 287.120.8 is inapplicable.

Commission's Final Award denying compensation was reversed and remanded.

V. Practical Guidelines

A. <u>Types of Experts</u>

1. Psychiatrist/Psychiatric NP
    - Practitioners that can prescribe medication to treat mental health issues.
2. Psychologist
    - Psychologists are primarily focused on psychotherapy and treat emotional and mental injury suffering patients with behavior interventions.
3. Neurologist
    - A practitioner who is a specialist in the anatomy, functions, and organic disorders of nerves and the nervous system.

4. Neuropsychologist
    - A psychologist who primarily studies the relationship between behavior, emotion, and cognition alongside brain function.
5. Social Workers/LCSW
    - These are professionals who facilitate talk therapy and counseling.

VI. Psychiatric IMEs

A. Clinicians

1. May seek collateral sources of information to provide good care, but care is not withheld if the sources are not available
2. Confidential
3. Beneficence

B. Forensic Examinations

1. Medical and psychiatric knowledge required to help answer a legal question
2. Collateral sources of information are required
3. Not confidential
4. Opinion may be harmful or at least not helpful
5. What are some challenges for Forensic Psychiatric IME's?
    - Diagnostic challenges with manual-based syndromes
    - Lack of full longitudinal history
    - No laboratory or imaging findings
    - Everyone believes they are a psychiatrist

C. What information does the psychiatric IME need to know about the Claimant?

1. Past medical/surgical history, medications, allergies etc.
2. Past psychiatric/substance use history
3. Personal history
4. Work history
5. Legal history
6. Family history
7. Educational history

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MEDICARE SECONDARY PAYER COMPLIANCE

I. BACKGROUND

As a federal cost-saving statute enacted in 1980 to combat increasing costs of Medicare, the Medicare Secondary Payer (MSP) makes the government a secondary payer when a Medicare recipient has another source of primary insurance coverage. In 2003, the MSP was expanded to include other responsible sources, such as tortfeasors, as primary payers responsible for payment of the beneficiary's medical expenses. Under the MSP, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made" by a primary payer. 42 USCA §1395y(b)(2). This statute implicates payment for past medical expenses (those incurred prior to a settlement, judgment or award) and future medical expenses (those incurred after a settlement, judgment, or award). Medicare's interests must be considered regarding both past medical and future medical expenses.

II. OVERVIEW OF SECTION 111 REPORTING REQUIREMENTS

Medicare was introduced in 1965 as a primary source of payment and amended in 1980 to be a secondary source under the Medicare Secondary Payer (MSP) statute. This update made workers' compensation and primary insurers the primary payers. The MSP requires significant data collection and transparency to enforce.

If payments are made to Medicare beneficiaries, they must be reported under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). The Centers for Medicare & Medicaid Services (CMS) introduced MMSEA to help identify primary payers and support more accurate benefits payments. In short, it helps CMS to avoid paying for benefits that should be covered by primary insurance providers or workers' compensation.

Responsible Reporting Entities (RRE) are parties that are subject to S111 requirements. They include Group Health Plans (GHP) and Non-Group Health Plans (NGHP) that function as an insurer or self-insurer.

A. Update to Section 111 Reporting Requirements:

Beginning April 4, 2025, the existing Section 111 reporting process will be expanded to capture information regarding workers' compensation claims involving Medicare beneficiaries that report settlements which include a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA). Responsible Reporting Entities (RRE's) will be required to report certain data, which includes:

1. MSA Amount: Dollar amount of the MSA
2. MSA Period: Time in years MSA expected to cover beneficiary
3. Lump / Annuity

4. Initial deposit amount
5. Annual deposit amount
6. Case control number
7. Professional Administrator EIN (if applicable)

The longstanding WCMSA submission process will remain in place, but the reporting of these WMCSA data points will be required beginning in April 2025. The current $25,000 WMCSA review threshold will not apply to these new fields. The information needs to be reported regardless of whether the threshold is met. The data collected via Section 111 will serve to supplement the existing voluntary WCMSA process.

Currently, parties are only required to submit WCMSA's in cases where settlements are $25,000 or higher. Beginning April 4, 2025, all RRE's will be required to report all WCMSA's to CMS regardless of the settlement amount. This will give CMS significant insight and visibility into all WCMSA's to better protect their interests.

III. PAST MEDICAL: Conditional Payments

A. Statutory Authority: 42 USC §1395y(b)(2)- Demonstrated Responsibility

Medicare has been given authority to make payment for an item or service if a primary plan has not made or cannot reasonably be expected to make payment promptly. 42 USC §1395y(b)(2)(B)(i).

These payments are conditioned on reimbursement from "a primary plan, and an entity that receives payment from a primary plan . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 USC §1395y(b)(2)(B)(ii).

A primary plan's responsibility for payment may be demonstrated by "a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." 42 USC §1395y(b)(2)(B)(ii).

B. Statutory Authority: 42 USC §1395y(b)(2)- Who Can Sue

Medicare may bring an action against "any or all entities that are or were required or responsible (directly as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment under a primary plan."
42 USC §1395y(b)(2)(B)(iii).

In addition to a direct cause of action, Medicare is subrogated to any right of an individual or other entity to payment under a primary plan.
42 USC §1395y(b)(2)(B)(iv).

Additionally, “There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement).
42 USC §1395y(b)(3)(A).

C. Statutory Authority: Double Damages

Medicare may collect double damages. 42 USC §1395y(b)(2)(B)(iii).
Statutory authority: statute of limitations

Medicare has three years from the date of the receipt of notice of a settlement, judgment, award, or other payment made to bring an action for reimbursement. 42 USC §1395y(b)(2)(B)(iii).

D. Recovery of Conditional Payments 42 C.F.R §411.24

CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers’ compensation, any liability or no-fault insurance, or an employer group health plan.

Amount of recovery is the lesser of (a) the amount of the Medicare primary payment or (b) the full primary payment amount that the primary payer is obligated to pay. If legal action is necessary to recover from the primary payer, CMS may recover twice the amount of the Medicare primary payment.

CMS has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

Must reimburse Medicare within 60 days. Interest may accrue from the date when notice or other information is received by CMS that payment has been or could be made under a primary plan.

If Medicare makes a conditional payment with respect to services for which the beneficiary has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

E. Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement. 42 C.F.R §411.24.37

1. Recovery against the party that received payment:
    a. General rule: Medicare reduces recovery for procurement costs if costs incurred because the claim was disputed and the costs are borne against the party against CMS seeks to recover.
    b. Special rule: If CMS must file suit because the party that received payment opposes CMS’s recovery, the recovery is the lower of (a) the Medicare payment

or (b) the total judgment or settlement amount, minus the party's total procurement cost.

F. Limitations on Medicare payments for services covered by workers' compensation. 42 C.F.R. §411.40-47.

1. Medicare does not pay for any service which payment has been made or can reasonably be expected to be made under a workers' compensation law or plan. 42 C.F.R §411.24.40
2. Beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation. 42 C.F.R §411.24.43(a)

G. Limitations on Medicare payments for services covered by workers' compensation. 42 C.F.R. §411.40-47.

1. If a claim is denied for reasons other than not being a proper claim, Medicare will pay for the services if covered under Medicare. 42 C.F.R §411.24.43(d)

H. A conditional payment may be made if either:

1. The beneficiary has filed a proper claim, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.
2. The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

IV. CASE LAW

A. The United States may recover, against "any entity."

1. *U.S. v. Harris*, 2009 WL 891931 (N.D.W. Va 2009) (unpublished)
2. *U.S. v. Stricker*, 2010 WL 6599489 (N.D. Ala. 2010) (unpublished)

B. Allocation of settlement proceeds

1. *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010)
2. *Mason v. Sebelius*, 2012 WL 1019131, (D.N.J. 2012) (unpublished)

C. Interplay between MSP and workers' compensation law

1. *Caldera v. Ins. Co. of the State of Pa.*, (5th Cir. 2013)

D. Collection practices of CMS

1. *Haro v. Sebelius*, 747 F.3d 1099 (9th Cir. 2014)

E. Private cause of action and extension to Medicare Advantage Programs

1. *In re Avandia Marketing, Sales Practices, and Products Liability Litigation*, 685 F.3d 353 (3rd Cir. 2012).
2. *MSP Recovery, LLC v. Allstate Ins. Co.,* 835 F.3d 1351 (11th Cir. 2016).

F. Four-year statute of limitations for Medicare Advantage Organization (MAO) to bring private cause of action under MSP Act

1. *MSP Recovery Claims Series 44, LLC v. Bunker Hill Ins. Co.*, 683 F. Supp. 3d 172 (D. Mass. 2023)

V. FUTURE MEDICAL: MSAs

A. Statutory Authority

1. Medicare may not pay for a beneficiary's medical expenses when payment "has been made *or can reasonably be expected to be made*" by a primary payer. 42 USCA §1395y(b)(2).
2. No other statutory guidance

B. Regulatory Authority

The regulations only address future medical under workers' compensation claims and are silent regarding future medical in liability claims. This is expected to change.

CMS has announced plans to seek comments regarding establishing MSA process for liability claims.

If a lump sum compensation award stipulates the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment. C.F.R §411.24.46(a)

Lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan. C.F.R §411.24.46(b)(1)

"If settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition." C.F.R §411.24.46(b)(2)

1. Regulation indicates Medicare will not pay for treatment of that condition, but what if it does? Can Medicare disregard the settlement and claim all payments as conditional payments?

C. Basic rule:

If settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare. C.F.R §411.24.46(d)(1)

D. Exception:

If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump sum settlement allocated to future medical expenses. C.F.R §411.24.46(d)(2)

E. CMS Publications

Publications and information posted by CMS, such as the WCMSA Reference Guide, regional office memoranda or information on the CMS website have no force of law. CMS only gives guidance in workers' compensation cases. There is no formal guidance in liability context, although CMS has repeatedly emphasized that while liability settlements and MSAs will not be reviewed for approval, the parties need to take Medicare's interest into account.

WCMSA Reference Guide reflects information compiled from all WCMSA Regional Office Memoranda and information provided on CMS website.

CMS admits there is no statutory or regulatory requirement to submit WCMSA proposal to CMS for review in any case.

In many situations, the parties to a work comp settlement choose to pursue a CMS-approved WCMSA amount in order to establish with certainty with respect to the amount that must be appropriately exhausted before Medicare begins to pay for care related to the WC settlement, judgment, award, or other payment.

Any claimant who receives a work comp settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interests with respect to future medicals into account. If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received a portion of a payment either directly or indirectly. Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted.

Once the CMS-approved set-aside is exhausted and accurately accounted for to CMS, Medicare will pay primary for future Medicare-covered expenses related to the work comp injury that exceed the approved set-aside amount.

The primary benefit of seeking CMS approval is "the certainty associated with CMS reviewing and approving the proposed amount with respect to the amount that must be appropriately exhausted."

If the parties to a WC settlement stipulate to a WCMSA but do not receive CMS approval, CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses in the case, even if they would ordinarily have been covered by Medicare. However, if CMS approves the WCMSA and the account is later appropriately exhausted, Medicare will pay related medical bills for services otherwise covered and reimbursable by Medicare regardless of the amount of care the beneficiary continues to require.

1. CMS states establishing a WCMSA is not necessary when ALL of the following are true:
    a. The employee is only being compensated for past medical expenses;
    b. There is no evidence that the individual is attempting to maximize the other aspects of the settlement; AND
    c. The employee's treating physicians conclude in writing that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.
2. CMS threshold for review and approval of a WCMSA
    a. Claimant is currently Medicare eligible and total settlement is over $25,000
        i. "Medicare eligible" includes:
            a) Age 65 or older;
            b) Receiving SSDI benefits for more than 24 months; or
            c) End stage renal failure
    b. Claimant is reasonably expected to become Medicare eligible within 30 months and total settlement is over $250,000
        i. "Reasonably expected to become Medicare eligible" includes:
            a) Age 62.5 or older;
            b) Applied for SSDI benefits;
            c) Appealing denial of SSDI benefits; or
            d) End stage renal disease, but not yet qualified for Medicare based on that disease.

CMS review thresholds are not a "safe harbor." The parties must consider Medicare's interests in all work comp cases.

No statement in the settlement of the amount needed to fund the WCMSA is binding on CMS unless and until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount that adequately protects Medicare's interests as specified by CMS as a result of its review.

CMS does not compromise or reduce future medical expenses related to a WC injury. Some submitters have argued that C.F.R §411.24.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a work comp injury.

F. Re-review process
    1. Available if:
        a. The original determination contained obvious mistakes
        b. Additional evidence is available that pre-dates the original submission
        c. Newly expanded re-review process

d. A party may seek re-review of previously approved WCMSA when
   i. amount differs by at least 10% or $10,000, whichever is greater.
   ii. The original submission occurred between one and four years before the date of Amended Review request
2. Can only request Amended Review once
3. Changes must include more than just substituting generic drug types for brand name

VI. COMMON WC / WCMSA QUESTIONS:

A. What is a WCMSA?

A WCMSA is a financial arrangement where CMS agrees to have Medicare pay for treatments and medications related to your settled workers' compensation injury after you can show that you spent a CMS approved amount you set aside from your workers' compensation settlement to pay for future medical expenses.

B. What is covered by the WCMSA?

The claimant / beneficiary can only use funds for expenses related to their work injury, such as doctor visits or medications.

C. What if the claimant wants to use the settlement for things not covered by Medicare?

The parties may want to negotiate a separate allotment for such things before settlement.

D. How are the funds used?

The WCMSA portion of the settlement goes into a bank account in the claimant's name and future medical treatment is paid from that.

E. What if the claimant runs out of money?

The claimant needs to send an attestation letter to the Benefits Coordination and Recovery Center (BCRC) that they ran out of money. Medicare will start paying for future treatment if they can verify that the WCMSA money was spent appropriately.

F. What happens to the WCMSA if the claimant passes away?

If money remaining in WCMSA, some settlements allow estate to retain funds while others request the funds be returned to the insurance carrier. This needs to be negotiated.

G. How does attestation work?

Claimant needs to fill out an annual attestation form and mail it to BCRC.

H. How is CMS approval of a WCMSA amount obtained?

Generally, there are four steps involved in creating a CMS-approved WCMSA. These steps are:

1. Analysis of the claim and medical information to determine the amount of money required for the fund.
2. Negotiation of a tentative settlement and preparation of draft settlement documents to settle WC case, incorporating terms for creation and administration of the WCMSA.
3. Obtaining approval from CMS for the amount of the proposed WCMSA
4. Finalizing the settlement and funding the WCMSA

I. Are you required to submit a WCMSA?

There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS established policies and procedures to obtain approval.

J. What happens if the CMS does not approve a WCMSA?

Then CMS is not bound by the set-aside amount stipulated and may refuse to pay for future medical expenses related to the WC work-related injury, even if they would ordinarily have been covered by Medicare.

K. When will CMS review a proposed WCMSA?

When one of the following are met:

1. The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000; or
2. 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 or lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

L. How do I submit a WCMSA?

A WCMSA can be submitted: 1) through the WCMSA portal on the internet; or 2) by paper submission through the mail. The portal method is preferred.

M. How do I report a workers' compensation case?

All workers' compensation occurrences that involve a Medicare beneficiary should be reported to the BCRC. Provide the following information:

1. Injured person's name, injured person's Medicare ID, date of incident, nature of illness / injury, name and address of workers' compensation insurance carrier, name and address of the injured person's legal representatives, name of insured, policy / claim number.
2. Once this information is received, the BCRC will apply it to beneficiary's Medicare record and send it to Commercial Repayment Center (CRC) for processing. Medicare will then send information to the insurer outlining next steps in the process.

If you are a Responsible Reporting Entity making an initial report of ongoing responsibility, use the Section 111 COB Secure Website for reporting.

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