June 2016

ARTHUR CHAPMAN
KETTERING SMETAK & PIKALA, P.A.
ATTORNEYS AT LAW

Volume XV

WISCONSIN WORKER'S COMPENSATION UPDATE

IN THIS ISSUE

WISCONSIN WORKER'S COMPENSATION PRACTICE GROUP

Susan E. Larson, Shareholder
Charles B. Harris, Sr. Attorney
Jessica L. Ringgenberg, Associate

Karen R.S. Tulk, Paralegal
Bao Vang, Paralegal

✦ PASS IT ON ✦

Please share this update with others.

CASE LAW UPDATE

DECISIONS OF THE WISCONSIN COURT OF APPEALS

EXCLUSIVE REMEDY

Ninedorf v. Joyal, No. 2014AP2762 (Wis. Ct. App. 2016). Mr. Ninedorf and Mr. Joyal worked for General Beer-Northwest, Inc., a beverage distributor. Late afternoon on a Friday, a customer requested an order of beer from Mr. Joyal. The two men decided to deliver the beer together. They anticipated they would visit bars on their own time after the delivery. After the beer was delivered they stayed at that location for several drinks. They considered work to be done at that point. They went to several other bars in a nearby town and had ten to twelve drinks. On their way back home, while Mr. Joyal was driving, they were involved in a motor vehicle accident. Mr. Ninedorf was paralyzed. The Circuit Court granted summary judgement to Mr. Joyal's personal automobile insurer on the basis that the exclusive remedy rule applied because Mr. Ninedorf was within the course of employment at the time of the injury.

continued on next page . . .

Susan E. Larson
SELarson@ArthurChapman.com

Charles B. Harris
CBHarris@ArthurChapman.com

Jessica L. Ringgenberg
JLRinggenberg@ArthurChapman.com

ABOUT OUR ATTORNEYS

Our group of worker's compensation law attorneys has extensive experience representing employers, insurers, third-party administrators, and self-insured employers in all phases of worker's compensation litigation. Contact us today to discuss your worker's compensation needs.

811 1st Street
Suite 200
Hudson, WI 54016
Phone 715 386-9000 Fax 612 339-7655

500 Young Quinlan Building
81 South Ninth Street
Minneapolis, MN 55402
Phone 612 339-3500 Fax 612 339-7655

www.ArthurChapman.com

The Court of Appeals affirmed. Numerous maps and route options via MapQuest and Google Maps revealed the city where the men were last drinking was a reasonable place to drive through between the delivery of beer and returning home. Once the men completed drinking at the bars, and returned to their car and route home, their deviation from employment was complete. They resumed their trip home along a reasonable route and were back in the course of employment. Intoxication does not negate worker's compensation coverage. The men returned to the course of employment at that time and therefore workers' compensation benefit are the exclusive remedy. [Comment: This case began in civil court. General Beer-Northwest, Inc.'s worker's compensation insurer denied coverage on the basis that Mr. Ninedorf was not in the course of employment. General Beer-Northwest, Inc.'s liability insurer denied the case on the basis that he was in the course of employment. The only insurer affected by the summary judgement and this decision was Mr. Joyal's personal automobile insurer.]

Insurance Coverage

Rhyner v. Rydberg, No. 2015AP2010 (Wis. Ct. App. 2016). General Casualty Company of Wisconsin issued a worker's compensation policy to Veterinary Medical Services Corporation. Ms. Rhyner sued Mr. Rydberg for an intentional tort in the nature of sexually groping her while both were at work for Veterinary Medical Services Corporation. Mr. Rydberg sought coverage for the claims from General Casualty. On summary judgement, the Circuit Court determined that General Casualty had no initial duty to defend Mr. Rydberg, no ongoing duty to defend and no duty to indemnify Mr. Rydberg in the event he is liable to Ms. Ryhner. The Court of Appeals affirmed. Ms. Rhyner brought her allegations against Mr. Rydberg under the assault exception of Wis. Stat. 102.03(2). She did not seek worker's compensation benefits. Wis. Stat. 102.03(2) provides an exception to the exclusive remedy and recovery provisions of worker's compensation when an employee is injured by another employee. General Casualty's worker's compensation policy does not cover individual employees. It provided worker's compensation coverage to the employer for worker's compensation claim. Mr. Rydberg was not an insured under the policy and this action was not a worker's compensation claim. The policy language provided the right and duty to defend claims, proceedings or suits against the employer for benefits payable by the insurance. The only benefits payable by the insurance per the policy were benefits required of the employer by the worker's compensation law. General Casualty's worker's compensation policy was not intended to cover the claim asserted. ✦

There is still time to Register!
2016 Workers Compensation Seminars

Thursday, June 9, 2016
McNamara Alumni Center, University of Minnesota
Minneapolis, Minnesota

Thursday, June 16, 2016
Crowne Plaza, Wauwatosa, Wisconsin

Contact Marie Kopetzki at 612 225-6768 or email
mkkopetzki@arthurchapman.com for more details or to register.

Decisions of the Wisconsin Labor and Industry Review Commission

Arising Out Of

Austin v. Seneca Foods, Claim No. 2014-030188 (LIRC Jan. 26. 2016). The applicant alleged that he sustained a work-related knee injury while working on a machine. He testified that he had no problems with his knee prior to that date. The applicant testified that he told his group leader about the incident the night it occurred. The group leader testified that she was not working the night of the alleged incident. The applicant also alleged he told a supervisor about the incident the following week. The supervisor denied that occurred. The applicant did not seek treatment for several weeks. During that time, he worked without restrictions. The supervisor testified that, a few weeks prior to the hearing, the applicant told him the condition was not work related. An unnamed administrative law judge held the applicant sustained a work-related injury and awarded benefits. The Labor and Industry Review Commission reversed. The applicant was not credible with respect to his testimony regarding notice allegedly provided to the group lead and supervisor. The supervisor was credible in his testimony that the applicant reported his condition was not work related but that his doctor characterized it that way. When a treating physician bases his or her opinion on an inaccurate history of events, that opinion cannot credibly carry the worker's evidentiary burden.

Chovanec v. Wal-Mart Associates, Inc., Claim No. 2014-030273 (LIRC February 26, 2016). The applicant alleged she sustained an injury nine minutes after she punched out from her work shift. At the time, she was looking for a manager to open a door in the back of the employer's store so that she could remove some of the employer's tables from the store to use at her private yard sale. The employer had given the applicant permission to do so on this occasion, and had done so in the past. Administrative Law Judge Enemuoh-Trammell determined the applicant was not in the course of her employment at the time of the alleged injury. The Labor and Industry Review Commission affirmed. Even if (as alleged) the employer lent its tables to its employees to improve morale and the employer therefore received a benefit from loaning the tables, that does not mean the applicant was furthering the interest of the employer such as to put the applicant in the course of her employment while she was in the process of borrowing tables. Further, the applicant was not going from her employment in the ordinary and usual way.

Delo v. County of Clark, Claim No. 2014-026382 (LIRC April 11, 2016). The applicant slipped and fell while throwing a roll of fence, which was four feet long, two feet in diameter and weighed 100 pounds, over his right shoulder. He felt as though he had torn his scrotum or groin when he fell. His buttock and hip hurt as well. The applicant felt nauseated but did not vomit. He rode around with a coworker and did not do a lot of work the rest of the day. The applicant told his foreman and the office that he had hurt his groin in the fall when he returned to the shop later the same day. He did not seek treatment right away because he thought he had just pulled something. The applicant did take aspirin and ibuprofen and iced his groin ever night. The pain improved after a couple weeks, but still caused intense pain when he shifted to the right side. He was diagnosed with an inguinal hernia after he initiated medical treatment, approximately three weeks post injury. The physician's assistant who first evaluated the applicant immediately suspected an inguinal hernia was sustained. He underwent surgery a few weeks after the diagnosis and went on to have a full recovery. Dr. Goodman performed a record review at the request of the respondents. He opined that the slip and fall and stretching of the groin or strain to the right hip was not compatible with the development or aggravation of an inguinal hernia. Administrative Law Judge Sass held the applicant did sustain a hernia injury as a result of the work-related injury, and awarded all benefits. The Labor and Industry Review Commission affirmed. The *Meade/McCarthy* standards (special standards or guidelines for evaluating inguinal hernias) are guidelines only for the internal use by the Commission, by which the credibility or probativeness of testimony can be tested. The courts have held they will not reverse the Commission, even if the commission completely ignores the *Meade/McCarthy* guidelines, as long as there is substantial and credible evidence to support the Commission's decision. *See Gleiss v. Hamischfeger and E.F. Brewer*

Co. v. DILHR. The applicant in this case met some of the *Meade/ McCarthy* standards. That, along with proper consideration of the medical experts, results in the claim being compensable.

Jespersen v. Appleton Electric LLC Electrical Group, Claim No. 2014-009179 (LIRC April 28, 2016). The applicant, who formerly lived in Illinois, was hired by the employer. As part of the hiring package, he was given the right to live in temporary housing for up to 60 days and the use of a rental car for up to 14 days. Nine days after starting work, he slipped and fell in the bathroom shower at the temporary housing. He alleged that he was a traveling employee and therefore in the scope of his employment while in the temporary housing. The unnamed administrative law judge held the applicant was in the course of his employment and awarded benefits. The Labor and Industry Review Commission reversed. The applicant had relinquished the apartment he rented in Illinois immediately. He began looking for permanent housing in Milwaukee. He had his furniture in storage. While the premises in which he was living were "temporary," his commitment to living in Milwaukee was permanent. Therefore he was not a traveling employee and the injuries sustained were not compensable.

O'Brien v. Dept. of Corrections, Claim No. 2014-007277 (LIRC April 28, 2016). The applicant sustained an injury to his neck in 2007 while involved in a training exercise with the U.S. Army. While employed by the employer at this time, he was not in the course of employment for the employer when this occurred, and was instead on military duty. He was originally diagnosed with a "stinger." He underwent extensive treatment, culminating with a two-level cervical fusion (C5-C7) in May 2013. The applicant was released back to work in August 2013. He continued to report ongoing cervical symptoms. On September 6, 2013, while seated in a chair at work, the chair broke and the applicant fell backwards. The applicant alleged he had to jerk his neck forward in order to avoid hitting his head during the fall. In February 2014, the applicant underwent another surgery because of ongoing pain. The surgeon diagnosed him with a pseudo arthrosis at C5-6 and determined that the screws from the prior surgery were loose. A C5-C7 revision fusion was performed. There was conflicting medical evidence regarding whether the September 2013 injury was the cause of the pseudo arthrosis. Dr. Boco performed a record review and opined the cause of the pseudo arthrosis was probably due to the applicant's continuing to smoke post-surgery. The unnamed administrative law judge held the applicant did sustain a work-related injury, resulting in the need for the fusion revision, and awarded benefits. The Labor and Industry Review Commission reversed. The physical symptoms, before and after the September incident, remained substantially the same. There were no radiological films that would verify that the bone had ever actually fused after the first procedure and had thereafter been broken as a result of the September fall. The treating physician failed to explain the basis behind his opinion and did not provide any evidence in contrast to Dr. Boco's opinion regarding the cause of the pseudo arthrosis.

Smoody v. Arora Health Care, Inc., Claim No. 2013-007163 (LIRC April 28, 2016). The applicant alleged she sustained an injury as a result of a slip and fall near a doorway. Just before she walked through the doorway, a janitor had cleaned the floor using a floor cleaning machine. This machine used a mixture of cleaning fluid and water. The machine automatically would leave the floor in a condition where any remaining solution would normally evaporate within thirty seconds. This was done through the use of squeegees which directed the used solution to a location where it was vacuumed up. The applicant's initial indication at the scene was that she did not know why she fell. The janitor who was cleaning the floors immediately came to her aid. The janitor testified the floor was not slippery in the area and the floor was dry. A security officer, on the day involved, walked behind the floor scrubbing machine in an attempt to slip and was not able to do so. Administrative Law Judge Michelstetter held the applicant did not prove that the fall was related to any hazard related to the work environment. The Labor and Industry Review Commission affirmed. An idiopathic fall (one that is due to a personal condition of the employee) is not related to the employment and is not compensable. Similarly, a truly unexplained fall (such as the one involved) likewise is not related to employment and the effects of such a fall are not compensable

Trexell v. Aurora Health Care, Inc., Claim No. 2014-001552 (LIRC May 23, 2016). The applicant alleged she sustained a knee injury while kneeling down on a floor to draw blood from a patient. Dr. Bartlett performed an independent medical examination. He opined her condition was naturally occurring progression of degenerative arthritis. He opined that kneeling followed by a power up would provide excessive force to the degenerative knee and cause the onset of symptoms. However, he opined there was no evidence the condition was accelerated beyond normal progression. Additionally, there was a dispute over whether

or not the applicant reported the injury to the head of nurses as alleged. She alleged that the head of nurses told her to "wait and see" how her condition progressed before filing a formal report of injury. Medical records reflect she reported experiencing symptoms for close to two months before initiating medical treatment. The unnamed administrative law judge held the applicant sustained a work-related injury. The Labor and Industry Review Commission reversed. It is difficult to believe the head of nurses would not advise the applicant to formally report the incident or seek medical treatment. While she testified to the exact date the incident occurred, she told her doctors she had experienced pain for approximately two months without reporting a specific incident. It is not credible that the applicant, after experiencing a burning/poking/pulling sensation in her right knee, which caused pain and swelling and also caused her to alter her physical routines, would wait for months to seek treatment. [Comment: The Commission consulted the administrative law judge to determine his demeanor impressions. The unnamed administrative law judge indicated the applicant was "unflappable" and convinced the judge that her work exposure substantially contributed to her injury, and that he believed her testimony. Despite not having any live testimony, the Commission disagreed with the applicant's credibility and instead specifically held that her testimony regarding the alleged incident/injury was not credible.]

Bad Faith

Graff, Jr. v. E&A Enterprises, Inc., Claim No. 2006-001645 (LIRC Feb. 5, 2016). The applicant sustained an admitted work injury in December 2005. The parties entered into a limited compromise agreement in January 2009. The limited compromise agreement included a provision addressing a Medicare Set-Aside Account. The Medicare Set-Aside Account was not funded. On May 25, 2012, the employer and insurer were held to be in bad faith as a result of not funding the account. The employer and insurer still did not fund the account. Another application for bad faith was filed on July 19, 2013 for failure to fund the Medicare Set-Aside Account. The parties entered into another limited compromise agreement to resolve the bad faith claim. The agreement was approved via an Order dated December 17, 2013. The parties then attempted to negotiate an agreement for the terms of the Medicare Set-Aside Account, between January 2014 and October 2014. There was an agreement; however, the employer and insurer could purchase an annuity from a third-party to fund the agreement. However, the applicant objected to language to make him financially responsible if the third- party annuity failed. The applicant's medical condition worsened. He was scheduled for another surgery on August 4, 2014. This had to be rescheduled approximately three weeks because the insurer did not respond to requests from the hospital. On August 1, 2014, the applicant filed another application for bad faith for failure to fund the Medicare Set-Aside Account. Two months later, the applicant made the employer and insurer aware of a Department memorandum from July 2013. This stated the annuity was subject to certain conditions, including requiring that the insurer remain liable for payments required in the event of the annuity company's insolvency. [This was the opposite of the position alleged by the employer and insurer to prolong the negotiations.] Administrative Law Judge Roberts noted that the Compromise Agreement provided that the insurer would pay the medical expense until the Set-Aside was funded. He determined that, therefore, medical bills were being paid. He noted that there had been extended negotiations over the precise terms and wording of the MSA. Because the respondents immediately dropped the language upon being furnished with a copy of the Department's policy, it was reasonable to assume that the respondents had simply been unaware of the Department's policy. This was not bad faith. The Labor and Industry Review Commission affirmed. The Circuit Court reversed and remanded the case to the Commission for further action. Judge Vale held that simply negotiating does not amount to a good faith effort to comply with the requirement that a Medicare Set-Aside Account be set up. To hold otherwise would allow the employer and insurer to use the negotiation process to delay proceeding and coerce the applicant into accepting an unfavorable position. That decision was not appealed. On remand, the Commission awarded the applicant the maximum bad faith penalty of $30,000.00. This was less than 10% of the amount of the Medicare Set-Aside Account. The delay in setting up the Medicare Set-Aside Account had serious and negative consequences for the applicant. His treating physician opined the delay was detrimental because the applicant became weaker during the period of delay, and put him at greater risk of permanent nerve damage. In addition he experienced anxiety because of an uncertainty as to whether he would be able to receive the necessary medical treatment.

Choice of Provider

Adams v. Eland Electric, Claim No. 2002-004604 (LIRC, Feb. 22, 2016). The applicant sustained a work-related back injury in September 2001. He did not require emergency transportation directly to the hospital. He went home and then drove himself to Door County Memorial Hospital the day after the injury. He then started treating with a chiropractor, Dr. Wipperfurth, beginning the month after the injury and for approximately three months. The insurer paid for the medical expenses. The applicant then switched to a different chiropractor, Dr. Servais. Dr. Servais referred the applicant to a surgeon who recommended, and performed, surgery. The surgeon referred the applicant to physical therapy. The insurer paid medical expenses through the end of healing. The applicant reported increased pain in 2006, and again in 2011, and returned to Dr. Servais on both occasions. In July 2012, the applicant treated with Dr. Quidzinski. Dr. Servais and Dr. Quidzinski referred the applicant to the Pain Center, where he treated with several physicians. One of those physicians referred the applicant to another surgeon for an evaluation. The applicant then switched treatment to Dr. Perlewitz upon referral of the applicant's attorney. Dr. Perlewitz recommended and performed another surgery. The applicant continued to undergo treatment on recommendations from Dr. Perlewitz, including pain management, physical therapy and use of medication. The parties disagreed on whether the 2012 surgery was causally related to the 2001 injury and this treatment was not conceded. Administrative Law Judge Faulkner determined the surgery was causally related to the injury, but held that Dr. Perlewitz was the applicant's third choice of provider. He denied payment for all medical expenses associated with this physician, including the cost of the 2012 surgery. The Labor and Industry Review Commission affirmed the denial of medical expenses. The applicant exceeded two choices for medical providers. Door County Memorial Hospital was the first treater. Dr. Wipperfurth was the second. Dr. Servais and his chain of referrals was the third treater. Within that chain was Dr. Quidzinski, because he was a treater within the Aurora system and involved with treatment on referral from Dr. Servais. All other treaters until Dr. Perlewitz were within Dr. Servais' chain of referrals. Dr. Perlewitz was the fourth treater. Wis. Stat. Section 102.42(2)(a) governs the applicant's entitlement to choices to health care providers beyond a second choice, without agreement from the employer and insurer. The statue provides: "...in case of an emergency, the employer may arrange for treatment without tendering a choice [of treating practitioner]. After the emergency has passed the employee shall be given his or her choice of attending practitioner at the earliest opportunity. The employee has the right to a second choice of attending practitioner on notice to the employer or its insurance carrier. Any further choice shall be by mutual agreement. Partners and clinics are considered to be one practitioner. Treatment by a practitioner on referral from another practitioner is considered to be treatment by one practitioner." Here, treatment the day after the injury, at urgent care, does not constitute "emergency" treatment. The employer had nothing to do with the applicant treating at Door County Memorial Hospital. Therefore it counted as the first choice. There is no evidence the applicant was referred to Dr. Wipperfurth by Door County Memorial Hospital. The applicant then chose to treat with Dr. Servais on his own accord. Therefore, those physicians constituted the second and third choices. The employer and insurer approved payment to Dr. Servais and his referrals even though he was the applicant's third choice. Payment without objection is evidence of mutual agreement. All medical treatment within the chain of referrals from Dr. Servais is compensable due to payment without objection. The "mutual agreement" contemplated by the statute refers to the choice of provider not the extent of treatment. Dr. Perlewitz is a fourth choice. There was no mutual agreement to the treatment. Therefore, all medical treatment is denied, including the cost of the fusion surgery. While the first two treating providers are not always a "choice", and the applicant can choose not to submit medical bills from the first treating providers, and thereby have his "choices" be the latter physicians, that did not occur here. The applicant submitted medical bills to the insurer from Dr. Wipperfurth. The applicant cannot "undo" that by failing to include the expenses on the WKC-13 and request a credit back to the insurer for the treatment. The applicant does not have the right to take back its choice of practitioner by declaring it no longer wants reimbursement after it

See past newsletters online at:

www.ArthurChapman.com

Click the *Workers Compensation Practice Area and look under Resources.*

already sought reimbursement. Further, just because the applicant could not obtain a billing statement from Door County Memorial Hospital, the provider was included on the WKC-3 and the applicant sought medical mileage from the provider. The length of time between treatments (approximately ten years) does not restart the applicant's choice of providers. Public policy concerns regarding the ability to reinitiate treatment in the chain of the first two "choices" cannot be accommodated without ignoring the statute's plain meaning.

Claim Preclusion

Longtine v. S&J Bus Services, Claim No. 2004-038762, (LIRC Jan. 26, 2016). The applicant alleged that he sustained a work-related injury on or about August 1, 2003. In October 2006, a hearing was held to address the applicant's claims for temporary and permanent disability. Administrative Law Judge Smiley denied the applicant's claims in their entirety. This decision was affirmed by the Labor and Industry Review Commission. The Circuit Court and Court of Appeals also affirmed the decision. The applicant filed several Motions for Reconsideration. These were all denied (the last via an Order dated September 1, 2010). The applicant filed another Hearing Application on July 31, 2015 seeking benefits as a result of the same alleged injury. Administrative Law Judge Smiley denied the applicant's claims and dismissed the application with prejudice. The Labor and Industry Review Commission affirmed. The applicant's claims are barred by claim preclusion. The applicant is bound by the prior final orders issued by the various administrative agencies and appellate bodies. He cannot re-litigate the claim which was previously denied.

Evidence

Sorenson v. Woodland Face Veneer, LLC, Claim No. 2012-006668 (LIRC Feb. 22, 2016). The applicant worked as a full time inspector/patcher of veneer panels. She used a light to inspect panels and multiple hand tools to repair tears and defects. The applicant was diagnosed with de Quervain's synovitis as a result of her job duties. Dr. Bax performed an independent medical examination and opined the condition was not work related. Dr. Bax based his opinion on the medical history, the job duty video and, to some extent, upon the ergonomic assessment. The job duty video did not show the applicant performing any duties. Further, it did not show inspection of specific panels which the applicant testified she worked on most often. Administrative Law Judge Landowski awarded the benefits sought by the applicant. The Labor and Industry Review Commission affirmed in part and reversed in part. That the job duty video does not show the applicant performing the job is not a basis for rejecting the video. The difference between use of a type of hammer and type of wood is not significant enough to reject the video. Further, the independent medical examiner opined his opinion would remain the same even if the ergonomic report was not considered. Therefore the merits of the testing forming the basis for the report do not need to be considered. [Editors note: Administrative Law Judge Landowski rejected the ergonomics test on the basis that it did not meet the *Daubert* test. This was not addressed by the Labor and Industry Review Commission. This United States Supreme Court case addressed the rules of evidence required in federal cases for scientific evidence. The Daubert court held that generally acceptance is not a necessary precondition to the admissibility of scientific evidence under the federal rules. The trial judge must make a preliminary assessment of whether the expert scientific testimony's underlying reasoning or methodology is scientifically valid and properly can be applied to the facts at issue. Many considerations bear on this inquiry, which must be flexible in nature. The trial judge has the task of ensuring that an expert's testimony rests on a reliable foundation and is relevant to the task at hand. Pertinent evidence based upon scientifically valid principles satisfies those demands. Administrative Law Judge Landowski determined that the ergonomic assessment, for unknown reasons, did not meet this requirement and therefore rejected the testing and the opinions which allegedly relied upon the testing.]

Medical Causation

Peterson v. Manion Truss & Components, Inc., Claim No. 2003-023523 (LIRC March 15, 2016). The applicant sustained an admitted work-related injury when he was hit in the head with a truss. He had pre-existing conditions of bi-polar disorder, severe depression, and alcohol abuse which resulted in alcohol related hepatitis. Dr. Quenemoen opined the applicant reached the end of healing and sustained no permanent partial disability. The applicant obtained employment as an over the road truck driver. He regularly abused stimulants, cocaine and ephedra during this employment. He was hospitalized for psychosis beginning several years later (on multiple occasions) and diagnosed with schizophrenia, paranoid type and depressive disorder. During treatment, the applicant acknowledged that he

was a heavy user of cocaine and methamphetamines. The applicant then began to treat for headaches, neck pain, upper shoulder pain, back pain and hip pain which he related to the work-related injury. Dr. Konowolchuck and Dr. Burgarino performed independent medical examinations at the respondent's request. They both determined the applicant's symptoms were not related to the work injury. The applicant's treating physician and his chiropractor opined the conditions were causally related the injury. Administrative Law Judge Michelstetter denied the applicant's claims. He determined the applicant's reports relied heavily on his subjective reports of his current symptoms. The objective findings were normal. The applicant was not credible. He provided different explanations to various physicians, he exaggerated his symptoms at the hearing and incorrectly reported aspects of his medical history (including denying legal or illegal drug use). The treating physician's statement that there is the 'appearance of a link' between the condition and work-related injury is not a medical conclusion made to a reasonable degree of medical certainty. The Labor and Industry Review Commission affirmed. The applicant appealed on the basis that he did not understand why his alleged drug abuse and drinking a beer or two would affect his claims. He also denied any history of drug abuse and indicated he was not sure why the records would reflect the same. The Commission determined the respondents' experts were more credible than the applicant's experts, and the denial was supported by the record.

Medical Expenses (Reasonableness)

Brantley v. County of Kenosha, Claim No. 2014-008087 (LIRC April 11, 2016). The applicant sustained a compensable cervical strain, low back strain and left leg contusion as a result of a slip and fall in the employer's parking lot. The applicant underwent a three level cervical fusion. There was a dispute over causation for the cervical condition as well as the cost of the surgery and related expenses. Administrative Law Judge Phillips, Jr. held the applicant did sustain a compensable cervical injury, which resulted in the need for the multi-level cervical fusion, and awarded all benefits sought. The Labor and Industry Review Commission affirmed the decision with respect to causation. However, in addition to disputing causation, the respondents alleged the charges for the medical treatment related to the surgery were unreasonably high. The respondents alleged Dr. Ahuja performed the surgery for his own financial gain and pointed to several federal indictments against the doctor for charges related to alleged tax fraud. Additionally, the respondents cited an audit by a DWD approved database for determining the reasonableness of medical expenses in the Department's health cost dispute resolution process. The Commission held there was a reasonable dispute about the reasonableness of the fees of the surgeon's bills. The bills were referred to the Health Cost Dispute Resolution Process and the respondents were directed to notify the health service provider that the reasonableness of its fee was in dispute under Wis. Stat. §102.16 and to proceed along that dispute route for a determination as to the extent of charges payable by the respondents to the various medical entities.

Medical Expenses (Necessity)

Corb v. Christopher East Health Care Center, Claim No. 1997-049977 (LIRC April 11, 2016). The applicant sustained an admitted ankle injury in August 1997. In 2004, she underwent an ankle fusion with was admitted to be causally related to the 1997 injury. X-rays in 2006 and subsequent years were interpreted as showing a solid fusion. She continued to report ongoing symptoms. An ankle arthroscopy was performed in November 2012. Dr. Viehe performed a medical records review. He opined the November 2012 arthroscopy was not necessary. Specifically he opined the applicant previously underwent a successful ankle fusion and had ankyloses of the tibiotalar joint. Dr. Viehe opined an ankle arthroscopy could not even have been performed. He opined this procedure was impossible and he was not exactly sure what procedure was even performed. He noted there was no mention of the prior ankle fusion in the operative report from the November 2012 surgery. The treating physician responded by opining the surgery was reasonable and necessary. He opined that she did not desire to have an ankle fusion and that the ankle arthroscopy was appropriate. Dr. Noonan subsequently performed an independent medical examination. He opined that he was not sure how she underwent an ankle arthroscopy after she had an ankle fusion. He opined there was no joint to arthroscope. He opined it was more probably than not, a sham surgery. Dr. Noonan opined the way the applicant as treated would almost be considered malpractice and gross negligence. The treating physician responded by maintaining his opinion and

noting that Dr. Viehe and Dr. Noonan did not examine the applicant prior to this procedure. Administrative Law Judge Martin held the surgery was reasonable and necessary. He awarded benefits as a result of that procedure. The Labor and Industry Review Commission affirmed in part and reversed in part. Wis. Stat. §102.42(1m) provides that, if an employee who has sustained a compensable injury "undertakes in good faith invasive treatment that is generally medically acceptable but that is unnecessary" the employer is required to pay all disability benefits that result from that treatment. Because the procedure was recommended by a physician, the good faith of the applicant was not in question. The operative procedures reportedly performed were generally medically acceptable because they were not 'trial' types of treatment. There was no opinion that the procedure itself was not a generally medically acceptable type of procedure. The applicant was therefore awarded disability benefits. Wis. Stat. §102.18(1)(bg)(2) provides that, if the necessity of treatment is in dispute, the Department can obtain the opinion of an expert regarding the necessity. (A similar provision applies in situations where the reasonableness of a charge is disputed.) The Commission ordered that the insurer advise the medical providers that the necessity of the treatment was in dispute and undergo the process outlined in Wis. Stat. §102.18(1)(bg)(2).

Permanent Partial Disability

Papala v. Aurora Advanced HealthCare, Inc., Claim No. 2011-000617 (LIRC March 15, 2016). The applicant sustained a femur fracture as a result of a work-related injury. The fracture was located mid-shaft to the end of the femur bone, approximately two inches above the knee. The fracture extended up and down the femur. The repair included attachments above the knee and into the hip, with a subsequent revision surgery to alter the fixation at the knee. The applicant was released to work without any restrictions post recovery. He reported some episodes of pain and daily cramps. The treating physician opined the applicant sustained 31% permanent partial disability. However, he did not identify the joint at which the permanency was assessed (i.e. the knee or the hip). Dr. Aschliman performed an independent medical examination at the respondents' request. He opined the applicant sustained 10% permanent partial disability to the knee as a result of the femur fracture. Administrative Law Judge Enemuoh-Traummel awarded the applicant 31% permanent partial disability to the hip. The Labor and Industry Review Commission affirmed the award of permanency at the hip, but modified the amount awarded. Wis. Stat. §102.55 and Admin. Code § DWD 80.32 indicate that permanent partial disability is equivalent to amputation at the next most proximal joint. Here, that was the hip. Dr. Aschliman underestimated the injury by rating permanency at the knee. However, the symptoms reported by the applicant do not require assessment of 31% permanency to the hip. The proper rating is 26% permanent partial disability to the hip. [Editor's note: The rationale behind a 5% reduction is based upon Wis. Stat. §102.18(1)(d). This provision indicates that an award of physical permanent partial disability which falls within a range of 5% of the highest or lowest estimate of permanent partial disability made by a practitioner which is in evidence, is presumed reasonable, provided it is not higher than the highest or lower than the lowest estimated in evidence.]

Permanent Total Disability

Phalin v. NFI Interactive, Claim No. 2009-020658 (LIRC, Feb. 22, 2016). The applicant sustained an admitted work-related injury. The employer and insurer conceded the work restriction resulted in 80% loss of earning capacity. Surveillance demonstrated the applicant was able to operate a tractor pulling a cultivator and crumbler on a farm field for nearly two hours. The applicant was seated in the tractor and operated it over uneven ground. The applicant appeared to steer the tractor notwithstanding the auto-steer. He frequently turned back to look at the equipment he was pulling. The applicant was out of the tractor for approximately thirty minutes. He walked across uneven field. He stooped and bent at the waist to work on an attachment to the trailer. He ascended and descended steps leading to the cab of the tractor on several occasions. The applicant reported to his treating physician that his back pain was not a problem all the time, and that he had only occasional back pain. The therapist who performed the functional capacity evaluation did not opine that part time work was necessary. The treating physician opined the applicant could only work part time. The independent medical examiner opined fewer restrictions were necessary (than he had originally opined) after observing the surveillance. The vocational experts opined the applicant sustained between 65% and *odd-lot* permanent total disability, depending upon the medical restrictions considered, even after the adjustment of restrictions post surveillance. Administrative Law Judge Endter held the applicant was *odd-lot* permanently and totally disabled. The Labor and

Industry Review Commission reversed. The opinions of the independent medical examiner are the most credible restrictions. The surveillance is consistent with the applicant's ability to perform various activities without apparent difficulty and with the applicant's report of only occasional symptoms. The applicant has therefore not made a prima facie case of *odd-lot* permanent total disability. There is no evidence the applicant sustained any loss of earning capacity beyond the 80% stipulated to by the parties.

Procedural Issues

Aldrich v. OEM Fabricators, Inc., Claim No. 2013-011454 (LIRC February 26, 2016) A hearing was held and the record left open approximately six months to allow the applicant to obtain telephone records. The applicant requested additional extension of time to obtain the records. Administrative Law Judge Roberts denied the request for additional extension and closed the record on December 9, 2015. A decision was dated and mailed on December 22, 2015. This decision dismissed the applicant's claims. The last day on which a timely petition for review could have been filed was January 12, 2016. The applicant's petition for review was filed on January 25, 2016. Petitions for review must be filed within 21 days from the date of mailing of the findings and order per Wisconsin Administrative Code § LIRC 1.02. The Labor and Industry Review Commission determined the petition for review was not timely. The petition was dismissed. In his petition, the applicant indicated he was still attempting to obtain telephone records to establish that he called the employer on a specific date. The applicant did not otherwise explain why the petition for review was late. The Commission can therefore not determine the reason was something beyond the applicant's control. If the applicant believes there is such a valid reason, he can provide that to the Commission. The Commission will then determine whether the explanation amounts to probable good cause. Further, Administrative Law Judge Roberts reasonably exercised his discretion in closing the record when he did so. If the applicant obtains the records within one year of the date of the decision, the applicant can submit the records to the Commission. The Commission would then review the submission and determine whether additional action is warranted.

Unreasonable Refusal to Rehire

Just v. K&L Sales, Claim No. 2012-013259 (LIRC Jan. 28, 2016). The applicant received five written warnings for a variety of job performance issues between July 2011 and November 2011. These warnings were for failing to print customer orders, viewing his Facebook account while working, insuring packages his employer told him to not insure, making a mistake about the quantity of the order shipped and typing the wrong order number (which resulted in the mis-shipping of an order to the wrong customer). The applicant sustained a work-related injury to his shoulder in May 2012. He was provided light-duty restrictions in June 2012. He worked within those restrictions. He was released without restrictions in September 2012. He was returned to his date of injury position. The applicant was discharged in November 2012. He was told the layoff was because of the lack of work. He was the only shipping worker laid off at that time. The employer alleged the applicant was chosen for the layoff because his job performance was the weakest, and noted the warnings given in 2011. One week prior to the layoff, the employer had hired another worker in the department. This was done on a trial basis and the worker was employed less than 60 days. The applicant underwent additional medical treatment shortly after the layoff in November 2012. He was provided restrictions on his activities as part of this treatment. The employer was contacted when the employee was again released without restrictions in June 2013. The employer indicated it did not have work available for the applicant. In October 2013, the applicant obtained employment elsewhere at a higher wage. The unnamed administrative law judge denied the applicant's claims. The Labor and Industry Review Commission reversed. The applicant met his burden of showing a prima facie case. The fact that the employer hired a new employee one week before terminating the applicant undercuts the employer's testimony that the applicant was discharged due job performance when economic circumstances required one person to be laid off. The employer would not have hired another shipping worker, even temporarily, one week before the layoff if lack of work was really the reason. The employer did not show reasonable cause for the discharge. However, the employer would not have had work available within the applicant's restrictions for approximately seven months because the restrictions ultimately imposed exceeded the requirements of date of injury position. The applicant was therefore entitled to penalties only for the few days between the discharge and imposition of restrictions (in November 2012) and between June 2013 and October 2013 (from when he was released to work without restrictions until he obtained employment at a higher wage). ✦

Arthur Chapman
Kettering Smetak & Pikala, P.A.
ATTORNEYS AT LAW

811 1st Street
Suite 200
Hudson, WI 54016
Phone 715 386-9000
Fax 612 339-7655

500 Young Quinlan Building
81 South Ninth Street
Minneapolis, MN 55402
Phone 612 339-3500
Fax 612 339-7655

www.ArthurChapman.com

Disclaimer

This publication is intended as a report of legal developments in the worker's compensation area. It is not intended as legal advice. Readers of this publication are encouraged to contact Arthur, Chapman, Kettering, Smetak & Pikala, P.A. with any questions or comments.