Workers’ Compensation
Kansas • Missouri • Illinois • Oklahoma • Nebraska • Iowa • Arkansas

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I. JURISDICTION

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

II. ACCIDENTS

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

b. Exception: victims of crimes of violence.

c. Maximum compensation is 26 weeks.

4. Heart or cardiovascular injury, accident, or disease Ark. Code Ann. § 11-9-114
   a. Compensable only if an accident is the major cause of the physical harm.
   b. The employee must show that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the employee’s usual work or that an unusual and unpredictable incident occurred which was the major cause of the physical harm and stress must not be considered.

   a. Employee must show that the hernia occurred immediately following and as a result of sudden effort, severe strain, or the application of force directly to the abdominal wall; that there was severe pain in the hernia region that caused the employee to immediately cease work; that the employee gave the employer notice within 48 hours afterward and that medical attention was required within 72 hours.

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

III. NOTICE Ark. Code Ann. § 11-9-701
   A. Notice of the accident should be given immediately after it occurs and must be reported on the appropriate form prescribed or approved by the Commission (Form N).

   B. Failure to give notice will not bar a claim if:
      1. The employer had knowledge of the injury; or
      2. If the employee had no knowledge that the condition or disease arose out of and in the course of employment; or
3. If the Commission excuses the failure due to a satisfactory reason that the notice could not be given.


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

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

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

V. CLAIM FOR COMPENSATION

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

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

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

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

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

VI. INTENT TO ACCEPT OR CONTROVERT CLAIM Ark. Code Ann. § 11-9-803
A. Employer must file a statement of its intent to accept or controvert a claim (Form 2) within fifteen days of the date upon which it receives notice of the alleged injury.

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

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

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

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

B. However, the employee may request a one-time change of physician from the employer or carrier.

1. If the employee’s request for a change of physician is denied, the employee can petition the Commission and if the Commission agrees, they may select the physician if they do not agree with the employee’s choice.

2. When the employee petitions for a change of physician, the new physician must be either:
   a. Associated with the managed care entity chosen by the employer, or
   b. The regular treating physician of the employee provided the following factors are met:
      i. the physician maintains the employee’s medical records;
      ii. the employee has a bona fide doctor-patient relationship with they physician;
      iii. there is a history of regular treatment prior to the onset of the compensable injury;
      iv. the primary care physician agrees to refer the employee to the managed care entity for specialized treatment; and
      v. the primary care physician agrees to comply with the rules, terms, and conditions regarding services performed by the managed care entity chosen by the employer.

C. Treatment furnished by any physician other than the ones selected according to these methods, except emergency treatment, will be at the employee’s expense.

1. Exception: If the employer does not deliver to the employee, either in person or by certified mail, a copy of a notice which explains the employee’s rights and responsibilities concerning a change of physician, then the changes of
physician rules do not apply and the employer will be responsible for the unauthorized treatment.

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

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

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

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

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

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

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

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

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

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

X. DISABILITY BENEFITS

1. Compensation rate is two-thirds of average weekly wage (AWW) up to statutory maximum.
2. The statutory maximum TTD rate for an injury during the 2015 calendar year is $629.00.
3. If an injured employer refuses suitable employment he loses any entitlement to compensation unless the Commission determines the refusal is justifiable.
4. Waiting period:
   a. For the first seven calendar days, no TTD is due.
   b. For more than seven, but less than fourteen days, only the second week is due.
   c. For more than fourteen days of disability, go back to the first day of disability.
   d. The waiting period does not include the date of injury.
5. TTD is calculated using the calendar week with each day being one-seventh of the week.
6. Failure to pay TTD without an award within fifteen days after it becomes due is an eighteen percent penalty which must be paid at the same time as the installment unless notice of controversion is filed or an extension is granted.
7. If a TTD installment payable under an award is not paid within fifteen days after it becomes due, there is a twenty percent penalty.
8. Willful failure to pay a benefit results in a penalty up to thirty-six percent.

   1. Compensation rate is 2/3 of the difference between the employee’s average weekly wage prior to the accident and his wage-earning capacity after the injury.

   1. Compensable injury must be the major cause (more than 50%) of the injury for Claimant to receive permanent benefits.
   2. Compensation rate is 75% of TTD rate up to the statutory maximum if the TTD rate is $205.35 or greater. If TTD rate is below $205.35, PPD rate is 2/3 of average weekly wage.
   3. The statutory maximum PPD rate for an injury during the 2015 calendar year is $472.00.
   4. Permanent partial disabilities not listed in the statutory schedule will be apportioned to the body as a whole with a value of four hundred fifty weeks.
   5. In claims for disability in excess of permanent partial impairment for unscheduled injuries (wage loss claims), the Commission may take into account the employee’s age, education, work experience, and other matters that may affect his future earning capacity.
   6. Compensation is allowed after twelve months after the injury, for serious and permanent facial or head disfigurement for not more than $3,500.
7. The clinical impairment rating must be pursuant to the AMA Guides to the Evaluation of Permanent Impairment (4th Edition).
   a. If the employee is back to work, only the clinical rating is due.
   b. If the employee is unable to return to work, the rating is negotiable and can be awarded by the ALJ.
8. PPD payments should start from the date the rating is given and notification in writing should be given to the injured employee.

D. Permanent Total Disability (PTD)
1. Permanent total disability means the inability because of compensable injury or occupational disease to earn any meaningful wages in the same or other employment.
2. Compensation rate is 2/3 of the average weekly wage.
3. The statutory maximum PTD rate for an injury during the 2015 calendar year is $629.00.
4. The employer or carrier may, annually, require the injured worker receiving permanent total disability benefits to certify that he is permanently and totally disabled and not gainfully employed.
5. As of January 1, 2015 the cap for PTD is 325 times the maximum total disability rate established at the date of injury.

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

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

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

XI. PROCEDURE

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

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

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

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

2. The claim will be assigned to one of six geographic districts throughout the state, based on the county in which the injury occurred or the district in which the respondent’s place of business is located if the injury occurred outside the state.

3. Ark. Code Ann. § 11-9-704. The Commission must notify the employer and any interested parties that an employee has filed a Claim for Compensation within ten days of such a filing.

4. Ark. Code Ann. § 11-9-702. If the employee fails to request a hearing within six months of filing his or her claim the claim may, upon motion and hearing, be dismissed without prejudice, allowing the employee to refile his claim within the two-year statute of limitations.

E. Employer’s Response (Form 2)

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

2. Form 2 may be required well before the employee files a Form C.

3. Employer may request a time extension if a good faith, but unsuccessful effort has been made to obtain medical records rendering the employer unable to determine the validity of an employee’s claim.

F. Payment of Benefits

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

G. Disputed Claims

1. Preliminary Conference
   a. Mediation Conferences will be held in all cases in which the amount in dispute is less than $2,500.
   b. For cases in which the amount in dispute is more than $2,500 the parties may request a voluntary mediation if all parties agree.
   c. The conference will be informal, nonbinding, and confidential, by telephone or in person.
   d. Attendance by the parties or a representative is required and the mediator is authorized to compel attendance, however the mediator is not authorized to compel settlement.
   e. Following the conference, the Report of Mediation Conference (Form R) is placed in the file and copies are sent to all the parties.

2. Depositions
   a. Any party may conduct depositions after the claim has been controverted by the filing of Form 2, however prior to the time a case has been
controverted, the Commission may order depositions for good cause shown and upon application of either party.

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

4. Hearing
   a. Either party may file an application for a hearing that clearly identifies the specific issues of fact or law in controversy and the applying party’s contentions.
   b. If ordered, the Commission must give interested parties ten days notice of the hearing.
   c. The hearing will be held in the county where the accident occurred, or the county of the employer’s residence or place of business if the injury occurred outside the state.
   d. Evidence may include verified medical reports provided the party using the reports has given opposing counsel notice and copies of all records and reports within seven days of the hearing.
   e. Expert testimony is only permissible if such testimony complies with the requirements of Daubert and Kumho.

5. Award
   a. The order denying the claim or making the award will be filed in the office of the Commission and a copy will be sent to each party.

6. Appellate Process
   a. Full Workers’ Compensation Commission
      i. 30 days from the date of receipt of the order or award to file application for review
      ii. Will review the evidence, or hear the parties, their representatives, and witnesses.
   b. Court of Appeals
      i. 30 days from the date of receipt of the order or award to file notice of appeal
      ii. Notice filed in office of commission
      iii. Court will review only questions of law and may modify, reverse, remand for rehearing, or set aside the order or award upon any of the following grounds, but no others:
           (a.) The commission acted without or in excess of its powers
           (b.) The order or award was procured by fraud
           (c.) The facts found by the commission do not support the order or award
(d.) The order or award was not supported by substantial evidence of record

XII. DEFENSES

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

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

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

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

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

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

   1. A false statement in an employment application will bar workers’ compensation benefits if the following conditions are shown:
      a. The employee knowingly and willfully made a false representation as to his or her physical condition;
      b. The employer relied upon the false representation;
      c. The reliance upon the false misrepresentation was a substantial factor in hiring the employee; and
      d. There is a causal connection between the false representation and the injury.
   2. For the defense to apply, the questions asked on the employment application must request factual information, not an opinion.
RECENTLY ASKED QUESTIONS
FROM ISSUES ADDRESSED IN RECENT ARKANSAS CASES

SUPREME COURT OF ARKANSAS

Q: Can an injury, suffered by an employee in a golf cart operated by a co-employee during a golf game at a sales meeting, be considered within the scope and course of employment and fall under workers’ compensation protections?

A. Yes. In Curtis an employee was injured in a golf-cart accident that occurred during a golf game at an employer sponsored sales meeting. The Supreme Court of Arkansas affirmed the lower Courts finding that the accident constituted a work-related injury. The employer had organized the event, and “[a]lthough participation in the golf outing was not mandatory”, the purpose of the golf outing was a “team-building exercise” that ultimately benefitted the employer. The employer “wanted a relaxed environment for free flow of thoughts and ideas” and they “specifically paired groups in an effort to mix employees … in order to create a dialogue.” Next, the Court determined that, “although the employee and co-employee were in a golf cart at the time of the injury, …they were ‘nevertheless acting within the course and scope of their employment at the time of the injury.’ The fact that the golf cart was not a physical business location or the Employer’s normal place of business is of no consequence.”


Q. Is there immunity from a tort action for a co-employee who, during a work sponsored golf game, drove the golf cart that injured the employee bringing the action?

A. Yes. In Curtis, the Arkansas Supreme Court affirmed the Court of Appeals decision that an employee injured in a golf-cart accident could not bring a negligence claim against the co-employee who drove the golf cart because the co-employee was immune from such negligence claims asserted by the injured employee. In a workers' compensation context, immunity from a tort action is only extended to supervisors or co-employees if, at the time of the accident, they are fulfilling the employer's duty to provide a safe place to work and are essentially acting as an arm of the employer. In such cases, because the employer is immune from suit in tort, a co-employee who is acting on behalf of the employer by providing a safe place to work is entitled to that same immunity. The co-employee who drove the golf cart was acting as an “arm of the employer,” fulfilling employer’s duty to provide a safe place to work for employees who participated in the golf outing during a sales meeting, and thus the co-employee was immune under Workers' Compensation Act from the injured employee's negligence action against him arising from the golf cart accident, because the co-employee was driving golf cart in the course and scope of his employment, and the golf outing was within workplace bounds.
Q. **Does the Workers’ Compensation Commission, as opposed to the Circuit Court, have exclusive jurisdiction to determine whether an employer-employee relationship exists?**

A. Yes. In *Entergy*, the worker, a subcontractor's employee, was killed by a steel beam while attempting to install a part on a generator at a nuclear power plant. The Arkansas Supreme Court found that the Commission, not the Circuit Court, had exclusive jurisdiction to determine whether an employer-employee relationship existed between the deceased worker, owner of nuclear power plant, and contractor, for purposes of determining whether owner and contractor had tort immunity from negligence and wrongful death action arising from the accident.

*Entergy Arkansas, Inc. v. Pope Cnty. Circuit Court, 452 S.W.3d 81 (2015).*

Q. **In a civil action filed by the estate of an employee against the employer, is an estate’s constitutional challenge to the state’s exclusive remedy defense considered forum shopping?**

A: Yes. In *Central Flying Services*, the employee, who had been a pilot for the employer, died in a work-related airplane crash and his estate filed suit against the employer. When the employer raised the exclusive remedy defense, the estate filed a reply challenging the constitutionality of the defense. The employer sought a writ of prohibition to block consideration of the issues by the trial Court. The Supreme Court agreed. When the question of exclusivity was raised, it was up to the Commission, not the trial Court, to determine that issue. The Court acknowledged that the Commission did not have the authority to pass on a constitutional question, but the issue nevertheless should first be raised at the ALJ or Commission level. The constitutional issue could not be isolated. The estate had not taken into consideration that the tort claim—the basis for the estate’s entire complaint—was one that fell within the exclusive province of the Commission. Thus, the order of prohibition was granted.

*Cent. Flying Serv., Inc. v. Pulaski Cnty. Circuit Court, 2015 Ark. 49 (2015).*

**COURT OF APPEALS OF ARKANSAS**

Q. **When an employee is engaging in both a personal and an employment related task are they considered to be performing employment services within the course and scope of employment?**

A. It depends. In the *Best Western* case, an employee was injured when she fell down the stairs on her way to a laundry room. The employee was engaged in two tasks when
she fell. She testified that she was carrying personal food to place in a refrigerator, but her primary purpose was to retrieve clean towels for the hotel room that she was cleaning. The Court found that when an employee suffers an injury while performing a mixture of tasks that the task behind the primary purpose would determine whether the employee was performing employment services within the course and scope of employment.


**Q. Is a gradual onset injury considered an “accidental injury” under the statute of limitations for filing claims under Workers’ Compensation law?**

A. No. The workers’ compensation statute defining compensable injuries that are accidental does not apply to gradual-onset injuries. In *Estrada*, the injured Claimant’s gradual-onset back injury, was not an accidental injury under the statute of limitations because the back injury was not caused by an accident or by a specific incident that occurred at an identifiable time and place, but instead began as mild back pain that worsened little by little and was controlled by non-prescription medication. Even though Claimant reported the back pain to a physician more than two years prior to filing a claim for compensation, the statute of limitations does not begin to run unless a compensable injury has first been found.


**Q. When an employer pays an employee “full wages” during a period of disability and the employee is subsequently awarded TTD benefits for that period, is the employer entitled to a credit under the statute for the amounts paid to the employee?**

A. Yes. In *Parker*, the Claimant filed an EEOC suit when she was fired by the employer during her time of disability. The suit was later settled with the employer and the employer paid “lost wages” as part of the settlement. The employee filed a workers compensation claim and the commission found Claimant was entitled to past TTD. The Court of Appeals, however, found that although past TTD was owed the employer was not required to pay as doing so would be a double recovery. The statute that governs credit due an employer for full wages paid a Claimant during disability disqualified the worker from receiving TTD benefits during a period in which she received full wages, even though those wages were paid as part of a settlement, and thus employer was entitled to a credit for the amounts paid through the settlement as full wages that were commensurate with the Claimants’ TTD rate for that period of disability. However, the employer was not entitled to credit for any amount paid in excess of the TTD rate.

Q. If an employer accepts liability for payment of a permanent impairment and concedes that the compensable injury was the major cause of the impairment, is the claimant required to prove that the compensable injury was the major cause of the disability in order to receive permanent disability benefits?

A. No. The court in *Gilstrap* found Arkansas Code §11-9-102(4)(F)(ii)(a) to provide that “[p]ermanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability OR impairment” (emphasis added). The code section does not require the compensable injury be the major cause of both the disability and the impairment because the statute uses the term “or”. Therefore, the claimant is not required to show that the compensable injury is the major cause of the disability because the statutory major-cause requirement is satisfied when the record shows a physical impairment resulting from the compensable injury. When an employer stipulates that an injury resulted in impairment, it cannot later argue to the contrary when discussing disability.


Q. Is an overdose of pain medication causally related to a work injury and a reasonable response to work related pain when the claimant has a history of susceptibility to addiction and of abuse of medications prior to the compensable injury?

A. No. Although other similar cases, such as *Eagle Safe Corp. v. Egan*, 39 Ark. App. 79 (1992), have found a resulting overdose of pain medication to be a reasonable response to work related pain and causally related to work injuries, the claimant in this case had a history of abuse of opiates and a susceptibility to addiction. In addition, his injury occurred four years prior to the overdose and was too attenuated to attribute to the death. Furthermore, the fact that the decedent was able to travel and perform job functions as a football coach supports the finding that the overdose was not in response to uncontrolled pain, but was instead the result of his drug addiction.


Q. If a claimant ultimately voluntarily resigns from her job with the employer, is she entitled to wage-loss disability even if the accommodations made by the employer were unusual and somewhat embarrassing for the claimant?

A. No. In *Templeton*, the employer provided accommodations to the claimant that included allowing her to stock shelves from a seated position, lay down as needed in her vehicle, and provided assistance to her by having an additional employee on duty to help as needed. The claimant felt embarrassed by having to rest in her vehicle, and felt ridiculed for having to ask for assistance and ultimately resigned. Although the claimant was admittedly embarrassed by the accommodations as provided by the
employer, she voluntarily resigned from her position and did not seek further employment and therefore refused suitable employment offered to her by her employer and is not entitled to additional wage-loss disability.


**Q. When a claimant was injured on the way to visit a client while picking up groceries for the client is the employee performing employment services at the time of injury?**

**A.** No. If the claimant is not engaged in the primary activity that she was hired to perform or in incidental activities that are inherently necessary for the performance of the primary activity they are not considered to be advancing the employers interest either directly or indirectly. The court in *Black* found that although the claimant, a caregiver, was picking up groceries on the way to visit a client for whom she would use the groceries to cook for, she was not performing employment services at the time of the injury, because she was not required or expected by her employer to provide groceries for her clients, and she acknowledged that on the day of the injury she was not directed by the client to purchase groceries. Although her actions may have been generous and admirable and have the appearance of being beneficial, these actions were not part of her job duties and thus not in the performance of employment services.


**Q. Is a separated spouse [widow] entitled to benefits as a partial dependent when the deceased only provided occasional amounts of money for support?**

**A.** No. Numerous monetary contributions are not enough to provide a basis for a reasonable expectation of support. In *Moss*, the spouse/widow had been separated from the deceased for 12 years. She testified that she occasionally received monetary support, ranging in amounts from $100 to $300 in various months, from her separated spouse up until his death. The Court held widow was not entitled to benefits, because she did not provide any corroborating evidence that the claimant was providing anything other than occasional amounts of money for support, she had not filed a joint income tax return with the deceased, and had not taken legal action to obtain any consistent level of support from the deceased. Although the deceased may have provided the widow with small amounts of money at irregular intervals, this was not enough to establish a reasonable expectation of support because the support was not provided on a routine, systematic, or continuous basis.

Q. **Is there evidence of a psychological injury, as required under Arkansas Code §11–9–113, that a diagnosis has been made by a licensed psychiatrist or psychologist, when the diagnosis is made by a non-psychiatrist/psychologist, but later reviewed and approved by one?**

A. Yes. In *Rose Aircraft Services*, the Court of Appeals discussed that Arkansas Code §11–9–113 required that the Claimant prove that a licensed psychiatrist or psychologist diagnosed her with a condition that meets the criteria established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders and that her condition and need for treatment were caused by her compensable injury.

Here, the Commission found that, while a licensed counselor and a neurologist had diagnosed the Claimant with a psychological disorder, there were no reports from either a licensed psychiatrist or a licensed psychologist indicating any type of diagnosis or treatment plan as required by the statute. However, the Court of Appeals found that the licensed counselor’s diagnosis and treatment plan had been reviewed and approved by a clinical supervisor of the mental health facility, where she worked, who was a licensed Psychiatrist. The Court reasoned that even though the diagnosis and treatment plan were not directly made by the psychiatrist, the indirect review and approval of the diagnosis and treatment plan by the supervisor would suffice under the statute.


Q. **Is an injury considered to be performing employment services such that the injury is deemed arising out of and in the course of employment when a truck driver is killed when crossing a street on the way to his truck, but after stopping to have breakfast while he waited for his delivery?**

A. Yes. In *Razorback Concrete*, the deceased driver had arrived at his delivery destination at a time prior to the gates being open for drop-off. The driver then drove the truck to a diner and had breakfast. When crossing the street to return to his truck to complete the delivery he was struck by a car and killed. The employer argued that the Driver was not actually back in his work truck or on company property at the time he was injured. Further, the employer argued that the driver remained on a purely personal deviation from his work at the time of his injury. The Court of Appeals held that the driver was performing employment services at the time he was killed. The Court reasoned that the driver was on paid company time, responsible for his truck during his workday, a half mile away from the employer’s locked and gated facility, and was returning to work after this permissible deviation had been completed. The Court emphasized that the driver was responsible for his shipment and truck at all times, even while he was on his break for breakfast.

Q. Is an injury considered to be performing employment services such that the injury is deemed arising out of and in the course of employment when a hospital nurse on her way to lunch in the same hospital is injured when getting on the elevator to go to the lunchroom floor?

A. No. In the St. Bernard Hospital case, a nurse who was taking a lunch break was injured when she tripped getting on an elevator to go to a different floor where the lunch cafeteria was located. The nurse did not clock out for lunch; however, the hospital deducts 30 minutes for lunch for all employees automatically. The nurse argued that she was always on duty and performing employment services because she could be called back to her station at any time and in addition, the hospital had a policy that “all employees were to be helpful to anyone at any time.” However, the Court of Appeals found that the injury did not occur within the course and scope of her employment. They reasoned that the nurse was on a personal errand to retrieve food for her own benefit. The employee handbook provided that an employee should be considered to be “completely relieved” of her work responsibilities while on break. They also noted that the nurse specifically left her patient in the hands of another employee before she went to retrieve her lunch. Therefore, even though there was an expectation to assist at any time the nurse was not engaged in any job duty/task at the time of the injury and was not advancing the employer’s interest directly or indirectly.

I. Compensability Standard
   A. Accident or accidental injury must arise out of and in the course of employment.
      1. Accident arises out of the employment when there is a causal connection between the employment and the injury.
      2. Injury must be traceable to a definite time, place, and cause.
   B. The petitioner must show that the condition or injury might or could have been caused, aggravated, or accelerated by the employment.

II. Average Weekly Wage (AWW)
   A. General Rule: Divide the year’s earnings of an individual by the number of weeks worked during the year (52).
      1. Ex. Sum of wages for previous 52 weeks prior to the accident = $40,000
         $40,000/52 = $769.23
   B. If an employee lost five or more calendar days during a 52-week period prior to the accident, then divide annual earnings by the number of weeks and portions of weeks the employee actually worked.
      1. Ex. Sum of wages for previous 52 weeks prior to the accident = $30,000 but petitioner missed 10 days = $30,000/50 = $600.00
   C. If employee worked less than 52 weeks with the employer prior to the injury, divide amount earned during employment by number of weeks worked.
      1. Ex. Employee 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 regularly worked.
      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 by 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.

1. Claimant’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.

III. Benefits and Calculations

A. Medical Treatment—Pre-2011 Amendments: Employee chooses provider, and employer is liable for payment of:

1. First Aid and emergency treatment.
2. Medical and surgical services provided by a physician initially chosen by the employee 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 employee.
4. If employee still feels as if he needs to be treated by a different doctor other than the first two doctors selected by the employee (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 employee.
6. If injury results in damage to denture, glasses or contact lenses, the employer shall replace or repair the damaged item.
7. Furnishing of a prosthetic or repairing damage to dentures, glasses or contacts is not an admission of liability and is not deemed the payment of compensation.

B. 2011 Amendments (In effect for injuries on or after September 1, 2011)

1. Section 8(4) of the Act now allows employers to establish preferred provider programs (PPP) consisting of medical providers approved by the Department of Insurance. The PPP only applies in cases where the PPP was already approved and in place at the time of the injury. Employees must be notified of the program on a form promulgated by the IWCC.
2. Under the PPP, Employees 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 employee may choose a physician from outside the network.
3. Employees 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 an employee chooses non-emergency treatment prior to the report of an injury, that also constitutes one of the employee’s two choices of physicians.

C. Medical Fee Schedule—Illinois Legislature recently 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 incapacity 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—as of 02/01/06 the Illinois minimum wage is higher ($6.50/hour).

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

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

G. Person as a whole—Maximum of 500 weeks
1. General rule if injury is not listed on rate card, it is a person as a whole injury.
2. Common for back injuries.
3. Rate used is 60% of AWW.

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

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

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

K. Death
   1. Maximum that can be received can't exceed the greater of $500,000 or 25 years.

L. PTD—Only arises when employee is completely disabled which means the employee is permanently incapable of work.
   1. Can be statutory
      a. Statutory permanent total disability 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.
   2. Odd-lot permanent total disability
      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. The petitioner must establish the unavailability of employment to a person in his or her circumstances.
b. 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.

c. 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 employee 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 employee to his previous earning level.
   c. Likelihood that the employee would be able to obtain employment upon completion of his training.
   d. Employee’s work-life expectancy.
   e. Evidence that the employee has received training under a prior rehabilitation program that would enable the claimant to resume employment.
   f. Whether the employee 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 TTD.

2. A component of vocational rehabilitation.

3. Maintenance is paid once claimant at MMI, and undergoing vocational rehabilitation.

4. Two common situation:
   a. When employee is undergoing vocational rehabilitation and then placed at MMI, maintenance picks up where TTD ceases (at the TTD rate) – similar to a continuation of TTD.
   b. When employee has completed a vocational rehabilitation program and has yet to be placed in the labor market.

O. Wage Differential—Compensates for future wage loss

1. 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.
2. Employee receives 2/3 of 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.

3. 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 provides that physicians may now submit an impairment report using the most recent American Medical Association (AMA) guidelines. 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. 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.

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

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

C. An employee 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 employee’s two choices of physicians.

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

V. Medical Fee Schedule
A. The 2011 Amendment to Section 8.2(a) of the Act reduces all current fee schedules by 30% for all treatment performed after September 1, 2011, and reduces the current 76% of charge default to 53.2%. 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.
B. 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. Payments made more than 30 days after the required information is received are subject to a 1% monthly interest fee. (Prior to the 2011 Amendments, this fee accrued after 60 days; now it accrues after only 30 days).

VI. Illinois Workers' Compensation Procedure

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

B. Pretrial Procedure
   1. Depositions – Cannot take the Employee's deposition.
   2. Subpoenas—easy to get, normally Arbitrator has signed in advance
   3. Records of Prior Claims—determine if credit allowed
   4. Section 12 Medical Examination—employee must comply
      a. Used to avoid penalties
      b. Used to investigate petitioner's prior treatment and diagnoses
      c. Can be scheduled at reasonable intervals
      d. Must pay mileage
   5. Settlement

C. Arbitration Procedure
   1. When application is filed, the Commission assigns the docket location (normally within the vicinity of where the injury occurred).
   2. Cases appear on the call docket on three month intervals until the case has been on file for three years, at which point it is set for trial unless a written
request has been made to continue the case for good cause. (This request must be received within 15 days of the status call date).

a. The case is referred to as "above the red line," and red line cases are available on the call sheet at the Illinois Workers' Compensation Commission website. If no one for the petitioner appears on a red line case at the status conference, the case can be dismissed by the arbitrator for failure to prosecute.

3. If a case is coming up on the call docket, a party can request a trial. This request must be served on opposing counsel 15 days before the status call. At the status call, the attorneys will select a time to try the case.

4. If both parties are in agreement, they may request a trial at the monthly call docket.

5. If a case is not coming up on the call docket, and a party has a need for an immediate hearing, the party can file a motion to schedule the case for a 19(b) hearing. The party requesting the 19(b) hearing must only give the other party 15 days notice.

a. A 19(b) hearing is not proper where the employee has returned to work and the only benefit in dispute amounts to less than 12 weeks of temporary total disability.

6. A pretrial conference can be requested by either party prior to the start of a trial. The benefit of a pretrial conference is that the same arbitrator over a pretrial conference will hear the actual trial, so the parties will have a good idea how the arbitrator feels about the case or a particular issue. Both parties must consent to a pretrial conference.

7. Emergency Hearings under Section 19(b-1)

a. Employee not receiving medical services or other compensation.

b. Employee 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

d. Effectively serves the same purposes as a 19(b) hearing but fixes deadlines.

8. If a case is tried by an arbitrator and the arbitrator's award resolves the case (i.e., the parties do not reach a settlement) medical benefits will remain open.

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 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.
VII. Jurisdiction - Illinois jurisdiction is appropriate when:
   A. If the employee is injured in Illinois, even if the contract for hire is made outside of Illinois.
   B. The employee’s employment is principally localized within Illinois, regardless of the place of accident or the place where the contract for hire was made.
   C. If the last act necessary to complete the contract for hire was made in Illinois.

VIII. Employee must provide notice of the accident.
   A. An employee shall give notice to the employer as soon as practicable, but not later than 45 days after the accident.
   B. Defects/Inaccuracy in the notice is no defense unless the employer can show it was unduly prejudiced. This is difficult to show in Illinois because the employee directs medical treatment.

IX. Accident Reports
   A. Employer must file a report in writing of injuries which arise out of and in the course of employment resulting in the loss of more than three scheduled workdays. This report must be filed between the 15th and 25th of each month.
   B. For death cases, the employer shall notify the Commission within two days following the death.
   C. These reports must be submitted on forms provided by the Commission.

X. Application filing periods - Statute of Limitations
   A. Must file within three years after the date of accident or two years after the last compensation payment, whichever is later.
   B. In cases where injury is caused by exposure to radiological materials or asbestos, the application must be filed within 25 years after the last day that the employee was exposed to the condition.

XI. Penalties relating to actions of Employer/Insurer
   A. 19(k) Penalty for delay—PPD, TTD and/or Medical
      1. When there has unreasonably delayed payment or intentionally underpaid compensation.
      2. 50% of compensation additional to that otherwise payable under the Act.
      3. This section 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 the utilization review as a factor in determining the reasonableness and necessity of medical bills or treatment. Utilization review can also be utilized to avoid penalties.
   B. 19(l) Penalty for delay—TTD
1. If employer or insurance carrier fails to make payment “without good and just cause”
2. The arbitrator can add compensation in the amount of $30/day not to exceed $10,000.
3. This section invoked even if the payment is not a result of bad faith
4. Generally penalties are not awarded if 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.

XII. Penalties relating to actions of the petitioner

A. Intoxication
   For accidents before September 1, 2011, if the court finds that accident occurred because of intoxication then injury is not compensable.
   1. Intoxication not per se bar to workers’ compensation benefits.
   2. Intoxication will preclude recover if it is the sole cause of the accident or is so excessive that it constitutes a departure from employment.

   For accidents on or after September 1, 2011, the Amended Section 11 of the Act provides that no compensation shall be payable if:
   1. The employee’s intoxication is the proximate cause of the employee’s accidental injury.
   2. At the time of the accident, the employee was so intoxicated that the intoxication constituted a departure from the employment.

   The 2011 Amendment provides that if at the time of the accidental injuries, there was a 0.08% or more by weight of alcohol in the employee’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 employee refuses to submit to testing of blood, breath, or urine, there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee’s injury. The employee can rebut the presumption by proving by a preponderance of the evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries.

B. Unreasonable/Unnecessary Risk
   1. If employee 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.

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

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

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

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

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

E. Applies only to diseases that are "slow and insidious"
   1. Ex: kidney ailment cause from repetitive exposure to liquid coolant.
   2. Ex: asthma aggravated by white oxide dust.

XIV. Repetitive Trauma - Covered under the Workers’ Compensation Act

A. Date of Injury for Repetitive Trauma
   1. Date of injury is the date on which the injury “manifests itself.”
   2. “Manifests itself”—General Standard—the date on which both the fact of the injury and the causal relationship of the injury to the claimant’s employment would have become plainly apparent to a reasonable person—Landmark case: Peoria County Belwood Nursing Home v. Indus. Commn., 505 N.E.2d 1026 (Ill. App. 1987).

   3. The Belwood Standard has been expanded slightly over the years.
   4. Courts have found date of injury to be:
      a. Date injury became apparent to a reasonable person. Last date of work at the employer prior to the disablement (time at which employee can no longer perform his job).

XV. Third-Party Recovery

A. Workers’ Compensation Act prohibits employees from bringing tort actions against their employers

B. An injured employee may pursue tort action against a third party.
C. The third party has a right to contribution from the employer which is limited to its liability under the Workers’ Compensation Acts.

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

XVI. 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.

C. Ex. Waitresses arguing over tables and the argument turns physical when one waitress strikes the other—this is compensable.

XVII. Minors (under 16 years of age)

A. Receive a 50 percent 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).

XVIII. Voluntary Recreation

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.

XIX. 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.
Q: Can an injury, which occurred as a result of a neutral risk to the public, arise out of and in course of the employment when the employee is a traveling employee?

A: Yes. Workers' compensation employee, who was a traveling employee, sought judicial review of decision of Workers' Compensation Commission denying benefits for injuries he received while working for city and tripping over a curb. The Circuit reversed finding that when a traveling employee is exposed to a certain risk while working, he is presumed to have been exposed to a greater degree than the general public. The Court reasoned that typically, injuries resulting from a neutral risk, such as tripping over a curb, do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. When, as in the case of a traveling employee, where the employee's job requires him to travel the streets, the risks of the street become one of the risks of his employment. The court held that the Employee, who was a plumbing inspector for city, was exposed to risk of traversing a curb to a greater degree than a member of general public by virtue of status as a traveling employee at time of accident. The injury, which the employee suffered when he tripped over the curb, was sustained not only in the course of his employment, but it also arose out of his employment with the City.

Nee v. Illinois Workers' Comp. Comm'n, 2015 IL App (1st) 132609WC

Q: Does the Illinois 3-year Statute of Limitations limit the evidence an employee may present regarding his or her work activities to only those activities occurring within the three years prior to the filing of the employee's application for adjustment of claim or manifestation date of his or her repetitive-trauma injury?

A: No. Appeal was taken from the Circuit Court’s determination that evidence outside the 3 year statute of limitations period could not be considered with regards to a repetitive trauma claim. The employee alleged a repetitive-trauma injury to her left shoulder, which she asserted developed gradually over time as she utilized her left upper extremity when performing her work duties. As part of her evidence, employee tried to introduce work history which extended beyond the limitations period. On Appeal, the court reasoned that looking to the plain and ordinary language of the statute, there was no evidentiary limitation. The Statute provided limits with respect to the filing of a claim for benefits, not what evidence may be presented to support any particular claim. Thus, it reasoned that a employee's work history may be necessary and relevant to determining whether she sustained such a work-related, gradual injury. The Appeals court vacated the the circuit court's judgment and remand for further proceedings.
Q: Can an employer terminate TTD benefits when an employee is terminated for cause prior to reaching MMI?

A: No. The Arbitrator determined employee sustained accidental injuries that arose out of and in the course of his employment on March 7, 2010, and awarded him (1) 23 2/7 weeks' temporary total disability (TTD) benefits from June 13 to November 22, 2011; (2) $14,227.41 in medical expenses; and (3) prospective medical expenses. The Commission vacated the award for temporary benefits holding employee's for-cause termination, arising out of theft from employer, was a refusal of light-duty work that would preclude TTD benefits. The Court of Appeals vacated the Commission’s decision. It held that an employee is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit i.e., whether the employee has reached MMI. Furthermore, TTD benefits may be suspended or terminated if the employee (1) refuses to submit to medical, surgical, or hospital treatment essential to his recovery; (2) fails to cooperate in good faith with rehabilitation efforts; or (3) refuses work falling within the physical restrictions prescribed by his doctor. When an employee who is entitled to receive workers' compensation benefits as a result of a work-related injury is later terminated for conduct unrelated to the injury, the employer's obligation to pay TTD workers' compensation benefits continues until the employee's medical condition has stabilized and he has reached MMI.

Matuszczak v. Illinois Workers' Comp. Comm'n, 2014 IL App (2d) 130532WC, ¶ 1, as modified on denial of reh'g (Dec. 22, 2014)

Q: Can a co-employee or brother of a workers’ compensation employee file a retaliatory discharge complaint against the employer where he had no involvement or participation in the workers’ compensation claim?

A: No. Plaintiff David Shakboua filed for retaliatory discharge under the Illinois Workers' Compensation Act, against the employer. The circuit court dismissed the complaint and plaintiff appealed, arguing that a brother and co-employee of a workers' compensation complainant who is involved in the investigation should be allowed to file a retaliatory discharge complaint. Plaintiff did not witness the accident or have any knowledge of the accident and did not take part in any proceedings under his brother's workers' compensation claim. The Court of Appeals affirmed the circuit court's dismissal. It held the dismissal of plaintiff's claim of retaliatory discharge under the Illinois Workers' Compensation Act related to his brother's filing for workers' compensation benefits and whistleblowing was proper where plaintiff did not file a workers' compensation claim, there are no allegations that plaintiff: participated in any workers' compensation

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proceedings; reported any illegal or improper conduct by defendant; was discharged in retaliation for any reporting of improper conduct, or that plaintiff's discharge violated clearly mandated public policy. The court did infer that if plaintiff had involvement in the workers’ compensation claim or was a witness to the claim, that he would be able to bring a retaliatory discharge claim.

**Shakboua v. City of Chicago, 2014 IL App (1st) 131804-U**

**Q:** Can an employer terminate TTD benefits of an employee who retires, when the employee has not reached MMI but the employer could accommodate his light-duty restrictions?

**A:** Yes. The Commission concluded that the employee's voluntary retirement was the equivalent of refusing the accommodated duty which the employer had available but for his retirement, and as a consequence he was not entitled to TTD benefits. The Court of Appeals affirmed finding that the Commission's decision to deny employee TTD benefits after his voluntary retirement 6 months after accident is not against manifest weight of evidence. The Court reasoned that the purpose of the Act is to compensate an employee for lost earnings resulting from work-related injuries. When, as in this case, work within an injured employee's medical restrictions is available and the employee does not avail himself of the opportunity by voluntarily retiring, continued payment of TTD benefits does not further that purpose. In such a case, the employee's lost earnings are the result of his volitional act of removing himself from the work force, not his work-related injuries.

**Sharwarko v. Illinois Workers' Comp. Comm'n, 2015 IL App (1st) 131733WC**

**Q:** Does an injury arise out of and in course of employment when an employee injures himself while playing in a recreational basketball game during his shift and on the employer's premise?

**A:** Yes. The employer, Taylorville Fire Department, appealed the order of the circuit court which confirmed decision of the Illinois Workers’ Compensation Commission, finding that the right ankle injury of the employee, which he sustained during a 3-on-3 basketball game at the fire station, arose out of and in the course of his employment. Typically under the Act, injuries occurring during the course of recreational events are simply not compensable irrespective of whether it may be said they arise out of and in the course of employment except to the extent that an employee is ordered or assigned by the employer to participate in the program. The Appeals court affirmed the decision of the Commission that the employee's injuries arose out of and in the course of his employment, noting that the injuries occurred during a firehouse basketball game, where the employee was on duty and unable to leave, where the employee was asked to participate in the game by his shift supervisor, and where the employer encouraged participation in sports and fitness.
Q: Did an employee suffer an injury arising out of and in the course of his employment when he did not receive any medical treatment after the alleged injury and a co-worker testified the employee did not do anything unusual on the day in question?

A: No. The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. In deciding the matter, it is the function of the Commission to judge the credibility of the witnesses, determine the weight to be given their testimony, and resolve conflicting medical evidence. Id. For a finding of fact to be against the manifest weight of the evidence, a conclusion opposite to the one reached by the Commission must be clearly apparent. The alleged work accident giving rise to this action was unwitnessed. The claimant testified, however, that he reported the accident to his supervisor, and his testimony in this regard was unrebutted. He testified that, following the accident, he was in pain and was limping. However, the claimant's co-worker, Yanez, testified that he was working in the same general area as the claimant and observed nothing unusual about the way that the claimant was walking during his work shift or at the end. A number of facts in evidence support the Commission's conclusion that the claimant failed to prove that he suffered accidental injuries on October 20, 2006, which arose out of and in the course of his employment with Field. The claimant sought no medical care on the day of his alleged injury. Yanez contradicted the claimant's testimony that he was limping by the end of his work shift on October 20, 2006. And, there is a total absence of any reference to a work accident in the claimant's medical records until six days after this claim was filed, some two months after the alleged accident. No doubt, there is also evidence in the record supporting the claimant's assertion that he injured his left foot while working on October 20, 2006; namely, his own testimony and the fact that he stated that he reported an accident to his supervisor on that same day. In the last analysis, however, the issue is one of fact to be resolved by the Commission; and, although the appellate court may not have not reached the same conclusion, it cannot say that, based upon the record before it, the Commission's decision was against the manifest weight of the evidence.

Sanchez v. Illinois Workers' Compensation Com'n, 2015 IL App (1st) 132560WC

Q: How should an employee's average weekly wage be calculated when he worked varying hours due to the nature of his employment as a union carpenter?

A: The compensation shall be computed on the basis of the “Average weekly wage” which shall mean the actual earnings of the employee in the employment in which he was
working at the time of the injury during the period of 52 weeks ending with the last day of the employee’s last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. The court held that the Commission erred in proceeding to its calculation under the second method without making a threshold finding of the number of days lost by the claimant. The claimant’s wage statement established that, although he worked 40 hours per week when work was available, there were many weeks when he worked only between 24 and 32 hours, and often in partial days. The claimant testified that he had missed some full days during the year prior to his injury due to inclement weather. However, there was no specific proof as to how many work days, or calendar days, he actually lost. As stated above, without proof that the employee lost five or more full days, the second method cannot properly be employed to determine average weekly wage. It was the claimant’s burden to prove the number of days that he lost in the year prior to his injury. However, the claimant’s lost time under section 10 must include the parts of those days when he was required to report to work, and did so report, but was then sent home without pay. In order to factor out this time and arrive at the number of weeks “and parts thereof” that the claimant actually worked, it will be necessary to begin with the number of hours the claimant worked per week. Accordingly, the court remanded the case to the Commission to determine “whether the claimant lost 5 or more calendar days in the year before his work injury.”

R & D Theil v. Illinois Workers’ Compensation Com’n, 2014 IL App (2nd) 131206WC-U

Q: Did an employee meet his burden proving he sustained an accident arising out of and in the course of employment where the only doctor to offer an opinion on the issue of casual connection was an expert selected by employees attorney?

A: No. The claimant’s expert, Dr. Newman, noted in his report that the claimant was a shelver at the library. However, The Commission noted that there was no evidence in Dr. Newman’s report that he was aware of the average weight of the books or the frequency with which the claimant reached with her right arm or the frequency with which she performed overhead lifting with her right arm. The Commission found it significant that there was no evidence that Dr. Newman reviewed the video job description submitted by the employer. Here, the Commission discounted the testimony of the claimant’s expert because he did not demonstrate foundational knowledge of the weight of the books or the frequency of shelving. As such, the Court affirmed the Commission’s division that claimant failed to prove that she sustained an injury arising out of and in the course of her employment.

Liu v. Illinois Workers’ Compensation Com’n, 2014 IL App (1st) 132858WC-U
Q: Does the “missing witness rule” attach where claimant’s counsel merely requested the witness be presented and did not subpoena the witness to testify at the hearing?

A: No. Claimant did not subpoena the witness to testify or otherwise attempt to set up a deposition. Rather, claimant's counsel simply sent an email to respondent's counsel demanding respondent to produce the witness. To allow an adverse inference from a party's failure to produce a witness, the following foundational requirements must be established: “(1) the missing witness was under the control of the party against whom the inference is drawn, (2) the witness could have been produced in the exercise of reasonable diligence, (3) the witness was not equally available to the party in whose favor the inference is drawn, (4) a reasonably prudent person would have produced the witness if the party believed the testimony would be favorable, and (5) no reasonable excuse for the failure to produce the witness is shown.” Claimant has not met several of the foundational requirements that would allow the missing-witness inference to be drawn. First, it is not apparent that the witness was under the control of respondent. While an employee may be deemed to be under the control of an employer, the witness was employed by respondent's insurance carrier rather than by respondent. Second, claimant chose to send an e-mail rather than a subpoena did not render the witness unavailable to him. Finally, we note that the testimony the Commission inferred the witness would have given was cumulative of claimant's testimony, as claimant testified he repeatedly sought and was denied treatment. As such, it was outside the scope of the missing-witness rule.

Liquid Transport Corp. v. Workers’ Compensation Com’n, 2014 IL App (5th) 130137WCWC-U

Q: How is the “law-of the case doctrine” applicable where a matter is tried before the Commission on a 19(b) hearing regarding whether a causal connection existed between the claimant's accident and her current conditions of ill-being and later tried on an additional 19(b) hearing on the same issue?

A: The issue in this workers' compensation case concerns the application of the law-of-the-case doctrine in a second 19(b) hearing. The issue involves the claimant's complaints of persistent neck, back, leg, and arm pain following a workplace accident, which occurred in December 2002, and whether her continual pain following a first 19(b) hearing is causally related to the accident. Under the law-of-the-case doctrine, once an issue is litigated and decided, that ends the matter and the unreversed decision of a question of law or fact made during the course of the litigation settles that question for all subsequent stages of the suit. A party's failure to challenge a legal decision when it had the opportunity to do so renders that decision the law of the case for future stages of the same litigation.

Harrell v. Illinois Workers’ Compensation Com’n, 2015 IL App (1st) 140762WC
Q: Must the Commission consider whether the claimant's accident “accelerated” his condition of ill-being when determining if the need for surgery is causally related to his employment?

A: Yes. It is axiomatic that to be compensable, a claimant's condition of ill being must be caused by a work-related accident. However, employment need not be the sole cause of the injury; to be compensable, it is sufficient if it is a cause. Moreover, an employer takes his employees as he finds them. Even where a pre-existing condition makes an employee more vulnerable to an injury, compensation may be awarded if employment is a causal factor in the resulting injury. Finally, a claimant may recover where an underlying condition has been accelerated by employment.

Kroeschell, Inc. v. Illinois Workers’ Compensation Com’n, 2014 IL App (1st) 131702WC-U

Q: If a company is responsible for providing workers’ compensation benefits for an injured employee, should they also be required to answer to that employee for civil damages in a negligence suit?

A: No. Plaintiff appealed the trial court’s order denying her motion for summary judgment and granting the defendant’s motion for summary judgment. The plaintiff did not believe that defendant should be considered a joint employer, and therefore should not be granted immunity from workers’ compensation. Employee argued that defendant, Centegra, a health care system that operated the hospital, was not her joint employer because the job posting she responded to was from the hospital and Centegra did not receive any benefit from her services. Plaintiff was injured when she tripped over a cord in the laboratory where she worked within the hospital. She brought a workers’ compensation claim and then attempted to bring a civil claim for negligence against Centegra and the hospital. The trial court held, and the Appellate Court affirmed, that Centegra had immunity under the Workers’ Compensation Act because they were a joint employer. The appellate court listed several factors to support their position, such as: plaintiff’s paychecks were paid by Centegra from their own account, Centegra received a benefit from plaintiff’s work, Centegra controlled the work that was done within the hospital, and they provided workers’ compensation benefits for the plaintiff/employee. The appellate court agreed that Centegra was plaintiff’s joint employer and therefore, immune from being required to respond to a negligence suit in civil court by employee.

Kay v. Centegra Health Sys., 2015 IL App (2d) 131187

Q: If an unmarried claimant dies without any dependents, can his estate recover his PPD benefits that accrued prior to the employee’s death, or alternatively, do the benefits abate upon the employee’s death?
A: Yes. An estate can recover PPD benefits that accrued prior to the death of the claimant, regardless of whether they have living dependents at the time of their death. Plaintiff appealed the Commission’s decision denying the estate the ability to recover PPD benefits that accrued before the claimant passed away. The Commission held that the estate should not be able to recover because the claimant did not have any living dependents at the time of her death, pursuant to Section 8(e)(19) and Section 8(h). The Circuit Court affirmed the Commission’s decision for the same reason. The Appellate Court found that the Commission and Circuit Court incorrectly interpreted the provisions listed above. The Appellate Court found that these provisions do not limit who is able to recover the benefits upon the death of the claimant and do not bar the employee’s estate from collecting accrued benefits. In addition, the Appellate Court noted that there is no mention of accrued benefits in Section 8(h) that would bar the employee’s estate from recovering said benefits. As a matter of policy, the Appellate Court also held that a rule contrary to allowing the estate to recover the benefits would incentivize prolonged litigation by the employer in order to avoid payment of benefits in anticipation of death.

Bell v. Illinois Workers' Comp. Comm’n, 2015 IL App (1st) 140028WC

Q: Are intentionally inflicted injuries by a co-employee ‘accidental’ if they are not expressly authorized or ordered by the employer?

A: Yes. Injuries inflicted intentionally upon an employee by a co-employee are to be considered ‘accidental’ within the meaning of the Workers’ Compensation Act because such injuries are unforeseeable and unexpected to both the employee and the employer. The employee named Addus, the employer, as the only defendant in the case. The employee appealed the trial court’s decision to grant the defendant-employer’s motion to dismiss. The Act does not bar civil action against an employer for intentionally inflicted injuries caused by a co-employee, but the injury must have been ordered or expressly authorized. The Appellate Court affirmed the dismissal because the plaintiff did not allege that the injury was at the direction or express authorization of the employer, which is required in order to hold the employer responsible under the Act. Therefore, because the injury was not ordered or authorized by Addus, the motion to dismiss was properly granted.

Mason v. Addus Healthcare, Inc., 2015 IL App (1st) 131906-U

Q: Under the exclusivity provision of §287.280 of the Workers’ Compensation Act, is an employer protected from being named a defendant in a civil negligence action if they do not provide workers’ compensation insurance?

A: No. Employers are not protected from being named the defendant in a civil negligence case brought by an injured employee if they do not carry workers’ compensation insurance. The employee was working for Securitas Security Services as a security guard when he was assigned to be a security guard at the employer, Manheim’s, premises. Manheim employed security guards through Securitas Security Services. The
employee was injured when he fell on Manheim’s premises during his shift one evening. Manheim admitted that he was not insured under Securitas’ Workers’ Compensation Insurance Policy and did not provide any insurance of his own. The trial court granted Manheim’s motion for summary judgment because they believed he was protected under the exclusivity provision because he was an employer and was not the primary insurance carrier. The employee appealed the trial court’s grant of summary judgment and argued that Manheim was not protected by the exclusivity provisions because Manheim admitted to not having workers’ compensation insurance as required by §287.280, and therefore forfeited his protection against civil claims. The Appellate Court reviewed the lower court’s decision de novo and reversed the grant of summary judgment and remanded it back to the lower court. The Appellate Court followed the strict construction and plain language of §287.280 and held that the employer was required to insure its full liability under the Workers’ Compensation law or suffer the provided penalty, which included the employee’s election to file a civil suit.


Q: Can an employer be required to pay 25% of the employee’s attorney fees on future medical expenses under Section 5(b)?

A: No. Section 5(b) does not require an employer to pay for attorney fees regarding future medical expense. The employee filed a motion against the employer, Area, demanding 25% payment of attorney fees for suspended medical bills, long-term care, or other compensable benefits. The Circuit Court granted this motion, which allowed the employee’s counsel to receive a fee on suspended future medical payments. The employer argued that this would amount to a double recovery of attorney fees. The Court looked at Section 5(b) and determined that the plain language does not require an employer to pay attorney fees for suspended future medical payments. Considering the legislature’s intent, the Court looked at Section 5(b) and 8(a) and determined that if the legislature wanted to include future medical expenses in Section 5(b), they would have drafted it similar to how they drafted 8(a), which does include medical expenses. In addition, the Court looked at Illinois’ sister-state, Indiana. In a similar case, Indiana held that an employer in a workers’ compensation claim was not required to pay attorney fees to an injured worker’s attorneys on future medical expended that the employer would have paid but for the third-party tort action. The Appellate Court held that the Circuit Court erred in ruling that the employer was required to pay 25% attorney fees to employee’s counsel for suspended future medical expenses.

Bayer v. Panduit Corp., 2015 IL App (1st) 132252-U
I. PERSONAL INJURY

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

1. Personal injury:
   a. An injury to the body, the impairment of health, or a disease, which comes about not through the natural building up and tearing down of the human body, but because of a traumatic or other hurt or damage to the health or body of an employee. The injury to the human body must be something that acts extraneously to the natural processes of nature, and thereby impairs the health, overcomes, injures, interrupts, or destroys some function of the body, or otherwise damages or injures a part or all of the body.
   b. Repetitive trauma:
      i. The injury to the body in repetitive trauma cases occurs when pain or physical inability prevents the employee from continuing to work.

2. An injury, to be compensable, must arise out of and in the course of the employment:
   a. “Arise out of” – requires proof of a causal connection between the conditions of the employment and the injury. The injury may not have coincidentally occurred while at work, but must in some way be caused by or related to the working environment or the conditions of the employment.
      i. Special Cases—
         (1). Actual risk: an injury is compensable if the employment subjected the claimant to the actual risk that caused the injury, i.e. some causative contribution by the employment must exist.
         (2). Idiopathic causes: compensable only if caused or precipitated in part by some employment-related factor, or that the effects of the injury were worsened by the employment.
         (3). Horseplay: non compensable when an employee of his or her own volition initiates or actively takes part in an activity that results in injury. Victim/nonparticipant will be compensated.
         (4). Assault: generally compensable if it arises from an actual risk of the employment. If the assault is a willful act of a third party directed against the employee for reasons personal to the employee, then it will not be compensable.
   b. “In the course of” – the injury must take place within the period of the employment, at a place where the employee reasonably may be, and while the employee is fulfilling work duties or engaged in activities incidental thereto.
      i. Coming and going: an accident that occurs while an employee is going to or coming from work does not arise out of and in the course of employment.
ii. Exceptions:

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

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

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

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

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

B. Occupational Disease – Defined by Statute, chapter 85A

1. Occupation 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 “dependants” as defined by the Iowa Workers’ Compensation Act.- § 85A.6.
      b. Employees that incur occupational disease, but are able to continue in employment, are not entitled to compensation but are entitled to reasonable medical treatment.

5. Apportionment – § 85A.7(4)
   a. Where an occupational disease is aggravated by a non-compensable disease or infirmity, or, a non-compensable disease or infirmity is aggravated by an occupational disease, compensation shall be in proportion to the amount that is solely caused by the occupational disease.
   b. Either the number of weekly payments, or the amount of such payments, may be reduced as determined by the Commissioner.

6. Exclusions – § 85A.7
   a. Employees are not entitled compensation if they misrepresent, in writing, that they had not been previously disabled, terminated, compensated, or missed work because of an occupational disease.
   b. Compensation for existing diseases shall be barred if the employer can prove the disease existed prior to the employment.
i. The employer shall have the right to have an employee examined prior to employment and may require a waiver, in writing, of any and all compensation due to an occupational disease. § 85A.25

c. Compensation for death shall not be payable to any dependent whose relationship to the deceased employee was created after the beginning of the first compensable disability.

i. This rule does not apply to children born after the first compensable disability to a marriage existing at the beginning of such disability.

d. Miscellaneous exclusions: no compensation shall be allowed if the occupational disease:

i. is the result of an employee intentionally exposing themselves to the occupational disease;

ii. is the result of the employees intoxication;

iii. is the result of employees addiction to narcotics;

iv. as a result of the employees commission of a misdemeanor or felony;

v. as a result of employees refusal to use the safety appliance or protective device;

vi. as a result of employees refusal to obey a reasonable written rule, made by the employer, and posted in a conspicuous position in the workplace;

vii. as a result of the employees of failure or refusal to perform or obey a statutory duty;

viii. The employer bears the burden of establishing these defenses.

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

1. Occupational Hearing Loss is the portion of permanent hearing loss that exceeds average hearing levels that arises out of and in the course of employment and is causally related to excessive noise exposure.

a. 25 decibels in either ear is equivalent to a 0% hearing loss.

b. An average of 92 decibels in either ear is equivalent to a 100% hearing loss.

2. Applicable to all "employers" and "employees" as defined by the Iowa Workers' Compensation Act.

3. Limitations:

a. Occupation Hearing Loss does not include loss of hearing attributable to age or any other condition or exposure not arising out of and in the scope and course of employment.

b. Compliance with the findings and orders of the Commissioner or Court shall discharge the employer and carrier for all future obligations under the Iowa Occupational Hearing Loss statute. § 86B.13

4. Compensation

a. A claim for compensation for hearing loss may not be made unless and until there is a change in the claimant’s employment situation generally as the result of the occurrence of any one of the following events:
i. Transfer from excessive noise exposure employment by an employer;
ii. Retirement;
iii. Termination of the employer-employee relationship, which may include simply a change in ownership of the business

b. Compensation for Occupational Hearing Loss is calculated using 175 weeks for total loss, and a proportional period of weeks relating to partial hearing loss.

c. Determination of hearing loss shall be made by the employer's regular or consulting physician or a licensed, trained, and experienced audiologist.

d. If the employee disputes the assessment, he or she may select a physician or licensed, trained, and experienced audiologist to provide an assessment.

5. Apportionment
   a. Any amounts paid under this section by a previous employer, or under a previous claim, shall be apportioned and the employer is only liable for the increase in hearing loss sustained in the scope and course of employment.

6. Employer/Employee Duty:
   a. Employees have an affirmative obligation to submit to periodic testing of their hearing.
   b. If, after testing, the employer learns that the employee’s hearing level is in excess of 25 decibels, the employer must inform the employee as soon as practicable after the examination.
   c. Employers have an affirmative obligation to inform employees if they are being subjected to sound levels and duration in excess of the acceptable limits as indicated in IA § 85B.5.
   d. An employer liable for an employee’s occupational hearing loss under this section must provide the employee with a hearing aid, unless the hearing aid will not materially improve the employee’s ability to communicate. § 85B.12

7. Notice
   a. An employee may file a claim for Occupational Hearing Loss, at the earliest, one month after separation of the employment which caused the hearing loss with a two year statute of limitations.
   b. The date used for calculating the “date of the injury” shall be the date the employee:
      i. Was transferred from the environment causing the hearing loss;
      ii. Retired;
      iii. Was terminated from employment.
   c. In the event an employee is laid off for longer than one year, the Occupational Hearing Loss must be reported within six months after the date of the layoff.

8. Exclusions
a. If an employee fails to use, or refuses, employer-provided hearing protective devices, as long as the opportunity and requirement are communicated to the employee in writing.

b. An employee’s failure to submit to period testing in accordance with IA 85B.7 precludes recovery under this section.

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

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

II. JURISDICTION - IA Code §85.3, §85.71

A. Act will apply where:
   1. The injuries occurred or occupational disease was contracted in Iowa while in the scope and course of employment.
   2. Employer is a resident of Iowa.
   3. Employer is a nonresident of Iowa, but for whom services are performed within Iowa by any employee.
   4. The employer corporation, individual, personal representative, partnership, or association has the necessary minimum contact with Iowa.
   5. The injury occurred outside of the territorial limitations of Iowa, if:
      a. The employer has a place of business in Iowa, and;
         i. The employee regularly works from that place of business, or;
         ii. The employee is working under a contract which selects Iowa as the forum state, or;
         iii. The employee is domiciled in Iowa.
      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:
   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 dependants 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 dependants 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 dependants 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.
   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, or
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. AVERAGE WEEKLY WAGE/COMPENSATION RATE – § 85.36 & § 85.37

A. Average Weekly Wage (AKA Gross Weekly Earnings)
   1. The weekly earnings of the employee are computed by averaging the total spendable earnings in the thirteen weeks prior to the injury. § 85.36. However:
      a. If the employee’s wage is reduced because of reasons personal to the employee, i.e. sickness or vacation, the employee’s weekly earnings shall be based on the amount the employee would have earned.
      b. If a week “does not fairly reflect the employee’s customary earnings” the week shall be replaced by the closest previous week which fairly represent the employee’s earnings.
      c. The overtime rate is not included. Overtime hours are computed at straight time.
         i. Exception for part time employees.
      d. Irregular bonuses, expense allowances, and employer’s contributions to benefit plans are not included in the average weekly wage.
   2. Special Cases –
      a. Part-time employees: If the employee earns less than the usual weekly earnings of a regular full-time adult laborer in the same industry and
locality, then the weekly earnings are 1/50\textsuperscript{th} of the total earnings which the employee has earned in the prior 12 calendar months, including premium pay, shift differential, and overtime pay from all employment.

b. **Employees with indeterminate earnings**: In situations where the employee’s earnings can not be determined, the gross weekly earnings are based on the usual earnings for similar services rendered by paid employees.

c. **Volunteer Firefighter, EMT, and Reserve Peace Officers**: Any compensation earned by a volunteer firefighter, emergency medical care provider, or reserve peace officer shall be disregarded for purposes of calculating gross weekly earnings in the event of a compensable injury. The gross weekly earnings are calculated from the **greater of**:

i. The amount the employee would receive if injured in the scope and course of his or her regular job.

ii. 140\% of the state average weekly wage.

d. **Apprentice or Trainee**: Gross weekly earnings may be augmented if the apprentice or trainee’s wages would have increased absent the work-related injury.

e. **Inmates § 85.59**: Inmates are due the minimum compensation rates under 85.34 in the event of injury or death.

f. **Elected or Appointed Official**: An elected or appointed official has the option of choosing between:

i. Their rate of pay as an elected official, or:

ii. 140\% of the state average weekly wage.

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

B. **Compensation Rate**

1. 80\% of the employee’s weekly spendable earnings, subject to maximums set by the Division of Workers’ Compensation

a. No calculations are necessary—Consult the charts available at [www.iowaworkforce.org/wc](http://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
X. 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.

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.

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

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

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

F. Interest
1. Interest should be volunteered when any late payments are made. Penalties
will not be assessed on late interest payments, but interest will continue to
accrue
2. If delay in payment of benefits is due to neglect of the claimant, interest is not
payable
3. Interest is calculated in a 3 step process as follows:
   a. Step 1:
      i. Locate the number of weeks during which benefits are payable in column A of the 10% interest table contained in the Division's manual for the year corresponding to the late payments
      ii. Locate the interest multiplier from that line from the same table in column B
      iii. Multiple the weekly benefit amount by the interest multiplier to determine interest payable
   b. Step 2:
      i. Compute the interest from the end of the period during which benefits are payable until date benefits are actually paid using the following formula: \( I = P \times R \times T \)
         1. \( I \) = Interest
         2. \( P \) = principal (the total # of weeks/days to 3 decimal points of compensation due x compensation rate)
         3. \( R \) = rate of interest (10%)
         4. \( T \) = time (# of weeks from end of period during which benefits are payable until date of payment, divided by 52)
   c. Step 3:
      i. Add result from Step 1 to result from Step 2

XI. 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 dependants who are wholly dependent on the earnings of the employee for support at the time of the injury.
C. A dependant spouse shall receive weekly payments, commencing from the date of death, for the life of the dependant spouse, provided that that the spouse does not remarry. In the event of remarriage, two years of death benefits shall be paid to the surviving spouse in a lump sum if there are no children entitled to benefits.
D. Dependent children shall receive a proportional share of weekly benefits commencing from the date of death until the age of 18, unless dependency extends beyond the age of 18 if actual dependency continues. Full-time enrollment in any accredited educational institution shall be a conclusive showing of actual dependency.
E. Dependent children who are physically or mentally incapacitated from earning at the time of the injury causing death shall receive a proportional share of weekly benefits for life, or until they shall cease to be physically or mentally incapacitated from earning.

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

XIII. 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.

XIV. SETTLEMENTS - § 85.35

A. Types of Settlements:

1. Agreement for Settlement
   a. Parties may enter into an agreement as to the amount and extent of compensation due and file with the Commissioner.
   b. This type of settlement will not end future rights or medical benefits

2. Compromise Settlement (AKA Special Case Settlement or Closed File)
   a. When there is a dispute as to whether or not the employee is entitled to benefits, parties may enter into a compromise settlement
      i. There must be at least one issue in dispute and it must be clear what the dispute is. Nature and extent of the injury are generally not sufficient without supporting medical to clearly describe the dispute.
   b. This type of settlement ends the employee’s future rights to any benefits
B. General Settlement Information:

1. Full Commutation:
   a. Lump sum payment of all remaining future benefits
   b. Must be at least 10 weeks of benefits remaining from date of the end of the healing period or temporary total disability period. If less than 10 weeks are remaining full commutation will not be allowed.
   c. Once approved this will end all of employee’s future rights to any additional benefits including medical
   d. To be approved, parties must show the employee has a specific need and the lump sum is in the best interest
      i. Pro se employees must complete a Claimant’s Statement expressing that need

2. Partial Commutation:
   a. Lump sum payment of a portion of the remaining benefits
   b. Establishes the employee’s entitlement to disability benefits but it does not end future rights.

3. Settlement language may not include “any and all injuries” or “other states or jurisdictions.”

XV. 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
Q: Does the Deputy Commissioner have the authority to demand a first report of injury in circumstances beyond those expressly established in Iowa Code section 86.11?

A: Yes. The Iowa Supreme Court determined that an employer is required to file a first report of injury upon demand by the Workers' Compensation Commissioner. Iowa Code section 86.11 states that an employer must file a first report of injury if an employee is incapacitated for more than three days or suffered any permanent total or permanent partial disability. While this section mandates two circumstances in which a first report of injury must be filed, nothing in the language either expressly or impliedly limits the Commissioner's authority to establish additional circumstances in which a first report of injury must be filed.


Q: Will failure to file a first report of injury due to an employer’s belief that they are not required to constitute “good cause?”

A: No. As long as the Commissioner follows the proper procedures as required by Iowa Code section 86.12, an employer’s belief that they are not required to file a first report of injury is not enough to show good cause for why it failed to file the demanded report.


Q: Can the expense of an independent medical evaluation obtained outside the statutory process be taxed to the employer?

A: No. In Des Moines Regional Transit Authority v. Arbreina Young, the Claimant arranged an independent medical examination without authorization by the employer. At the hearing, the Claimant submitted the report from the unauthorized examination as evidence. The deputy Commissioner taxed the expense of the unauthorized examination and report as costs against the employer under Iowa Code section 85.39 which governs the assessment of costs in a hearing. The District Court affirmed the Commissioner's award for the full cost of the independent medical examination. The Iowa Supreme Court reversed the decision and held that the legislature only gave the Commissioner discretion to tax costs incurred in the hearing before the Commissioner. It did not grant authority to restructure the statutory process for which employers are obligated to reimburse the employee for an independent evaluation. The
Court found that only the costs associated with the preparation of the written report can be assessed as costs of the hearing, but the employer is not required to pay for any unauthorized independent medical evaluation.


**Q: When will a Claimant be found to be totally and permanently disabled?**

**A:** Under the odd lot doctrine, the Commission can find a claimant has suffered a total disability if she can only perform work so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist. In *Gits Manufacturing Company v. Frank*, the Commission found the Claimant to be totally and permanently disabled. The Claimant sustained a work related injury that caused shortness of breath. Because of this condition, Claimant’s physician opined that the Claimant was unable to work in environments that contained smoke, dust fumes or vapors. Due to these restrictions, Claimant would be unable to return to the type of position she had held her entire life pre-injury. Furthermore, she did not have the requisite skills to obtain a different position without additional training.

The Supreme Court affirmed the judgment of the District Court finding that substantial evidence supported the Commission’s findings that Claimant was totally and permanently disabled. The Supreme Court held that when a worker produces substantial evidence that they are not employable in the competitive labor market, the burden to produce evidence of suitable employment shifts to the employer. Because it was unlikely that the Claimant could return to a full-time position with her condition, the Court found that there was enough evidence to support the Commission’s findings.


*A recent Iowa Court of Appeals case similarly concluded that a Claimant sustained a total and permanent disability when the Claimant was unable to be gainfully employed following his work-related injury. The Court considered his age, lack of education and poor academic skills relevant factors in support of the Commissioner’s decision. The Claimant established that he could not compete for jobs in his field, nor could be realistically retain other positions given his cognitive limitations and physical restrictions.*

*Hydecker Wheatland Co. v. Bruce*, 862 N.W.2d 413 (Iowa Ct. App. 2015).

**COURT OF APPEALS OF IOWA**

**Q: Will an employee’s bonuses be included in their gross earnings when calculating the employee’s rate of compensation?**
A: It depends. If an employee’s bonuses can be considered regular, or likely to occur, the Court may consider the employee’s bonuses to be part of the gross earnings. Two recent Iowa Court of Appeals cases found that an employee’s bonuses were such a regular part of the Claimant’s expected compensation that they were considered part of the employee’s earnings.

In *Menard Incorporation v. Rhonda Scheffert*, the Claimant received a percentage of the department’s profit every year that she worked for the employer. While the Claimant was not eligible for the bonus at the time of her injury in November of 2008, she was in fact paid a bonus the following year for her work in 2008.

Similarly, in *Pella Corporation v. Renee Minar*, the Claimant received two bonuses on an annual and quarterly basis. The deputy reasoned that the regularity of the payments, regardless of the bonus language in the employee handbook, made the bonuses part of the earnings that the employees expected. The Court held that if it did not include the bonus amounts, it would artificially skew the Claimant’s actual earnings and produce an inaccurate rate.


Q: Can an employee recover under the cumulative injury doctrine when they have only suffered two acute injuries?

A: Yes. The prototypical cumulative injury case usually includes years of continuous, repetitive movement which takes a physical toll on the worker’s body. However, the acceptance of gradual injury as the mechanism of harm does not exclude the idea that acute injuries can contribute to the employee’s compensable disability under the cumulative injury doctrine. In *West Des Moines Community Schools v. John Fry*, the Claimant suffered an acute injury in January 2007 during the course of employment. The Claimant also suffered an injury in October 2008. The Deputy Commissioner found that the cumulative work injury began in January 2007 and manifested in 2008 which he found to be the cause of the permanent impairment.

The Court discussed its prior decision in *Floyd v. Quaker Oats*, wherein it decided that a Claimant could recover by way of a cumulative-injury claim for any functional disability shown to have occurred as a result of day-to-day activities in the workplace subsequent to a traumatic injury. It recognized that full compensation is allowed for the result of workplace activities aggravating a preexisting condition.

Like *Floyd*, the Court in this case determined that the Claimant’s injury began with an acute injury in January 2007 and manifested in another acute injury in September 2008. Between these injuries, Claimant performed rigorous and repetitive physical work activities during his employment and may recover by way of a cumulative-injury claim for any functional disability resulting from his day-to-day activities.
West Des Moines Community Schools v. Fry, 859 N.W. 2d 671 (Iowa Ct. App. 2014).

Q: Does an employer’s offering of additional personal days create such an unusual weekly schedule that sensible outcomes cannot be reached under typical statutory calculations?

A: No. Unless the amount of personal days greatly offsets an employee’s regular work schedule, the use of statutory calculations will properly measure a weekly rate.

Vitzthum v. KLM Acquisition Corp., 856 N.W. 2d 383 (Iowa Ct. App. 2014).

Q: When is a weekly compensation payment sufficiently made?

A: Weekly compensation payments are ‘made’ when they are mailed to the Claimant. In Vitzthum v. KLM Acquisition Corp., the Claimant argued that penalty benefits were proper based on the concept that payments are made when the check is received versus when the check is mailed. The Court held that that the employer’s payments were timely paid because they were mailed at the end of each compensation week.

Vitzthum v. KLM Acquisition Corp., 856 N.W. 2d 383 (Iowa Ct. App. 2014).

Q: Is a claimant entitled to any weekly benefits during periods that the claimant is working part time?

A: Yes, although the employer may receive a credit proportionally for the week the Claimant was able to work a partial week. In Mercy Hospital v. Susan Goodner, the record evidence was that from and after the date of injury in January 2000 until the hearing on April 30, 2009, Claimant had at times worked full time, at times part time, and at times not at all. The employer conceded that they owed benefits for any time the Claimant was not working at all, but argued she was not entitled to benefits during any time period she was working full time. The question remained whether the Claimant was entitled to any weekly benefits during periods when she was working part time between January 2000 and April 30, 2009.

The Iowa Court of Appeals determined that the agencies decision to compensate the Claimant applied to weeks when she was unable to work, whether that was a full or a partial week. However, the judgment allowed the employer to receive a credit proportionally for the weeks when the Claimant was able to work a partial week.

Q: In review-reopening proceedings, how long will the Court require healing period benefits to be awarded?

A: Until the Claimant has reached Maximum Medical Improvement. Even if the Claimant says they are pain free, only when it is medically indicated that significant improvement from the injury is not anticipated will healing period benefits be cut off.

_Hill Concrete v. Dixon_, 858 N.W.2d 26 (Iowa Ct. App. 2014).

Q: Does the employer/insurer have to pay for injuries that resulted from an altercation developed out of personal animosity?

A: No. Pursuant to Iowa Code section 85.16(3), an employer/insurer may assert an affirmative defense that the injury was the result of a “willful act of a third party directed against the employee for reasons personal to such employee.” The statute is a complete defense to recovery.


Q: When does the ninety-day statutory provision period to notify an employer of a work related injury begin?

A: The notice period will not begin to run until the employee knows that the physical condition is serious enough to have a permanent adverse impact on the Claimant’s employment or employability. Once the employee recognizes the injuries ‘nature, seriousness and probable compensable character’ will the ninety-day period begin to run.

In _Chapman v. Ameristeel_, the Claimant was time barred from bringing his workers’ compensation claim because he failed to provide notice of his work-related injury to his employer before the ninety-day period ended. The Deputy Commissioner determined that the notice period began once he saw his physician and expressed concern that he “could not do his job because he was losing his grip with tools.” The Claimant took a family medical leave for a serious health condition that made him unable to perform the essential functions of his job. While the employer knew that the Claimant was injured, the statute requires actual notice to the employer that the injury might be work connected. Because the Claimant filed a petition for Workers’ Compensation benefits over a year after he knew of the injury, he was time barred from bringing his claim pursuant to Iowa Code section 85.23.

Q: When the Commissioner awards the fifty-percent penalty for denial, delay or termination of benefits, is this penalty applied to the unpaid portion of the award or the total award?

A: The unpaid portion of the award. In a recent Iowa Court of Appeals case, the Court held that the employer/insured should only pay a penalty for the payments it was required to make less credits for the disability payments already paid.


Q: Is an employer required to provide individualized counseling to an injured employee’s spouse?

A: No. In Hoyt v. Wendling Quarries, Claimant sustained a traumatic work-related injury for which the employer authorized mental health treatment. The doctor recommended that the Claimant’s wife engage in individualized counseling because she served as the Claimant’s primary caretaker and would be better able to provide if she could manage her own distress. The Claimant filed a petition for alternative medical care pursuant to Iowa Code section 85.27, seeking to compel the employer to pay for individualized counseling services for his spouse.

The Iowa Court of Appeals concluded that the plain language of the statute does not require the employer to pay for individualized counseling services for someone other than the injured employee even where such treatment may benefit the injured employee. While the agency recognized that it had previously authorized marital counseling in which an injured worker’s spouse participated, the agency explained that such counseling also included the injured worker and was not individualized counseling for the spouse. The Court held that such counseling is materially different than Claimant’s request for alternative care in which he seeks individualized counseling for his spouse, therefore, was not required.


Q: Is a heart attack considered a compensable injury if the Claimant already had a latent heart disease?

A: Possibly. If a Claimant can establish that some employment incident or activity was a proximate cause health impairment on which he basis his claim, it may be found to be compensable. While a mere possibility of causation is not sufficient, absolute certainty is not required to be shown. Whether an injury has a connection to the employment is essentially within the domain of expert testimony.

Q: Is an employee bound by a signed “Legal Remedies” agreement, which limits legal remedies to those claims available through Workers’ Compensation, when an employee argues the provision was not sufficiently clear and unequivocal to put him on notice that he was waiving all potential claims against his employer?

A: Yes, so long as the terms used in the agreement are in common use and are not presented in a way that creates ambiguity in their meaning. In *Hargrave v. Grain Processing Corporation*, the Iowa Court of Appeals examined the language in the employer’s employment agreement which stated “my sole legal remedies in the event of a work related injury will be the Company’s Workers’ Compensation insurance and will not include any claim for damages against that Customer.” The Court found that the parties’ intent was clear and unambiguous, thus the contract should be enforced as it is written.


Q: Does the Commissioner have to accept all expert opinions and give them the same weight when determining medical causation?

A: No. The Commissioner is free to either accept or reject the opinions of an expert, particularly when opinions between experts are conflicting. Even when there is uncontroverted medical testimony the Commissioner may reject it. However, he must do so with specificity and his findings must always be supported by substantial evidence. The Commissioner may accept or reject an expert opinion in whole or in part.

Furthermore, the Iowa District Court, Court of Appeals and Supreme Court are bound by the Commissioner’s factual determinations if they are supported by substantial evidence in the record before the Court when that record is viewed as a whole. Evidence is not considered insubstantial just because it may support a finding different from that made by the Commissioner.


Q: May the Commissioner consider the opinions of experts collectively when deciding causation?

A: Yes. The Commissioner may weigh the opinions of multiple experts and use selected parts of their opinion to make a decision so long as there is substantial evidence of causation nonetheless.
Q: Is an employer required to give a Claimant notice when they are no longer authorizing medical care for further injuries?

A: Yes. In *Ramirez-Trujillo v. Quality Egg*, the employer/insured paid for medical expenses until the Claimant was discharged from medical care and returned to work without restrictions. The Claimant subsequently suffered an unrelated injury while she was away from work. She then sought additional medical care for this injury but never notified the employer or staff at the medical center that she believed the injuries were work related.

Iowa Code section 85.27(4) provides that if the employer chooses the care, the employer shall hold the employee harmless for the cost of care until the employer notifies the employee it is no longer authorizing all or any of the care. The Iowa Court of Appeals held that the employer had a duty under this section to notify the Claimant that any further medical care for her injury was no longer authorized and the reason for the change in authorization.


Q: Does the Court of Appeals reweigh factual determinations of the Commissioner?

A: No. The task of the Court of Appeals is not to reweigh the competing evidence, but rather to focus on the Commissioner’s material findings in light of the record as a whole and to examine the Board’s explanation of why the relevant evidence in the record supports those findings. In *EMCO v. Sehic*, the Court of Appeals applied this standard to affirm the Commissioner’s finding that the Claimant suffered an industrial disability. The Court held that making a determination as to whether evidence ‘trumps’ other evidence or whether one piece of evidence is ‘qualitatively weaker’ than another piece of evidence is not an assessment for the District Court or the Court of Appeals to make. Because at least one doctor, whom the Commissioner found to be most convincing, expressed that the Claimant had an industrial disability, there is some evidence supporting the causal connection and the Court is statutorily obligated to afford the Commissioner’s findings of fact.

However, if the Commissioner simply ignores or overlooks record evidence, the appropriate remedy is to remand the case for the purpose of allowing the agency to re-evaluate the evidence.” In *JBS Swift v. Wayne Hedberg*, the Commissioner found the Claimant to be totally and permanently disabled based on the fact that the vocational expert had not provided any viable options for jobs that the Claimant could work.
Because the vocational expert had provided such options and the Commissioner’s decision was based on this false recollection, the Court of Appeals decided that this was an abuse of discretion and remanded the case to the agency for re-evaluation.


**Q: Does the Commissioner have to consider future professions when calculating a Claimant’s lost earning capacity?**

**A:** It depends. In **Bell v. 3E**, the Commissioner did not consider the Claimant’s possible career as a firefighter when determining his lost earning capacity. The Claimant argued that the Commissioner erred in calculating the extent of his industrial disability because the Commissioner rejected evidence in the record comparing his pre-injury and post-injury capacity as a firefighter. The Court held that the Claimant provided no objective proof that he was capable of becoming a firefighter immediately prior to his injury. Therefore, the Commissioner properly considered Claimant’s minimal work experience as a firefighter when choosing not to include any lost earning capacity from employment in this field.

**Bell v. 3E**, 863 N.W.2d 36 (Iowa Ct. App. 2015).

**Q: When does a scheduled member injury convert to a body-as-a-whole injury?**

**A:** If the effects of the loss of the member extend to other parts of the body and interfere with their efficiency, the schedule allowance for the lost member is not exclusive. An injury to a scheduled member may, because of after effects or compensatory change, result in permanent impairment of the body as a whole.


**Q: What factors are considered in determining whether a Claimant suffers an industrial disability?**

**A:** When an injury results in a permanent disability to a part of the person that is not a scheduled member, it is referred to as an industrial disability that is compensated according to the percent that the disability reduced the Claimant’s earning capacity. The focus is not solely on what the worker can or cannot do; industrial disability rests on the ability of the work to be gainfully employed.

In **Architectural Wall Systems v. Donald Towers**, the Iowa Court of Appeals held that the Claimant sustained a 60% industrial disability. The court considered the Claimant’s functional impairment, age, education, work experience, qualification, ability to engage in similar employment, and adaptability when considering the Claimant’s prospects for
relocation in the job market and calculating his industrial disability. The Court held that not only was he unable to reenter the profession for which he previously worked, but his permanent restrictions limited his capacity to engage in manual labor, the only work for which he was reasonably suited.


**Q: Is a Claimant required to file a separate petition for each type of Workers’ Compensation benefit sought from the employer arising out of the same injury?**

A: No. Nothing in the Iowa Code section 85.27 statute requires an injured worker to file a separate original notice and petition for each type of benefit the injured worker requests. A Motion to Amend is the proper procedural course to take when a petition alleging the same injury, for the same date, against the same employer is already on file.

Heritage Care & Rehab. v. True, 863 N.W.2d 37 (Iowa Ct. App. 2015).

**Q: When is a case eligible for a review-reopening hearing?**

A: One way to satisfy the reopening requirement is to show the worsening of the claimant’s physical condition compared to the physical condition after the original injury. So long as the worsening is supported by substantial evidence, the Commissioner may reopen an award for payments or agreement for settlement. In Anderson News v. Julie Reins, the Commissioner found that a review-reopening hearing was appropriate because the claimant was suffering from a worsening condition which was supported by her testimony and medical evidence.

In Lull-Gumbusky v. Great Plains Communication, the Commissioner found that the Claimant had no additional impairment related to the original injury. He noted that her mental health status had not changed substantially since he saw her originally and she could not prove any economic or other related change resulting from the original injury. Therefore, there was substantial evidence to support the Commissioner’s decision to deny reopening the claim.


**Q: In a review-reopening hearing, must the Commissioner consider the Claimant’s earning capacity when increasing the Claimant’s permanent partial impairment rating?**
A: Yes. The Commissioner must explicitly consider whether the Claimant suffered a loss of earning capacity that would warrant an increase in the benefits.


Q: Will a Claimant be entitled to alternative medical care for an unauthorized treating physician?

A: No. So long as the employer designates an authorized treating physician, the Claimant may not choose their own physician without authorization and still be entitled to medical expenses.


Q: When is a Claimant entitled to Second Injury Fund Benefits?

A: Under Iowa Code section 85.64, if an employee who has previously lost, or lost the use of, one hand, one arm, one foot, one leg or one eye, becomes permanently disabled by a compensable injury which has resulted in the loss of use of another such member or organ, the employer shall be liable only for the degree of disability which would have resulted from the latter injury if there had been no pre-existing disability.

In Bolton v. Second Injury Fund of Iowa, the Claimant sustained an injury to his right hand while at work. He sought benefits from the Second Injury Fund alleging that he sustained a first qualifying injury to his left knee twenty-five years prior. The Deputy Commissioner found that the Claimant had failed to establish his knee injury as a first qualifying injury because he never mentioned knee pain to his doctors nor is there any evidence in the record to suggest ongoing pain in the knee. The Iowa Court of Appeals agreed that substantial evidence supported the Commissioner’s decision denying Second Injury benefits.


Q: Can a Claimant bring a common-law cause of action against an insurer for bad-faith denial or delay of insurance benefits in a Workers’ Compensation case?

A: Yes. The tort has been extended to include Workers’ Compensation cases. The tort of bad faith only arises when the insurance company intentionally denies or fails to process a claim without a reasonable basis for such action. To establish bad faith on the part of a defendant, the plaintiff must prove two elements. First, the plaintiff must establish the defendant objectively “had no reasonable basis for denying benefits under
the policy.” Second, the plaintiff must establish the defendant subjectively “knew or had reason to know that its denial or refusal was without reasonable basis.”

A defendant can disprove the first element of bad faith, by showing that a claim for benefits is objectively “fairly debatable.” A claim is “fairly debatable” if it is open to dispute on “any logical basis.” In *Saltern v. HNI Corp*, the Plaintiff’s petition stated that she slipped and fell on the ice, causing her work related injury. However, neither the Plaintiff’s nor her coworker’s written report of the incident mentioned ice. Furthermore, the defendant’s initial investigation revealed no ice in the area where the Plaintiff fell. Because of this, the Iowa Court of Appeals found that the defendants had a reasonable basis to deny her benefits.

*Saltern v. HNI Corp.*, 856 N.W.2d 1 (Iowa Ct. App. 2014).
KANSAS WORKERS’ COMPENSATION
Applies to injuries occurring on or after May 15, 2011.

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

A. Act will apply if:
   1. Accident occurs in Kansas.
   2. Contract of employment was made within Kansas, unless the contract specifically provides otherwise.
   3. Employee’s principal place of employment is Kansas.

II. ACCIDENTS

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

B. Repetitive Use, Cumulative Traumas or Microtraumas– K.S.A. 44-508(e)
   1. “The repetitive nature of injury must be demonstrated by diagnostic or clinical tests.”
   2. “The repetitive trauma must be the prevailing factor in causing the injury.”
   3. Date of accident shall be the earliest of:
      a. Date the employee is taken off work by a physician due to the diagnosed repetitive trauma;
      b. Date the employee is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;
      c. Date the employee is advised by a physician that the condition is work related; OR
      d. Last day worked, if the employee no longer works for the employer.
e. In no case shall the date of accident be later than the last date worked.

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

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

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

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

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

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

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

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

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

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

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

A. Employer / carrier must file with the Division of Workers’ Compensation within 28 days of obtaining knowledge of any accident that requires an employee to miss more than the remainder of the shift in which the injury occurred.
   1. Civil penalties are possible for failure to file.
   2. Failure to file within 28 days extends the statute of limitations from 200-days to one year from the date the period begins to run.
3. Accident report cannot be used as evidence.

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

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

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

VI. MEDICAL TREATMENT

A. K.S.A. 44-510h
   1. Employer has the right to select the treating physician.
   2. Employee has $500 unauthorized medical allowance for treatment.
   3. Rebuttable presumption that employer’s obligation to provide medical treatment terminates upon the employee reaching maximum medical improvement.
   4. Medical treatment does not include home exercise programs or over-the-counter medications.

B. K.S.A. 44-510k
   1. After an award, any party can request a hearing for the furnishing, termination or modification of medical treatment.
   2. ALJ must make a finding that it is more probably true than not that the injury is the prevailing factor in the need for future medical care
   3. If the claimant has not received medical treatment (excluding home exercise programs or over-the-counter medications) from an authorized health care provider within two years from the date of the award or the date the claimant last received medical treatment from an authorized health care provider, there is a rebuttable presumption no further medical care is needed.

C. K.S.A. 44-515
   1. All benefits suspended if employee refuses to submit to exam at employer’s request.
   2. Employee may request that a report from any examination be delivered within a reasonable amount of time (no longer 15 day requirement).
VII. AVERAGE WEEKLY WAGE – K.S.A. 44-511

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

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

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

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

A. Temporary Total Disability
   1. Two-thirds of Average Weekly Wage (AWW) from above, subject to statutory maximum determined by date of injury
   2. Seven-day waiting period.
      *No temporary total disability for first week unless off three consecutive weeks.
   3. Exists when the employee is “completely and temporarily incapable of engaging in any type of substantial gainful employment.”
   4. Treating physician’s opinion regarding ability to work is presumed to be determinative.
   5. Employee is entitled to temporary total disability benefits if employer cannot accommodate temporary restrictions of the authorized treating physician.
6. No temporary total disability benefits if the employee is receiving unemployment benefits.

7. Insurer or self-insured employer MUST provide statutorily mandated warning notice on or with the first check for temporary total disability benefits.

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

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

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

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

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

C. An Administrative Law Judge will be assigned

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

E. Benefits to Consider at Preliminary Hearing:
   1. Medical treatment (including change of physician).
      a. Ongoing or past bills.
   2. Temporary total or temporary partial benefits (including rate).
      a. Prospective or past benefits.
   3. Medical records and reports are admissible.
4. Witnesses may be necessary.
5. Opportunity for decision on ultimate compensability issues.

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

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

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

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

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

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

B. Generally after claimant reaches maximum medical improvement.

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

D. Process varies from Judge to Judge.

E. Issues regarding final award or settlement are considered.

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

A. Maximum Awards
   1. Functional Impairment Only - $75,000
      a. Cap now applies even if temporary total or temporary partial disability benefits were paid.
b. $75,000 cap does not include temporary total or temporary partial disability benefits paid.

2. Permanent Partial Disability - $130,000
   a. Cap includes temporary total or temporary partial disability benefits paid

3. Permanent Total Disability - $155,000
   a. Cap includes temporary total or temporary partial disability benefits paid

4. Death benefits - $300,000
   a. Includes $1,000 for appointment of conservator, if required.

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

C. Scheduled Injuries
   1. Includes loss of and loss of use of scheduled members
   2. Combine and rate multiple injuries in single extremity to highest scheduled member actually impaired
   3. Formula
      a. (scheduled weeks – weeks TTD paid) x rating % x compensation rate
   4. Example
      a. Arm Injury = 210 weeks
      b. TTD paid = 10 weeks
      c. Rating = 10%
      d. Compensation Rate = $546
      i. \[(210 \text{ weeks} - 10 \text{ weeks}) \times 10\% \times 546 = 20 \text{ weeks} \times 546.00\]
      = $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. \((415 \text{ weeks} - \text{weeks TTD paid in excess of 15 weeks}) \times \text{rating} \% \times \text{compensation rate}\)

4. Example
   a. TTD paid = 25 weeks
   b. Rating = 15% Body as a Whole
   c. Compensation Rate = $546.00
      i. \((415 \text{ weeks} - 10 \text{ weeks}) \times 15\% \times 60.75 \text{ weeks} \times \$546.00 = \$33,169.50\)

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. \(((\text{Wage Loss} \% + \text{Task Loss} \%) / 2) \times (415 \text{ weeks} - \text{weeks TTD paid in excess of 15 weeks}) \times \text{compensation rate}\)
      i. Wage Loss: “the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is capable of earning after the injury.”
         (a) Consider all factors to determine the capability of the worker, including age, education and training, prior experience, availability of jobs, and physical capabilities.
         (b) Legal capacity to enter contract of employment required.
         (c) Refusal of accommodated work within restrictions and at a comparable wage results in presumption of no wage loss
      ii. Task Loss: “the percentage to which the employee, in the opinion of a licensed physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the five-year period preceding the injury.”
(a) Task loss due to pre-existing permanent restrictions not included

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

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

F. Death Cases – K.S.A. 44-510b
   1. Cap - $300,000 total
      a. Can exceed as children receive benefits above cap to age 18.
   2. 50% to surviving spouse – 50% to surviving children.
   3. $40,000 lump sum paid at outset.
   5. Children can extend benefit receipt to age 23 if they remain in accredited school. Can exceed the $300,000.00 cap only to age 18.

XII. REGULAR HEARING – FULL TRIAL

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

  c. Penalties again apply per K.S.A. 44-512a.

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

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

XIII. SETTLEMENTS – K.S.A. 44-531

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

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

C. Most common settlement format is Settlement Hearing before Special Administrative Law Judge with a court reporter present.
   1. FORMAT:
      a. Claimant is sworn in.
      b. Claimant is asked to describe his/her accident(s).
      c. Judge asks claimant if he/she is receiving any medical bills.
         i. Court will generally order payment of valid and authorized bills.
      d. Terms of settlement will be explained and read into record by Employer’s attorney.
      e. Unrepresented claimant will receive explanation from Judge that he/she could hire an attorney.
i. Explanation will detail that attorney could send claimant to a rating doctor of his/her choice – or claimant does not have to hire an attorney to get a rating from his/her own doctor.

f. Most importantly, in a full and final settlement, the court will explain that claimant is giving up all rights to future medical.

i. Additional payment can be made to compromise future medical.

g. If claimant is out of state, settlement hearing can occur by telephone or by written joint petition and stipulation.

XIV. DEFENSES

A. Drugs and Alcohol – K.S.A. 44-501(b)(1)
   1. Employer not liable if the injury was contributed to by the employee’s use or consumption of alcohol or drugs.
   2. There is a .04 level which will establish a conclusive presumption of impairment due to alcohol. Impairment levels for drugs set by statute.
   3. Rebuttable presumption that if the employee was impaired, the accident was contributed to by the impairment.
   4. Refusal to submit to chemical test results in forfeiture of benefits if the employer had sufficient cause to suspect the use of alcohol or drugs or the employer’s policy clearly authorizes post-injury testing.
   5. Results of test admissible if the employer establishes the testing was done under any of the following circumstances
      a. As a result of an employer mandated drug testing policy in place in writing prior to the date of accident
      b. In the normal course of medical treatment for reasons related to the health and welfare of the employee and not at the direction of the employer
      c. Employee voluntarily agrees to submit a chemical test

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

3. Parking lot cases – key question is whether employer owns or controls the lot.

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

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

XV. OTHER ISSUES

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

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

XVI. RECENT LEGISLATIVE CHANGES

A. Senate Bill 187 was signed into law by Governor Sam Brownback on April 16, 2013, and published in the Kansas Register on April 25, 2013 (available at http://www.kssos.org/pubs/register%5C2013%5CVol_32_No_17_April_25_2013_p_381-444.pdf).

B. Notice
   1. Reduces time for the injured worker to give notice of repetitive trauma or accident.
a. 20 calendar days from the date of accident or injury by repetitive trauma;

b. 20 calendar days from the date the employee seeks medical treatment for the injury; or

c. 10 calendar days from the employee’s last day of actual work for the employer.

C. Selection of Administrative Law Judges and Board Members
   1. A seven member committee meets to determine if an ALJ or Board member should be retained and makes nominations to the Secretary of Labor for any vacancies.
   2. Each of the following entities will have a representative on the committee:
      a. Kansas Secretary of Labor;
      b. Kansas Chamber of Commerce;
      c. the National Federation of Independent Business;
      d. Kansas AFL-CIO;
      e. Kansas State Council of the Society for Human Resource Management;
      f. the Kansas Self-Insurers Association; and
      g. A selected nominee by the Secretary of Labor from an employee organization or professional employee’s organization.

D. Recusal of Administrative Law Judges
   1. If the judge declines a recusal request, an appeal is made to the Workers' Compensation Appeals Board.
   2. If the requesting party is not satisfied with the Board's decision, the aggrieved party may appeal to the Court of Appeals.

E. American Medical Association Guides to the Evaluation of Permanent Impairment
   1. The AMA Guides 6th Edition will apply to injuries occurring on or after January 1, 2015.
Q. Whether a Claimant was engaged in normal activities of day-to-day living when he felt a pop and pain in his right knee after stepping off and walking around a backhoe he had been operating?

A. No. The Court of Appeals held that the Claimant was not engaged in normal activities of day-to-day living when the injury occurred. The primary question in determining if an injury arises out of and in the course of employment is whether the activity that resulted in the injury "is connected to or is inherent in," the performance of the job. Here, the injury occurred when Claimant was performing a job duty. He was required to operate the backhoe and there was no evidence suggesting Claimant’s injury occurred outside the time frame in which he was operating the machine. Case law interpreting the pre-2011 version of the Workers Compensation Act remains applicable when determining whether an injury was the result of the normal activities of day-to-day living.


Q. Did the Court of Appeals commit error when it reversed the Board’s interpretation of undisputed facts that injuries sustained by an oil drilling employee while commuting home from a remote job site was in the course and of his employment?

A. Yes. The Kansas Supreme Court held the Court of Appeals erred when it determined that there was only one interpretation of undisputed facts. The Supreme Court determined there was substantial competent evidence to support the Board's determination that an oil drilling employee was not barred by the coming and going rule when:

(1) claimant’s job as an oil drilling crew member required him to travel to ever-changing remote job sites;
(2) claimant would not have been employed had he not been willing to travel; to those multiple job sites; and
(3) employer provided an elective travel option to its employees.

Williams v. Petromark Drilling, LLC, 299 Kan. 792, 326 P.3d 1057 (June 6, 2014)

Q. Did Claimant sustain her burden of proving she developed a peanut allergy arising out of and in the course of her employment?

A. No. The Court of Appeals denied Claimant’s appeal of an adverse Board decisions which held Claimant failed to prove that her peanut and nut allergy constituted an
“injury” or that there was a causal connection between such allergy and her work activities. On the first point, objective medical tests came back negative for allergies and none of the treating or examining physicians determined that claimant had any allergic reaction. On the second point, even assuming a nut allergy had been established, claimant failed to show that it was in any way the result of her work at employer’s candy manufacturing plant. Claimant admitted to off work exposure to nuts throughout her life and there was no evidence submitted about the quantity or quality of claimant’s workplace exposure. It is not necessary for a claimant to prove physical findings of an allergic reaction. However, she must present evidence that an allergy actually exists. Claimant failed to present such evidence.


**Q. May an Administrative Law Judge exclude the testimony and report of a court-appointed independent medical examination as a sanction for counsel’s violation of a no-contact order?**

**A.** Yes. In this case, the claimant’s attorney attempted to obtain a more favorable causation and impairment opinion through multiple ex-parte communications with the court-appointed neutral examining physician. The Administrative Law Judge excluded reports prepared by the Court appointed neutral independent medical examiner as well as reports prepared by another medical expert who relied in part on such tainted reports of the neutral as a sanction to punish the claimant’s attorney. The Court of Appeals affirmed the Appeal’s Board’s exclusion of subsequent reports prepared by the Court appointed independent medical examiner as a sanction for Claimant’s attorney’s ex-parte communications. The Court has a substantial interest in obtaining unbiased opinions from neutral examining physicians. It was not unreasonable to impose such sanctions to punish and deter claimant’s counsel from violating orders appointing a neutral doctor which prohibited either party from communicating with the physician.


**Q. Does the impairment defense set forth in K.S.A. 44-501(b)(1) apply when there is evidence of Claimant’s prior use of cigarettes and crack cocaine?**

**A.** No. K.S.A. 2010 Supp. 44-501(d)(2) - now codified at K.S.A. 44-501(b)(1) = relieves an employer of liability for workers compensation benefits 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.” The statute further requires that the employee be “impaired” due to alcohol or drugs at the time of the injury. In _Young_ Employer’s medical expert opined that claimant’s adult-onset asthma was the result of both workplace exposure to grain dust and prior use of cigarettes/crack cocaine. Employer argued that tobacco and cocaine, therefore, were drugs, chemicals,
compounds or substances that had contributed to claimant’s medical condition and resulting disability. Claimant countered that the drug/alcohol defense was inapplicable because he was not “impaired” by tobacco or cocaine on date of the onset of his occupationally-related asthma. The Court of Appeals sided with the employee, holding that the employer must establish both “impairment” at time of injury and that such impairment contributed to the employee’s injury or disability. Employer failed to establish evidence of contemporaneous impairment at the time of the injury. Therefore, the defense failed.


Q. How does the permanent partial disability (PPD) reduction for pre-existing disability affect the statutory cap for PPD benefits set forth in K.S.A. 44-510f?

A. K.S.A. 44-510f sets employer’s maximum liability for disability compensation for any one work-related injury, including a maximum award for PPD benefits. K.S.A. 44-501(c) requires the award of compensation to be reduced by the percentage of the preexisting functional impairment. The Court of Appeals held that when a claimant would have exhausted the statutory PPD cap before reaching the statutory maximum of 415 weeks, the pre-existing functional impairment should be reduced against the statutory PPD cap and not the overall work disability percentage. Thus, when the full work disability percentage results in an award of the $130,000 statutory maximum, the preexisting function impairment should be applied to that cap.

Ward v. Allen County Hospital, 50 Kan.App.2d 280, 324 P.3d 1122 (May 9, 2014)

Q. Must a claimant’ social security retirement benefits be offset from his workers compensation benefits when the claimant was not retired as of the date of his work-related injury, but had previously commenced to draw Social Security retirement benefits?

A. Yes. K.S.A. 2009 Supp. 44-501(h) – now codified at K.S.A. 44-501(f) - provides that if the employee receives retirement benefits under the federal Social Security Act, any compensation benefit payments which the employee is eligible to receive “shall be reduced by the weekly equivalent amount” of such retirement benefit, but in no event shall the compensation amount be reduced below what he would receive for his functional impairment only. The Court of Appeals held that because claimant had not retired as of date of injury, his Social Security benefits must be offset from his workers compensation benefits. Had claimant first retired and started receiving Social Security benefits and then returned to work to supplement those benefits, then his workers compensation award would not have been subject to the Social Security offset.

Q. Is an award automatically stayed on appeal, except for those benefits due during the 10 weeks preceding the Board decision until the time of the decision by Court of Appeals?

A. No. The Court of Appeals recently reversed prior Board decisions finding automatic stay for payment of accrued benefits pending appeal to the Court of Appeals and Workers Compensation Board. The Court of Appeals determined that the plain and unambiguous language of 44-556(b) does not provide for an automatic stay of benefits pending judicial review. The employer may request a stay of benefits from the Workers Compensation Board or Court of Appeals by filing a motion to the reviewing court under K.S.A. 77-616. The applicable court "may" grant the request.

Nuessen v. Sutherlands, No. 111,417 (June 12, 2015)

Q. Is the respondent entitled to a reduction for preexisting impairment where there is no overlap in the weeks between the prior award and the new accident?

A. No. In an unreported decision, the Court of Appeals held that where there is no overlap between the first two awards and the third award in the weeks of benefits, KSA 44-510a prevents an offset for preexisting impairment.

Wyrick v. Bingham transportation, No. 111,201 (February 20, 2015)
MISSOURI WORKERS’ COMPENSATION

I. JURISDICTION RSMo §287.110.2

A. Act will apply where:
   1. Injuries received and occupational diseases contracted in Missouri.
   2. Contract of employment made in Missouri, unless contract otherwise provides.
   3. Missouri is the principle place of employment for the employee 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 diseases 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 new legislative term, and the courts have not ruled on its meaning.

III. NOTICE RSMo §287.420

A. 30 days to report traumatic accident to employer.

B. In repetitive trauma/occupational diseases, the employee has 30 days from the diagnosis of the condition to report the accident 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. Employer must show prejudice by claimant’s failure to report accident within 30 days to sustain notice defense.

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

IV. REPORT OF INJURY RSMo §287.380

A. A Report of Injury should 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, the 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.

**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 may result in acceptance of facts in claim.**

D. Continue investigation, attempt settlement if appropriate.

**VII. MEDICAL TREATMENT RSMo §287.140**

A. Employer provides and selects.

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

C. **Under the new legislative changes, mileage is only paid when the exam or treatment is outside of the local metropolitan area from the employee’s principal place of employment.**

D. **Vocational Rehabilitation**
   1. Never mandatory.
   2. Used to take a potential permanent total to another vocation.
   3. **Under the new legislative changes, the claimant must now submit to “appropriate vocational testing” and a “vocational rehabilitation assessment.”**
4. **50 percent reduction if claimant fails to cooperate.**

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.

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

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

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

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

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

IX. **DISABILITY BENEFITS**

A. **Temporary Total Disability  RSMo §287.170**
   1. Compensation rate two-thirds Average Weekly Wage (AWW) up to maximum. (See rate card)
   2. Multiple employments
      a. Base AWW on wages of employer where accident occurred only
      b. Do not include wages of other employers
3. Waiting period – three days of business operation with benefits paid for those three days if claimant is off fourteen days.
4. May not owe temporary total disability benefits if claimant is terminated for cause.

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. Can be owed for scheduled as well as whole body injuries.

C. Permanent Partial Disability RSMo §287.190
1. "Permanent partial disability" means a disability that is permanent in nature and partial in degree.
2. Permanent partial disability or permanent total disability must be demonstrated and certified by a physician and based upon a reasonable degree of medical certainty.
3. On minor injury claims, the Administrative Law Judge (ALJ) may allow settlement without a formal rating report.
4. Part-time employees must use “same or similar” full-time employees wage. (For PPD only)
5. No credit for temporary total disability benefits paid.
6. There are no caps for benefits.
7. Disfigurement:
   a. Applicable to hands, arms, neck and face
   b. Maximum is forty weeks.
   c. Must be decided by ALJ if claimant is unrepresented.
   d. If claimant is represented, disfigurement can be compromised.
8. If a claimant sustains severance or complete loss of use of a scheduled body part, the number of weeks of compensation allowed in the schedule for such disability shall be increased by 10 percent.
9. When dealing with minors, you must consider increased earning power for PPD (not TTD).
10. Calculation of Permanent Partial Disability
    a. Claimant has a rating of 10 percent permanent partial disability to the body as a whole.
    b. Claimant qualifies for the maximum compensation rate for his date of accident of $422.97.
    c. Value of rating would be $16,918.80. (400 wks X 10% X $422.97)

D. Permanent Total Disability RSMo §287.190
1. Definition: inability to return to any employment or not merely the employment in which the employee was engaged at the time of the accident.
2. Benefits are paid weekly over the claimant’s lifetime.
3. Law does allow lump sum settlements based on a present value of a
permanent total award.
4. If the permanent total disability is the result of the work-related accident and a pre-existing condition(s), rather than the work accident alone, the Second Injury Fund would be liable for the permanent total award.

E. Death  RSMo §287.240
1. Death resulting from accident/injury.
   a. Total dependents (spouse and children) receive lifetime benefits.
   b. If spouse remarries, he/she receives only two additional years of benefits from remarriage date.
   c. Children receive benefits until the age of 18, or 22 if they continue their education full-time at an accredited school.
   d. Total dependents take benefits to the exclusion of partial dependents.
   e. Partial dependents take based on the percentage of dependency.
   f. Lump sum settlements are allowed.
2. Death unrelated to accident.
   a. Any compensation accrued but unpaid at the time of death is paid to dependents.
   b. General Rule: if no PPD rating by time of death, no PPD is paid.
   c. Benefits may continue to the dependents of the employee if claimant dies from unrelated causes.

X. PROCEDURE

A. Walk-through 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 claimant sitting before Administrative Law Judge with explanation of rights and benefits.
3. ALJ now must approve settlement agreed to between employer and employee as long as employee informed of rights and done without undue influence. The old unwritten minimum disability percentages for various injuries are essentially voided.
4. Settlement values can vary 3-7 percent between venues.
5. If claimant 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 the Claimant is in need of treatment or is ready to settle the claim.
3. Claims need to be assigned to counsel.
4. Need to have a rating report, if applicable.
5. Many cases settle at this time.
6. If claimant 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. Administrative Law Judges may not offer any legal advice.
4. Informal settings used to facilitate settlement or outlining of issues.
5. Alternatives at conclusion are:
   a. Mediation
   b. Continue and reset
   c. Settlement
      Note: Unrepresented claimants 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: 10:30 AM. 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 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 60 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 or Carrier if thirty-day status letter was sent to opposing counsel and no response was received.
3. If claim is dismissed, claimant 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 and Offsets
1. Spousal and Child Support Liens
   a. Lien must be filed with the Division of Workers’ Compensation.
   b. Temporary Total Disability: the maximum withheld is 25 percent of the weekly benefit.
   c. Permanent Partial Disability: the maximum withheld is 50 percent of the total settlement.
   d. Benefits generally paid to the Clerk of the Circuit Court.
2. Attorney Liens
   a. Lien must be filed with the Division of Workers’ Compensation.
   b. Must be satisfied prior to payout of proceeds.

XI. DEFENSES

A. Arising out of and in the course of:
1. There must be a causal connection between the conditions under which the work was required to be performed and the resulting injury. The injury results from a “natural and reasonable incident” of the employment, or a risk reasonably “inherent in the particular conditions of the employment” **AND** the injury is the result of a risk “peculiar to the employment.”
   a. *Risks to Public at Large*-generally not compensable
   b. *Acts of God*-not compensable
   c. *Personal Assault*-generally not compensable
   d. *Horseplay*-generally not compensable
   e. *Personal Errands/Deviation*-Generally not compensable
   f. *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.
   g. *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.
   h. *Mental Injury*: (RSMo. §287.120.8) Claimant must show that mental injury resulting from work-related stress was extraordinary and unusual to receive compensation. The amount of work stress shall be measured by objective standards and actual events. Mental injury is not compensable if it resulted from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or any similar action taken in good faith by the employer.

** Amendments made to the The Workers’ Compensation Act in 2005 require that the statute to be **strictly construed**. This could potentially impact all common law doctrines such as the Personal Comfort Doctrine and Mutual Benefit Doctrine.

B. “In the course of”
   1. Must be proven that the injury occurred within the period of employment at a place where the employee may reasonably be, while engaged in the furtherance of the employer’s business, or in some activity incidental to it.
      a. *Coming and going*: Broad exceptions to this rule.
      b. *Parking Lot*: If the employer exercises ownership and controls the parking lot, an accident occurring on the lot will generally be found compensable.
      c. “Dual Purpose Doctrine” If the work of the employee creates the necessity for travel, he/she is in the course of his employment, though he is serving at the same time some purpose of his own.
      d. *Frolic*: “Temporary Deviation”

C. Other Defenses
   1. *Recreational Injuries*: (RSMo. §287.120.7) Not compensable unless the employee’s attendance was mandatory.
   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 un witnessed 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. **Statute of Limitations:** (RSMo. §287.430) Two years from the date of last benefits paid, unless the Report of Injury is not timely filed by the employer. The statute increases to three years from the date of last benefits paid if the Report of Injury is not timely filed. Employer has 10 days to contact the Division of Workers’ Compensation from the date they are notified of the accident; thereafter they have 30 days to file the Report of Injury with the Division.

5. **Notice of Accident to Employer:** (RSMo. §287.420) Claimant must give written notice of the time, place, and nature of the injury as soon as practicable after the happening thereof, but not later than 30 days after the accident. If notice is given after the 30 day period, the claimant must show that the employer was not prejudiced by the failure to give notice.

6. **Alcohol/Controlled Substance**
   a. **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.
   b. **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 if injury was sustained “in conjunction” with use of alcohol or non-prescribed controlled drugs.

7. **Medical Causation**

8. **Employer/Employee Relationship**
   a. **Owner and Operator of Truck:** Complete defense if the alleged employer meets the standards set out in RSMo. §287.020.
   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.”

9. **Intentional Injury** (RSMO §287.120.3)
10. **Last Exposure Rule** (RSMo. §287.063 and 287.067.7)
11. **Idiopathic (Unexplained or Unique to the Individual) Fall**
12. **Accidental Injury:**
   a. **Old Law –** (RSMo. §287.020.2) An injury is compensable if it is clearly
work related. An injury is clearly work-related if work is a **substantial factor** in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a **triggering** or **precipitating factor**.

b. New Law– (RSMO §287.020.2-3) **prevailing factor**
   i. Unexpected traumatic event or unusual strain.
   ii. Identifiable by time and place of occurrence.
   iii. Caused by a specific event during a single shift.
   iv. Not compensable if work was a precipitating factor.
   v. Accident is prevailing factor in causing medical condition **AND** disability. Prevailing factor is the primary factor.
   vi. Does not come from a hazardous risk unrelated to the employment to which employee would be equally exposed to both in and out of employment.

13. **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 had made reasonable effort to enforce use of safety devices in compliance with rules.

**XII. TORT ACTIONS AGAINST EMPLOYERS – The Missouri Alliance Decision**

A. Labor groups challenged the constitutionality of the 2005 amendments.

B. If a work-related incident meets the definition of “accident” and if it causes “injury” as defined by the Act, then workers’ compensation is the “exclusive remedy.”

C. If not, the employee is free to proceed in tort.

D. Types of injuries and accidents at issue:
   1. Injuries that do not meet the definition of “accident,” including repetitive trauma injuries;
   2. Accidents that do not meet the definition of “injury”;
   3. Injuries for which the accident was not the “prevailing factor,” but was the “proximate cause”;
   4. Injuries from idiopathic conditions.

E. Likely types of claims:
   1. Common law negligence;
   2. Premises liability;
   3. Respondeat superior.
RECENTLY ASKED QUESTIONS
FROM ISSUES ADDRESSED IN RECENT MISSOURI CASES

Q: If an employee is descending a set of stairs in the parking lot after having clocked out, can his injury be said to have occurred during a “single work shift” under R.S.Mo. § 287.020.5?

A: Yes. In James Cotter (Inj. No. 12-46083; December 30, 2014), the claimant testified that, after completing his shift at work, he exited the hospital, and walked down a set of stairs in the parking lot. Due to poor lighting, the last two steps seemed to blend together, and the claimant fell. Although the Commission affirmed the ALJ’s denial of compensability on other grounds, the Commission rejected the ALJ’s reasoning and stated, “[A]n employee does not necessarily have to be ‘on the clock’ to sustain an accident.”

Q: Can the claimant toll the statute of limitations by seeking treatment on his own and either paying the bills himself, or processing the bills through his private health insurance?

A: No. In Dungan v. Fuqua Homes, Inc., 437 S.W.3d 807 (Mo. Ct. App. W.D. 2014), the claimant suffered a compensable injury on 12/18/08, and obtained authorized medical treatment. The employer filed a timely Report of Injury. The insurer made its last payment for treatment on 02/19/09. The claimant sought treatment on his own beginning on 11/11/10, and the insurer told him he would need to pay for it himself. The claimant filed a Claim for Compensation on 10/31/11. The Commission found the Claim was barred by the 2-year statute of limitations.

On appeal, the claimant argued his claim was timely filed because it was filed within 2 years of the date of the last medical payment made under Chapter 287 in that his personal insurance company made payment within 2 years of the date of the injury, and his claim for compensation was filed less than a year after that payment.

In affirming the Commission, the Court cited Bryan v. Summit Travel, Inc., 984 S.W.2d 185 (Mo. Ct. App. 1998) for the proposition that, if payments for medical treatment are not made by the employer or the employer’s insurance provider, the payments do not fall within the ambit of § 287.430.1 and, accordingly, do not toll the statute of limitations. The Court was not concerned with the fact that the insurer evidently told the claimant to seek the care on his own.

Q: Can TTD benefits be terminated for post-injury misconduct if the termination is attributable to the accumulation of absences, at least some of which occurred prior to the work injury?
A: Probably not. In *Glenda Buchanan* (Inj. No. 12-103444; November 21, 2014), the claimant alleged the contraction of an occupational disease arising out of the performance of her job duties at the employer. On December 3, 2012, she was 1 or 2 minutes late for work because she was caught by a train. The employer terminated the claimant on December 5, 2012 because she had accumulated too many attendance points. In her Claim for Compensation, the claimant alleged a date of injury of December 1, 2012.

In finding the claimant was not terminated for post-injury misconduct, the Commission stated, “[E]mployee is alleging a gradual onset occupational disease sustained each day in the course of her employment through December 2012, so we cannot say that each of the attendance incidents leading up to her discharge from employment occurred ‘after’ employee sustained the injuries she claims herein.”

Q: If an employee slips on ice in a parking lot, can the employer successfully deny the compensability of the injury based on the "equal exposure" rule?

A: Probably not. In *Scholastic, Inc. v. Viley*, 452 S.W.3d 680 (Mo. Ct. App. W.D. 2014), the claimant slipped and fell on ice in the parking lot of his employer. It was undisputed that the employer did not own the parking lot.

With regard to the "equal exposure" issue, the Court noted that, like the claimant in *Duever v. All Outdoors, Inc.*, 371 S.W.3d 863 (Mo. Ct. App. 2012), the claimant's injury was caused by an unsafe condition on the ground at the employer's worksite (albeit extended premises), *i.e.*, an ice-covered parking lot. The claimant was injured by slipping and falling on an icy parking lot *because* he was at work.

The Court reiterated their prior findings in *Dorris v. Stoddard County*, 436 S.W.3d 586 (Mo. Ct. App. 2014), and noted that the hazard is not the hazard of slipping on ice in general, but rather the hazard of slipping on that ice in that particular parking lot. Because the claimant was exposed to ice and now in the south parking lot only while he was coming to work or going from work, he was not exposed to that hazard in his normal, nonemployment life.

Q: If an employee slips on ice in a parking lot that is not owned by the employer, can the injury still be compensable?

A: Yes. In *Scholastic, Inc. v. Viley*, 452 S.W.3d 680 (Mo. Ct. App. W.D. 2014), the claimant slipped on a patch of ice in the parking lot. The employer relied on *Hager v. Syberg's Westport*, 304 S.W.3d 771 (Mo. Ct. App. 2010). In *Hager*, the lease gave the employer the *right to use* parking facilities which were shared with occupants and guests of other premises. The Court in *Hager* defined *control* as "1. To exercise power or influence over... 2. To regulate or govern... 3. To have a controlling interest in."
However, in Viley, the lease included a provision granting the employer **exclusive use** for parking of the employer's automobiles in both the north and south parking lots. Therefore, those parking lots were not common facilities because they were not provided for the common or joint use of the employer, landlord, and other tenants. The Court also found that the employer exercised "control" over the lots by, on various occasions, ejecting non-employees from the lots. The employer had also routinely contacted the landlord to request maintenance for the lots - a service that the landlord was obligated to perform under the lease - and on occasion had expressed displeasure with the snowy and icy conditions of the lots. Therefore, the Commission was free to determine that the employer was authorized to, and did, exercise power over, regulate, and govern the lots.

**Q:** If an employee is terminated after exercising his rights under the Workers' Compensation Law, does he have to prove he was terminated solely because he exercised those rights?

**A:** No. In *Templemire v. W&M Welding, Inc.*, 433 S.W.3d 371 (Mo. banc 2014), the claimant was terminated while resting his foot after being told to wash a railing. Although the prior rule was that an employee could make a case for retaliatory discharge only if the exercise of his rights under the Workers' Compensation Law was the exclusive reason for his termination, the Court in *Templemire* held the exercise of the employee's rights need only be a "contributing" factor.

**Q:** R.S.Mo. § 287.020.3(1) states, "An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability."

**Can the aggravation of a preexisting condition be compensable under this standard for medical causation?**

**A:** Yes. In *Barbara Fagins* (Inj. No. 09-093079; June 3, 2014), the claimant was robbed at gunpoint. The evidence at Hearing indicated the claimant suffered serious preexisting psychiatric disability. The Labor and Industrial Relations Commission reversed the ALJ's denial of benefits and held the aggravation of a preexisting condition can constitute a compensable injury if the work accident was the prevailing factor in causing the aggravation of the preexisting condition.

See also *Betty Shackleford* (Inj. No. 10-087428; June 19, 2015) wherein the Commission stated:

The question of medical causation of any alleged injury by accident must turn on the plain language of § 287.020.3(1) RSMo, which we are required to strictly construe by
Q: If the claimant is found to be permanently and totally disabled, but not due to the last accident, in and of itself, must the claimant’s permanent and total disability necessarily be due to the last accident in combination with the claimant’s preexisting disabilities?

A: No. In Ottavio Tarpeo (Inj. No. 08-122569; January 15, 2015), the ALJ did not believe the claimant’s bilateral knee condition stemming from his employment rendered the claimant permanently and totally disabled. The ALJ also did not believe the claimant’s preexisting depression was disabling enough to establish liability against the Second Injury Fund.

Perhaps most interestingly, the ALJ seemed to be of the opinion that the claimant’s inability to effectively communicate in English played a large part in his inability to compete for employment in the open labor market. However, his inability to speak English could not be considered disabling for purposes of Second Injury Fund liability because it was not due to an inability to learn, but rather a lack of education.

Q: The claimant was crossing a public street while returning from a fast food restaurant on his lunch break. A gust of wind knocked him to the ground. Compensable?

A: Probably not. In Rifet Obic (Inj. No. 11-044808; December 30, 2014), the claimant was walking on a public street returning from a Lee’s Chicken restaurant where he had been eating lunch on his lunch break. A strong gust of wind knocked him to the ground resulting in his injuries. In denying compensability, the Commission noted that risk or hazard of exposure to wind gusts is not only unrelated to the claimant’s employment, but was increased when the claimant left his place of employment to purchase his lunch. The Commission further indicated there was nothing about the claimant’s workplace or work duties that necessitated his leaving to eat lunch, nor any evidence that the employment was located in an area more prone to wind gusts than elsewhere.
In light of recent case law narrowing the meaning of "hazard" or "risk" under R.S.Mo. § 287.020.3(2), it is not clear whether the result would have been different if evidence would have been presented to support the notion that the specific street where the claimant fell was more prone to wind gusts than other places.

Q: Can a claimant reactivate a settled claim in order to obtain a new prosthetic device that was not present prior to the reactivation?

A: Probably. In Pierce v. Zurich American Ins. Co., 441 S.W.3d 208 (Mo. Ct. App. W.D. 2014), the claimant underwent two knee surgeries, but settled his case with a provision indicating medical benefits would be left open for one year. At the time of settlement, both the authorized treating physician and the claimant's IME physician agreed that the claimant required a total knee replacement, though they disagreed about whether the total knee replacement was causally related to the work accident.

One month after the settlement, the claimant demanded the total knee replacement. The employer returned the claimant to the authorized treating physician, who again opined that the knee replacement would not be related to the work accident. The employer refused to authorize the total knee replacement, so the claimant sought a declaratory judgment and specific performance of the settlement agreement. The trial court dismissed the claimant's petition, finding the Labor & Industrial Relations Commission had exclusive subject matter jurisdiction over the issue.

The Court of Appeals reversed the trial court because they did not feel this was an issue of "subject matter jurisdiction," but rather whether the trial court had the authority to proceed in the case in light of the exclusivity clause of the Workers' Compensation Law.

Most importantly, the Court noted that the reactivation provision of § 287.140.8 RSMo (i.e., "The claim shall be reactivated only after the claimant can show good cause for the reactivation of this claim and the claim shall be made only for the payment of medical procedures involving life-threatening surgical procedures or if the claimant requires the use of a new, or the modification, alteration or exchange of an existing, prosthetic device") appeared to provide the mechanism of relief sought by the claimant because he was seeking a "new…prosthetic device."

The Court went on to state,

"Nothing in the language of § 287.140.8, therefore, suggests a previous award of a prosthetic device is a necessary prerequisite for reactivation. Rather, the only requirements Missouri courts have specified are: '(1) a claim for compensation must have been filed within the time frame of the statute of limitation; (2) the claim for compensation must have been settled; and (3) good cause must be shown for the reactivation of the claim.' Clanton v. Teledyne Neosho, 960 S.W.2d 532, 534 (Mo. Ct. App. S.D. 1998)."
Q: If the claimant retains surgical hardware following a surgery that is found to be reasonably required to cure and relieve the effects of the injury, will future medical benefits be awarded at Hearing under R.S.Mo. § 287.140.8?

A: Most likely. In Ronald Gamble (Inj. No. 08-087820; January 15, 2015), the claimant underwent an ulnar shortening procedure that involved the placement of hardware in his wrist. Although the ALJ held that the work accident was not the prevailing factor in causing the claimant’s ulnar impaction syndrome (the medical condition the ulnar shortening procedure was designed to fix), the ALJ found the ulnar shortening procedure was reasonably required to cure and relieve the effects of the work-related injury (i.e., a TFCC tear in the claimant’s wrist).

Dr. Schlafly, the claimant’s IME expert, testified there was only a “remote possibility” that the hardware in the claimant’s wrist would need to later be surgically removed or treated.

Nevertheless, the Commission affirmed the ALJ’s Award of future medical benefits to remove or revise the hardware in the future, and cited the dictionary definition of “brace” as “something that transmits, directs, resists, or supports weight or pressure...an appliance that gives support to moveable parts (as a joint or a fractured bone).”

Q: Can the claimant’s attorney be awarded 25% of the amount the employer/insurer paid in medical bills if the medical bills were paid prior to Hearing?

A: Probably not. In Sterling v. Mid America Car, Inc., 456 S.W.3d 473 (Mo. Ct. App. W.D. 2014), the claimant incurred $38k+ in medical expenses before hiring an attorney and filing a Claim for Compensation in December 2011. Following the deposition of the claimant, the employer sent correspondence to claimant’s counsel indicating it intended to pay the claimant's medical bills. Claimant's counsel responded with a letter indicating he was entitled to a 25% attorney's lien on the proceeds paid by the employer for the medical bills or for any items of compensation. By July 2012, the employer had negotiated with the health care providers to pay $18k+ in satisfaction of the medical bills, and paid the providers directly.

The ALJ specifically found that claimant's counsel was not entitled to a 25% lien on the $38,462.07 in undiscounted medical bills. The Commission affirmed. The Court of Appeals noted that, within three months of the claimant filing his Claim, the employer agreed to pay the claimant's medical bills. During that time, claimant's counsel filed a claim, provided the employer with copies of the claimant's medical bills, attended the claimant's deposition, and offered a settlement compromise. There was no evidence detailing claimant's counsel's specific efforts to recover payment from the employer for the medical bills. Therefore, the Court could not say that the denial of a 25% lien on the undiscounted medical bills amounted to an abuse of discretion.
The claimant further argued that allowing employers to negotiate with and pay medical bills directly to the medical providers after they initially deny liability permits employers to manipulate the system and escape liability for the effort expended by attorneys in recovering payment of a claimant’s medical bills. The Court of Appeals indicated they were inclined to agree that, by directly negotiating with and paying medical providers after initially denying liability, employers interfere with an attorney's ability to collect attorney's fees for the effort expended in recovering payment for their clients' medical expenses, but there was no statute proscribing the employer's conduct.

Q: R.S.Mo. § 287.020.2 defines “accident” as an unexpected 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. Can a worker’s act of spending an entire shift performing a repetitive lifting task constitute an accident?

A: Yes. In Mark Barrientos (Inj. No. 10-108268; February 10, 2015), the claimant could not identify a specific lifting incident that caused his low back injury. However, after a particularly strenuous day, the claimant woke up in the middle of the night with excruciating back pain. The ALJ denied compensability, based partially on the statute’s use of the singular form of the words “event” and “strain,” and the claimant's inability to identify a singular event or strain that caused his low back problems.

The Commission affirmed the denial of benefits, but rejected the ALJ’s reasoning with regard to the words “event” and “strain.” The Commission held that the only temporal limitations in § 287.020.2 are that an accident must be identifiable by time and place of occurrence, and that an accident must occur during a single work shift. The Commission noted it is not unusual to refer to a series of discrete occurrences as a singular “event” (e.g., “I attended the event last night with my spouse”) or to a series of discrete exertions as a “strain” (e.g., “I think I strained by back lifting and drilling screens for 8 hours”).

Q: If a case goes to a Final Hearing, and the claimant alleges an injury to a body part stemming from a specific accident, and the claimant loses, can he/she request another Final Hearing alleging injury to the same body part due to repetitive trauma?

A: Probably not - If the cases are thought to arise out of essentially the same set of facts.

In Johnson Controls, Inc. v. Trimmer, 2015 WL 1813915 (Mo. Ct. App. W.D. 2014), the claimant filed a Claim for Compensation alleging an acute injury having occurred on 09/09/03. Because the medical records did not support the allegation that the claimant suffered an acute injury on that date, compensability of the claim was denied. However, the ALJ pointed out that, had the claimant alleged a repetitive trauma injury to his left shoulder, the claim likely would have been compensable. The Commission affirmed.
On 10/21/05, the claimant filed a new Claim for Compensation alleging a repetitive trauma injury to his left shoulder. The date of injury plead on the claim was also 09/09/03. The employer asserted that the claim was barred by *res judicata* because it involved the same injury for which a hearing was held in August 2005 and benefits were denied. On 02/17/11, the ALJ awarded benefits, and the Commission affirmed.

The Court of Appeals reversed, holding that the claimant’s claim was barred by the doctrine of *res judicata*. The Court pointed out that, in the initial Hearing, one of the issues to be adjudicated was whether the claimant suffered an accident or *occupational disease* arising out of and in the course of employment. Despite having stipulated that the ALJ would consider and determine the occupational disease issue, the claimant failed to present evidence sufficient to meet his burden of proving that his left shoulder injury was the product of an occupational disease.

The Court of Appeals also pointed out that the doctrine of *res judicata* precludes a litigant from later bringing a claim that *should* have been brought in the first lawsuit. Furthermore, claim preclusion prevents reassertion of the same claim even though additional or different evidence or legal theories might be advanced to support it.

Q: R.S.Mo. § 287.195 states, “In all claims for compensation for hernia resulting from injury arising out of and in the course of employment, it must be definitively proved to the satisfaction of the division or the commission: (1) That there was an accident or unusual strain resulting in hernia; (2) That the hernia did not exist prior to the accident or unusual strain resulting in the injury for which compensation is claimed.”

Are occupational disease hernia claims allowed as compensable under the Act?

A: **Yes**, In *Rizo Sadic* (Inj. No. 10-096313; December 5, 2014), the claimant alleged he sustained a hernia from repeated heavy lifting at work up to September 17, 2010. The ALJ denied compensability, based partially on the finding that the Act does not allow for hernias attributable to repetitive trauma to be compensable.

Although the Commission affirmed the denial of benefits, the Commission rejected the ALJ’s finding that the Act does not allow for occupational disease hernia claims. The Commission held that § 287.195 only applies to hernias resulting from *injury*, which the Commission found explicitly excludes occupational diseases under R.S.Mo. § 287.020.3(5). Therefore, § 287.195 does not prevent an employee from claiming (and proving) a compensable hernia resulting from occupational disease under R.S.Mo. § 287.067.

Q: If the claimant returns to the job he worked prior to his January 2008 accident, and continues to work for two years, can he still be found permanently and totally disabled as a result of the January 2008 accident, in and of itself?
A: Yes. In *Archer v. City of Cameron*, 2015 WL 550708 (Mo. Ct. App. W.D. 2015), the claimant suffered an injury to his cervical spine, thoracic spine, and lumbar spine on January 16, 2008. He underwent a lengthy course of conservative treatment before being released with permanent restrictions. He continued to work for the employer from the fall of 2008 until September 2010, when he suffered a second injury to his thoracic spine and lumbar spine. During that time, the claimant received assistance from coworkers if he was unable to perform work tasks. He did not perform any heavy lifting. He took frequent breaks to alleviate his pain, and he frequently missed work due to pain. His absences were deducted from his sick and vacation pay.

The ALJ found the claimant to be permanently and totally disabled as a result of the two injuries in combination, and awarded PTD benefits against the SIF. The Commission reversed. The Commission held the claimant was permanently and totally disabled as a result of the 2008 injury considered in isolation, and found the claimant sustained no permanent disability as a result of the September 2010 injury. The Court of Appeals affirmed.

Q: Do the statutory and regulatory requirements for establishing a claim for hearing loss against the employer/insurer apply to establishing a preexisting disability for the purpose of establishing Second Injury Fund liability?

A: No. In *Raymond Priest* (Inj. No. 10-097781; June 17, 2015), the claimant suffered from significant hearing deficits since childhood, but the ALJ determined he could not calculate the claimant’s preexisting hearing loss disability because the hearing loss allegation was not predicated on the statutory and regulatory requirements for calculating hearing loss PPD under § 287.197 RSMo and 8 CSR 50-5.060.

The Commission reversed. They noted that the statutory requirements of § 287.197 apply only to claims against an employer for losses of hearing due to industrial noise, but the claimant was seeking benefits from SIF for the synergistic interaction between his primary injury and the hearing loss he suffered since childhood.

Q: If the employee cannot identify the cause of his fall, can he establish a compensable injury?


The Court of Appeals stated, "The Commission's focus should not have been on what Gleason was doing when he suffered his injuries - he had fallen from the top of a railcar where he was conducting an inspection - but rather should have been focused on
whether the risk source of his injury - falling 20 to 25 feet from the top of a railcar - was a risk to which he was exposed equally in his normal nonemployment life." Because this risk source is plainly not one to which a worker would be exposed in normal nonemployment life, Gleason's fall while engaged in the risk source establishes a causal connection between his injuries at issue and his work activity. It was thus not necessary for Gleason to establish why he fell because he had already established that he was exposed to an unusual risk of injury that was not shared by the general public.

Q: If the employee can demonstrate that the hazard that caused her injury came from a risk to which she would not be exposed in her normal, nonemployment life, need she make any additional showing to prove her injury arose out of and in the course of employment?

A: Maybe not. In Judy West (Inj. No. 14-006600; May 29, 2015), the Commission pointed out that, prior to 2005, the courts generally held that "arising out of" and "in the course of" employment were two separate tests, both of which must be met. Simmons v. Bob Mears Wholesale Florist, 167 S.W.3d 222, 225 (Mo. Ct. App. 2005). Previously, "in the course of employment" referred to the time, place, and circumstances of the injury. Cruzan v. City of Paris, 922 S.W.2d 473, 475 (Mo. Ct. App. 1996).

However, the Commission questioned whether the "two separate tests" analysis survives the 2005 amendments. The Commission compared Harness v. Southern Copyroll, Inc., 291 S.W.3d 299, 305 (Mo. Ct. App. 2009), wherein the Court of Appeals stated that to prove an injury is sustained "in the course of employment" an employee must show that the "injury occurs within a period of employment at a place where the employee may reasonably be fulfilling the duties of employment" with Johme v. St. John's Mercy Healthcare, 366 S.W.3d 504, 509-10 (Mo. 2012), wherein the Supreme Court suggested that, given the legislature's sweeping abrogation in § 287.020.10 RSMo of the entire body of case law interpreting the meaning of the phrases "arising out of" and "in the course of" employment, the post-2005 language (which does not refer to the time or place an injury is sustained, but rather emphasizes unequal exposure to work-related risks or hazards) now constitutes the exclusive test for determining what injuries "arise out of" and "in the course of" employment.

In other words, in light of the Johme decision, it is unclear whether (and to what extent) an employee who satisfies the unequal exposure test under § 287.020.3(2) RSMo would be required to make any additional showing in order to demonstrate her injuries arose out of and in the course of any employment.

Q: The claimant was asked by her supervisor to go across the street to the employer's new building and examine the new countertops being built. While walking across the street, the claimant fell. Although the street had cracks in the pavement, the claimant could not confidently testify that the cracks in the street were what caused her to fall. Compensable?
A: Yes. In Dorris v. Stoddard County, 436 S.W.3d 586 (Mo. Ct. App. S.D. 2014), the Court of Appeals determined that nothing in the workers' compensation law requires the claimant to testify to the exact cause of the accident. The claimant testified she was not prone to frequent falls, and she did not suffer from seizures. Photographs were introduced at Hearing showing the poor condition of the pavement. The Court felt it was reasonable for the Commission to infer that the claimant tripped on a crack in the street.

The Court stated, "There is no requirement that a claimant must personally identify the specific cause of her fall; a reasonable inference regarding the cause was sufficient. In fact, it is well settled that to prove causation in slip-and-fall cases 'a plaintiff may rely on circumstantial evidence' because he or she 'will not know exactly what happened or what caused the fall.'"

The Court also rejected the employer's equal exposure argument. The Court distinguished the case from Miller and Johme, and found the facts more comparable to Duever. The Court stated:

'As in Duever, there was evidence of a hazardous condition in the surface on which Claimant was walking, i.e., there were cracks in the road that Claimant was required to cross, and it was a busy street that required her to pay attention to traffic. Furthermore, as in Duever, the fall occurred while Claimant was completing a task related to her work. Claimant's supervisor had asked Claimant to go look at the new workstations, and Claimant would have reported any deficiencies she observed. Finally, the accident occurred during the workday while Claimant was 'on the clock[.]' Claimant was exposed to cracks in that particular street because of her employment. There is no evidence in the record that Claimant had any exposure to this particular hazard during her nonemployment life and therefore, the record could not support a conclusion by the Commission that she was equally exposed to that hazard in her nonemployment life, as urged by employer."

Q: The claimant provided in-home care for disabled adults. Her schedule often required her to work multiple 17+ hour shifts on consecutive days. On 03/16/11, the claimant had worked 13 hours into her second consecutive 17.5 hour shift. During the night, the claimant got up from the couch to go outside and smoke a cigarette. She testified that she remembers reaching for her purse, and nothing else until after the fall (when she woke up on the floor). Compensable?

A: Yes. In Martha Sampley Riggins (Inj. No. 11-019035; May 14, 2015), the claimant alleged that the risk source causing her fall was her work schedule, specifically, the extensive overnight shifts she was required to work making it impossible for her to get adequate sleep. The ALJ found that the extremely long overnight work shifts were the risk source to which the claimant was not equally exposed in her normal nonemployment life.
The Commission added that the claimant's inability to recall or identify what caused her to fall is irrelevant in light of Dr. Schwartz's persuasive opinion, which establishes that the duties of her work created an increased risk of sustaining an accidental injury. The Commission felt the claimant's injuries resulted from a unique condition of her employment: namely, her variable shift schedule and the series of long overnight shifts she worked before the accident.

**Q:** Can the employer/insurer be required to pay for a three-level fusion to cure and relieve the effects of a lumbar strain?

**A:** Yes. In *Randolph County v. Moore-Ransdell*, 446 S.W.3d 699 (Mo. Ct. App. W.D. 2014), the claimant suffered a lumbar strain, which was superimposed on significant degenerative disc disease at L3-4, L4-5, and L5-S1. The claimant's treating physician, who performed the three-level fusion, opined that the lumbar strain suffered as a result of the work injury was the primary factor in causing the claimant's permanent disability.

The Court found the record contained sufficient evidence to support the Commission's determination that the claimant's workplace accident was the "prevailing" or "primary" factor that caused her injuries:

- The medical history indicated the claimant was "well" before her injury, and that her problems were new as of her first visit to Dr. Komes soon after the injury.
- The Commission found the claimant testified credibly to the squatting and twisting necessitated in pulling a file out of a low, full file drawer in the course of her employment, and the immediate and intense low back pain resulting from that injury.
- The Commission determined that Dr. Highland was more persuasive than Dr. Chabot, and the Commission stated it based its award on the testimony of the claimant and Dr. Highland.

Judge Ahuja dissented, believing the work accident merely triggered the claimant's preexisting degenerative disc disease to become symptomatic, and that it was this preexisting degenerative condition - *not* the workplace incident - which caused her PPD.

**Q:** In order to establish a work-related stress claim, must a claimant present evidence of similarly situated employees?

**A:** No. In *Linda Mantia* (Inj. No. 08-096413; April 28, 2015), the claimant alleged she sustained mental stress from witnesses a number of horrific scenes while working for MODOT. In reversing the ALJ's denial of benefits, the Commission cited 14 specific instances where the claimant had encountered things such as a child burning alive, kicking a woman's decapitated head, and a co-worker's head getting run over by another vehicle.
The Commission noted that, in 2005, the legislature abrogated all case law interpretations of the meaning or definition of "arising out of" and "in the course of employment." § 287.020.10 RSMo. All decisions applying a similarly situated employee standard under § 287.120.8 involved an injury predating the 2005 amendments to Chapter 287.

The Commission pointed out that § 287.120.8 requires the use of "objective standards" to determine whether "actual events" identified by an employee involve stress to such degree as to qualify as "extraordinary and unusual." The Commission cited the dictionary definition of "objective" as: "the use of facts without distortion by personal feelings or prejudices," "perceptible to persons other than an affected individual," and "of such nature that rational minds agree in holding it real or true or valid." *Webster's Third New International Dictionary* 1556 (2002). The Commission expressed confidence that all rational minds would agree in holding the events and incidents of stress experienced by the claimant "real or true or valid." The Commission noted it was not relevant that Dr. Stillings felt these kinds of experiences were "part and parcel" of the job of highway workers.

Q: On January 4, 2008, the claimant suffered an injury to his left knee when, while walking back to his work truck to retrieve materials, he stepped on a frozen dirt clod. Compensable?

A: Yes. In *Young v. Boone Electric Cooperative*, 2015 WL 1744132 (Mo. Ct. App. W.D. 2015), the employer argued that the risk from which the injury arose - slipping on a frozen dirt clod - was not related to the claimant's employment under *Miller* and *Johme*. However, the Court of Appeals found that the employer's reliance on these cases was misplaced because the claimant was injured because he was at work, not merely while he was at work. The Court of Appeals noted that *Duever v. All Outdoors, Inc.*, 371 S.W.3d 863 (Mo. Ct. App. 2012) (wherein the claimant was injured when he slipped on a piece of ice in the parking lot of his office on his way back inside after holding a safety demonstration in the lot) was directly on point.

The employer also argued that the claimant lived on a farm and, thus, was equally exposed to clods of dirt in his nonemployment life. The Court of Appeals cited *Dorris v. Stoddard County*, 436 S.W.2d 586 (Mo. Ct. App. 2014) as support for the rule that the "hazard or risk" cannot be identified so generally. Because there was no evidence to support a conclusion that the claimant was equally exposed to the hazard of slipping on frozen dirt clods at that particular work site in his nonemployment life, the Court rejected the equal exposure argument.

Q: Can the Commission award temporary total disability benefits after the claimant has reached MMI?
A: Probably not. In *Greer v. Sysco Food Services*, 2014 WL 6464473 (Mo. Ct. App. E.D. 2014), the Commission awarded TTD benefits to the claimant after the date the Commission determined the claimant had reached MMI. The Commission based the award of TTD on the fact that the words "maximum medical improvement" are not contained in the statute and, therefore, they were not precluded from awarding TTD for a period of time after the claimant had reached MMI.

The Court of Appeals disagreed, noting the concept of TTD is a judicial creation defined by case law, and not statute. Maximum medical improvement is one of various well-recognized terms courts use to determine when an employee's condition has reached the point where further progress is not expected. *Cardwell v. Treasurer of State of Mo.*, 249 S.W.3d 902, 909 (Mo. Ct. App. 2008). The Court reversed the Commission's award of TTD benefits.

Q: Can an employer cut off PTD benefits, after an Award has been issued, because the claimant failed to appear for an IME?

A: In *SSM Health Care v. Hartgrove*, 456 S.W.3d 467 (Mo. Ct. App. W.D. 2014), the claimant was found to be permanently and totally disabled as a result of her work-related injury. In February 2014, the employer suspended the claimant's benefits after the claimant failed to appear for an IME.

The Court noted that § 287.210.1 states, "After an employee has received an injury he shall from time to time thereafter during disability submit to reasonable medical examination at the request of the employer…and if the employee refuses to submit to the examination, or in any way obstructs it, his right to compensation shall be forfeited during such period unless in the opinion of the commission the circumstances justify the refusal or obstruction."

The Court also noted that § 287.203 states, "Whenever the employer has provided compensation under section 287.170, 287.180 or 287.200, and terminates such compensation, the employer shall notify the employee of such termination and shall advise the employee of the reason for such termination. If the employee disputes the termination of such benefits, the employee may request a hearing before the division and the division shall set the matter for hearing within sixty days of such request and the division shall hear the matter on the date of hearing and no continuances or delays may be granted except upon a showing of good cause or by consent of the parties. The division shall render a decision within thirty days of the date of hearing." § 287.200 relates to compensation to be paid for permanent total disability.

Finally, the Court referenced § 287.470, which states, "Upon its own motion or upon the application of any party in interest on the ground of a change in condition, the commission may at any time upon a rehearing after due notice to the parties interested review any award and on such review may make an award ending, diminishing or increasing the compensation previously awarded."
The Court ultimately determined that the employer did not have the right to terminate benefits unilaterally. The employer should have filed an application for review with the Commission, pursuant to § 287.470 - without suspending the claimant's benefits.

Q: Is it sufficient to plead common law negligence in a claim of co-employee liability for a workplace injury which occurred between the 2005 and 2012 amendments of the Act?

A: Yes. In Leeper v. Asmus, 440 S.W.3d 478, 480 (Mo. Ct. App. 2014), the appeal came after the trial court dismissed the plaintiff's amended petition for failure to state a claim because it did not meet the “something more” test that was implemented in Hansen v. Ritter, 375 S.W.3d 201 (Mo. Ct. App. 2012). In Hansen, the court held that, subject to the 2005 amendment of the Act, injured employees could separately pursue a cause of action against negligent co-employees so long as the co-employee owed the injured employee a duty of care at common law.

§ 287.120.2 was amended in 2012 to extend exclusivity protection to co-employees, unless the employee was injured as a result of the co-employee’s “affirmative negligent act that purposefully and dangerously caused or increased the risk of injury.”

The plaintiff argued that his amended complaint sufficiently plead the cause of action for co-employee negligence at common law. In this case, the plaintiff alleged that his co-employee breached a personal duty of care owed to him when the co-employee failed to perform his job duties in the safe manner in which he was directed. The Court determined that the plaintiff sufficiently plead a cause of action for co-employee negligence at common law because his amended petition alleged facts that support the existence of a personal duty of care at common law. The trial court’s judgment dismisses the action with prejudice was reversed and remanded.

Q: Is summary judgment proper if it is unclear whether the actions of the employee’s supervisors constituted a breach of their employer’s non-delegable duty to maintain a safe work environment or if they constituted a breach of their own personal duty of care owed to the employee?

A: No. Prior to 2005, the Act’s exclusivity provision did not encompass co-employee as part of the employer. After the amendments in 2005, the court held that at common law, the negligence of an employee in performing an employer’s non-delegable duties did not affect an injured employee’s right to seek recovery from the employee.

In McComb v. Norfus, No. WD 77761, 2015 WL 1813573 (Mo. Ct. App. Apr. 21, 2015), the Court held that they must first determine whether a co-employee owed a duty of care in negligence at common law. To determine whether the employee’s death was attributable to the breach of a non-delegable duty of the employer, the Court asked
questions regarding the source of the duty and details of the employer’s policy. There was conflicting testimony regarding the answers to these questions, which showed that there was a genuine issue of material fact. Therefore, the Court held that genuine issue of material fact as to whether employee’s supervisors were simply carrying out their employers non-delegable duty to maintain a safe work environment, as would trigger workers’ compensation exclusivity provision, when supervisors directed the employee to drive in hazardous conditions, precluded summary judgment.

A. Act will apply where:
   1. Injuries occurred or occupational diseases contracted in Nebraska while in the scope and course of employment.
   2. Employer is a resident employer performing work in Nebraska who employs one or more employees in the regular trade, business, profession, or vocation of the employer.
   3. Injuries received and occupational diseases contracted outside Nebraska, unless otherwise stipulated by the parties, if—
      a. The employer was carrying on a business or industry in Nebraska; and
      b. The work the employee was doing at the time of the injury was part of or incident to the industry being carried on by employer in Nebraska.
         i. Domicile of the employer or employee and the place where the contract was entered into may be circumstances to aid in ascertaining whether the industry is located within the state.

B. The Act will not apply where:
   1. Employer is a railroad engaged in interstate or foreign commerce.
   2. The employee is a household domestic servant in a private residence.
   3. The employer is engaged in agricultural operations and employees only agricultural employees, with certain exceptions.
   4. The employee is subject to a federal workers’ compensation statute.

II. PERSONAL INJURY

   1. An unexpected or unforeseen injury happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury.
      a. For repetitive trauma—
         i. "Unexpected or unforeseen" requirement is satisfied if either the cause was of an accidental character or the effect was unexpected or unforeseen;
         ii. "Suddenly and violently" element is satisfied if the injury occurs at an identifiable point in time requiring the employee to discontinue employment and seek medical treatment.
   2. An "injury" means violence to the physical structure of the body and such disease or infection as naturally results therefrom.
      a. Special cases—
         i. Heart attack – legal and medical causation;
(a) **Legal:** Court determines what kind of exertion satisfies "arising out of employment."

(b) **Medical:** Medical evidence establishes employee’s exertion in fact caused his or her heart attack.

ii. *Mental/Psychiatric* – requires a physical component and medical testimony linking mental health disorder with physical injuries sustained or occupational disease contracted.

iii. *Mental/Mental* – requires condition causing the injury to be extraordinary or unusual when compared to the normal conditions of employment and causation established by competent medical evidence. Applies only to First Responders, ie Police, Firefighters, and EMTs.

3. An injury, to be compensable, must arise out of and in the course of the employment:
   a. "Arise out of" – there must be a causal connection between the conditions under which the work was required to be performed and the resulting injury.
      i. Special Cases—
         (a) *Risks to Public at Large/Acts of God:* generally not compensable unless employment duties put employee in position they might not otherwise be in which exposes them to risk, even though risk is not greater than that of general public (positional risk doctrine).
         (b) *Idiopathic cause:* non-compensable unless employment placed employee in position of increased risk.
         (c) *Horseplay:* compensable if deviation from work was insubstantial and did not measurably detracted from work.
         (d) *Assault:* injury may be compensable depending on reason for assault—
            (i.) *Work conditions:* generally compensable.
            (ii.) *Personal animosity:* generally not compensable.
   b. "In the course of" – the injury must arise within the time and space boundaries of employment, and in the course of an activity whose purpose is related to the employment.
      i. *Coming and going:* No recovery for injury while coming to or going from employer’s workplace or jobsite. Injuries which occur on the employer's premises are generally compensable if no affirmative defenses apply.
      ii. *Exceptions:*
         (a) *Dual Purpose:* If the employee is injured while on a trip which serves both a business and personal purpose, the injuries are compensable if the trip involves some service to the employer which would have caused the employee to go on the trip, and the employee selected a "reasonable and practical" route.
(b) **Employer Created Condition**: when a distinct causal connection exists between an employer-created condition and the occurrence of an injury, the injury will be compensable.

(c) **Minor deviation**: acts incidental to employment.

(d) **Personal convenience**: acts an employee may normally be expected to indulge in under the conditions of his work, if not in conflict with specific instructions, are generally compensable.

(e) **Parking lot**: If owned, maintained, or otherwise sponsored by employer.

(f) **Employer-supplied transportation**: If provided for work-related reason and not merely for employee benefit or convenience.

(g) **Commercial traveler**: If the employee’s occupation requires that he or she travel, and there is no easily identifiable labor hub.


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.


A. Notice of injury is required “as soon as practicable” following the accident.

B. In repetitive trauma/occupational diseases, notice is required as soon as practicable from time employee’s condition becomes an “injury.”

C. The notice must be written and include the time, place and cause of the injury, except that if employee can show that employer had actual or constructive notice of the injury, no written notice is required.

D. Notice given five months after the injury is “unreasonable” per se.

**IV. REPORT OF INJURY – Neb. Rev. Stat. § 48-144.01**

A. **FROI – First Report of Injury**
1. For every Reportable Injury (including medical only injuries) arising out of and in the course of employment, a report of injury must be electronically filed with the Nebraska Workers’ Compensation Court within ten days of the reportable injury.
   a. Reportable Injury means those injuries or diagnosed occupational diseases that result in:
      i. death, regardless of the time between the death and the injury or onset of disease;
      ii. time away from work;
      iii. restricted work or termination of employment;
      iv. loss of consciousness; or
      v. medical treatment other than first aid.
   b. Failure to file injury report within 10 days of accident results in tolling of statute of limitations under § 48-137 such that two year statute of limitations does not begin to run until the report is filed.

2. A First Report of Injury is required:
   a. In the event of an injury, even if liability is denied;
   b. A change is necessary to a previously filed report;
   c. A denial is made at any time;
   d. The claim has been acquired by another carrier.

3. Any employer who fails to file a report is guilty of a Class II Misdemeanor for each such failure.

B. SROI – Subsequent Report of Injury
1. in every case where a benefit payments have been made, a subsequent report of injury shall be electronically filed with the court by the employer or its insurance carrier.

2. A Subsequent Report of Injury is required when:
   a. The first indemnity payment has been made;
   b. A change is necessary to a previously filed report;
   c. A claim has been denied;
   d. Every 180 days the claim has been open
   e. Benefits have been reinstated;
   f. The claim has been closed;
   g. Jurisdiction has been changed.


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.


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.


a. Injury to trunk of body, neck or head, but not including shoulder or injuries below the trochanteric neck of the femur.

b. Injuries to two scheduled members from the same accident which combine to create a loss of earnings of more than thirty percent are compensated on the basis of loss of earning capacity.

c. Compensation rate is percentage of lost earning capacity multiplied by two-thirds of AWW.

d. Payable for 300 weeks.

e. Deduction for weeks TTD benefits paid.

4. Calculation of Permanent Partial Disability

a. Scheduled Member Injury:

i. Claimant has a rating of 10 percent permanent partial disability to the foot, which qualifies for 150 weeks of benefits.

ii. Claimant qualifies for maximum compensation rate for his date of accident of $644.00.

iii. Award would be $9660.00 (150 wks X 10% X $644).

iv. No credit for TTD paid.

b. Body as a Whole:

i. Claimant qualifies for maximum compensation rate for his date of accident of $644.00.

ii. Claimant has a 50% loss of earning capacity.

iii. Claimant received TTD benefits for 20 weeks (300 – 20 = 280 wks payable).

iv. Award would be $90,160.00 (280 wks X $644.00 X 50%).


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

e. Reasonable expenses of burial, not exceeding $10,000.00.

XI. DEFENSES

A. Statutory:

   (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.

   must give written notice of the time, place, and nature of the injury as soon as
   practicable after the happening thereof. The Supreme Court has ruled that
   five months is per se unreasonable.

B. Other Defenses:

1. Failure to Use Provided Safety Devices: compensable only if failure to use
   safety devices amounted to willful negligence.

2. Intoxication: Intoxication will bar recovery if, at the time of the injury, the
   Plaintiff was in a state of intoxication and the intoxication caused or
   contributed to the cause of the injury. The employer must not have known
   about the intoxication.

3. Violation of a Safety Rule: An employer may prevail where the employer has:
   a. a reasonable rule designed to protect the health and safety of the
      employee,
   b. the employee has actual notice of the rule
   c. the employee has an understanding of the danger involved in the violation
      of the rule
   d. the rule is kept alive by bona fide enforcement by the employer, and
   e. the employee has no bona fide excuse for the rule violation.
4. **Recreational Injuries:** Generally compensable when:
   
a. they occur on the premises as a regular incident of employment;
   
b. the employer, by expressly or impliedly requiring participation brings the activity within the orbit of employment; or
   
c. the employer derives substantial direct benefit from the activity beyond value of improvement in employee health and morale.

5. **Independent Contractor:**
   
a. "Independent Contractor" – one who, in course of independent occupation or employment, undertakes work subject to will or control of person for whom the work is done only as to result of the work and not as to methods or means used; such person is not employee within meaning of workers' compensation statutes.
   
   i. Exception – if the employer has created a scheme, artifice or device to enable them to execute work without providing workers' compensation coverage, then liability will be imputed to the employer.
   
   b. To be eligible for compensation under Workers’ Compensation Act, alleged employee must prove that he or she is an “employee” in order to invoke jurisdiction of Workers' Compensation Court.

**XII. PENALTIES**

A. Absent a reasonable controversy, the employer or insurance carrier must pay, within thirty days, all medical and indemnity benefits due and owing to the employee and medical providers. Failure to do so will result in:
   
   1. A 50% penalty on all indemnity benefits due and owing, plus interest and/or;
   
   2. Attorney’s fees and interest for securing payment of all medical expenses not timely made.

B. A reasonable controversy is;
   
   1. The existence of any reasonable factual dispute that, if proven true, would absolve the employer or insurance carrier of liability, or;
   
   2. Any unanswered question of law which bears on the outcome of compensability.

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Q: When has an “accident” occurred for purposes of compensation under the Workers’ Compensation Act?

A: The phrase “suddenly and violently” as used in definition of “accident” under the Workers’ Compensation Act, does not mean “instantaneously with force,” but, rather, requires only that the injury manifest at an identifiable point in time. The identifiable point in time at which a repetitive trauma injury manifests is when there is a sudden result, characterized by an employee’s discontinuing employment and seeking medical treatment, or when there is a sudden cause, such as a brief exposure to toxic fumes.

In Potter v. McCulla, the claimant worked as a dental hygienist and suffered a repetitive trauma injury to her neck arising out of her employment. The Workers’ Compensation Court determined that the date of injury was the date on which she first missed work due to her pain, even though she had previously sought medical treatment. The Court held that although the Claimant may have experienced pain associated with her employment and sought medical treatment for that pain, no disability had manifested until there was a diminution of employability. This diminution can reasonably be said to occur when the injury interferes with the Claimant’s ability to do their job.


Q: Does a higher appellate court reweigh factual determinations of the Workers’ Compensation Court?

A: No. In determining whether to affirm, modify, reverse, or set aside a judgment of the Workers’ Compensation Court review panel, a higher appellate court reviews the findings of the trial judge who conducted the original hearing. The findings of fact of the trial judge will not be disturbed on appeal unless clearly wrong. Determining causation of an injury or disability is an example of an issue of fact in a Workers’ Compensation case.


Q: Will an injured employee be reimbursed for nursing care in the employee’s home or at a nursing home?

A: It depends. If the care is necessitated by a work-related injury, the costs generally will be awarded so long as the cost of the care is fair and reasonable. For compensability of in-
home care to an injured worker, the Court’s focus is on the nature of the service provided, not the status or devotion of the provider of the service.

In Simmons v. Precast Haulers Inc., the Claimant’s spouse provided nursing services to the Claimant. The Court held that the Claimant’s spouse was providing the same services that an “on-call,” paid third-party nurse would have, thus the fact that the spouse lived in the home was irrelevant. The fact that the spouse was able to sleep or perform household tasks during “on-call” time was irrelevant because if the employer provided services of an outside professional, that professional would be entitled to pursue his or her own interests during such “on-call” periods without diminution of compensation.


COURT OF APPEALS OF NEBRASKA

Q: When a Claimant suffers multiple injuries, when will they be found to have reached maximum medical improvement?

A: When all of Claimant’s injuries resulting from an accident have reached maximum medical healing. In Canas-Luong v. Americold Realty Trust, the Claimant suffered both physical and psychological injuries as a result of an accident that occurred during the course of employment. While the Claimant had reached maximum medical improvement with respect to the physical injuries to her body, she had not reached maximum medical improvement for her psychological injuries. The Court found that it must wait to award permanent disability benefits until after the Claimant reached maximum medical improvement for all of her disabilities.


Q: Will a Claimant’s per diem be included when calculating average weekly wage?

A: It depends. The Nebraska Supreme Court previously concluded that allowances made to an employee for board, lodging or similar advances, although the money value of such advantages may be fixed by the parties at the time of hiring, must constitute a real and reasonably definite economic gain to the employee before they can be considered wages.

In Fayle v. Thiesen, the Nebraska Court of Appeals held that the Claimant did not meet his burden of proving that his per diem constituted a real and definite economic gain. While the claimant was paid per diem on a weekly basis, the amounts fluctuated and did not correspond with how many days or hours the Claimant worked in a particular week. Because of this, Claimant’s per diem was not included in the calculation of his average weekly wage.
Q: Can the higher appellate courts reweigh the credibility determination of a doctor’s testimony?

A: No. The Compensation Court is the sole judge of the credibility of witnesses and the weight to be given to their testimony.


Q: Can a Claimant who has reached maximum medical improvement simultaneously be approved for further treatment?

A: No. In Kelsey v. Sandy Pine Systems, the Compensation Court found that the Claimant had reached maximum medical improvement for his injuries, yet approved the Claimant for shoulder surgery. The Nebraska Court of Appeals found this to be an inconsistent finding because the basis of indicating the Claimant has reached maximum medical improvement is that the employee has reached the point when his or her medical condition will not further improve. Therefore, the Court may not award permanent disability and also approve further treatment.

Likewise, in Adamson v. Horizon West Inc., the Compensation Court found that the Claimant had reached maximum medical improvement for his psychological injury while also ordering continuing psychological treatment. The Nebraska Court of Appeals reversed the decision of the lower court stating that a Claimant has not reached maximum medical improvement until all the injuries have reached maximum healing. Because there was insufficient evidence to support a finding that the Claimant had reached maximum healing for his psychological conditions, the Compensation Court erred in stating that claimant had reached maximum medical improvement.


Q: When can the Court modify an award?

A: In order to obtain a modification of an award, an applicant must prove that the increase or decrease in capacity was due solely to the injury resulting from the original accident. The applicant must prove there is a material and substantial change for the better or worse in the condition. If medical testimony is the basis for an award, it must be sufficiently definite and certain that a conclusion can be drawn that there was a causal connection between the accident and the disability.
In *Williams v. EGS*, the Claimant originally injured his foot, resulting in a permanent partial disability. The Claimant sought a modification of the award when he allegedly fell due to his injured foot and subsequently injured his shoulder. The medical opinion stated that the Claimant’s previous injuries *more than likely* contributed to an increase in incapacity. The Court of Appeals of Nebraska held that this did not justify modifying the award because it did not establish that his increase in incapacity was solely due to his original injuries.


**Q:** Will incarceration after sustaining a compensable injury bar the Claimant’s receipt of disability benefits?

**A:** No. Unless there is a Workers’ compensation statute that provides so, the employer/insurer may not discontinue benefits solely because the Claimant is incarcerated.


**Q:** What does the Court consider when determining whether the Claimant has sustained diminished employability or impaired earning capacity?

**A:** A Workers’ Compensation Court must generally determine two issues. First, that the employee can no longer earn wages doing the same kind of work for which he or she was trained or accustomed to performing. Second, that the employee lacks the skills needed to perform other work that is within the employee’s physical limitations and for which a stable market exists. Both temporary and permanent disability benefits are awarded for diminished employability or impaired earning capacity and do not depend on a finding that the claimant cannot be placed with the same employer or a different one.


**Q:** When will an expert’s testimony be admissible in a Workers’ Compensation Case?

**A:** In order for an expert’s testimony to be admissible the witness must qualify as an expert, the testimony must assist the trier of fact to understand the evidence or determine a fact in issue, the witness must have a factual basis for the opinion and the testimony must be relevant.

Q: When will the Court award future medical expenses?

A: In order for the Court to award future medical expenses, there must be evidence in the record to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the Claimant’s injury. In Santos Saravia v. Foods, the Court of Appeals of Nebraska reversed the decision of the trial court awarding future medical care. In this case, the Claimant did not testify as to any ongoing or future medical care in regard to his injury, nor did he present any evidence about a need for future medical care. Because of this, the Court of Appeals held that the trial court erred in awarding future medical expenses.

Similarly, in Gittins v. Windstream Corporation, the Court of Appeals of Nebraska reversed the decision of the Compensation Court’s order awarding future medical care. In this case, the authorized physician determined that the Claimant had reached maximum medical improvement and that it was not likely he would need any form of future medical care. However, Claimant unilaterally sought treatment from another, unauthorized physician. Because the Claimant sought his own medical care, and was not referred to this physician by his authorized doctor, the Court of Appeals held that the Claimant was not entitled to future medical expenses based on Claimant seeking his own care.


Q: What does the Compensation Court have to do in order to comply with Rule 11(A) of the Workers’ Compensation Court?

A: Rule 11(A) requires the Workers’ Compensation Court to write decisions that “provide the basis for a meaningful appellate review.” The judge must “specify the evidence upon which the judge relies” in order to provide a reasoned opinion. In Wildman v. George Witt Service, Inc. the Court of Appeals of Nebraska held that the Compensation Court failed to comply with Rule 11(A) because the Court did not discuss an issue clearly raised about the Claimant’s conduct. Because the Court never mentioned the issue in its decision, there was no way to determine if the Court considered the issue, or forgot to address the issue at all. The Compensation Court is obligated to present a decision from which the Court of Appeals can ascertain its rulings and the basis so it may effectively review them. Because the Compensation Court did not clearly include it’s consideration of the matter, the Court did not comply with Rule 11(A).


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I. JURISDICTION
   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 received benefits in another state for said injury and the claim was
prosecuted to final determination in said state.

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 caused as a result of 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 and the
employee shall have completed at least 180 days of continuous active
employment.

III. NOTICE - (85A O.S. §§ 67-68):
   A. Cumulative Trauma and Occupational Disease Notice:
1. Written notice must be given to the employer of occupational disease or cumulative trauma by the employee within six months after first distinct manifestation of disease or cumulative trauma or within six months after death.

B. Single Event Notice:
   1. Unless an employee gives oral or written notice to the employer within 30 days of the date the injury occurs, there will be a rebuttable presumption that the injury is not work related.

C. Rebuttable Presumption:
   1. Unless an employee gives oral or written notice to the employer within 30 days of the employee’s separation from employment, there is a rebuttable presumption that the occupational disease or cumulative trauma did not arise out of or in the course of the employment.

IV. EMPLOYER’S NOTICE TO THE COMMISSION (85A O.S. § 63):
   A. Within ten days of the date of receipt of notice or ACTUAL 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

VII. MEDICAL TREATMENT - (85A O.S. § 50):
   A. The employer has the right to choose the treating physician.
   B. If the employer fails or neglects to provide medical treatment within five days after actual knowledge is received of the injury, the employee may select the treating physician at the expense of the employer.
   C. Diagnostic testing shall not be performed shorter than six months from the date of the last test without good cause shown.
D. Unless recommended by a treating physician or an independent medical examiner, continued medical maintenance should not be awarded by the Commission.

E. An employee claiming benefits under this Act shall submit him/herself to medical examination, otherwise rights and benefits shall be suspended.

F. Mileage is reimbursed to the claimant for mileage in excess of 20 miles not to exceed 600 miles.

G. Payment for medical care as required by this Act is due within 45 days of receipt by the employer or insurance carrier of a completed and accurate invoice unless there is a good faith reason to request additional information. Thereafter, the Commission may assess a penalty of up to 25% of any amount due under the fee schedule that remains unpaid on the finding by Commission that no good faith existed for the delay. A pattern of willfully and knowingly delaying payments can result in a civil penalty of not more than $5,000.00.

H. If an employee misses a scheduled appointment with a physician, the employer's insurance company shall pay the physician a reasonable charge determined by the Commission for the missed appointment. In absence of a good faith reason for missing the appointment, the Commission shall have the employee reimburse the employer and insurance carrier.

VIII. VOCATIONAL REHABILITATION – (85A O.S. § 45):

A. An injured employee who is eligible for permanent partial disability under this section is entitled to receive vocational rehabilitation services. Vocational rehabilitation services and training shall not exceed a period of 52 weeks.

B. On application of either party or by order of an ALJ the Vocational Rehabilitation Director shall assist the Commission to determine if a claimant is appropriate to receive vocational rehabilitation services. If appropriate, the ALJ can refer the employee for an evaluation. The cost of evaluation shall be paid by the employer. If following the evaluation, the employee refuses services, or training ordered by the ALJ or fails to make a good faith attempt in vocational rehabilitation, the cost of the evaluation and services or training may, in the discretion of the ALJ, be deducted from any remaining PPD award.

C. Request for vocational services must be filed within 60 days of permanent restrictions.

D. If retraining requires residence away from employee’s residence, reasonable room, board, tuition and books shall be paid.

E. If the employee is actively and in good faith participating in a retraining program to determine permanent total disability, he may be entitled to 52 weeks of temporary total disability benefits, plus all tuition and vocational services. The employer or employer’s insurance carrier may deduct the amount paid in tuition from compensation awarded to the employee.
IX. AVERAGE WEEKLY WAGE – (85A O.S. 59):
A. Average weekly wage is determined by dividing the gross wages by the number of weeks of employment for maximum of 52 weeks.
B. If an injured employee works for wages by the job, the average weekly wage is determined by dividing the earnings of the employee by the number of hours required to earn the wage, then multiplying the hourly rate by the number of hours in a full time work week for employment.

X. DISABILITY BENEFITS
A. Temporary Total Disability (85A O.S. § 45):
1. 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.
2. Maximum TTD is 104 weeks.
3. TTD is not paid for the first three days of the initial period of TTD.
4. 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.
5. If the employee is released by the treating physician for all body parts, misses three consecutive medical treatment appointments without valid excuse, fails to comply with medical orders of the treating physician or abandons care, the employer may terminate TTD by giving notice to the employee or their counsel.
6. If employee objects to determination of TTD, the Commission shall set a hearing within 20 days to determine if TTD should be reinstated.

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.

C. Permanent Partial Disability (85A O.S. § 45-46):
1. Permanent Partial Disability may not exceed 100% to the body part or body as a whole. (The language indicating that surgical body parts are not included is no longer in the Workers’ Compensation Act)
2. A physician’s opinion of the nature and extent of permanent partial disability benefits to parts of the body other than scheduled members, must be based solely on criteria established under the current 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 $323.00 per week.

5. Maximum permanent disability is 350 weeks to the body as a whole, a reduction from the previous 500 weeks.

6. Except for settlements, payment of permanent disability shall be deferred and held in reserve by the employer or insurance carrier if the employee has reached maximum medical improvement and is released to return to work by the treating physician and then returns to work at the pre-injury or equivalent job for a term of weeks determined by dividing the dollar amount by 70% of the employees average weekly wage.

7. If for any reason the employer terminates the employee, other than for misconduct as defined in Section 2, the remaining permanent partial disability shall be paid in a lump sum.
   a. If the employee is discharged for misconduct, the employer has the burden to prove the employee engaged in misconduct.

8. If an employee refuses an offer to return to the pre-injury equivalent job, the PPD shall be deferred for each week of refusal.

9. Attorney fees for permanent disability shall be paid in full at the time of the deferral.

10. The employer shall receive credit for pre-existing apportionment. Apportionment does not apply to TTD or medical treatment. If the pre-existing impairment is the result of an injury sustained while working for the employer for whom workers’ compensation benefits are currently being sought, any award of compensation shall be reduced by the current dollar value attributed under the Administrative Workers’ Compensation Act to the percentage of permanent partial impairment determined to be pre-existing.

11. An employee cannot receive payment on two permanent partial disability orders at the same time.

12. 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.

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 death did not result from the injury.

B. A common-law spouse shall not obtain benefits under this section unless there is an order from a court of competent jurisdiction ruling a common-law marriage existed between the decedent and surviving spouse.

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 is children but no surviving spouse, each child $25,000.00 and 50% of the average weekly wage 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 of by technical or formal rules of procedure except provided by this act.

2. Hearings to be Public – Records.
   a. Hearings before the Commission shall be open to the public and shall be stenographically reported. The Commission is authorized to contract for the reporting of the hearings.
   b. The Commission shall, by rule, provide for the preparation of a record of all hearings and other proceedings before it.
   c. The Commission shall not be required to stenographically report or prepare a record of joint petition hearings.
   d. All oral and documentary evidence shall be presented to the ALJ during the initial hearing on a controverted claim. Medical reports shall be furnished to opposing party at least 7 days prior to the hearing. Witness shall be exchanged 7 days prior to hearing.
   e. Expert testimony should not be allowed unless it satisfies the requirements of Federal Rules of Evidence 702.

B. Workers’ Compensation Commission Powers (85A O.S. § 73):

1. The Commission shall have the power to preserve and enforce order during, or proceeding before it, issue subpoenas, administer oaths and compel attendance and testimony as well as production of documents. Any person or party failing to take the oath, attend, produce documents or comply with final judgment of Administrative Law Judge or Commission or willfully refuses to pay uncontroverted medical or related expenses within 45 days can be held in contempt and fined up to $10,000.00.
C. Appeals (85A O.S. § 78):
   1. Any party feeling aggrieved by a judgment decision or award made by Administrative Law Judge may within 10 days of issuance appeal to the Workers’ Compensation Commission. The Commission may reverse, modify or affirm the decision that was against the clear weight of evidence or contrary to law.
   2. The judgment decision or award of the Commission shall be final and conclusive on all questions within its jurisdiction between the parties unless an action is commenced with the Supreme Court within 20 days of the award or decision.

D. Certification to District Court (85A O.S. § 79):
   1. If an employee fails to comply with final compensation judgment or award, any beneficiary may file a certified copy of the judgment or award in the office of the district court of any county in this state where any property of the employer may be found.

E. Workers’ Compensation Commission – Limited Review of Compensation Judgment (85A O.S. § 80):
   1. Except in the case of joint petition settlement, the Commission may review a compensation judgment, award or decision any time within six months of termination of the compensation fixed in the original compensation judgment or award on the Commission’s own motion or application of either party, on the ground of a change of physical condition or on proof of erroneous wage rate. On review, the Commission may make judgment or award terminating, continuing, decreasing or increasing the compensation previously awarded subject to the maximum limits provided for this in Act.

XIV. DEFENSES

A. “Course and scope of employment” (85A O.S. §2(13)): Injury must derive from an activity of any kind or character for which the employee was hired and that relates to and derives from the work, business, trade or profession of an employer, and is performed by an employee in the furtherance of the affairs or business of an employer. The term includes activities conducted on the premises of an employer or at other locations designated by an employer and travel by an employee in furtherance of the affairs of an employer that is specifically directed by the employer. This term does not include:
   1. An employee’s transportation to and from his or her place of employment,
   2. Travel by an employee in furtherance of the affairs of an employer if the travel is also in furtherance of personal or private affairs of the employee,
   3. Any injury occurring in a parking lot or other common area adjacent to an employer’s place of business before the employee clocks in or otherwise begins work for the employer or after the employee clocks out or otherwise stops work for the employer, 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 and the work break is authorized by the employee'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)).

1. If, within twenty-four (24) hours of being injured or reporting an injury, an 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)),

G. Preexisting condition - except when the treating physician clearly confirms an identifiable and significant aggravation incurred in the course and scope of employment (85A O.S. §2(9)(b)(6)).

H. Mental Injury or Illness (85A O.S. § 13):

1. A mental injury or illness is not a compensable injury unless caused by a physical injury to the employee, and shall not be considered an injury arising out of and in the course and scope of employment or compensable unless demonstrated by a preponderance of the evidence

   a. Physical injury limitation shall not apply to any victim of a crime of violence.
2. No mental injury or illness under this section shall be compensable unless it is also diagnosed by a licensed psychiatrist or psychologist and unless the diagnosis of the condition meets the criteria established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders.

3. Where a claim is for mental injury or illness, the employee shall be limited to twenty-six (26) weeks of disability benefits unless it is shown by clear and convincing evidence that benefits should continue for a set period of time, not to exceed a total of fifty-two (52) weeks.

4. In cases where death results directly from the mental injury or illness within a period of one (1) year, compensation shall be paid the dependents as provided in other death cases under this act.
   a. Death directly or indirectly related to the mental injury or illness occurring one (1) year or more from the incident resulting in the mental injury or illness shall not be a compensable injury.

I. Heart claims (85A O.S. § 14):

1. A cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death is a compensable injury only if, in relation to other factors contributing to the physical harm, the course and scope of employment was the major cause.

2. An injury or disease included in subsection A of this section shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the employee's usual work in the course of the employee's regular employment, or that some unusual and unpredicted incident occurred which is found to have been the major cause of the physical harm.
   a. Physical or mental stress shall not be considered in determining whether the employee or claimant has met his or her burden of proof.

J. Notice - (85A O.S. § 67-68)

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. If during the one year following the filing of the claim, the employee receives no weekly compensation or medical treatment from the alleged injury, the claim shall be barred thereafter.

2. 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.

3. A claim for compensation for disability on account of silicosis or asbestosis shall be filed with the Commission one year after the time of disablement and the disablement shall occur within three years from the last date of injurious exposure.

4. A claim for compensation for death benefits shall be barred unless it is filed within two years from the date of death.
5. If within six months after filing a claim no bonafide request for a hearing has been made, the Court may on a motion or after hearing dismiss the claim with prejudice.

6. Time for filing additional compensation shall be one year from the last payment of disability compensation or two years from the date of injury whichever is greater. (It is unclear what additional compensation may mean.)

7. Replacement of medical supplies or prosthetics shall not toll the statute of limitations.
Q. Can non adopted stepsons receive dependent death benefits?

A. Maybe; Dependents must prove actual dependency at time of employee’s death. Claimant Carol Ann Taylor (spouse of decedent) challenges an order of a three-judge panel of the Workers’ Compensation Court affirming the trial court’s finding that her 2 minor children, non-adopted stepsons of Decedent, were not entitled to death benefits as dependents.

The Court of Civil Appeals of the State of Oklahoma sustained the order of the workers’ compensation court and found that the Decedent’s stepsons are not entitled to an award of weekly income death benefits. Pursuant to the law in effect at time of Decedent’s death, the stepsons were entitled to weekly income benefits only on proof of actual dependency. Title 85 O.S. 2011 §337(A). Because the date that Decedent had stopped providing support for the stepsons falls outside of the one-year timeframe for determining dependency under the Falcon Drilling test, Decedent’s stepsons are not entitled to an award of weekly income death benefits pursuant to 85 O.S. 2011 §337.

Carol Ann Taylor v. Davis Pipe Testing, 2015 OK CIV APP 11

Q. If surgery is later recommended is a Claimant entitled to back TTD beyond initial TTD limitations?

A. Yes in cases where the injuries are not considered “nonsurgical soft tissue.” Claimant Tom Franklin Weldon challenges an order of a three-judge panel of the Workers’ Compensation Court denying Claimant’s request for pre-surgery, temporary total disability in excess of 24 weeks.

The Court of Civil Appeals of the State of Oklahoma vacated and remanded the workers’ compensation trial court order and found that Claimant’s injury is not of a type that is subject to either the 8-week or the 16-week temporary total disability limit for “nonsurgical soft tissue” in 85 O.S. Supp. 2009 §22(3)(d). Nothing in the record or the parties’ briefs indicates that the parties stipulated, or that the workers’ compensation court found, that Claimant’s injury was, at any point, a soft tissue injury. Further, no finding was made by the lower tribunal that Claimant’s injury resulted from “cumulative trauma”. Therefore, under 85 O.S. Supp. 2009 §22(3)(d) and Bonant, Claimant’s injury is by definition not a “soft tissue injury” and is controlled by the time limitations of §22(2)(c) allowing TTD benefits up to a “maximum of 156 weeks in the aggregate”.

Tom Franklin Weldon v. Flex-N-Gate, 2015 OK CIV APP 14
Q. **Is the Court required to view surveillance video/evidence in open court?**

A. No. Employer LMR Oil, LLC challenges an order of the Workers’ Compensation Court determining compensability and awarding temporary total disability benefits to Claimant Jennifer Frazier. Specifically, Employer argues that the trial court’s order is contrary to the weight of the evidence, that the trial court improperly shifted the burden of proof to Employer, and that the trial court violated Employer’s due process rights by refusing to play a surveillance video in open court, by advocating on behalf of Claimant, and by prejudging the claim before reviewing the evidence.

The Court of Civil Appeals of the State of Oklahoma sustained the workers’ compensation court order, with the exception to its decision regarding the cause of Claimant’s termination from employment, and found that the trial court’s decision regarding compensability and TTD are not contrary to the weight of evidence and the court did not improperly shift the burden of proof to employer. The Court further found that the employer failed to show that its rights were violated by the trial court’s decision not to view the surveillance video in open court, or that the trial court unfairly advocated on behalf of Claimant or otherwise prejudged the evidence. However, the Court held that the trial court’s finding that Claimant was not terminated for cause cannot be upheld because that issue was not before the Court.

Employer has filed writ of certiorari to the Oklahoma Supreme Court.

[LMR Oil, LLC. v. Jennifer Frazier, OK Supreme Court, 111,930](#)

Q. **Are injuries from parking lot falls compensable? Is walking into work from lunch an essential job function?**

A. Yes according to the Oklahoma Court of Civil Appeals, Division IV but likely no according to other divisions.

Claimant Mary Ewy challenges an order of a three-judge panel of the Workers’ Compensation Court affirming the order of the trial court’s denial of Claimant’s compensation claim on the basis that Claimant’s injury occurred in an area where essential job functions are not performed. Claimant Ewy was returning from lunch break when she fell on a sidewalk walking into the building. She sustained injuries. Claimant voluntarily left for lunch.

The Court of Civil Appeals of the State of Oklahoma vacated the order of the workers’ compensation court and found that, under the second exclusion in 85 O.S. 2011 §312(6) providing that injuries occurring in areas where essential job functions are not performed are not compensable because outside the course of employment, Claimant’s activities were related to her needs to eat and drink which are sufficiently related to her employment, even if indirectly. Further, Claimant’s ministration to these needs occurred during the time allotted by employer and her injury occurred while rightfully on the sole
sidewalk to the front door of Employer’s building. Therefore, the time, place, and circumstances of the accidental injury reveal that it occurred in the course of Claimant’s employment.

In 2011 the law changed regarding parking lot cases. Title 85 Section 312, Paragraph 6, “Employment shall be deemed to commence when an employee arrives at the employee’s place of employment to report for work and shall terminate when the employee leaves the employee’s place of employment, excluding areas not under the control of the employer or areas where essential job functions are not performed;”. As defense attorneys, we have had some success in denying parking lot cases as generally parking lots are not where essential job functions are performed. In Leandro v. American Staff Corp., 2013 OK CIV APP 68, the Court denied injury sustained in a fall in a parking lot on a break as the parking lot was not where essential job functions were performed. Subsequently, a different division of the Court of Civil Appeals upheld an injury occurring in a parking lot in Carney v. Direct TV Group, Inc., 2014 OK CIV APP 4. In that case, there are now three parking cases from the Court of Civil Appeals finding differently. This issue is ripe for the Supreme Court review.

Mary Ewy v. Southwest Cupid, 2015 OK CIV APP 37

**Q. Is a slip and fall injury occurring while on break in a common area of a building not owed by the Employer compensable?**

A. No. According to Oklahoma Court of Civil Appeals, Division 1. Claimant Amanda Carroll challenges an order of the Workers’ Compensation Court of Existing Claims finding that Claimant did not sustain a compensable injury when Claimant fell in a puddle of water in a building where employer’s office was located while on a break but was in a common area not owned or maintained by the employer.

The Court of Civil Appeals of the State of Oklahoma sustained the trial court’s order and found that its decision was not against the clear weight of evidence. Pursuant to 85 O.S. 2011 §312(6), an injury occurring in an area not under the control of the employer or where essential job functions are not performed is not compensable because they did not arise out of and in course of employment.

Amanda Carroll v. Capitol One Auto Finance, 2015 OK CIV APP 27

**Q. Is a commutation order a “last order” for calculation of statute of limitation to request reopen due to change of condition for the worse?**

A. Yes. Employer AMS Staff Leasing Inc. challenges an order of the workers’ compensation court granting Claimant’s request to commute to a lump sum a portion of his disability award and whether this order extended the statutorily established period of time within which Claimant could seek to reopen his claim.
The Court of Civil Appeals of the State of Oklahoma sustained the workers’ compensation court’s order and found that the order qualifies as a “last order” that triggered the running of a 3-year statutory period within which Claimant’s request to reopen his claim could be filed.

AMS Staff Leasing Inc. v. DJ Thompson Court, 2015 OK CIV APP 15

Q. Can the Oklahoma Treatment and Official Disability Guidelines be applied retroactively?

A. No. Claimant challenged an order of the Workers’ Compensation Court of Existing Claims that retroactively applied 85 O.S. 2011 §326(G) and the statutorily incorporated guidelines to employee’s previous award for medical treatment that predated §326.

The Supreme Court of Oklahoma vacated and remanded the Workers’ Compensation Court of Existing Claim’s order and found that the Claimant’s right under a former statute to necessary medical treatment that became a court award prior to the effective date of both 85 O.S. 2011 §326(G) and its incorporated guidelines could not be extinguished by a retroactive application of the statute/guidelines to the Claimant without violating Art. V §54, Okla. Const. which provides that “the repeal of a statute shall not…affect any accrued right…by virtue of such repealed statute.”

Barbara Shepard v. The Oklahoma Department of Corrections, 2015 OK 8

Q. Does the Oklahoma Workers’ Compensation Commission have the authority to review/hear appeals from the Court of Existing Claims?

A. No. Application for Original Jurisdiction to challenge seven provisions of 85A which gave the Workers’ Compensation Commission (Commission) authority to hear appeals from the Court of Existing Claims (CEC) and exert administrative authority over the CEC.

On April 17, 2014, a unanimous Supreme Court granted Original Jurisdiction and opined that “All aspects of the adjudication of claims for injuries occurring prior to February 1, 2014,” shall be vested in the CEC. The Commission was prohibited from reviewing any CEC orders. The effect of the decision created two separate workers’ compensation systems in Oklahoma—one for injuries occurring before February 1, 2014, and another for new law claims occurring on or after that date.

Carlock v. Workers’ Compensation Commission, 2014 OK 29
Q. Is the Oklahoma Workers’ Compensation Commission required to provide court reporters for hearings before the Administrative Law Judges and the Commission en Banc?

A. Yes. Application for Original Jurisdiction and Petitions for Writ of Mandamus and Prohibition to require the Commission to provide court reporters for the reporting of hearings before the administrative law judges and the Commission en Banc. On November 17, 2014, the Supreme Court voted 7-2 to assume Original Jurisdiction and grant the Writs of Mandamus and Prohibition. The effect of the decision was to order the Commission to provide a court reporter to report all hearings and prohibit the Commission from providing only an audio recording in lieu of a court reporter.

Williams v. Workers’ Compensation Commission, 2014 OK 98

Q. Are infections and communicable disease injuries which are contracted in a hospital or sanitarium compensable under Title 85A?

A. Yes. The appeal challenges the constitutionality of Section 65(D)(2) which restricts compensability for infectious and communicable diseases to cases in which the disease is contracted in a hospital or sanitarium that treats such disease. The case challenges the grant of exclusive remedy, Section 5(C), even if there is no remedy available in Title 85A. The appeal argues that this provision is a “special law” and is unconstitutional because it provides disparate treatment of members of a single class.

This case has been settled. Petitioner has dismissed the appeal because the legislature corrected the glaring problem of making many claims for police, fire, and emergency personnel not compensable. SB 776 has been signed into law and returns to the old law definition of compensability. An infectious or communicable disease will be compensable in Oklahoma if it “arises out of employment.”

Deason v. Integris Baptist Medical Center, Supreme Court No. 113,648

Q. Does the AMA guides, 6th edition apply to scheduled members?

A. No. Claimant suffered an admitted compensable injury to his right eye. Claimant sought a finding of compensability; continuing medical maintenance; and permanent partial disability benefits for loss of right eye based on 85 O.S., §46(E). Further, Claimant argued that in the event payment of partial disability awarded is deferred pursuant to 85A O.S., §45(C)(5), deferral is unconstitutional because it constitutes an impermissible special law, denies the Claimant an adequate remedy, and offends due process of law and equal protection of the laws. Insurer admitted liability for the compensable right eye but argued an award of permanent partial disability for loss of the eye based on 85A O.S., §46(E) was improper, and, instead, should be for partial loss of vision based on the American Medical Association’s Guides to the Evaluation of Permanent Impairment,
6th Edition. Insurer also requests payment of the permanent partial disability award be deferred pursuant to 85A O.S., §45(C)(5) and further argued against the constitutional concerns raised by the Claimant.

The Oklahoma Workers' Compensation Commission found that Claimant sustained an admitted compensable injury to her right eye; that Claimant has proven by a preponderance of the evidence that he has a total loss of use in the right eye and that an award of permanent partial disability was proper; that the eye is defined as a scheduled member in 85A O.S., §2(40) and as such is specifically exempt from the requirements of evaluation under the AMA Guides; that Insurer’s request that payment of the permanent partial disability award for the right eye injury be deferred pursuant to 85A O.S., §45(C)(5) is denied; that Claimant has established by a preponderance of the evidence his entitlement to continuing medical maintenance; that Claimant’s request for lifetime continuing medical maintenance is denied; that Claimant has failed to establish by a preponderance of the evidence that he sustained a compensable consequential injury to the left eye, psychological overlay, or the trigeminal nerve; and that the Workers’ Compensation Commission is an administrative agency rather than a court and is without power to decide the Claimant’s arguments that provisions of the Administrative Workers’ Compensation Act are unconstitutional.


Oklahoma Workers Compensation Commission Decision

Q. Can the Workers’ Compensation Commission deliberate on appeals outside of public meeting or hearing?

A. No. Chairman Troy L. Wilson of the Workers’ Compensation Commission raised 3 questions relating to the ability of the Commission to confidentially deliberation during appeal proceedings outside the presence of the parties and the public in executive session or outside of a public meeting:

(1) If the Workers’ Compensation Commission, in hearing appeals from judgments, decisions, or awards made by administrative law judges, arbitrators or appeals committees, is not subject to Article II of the Administrative Procedures Act (APA) governing individual proceedings, may the Commission lawfully enter into executive session under the Open Meeting Act to deliberate in order to render decisions on the appeals brought before them?

(2) If the Commission is not permitted to enter into executive session under the Open Meeting Act, is the Commission permitted to deliberate regarding the appeals by virtue of the deliberative process privilege?

(3) If the Commission is not permitted to deliberate outside of a public meeting under the Open Meeting Act or under the deliberative process privilege, is there
another statutory provision or privilege permitting the Commission to maintain the confidentiality of the deliberation process?

The Attorney General opined that the statutes in question are clear in their meaning: Public bodies are permitted to engage in deliberations in an executive session for purposes on an individual proceeding, under both the APA and the Open Meeting Act, only when used in conjunction with the procedures found in Article II of the APA. Explicitly exempting the Commission from Article II of the APA, the Legislature removed the Commission’s ability to confidentially deliberate under this provision. This also excluded the Commission from using the Open Meeting Act to engage in deliberations in executive sessions. There are no other statutory provisions or privileges which are directly applicable to the Commission that would authorize it to hold confidential deliberations. The Open Meeting Act intended to restrict the ability of agencies to confidentially deliberate. The clear statutory language controls the analysis and the Attorney General deferred to the Legislature’s determination that the public’s interest is better served by the Commission holding its deliberations in an open meeting.

Attorney General Opinion 2014-14

PENDING APPEALS

Q. Is exclusive remedy dead in claims under the Oklahoma Workers’ Compensation Commission?

A. Claimant filed negligence action in District Court. Employer filed to dismiss said action. The District Court denied motion to dismiss since Title 85A (Workers’ Compensation) requires an injury to be unforeseen therefore the Employer cannot claim exclusive remedy before the Workers’ Compensation Commission as there potentially no remedy available.

The Oklahoma Supreme Court has granted certiorari and the appeal is pending.

Duck v. Morgan Tire – pending before the Oklahoma Supreme Court

Q. Does the Oklahoma Workers’ Compensation Commission have the authority to hear retaliatory discharge or discrimination claims arising under the Title 85A?

A. Application for Original Jurisdiction to determine constitutionality of 85A O.S. § 7 which gives Commission authority to hear retaliatory discharge or discrimination claims arising under the AWCA. The Court will decide whether such claims will continue to be heard in district court or before the Workers’ Compensation Commission, with direct appeal to the Supreme Court.
The Supreme Court accepted Original Jurisdiction but recast the Original Jurisdiction Application as an Appeal. The case is fully briefed and submitted.

Young v. Station 27, Inc., Supreme Court No. 113,334 Decision Pending

Q. Is the 180 days minimum employment with an Employer provision to allege cumulative trauma valid?

A. The appeal challenges the constitutionality of Section 2(14) which excludes a claim for cumulative trauma unless an employee works for an employer a minimum of 180 days continuously. The appeal challenges this provision as a “special law.” In addition the appeal challenges the exclusive remedy under Title 85A when there is remedy available.

The case is fully briefed and submitted. Decision Pending. Senate and House have until June 29 to submit briefs in regard to the constitutionality of the challenged section and the entire law.

Torres v. Seaboard Foods, Supreme Court No. 113,649

Q. Does the definition of compensable injury under Title 85A include idiopathic injury is not specifically included in the definitions?

A. The appeal challenges the ALJ’s interpretation of Section 2(9)’s definition of a “compensable injury” to include an idiopathic injury. The term idiopathic is not included in the new law. The appeal argues that this provision is a “special law” and is unconstitutional because it provides disparate treatment of members of a single class.

The exclusive remedy is also challenged.

Mullendore v. Mercy Hospital Ardmore, Supreme Court No. 113,560 Decision Pending

Q. Are injuries occurring on the parking lot during lunch break compensable?

A. The appeal challenges the constitutionality of Section 2(13) which excludes injuries that occur in a parking lot during a lunch break. The case will decide if ingress and egress to a worker’s work station, especially on Employer’s property, is an integral part of the employment. In addition this case challenges the grant of exclusive remedy, Section 5(C), even if there is no remedy available in Title 85A. The appeal argues that this
provision is a “special law” and is unconstitutional because it provides disparate treatment of members of a single class.

Robinson v. Fairview Fellowship Home, Supreme Court No. 113,735
The case is fully briefed and submitted. Decision Pending

Q. Are injuries occurring in common areas compensable?

A. The appeal challenges the constitutionality of Section 2(13)(c) which excludes injuries that occur in a common area. Claimant slipped in the stairwell leaving his work station on the second floor on his way to an employer-controlled parking lot. The case will decide if ingress and egress to a worker’s work station, especially on Employer’s property, is an integral part of the employment.

This case also challenges the grant of exclusive remedy, Section 5(C), even if there is no remedy available in Title 85A. The appeal argues that this provision is a “special law” and is unconstitutional because it provides disparate treatment of members of a single class.

Brown v. Claims Management Resources, Supreme Court No. 113,609
The case is fully briefed and submitted. Decision Pending

Q. Is an injury occurring on an authorized break but outside the employer’s facility compensable?

A. This appeal challenges the constitutionality of Section 2(13)(d) which allows compensability of an injury that occurs on an authorized break ONLY if the injury occurs “inside employer’s facility.” In this case, Claimant worked at a non-smoking nursing home and was on an authorized smoking break on Employer’s sidewalk outside Employer’s building at the time of the injury. The case will decide if ingress and egress to a worker’s work station, especially on Employer’s property, is an integral part of the employment. This case also challenges the grant of exclusive remedy, Section 5(C), even if there is no remedy available in Title 85A. In addition, the appeal argues that this provision is a “special law” and is unconstitutional because it provides disparate treatment of members of a single class.

Nowlin v. Medicalodges, Inc., Supreme Court No. 113,607
The case is fully briefed and submitted. Decision Pending

Q. May an opt out plan under the Oklahoma Injury Benefit Act have stricter reporting timelines than those under Title 85A?
A. The district court action is a comprehensive constitutional challenge of OPT OUT, the Oklahoma Injury Benefit Act. The Plaintiff, whose claim was denied because she failed to report the injury within 24 hours to a toll-free number, requests the Court to prohibit the Insurance Commissioner from approving additional OPT OUT plans unless they provide reasonably similar benefits in dollar amount, percentage, and duration. A hearing on Doak’s Motion to Dismiss is set for July 31 before Oklahoma County District Judge Roger Stuart.

Jenkins v. Doak, Oklahoma County District Court No. CV-2015-784

Q. Can compensability be denied when Employer pays mileage to and from work for a special mission?

A. Constitutionality of the limitation on compensability while employer is going to and from work when Employer is paying mileage for a special mission.

Pina vs. American Piping Inspection Inc., Supreme Court No. 113,899
Record is completed. Case is being briefed by parties at this time. Decision Pending

Q. Are the Title 85A provisions allowing termination of benefits due to missed medical appointments without valid excuse constitutional?

A. Constitutionality of 85A O.S. § 57 which makes a claimant ineligible for further benefits if he or she misses two medical appointments without a valid excuse. Lack of transportation, according to the statute, is not a valid excuse. In an admitted injury, Claimant missed three doctors’ appointments, so PPD and other further benefits were denied.

Gibby vs. Hobby Lobby Stores, Inc., Supreme Court No. 114,065
Waiting on Record Completion.

Q. Is the application of the AMA guides, 6th edition valid for injuries 2/1/2014 and forward?
Is the PPD deferral provision for injuries 2/1/2014 and forward valid?

A. These appeals challenge the use of the AMA guides, 6th edition to rate disability. In addition the appeal challenges the PPD deferment provision and the use of the AMA Guides, 6th edition to rate disability to scheduled members.

Smith vs. Baze Corp. Investments, Supreme Court 113,811
Maxwell v. Sprint PCS, Supreme Court No. 113,898
The Oklahoma Supreme Court has granted the motion to retain the appeals. Smith and Maxwell are to be decided together.

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810:10-1-7(d) Forms and Other Documents Generally
- Under the proposed changes, an electronic signature using acceptable electronic signature technology may be used to sign a document or form and shall have the same force and effect as a hand written signature.

- Proposed changes add in definitions of “acceptable electronic signature technology” and “electronic signature”

810:10-1-9 Who may appear before the Commission
- Under the proposed changes, a corporation, LLC, insurance carrier, individual risk employer, and group self-insurance association, may appear only by its attorney. The current rules allow a designated representative with full settlement authority to appear. This change eliminates non-lawyer representatives for the above mentioned entities.

- Under the proposed changes, persons other than non-licensed attorneys, including adjusters, may file standard reporting forms such as Employer's first notice of injury. Currently, there is no similar rule.

810:10-1-11 Designation of agent for service of notice
- Under the proposed changes, if no agent for service is designated, notices and correspondences can longer be sent to the President and CEO of CompSource Oklahoma, if the insurer is Compsource Oklahoma

810:10-1-12 Prohibited Communications
- Under the proposed changes, “Commission Counselors” and “Commissioners” were added to the list of individuals who shall have no ex parte communications with the ALJ

810:10-3-5 Preliminary Conferences
- The proposed changes, change “Counselor Division” to “Benefit Review Officer.”

- Under the changes, the first prehearing conference shall be directed to the preliminary hearing conference docket of a Benefit Review Officer

- The changes implement 85A O.S. §70 and states that Benefit Review Officer duties include:
  1. Assist unrepresented claimants
  2. Narrow and define disputed issues
3. Facilitate informal dispute resolution & provide an opportunity for a binding settlement
4. Prepare at the conclusion of the preliminary conference stipulations of all contested and uncontested issues
5. Draft a written summary report of the conference within 5 days after Preliminary conference is closed to be filed in the case

- Under the proposed changes, all unresolved contested issues shall be set by the Commission on the assigned ALJ's docket upon filing of a CC-Form 9 or CC-Form 13

810:10-5-2 Claim for Compensation
- The proposed changes authorize the Commission to send an electronic copy of the claim for compensation to the service agent. Under the current rules, the form is sent via mail.

810:10-5-5 Review of Adverse Benefit Determination by Qualified Employers
- Under the proposed changes, Claimant has 1 year to request review of Adverse Benefit Determination. The current rules have no such limitation.
- Under the proposed changes, the Commission hears the matter. Under current rules, the Commission may hear the matter or refer it to an ALJ.
- Under current rules, findings of fact contained in the employer's record shall be considered conclusively established unless clearly erroneous. The proposed changes remove this rule.
- Under the proposed changes, the qualified employer's written argument shall be accompanied by an appendix that includes a copy of the employer's benefit plan and the entire record established by the employer's internal appeal process. There is no current rule on this issue.

810:10-5-6 Commission Relief regarding agreements to arbitrate
- New Proposed Rule which implements 85A O.S. §211
- An application for judicial relief involving an arbitration matter under the Workers Compensation Act shall be made to the Commission by filing of a CC-Form-300 Request for Proceeding Regarding Arbitration Agreement
- The CC-Form-300 shall be served in the manner provided by law for the service of a summons in the filing of a civil action and shall have a certificate of service setting forth the manner of such service

810:10-5-7 Claim for Discrimination or Retaliation
- Proposed new rule implementing 85A O.S. §7

- A claim for discrimination or retaliation shall be commenced by filing an executed prescribed CC-Form-3C Claim for Discrimination or Retaliation with the Commission. The form shall be filed in the underlying workers’ compensation claim filed pursuant to the workers compensation act & use the same Commission file number.

- The CC-Form-3C shall be served on respondent and shall have a certificate of service setting forth the manner of service.

- A CC-Form-9 must be filed to request a hearing.

810:10-5-30 Pre-hearing Conference
- Under the proposed changes, ALJ shall set matters for prehearing conference on the ALJ’s docket or a Benefit Review Officer’s docket. The current rules do not specify a specific docket.

810:10-5-31 Discovery
- Under the proposed changes, any party may commence with discovery methods. The current rule requires the ALJ upon his own motion or the motion of either party, to permit or perform discovery.

- Proposed change requires that discovery disputes be resolved by filing a CC-Form 13 requesting a prehearing conference. Current rule has no such requirement.

- Proposed change requires that subpoenas be issued by an attorney authorized to practice law in the state of Oklahoma. Current rule has no such requirement.

- Proposed change requires that no depositions, interrogatories, interrogatory answers, requests for production of documents and things, requests for admissions, or responses thereto, shall be filed with the Commission, except as ordered by the ALJ.

810:10-5-45 Travel Expenses
- Under the proposed change, the mileage reimbursement threshold is changed from 40 miles to 20 miles round trip.

810:10-5-46 Evaluation of Permanent Impairment
- The proposed change implements 85A O.S. §46(A) and 85A O.S. §46(C)

- Under the proposed change, except for amputation or permanent total loss of use of a scheduled injury, evaluation for permanent impairment shall be
evaluated as a percentage of whole body impairment not to exceed 350 weeks.

810:10-5-48 Sessions, Hearings and Venue, Generally
- The proposed changes eliminate audio recording of hearings before the ALJ and Commission and requires that they be stenographically recorded by a Commission reporter

810:10-5-50 Settings of Matters
- Proposed changes eliminate language allowing the Commission to hear appeals of orders of the Workers Compensation Court of Existing Claims

810:10-5-53 Hearings
- Current language says that ALJs may “permit discovery…”
- Proposed change says that ALJs may “facilitate discovery…”

810:10-5-66 Appeal of Commission Administrative Law Judge Order
- Proposed changes require that a Request for Review be accompanied by a designation of record filed by the appealing party and a copy submitted to the Commission reported and all parties in the case concurrently with or before filing a Request for Review and a non-refundable filing fee of $175.00. Under the current rules, there is no filing fee.

- Proposed changes eliminate subsection stating that oral arguments before the commission shall be permitted only at the discretion of the Commission. This seems to suggest that under the proposed changes, oral arguments will be required for all appeals

- Proposed changes require that 4 copies of the written argument be submitted to the Commission. Current rules require only 2 copies.

- Proposed changes authorize the Commission to dismiss an appeal with prejudice when appellant fails to timely file the written argument and fails to respond to the Commission’s order to file the required written argument. There no current rule.

- Proposed changes allow the Commission to enter default judgment against the opposing parties when opposing parties failed to timely file the written response and have failed to timely respond to the Commission’s order to file the required written argument. There no current rule.

810:10-5-67 Appeal of Order issued by Judge of the Court of Existing Claims
- Proposed changes eliminates this rule
- The current rule allows a party to appeal an ALJ's decision to the Commission; states that an order of the commission may be appealed to the Oklahoma Supreme Court within 20 days; and decisions of the court of existing claims will be reviewed by the commission only for procedural deficiencies and to ensure the record is complete

810:10-5-85 Dismissals
- Under the current rule, the Commission, on motion and after notice and hearing, may dismiss a claim if no bona fide request for hearing has been made within 6 months of the filing of the claim.

- The current changes argument this rule. Under the current changes, the Commission may set claims on the disposition docket if no bona fide request for hearing has been made within 6 months of the filing of the claim. The proposed changes give the Commission power to move these claims to the disposition docket absent a motion.

810:10-5-95 Joint Petition Settlements
- Proposed changes change all references to "Counselor" to “Benefit Review Officer”

- Under the current rules, the settlement hearing is recorded by the ALJ or division counselor at no cost to either party. Either party may request a transcript at their own expense.

- Under the proposed changes, there must be a stenographic record of the terms and conditions of an approved joint petition settlement and the understanding of the claimant concerning the effect of the settlement made. The record must be transcribed at the expense of the employer and insurance carrier. Medical reports and other exhibits shall be affixed to the transcript.

810:10-5-105 Fees
- Proposed change requires a fee of $45.00, plus postage, if any, for a Commission handbook.

810:15-5-4 Medical Interlocutory Order
- New Proposed Rule

- Proposed language, “‘Medical Interlocutory Order’ or ‘MIO’ means a medical interlocutory order provided a prescribing doctor or pharmacy in instances where preauthorization denials of a previously prescribed and dispensed drugs(s) excluded from the closed formulary poses an unreasonable risk of a medical emergency”
The proposed changes indicate that the purpose of this section is to provide a prescribing doctor or pharmacy an ability to obtain a medial interlocutory order in instance where preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonably risk of a medical emergency as defined by 810:15-1-2

Under the proposed changes, an MIO will be issued if it contains certain information such as employees, name, DOB, prescribing doctor's name, name of drug/dosage, MIO requester's name and contact info, a statement that a preauthorization requests for a previously prescribed & dispensed drug, which is excluded from the closed formulary, has been denied by the insurance carrier, statement that the potential medical emergency has been documented in the preauthorization process, notification to insurance carrier, and signature

- Commission may process & approve an incomplete request at its discretion

An approved MIO shall be effective retroactively to the date the complete request for an MIO is received by the commission

The MIO shall continue until the later of:

- Final adjudication of a medical dispute regarding the medical necessity and reasonableness of the drug contained in the MIO
- Expiration of the period for a timely appeal
- Agreement of the parties

The Insurance Carrier shall reimburse the pharmacy for prescriptions dispensed in accordance with MIO

- Once reimbursement is no longer required, it is the insurance carriers responsibility to notify the prescribing doctor, injured employee, and dispensing pharmacy

A party may seek to dispute, reverse, or modify an MIO issued, by filing a written request for a hearing before an ALJ

810:15-9-1 Independent Medical Examiner Qualifications

- Proposed change requires physicians to attend programming in the Official Disability Guides if a treating physician and/or in the American Medical Association’s “Guides to the Evaluation of Permanent Impairment” if they are a physician rating permanent impairment. Currently there is no such requirement.

810:15-15-13 Medical Dispute Resolution of Fee Disputes
- Under the current rules, medical fee disputes must be initiated within 1 year of the date the services were rendered which are subject of the dispute. The proposed changes eliminate the 1 year limitation. Thus, there is no time limitation on when medical fee disputes may be initiated.

810:25-7-2 Hearing Process and (Consent Agreements- Proposed Language)

- New proposed rule regarding consent agreements
- Under the proposed rules, an employer served with a proposed judgment may waive its right to a contested hearing and execute a consent agreement with the Commission for a reduced penalty. The employer shall secure payment of compensation within the meaning of 85A O.S. §38 as a condition to executing a consent agreement. In determining the rate of reduction in penalty, consideration shall be given to the appropriateness of the penalty in light of the business of the employer charged, the gravity of the violation and the extent to which the employer charged has complied with the provisions of 85A O.S. §38 or has otherwise attempted to remedy the consequences of the violation. The penalty amount shall never be reduced to less than the amount in premiums saved by the employer’s noncompliance

  o The Consent Agreement becomes void if the employer defaults on payment under the agreement or if the agreement was obtained by fraud or misrepresentation of material fact.

  o The Commission may institute collection proceedings independently or in district court, including, but not limited to, an asset hearing, garnishment of income and wages, judgment lien against personal and/or business properties, upon any penalties becoming final under provisions of 85A O.S. §40

810:25-11-3 Approval of New Members of the Association

- Under the proposed rules, the commission shall approve new members upon finding the applicant is solvent, that the applicant has the financial ability to meet its obligations as a member, and proof that the applicant is in compliance with the legal requirements specified in this subchapter. Current rules have no such requirement.

810:25-11-17 Third-Party Administration

- Under the proposed changes, a company providing marketing services to a self-insurance program must be approved by the Commission’s Insurance Division. The company requesting approval must submit to the commission’s Insurance Division all marketing material prior to being utilized by an association. Currently, there is no similar rule.

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TITLE 85A: A YEAR LATER

I. Section 2: Definition

A. Child:
   1. Child is defined as a natural or adopted son or daughter of employee under the age of 18 years.
   2. A son or daughter between the ages of 18-23 if enrolled in school full time.
   3. A son or daughter who is over 18 but physically or mentally incapable of self-support.
   4. The term child includes posthumous child, a child legally adopted or one for whom adoption proceedings are pending at the time of death, and actually dependent step-child, or actually dependent acknowledged child born out of wedlock.

B. 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 caused as a result of 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 does not include:
      a. Fight cases that are the result of non-employment –related hostility.
      b. Horseplay unless you are an innocent victim.
      c. Recreational or social activities.
      d. Injury afflicted at the time on an employee at a time when the employment services are not being performed or before the employee was hired or after termination.
      e. If, within 24 hours of being injured or reporting injury, an employee tests positive for intoxication, there is presumption that the injury is not work-related but can be overcome by clear and convincing evidence.
      f. Age related degeneration.
      g. Any pre-existing condition except when a treating physician finds a significant and identifiable and significant aggravation occurring in the course and scope of employment.
   4. Compensable injury shall be established by objective medical evidence.
   5. An employee has to prove by a preponderance of the evidence that he or she suffered a compensable injury.
6. Benefits shall not be payable for condition which results from a nonwork-related independent intervening cause following a compensable injury which prolongs disability, aggravation or requires treatment.

C. Compensation is defined as money allowance payable to the employee or to his/her dependants including the medical services and supplies and funeral expenses.

D. Consequential injury is defined as 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.

E. Continuing medical maintenance is treatment to maintain claimant’s condition resulting from a compensable injury and shall not include diagnostic tests, surgery, injections, counseling, physical therapy or pain management devices or equipment.

F. Course and scope of employment means an activity of any kind or character for which the employee was hired and relates to, and derives from the work and is performed by the employee in the furtherance of the affairs or business of the employer.
   1. Course and scope of employment does not include employee’s transportation to and from his place of employment.
   2. Travel by an employee in furtherance of the affairs of an employer if the travel is also for personal or private affairs.
   3. Any injury occurring in the parking lot or other common area adjacent to the employer’s place of business before the employee clocks in or otherwise begins work or after the employee clocks out.
   4. Any injury occurring while the employee is on a work break unless the injury occurs while the employee is on the work break inside the employer’s facility and the work break is authorized.

G. Cumulative trauma is defined by 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 and the employee shall have completed at least 180 days of continuous active employment.

H. Gainful employment means that the capacity to perform employment for wages for a period of time that is not part-time, occasional or sporadic.

I. Major cause: major cause is defined as more than 50% of the resulting injury, disease or illness and shall be established by a preponderance of the evidence. A finding that the work place was not the major cause of injury, disease, or illness shall not adversely affect the exclusive remedy provisions.

J. Misconduct is defined as:
   1. Unexplained absenteeism or tardiness.
   2. Willful or wanton indifference to neglect of the duties required.
   3. Willful or wanton breach of any duty required by the employer.
   4. The mismanagement of a position of employment by action or inaction.
5. Actions or admissions that place in jeopardy the health, life and property of self or others.
6. Dishonesty.
7. Wrong doing.
8. Violation of law.

K. Objective findings are those that cannot come under the voluntary control of the patient.
   1. In determining PPD the rating physician shall use the most current edition of the AMA Guides.

L. Permanent disability means the extent expressed in a percentage of a loss of portion of total physiological capabilities of the human body.

M. Permanent partial disability means a permanent disability or loss after MMI which prevents an employee from returning to his/her pre-injury or equivalent job.

N. Pre-injury or equivalent job means the job employee was working for the employer at the time of injury or any employment offered by claimant’s employer that pays at least 100% of the employee’s average weekly wage.

O. Surgery does not include an injection or the forcing of fluids under the skin for treatment or diagnosis.

II. Section 4:

A. If any part of this act is deemed to be unconstitutional it shall not make the entire act unconstitutional or invalid.

III. Section 5: Exclusive Remedy

A. The act still provides for exclusive remedy of workers’ compensation injuries.

B. Exclusive remedy shall not apply if an employer fails to secure the payment of compensation due to the employees required by this action or, the injury is caused by an intentional tort committed by the employer. An intentional tort exists only as a result of willful, deliberate and specific intent of the employer to cause injury. The immunity of exclusive remedy does not extend to actions against another employer or employee or third party claim.

IV. Section 6: Fraud

A. Any person or entity who makes a material false statement or representation or willfully and knowingly omits or conceals material information for obtaining any benefit or payment, increasing any claim for benefit or payment, or obtaining workers’ compensation coverage under this act, shall be guilty of a felony.

B. If an injured employee is charged with workers’ compensation fraud, any pending workers’ compensation proceeding, including benefits shall be stayed after the
preliminary hearing is concluded and the claimant is bound over and shall remain stayed until the final disposition of the criminal case.

V. Section 7: Discrimination

A. The employer may not discriminate or retaliate against an employee when the employee has, in good faith, filed a claim under this act, retained representation, instituted a proceeding under this act, or testified in any proceeding under this act.

B. The Commission has exclusive jurisdiction to hear discrimination claims under this act.

C. If the Commission determines that defendant has violated a section of this act, the Commission may award the employee back pay of up to $100,000.00 with credit for interim earnings by a reasonably diligent person.

D. The prevailing party can get cost and attorney fees.

E. No employer may discharge an employee for absenteeism during a period of temporary total disability.

F. Notwithstanding any other provisions, an employer does not have to rehire or retain an employee who is physically unable to perform the duties subject to ADA rules.

VI. Section 13: Mental injuries

A. A mental injury/illness is not compensable unless accompanied by a physical injury except to any victim of a crime of violence.

B. A mental injury/illness under this section shall be compensable only if diagnosed by a licensed psychiatrist or psychologist.

C. Maximum disability for mental injury is 26 weeks. We presume this means temporary total disability, unless by clear and convincing evidence the claimant establishes that the benefits should be continued, cannot exceed 52 weeks.

D. In a case where death results directly from the mental injury or illness within a period of one year, compensation shall be provided to the defendants per the death claim statute.

E. Death directly or indirectly related to the mental illness occurring one year or more from the incident resulting in the mental injury or illness shall not be compensable.

VII. Section 14: Heart claims

A. Cardiovascular, coronary, pulmonary, respiratory or cerebrovascular accidents or myocardial infarctions causing injury, illness or death is compensable only if the injury, in relation to other factors contributing to the physical harm, in the course and scope of the employment was the major cause.
B. Injury or disease in this section shall not be deemed compensable 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 or unpredicted incident occurred which is found to have been the major cause of the physical harm.

C. Physical or mental stress shall not be considered in determining whether the employee or claimant has met his/her burden of proof (Editor’s note: I do not know of another kind of stress other than physical or mental).

VIII. Section 16: ODG

A. ODG is to be recognized as a primary standard of reference however, the medical treatment guidelines are not requirements, mandates or standards.

IX. Section 19: The Commission

A. The Commission shall consist of three full time commissioners, each having three years workers’ compensation experience. They are appointed for six years, staggered terms.

B. The Commission shall have the authority to adopt reasonable rules within its respective areas of responsibility including the rules of procedure for administrative hearings.

X. Section 20: Administrative Law Judges

A. The Commission has given powers to appoint Administrative Law Judges to hear all claims for compensation.

1. The Administrative Law Judge shall be licensed to practice law in this state for a period of not less than three years and shall have three years workers’ compensation experience.

B. The Commission can remand any case to an Administrative Law Judge for the purpose of additional evidence, assessment of penalties, and prescribe rules governing the representation of employees, employers and carriers in respect to claims before the Commission.

XI. Section 22: Additional Commission Powers

A. The Commission may appoint as many persons as necessary to be administrative law judges as well as examiners, investigators, IME’s and clerks.

B. The Commission shall have the power and duties to hear compromise settlements, review Own Risk applications, monitor Own Risk and self-insured groups, hear claims concerning disputed medical bills, appoint mediators.
XII. Section 27:

A. Workers’ Compensation Commission shall be vested with jurisdiction over all claims filed pursuant to the Administrative Workers’ Compensation Act.
B. Claims shall be heard by an administrative law judge sitting without a jury.
C. The Commission, upon application of any party, shall order a hearing. Upon a hearing, either party may present evidence and be represented by counsel. The decisions of administrative law judge shall be final as to all questions of fact and law except as provided by this act.
D. Decisions of the ALJ shall be issued within 30 days following the submission of the case by the parties.
E. The power and jurisdiction of the Commission over each case shall be continuing and it may from time to time, make modifications of orders.
F. The ALJ’s can determine challenges to an agreement to arbitrate under the Workers’ Compensation Arbitration Act.

XIII. Section 31 through 34: Multiple Injury Trust Fund

A. Oklahoma Administrative Workers’ Compensation Act still provides for the multiple injury trust fund (MITF) to handle combined disability claims involving permanent total disability. The rules remain largely unchanged.

XIV. Section 36: Secondary Liability

A. 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.

XV. Section 43: Third Party Liability

A. 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.
B. The employer or employer’s carrier shall be entitled to reasonable notice and opportunity to join the third part action.
C. 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.
D. 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.

XVI. Section 44:

A. Any benefit payable to an injured employee under this act shall be reduced in
amount equal to dollar for dollar, the amount of benefits an injured employee has
previously received for the same medical services or period of disability, however, the reduction does not apply to benefits received from a group policy
for disability if the injured employee has paid for the policy.

XVII. Section 45: Temporary Total Disability/Temporary Partial Disability/Permanent Partial
Disability/Permanent Total Disability

A. 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.
B. Maximum TTD is 104 weeks.
C. TTD is not paid for the first three days of the initial period of TTD.
D. 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.
E. If the employee is released by the treating physician for all body parts
adjudicated by the Commission, misses three consecutive medical treatment
appointments without valid excuse, fails to comply with medical orders of the
treating physician or abandons care, the employer may terminate TTD by giving
notice to the employee or their counsel.
F. If employee objects to determination of TTD, the Commission shall set a hearing
within 20 days to determine if TTD should be reinstated.
G. Temporary partial disability--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.
H. If the employee refuses alternative work, they shall not be entitled to temporary
total or temporary partial disability benefits.
I. Permanent Partial Disability, must be supported by objective medical evidence.
J. Permanent Partial Disability may not exceed 100% to the body part or body as a
whole.
K. 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 current edition of the AMA Guides. This
seems to indicate that scheduled numbers do not have to rely solely on the AMA
Guides. All parties may submit a report from an evaluating physician.
L. Permanent disability should not be allowed to a body part for which no medical treatment has been received.

M. Permanent partial disability shall be 70% of the average weekly wage, not to exceed $323.00 per week.

N. Maximum permanent disability is 350 weeks to the body as a whole, a reduction from the previous 500 weeks. The weeks for body parts not rated whole man have stayed the same from the Workers’ Compensation Code.

O. Except for settlements, payment of permanent disability shall be deferred and held in reserve by the employer or insurance carrier if the employee has reached maximum medical improvement and is released to return to work by the treating physician and then returns to work at the pre-injury or equivalent job for a term of weeks determined by dividing the dollar amount by 70% of the employees average weekly wage. Essentially, the PPD award is held in abeyance and reduced by 70% of the average weekly wage for each week claimant works after having been released at MMI, in a pre-injury or equivalent job.

P. If for any reason the employer terminates the employee, other than for misconduct as defined in Section 2, the remaining permanent partial disability shall be paid in a lump sum.

Q. If the employee is discharged for misconduct, the employer has the burden to prove the employee engaged in misconduct.

R. If an employee refuses an offer to return to the pre-injury equivalent job, the PPD shall be deferred for each week of refusal.

S. Attorney fees for permanent disability shall be paid in full at the time of the deferral.

T. The employer shall receive credit for pre-existing apportionment. Apportionment does not apply to TTD or medical treatment. If the pre-existing impairment is the result of an injury sustained while working for the employer for whom workers’ compensation benefits are currently being sought, any award of compensation shall be reduced by the current dollar value attributed under the Administrative Workers’ Compensation Act to the percentage of permanent partial impairment determined to be pre-existing.

U. An employee cannot receive payment on two permanent partial disability orders at the same time.

V. 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.

W. An injured employee who is eligible for permanent partial disability under this section shall be entitled to receive vocational rehabilitation services. Vocational rehabilitation services and training shall not exceed a period of 52 weeks.

X. Permanent total disability shall be 70% of the average weekly wage or TTD rate. Benefits are payable until claimant reaches the age maximum of social security retirement benefits or for period of 15 years whichever is longer. If claimant dies of causes unrelated to the injury or illness, benefits cease on the date of death. Any person entitled to revive the claim shall receive a one time lump sum
payment equal to 26 weeks of permanent total disability benefits. 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. 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.

Y. 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.

Z. The Commission shall hire a Vocational Rehabilitation Director to help injured workers return to the work force. The Vocational Rehabilitation Director shall issue administrative orders for vocational rehabilitation evaluation for injured employees unable to return to work for at least 90 days. All administrative orders are subject to appeal to the full Commission.

AA. There shall be a presumption in favor of ordering vocational rehabilitation for injured workers under the following circumstances, truck drivers or laborers with traumatic brain injury, stroke or uncontrolled vertigo, truck driver or laborer performing high risk tasks and the medical condition of seizures; bilateral wrist fusions for manual laborers; workers with radial head fractures with surgical excision; heavy laborers with heart conditions; heavy laborers with multilevel neck and back fusions greater than two levels; laborers performing overhead work with massive rotator cuff tears with or without surgery; heavy laborers with recurrent inguinal hernias following unsuccessful surgery; heavy manual laborers with total knee or hip replacements; roofer’s with heel fractures; laborer of any kind with a total shoulder replacement; laborer with amputation of hand, arm, leg or foot; laborer with tibial plateau fracture or pilon fracture; laborer with ankle or knee fusions; driver with unilateral industrial blindness; laborer with three, four or five level positive diskogram in cervical or lumbar spine.

BB. On application of either party or by order of an ALJ the Vocational Rehabilitation Director shall assist the Commission to determine if a claimant is appropriate to receive vocational rehabilitation services. If appropriate, the ALJ can refer the employee for an evaluation. The cost of evaluation shall be paid by the employer. If following the evaluation, the employee refuses services, or training ordered by the ALJ or fails to make a good faith attempt in vocational rehabilitation, the cost of the evaluation and services or training may, in the discretion of the ALJ, be deducted from any remaining PPD award.

CC. An Administrative Law Judge may order vocational rehabilitation before an employee reaches maximum medical improvement if a treating physician believes it is likely it will be required to return to gainful employment.

DD. Request for vocational services must be filed within 60 days of permanent restrictions.

EE. If retraining requires residence away from employee’s residence, reasonable room, board, tuition and books shall be paid.
FF. 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.

GG. Maximum disfigurement is $50,000.00. No award for disfigurement shall be entered until 12 months from the injury.

HH. Benefits for a single event injury shall be determined by the law in effect at the time of the injury. Benefits for cumulative trauma or occupational disease or illness shall be determined by the law in effect at the time the employee knew or reasonably should have known of the injury. Benefits for death shall be at the time of death.

XVIII. Section 46: Weeks of PPD

A. Weeks for injuries to the body as a whole are reduced to 350 weeks; all other body parts remain essentially the same.

B. Permanent disability for amputation or permanent loss of use of a scheduled member shall be paid regardless of whether or not the injured employee is able to return to work.

C. Permanent loss of 80% or more vision of an eye shall be the same as loss of an eye.

D. Corrective lenses may be taken into consideration in evaluating the extent of loss of vision.

E. The sum of all permanent partial disability awards excluding awards against the Multiple Injury Trust Fund shall not exceed 350 weeks.

XIX. Section 47: Death Benefits

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 death did not result from the injury.

B. A common-law spouse shall not obtain benefits under this section unless there is an order from a court of competent jurisdiction ruling a common-law marriage existed between the decedent and surviving spouse. (It appears that the Administrative Workers’ Comp Act and its representatives could not dispute this in front of the Commission).

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 is children but no surviving spouse, each child $25,000.00 and 50% of the average weekly wage 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.

XX. Section 48:

A. If injury or death is sustained by a minor employed in violation of federal law, disability or death benefits should be doubled.

XXI. Section 49: Unemployment

A. An injured worker could not receive temporary disability for any week he received unemployment benefits. If however, TTD was controverted and later ordered the claimant will get TTD at the difference between the unemployment rate and the TTD rate.

XXII. Section 50: Medical Treatment

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

B. If the employer fails or neglects to provide medical treatment within five days after actual knowledge is received of the injury, the employee may select the treating physician at the expense of the employer.

C. Diagnostic testing shall not be performed shorter than six months from the date of the last test without good cause shown.

D. Unless recommended by a treating physician or an independent medical examiner, continued medical maintenance should not be awarded by the Commission.

E. An employee claiming benefits under this Act shall submit him/herself to medical examination, otherwise rights and benefits shall be suspended.

F. Mileage shall be 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 shall be due within 45 days of receipt by the employer or insurance carrier of a completed and accurate invoice unless there is a good faith reason to request additional information. Thereafter, the Commission may assess a penalty of up to 25% of any amount due under the fee schedule that remains unpaid on the finding by Commission that no good faith existed for the delay. A pattern of willfully and knowingly delaying payments can result in a civil penalty of not more than $5,000.00.

H. If an employee misses a scheduled appointment with a physician, the employer's insurance company shall pay the physician a reasonable charge determined by the Commission for the missed appointment. In absence of a good faith reason for missing the appointment, the Commission shall have the employee reimburse the employer and insurance carrier.
XXIII. Section 53

A. An injured employee shall submit to physical examinations and treatment by another qualified physician designated or approved by the Commission as it may require from time to time.

B. In cases where the Commission directs examinations, no compensation shall be payable during a period which the claimant refuses to submit to examination or treatment.

C. Failure of an employee to obey the judgment of the Commission for examination or treatment within one month from the date of the judgment shall bar the right of the claimant for further compensation with respect to the injury.

XXIV. Section 54

A. The Commission can consider refusal of a surgery that does not involve unreasonable risk of life or additional serious physical impairment when determining permanent disability.

XXV. Section 56: Change of Physician

A. If the employer is not covered by certified workplace medical plan, the employer shall select the treating physician. The employee can move for one change of physician from a list of three doctors chose by the employer.

XXVI. Section 57: Missed Appointment

A. If an injured employee misses two or more scheduled appointments, he/she shall no longer be eligible to receive benefits under this act, unless; 1) missing the appointment was caused by extraordinary circumstances beyond the employee’s control, 2) the employee gave at least two hours prior notice and had a valid excuse.

B. Failure to obtain transportation shall not be considered extraordinary circumstances.

XXVII. Section 59: Rate

A. Average weekly wage shall be 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 shall be 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.
XXVIII. Section 61: Hernia

A. A hernia is compensable if it meets the definition of compensable injury under this act established by a preponderance of the evidence and the hernia occurred as a result of,
1. sudden effort, severe strain, or application of force directly to the abdominal wall,
2. there was severe pain in the hernia region,
3. the pain caused employees work to be substantially affected, and
4. notice was given to the employer within five days of the occurrence.

B. An injured employee will be entitled to six weeks of TTD for a hernia. If the employee refuses a hernia operation, he/she shall be entitled to 13 weeks plus appropriate medical care.

C. If the employee dies within one year as a direct result of the hernia or radical operation of the hernia, the employee’s dependants shall be entitled to death benefits.

XXIX. Section 62: Soft Tissue Injuries

A. TTD shall not exceed 8 weeks for nonsurgical soft tissue injuries regardless of the number of body parts.

B. If claimant receives an injection or injections, they should be entitled to additional 8 weeks of TTD.

C. 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.

D. Soft tissue includes but is not limited to sprains, strains, contusion, tendinitis and muscle tears, cumulative trauma is considered soft tissue. 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.

XXX. Section 63

A. Within ten days of the date of receipt of notice or knowledge of injury or death, the employer shall send the Commission a report providing factual information regarding the parties and injury.
B. Failure to do so can result in fines and action to join the employer from engaging in further employment.

XXXI. Section 67: Cumulative Trauma and Occupational Disease Notice

A. Written notice shall be given to the employer of occupational disease or cumulative trauma by the employee within six months after first distinct manifestation of disease or cumulative trauma or within six months after death.

XXXII. Section 68: Single Event Notice

A. 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.

B. 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.

XXXIII. Section 69: Statute of Limitations

A. 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. If during the one year following the filing of the claim, the employee receives no weekly compensation or medical treatment from the alleged injury, the claim shall be barred thereafter.

B. 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.

C. A claim for compensation for disability on account of silicosis or asbestosis shall be filed with the Commission one year after the time of disablement and the disablement shall occur within three years from the last date of injurious exposure.

D. A claim for compensation for death benefits shall be barred unless it is filed within two years from the date of death.

E. If within six months after filing a claim no bonafide request for a hearing has been made, the Court may on a motion or after hearing dismiss the claim with prejudice.

F. Time for filing additional compensation shall be one year from the last payment of disability compensation or two years from the date of injury whichever is greater. (It is unclear what additional compensation may mean.)

G. Replacement of medical supplies or prosthetics shall not toll the statute of limitations.

XXXIV. Section 72: Conduct of hearing or inquiry
A. 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.

B. 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.)

C. 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.

D. Expert testimony should not be allowed unless it satisfies the requirements of Federal Rules of Evidence 702.

XXXV. Section 73

A. The Commission shall have the power to preserve and enforce order during, or proceeding before it, issue subpoenas, administer oaths and compel attendance and testimony as well as production of documents. Any person or party failing to take the oath, attend, produce documents or comply with final judgment of Administrative Law Judge or Commission or willfully refuses to pay uncontroverted medical or related expenses within 45 days can be held in contempt and fined up to $10,000.00.

XXXVI. Section 78: Appeals

A. 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.

B. 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.

XXXVII. Section 79: Certification to District Court

A. 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.
XXXVIII. **Section 80**

A. Except in the case of joint petition settlement, the Commission may review a compensation judgment, award or decision any time within six months of termination of the compensation fixed in the original compensation judgment or award on the Commission’s own motion or application of either party, on the ground of a change of physical condition or on proof of erroneous wage rate. On review, the Commission may make judgment or award terminating, continuing, decreasing or increasing the compensation previously awarded subject to the maximum limits provided for this in Act.

XXXIX. **Section 82: Attorney fees**

A. Attorney fees shall not be valid unless approved by the Commission. (Although it does not specify, it is presumed that this does not include defense fees.)

B. An attorney may receive up to 10% for temporary disability and 20% of any permanent disability, permanent total disability or death compensation awarded to an injured worker from a controverted claim. If an employer makes a written offer of settlement for permanent disability, permanent total disability, death compensation and that is offered is rejected, the employee’s attorney may not recovery fees in excess of 30% of the difference between the award and the offer.

C. Attorney fees may not be collected for recovery on noncontroverted claims.

D. Attorney fees may not be awarded on medical benefits or services.

E. The attorney fee for a change of physician order is $200.00. Attorneys can get 10% on the reasonable value of vocational rehabilitation services. (It is unclear who pays the attorney fee.)

F. A controverted claim means that there has been a contested hearing before the Commission over whether or not there has been a compensable injury or whether the claimant is entitled to TTD, temporary partial disability, permanent partial disability, permanent total disability or death compensation. A request for change of physician is not a controverted claim for purposes of recovery attorney fees.

XL. **Section 84: Payment**

A. Compensation may be paid by a check, electronic funds transfer, issuance of debit cards or by state award.

XLI. **Section 86: Controverted Claims**

A. Each employer who controverts an employee’s right of compensation shall file with the Commission on or before the 15th day following notice of the alleged
injury or death, a statement on a form prescribed the Commission that the right to compensation is controverted.  (This will be a CC Form 2A.)

B. Failure to file a statement of controversion shall not preclude the employer’s ability to controvert the claim or cause it to waive any defenses and additional defenses can be plead at any time.

C. If the employer is unable to obtain sufficient evident on whether to admit or deny claim within 15 days, the employer may file for an extension of time for making payment or controverting a claim.

XLII.  Section 88: Disputes between parties

A. In the case where there are multiple employers or insurance carriers and the only dispute in the claim is the proper source of payment of benefits, the Commission shall direct that the appropriate compensation be paid on the equal basis by the carrier or self-insured employer.  Upon resolution of the issue the prevailing respondent shall be entitled to reimbursement from the other respondent of all monies paid with interest.

XLIII.  Section 92

A. Within thirty days after final payment of compensation has been made, the employer shall notify the Commission on a form prescribed by the Commission.  The form shall state that final payment has been made, the total amount of compensation paid and to whom.  Failure to comply can result in a $100.00 penalty.

XLIV.  Section 93

A. The Commission on its own initiative, may at any time while compensation payments are being made without an award and in any case the right to compensation has been controverted, or if payment of compensation has been suspended, make such investigation or cause medical examinations and hold hearings to determine and protect the rights of all parties.

XLV.  Section 94: Incarceration

A. An employee who is incarcerated shall not be eligible to receive medical or disability benefits under this Act.  (Note:  This says incarcerated, not convicted.)
WORKERS COMPENSATION EXIT STRATEGIES

ISSUES FACING EMPLOYERS WHEN FIRING AN EMPLOYEE WITH A WORKERS’ COMPENSATION CLAIM

I. RETALIATORY DISCHARGE CLAIMS


B. In order to prevail on a retaliatory discharge claim, the plaintiff must prove that the discharge was ‘based on’, ‘because of’, ‘motivated by’, or ‘due to’ the employer’s intent to retaliate. However, the employee no longer needs to prove the retaliation was the employer’s sole motive or reason for the termination. *Foster v. Alliedsignal, Inc.*, 293 F.3d 1187 (10th Cir. 2002).

C. An employer cannot be sued for retaliatory discharge simply because it failed to consider another position or to modify a job to accommodate an injured employee. *Griffin v. Dodge City Cooperative Exchange*, 23 Kan.App.2d 139, 147, 927 P.2d 958 (1996).

1. If a worker cannot return to work, he cannot maintain a cause of action for retaliatory discharge under Kansas case law. *Id.*


4. Another persuasive factor the Courts look for is whether the employee was fired before the full extent of his injuries is known. If fired prior to being diagnosed with a permanent injury, the *Griffin* holding is not applicable. See *Sanjuan v. IBP, Inc.*, 90 F.Supp.2d 1208 (D.Kan.2000); *Gertsch v. Central Electropolishing Co.*, 29 Kan.App.2d 405, 26 P.3d 87 (2001).

D. The employee must make out a prima facie case of retaliatory discharge, which raises a rebuttable presumption of retaliatory intent. The elements of its prima facie case are:

1. He or she filed a workers’ compensation claim for benefits, or sustained an injury for which he might assert a future claim for such benefits;

2. The employer had knowledge of plaintiff’s compensation claim, or the fact that he had sustained a work-related injury for which he might file a future claim for benefits;

3. The employer terminated the plaintiff’s employment; and

4. That a causal connection existed between the protected activity or injury, and the termination.
E. Once the plaintiff establishes his prima facie case, the burden shifts to the defendant to articulate a legitimate, non-retaliatory justification for the discharge. *Bausman v. Interstate Brands Corp.*, 252 F.2d 1111, 1116 (10th Cir. 2001).

F. If the employer meets this burden, the burden shifts back to the plaintiff to show by clear and convincing evidence that he was terminated in retaliation for exercising rights under the Workers' Compensation Act. *Bausman*.

G. An employee whose job-related injury prevented him from returning to his former position and whose employer had been unable to find another position for which employee was suited did not have a viable retaliatory discharge claim where discharge was due to policy of terminating workers who had for any reason taken six consecutive months' leave rather than any relation to employee’s workers’ compensation claim. *Rowland v. Val-Agrí, Inc.*, 13 Kan.App.2d 149, 766 P.2d 819 (1988).

II. **Return to work policies**

A. An effective return to work policy should accomplish three important business goals:

1. Reduce disability leave costs;
2. Maintain productivity of employees and work units; and

B. According to a publication produced by the Florida Partnership for Safety and Health with support from the Public Entity Risk Institute, the key components of a return-to-work policy are:

1. Process flow actions to be followed when an injury occurs;
2. An emergency plan that includes directions for reporting an injury, instructions for getting immediate medical help for the employee, and a list of phone numbers for all contacts involved;
3. A communication plan including a regular schedule of communication between all parties involved in the process flow; and
4. A transitional employment plan including modified employment or employment accommodations and/or alternate employment assignment to enable workers to safely transition back into the work environment after an injury.

C. The Office of Disability Employment Policy suggests the following strategies for implementation of an effective return to work policy:

1. Remain positive and keep an open mind about options for both you and your employee. The employee may be facing considerable stress and staying focused will assist both parties.
2. Avoid making assumptions about what and employee with a disability can do. Instead, use free resources available to facilitate their stay at work or returning to work. In many industries, flexible work arrangements, accessible technology and office automation have increased the capabilities of employees and make it easier for them
to accomplish their job tasks in alternative ways. You can also visit the Return-to-Work toolkit at 1.usa.gov/1d2RibP.

3. Network with other employers to share effective strategies.

4. Start an Employee Resource Group to encourage employees to work together to address health-related problems and issues that impact their workplace.

5. Cross train your employees so they are familiar with different types of jobs in your organization. This will allow others to temporarily cover for an employee with a disability and give you time to assist the employee to stay at work or return to work as soon as possible.

6. Implement workplace flexibility policies that help your employees remain productive on the job while also managing their disability.


D. In Kansas, an employee shall be entitled to temporary total disability benefits when the authorized treating physician has imposed temporary restrictions as a result of the work injury which the employer cannot accommodate. K.S.A. 44-510c(b)(2)(B).

1. An effective return to work policy that includes modifying tasks, alternative tasks, or flexible task structure can help to find an injured worker a position within the organization that fits with a physician’s temporary restrictions. This will allow the employer to save money by limiting the potential liability for temporary total disability benefits.

E. An employer must also consider whether the Americans with Disabilities Act (ADA) affect their employee’s rights.

1. Not all employees who have a workers compensation injury are protected by the ADA.

2. To be protected by the ADA, the employee must meet the definition of disability:
   a. A person who has a physical or mental impairment that substantially limits one or more major life activities,
   b. A person with a record of a physical or mental impairment that substantially limits one or more major life activities, or
   c. A person who is regarded as having a physical or mental impairment that substantially limits one or more major life activities

3. Policies requiring an employee to be “100% healed” often are seen as per se violations of the ADA.
   a. An employee can show that the employer regarded him as having a disability if the employer would not let him return to work until 100% healed.

4. Under the ADA, employers must consider job restructuring as a reasonable job accommodation, which includes reallocating or redistributing marginal job functions that an employee is unable to perform because of a disability.

5. Ideas for job accommodations can be found at: http://AskJAN.org/media/eaps/rtwEAP.doc.

6. For accommodation ideas by disability, see: http://AskJAN.org/media/atoz.htm.
TEMPLEMIRE V. W & M WELDING

Employers now face increased liability in workers’ compensation retaliatory discharge actions based on a new causation standard established by a recent Missouri Supreme Court decision. Under the new standard announced in Templemire v. W & M Welding, on April 15, 2014, employees need only prove that the filing of a workers’ compensation claim was a “contributing factor” to the employee’s discharge, termination, or discipline rather than the “sole, exclusive factor.”

The Old Standard
The Templemire decision overturned the Missouri Supreme Court’s prior decisions in Handsome v. Northwestern Cooperage Co., 679 S.W.2d 273 (Mo. Banc 1984) and Crabtree v. Bugby, 967 S.W.2d 66 (Mo. Banc 1998), in which the Court adopted the “exclusive causal connection” standard for workers’ compensation retaliatory discharge actions. Under this standard, the employee was required to prove that the exercise of the employee’s rights under the workers’ compensation statute was the “sole, exclusive factor” in the employee’s termination or discipline. However, the Templemire decision overturned Handsome and Crabtree and instead found that in a workers’ compensation retaliatory discharge action, the employee need only show that the filing of a workers compensation claim was a “contributing factor” to the adverse employment action. Under this new standard, an employer may be held liable even if the employer had a legitimate, non-discriminatory reason for terminating or disciplining the employee.

Facts of Templemire v. W & M Welding
Mr. Templemire was an employee assigned to light duty as a result of a work related injury. Mr. Templemire was terminated after the employer discovered him taking a break. The parties exchanged words, and Mr. Templemire asked his supervisor if he was sure the employer wanted to fire him, “because he was going to go home and call workman’s comp.” Furthermore, Mr. Templemire stated that he needed to take a break for his foot and if the employer did not like it, he could take it up with Mr. Templemire’s physician. The employer’s stated reason for terminating Mr. Templemire’s employment was insubordination.

After being discharged, Mr. Templemire called the insurance adjuster on his workers’ compensation claim. The adjuster then contacted the employer to discuss the termination. The adjuster’s notes from her conversion with the employer indicated that she informed him that Mr. Templemire’s work restrictions required him to take a break, and the employer indicated that he believed Mr. Templemire was “milking his injury” and that Mr. Templemire could sue him for whatever reason he wanted because he paid his premiums and attorneys to handle the issues. Mr. Templemire subsequently filed suit against his employer alleging he was fired in retaliation for filing a workers’ compensation claim. At trial, Mr. Templemire presented evidence of the employer’s statements to the insurance adjuster.

The Court in Templemire determined that the exclusive causation standard is contrary to the plain language of R.S.Mo § 287.780 which states, “No employer or agent shall
discharge or in any way discriminate against any employee for exercising any of his rights under this chapter. Any employee who has been discharged or discriminated against shall have a civil action for damages against his employer.” The Court reasoned that use of the phrase “in any way” is consistent with the application of a contributing factor standard rather than an exclusive factor standard. The Court further reasoned that the Court’s precedent in other Missouri employment discrimination cases supports the application of the contributing factor standard to causes of actions arising pursuant to § 287.780. Finally, the Court determined that the contributory factor standard is consistent with the purpose of the statute, which is to protect workers from retaliation for exercising their rights under Chapter 287.

Implications For Employers
Employers faced with the prospect of taking disciplinary action against an employee who has filed or is planning on filing a workers’ compensation claim need to be aware of the implications of the Templemire decision. It is no longer sufficient that the employer had some other reasonable motives behind the discharge or discipline of an employee. Instead, the focus of the inquiry is on whether the employee’s injury or filing of a workers’ compensation claim was a factor in the employer’s decision. As such, employers must keep accurate records detailing the reasons why discipline is being taken against an employee. Employers must also be consistent in their progressive disciplinary actions against all employees. Employers need to take all disciplinary actions knowing that the action may be reviewed or second guessed in a subsequent proceeding should the employee claim retaliation. Like other types of employment litigation, employers must strive to make the reasons for disciplinary actions transparent and fair so they will be upheld if reviewed by a neutral third party. Finally, Employers should consult with a legal expert prior to taking any adverse action against an employee who filed a workers compensation claim.
BAD TERMINATION LETTERS

Dear Mr. Employee,

I regret to inform you that your employment with ABC Manufacturing is hereby terminated, effective immediately. It has come to our attention that you are taking advantage of your employment with ABC Law by “milking” your injury. Multiple individuals, including co-workers and immediate supervisors, have come forward indicating that you are exaggerating your right foot injury and believe you can work well beyond Dr. Jekyll’s work restrictions. At ABC Manufacturing, we do not tolerate such actions. Therefore, effective immediately, your employment with ABC Manufacturing is hereby terminated.

Dear Mr. Employee,

Over the past year, ABC Services has accommodated your work activities per the treating physician’s recommendations. Despite the steps ABC Service’s has taken to accommodate you and your restrictions, you continue to complain about your pain and your workers compensation case. Such complaints negatively impact the morale of your fellow employees. Our output has significantly decreased since you returned to accommodated work. Your pessimism and constant complaints about the workers compensation system will no longer be tolerated. Your employment is terminated effective immediately.

Dear Mr. Employee,

ABC Law appreciates your hard work and dedication over the past 10 years. However, with your recent work injury you have significantly slowed down. Your numbers are down significantly since last month. As you are aware, speed affects profitability and the bottom line. Therefore, we regret to inform you that ABC Law is terminating your employment effective immediately. On the bright side, this will give you ample opportunity to focus on your health and continue to heal from your recent injury.
GOOD TERMINATION LETTER CONSIDERATIONS

• Identify and reference the written policy the employee violated or the performance expectation the employee failed to meet and the written penalty for the violation

• Reference specific events of the violation

• Reference any progressive discipline taken along the way if any including steps you’ve taken to counsel the employee

• Missouri - Comply with the Service Letter statute set out in 290.140 and 36.470
  ○ Under 290.140, if an employee makes a proper written request by certified mail, the employer, within 45 days after receipt of the request, must write a Service Letter setting forth the nature and character of service rendered by the employee, the duration, and the cause, if any, the employee was fired, laid off, or resigned.

  ○ A good termination may be derailed by a bad Service Letter

  ○ Service letter law applies if:
    ▪ The employer was a corporation doing business in Missouri.
    ▪ The employee worked at least 90 days for the employer,
    ▪ The employer employs at least 7 people, and
    ▪ The Service letter request was made within 1 year

  ○ If an employee properly requests a Service Letter and the employer fails to issue one, the employee can sue for damages, including putative in some cases.

  ○ In the event, the employer fails to send a Service Letter or lies about the reason for the termination or resignation, the employee may add the claim to their wrongful termination case or sue only for violation of the Service Letter statute.

  ○ Missouri public employees have may demand a Service Letter under 36.470 if:
    ▪ Employee worked at least 90 days
    ▪ A written request for a Service Letter was made (no certified mail requirement)
- The written request is sent to the head of the department or division employing the employee

  - It's a misdemeanor to refuse to provide a Service Letter when requested pursuant to 36.470
GOOD TERMINATION LETTER EXAMPLE

Dear Mr. Smith,

On December 20, 2014, you met with group manager, John Doe, and plant manager, Jane Doe. In that meeting, you were advised that you engaged in horseplay while on the plant floor when you threw a fake spider at a co-worker on December 18, 2014. Pursuant to Employee Handbook provision 45-100, employees are prohibited from engaging in horseplay on plant premises. You were issued a formal warning letter on that date pursuant to Employee Handbook provision 45-101. You were further advised that Employee Handbook provision 45-200 indicates that an employee who issued three formal warning letters will be terminated.

On January 3, 2015, you had a second meeting with Mr. and Mrs. Doe. You were advised that you violated Safety Rule 150 when you failed to lockout/tag out after working on hazardous machine on January 2, 2015. Safety Rule 150 set out in the Employee Handbook requires that all employees lockout/tag out after working on hazardous machine. You were issued a second warning letter on that date for failure to follow safety rules pursuant to Employee Handbook provision 45-102. At this meeting, you were again advised that if you receive one more formal warning letter your employment would be terminated.

Finally, on January 30, 2015, you attended a third meeting with Mr. and Mrs. Doe. In that meeting, you were advised that you did not appear for work on January 25, 2015. In that meeting you were issued a third warning letter.

To date, you have received three formal warning letters. You received formal warning letters on December 20, 2014; January 3, 2015; and January 30, 2015. As you were advised in each meeting, Employee Handbook provision 45-200 indicates that an employee who is issued three formal warning letters will be terminated. Therefore, pursuant to Employee Handbook provision 45-200, your employment is hereby terminated.

Sincerely,

John Smith
UNCLEAR DUTIES/REQUIREMENTS OF THE JOB

I. Missouri Standard: *The Templemire Decision* – Templemire lowered the standard for claims of retaliatory discharge in Missouri, requiring only that the employee show the filing of a workers' compensation claim was a "contributing factor" to the adverse employment action. Even with a legitimate, non-discriminatory reason for terminating or disciplining the employee the employer may be held liable for retaliatory discrimination under R.S.Mo. Section 287.780. See Templemire v. W & M Welding, Inc., 433 S.W.3d 371 (Mo. 2014).

II. Kansas Standard – While the standard is not as low in Kansas, Kansas still recognizes a common-law tort for retaliatory discharge to protect an employee’s exercise of statutory rights under the Kansas Workers Compensation Act, K.S.A. 44-501 et seq. Murphy v. City of Topeka, 6 Kan. App. 2d 488, 630 P.2d 186 (1981). Employers in Kansas may be held liable where it’s found that the exercise of rights under the workers’ compensation laws is the reason for the adverse employment action.

III. Lower Burden of Proof = Greater Risk of Liability
A. No exclusive or sole causation is required in Missouri
B. In Missouri, even with a legitimate reason for discharge, the employee only needs show that the existence of the workers' compensation claim was a "contributing factor"
C. The contributing factor standard means the employer is forced to show that the workers’ compensation claim played no role in the employment decision

IV. Impact on Job Duties and Responsibilities
A. Termination simply for insubordination can result in liability
B. Having some other reasonable motive for the discharge or discipline may be insufficient to avoid liability
C. Need a clear way to show that violation of job duties or responsibilities was the reason for termination or adverse employment action

V. What to Include in Job Duties/Responsibilities?
A. Document everything
   1. Keep accurate and detailed records of reasons for disciplinary actions against all employees
   2. Create forms for employee discipline that delineate specific requirements/duties of the job
   3. Maintain consistency in progressive disciplinary actions against all employees
   4. Regularly review employee duties and responsibilities with employees in performance reviews or through other assessments
B. Have clearly articulated job standards
1. More detailed standards and responsibilities = greater ability to prove a legitimate reason for termination
2. Use caution with restricted or altered work duties in the event an injured employee returns to work—changed duties or responsibilities could be considered adverse employment action giving rise to a claim
3. Quantifiable standards for job responsibilities and duties make it easier to document deficiencies in performance
4. Notify employees that they are failing to meet standards early, before any action is taken, and provide the opportunity to improve
5. Have a well-documented discipline policy detailing the impact of failure to meet job duties or requirements

C. Have a process for handling violations
   1. Remember that actions taken to discipline or discharge employees may be second guessed—if you have concerns about a particular course of action, odds are someone else will question it too
   2. Document your reasoning and the recourse taken
   3. Where duties or requirements are unavoidably broad or unclear, having a documented process for addressing deficiencies or violations becomes all the more important
   4. Timing is important – the closer to the filing of a workers’ compensation claim by the employee, risk of a retaliation claim becomes more likely and harder to disprove
   5. Follow the policies and process in place – selective application reduces its effectiveness and exposes you to risk

Ultimately, if you have an employee with a workers’ compensation claim and are concerned about termination and retaliation, seek legal counsel
MEDICARE ISSUES IN WORKERS’ COMPENSATION AND LIABILITY CLAIMS

LEGISLATIVE AND REGULATORY UPDATES

APPEAL RIGHTS FOR APPLICABLE PLANS
On February 27, 2015, CMs issued a final rule implementing certain provision of the SMART Act to establish a formal appeals process for applicable plans (liability insurance, no-fault insurance, and workers’ compensation) in situations where CMS seeks recovery for conditional payments directly from an applicable plan. The rule is effective April 28, 2015 and applies to demand letters issued on or after April 28, 2015. CMS is required to send notice to the beneficiary the applicable plan has appealed. The formal appeals process mirrors the process already established for other Medicare appeals. This process includes: 1) An “initial determination” (the MSP recovery demand letter), 2) a “redetermination” by the contractor issuing the recovery demand, 3) a “reconsideration” by a Qualified Independent Contractor, 4) a hearing by an administrative law judge, 5) a review by the Departmental Appeals Board’s Medicare Appeals Council, and 6) judicial review. All administrative appeals must be exhausted before judicial review is allowed. The appeal process is limited to the issue of the amount or existence of the claimed debt. The issue of who is the responsible party/correct debtor will not be allowed. Medicare’s decision regarding who or what entity it pursues for recovery is not subject to appeal.

CHANGE TO ICD-10 CODES FOR MANDATORY REPORTING
Effective October 1, 2015, RREs will be required to report ICD-10 diagnosis codes on claim reports with a CMS Date of Incident (DOI) on or after 10/1/15.

CHANGE IN REPORTING SSNs/HICNs
Effective January 5, 2015, where an RRE cannot obtain an individual’s HICN or full SSN, RREs may report the following data elements to enable CMS to identify a Medicare beneficiary: 1) last five digits of SSN, 2) first initial, 3) surname, 4) date of birth, and 5) gender. If all data elements cannot be obtained, the RRE must document its attempts to obtain this information.

LIABILITY CLAIM REPORTING THRESHOLDS
The reporting threshold for liability claims changed from $300 to $1000 for liability claims resolved on or after October 1, 2014.

COMING SOON
MFA on MSPRP
As part of the SMART Act, CMS will be implementing optional Multi-factor Authentication (MFA) services on the Medicare Secondary Payer Recovery Portal (MSPRP). MFA is the use of two or more different authentication factors to verify the
identity of a user. Verified users will have access to view unmasked claims data on the MSPRP.

Non-beneficiaries will still need a verified Proof of Representation or Consent to Release authorization to perform actions on cases. MFA and associated identity proofing process will be optional for MSPRP users. With proper authorization non-beneficiaries will be able to access information and perform actions previously only available to beneficiaries.

MFA is scheduled to be available on July 13, 2015 with user guides and training materials available upon implementation.

CONDITIONAL PAYMENT PORTAL AND PROCEDURE
A New portal to handle the conditional payment requirements of the SMART Act is expected to be operational no later than January 1, 2016. This portal will allow parties to report settlement amounts and receive final conditional payment information prior to the final settlement in accordance with the SMART Act. Further information will be available upon implementation.

CASE LAW UPDATES
Q: Do Medicare Advantage Organizations (MAOs) have the same rights to recovery of conditional payments as the federal government?

A: There is a split among the courts in various jurisdictions, but this issue is popping up all over the country. More courts are finding MAOs have the same recovery rights as the federal government and may recover double damages. Most recently, in *Humana v. Western Heritage Insurance Co.* (S.D. Fla March 16, 2015), the district court followed the same theory advanced in *In re Avandia Marketing Sales Practices & Products Liability Litigation*, 685 F.3d 353 (3rd Cir 2012). The Southern District of Florida found that a Medicare Advantage Plan is entitled to the same rights as the federal government under the MSP, including bringing cases in federal court and recovering double damages. Notably, the beneficiary had specifically represented to the insurer that she was not in a Medicare Advantage Plan, but the court still awarded double damages. This case has been appealed to the Eleventh Circuit, which has not yet weighed in on this issue.

Similarly in *Humana Ins. Co. v. Farmers Texas Cnty. Mut. Ins. Co.* (W.D. Tex. Sept. 24, 2014), the Court denied defendant’s motion for summary judgment finding that Humana could proceed with its claim for double damages under the MSP related to reimbursement of benefits paid under a Medicare Advantage Program. The Fifth Circuit has not addressed this issue yet. Humana simultaneously filed suit against Farmers in several other jurisdictions, including Kansas and the Western District of Missouri. Those suits do not have published decisions on this issue yet, but are still under litigation. The Sixth and Ninth Circuits have previously rejected these claims creating a conflict among the circuit courts.
Although some courts have rejected this argument, other courts have awarded substantial damages. Treating MAOs as equal to Medicare plans administered by the Federal Government creates several pitfalls for insurers. First, there is no central agency to coordinate discovery of claimed conditional payments for MAOs. Each organization is separately and privately maintained. Beneficiaries may have participated in Medicare Advantage Plans with multiple organizations. There is no process or procedure for checking with or receiving notification from MAOs of claimed entitlement to payment prior to settlement. Thorough investigation is necessary often causing uncertainty and delays in settlement.

Q: If a beneficiary or other entity seeks recovery of conditional payment amounts through the MSP’s private cause of action, can the defendant avoid liability by paying the claimed amount directly to Medicare in accordance with Medicare’s request and procedure for payment?

A: Not according to the Western District of Kentucky. In Estate of McDonald v. Indem. Ins. Co. of N. Am., 46 F. Supp. 3d 712 (W.D. Ky. 2014), the district court held: “Once a private cause of action claim has been lodged against a defendant, a defendant cannot escape the double damages provided for in that provision by paying single damages to Medicare.” In this case two years passed from a workers’ compensation court order finding that the employer/insurer was liable for treatment to a deceased worker without any payment to Medicare. The employer and its carrier did not inform Medicare of the award and Medicare did not request reimbursement until after the private cause of action was filed. After the suit was filed, Medicare sent a demand letter to the carrier, which was paid in full within 60 days of receiving the demand letter from Medicare in accordance with Medicare’s requirements. Nevertheless, the court still awarded double damages to the estate on top of the amount already paid directly to Medicare.

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THE MEDICARE SECONDARY PAYER STATUTE

BACKGROUND:

As a federal cost-saving statute enacted in 1980 to combat increasing costs of Medicare, the 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 taken into account regarding both past medical and future medical expenses.

There are four main resources to help the parties decipher their rights and responsibilities under the MSP: (1) the Act itself; (2) the federal regulations promulgated by the Secretary of Health and Human Services; (3) case law; and (4) memoranda and statements issued by the Centers for Medicare and Medicaid Services (CMS). Not all of these sources are equal and may be subject to conflicting interpretations.

PAST MEDICAL: Conditional Payments

Statutory Authority: 42 USC §1395y(b)(2)

- 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).

- 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).

- 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).

**Regulatory Authority: 42 C.F.R §411**

Agency regulations interpreting statutes are given deference if (1) Congress has not “directly spoken to the precise question at issue,” and (2) the agency's interpretation is reasonable. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–44, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). Federal Courts have held that certain regulations interpreting the MSP are entitled to *Chevron* deference. See *Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast and Southwest Areas Health and Welfare Fund*, 656 F.3d 277 (6th Cir. 2011) (interpretation reasonable because it furthers the Act's goal of preventing private plans from shifting costs to Medicare). Therefore, the regulations may be given the same force as the actual MSP statute, but must be scrutinized in conjunction with the MSP.

- 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.

- This section does not apply in the case of liability insurance or when failure to file a proper claim is due to mental or physical incapacity of the beneficiary
- “Proper claim” means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.” 42 C.F.R §411.24.21
- See Caldera v. Ins. Co. of the State of Pa. ---F.3d ----(5th Cir. 2013) (claimant could not recover from carrier under MSP when claimant failed to obtain necessary pre-authorization required by state workers’ compensation law).

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

Recovery against the party that received payment:

- 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.
- 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.

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

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)

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)

A conditional payment may be made if either:

- 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.
- The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

Case Law

The United States may recover, against “any entity.”

In *U.S. v. Harris*, 2009 WL 891931 (N.D.W. Va 2009), the United States sued plaintiff's attorney for failing to pay demand from Medicare for reimbursement of Medicare conditional payments arising out of product liability lawsuit. The claim settled for $25,000.00 releasing defendants of all liability. CMS asserted $22,500 in conditional payments and requested reimbursement in the amount of $10,253.59. After receiving a final demand letter, plaintiff’s attorney failed to reimburse CMS within 60 days.

The court granted summary judgment to the U.S. against Harris for $11,367.78 plus interest. The court held “Mr. Harris is individually liable for reimbursing Medicare in this case because the government can recover ‘from any entity,’ including an attorney.”

In *U.S. v. Stricker*, 2010 WL 6599489 (N.D. Ala) (currently in litigation), the United States sued plaintiff's attorneys, defendant drug companies, and defendant drug companies' insurance carriers to recover conditional payments. This is the first case where Medicare has named parties on both sides of the fence as responsible for resolution and reimbursement of conditional payments.

The underlying lawsuit involved pharmaceutical class action for injuries resulting from individual plaintiff's exposure to Monsato PCBs dating back to 2003. The class action
suit settled for $300,000,000.00 and involved 907 Medicare beneficiaries who had received a total of $67,156,770.01 in conditional payments.

The district court’s dismissal of the government’s suit as untimely was affirmed by the circuit court. 524 Fed.Appx. 500 (11th Cir. 2013).

Allocation of settlement proceeds

In Bradley v. Sebelius, 621 F.3d 1330 (11th Cir. 2010), a plaintiff settled wrongful death tort claims for the full amount of the defendant’s insurance policy limit of $52,500.00, which was approximately 10% of the claims’ total value. This settlement involved the estate’s claims as well as loss of consortium or companionship claims of the decedent’s ten children. Counsel for the estate and the children filed an application with the probate court to adjudicate the proper allocation of the settlement proceeds among the estate and children. Medicare was given notice of the probate court proceedings, but declined to appear or participate.

The probate court ordered that based on principles of equity, the medical expense recovery in the case was $787.50 and the independent survivors’ claims recovery was $51,712.50. CMS refused to recognize that the medical expense claim had been settled for less than 100% and demanded a net amount of $22,480.89 in conditional payment reimbursements. CMS relied on the “Medicare Secondary Manual” which states that “the only situation in which Medicare recognizes allocations of liability payments to non-medical losses is when payment is based on a court order on the merits of the case.” The court held that the field manual was not entitled to Chevron-style deference and was not entitled to the force of law. The circuit court found CMS was only entitled to $787.50 as CMS’s position “would have a chilling effect on settlement.” Furthermore, the Court stated “Without citing any statutory authority, regulatory authority, or case law authority, the Secretary and the district court’s reliance upon language in a field manual is unpersuasive.”

In Mason v. Sebelius, 2012 WL 1019131, (D.N.J. 2012) (unpublished), the plaintiff slipped and fell at the Showboat casino. Plaintiff agreed to release Showboat for all claims against it for liability stemming from the fall, including his wife’s claim, in exchange for a lump sum payment of $40,000.00. As a term of the settlement, the plaintiff agreed to indemnify Showboat against any liability for Medicare liens or claims for reimbursement.

The plaintiff sought an order from the Superior Court apportioning the settlement proceeds and declaring that no portion of the settlement was attributable to medical expenses. In this case, CMS intervened in the state court to oppose the motion and the court denied the motion concluding that such a determination must be made first through the Medicare administrative review process. CMS demanded reimbursement of $1,423.43 after reduction for procurement costs. Plaintiff paid the reimbursement, but sought a waiver and refund through the Medicare administrative appeals process. Ultimately, the appeals council denied the appeal.
Among other arguments, Claimant sought judicial review of the administrative decisions, after exhausting the administrative appeal process, asserting that Medicare reimbursement is not authorized under the MSP because his settlement was for an undifferentiated lump sum and not explicitly allocated to his medical expenses. The Court interpreted 42 U.S.C. §1395y(b)(2)(B)(ii) to clearly state that a lump sum settlement through a release and waiver such as plaintiff’s demonstrates the responsibility of the tort defendant primary plan for the subject medical expenses. Therefore, the Court affirmed the administrative finding that the plaintiff was required to reimburse the full conditional payment amount to CMS.

Interplay between MSP and workers’ compensation law

In *Caldera v. Ins. Co. of the State of Pa.*, ---F.3d ---- (5th Cir. 2013), the claimant brought suit against a workers’ compensation insurance carrier seeking double damages for past medical expenses paid by Medicare (**Note: suit brought by workers’ compensation claimant under private cause of action, NOT by CMS**). Defendant insurance carrier denied responsibility for payment of the disputed medical expenses because the claimant failed to obtain pre-authorization in accordance with Texas workers’ compensation law. Plaintiff argued the MSP preempts the Texas preauthorization requirement.

Citing numerous regulations found in 42 C.F.R. §411, the Court concluded that Congress intended the MSP to complement, not supplant, state workers’ compensation rules, including the preauthorization requirement. The Court found the claimant failed to file a proper claim in accordance with state-law requirements, and therefore, could not recover benefits from the primary payer. The Court held “Medicare can refuse to make a conditional payment, or it can seek reimbursement from the claimant himself. In any event, the claimant cannot succeed under the MSP.”

Collection practices of CMS

In *Haro v. Sebelius*, 789 F.Supp.2d 1179 (D. Ariz. 2011), a class action lawsuit challenged CMS’s administration of the MSP program, specifically with regard to seeking conditional payment reimbursement. The Court found that CMS’s application of the 60-day reimbursement requirement to support immediate collection activities against beneficiaries when the reimbursement claim is in dispute was neither rational nor consistent with the statutory scheme providing for waiver and appeal rights. Additionally, CMS had no authority to keep a claimant’s attorney from distributing undisputed settlement funds to the claimant pending the dispute.

Following this decision, CMS revised its standard “Rights and Responsibilities Letter,” conditional payment demand letters, and other publications to conform to the court’s opinion.
On review before the Ninth Circuit, the circuit court vacated the district court order and held that the Secretary’s interpretation requiring attorneys to withhold funds from their clients was rational and consistent with statute's text, history, and purpose. 2014 WL 21353, ---F.3d---- (9th Cir. 2013) (amended January 2, 2014).

Private cause of action and extension to Medicare Advantage Programs

*In re Avandia Marketing, Sales Practices, and Products Liability Litigation*, 685 F.3d 353 (3rd Cir. 2012) involves the expansion of the private cause of action under the MSP to private health insurance companies administering Medicare Advantage plans. The court held that health insurance companies that provide Medicare Advantage plans have the right to bring suit for reimbursement for expenses incurred treating insureds’ injuries resulting from manufacturer’s drug. The provision in the MSP establishing a private cause of action for damages was broad and unambiguous. Additionally, the court granted *Chevron* deference to the regulations, which clearly give Medicare Advantage organizations the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations.

**FUTURE MEDICAL: MSAs**

**Statutory Authority**

- 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).

- No other statutory guidance

**Regulatory Authority**

- The regulations only address future medical under workers’ compensation claims. The regulations are silent regarding future medical in 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)

- 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?

- This provision cannot be used by an employee to challenge terms of lump sum settlement under private cause of action when employee had never been required to pay for medical care arising from the injury and was not eligible for Medicare benefits. Frazer v. CNA Ins. Co., 374 F.Supp.2d 1067 (N.D.Ala 2005).

- 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)

- 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)

**CMS Publications**

- Publications and information posted by CMS, such as regional office memoranda or information on the CMS website is NOT given Chevron-style deference. Therefore, it has no force of law. See Bradley v. Sebelius discussed above.

- 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.

- Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide published November 6, 2013, 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 WC 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 WC 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 third party 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 WC 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 a WCMSA but do not receive CMS approval, then 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.

CMS states establishing a WCMSA is not necessary when ALL of the following are true:

- The employee is only being compensated for past medical expenses;
- There is no evidence that the individual is attempting to maximize the other aspects of the settlement; AND
- 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.

CMS threshold for review and approval of a WCMSA

- Claimant is currently Medicare eligible and total settlement is over $25,000
“Medicare eligible” includes:

- Age 65 or older;
- Receiving SSDI benefits for more than 24 months; or
- End stage renal failure

- Claimant is reasonably expected to become Medicare eligible within 30 months and total settlement is over $250,000

“Reasonably expected to become Medicare eligible” includes:

- Age 62.5 or older;
- Applied for SSDI benefits;
- Appealing denial of SSDI benefits; or
- 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 WC 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 WC injury.

**Case Law**

All federal case law discussing the requirements for protecting Medicare’s interests relative to future medical expenses results from liability claims. There are no published federal cases involving the merits of establishing MSAs under workers’ compensation. In fact, as discussed in more detail below, federal courts cannot exercise jurisdiction over Medicare claims under federal subject matter jurisdiction basis until the Medicare administrative appeals process has been exhausted. Although outside the scope of this
discussion, the liability cases that have evaluated the MSP on its merits have had to submit federal jurisdiction through alternate methods, such as diversity jurisdiction or an underlying federal question claim. Therefore, obtaining meaningful discussion regarding MSA issues in the courts is quite limited.

Subject Matter Jurisdiction

In *Walters v. Leavitt*, 376 F.Supp.2d 746 (E.D. Mich 2005), a Medicare recipient brought declaratory judgment suit against the acting Secretary of the Department of Health and Human Services concerning the rights of parties under MSP provisions. The plaintiff submitted he was unable to settle his state law tort action without knowing the amount the federal government will require in reimbursement or the amount to be set aside for future payments.

The Court held that until a claimant has exhausted his administrative remedies by going through the agency appeals process, a federal district court has no subject matter jurisdiction over his lawsuit seeking to recover on any claim arising out of the Medicare Act. Practically, this means the plaintiff could not have federal review of Medicare’s rights until he received a demand from Medicare and went through the administrative process. Plaintiffs must wait for Medicare to request recovery or deny payment for services to obtain federal review.

Allocation of settlement for future medical expenses and determination of amount needed to set-aside to adequately protect Medicare’s interests

In *Benoit v. Neustrom*, 2013 WL 1702120 (W.D. La. 2013), a plaintiff asked the court to enter a judgment approving settlement and declaring the interests of Medicare were adequately protected by the terms of the settlement, which included a possible allocation proportionate to Plaintiff’s recovery. The parties agreed to settle all issues for a lump sum payment of $100,000.00. After payment of fees, expenses, and Medicare conditional payments, the settlement amount reduced to $55,707.98.

The court set the matter for hearing and ordered service be made on the Secretary of Health and Human Services, Chief Counsel of the HHS/OGC for region VI and the Civil Chief of the Office of the US Attorney for the Western District of Louisiana. The US Attorney’s office sent a letter advising of a demand for conditional payment reimbursement, but did not participate in the hearing.

At the hearing, an MSA vendor gave cost projections for future Medicare-covered medical expenses ranging from $277,758.62 to $333,267.02. Plaintiff argued that 10% of the gross settlement proceeds would be an equitable amount to set aside to protect Medicare’s interests because the recovery he obtained was approximately 10% of the possible recovery he would obtain if he had prevailed on the liability issues.
The Court rejected Plaintiff’s suggested methodology, but did find that an equitable allocation was in order for the family to fund a special needs trust for much needed items not otherwise covered by Medicare. The court found the net amount to the plaintiff under the settlement was $18.2% of the mid-point in MSA ranges. Accordingly, the Court found that 18.2% of the net amount, or $10,138.00 was an adequate amount to set aside to protect Medicare’s interests. The court held that “Since CMS provides no other procedure by which to determine the adequacy of protecting Medicare’s interests for future medical needs and/or expenses in conjunction with the settlement of third party claims, and since there is a strong public interest in resolving lawsuits through settlement, the Court finds that Medicare’s interests have been adequately protected in the settlement within the meaning of the MSP.”

**Determination of necessary MSA Amount**

In *Sipler v. TransAm Trucking, Inc.*, 881 F.Supp.2d 635 (W.D. N.J. 2012), on the eve of trial, the parties verbally agreed to a lump sum settlement to settle all liability claims arising out of a personal injury action. Defendant sent Plaintiff a proposed release that included terms related to the plaintiff’s health insurance and obligations to Medicare. Plaintiff refused inclusion of the additional terms and moved to enforce the verbal settlement agreement.

Applicable state law provided a settlement agreement between parties to a lawsuit would be enforced notwithstanding the fact the writing does not materialize because a party later reneges. Therefore, the settlement agreement was enforceable. The issue was the appropriate terms of the settlement.

The court held that no federal law requires set-aside arrangements in personal injury settlements for future medical expenses. Although the court indicated MSAs are prudent in the workers’ compensation context (and incorrectly cited to the regulations as the MSP), the court found that unlike the workers’ compensation scheme which generally determines recovery on the basis of a rigid formula, tort cases involve noneconomic damages not available in workers’ compensation cases and a victim’s damages are not determined by an established formula. The Court stated “to require personal injury settlements to specifically apportion future medical expenses would prove burdensome to the settlement process, and, in turn, discourage personal injury settlements. In sum, the parties in this case need not include language in the settlement documents noting [plaintiff’s] obligations to Medicare or fashion a Medicare set-aside for future medical expenses.”


All the above claims were liability claims with federal jurisdiction separate and distinct from Medicare questions. The courts set the matter for hearing and ordered service be made on CMS representatives, including the Secretary of Health and Human Services, Chief Counsel of the HHS and the Civil Chief of the Office of the US Attorney. CMS did not appear or participate, but sent similar letters advising of no appearance or participation. The courts held evidentiary hearings admitting testimony of the claimant, testimony or reports of an “MSA expert,” and reports of treating physicians.

Based on the evidence presented, the courts made findings regarding the proper amount of an MSA and found that Medicare’s interests had been adequately protected in the settlement within the meaning of the MSP. None of the decisions have been selected for publication by the district courts or have been challenged on appeal or by other collateral methods. All courts found establishing an MSA in the approved amount adequately protected Medicare’s interests within the meaning of the MSP.