Worker's Compensation Seminar

2018

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

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2018 WORKER'S COMPENSATION SEMINAR

WEDNESDAY, JUNE 20, 2018 | WAUWATOSA, WISCONSIN

AGENDA

7:45 a.m. **Registration**

8:15 – 8:30 a.m. **Good Morning Wisconsin!**

8:30 – 9:15 a.m. **The Tipping Scales of Justice – Rulings from the Minnesota Workers' Compensation Courts**
Rick Nelson
"Judge" Rick Nelson rules on the Minnesota workers' compensation cases issued over the last year. Legislative and administrative rule changes will also be addressed.

9:15 – 9:45 a.m. **The Angle – Hot Topics in Vocational Rehabilitation**
Chris Tuft and Emily LaCourse
Vocational rehabilitation has recently been a source of "breaking news" on the workers' compensation channel. Join Chris and Emmy as they dig into hot topics in rehabilitation, and provide tips to help you manage this expense. (Minnesota)

9:45 – 10:00 a.m. **Refreshment Break**

10:00 – 11:00 a.m. **"Sue" – Handling Intervention, Subrogation, and Medicare Issues in Settlement**
Sue Conley, Chuck Harris, and Annie Davidson from Examworks
Viewed live before a studio audience, Sue's show brings the "party" to "third-party," while examining some of the thornier subjects in resolving claims. Sue takes you through the ins-and-outs of intervention claims, Chuck does the subrogation dance, and Examworks' Annie Davidson rounds out the show with a lively discussion on Medicare issues. (Minnesota & Wisconsin)

11:00 – 12:00 p.m. **The Expert Hour: A Conversation with Dr. Wojo**
Jim Pikala, Jessica Ringgenberg and Dr. Wojciehoski from Evalumed/MES
You've heard of Dr. Phil? He has nothing on Dr. Wojciehoski. In this episode, Dr. Wojciehoski will explain important aspects of human anatomy and Jim and Jessica will discuss how to use this information when evaluating injury claims and treatment requests. (Minnesota & Wisconsin)

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12:00 – 1:00 p.m. **Lunch**

1:00 – 1:45 p.m. **The Hot Seat – Wisconsin Case Law Update**
Chuck Harris and Susan Larson
Court is in session with "Judges" Susan and Chuck. They will review and rule on the latest worker's compensation cases issued by the LIRC and the appellate courts. They will also discuss recent and pending legislative changes.

1:45 – 2:15 p.m. **Truth or Consequences – Evaluating Misconduct/Substantial Fault Cases**
Chuck Harris and Susan Larson
Join Chuck and Susan as they cover an important topic that has been making headlines on the Arthur Chapman Channel – misconduct and its impact on worker's compensation claims. As the "HR" aspects of claims are becoming increasingly prevalent, Chuck and Susan will share their tips for putting these issues into context. (Wisconsin)

2:15 – 2:30 p.m. **Refreshment Break**

2:30 – 3:15 p.m. **Solved Mysteries – Investigation of Claims**
Ray Benning, Chuck Harris, Alicia Smith, and Jessica Ringgenberg
This panel of top investigative attorneys will provide tools to use to uncover the truth when investigating claims and determining the mechanism of an injury. They will also share their tips on how to analyze and compare medical diagnoses with mechanisms of injury, as well as how to effectively present findings to medical experts. (Minnesota & Wisconsin)

3:15 – 3:30 p.m. **Questions and Answers and Chris' Favorite Things!**
Rick Nelson, Chris Tuft and Alicia Smith

3:30 – 5:30 p.m. **Reception**

Arthur Chapman

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RANDAL F. WOJCIEHOSKI, D.P.M., D.O.

Curriculum Vitae

PERSONAL DATA

Permanent Address:

1066 Martin Island Drive
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Occupation:

Emergency Physician, Ministry Medical Group - St. Michael's Hospital
Medical Director, Ministry/Affinity Employer Solutions-Occ. Med
Medical Director, Ministry/Affinity Associate Health
Medical Director, Ministry Door County Mem. Hospital-Occ. Med
Ministry Saint Michael's Hospital-Ministry Health Care/Ascension
Ministry Medical Group (MMG)- Central Region
900 Illinois Avenue
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BOARD CERTIFICATION (AAPS)

Internal Medicine (1995-2006, Recertified 2006-2014, Recertified 2014-2022)
Emergency Medicine (1996-2006, Recertified 2006-2014, Recertified 2014-2022)
Emergency Medicine Oral Board Examiner (2004-present)

PROFESSIONAL LICENSURES (Medicine and Surgery)

DEA Number:	BW1479244
Florida	Number OS10638
Illinois	Number 036.124160
Iowa	Number 3802
Minnesota	Number 50469
Missouri	Number 2015043929
South Dakota	Number 8248
Wisconsin	Number 31414-21
Wisconsin	Number 606-25 (Podiatric Medicine and Surgery)

STAFF APPOINTMENTS

Ministry Saint Michael's Hospital, Emergency Medicine-Stevens Point, Wisconsin 07/1990-Present
Ministry Saint Clare's Hospital, Emergency Medicine (Courtesy)-Weston, Wisconsin 01/2005-Present
Ministry Good Samaritan Hospital, Emergency Medicine (Courtesy)-Merrill, Wisconsin 01/2005-Present
Ministry Sacred Heart Hospital, Emergency Medicine(Courtesy)-Tomahawk, Wisconsin 01/2005-Present
Ministry St. Mary's Hospital, Emergency Medicine (Courtesy)-Rhinelander, Wisconsin 01/2005-Present
Ministry Door County Memorial Hospital, Occ.Med (Courtesy)-Sturgeon Bay, Wisconsin 09/2015-Present

VISITING PHARMACEUTICAL FACULTY

Bristol-Myers-Squibb Company - Princeton, New Jersey 08543
Genentech, Inc. - South San Francisco, California 94080
Institute of Continuing Healthcare Education, Philadelphia, PA 19355
Orphan Medical - Minneapolis, Minnesota 55305
Roerig-Pfizer - New York, New York 10012
Schering-Plough, Kenilworth, NJ 07033

MEDICAL-LEGAL CONSULTANT

Court appearances in cases involving domestic violence, criminal actions, infectious disease, internal medicine, medical malpractice, personal injury, toxicology, trauma, worker's compensation, and wrongful death. Plaintiff and Defense Expert. Disability and competency examiner for alcohol, drug, and toxicology cases, as well as mental health commitments.

MEDIA CONSULTANT

Television, radio, and print appearances focusing on a variety of current medical topics. Syndicated newspaper columnist.

SENIOR AVIATION MEDICAL EXAMINER

FAA certified medical examiner performing Class I, II and III pilot medical examinations.

INDEPENDENT MEDICAL EXAMINER

Special interest in independent medical exams and medical record review on various conditions.

CLINICAL PHYSICIAN INVESTIGATOR

01/1993-12/2003 National Registry of Myocardial Infarction (1,2,3,4)

ACADEMIC BACKGROUND

Diploma:	Internal Medicine Residency --University of Wisconsin Marshfield Clinic Program—06/1992 Marshfield, Wisconsin
Degree:	Doctor of Osteopathy – 05/1989 University of New England - Biddeford, Maine
Degree:	Doctor of Podiatric Medicine – 05/1986 New York College of Podiatric Medicine, New York
Degree:	Marquette University, Milwaukee, Bachelor of Arts (Psychology) - (05/1982), Milwaukee, WI
Diploma:	Pacelli High School-05/1978 Stevens Point, Wisconsin
Diploma:	WI Registered Emergency Medical Technician-05/1978 Fox Valley Technical Institute, Appleton, Wisconsin

UNITED STATES NAVAL RESERVES ACTIVE DUTY

Direct Commissioned Officers Program, NAS-Pensacola, FL - 02/1990
Emergency Physician, Naval Hospital, San Diego, CA – 03/1991
Lieutenant Commander, Medical Corps, Individual Readiness Reserve (09/1989-09/2003)

CERTIFICATIONS

ABA-Advanced Burn Life Support – 01/1996(Current)
ACEP Advanced Pediatric Life Support – 01/1995(Current)
ATLS-Advanced Trauma Life Support – 031/90,03/1995, 03/2006(Current)
AHA Advanced Cardiac Life Support Instructor – 01/1989
AHA Advanced Cardiac Life Support – 05/1978(Current)
AHA CPR Instructor – 09/1978

EMPLOYMENT RECORD

04/2015-Present:	Medical Director, Consumer Health Connections, Milwaukee, WI
03/2015-Present:	Medical Director-Berkshire Hathaway Travel Protection, Stevens Point, WI
01/2016-Present:	Medical Consultant-BTE, Harley-Davidson, Milwaukee, WI
04/2012-12/2015:	Medical Director-Premise Health, Harley-Davidson Milwaukee, WI
05/2012-Present:	Medical Director, Rosholt Public School System
01/2010-Present:	Adventure 212º, Medical Director
03/2007-Present:	Encore Unlimited, Ltd. Medical Director
092007-Present:	Stevens Point Area Catholic Schools, Medical Director
09/2007-Present:	Maple Ridge Assisted Living, Owner

06/2004-12/2012:	AIG-TravelGuard Insurance-Medical Consultant
01/2006-12/2012:	MedEvent, Inc. Medical Director
01/2004-12/2009:	U.S. Bank-Stevens Point, WI Board of Directors
01/2000 – 12/2002:	Travel Care International-Flight Physician
01/1992 – 12/2002:	Midstate Technical College - Emergency Services Instructor
04/1994:	American Hawaii Cruise Lines - Cruise Physician
01/1991:	Riverview Hospital - Emergency Physician
07/1990-Present:	St. Michael's Hospital-Emergency Physician
07/1990 – 12/1998:	Novus - Emergency Physician
07/1990 – 06/1992:	National Emergency Services - Emergency Physician
08/1986 – 12/1987	CMPMC, Lewiston, ME - Podiatric Physician/Surgeon
01/1984 – 06/1986:	LaGuardia Community College, New York, NY - EMT
01/1983:	Bloomingdale's, New York, NY - Sales Associate
01/1982 – 12/1983:	Waupaca Area Ambulance, Ltd., Waupaca WI - EMT
01/1981 – 05/1982:	Curtis-Universal Ambulance, Milwaukee, WI - EMT
05/1980 – 01/1982:	A.J.Holly&Sons, Ltd. Waupaca, WI - EMT/Funeral/Assistant
08/1979 – 05/1981:	Marquette University, Milwaukee, WI - Resident Advisor
01/1977 – 12/1984:	Sentry Insurance, Stevens Point, WI - Fitness Assistant
01/1977 – 06/1978:	Mid-State Technical Institute, Stevens Point, WI - Instructor
01/1976 – 12/1983:	Free Lance Rescue Squad, Stevens Point, WI - Proprietor
01/1976 – 08/1978:	YMCA, Stevens Point, WI - Cardiac Rehabilitation Specialist
01/1976 – 05/1977:	Saint Michael's Hospital, Stevens Point, WI - Orderly

LECTURES

"Abdominal Wall Hernias," WI Worker's Compensation Seminar, Brookfield, WI (2012)
"ACC/AHA Guidelines for UA and NSTEMI," Green Bay Area Physicians, Green Bay, WI (2000)
"Acute Coronary Syndrome." Riverview Hospital, Wisconsin Rapids, WI (1999), CME, Green Bay, WI (1999, 2000), Stoughton Hospital, Stoughton, WI (2000), Dade Behring Seminar, Pewaukee, WI (2001).
"ACS and CQI in Emergency Medicine." Lake Region Hospital, Fergus Falls, MN (2002); ACEP, Seattle, WA (2002); Webcast (2002), St. Agnes Hospital, Fond du lac, WI (2003)
"Antimicrobial Resistance in Common Respiratory Pathogens". Michigan Health Care Center, Detroit, MI (1993), Bay City Medical Center, Bay City, MI (1992)
"Antibiotic Resistance in Streptococcus Pneumonia". St. John's Hospital, Detroit, MI; St. Joseph's Hospital, Fort Wayne, IN; UWSP Health Center, Stevens Point, WI (1994), Saint Michael's Hospital, Stevens Point, WI (1994); Sentry World, Stevens Point, WI (1994); Bay City Medical Center, Bay City, MI (1994); Toll-Free Memorial Hospital, West Branch, MI (1994); Portage View Hospital, Hancock, MI (1994); Marion Medical Society, Marion, IN (1994); Riverside Medical Center, Waupaca, WI (1994); Wisconsin Association of Osteopathic Physicians, Fall Seminar, Milwaukee, WI (1994); Fort Wayne Medical Society, Fort Wayne, IN (1995); Tri-County Medical Society, Peru, IN (1995); Cook County Medical Society, Chicago, IL (1995); Tri-County Medical Society, Lancaster, WI (1995); Iron Mountain Medical Society, Iron Mountain, MI(1995); Eau Claire Registered Nurses, Eau Claire, WI(1996); Central Wisconsin Mid level Providers, Stevens Point, WI(1996) St. Joseph's Hospital, Minot,ND, County Medical Meeting,Williston, ND(1997) , Fox Valley Family Practice Conference, Appleton,WI(1997), Winona Clinic, Winona, MN(1997), Pediatric Residents, Marshfield Clinic, Marshfield, WI(1998)
"Atrial Fibrillation: New Emergency Treatment". Marshfield Clinic (1992), St Michael's (1992)

"Back Pain: Causes and Treatment." Milwaukee, WI (2003), InMedical Seminar, Brookfield, WI (2004), Milwaukee, WI (2005), Chicago, IL (2005)
"Carbon Monoxide: The Silent Killer." Stevens Point Fire Department, (2000)
"Cervical Spine Injuries and Emergency Treatment." Sports Medicine Conference, St. Pt, WI (1995.96)
"Cocaine Abuse and Cardiac Manifestations". NCCCU Nurse Association, Stevens Point, WI (1996)
"Complementary/Alternative Medicine." WI Risk Management Conference, Madison, WI (2004)
"Complex Regional Pain Syndrome." Sedgwick Risk Management, Milwaukee, WI. (2011), Twin Cities Insurance Adjusters Association, Minneapolis, MN (2015)
"Crohn's Disease". Marshfield Clinic (1991)
"Cost-Effective Radiology." AMEX, Green Bay; American Family Insurance, Milwaukee, Wausau, WI (2004), American Family Insurance, Appleton, WI (2006), Work Comp Forum, Milwaukee, WI (2006)
"Current Trends in Thrombolysis of Pulmonary Emboli". St Michael's Hospital, Stevens Point (1993)
"Depression in Emergency Medicine." Central WI Physician Assistants, Stevens Point (1998)
"Domestic Violence in the Emergency Department". St. Agnes Hospital, Fond du Lac, WI (1995)"
"Effective IME's and Record Reviews." Corvel Seminar, Waukesha, WI (2005), Arthur Chapman Seminar, Milwaukee, WI (2015)
"Emergency Ethylene Glycol Treatment." Orphan Medical, Minneapolis, MN (1997)
"Evidence Based Treatment of Back Pain." Medical Systems WC seminar, Milwaukee, WI (2007), WC Presentation, Dubuque, IA (2008), GB WC Presentation, Milwaukee (2008), EBTSeminar, Minneapolis (2008), American Family Insurance Seminar, Rochester, MN (2008), West Bend Mutual, West Bend, WI (2009), Sentry Insurance, Stevens Point, WI (2009), American Family Insurance, Wausau, WI (2009), CMI, Bartlesville, AK (2009), Wisconsin Safety Council, WI Dells, WI (2013)
"Evidence Based Treatment of Carpal Tunnel", Secura Insurance Seminar, Appleton, WI (2008), NIS Seminar, Madison, WI (2008)
"Fetal Trauma in MVA's." Am Family, Madison, WI (2005), Wausau, WI (2005)
"Foot and Ankle Injuries in the Workplace." WI Workers Compensation Seminar, Brookfield, WI (2012)
"GP IIb/IIIa Inhibitors: Current Therapy." ACEP, Chicago (2001), IL. ACOI, Orlando, FL (2001).
"Hepatic Abscess". American College of Physicians State Conference, Lake Geneva, Wisconsin (1991)
"Hypertension: Current Trends and Treatments". Neilsville Hospital, Neilsville, WI (1992)
"Hypothermia Treatment." Stevens Point Fire Department, Stevens Point, WI (1994)
"Humor in the Emergency Department". WI Emergency Nurses Association - Waupaca, WI (1992)
"Introduction to Rapid Sequence Intubation." St. Michael's Hospital, Stevens Point, WI (2007)
"Low Impact Trauma." Acuity Insurance, Sheboygan, WI (2004)
"Motor Vehicle Trauma." General Casualty Insurance; UW-Madison, Madison, WI (2003, 2004), Northern WI Adjusters Association, Wausau, WI (2005)
"Migraine Headache: What's New?" Saint Michael's Hospital (1993)
"Medical Conditions manifesting in the Workplace." Workers Compensation Conference, Milwaukee (2006) Integrity Insurance, Appleton, WI (2007)
"MRSA-Current Trends and Treatments." University of WI/State of WI Claims Dept. Madison (2011)
"Occupational Allergies and Sick Building Syndrome." WI Voc Rehab Conference, Madison, WI (2009)
"Occupational Lung Disease." Risk Management Services, Minneapolis, MN (2011)
"Portage County EMS and You." Mended Hearts Group, St. Michael's Hospital, Stevens Point, WI (2000)
"Perspective on Thrombolytics: t-PA vs. APSAC". Marshfield Clinic (1990)
"Podiatric Medicine and Liability." WI Claims Council, Brookfield, WI (2009)
"Pneumonia and Chronic Disease". Marshfield Clinic (1990)

"Practical Podiatry for the Non-Podiatrist". Grandview Medical Center, Dayton, OH (1988); Marshfield Clinic, (1989); Good Samaritan Medical Center, Merrill Wisconsin (1991); St. Joseph's Hospital Fort Wayne, IN (1994); Riverview Hospital, Wisconsin Rapids, WI (1995), Worker's Compensation Conference, Milwaukee, WI (2005), St. Paul Traveler's Insurance, (2006)
"Pre-Hospital Defibrillation". Adams Hospital, Adams, WI (1993); Plover Fire Dept., Plover, WI (1994); Portage County First Responders, (1994), Waushara County EMI-I program (1997)
"Prescription Drug Fraud." Midwest Worker's Compensation Forum, Pewaukee, WI (2010), Secura Insurance, Appleton, WI (2011), Central WI Claims Adjusters, Wausau, WI (2011), WI Voc Rehab Annual Conference, Stevens Point, WI (2011), Wisconsin Safety Council, WI Dells, WI (2013), WI Work Compensation Seminar, Milwaukee, WI (2013), Integrity Legal Seminar, Minneapolis, MN(2016)
"Radiology: Cost-Effective Testing." (2004), American Express Casualty, Green Bay, WI
"Shoulder Exam and IME," Evalumed Seminar, Wausau, WI (2008)
"Skin Infections and Antimicrobial Treatment". Good Samaritan Medical Center, Merrill, WI (1992); Saint Joseph's Hospital, Fort Wayne, IN (1994)
"Slip and Fall Injuries and Liability." WI Claims Council, Brookfield, WI (2009)
"State of the Heart," Nashville Area Physicians, Nashville, TN (2003), Janesville, WI (2003)
"Status Epilepticus: Current Treatment." Midstate Epilepsy Conference, Stevens Point, WI (1995)
"Teens, Drugs, and Alcohol in Emergency Medicine." Keynote, Pacelli High School, St Pt, WI (2001)
"The Reduction of Hospital Medication Errors," PA Hospital Pharm. Assoc, Atlantic City, NJ (2003)
"Thrombolysis of the Pulmonary Embolism". Marshfield Clinic (1990)
Thrombolytic Therapy and the Acute Myocardial Infarction". Wisconsin Physician Assistants State Conference (1994); Waupaca County Medical Society (1994); Emergency Physicians; Lincoln, NE (1994); Riverside Medical Center, Waupaca, WI (1995)
Thrombolytic Update: MI and CVA." Fox Valley Critical Care and EMS, Appleton, WI (1998)
"Thrombolytics, AMI, and Emergency Medicine." Genentech, Inc. South San Francisco, CA (2000)
"Timely Treatment of the Acute MI". Theda-Clarke Medical Center Neenah, WI (1995); WI Association of Osteopathic Physicians, Fall Seminar, Milwaukee, WI (1995); Vernon Community Memorial Hospital, Viroqua, WI (1996); St Mary's Hospital, Detroit Lk, MN (1996); Community Hospital, Decorah, IA (1996)
"Timely Treatment of ACS." CME Programs, Marinette, WI (2001), Green Bay, WI (2001)
"Trauma and Pregnancy." American Family Insurance, Madison, WI (2004)
"Treatment of Supraventricular Tachycardia and Adenosine". Marshfield Clinic (1991)

PUBLICATION AND RESEARCH

To Your Health with Dr. Wojo, Randal F. Wojciehoski, DPM, DO Publications, (2007)
Fetal Trauma and Motor Vehicle Accidents. Emergency Medical Services, Vol. 34, No. 7, July 2005.
Nosebleeds. Emergency Medical Services, Vol. 34, No. 8, August 2005.
Unusual Resuscitations. Emergency Medical Services. Vol. 34, No. 8, September 2005.
Open Reduction of Lisfranc's Dislocation. *Journal of the American Podiatric Med. Assn*, Feb. 1989
Lupus Erythematosus: Systemic & Podiatric Manifestations. *Journal of Current Podiatric Medicine, (7/85)*
Ankle Sprains: Mechanism and Treatment. New York College of Podiatric Medicine, NY, NY (1984)
Chronic Mentally Ill and Ambulance Personnel. Marquette University, Milwaukee, WI (1982)
Sudden Infant Death Syndrome and Ambulance Personnel. Marquette University, Milwaukee, WI (1981-82)
Sentry Insurance CPR Program. Co-Author and Instructor.Sentry Insurance, Stevens Point, WI – 1977

TO YOUR HEALTH WITH DR. WOJO SYNDICATED NEWSPAPER COLUMN TOPICS

AAA, ACL injury, Achilles Tendonitis, Adult ADD, AEDs, Alcoholism, Alcohol Poisoning, Allergies, Alzheimer's Disease, Ankle Sprains, Annual Physicals, Antibiotic Resistance, Appendicitis, Asthma, Athletic Sudden Deaths, Atrial Fibrillation, Aspirin Benefits, Avian Flu, Aviation Medicine, AVM, Baby Boomer Exercise, Back Pain Injuries, Back Pain, Bariatric Surgery, Bee Stings, Berry Benefits, Bird Flu, Blastomycosis, Boating Safety, Botox, Breast Implants, Bronchitis, Brugada Syndrome, Burns, Caffeine, Capsule Endoscopy, Carbon Monoxide Poisoning, Carpal Tunnel Syndrome, Cerebral Aneurysm, CHF, Cholesterol, CLL, Cocaine Abuse, Cold Injuries, Cold Injuries 2008, College Alcohol Abuse, Complex Regional Pain Syndrome, Conjoined Twins, Colon Cancer, COPD, Coronary Artery Disease/Women, Core Fitness, Coughing, Coumadin, Croup, Current Lyme Disease Treatment, Dehydration, Diabetes 2007, Dignified Death, Diverticulitis, Dizziness, DKA, DVT, Dysphagia, Ear Infections, Eating Disorder, Ectopic Pregnancy, Eczema, Ehrlichiosis/Lyme Disease, Elderly Exercise, Emergencies, Emergency Medical Services, Energy Drinks, ER Visits, Ephedra, Emphysema, Evidence Based Medicine, Excessive Daytime Sleepiness, Falls, Febrile Seizures, Femur Fractures, Fentanyl Patches, Fever, Fibromyalgia, Food poisoning, Flu, Flu Vaccine Shortage, Freshman 15, Fructose Intolerance, Gardening Injuries, Gastroenteritis, GHB Poisoning, Golf Exercise, Golf Injuries, Golf Injuries 2, Gout, Hand-Foot-Mouth Disease, Head Injuries, Heat Injuries, Heat Illness, Hemorrhagic Shock, Hepatitis, Hiatal Hernia, Holiday Heart, Holiday Illnesses, HUS, Hyperlipidemia, Hypertension, Hypertension 2008, Hypothermia, Hypothyroidism, IBS, ICD,Immune System Health, Immunizations, Influenza Vaccine 06,Insomnia, Interstitial Cystitis, Intracranial Hemorrhage, iPods/Hearing Loss, Kidney Stones, Lactose Intolerance, LASIK, Leg Ulcers, Lightening Injuries, Low Carb Diets, Lung Cancer, Lyme Disease, Macular Degeneration, Male Breast Cancer, Malignant Hyperthermia, Medication Reconciliation, Mediterranean Diet, Melamine Toxicity, Meniere's Disease, Meningitis, Monkeypox Virus, Mononucleosis, Motion Sickness, MRSA, Multiple Sclerosis, Mumps, Muscle Cramps, Narcotic Drug Abuse, New Year's Resolutions, Novovirus, Obesity, Oral Allergies, OTC Meds, Otitis Media, Pancreatitis, Pediatric Emergencies, Pediatric OTC Meds, Plantar Fasciitis, Peptic Ulcer Disease, Personal Emotions, Pes Anserine Bursitis, Pine Allergies, Poisoning, Prescription Drug Abuse, Prostate Screening, Psoriatic Arthritis, Pulmonary Embolism, Rabies, Reye's Syndrome, Rheumatoid Arthritis, Rhinitis, Rocacea, Rotator Cuff Injury, Salmonella Poisoning, SARS, School Year Preparation, Sciatica, Scoliosis, Seasonal Affective Disorder, Seasonal Allergies, Seatbelt, Safety, Septic Shock, Shingles, SIDS, Sleep Apnea, Snow Boarding Injuries, Spina Bifida, Spinal Anesthesia, Spinal Cord Injuries, Sports Injuries, Sports physicals, Statins, STDs, Stroke, Summer Camp Medicine, Summer Problems, Sunburn, Swine Flu, Syphilis, Syncope, Tamiflu, Tennis Elbow, Tetanus, Typhoid Fever, TIA, Tinnitus, Transdermal Medications, Transient Global Amnesia, Traumatic Brain Injury, URI Prevention, UTI, Varicose Veins, Violence, Vioxx, Vitamins, Walking Health, Warts, Water Intoxication, Water Safety, West Nile virus, When to Go to ER, Whooping Cough, Women and Heart Disease

FACULTY APPOINTMENT

U W Medical School-P.A. Program- Clinical Instructor of Emergency Medicine
Marquette University-P.A. Program: Clinical Associate Professor of Emergency Medicine
Medical College of Wisconsin, Medical Student Preceptor, Emergency Medicine
Finch University-Chicago Medical School-Clinical Instructor, Emergency Medicine

AWARDS

Wisconsin Hospital Association 2006 Employee Pride Award, Sheboygan, WI

Ministry Health Care Circle of Excellence Award, 2000. Stevens Point, WI
Star of Life Award, 1999. Leadership in Portage County EMS, Stevens Point, WI
Who's Who in Health Care and Medicine, 1997-1998, 1998-1999 Edition
American Heart Association Good Samaritan Award 1994 Recipient - State of Wisconsin
American College of General Practitioners Preceptorship Grant 1989 Recipient-Chicago, IL
Central Wisconsin Health Foundation Scholarship 1984 Recipient - Stevens Point, WI
Who's Who Among Students in American Universities and Colleges 1981, 1982 Recipient - Marquette University Academic Scholarship 1978-1982 Recipient - Milwaukee, WI
American National Red Cross/President Carter National Merit Award for Selfless and Humane Action 1977

PROFESSIONAL ACTIVITIES AND MEMBERSHIPS

American College of Emergency Physicians (1990-present)
American Osteopathic Association (1986-2011)
American College of Physician Executives (2001-2006)
American Association of Physician Specialists (1993-present)
Associate Medical Producer-Ministry Healthcare Network/Marxx Productions (1998-2005)
Association of Emergency Physicians - Board of Directors (1992-1994)
Bylaws Committee, St. Michael's Hospital: Chairman (2003-2005)
Cardiovascular Service Development Team, St. Michael's Hospital (2000-2002)
Chairman, Department of Emergency Medicine, St. Michael's Hospital (1997-2001)
Chairman, Cardiovascular Services Quality Assurance, St. Michael's Hospital (2003-2005)
Continuing Medical Education Committee, Saint Michael's Hospital (1993-1995)
Corporate Physician Marketing Committee, Ministry Healthcare Network (1998-2001)
Credentials Committee, St. Michael's Hospital, (2005)
Emergency Care Committee CQI Facilitator, St. Michael's Hospital (1999-2001)
EMT Program Advisory Committee, Mid-State Technical College, WI Rapids (1998-2003)
Executive Committee, St. Michael's Hospital (1998-2001)
Marketing Oversight Committee, Ministry Health Care Network, Milwaukee, WI (1998-2003)
Medical Detoxification Continuous Quality Improvement Committee (1997-2002)
National Association of EMS Physicians (1995-2005)
Pharmacy and Therapeutics Committee, Saint Michael's Hospital (1993-1996)(2003-2004)
Quality Assurance Committee, Saint Michael's Hospital (1996-1998, 2005)
Utilization Review Committee, Saint Michael's Hospital (1997)
Wisconsin Medical Society (2004-present)

COMMUNITY SERVICE

Boys and Girls Club of Portage County, Board of Directors (2002-2004)
Community Leadership Memorial Steering Committee (1996-present)
Community Alcohol and Drug Abuse Center (CADAC), Board of Directors (1993-2006)
Eske Social Club Ltd, Board of Directors (2000-2003); President (2002-2003)
Portage County Home Health Care Advisory Committee, Board Member (1993 - 1997)
Pacelli High School Capital Fund Drive, Committee Member (1993)
Mid State Epilepsy Association - Professional Advisory Board (1994-1997)
Portage County Child Protective Services Board (1995-1997)
Portage County Death Investigation Committee (1995-1997)

SPACS Capital Campaign 2001-2002: Chairman. Raised $2.5 million.
Saint Michael's Foundation-Board of Directors (1995-2001); Sec./Treasurer (1996-2000), Chairman (2001-2003), Chairman Emeritus, (2004)
Stevens Point Area Catholic Schools (SPACS) Endowment Fund, Board of Trustees, (1999-present)
Stevens Point Airport Strategic Planning Team (2004)
Stevens Point Business Pilot's Association (2004-present)

EMERGENCY MEDICAL SERVICES

EMS Medical Director-Portage County (1990-2002)
EMS Advisory Council of Portage County-Chairman (1998-2002)
EMS Professional Advisory Board, Mid-State Technical College (1998-2008)
Portage County Ambulance Service and EMS - Medical Director (1990-2002))
Portage County Ambulance Service ET Intubation Program, Medical Director (1993)
Portage County Medical Society-Mini-Internship Preceptor (1994-1996)
Portage County Corporation Counsel, District Attorney's Office, and Human Services: Psychiatric, Alcohol, Drug and Competency Medical Examiner (Current)
Portage County Strategic Planning Committee for Emergency Medical Services (1995, 1999-2000)
Stevens Point Mayor's EMS Advisory Committee (1996-1997)
Waupaca County HAZMAT Drill - Medical Director (1993)

FAA LICENSURE and Training

Private Pilot ((7/00)
Instrument Rating (5/02)
Commercial Pilot License (12/03)
FAA Wings Program-Phase 1
Beech Pilot Proficiency Program
FAA Senior Aviation Medical Examiner (First, Second, Third Class Medicals)

REFERENCES

Ministry St. Michael's Hospital/Ministry Health Care, Stevens Point, WI (715) 346-5000
Mr. Jeff Martin, President and Regional CEO
Dr. Robert Tillotson, Emergency Department Medical Director
Patti Groholski, Employer Solutions Executive Director

September 2016

Annie M. Davidson
MSP Compliance Counsel
ExamWorks Clinical Solutions

Annie M. Davidson is a MSP Compliance Counsel for ExamWorks Clinical Solutions. Ms. Davidson has comprehensive experience in the areas of Medicare Secondary Payer (MSP) Act compliance and Medicaid recovery in liability, no-fault, and workers' compensation matters. Ms. Davidson provides high-quality legal analysis to ensure the integrity and quality of ExamWorks Clinical Solutions' Medicare Secondary Payer compliance services and related products. Additionally, she is a nationally recognized expert on MSP issues who presents regularly at local and national conferences.

Ms. Davidson is admitted to practice law in the State of Minnesota and the United States District Court for Minnesota. Prior to her work with ExamWorks Clinical Solutions, she practiced as an insurance defense litigator with a Minneapolis law firm. In that position, Ms. Davidson gained significant experience handling workers' compensation, liability, and no-fault cases and coordinated the firm's policies for handling Medicare requirements.

She is a member of the American Bar Association, the Minnesota State Bar Association, the Ramsey County Bar Association, and the National Alliance of Medicare Set-Aside Professionals. Ms. Davidson graduated cum laude from William Mitchell College of Law and received her Bachelor of Arts degree from the University of Minnesota, Twin Cities. In her free time, Ms. Davidson plays recreational sports and is active in local community affairs.

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2018 Worker's Compensation Seminar

June 20, 2018

Arthur Chapman
Kettering Smetak & Pikala, P.A.
Attorneys at Law

The Tipping Scales of Justice – Rulings from the Minnesota Workers' Compensation Courts

Richard C. Nelson

Arthur Chapman
Kettering Smetak & Pikala, P.A.
Attorneys at Law

Conclusion

I fully realize that I have not succeeded in answering all of your questions…

Indeed, I feel I have not answered any of them completely. The answers I have found only serve to raise a whole new set of questions; which only lead to more problems, some of which we were not even aware were problems.

To sum it all up… In some ways I feel we are as confused as ever, but I believe we are confused on a higher level and about more important things.

Questions?

Richard C. Nelson
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The Angle – Hot Topics in Vocational Rehabilitation

Christine L. Tuft
Emily A. LaCourse

Arthur Chapman
Kettering Smetak & Pikala, P.A.
Attorneys at Law

Communicating with a QRC

- Employer
- Adjustor
- Attorney involvement
- 5220.1801, subp. K1 – Adversarial communication

Rehabilitation File Closure

- Required Closure
- Good Cause Closure
- Closure for Failure to Cooperate

Communication Regarding Return to Work

- Medical Providers
- Job Descriptions
- Job Videos
- On-Site Job Analysis

Twitter Question

Form Hater
@formhater

If the employee's job status changes, can the plan be changed from the R-2?

12:25 PM – 14 June 2018

#thisisfakedonotfollow

Twitter Question

Big Box Risk Manager
@bigboxriskmanager

How can we most effectively use an on-site job analysis?
1:15 PM – 14 June 2018

#thisisfakedonotfollow

QRC Standard of Conduct

- Separate Roles and Functions
- Prohibited Conduct
- Consequences

Billing Standards

- 5220.1900, subp. 7
- Factors Influencing Billing
- Negotiating Bills

Twitter Question

The Real Queen Adjuster

@therealqueenadjuster

If an interpreter can be provided under a managed care plan, do we have to pay for an interpreter provided by a QRC?

1:25 PM – 14 June 2018

#thisisfakedonotfollow

Twitter Question

No Excuse for Not Working

@noexcusefornotworking

Should temporary jobs be included in a rehabilitation plan? (Goodwill)

1:35 PM – 14 June 2018

#thisisfakedonotfollow

Questions?

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CLTuft@arthurchapman.com

Emily A. LaCourse
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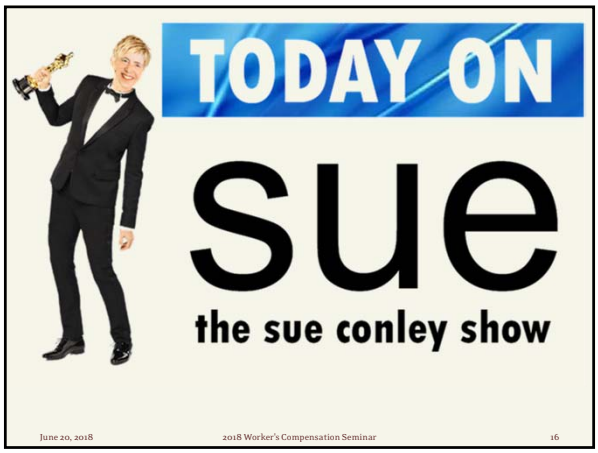

"Sue" - Handling Intervention, Subrogation, and Medicare Issues in Settlement

Susan K. H. Conley
Chuck B. Harris
Annie Davidson of Examworks

Arthur Chapman
Kettering Smetak & Pikala, P.A.
Attorneys at Law

Exclusion of Intervenor

Hansen v Dayton's, n/k/a Macy's, 71 W.C.D. 443 (WCCA 2011), summarily aff'd (Minn. Aug. 26, 2011) has a long procedural history. The parties attempted to extinguish Medica's interest as it had not timely intervened. After a 2002 stipulation was filed, leaving medical open, Medica intervened 1/6/2003 though no litigation at time. This motion led to Medica being an intervener.

Exclusion of Intervenor

Medica was excluded from settlement negotiations, that resulted in a full, final settlement of Employee's claims. There were no negotiations of Medica's interest; Medica was not a party to the stipulation, and therefore was entitled to 100% reimbursement because of its intervention filed 1/6/2003.

Hansen v. Dayton Hudson and Medica et.al, Intervenors, No. WC12-5407 (WCCA Jan. 22, 2013)

Take Away

- If an employer/insurer ARE AWARE that an entity paid benefits or is, in some way, involved in the case at some level, IT IS BEST to provide Notice of Right to Intervene. Medica intervened after settlement. If an entity has intervened at any point, NEGOTIATE with them.
- Parties knew about Medica, failed to negotiate with them.
- Medica reimbursed in full.

Exclusion of Intervenor

Employer and Employee both have duty to make inquiry as to existence of possible third party intervention interests. In *Fraker v. Pizza Hut*, 54 W.C.D.1 (1995), a more diligent inquiry would have disclosed that BCBS had made payments and had potential intervention interest.

Exclusion of Intervenor

- A medical provider that received payment from health care insurer cannot be excluded from settlement negotiations, and is entitled to difference between the amount allowed for the service under fee schedule and amount actually paid to provider.
- M.S. 176.191, Subd. 3, *Spaeth v Cold Spring Granite Co.*, 56 W.C.D. 136 (1996), aff'd in part, rev'd in part, 56 W.C.D. 161, 560 N.W. 2d 92 (Minn. 1997).

Take Away

- Work comp carrier denies primary liability.
- Health care provider pays provider for service, Noran Clinic Bill $2,000 and BCBS pays provider $1,000.
- Provider is entitled to the difference allowed under fee schedule and amount paid by BCBS. Thus, if fee scheduled amount is $850, that's what work comp carrier owes.

Settlement / Pretrial Conference

- An intervenor is NOT required to attend a settlement or pretrial conference or hearing, unless ordered by the Compensation Judge or pursuant to a Motion by a party.
- M.S. 176.361, Subd. 4 (Effective 8/1/2016)

Notice of Hearing

Intervenors must be given NOTICE of right to Intervene 60 days prior to hearing. Where an Intervenor is excluded from proceedings and NOT given an opportunity to be heard, the potential intervenor is entitled to full reimbursement of its claim.

Gamble v Twin City Concrete Products, File. No. WC 12-5518, Served and Filed July 8, 2013.

Failure to Intervene

Where the intervention motion was not filed within 60 days of being notified of right to intervene, the motion was not timely filed under M.S. §176.361, Subd. 2(a) and the potential claim can be extinguished.

Duehn v. Connell Car Care, Inc. and *Auto-Owners*, No. WC 16-6000 (WCCA March 20, 2017), *see* also *Erven v. Magnetation, LLC*, and *Western National Ins. Group*, No. WC 16-5903 (WCCA June 20, 2016).

Failure to Intervene

- When an Intervenor is being excluded from the Stipulation for failure to Intervene, a statement to that effect must be made in the Stipulation.
- A copy of the Notice of Intervention with an Affidavit of Service should be attached.
- A Judge may extinguish under M.S. §176.361, Subd. 2(a).

Take Aways

- If you are aware of an Intervenor, and are entering into settlement negotiations, you must make sure to send a NOTICE of RIGHT to INTERVENE and DO NOT finalize any settlement papers until 60 days has run.
- If they do NOT intervene, attach the NOTICE with the Affidavit of Service to the Stipulation to Exclude their interest.
- The Award should specifically list the interest to be excluded.

Take Aways

- The Stipulation should be served on the interests being excluded.
  M.R. 1420.1850
- If they have Intervened, make sure to Negotiate settlement with them.
- If settlement not reached and if the Stipulation is signed by Intervenor, the Stipulation must include a statement that the parties entered into **good faith** negotiations but were unable to reach settlement and intervenor reserves right to petition for hearing under subpart 3.

Parker-Lindberg

An Intervenor may proceed to establish entitlement to full reimbursement if prove effectively excluded from settlement proceedings, irrespective of a primary liability defense.

Mediation

- Must an Intervenor be given Notice of a Mediation?
- No statute or case law.

Conclusion

- Make sure to put every medical provider, health care insurer, disability carrier, or other potential lien holder on Notice of Right to Intervene.
- Keep record.
- If there is an Intervention make sure to include intervenor in settlement negotiations.
- If necessary to be at a Settlement Conference, file Motion to OAH, 20 days prior.

Chuck: The King Subro Geek

Wisconsin – §102.29

The proceeds will be distributed according to the provisions of 102.29, Wisconsin Statutes, as follows:

- $100,000.00 total amount of third party settlement.
- $40,000.00 to employee's attorney as cost of collection (fee and costs).
- $20,000.00 one-third of balance to employee.
- $20,000.00 to worker's compensation insurance carrier or self-insured employer as reimbursement for payment of
  - $10,000.00 in compensation, and
  - $10,000.00 in medical expenses.
- $20,000.00 balance to employee which shall constitute a cushion or credit against any additional claim under worker's compensation.

Annie: MSA Super Hero

MSAs & The Real-World

- I'm settling for under the $25,000 threshold with a beneficiary; I don't need to do an MSA, right?
- I have an approved MSA from 3 years ago, and we are close to settling now. Can I rely on it? Can I have it re-reviewed by CMS?
- The claimant applied for SSDI, but has been denied and is not appealing. Do I need to consider Medicare's interest with an MSA? Does the analysis change if s/he is appealing?
- New contractor as of March.

How to Speed Up the MSA Process

- MSA submission to CMS
  - Have most recent 2 years' of medical and pharmacy records, including personal records if the claimant hasn't been treating for the WC injury as of late. Need claim payment history too. Items and report dated within 6 months of submission date.
- Consider non-submission if you do not have everything CMS requires.
- Case doesn't meet CMS's workload review threshold?
  - Consider Evidenced-Based MSA to save on average 28%.

Conditional Payments & The Real-World

- Accepted vs. denied WC claims – does Medicare treat them the same when it comes to recovery?
- My case is at Treasury Department or has been offset against Federal funds/corporate taxes. Why and help?!
- My file is closed and has been closed for 2 years, why am I getting CP correspondence now?
- Medicare Advantage & Part D liens – what do I need to know?

How to Speed Up the CP Process

- WC claim with primary denial needs to be reported to BCRC to develop claim and investigate conditional payments, since ORM will never be reported.
- Ensure all accepted ICD 10 codes are correct in your claim system as these will be transmitted to CMS and used for recovery efforts.
- Timely file disputes and appeals to avoid Treasury action.
- Remember to report additional ICD 10 codes (denied, disputed, and consequential), TPOC information, and ORM termination date so that CMS will know the case closed on a full, final, and complete basis with future medical closed.

QUESTIONS?

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Chuck B. Harris
715 808-0513
CBHarris@arthurchapman.com

THE EXPERT HOUR: A CONVERSATION WITH DR. WOJO

DR. RANDAL WOJCIECHOSKI,
JAMES S. PIKALA, AND
JESSICA L. RINGGENBERG
ARTHUR CHAPMAN
KETTERING SMETAK & PIKALA, P.A.
ATTORNEYS AT LAW

Musculoskeletal Anatomy and Worker's Compensation

Randal F. Wojciehoski, D.P.M., D.O.
President, Medical Topics Unlimited, L.L.C.
Medical Director
Employer Solutions
Occupational Medicine, Cardiac Rehabilitation
Associate Health
Ascension Health Care
Harley Davidson, Corporate Medical Director

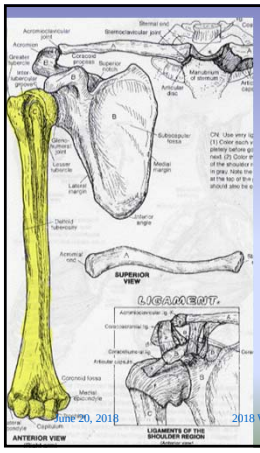
www.drwojo.com

- Emergency Physician, Ascension St.Michael's Hospital
- Medical Director, Employer Solutions
- Medical Director, MMG-Cardiac Rehab, Associate Health
- Medical Director, Harley-Davidson, Wisconsin
- Medical Director, Bershire-Hathaway Travel Protection
- Board Certified Emergency & Internal Medicine
- Podiatrist
- Medical-Legal Consultant
- Syndicated Columnist and Author
- Clinical Professor at Marquette, UW, Fitch Medical School
- Commercial Pilot

To Your Health with Dr. Wojo

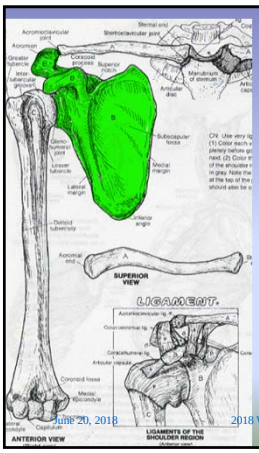
"Have Airplane, Will Travel!"

SHOULDER ANATOMY



Humerus

- **proximal end articulates with scapula to from shoulder**
- **distal end articulates with bones of the forearm to form elbow**

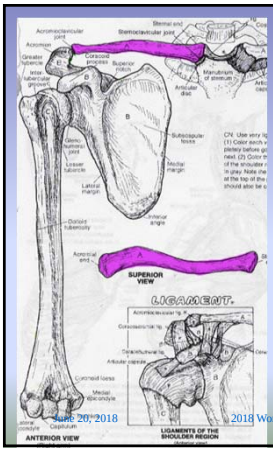


Scapula

- **the shoulder blade**

Glenoid fossa has ring of cartilage called labrum to deepen the articular surface

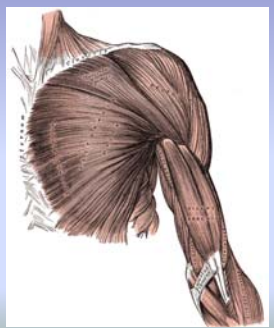
- **the glenoid fossa of the scapula articulates with the humerus to form the glenohumeral joint (shoulder)**
- **the acromion process articulates with the clavicle to from the acromioclavicular joint (tip of the shoulder)**

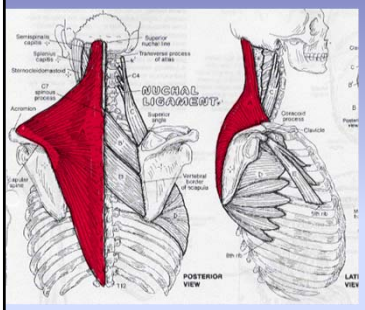


Clavicle

- **distally articulates with the acromion process to form the AC joint**
- **Proximally articulates with the sternum to form SC joint**

MUSCULATURE

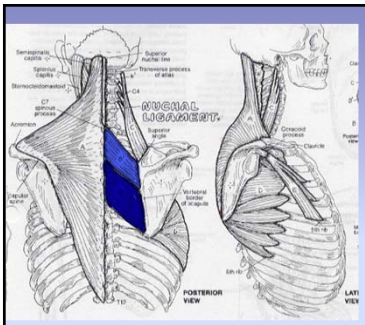




Trapezius

- large, triangular muscle
- starts at base of skull, runs out to tip of shoulder and down to the 12th thoracic vertebrae
- functions to shrug and square the shoulders

June 20, 2018 2018 Worker's Compensation Seminar 52



Rhomboids

- group of two muscles that run diagonally from the spine to the medial border of the scapula
- they function to retract the scapula

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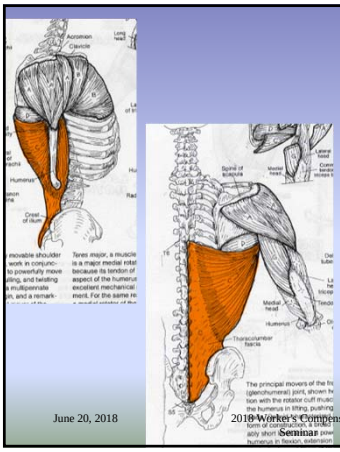
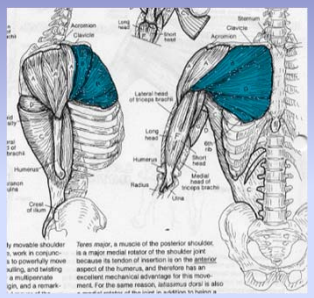


Latissimus Dorsi

- the “lats”
- gives wing like appearance to sides
- starts along the thoracic vertebrae of back and inserts on the anterior aspect of humerus
- functions extend , adduct and medially rotate the arm

June 20, 2018 2018 Worker's Compensation Seminar 54

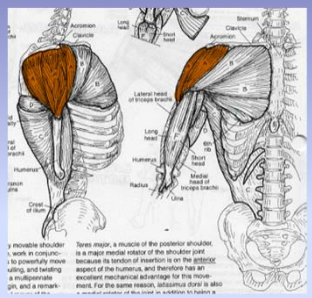
Pectoralis Major



- the chest muscle
- originates along the sternum and clavicle, inserts on the humerus
- it functions to:
  - ~ adduct
  - ~ flex
  - ~medially rotate the arm.

June 20, 2018 2018 Worker's Compensation Seminar 55

Deltoid



- the muslce that gives contour to the shoulder
- originates along the spine of the scapula and clavicle, inserts on the humerus
- all fibers abduct the arm
- anterior fibers: flex and medially rotate arm
- posterior fibers: extend and laterally rotate arm

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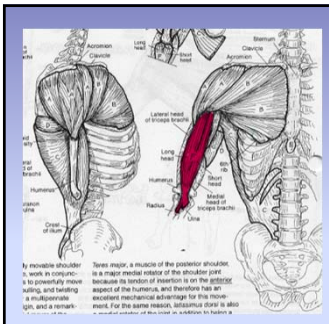
Biceps



- the “popeye” muscle
- on anterior aspect of arm
- crosses both the shoulder and elbow
- flexes the arm

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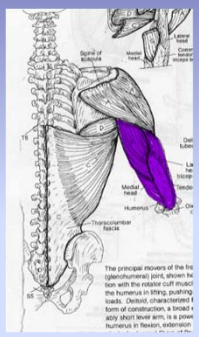
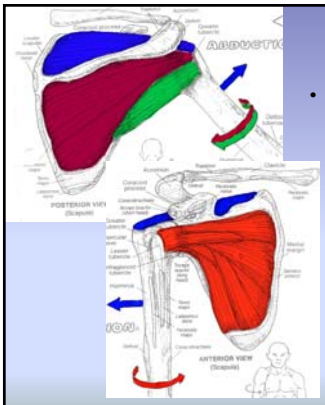


Triceps

- **on the posterior aspect of the arm**
- **crosses both the shoulder and elbow**
- **extends the arm**

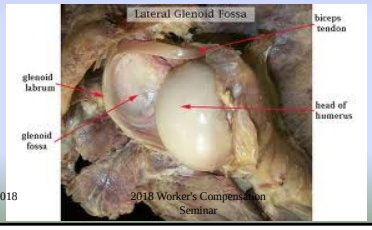


Rotator Cuff

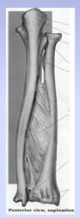
- **Group of four muscles that act to hold the head of the humerus into the glenoid fossa**
  - **Supraspinatus**
  - **Infraspinatus**
  - **Teres Minor**
  - **Subscapularis**

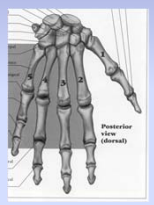
Labrum

- Ring of cartilage similar to the menisci of the knee.
- Deepens the articular surface of the genoid fossa and adds to the stability of the shoulder



Wrist Anatomy





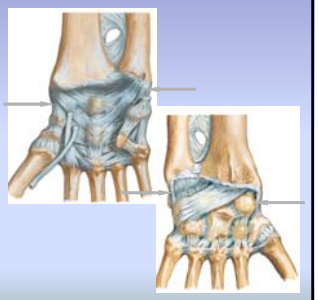
Carpal Bones and Articulations

- Proximal Row
  - Where can you palpate these?
    - Scaphoid
    - Lunate
    - Triquetrum
    - Pisiform
- Radiocarpal joint
  - Ulnocarpal joint
- Intercarpal joints
- Distal Row
  - Where can you palpate these?
    - Trapezium
    - Trapezoid
    - Capitate
    - Hamate
  - Intercarpal joints
  - Carpometacarpal joints (related to hand)

"Sacred Lovers Try Positions That They Cannot Handle"

Soft tissue of Wrist

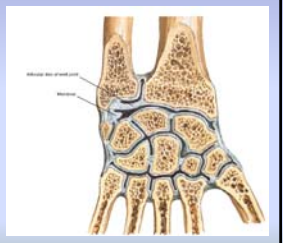
- Ligaments
  - Covered by a fibrous capsule
    - **Radial and ulnar collateral**
      - limit ulnar and radial deviation; collectively limits flexion and extension
    - Intercarpal and Carpometacarpal



June 20, 2018 2018 Worker's Compensation Seminar 64

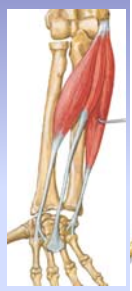
Soft tissue of Wrist

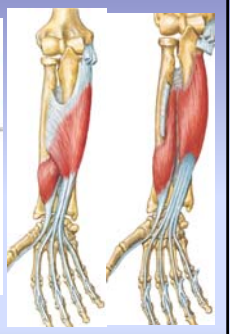
- Cartilage
  - Triangular Fibrocartilage Complex – TFCC
    - "Meniscus" between ulna and triquetrum
    - Ulnar collateral ligament and palmar ulnocarpal ligaments have attachments
    - Compressed with Pronation and Extension
    - Compressed with Ulnar deviation



June 20, 2018 2018 Worker's Compensation Seminar 65

EXTENSORS FLEXORS

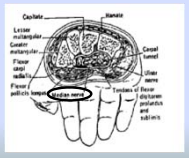


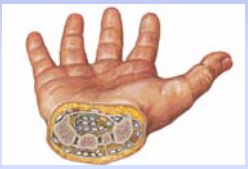


June 20, 2018 2018 Worker's Compensation Seminar 66

Wrist and Hand Anatomy

- Nerves/Vessels
  - Radial & ulnar artery and veins
  - Radial, ulnar, & median nerves
- **Carpal Tunnel** -
  - Flexor Tendons - 9
  - Median Nerve





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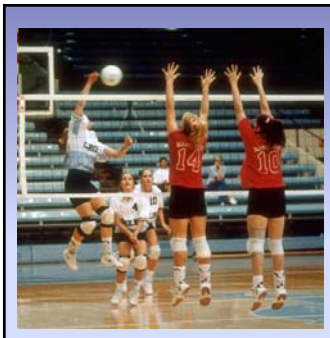
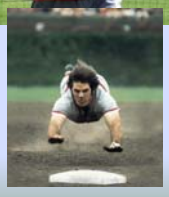




June 20, 2018 2018 Worker's Compensation Seminar 68

Wrist Injuries

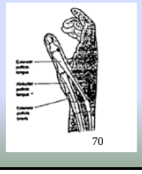
- Strains
  - Onset usually acute – FOOSH or Overexertion
  - S/S: Active ROM limited
- Wrist Ganglion
  - Herniation of the joint capsule or synovial sheath of a tendon.

Tx: Bible Therapy

June 20, 2018 2018 Worker's Compensation Seminar 69

Wrist Injuries

- deQuervain's Disease - thumb/wrist
  - stenosing tenosynovitis of the extensor pollicis brevis and abductor pollicis longus.
  - S/S: crepitation, tenderness, strength loss.
  - Special Test: = Finkelstein's test
  - Tx: RICE, NSAIDs



Wrist Injuries

- Sprains
  - Onset is usually acute – FOOSH or overexertion
  - Often diagnosed when other injuries are ruled out
    - Both active and passive ROM are effected
  - S/S: Laxity, pain, swelling, limited ROM
    - Pain is usually with overstretching
  - Special Tests: Varus/Valgus, Carpal Glide
  - PRICE, Rehabilitation, Taping for prevention

Wrist Injuries

- Triangular Fibrocartilage Injuries - TFCC
  - Onset is usually acute
  - MOI: Forced hyperextension of wrist with loading
  - S/S: Pain with pronation/extension and/or ulnar deviation; Pain with loading; Point tenderness; Swelling; Altered joint mechanics
  - Special Test: Valgus test elicits pain but no laxity and Varus test compresses and causes pain
  - Immobilization and Surgery are often necessary

Neural Injuries

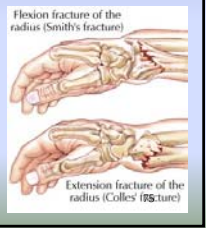
- Carpal Tunnel Syndrome
  - Compression of median nerve
    - Fibrosis of the synovium of flexor tendons secondary to tenosynovitis
  - MOI: Insidious onset with repetitive wrist movement (and finger movement); Acute onset with trauma; Progressive degeneration
  - S/S: numbness palmar thumb, index, middle fingers, dull ache, weak finger flexion (grip). May worsen with sleep.
  - Poor posture may predispose.
  - Special Tests: Tinel's sign and Phalen's
  - Tx: Conservative (PRICE, NSAIDs) and Surgical

Wrist Injuries

- Wrist Fractures
  - Distal Radius/Ulna and Forearm Fractures
  - Onset is acute
  - MOI: Hyperextension or hyperflexion combined with rotatory motion – FOOSH
  - S/S: Deformity felt and observed; Crepitus
  - Evaluated Neurovascular status
  - Tx: Splint, Ice, Referral

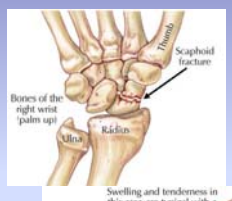
Wrist Injuries

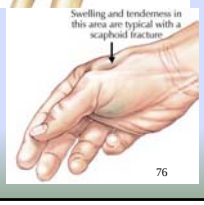
- Wrist Fractures
  - Distal Radius/Ulna
    - Colles' Fracture
      - MOI: hyperextension-fall on outstretched
      - S/S: "silver fork deformity" - radius & ulna posteriorly
    - Smith's Fracture (Reverse Colles)
      - MOI: hyperflexed
      - S/S: "garden spade deformity" - radius & ulna anteriorly



Wrist Injuries

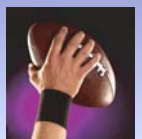
- Wrist Fractures
  - Scaphoid - most common carpal
    - MOI: fall on outstretched hand
    - S/S: wrist aches, pain in anatomical snuff box,
      painful handshake or with overpressure
    - Tx: Splint, Referral, Ice
      - Plain X-rays may not be enough
      - Immobilization (long and/or short) – 12 weeks
    - Risk: aseptic necrosis and non-union fractures
      - **Preiser's Disease**
      - Surgery may be necessary



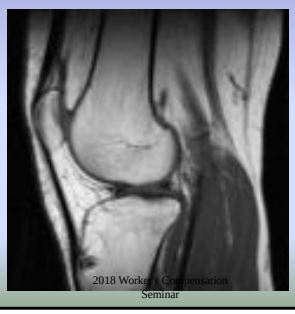


Wrist Injury Prevention

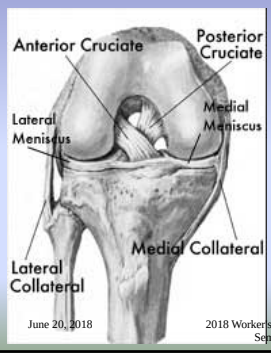
- Good technique!
  - But…these help

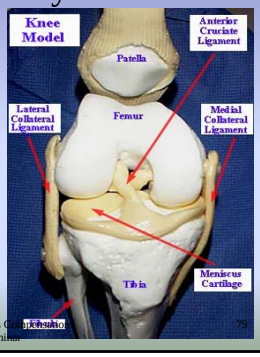


Knee Anatomy



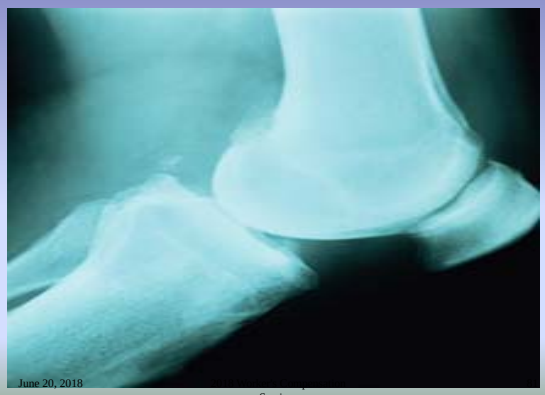
Anatomy



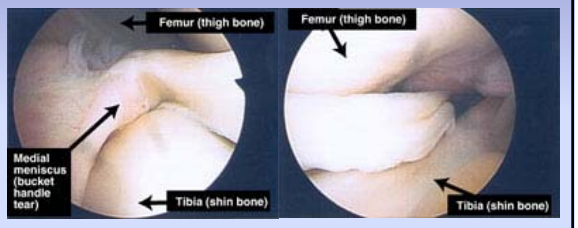


Functions of the Menisci

- Stability via deepening the tibial condyles.
- WB Shock Absorption (resilient nature) ~ 40-70% of loads
- Decrease loading stress and friction
- Lubricate joint
- Improved contact area leads to better weight distribution
- Wedged shape assists ACL and PCL with ant/post stability
- Assists joint nutrition by promoting synovial fluid distribution

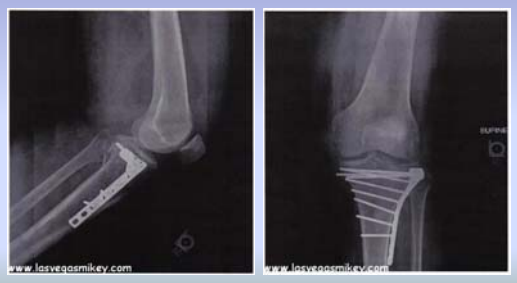


Bucket handle tear



June 20, 2018 2018 Worker's Compensation Seminar 82

Tibial Plateau Fracture

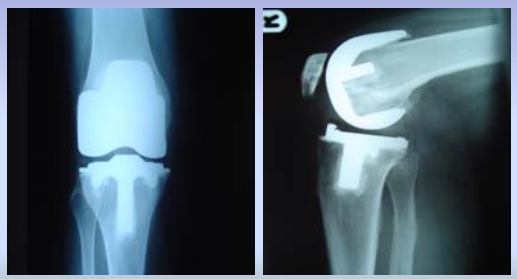


June 20, 2018 2018 Worker's Compensation Seminar 83

Osteoarthritis

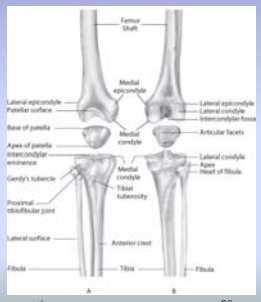
June 20, 2018 2018 Worker's Compensation Seminar 84

Knee Replacement



The Knee Joint

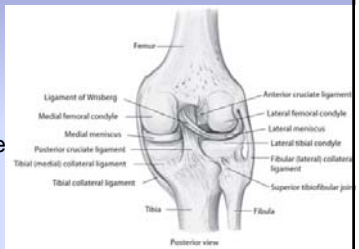
- Knee joint
  - largest joint in body
  - very complex
  - primarily a hinge joint



Modified for Prentice WE: *Arnheim's principles of athletic training*, ed 12, New York, 2006, McGraw-Hill; from Saladin, KS: *Anatomy &physiology: the unity of forms and function*, ed 2, New York, 2001, McGraw-Hill.

Bones

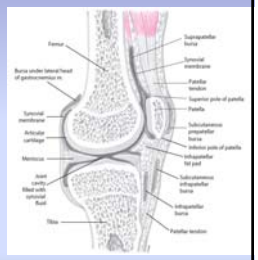
- Fibula - lateral
  - serves as the attachment for knee joint structures
  - does not articulate with femur or patella
  - not part of knee joint
  - Non-Weight Bearing



Modified from Anthony CP, Kolthoff NJ: *Textbook of anatomy and physiology*, ed 9, St. Louis, 1975, Mosby.

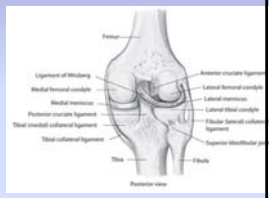
Bones

- Patella
  - sesamoid (floating) bone
  - imbedded in quadriceps & patellar tendon
  - serves similar to a pulley in improving angle of pull, resulting in greater mechanical advantage in knee extension



Joints

- Posterior cruciate ligament (PCL) injuries
  - not often injured
  - mechanism of direct contact with an opponent or playing surface
- Fibular (lateral) collateral ligament (LCL)
  - infrequently injured



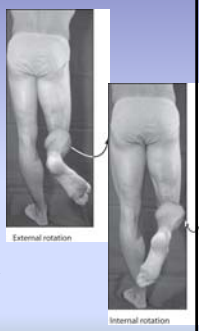
Modified from Anthony CP, Kolthoff NJ: *Textbook of anatomy and physiology*, ed 9, St. Louis, 1975, Mosby.

Movements

- Flexion
  - bending or decreasing angle between femur & leg, characterized by heel moving toward buttocks
- Extension
  - straightening or increasing angle between femur & lower leg

Movements

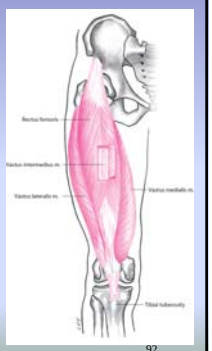
- External rotation
  - rotary movement of leg laterally away from midline
- Internal rotation
  - rotary movement of lower leg medially toward midline
- Neither will occur unless flexed 20-30 degrees or >



June 20, 2018 2018 Worker's Compensation Seminar 91

Muscles

- Quadriceps muscle group
  - extends knee
  - located in anterior compartment of thigh
  - consists of 4 muscles
    - rectus femoris
    - vastus lateralis
    - vastus intermedius
    - vastus medialis

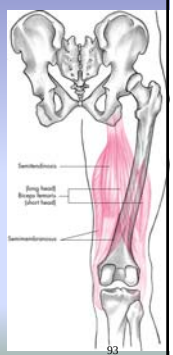


June 20, 2018 2018 Worker's Compensation Seminar 92

Muscles

Knee joint muscles location

- Posterior - primarily knee flexion
  - Biceps femoris
  - Semimembranosus
  - Semitendinosus
    - Sartorius
    - Gracilis
    - Popliteus
    - Gastrocnemius

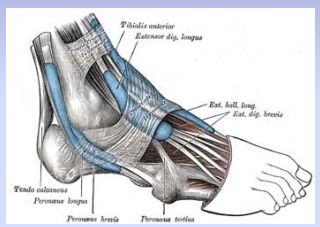


June 20, 2018 2018 Worker's Compensation Seminar 93

Hamstring Muscles

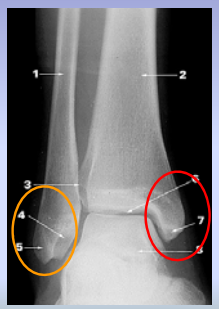
- Hamstring muscle strains very common
- "Running muscles" function in acceleration
- Antagonists to quadriceps muscles at knee
- Named for cordlike attachments at knee
- All originate on ischial tuberosity of pelvis
- Semitendinosus inserts on anteromedial tibia
- Semimembranosus inserts on posteromedial tibia
- Biceps femoris inserts on lateral tibial condyle & head of fibula

THE ANKLE AND FOOT



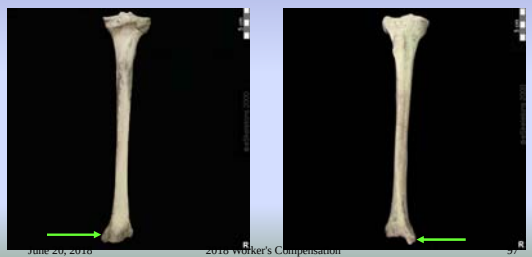
BONES

- A. Tibia
  - 1. condyle (lateral and medial)
  - 2. tibial tuberosity
  - 3. medial malleolus
- B. Fibula
  - 1. head
  - 2. lateral malleolus



Tibia

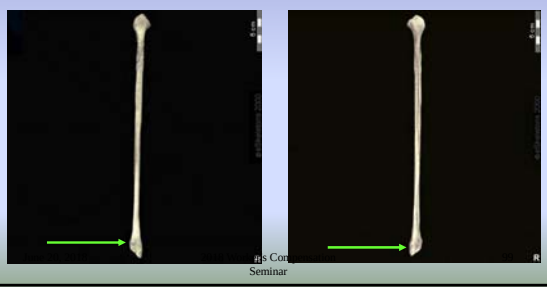
- Medial Malleolus



Tibia

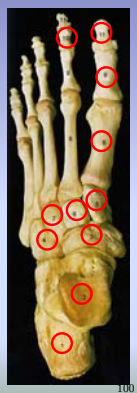
Fibula

- Lateral malleolus



BONES OF THE FOOT

- Tarsal bones
  - 1. Calcaneous
  - 2. Talus
  - 3. Navicular
  - 4. Cuboid (lateral, articulates with 4 and 5 metatarsals)
  - 5-7. Cuneiforms (medial, intermedial and lateral; articulate w/ 1-3 metatarsals)
- 8. Metatarsals (1-5 from the medial to lateral side)
- 9-11. Phalanges (distal, middle, proximal)



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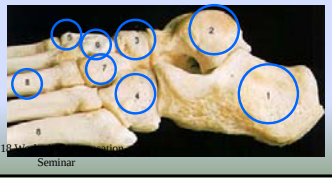
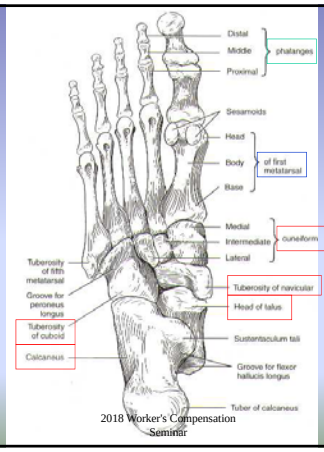
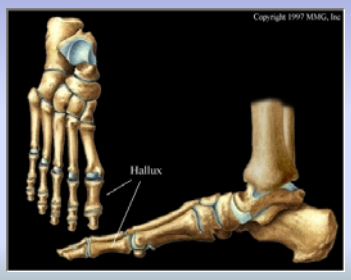


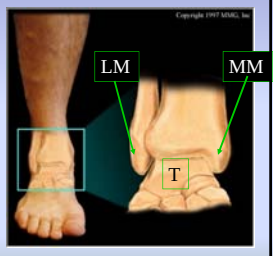


Hallux or Great Toe



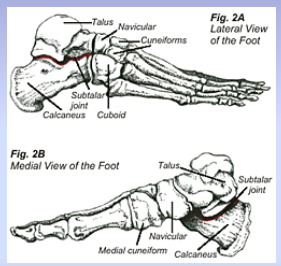
JOINTS

- 33 joints and 26 bones.
- Two major joints
- **The Ankle Joint**
- Plantarflexion and Dorsal flexion primarily occur here.



JOINTS

- The second major joint is the **Subtalar Joint**
- Articulation between the TALUS and CALCANEUS.
- Inversion and Eversion primarily occur here.



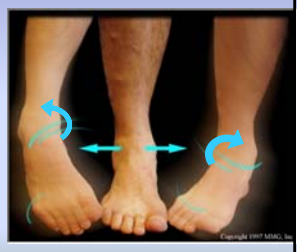
MOVEMENTS

Dorsal flexion [15-20°]

Plantar flexion [50°]

MOVEMENTS

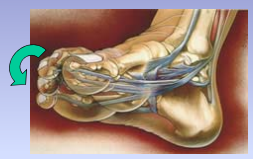
- **Inversion** - raising medial border (20-30°)
  - Supination is similar to Inversion + plantar flexion + adduction (toe in)
- **Eversion** - raising lateral border (5-15°)
  - Pronation is similar to Eversion + dorsal flexion + abduction (toe out)



Inversion Eversion

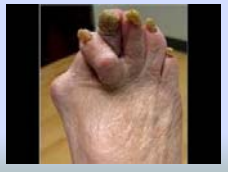
MOVEMENTS

- Toe flexion

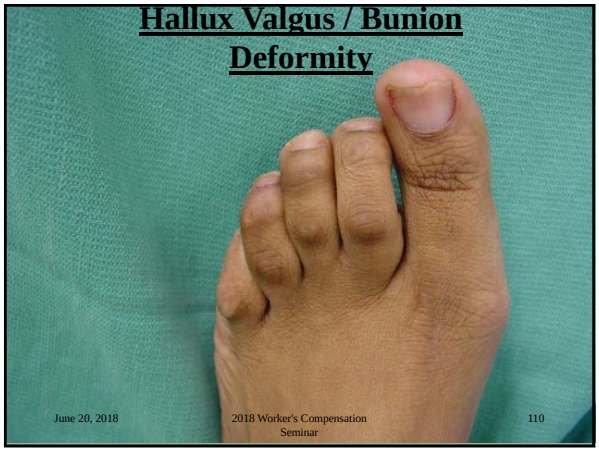


- Toe extension

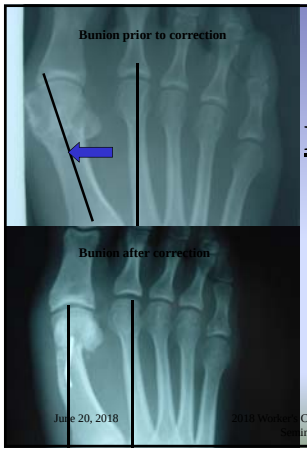
Common Foot & Ankle Problems

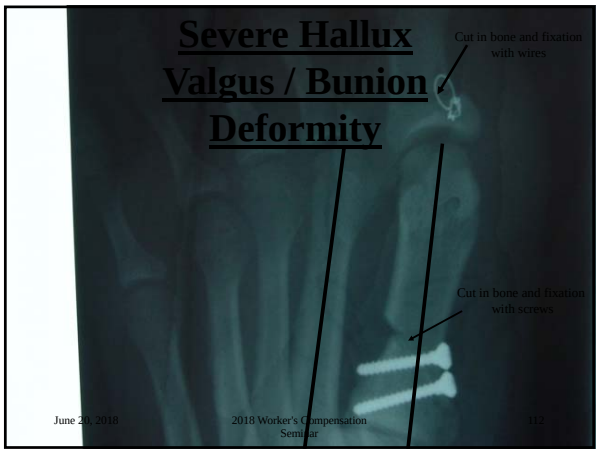


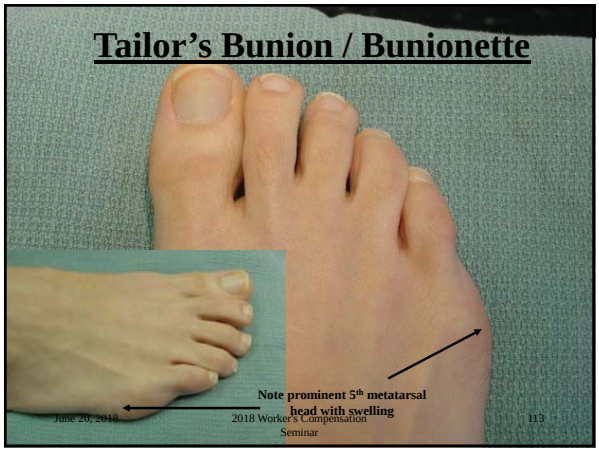
Hallux Valgus / Bunion Deformity

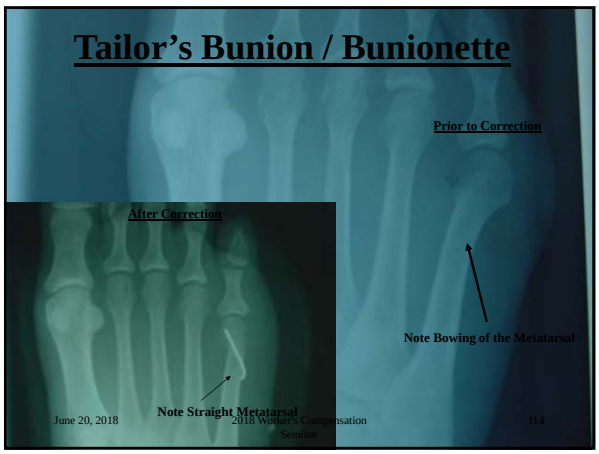


Hallux Valgus / Bunion Deformity




Severe Hallux Valgus / Bunion Deformity
Cut in bone and fixation with wires
Cut in bone and fixation with screws
June 20, 2018
2018 Worker's Compensation Seminar
112


Tailor's Bunion / Bunionette
Note prominent 5th metatarsal head with swelling
June 20, 2018
2018 Worker's Compensation Seminar
113


Tailor's Bunion / Bunionette
Prior to Correction
After Correction
Note Bowing of the Metatarsal
Note Straight Metatarsal
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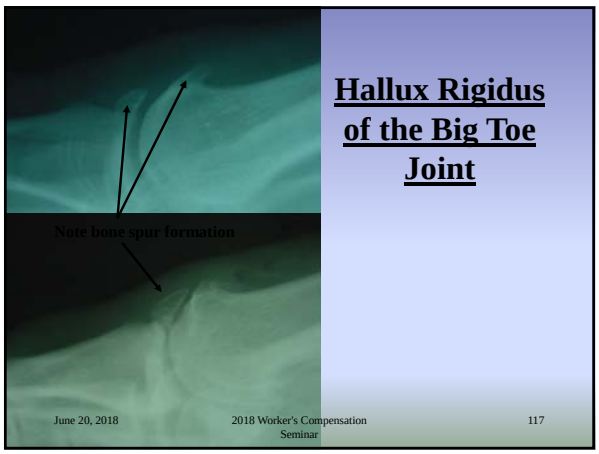
114


Hammertoe Deformity
June 20, 2018
2018 Worker's Compensation Seminar
115


Toe prior to surgery
Toe after surgery
Hammertoe Deformity
June 20, 2018
2018 Worker's Compensation Seminar
116


Hallux Rigidus of the Big Toe Joint
Note bone spur formation
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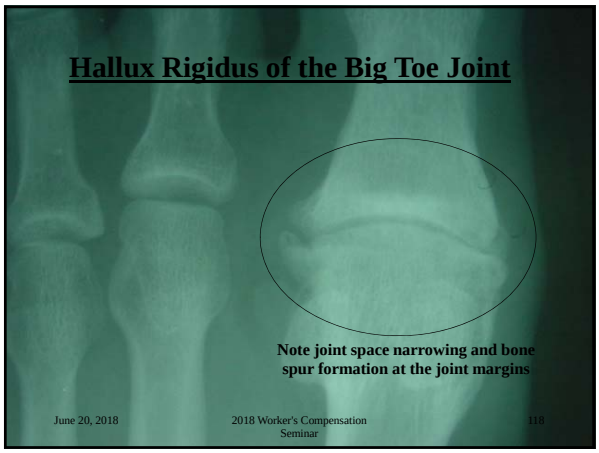
117


Hallux Rigidus of the Big Toe Joint
Note joint space narrowing and bone spur formation at the joint margins
June 20, 2018
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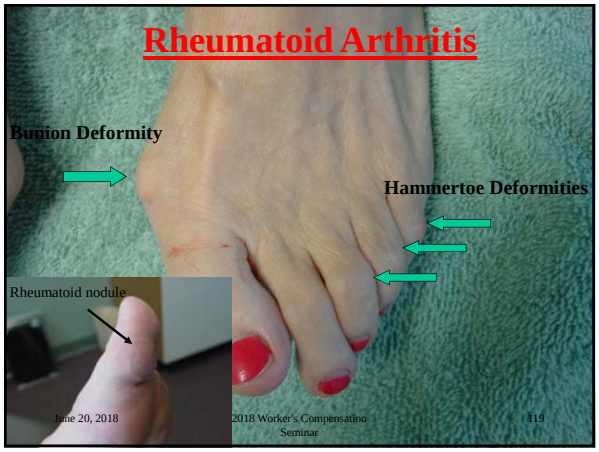
118


Rheumatoid Arthritis
Bunion Deformity
Hammertoe Deformities
Rheumatoid nodule
June 20, 2018
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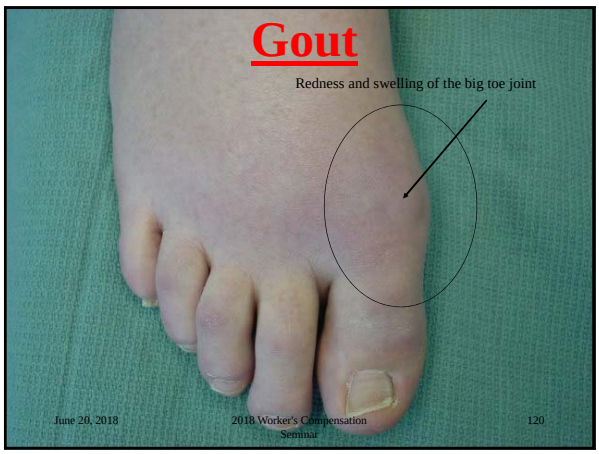
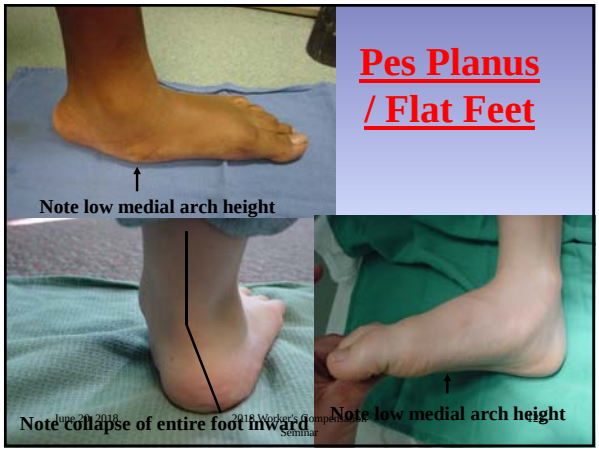
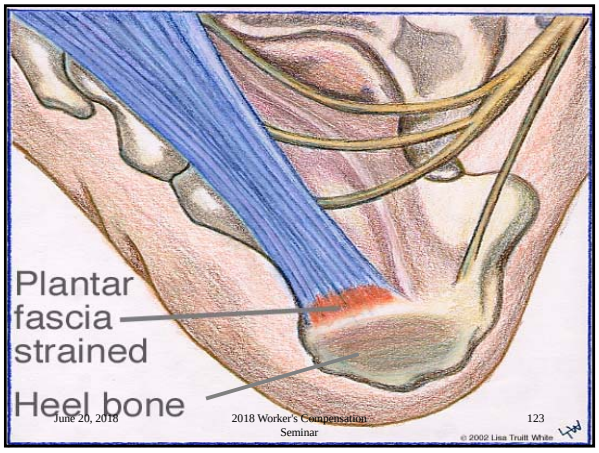
119


Gout
Redness and swelling of the big toe joint
June 20, 2018
2018 Worker's Compensation Seminar
120


Pes Cavus / High Arch Feet
June 20, 2018
2018 Worker's Compensation Seminar
121


Pes Planus / Flat Feet
Note low medial arch height
Note collapse of entire foot inward
Note low medial arch height


Plantar fascia strained
Heel bone
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123
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Ankle Sprain
(Swelling in area of ligament injury)
Bruising after ankle sprain
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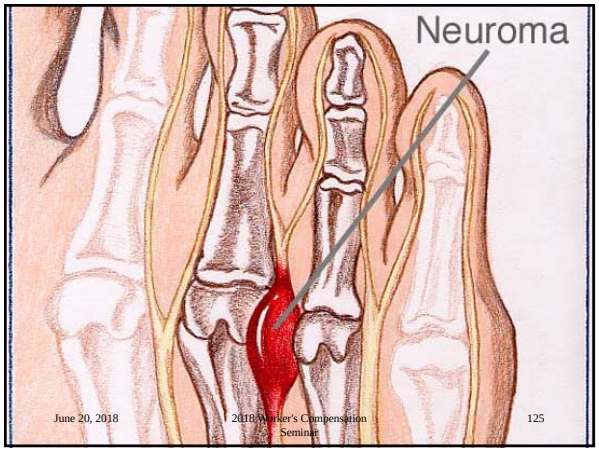
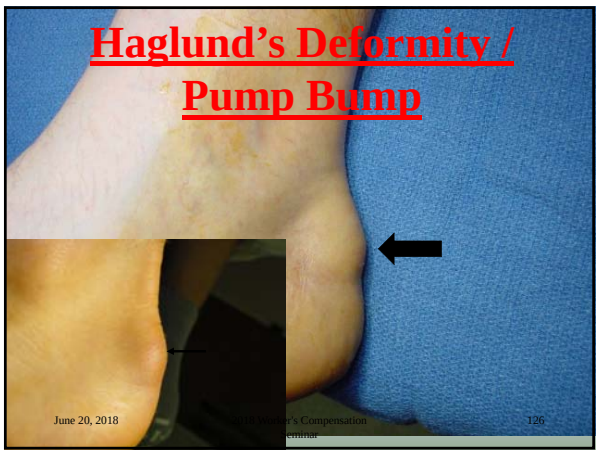
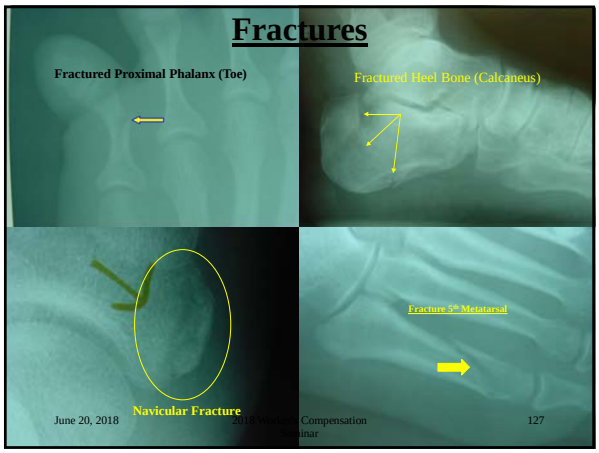
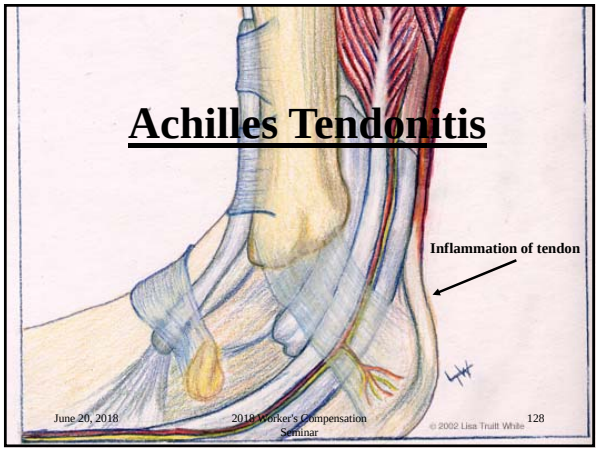
124


Neuroma
June 20, 2018
2018 Worker's Compensation Seminar
125


Haglund's Deformity / Pump Bump
June 20, 2018
126


Fractures
Fractured Proximal Phalanx (Toe)
Fractured Heel Bone (Calcaneus)
Navicular Fracture
Fracture 5th Metatarsal
June 20, 2018
127


Achilles Tendonitis
Inflammation of tendon
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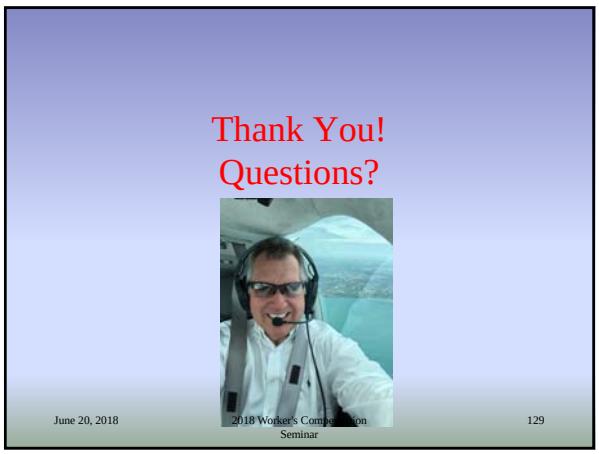
Thank You!
Questions?
June 20, 2018
2018 Worker's Compensation Seminar
129

Questions?

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The Hot Seat – Wisconsin Case Law Update

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Solved Mysteries – Investigation of Claims

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Attorneys at Law

Investigation of Claims

- Investigation Techniques
- Comparing Mechanisms of Injury with Medical Diagnoses
- Utilizing Findings on Mechanisms of Injury

"It's not the will to win that matters – everyone has that. It's the will to prepare to win that matters."

– Paul "Bear" Bryant, head coach, Alabama Crimson Tide

Investigation Techniques

The initial investigation can answer several key questions:

- What was the mechanism of injury?
  - Did an injury actually occur?
  - Did the condition/diagnosis arise out of work activities?
- Underlying or preexisting issues?
- Outside activities?
- Ulterior motives?
- Fraud?

Investigation Techniques

First Report of Injury (FROI) (Minnesota)

Employer's First Report of Injury of Disease (WKC-12) (Wisconsin)

- Often the first account of the alleged mechanism of injury.
- Use to compare to future documentation for inconsistencies.

Investigation Techniques

Accident Reports

- Many employers complete separate accident reports.
- Accident reports can contain more detail about an alleged mechanism of injury.
- Reports should be forwarded promptly to the adjustor.

Investigation Techniques

Statement of Employee

- Direct communication with the employee is valuable. Make the most of it. Obtain as much detail as possible, ask follow-up questions, and be curious!

Investigation Techniques

Central Index Bureau Check (CIB or ISO reports)

- Any previous, similar mechanisms of injury?
- These reports are useful in determining whether underlying/preexisting issues may be at play.

Investigation Techniques

Obtain Authorizations

- Medical Authorizations
  - Critical in obtaining medical records and background on any underlying/preexisting issues.
  - Get films!
- Prior workers' compensation files
  - Can contain information on prior mechanisms of injury, medical records, IME reports, etc.

Investigation Techniques

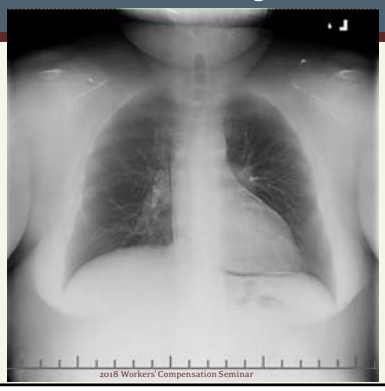
Obtaining authorizations to obtain medical records is key!

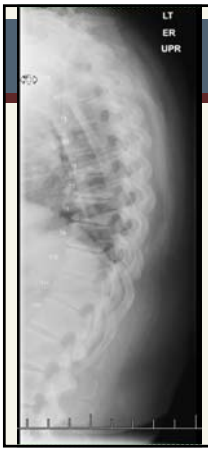
- Fact pattern: Employee is a bus driver. She is driving her route one day and goes over a "bump" in the road. Employee alleges she felt pain in her back. She files a Hearing Application alleging a T-11 fracture. Does she have one?

Investigation Techniques

DOI: 12/2/2015

Taken 5/14/2015





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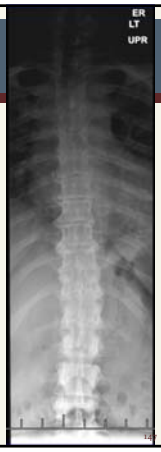
Taken: 12/5/2016



Investigation Techniques

Surveillance

- Use surveillance when the mechanism of injury is in question.
- Surveillance evidence alone usually cannot allow for an automatic denial of primary liability, but can assist IME doctors determine whether injury actually occurred.


Investigation Techniques

Surveillance

- Sometimes, media gives you the opportunity to do your own surveillance.
- Real life example:
  - Cathy Cashwell, a NC postal carrier, was collecting workers' compensation checks for many years, claiming that she had a shoulder injury and could not lift mail trays into a truck. And then…

Investigation Techniques

…Cathy was seen on TV on *The Price is Right*, spinning the "Big Wheel"…TWICE.

Investigation Techniques

Witness Statements

- When the alleged mechanism of injury is in question, secure written, signed, and dated statements from co-employees and witnesses.


Witness Statement

Investigation Techniques

Job Site Video

- Specific Injuries
  - Secure video before it is destroyed.
- *Gillette* Injuries (MN)/Occupational Injuries (WI)
  - Consider creating video of job duties as illustrative exhibit for judges and IME doctors.

Investigation Techniques

Job Site Photographs

- Obtain photographs of:
  - Location
  - Tools/objects involved
  - Physical injuries (if possible)

Investigation Techniques

Timing and Work Schedule

- Pay attention to when an employee is "on the clock."
- Would an employee be **doing** what he says at the **time** he says he was doing it?

Investigation Techniques

Social Media Investigation

- If possible, locate the employee via social media (Facebook, Instagram, Twitter). Doing so can help you verify the claimed mechanism of injury and any alleged ongoing symptoms.
- Public information is "fair game."
- Obtain screenshots and save them to your file.

Investigation Techniques

Social Media Investigation

By Amy Powell

Wednesday, August 13, 2014

A young beauty contestant was arrested Friday for workers' compensation fraud after authorities discovered her social media posts.

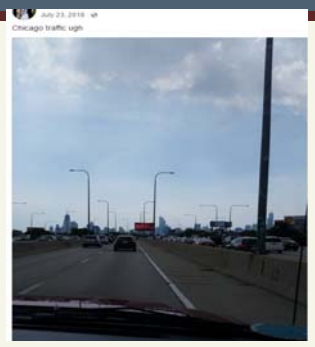
Shawna Lynn Palmer participated in this year's Miss Toyota Long Beach Grand Prix Beauty Pageant. A YouTube video shows the 22-year-old strutting onstage in high heels with the other contestants.

The problem? She was collecting worker's compensation benefits at the time on a foot injury.

Investigation Techniques

Social Media Investigation

Investigation Techniques



Investigation Techniques

Accident Reconstruction

- Ask yourself: does the mechanism of injury sound *physically possible*?
- It may be beneficial to obtain a report from a biomechanical engineer.
- Employed in high-value cases.

Investigation Techniques

Accident Reconstruction/Biomechanical Issues

- Fact Pattern: Employee was driving down a highway and was slowing down due to traffic congestion ahead. She was rear-ended by another driver and she alleges she sustained a number of injuries, including an injury to her neck, a TBI, and a "nutcracker" cuboid fracture. Did these injuries really occur?

Investigation Techniques

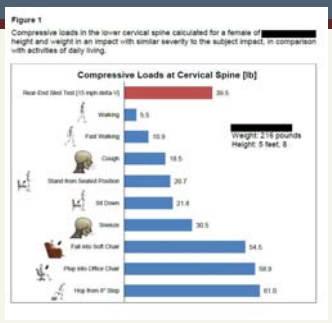


Chart from Erin Potma, Ph.D., P. Eng., Rimkus Consulting Group, Canada, Inc.

Comparing Mechanisms of Injury with Medical Diagnoses

After you have conducted a thorough of investigation of the mechanism of injury, take your analysis to the next level!

- Become familiar with various medical conditions and what can cause them.
- When thinking about a mechanism of injury, ask yourself: **does it make sense**?

Utilizing Findings on Mechanisms of Injury

Making Primary Liability Determinations

- Investigate promptly – deadlines are looming!

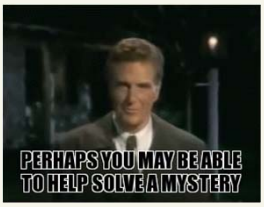
Utilizing Findings on Mechanisms of Injury

Obtaining Expert Medical Opinions

- Foundation is a key ingredient for a strong IME report. A thorough investigation will bolster foundation.
- A medical expert can help "set the record straight."
- A strong IME report can enable you to take many different strategic actions.

Conclusion

When investigating claims, be thorough, prompt, and critical, and think long-term, and…



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Questions & Answers / Conclusion

Thank you for attending!

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MINNESOTA WORKERS' COMPENSATION 2017-2018 CASE LAW UPDATE

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MINNESOTA WORKERS' COMPENSATION 2017-2018 CASE LAW UPDATE
TABLE OF CONTENTS

MINNESOTA WORKERS' COMPENSATION 2017-2018 CASE LAW UPDATE

§176.82 ACTIONS

***Sanchez v. Dahlke Trailer Sales, Inc.*, File No. A15-1183, Minn. Ct. App. (unpublished) Filed June 28, 2017**. The employee, an undocumented worker, was employed by the employer and was injured while using a sandblaster. After filing a workers' compensation claim, his deposition was taken, and the attorney for the employer asked about his immigration status. The employee acknowledged he was ineligible to work in the U.S. The next day, the employer put the employee on indefinite leave and made him sign a document indicating he was on unpaid, indefinite leave until he could show he could legally work in the U.S. The employee filed a claim for retaliatory discharge per Minn. Stat. §176.82. The employer filed a motion for summary judgment, which was denied. A second motion for summary judgment was filed, which was granted by the Anoka County District Court on the basis that there was no adverse employment action as a result of the employee filing a workers' compensation claim. The Minnesota Court of Appeals (Judge Reilly) reversed on the basis that the district court did not address whether the employer articulated a legitimate, nondiscriminatory reason for its action, nor did it consider whether the employer's reason was pretextual. The employer argued that requiring it to continue to employ an undocumented worker after discovering his immigration status would violate federal law. The Court of Appeals held that *Correa v. Waymouth Farms, Inc*., 664 N.W.2d 324 (Minn. 2003) determined that the Immigration Reform Control Act (IRCA) prevents employers from hiring illegal immigrants, but does not preclude an undocumented worker from filing a retaliatory discharge cause of action against the employer. To establish a prima facie case for wrongful retaliation under Minn. Stat. §176.82, the employee must demonstrate: (1) the employee engaged in statutorily protected conduct; (2) the employee suffered adverse employment action by the employer; and (3) the existence of a causal connection between the two. The filing of the workers' compensation claim satisfied the first prong. The parties were in dispute as to whether the employer's action satisfied the second prong, but the Court of Appeals held indefinite unpaid leave was an adverse employment action. With respect to the third prong, there was evidence the employer knew the employee was undocumented two years before the work injury and told the employee, following the initiation of the workers' compensation claim, that he did not like that the employee got an attorney involved. Because the appellants and the district court did not address the last two prongs, the order granting summary was reversed and the case was remanded for further proceedings.

***Daniel v. City of Minneapolis*, File No. A17-0141, Minn. Ct. App. (unpublished opinion), Filed December 18, 2017**. The employee worked as a firefighter for the Minneapolis Fire Department. He sustained numerous work-related injuries, including several ankle injuries for which he filed a claim under the Workers' Compensation Act. The employee was prescribed with tennis shoes with arch support and high ankle boots. The fire department stated that the employee could not wear his tennis shoes in the station house because they were not in conformity with the dress code. There were several meetings between the parties in an attempt to agree on a shoe. In January 2015, the employee began receiving workers' compensation benefits. In December 2015, the employee sued the city, alleging: 1) the fire department violated the Minnesota Human Rights Act by discriminating against his disability, failing to accommodate his disability, and retaliating against him for engaging in MHRA-protected conduct; and 2) the fire department violated the workers' compensation act by retaliating against him for seeking workers' compensation benefits and failing to provide continued employment when it was available. In March 2016, the employee settled his

workers' compensation claim on a full, final, and complete basis, closing out any claims he had made or could make under the Workers' Compensation Act. After this settlement, the city filed a motion for summary judgment, arguing that the district court lacked subject-matter jurisdiction over the employee's MHRA claims due to the exclusivity provision in the Workers' Compensation Act. The district court disagreed with the city and denied its motion. The city appealed. The Minnesota Court of Appeals (Judge Bratvold) determined that the Minnesota Supreme Court has ruled that the exclusivity provision of the Workers' Compensation Act precludes subject-matter jurisdiction over MHRA claims arising from an injury that is compensable under the Workers' Compensation Act. *See Karst; Benson.* Thus, it reversed the district court's decision to deny the city's motion for summary judgment related to the MHRA claim and remanded the case for further proceedings regarding the employee's claims pursuant to Minn. Stat. §176.82.

AGGRAVATION

Cochran v. Target Stores, File No. WC16-6013, Served and Filed June 5, 2017. The employee appealed from Compensation Judge Wolkoff's denial of his claim for benefits based on a determination that the employee's work injury was temporary and had resolved. The WCCA (Judges Hall, Stofferahn, and Sundquist) essentially made a *Hengemuhle* ruling, concluding that the compensation judge appropriately found the medical expert for the employer and insurer to be credible as to the question of whether the employee had recovered from his work injury, and he detailed his decision in that regard.

Azuz v. Vescio's, File No. WC17-6086, Served and Filed February 1, 2018. The employee sustained an admitted injury to her low back in April 2013 and benefits were paid. The evidence revealed that she had a pre-existing degenerative condition in the lumbar spine. As time went on, it was determined that the employee was not a surgical candidate. Her treating physician determined that maximum medical improvement had been reached and rated 10% permanent partial disability. The employee then moved to Chicago, where she underwent additional treatment. Ultimately, she underwent fusion surgery in the low back, with medical bills in excess of $200,000. Dr. Wengler performed an independent medical evaluation on behalf of the employee, determining that the work injury was a substantial contributing factor to her condition, opining that the surgery was appropriate, and assigning a 37% permanent partial disability rating. The employer's IME, Dr. Simonet, opined that the work injury was a temporary aggravation of her pre-existing degenerative disc disease. Compensation Judge Wolkoff determined that the employee's work injury was temporary in nature, and he denied all of the employee's claims. The WCCA (Judges Sundquist, Milun, and Hall) affirmed. There was no dispute in this case that the employee's injury was an aggravation of a pre-existing condition. The dispute was whether the aggravation was permanent or temporary. The judge appropriately cited to medical records supporting his decision of a temporary aggravation. The employee also argued that the judge did not analyze the appropriate factors in determining whether the aggravation was temporary or permanent. Pursuant to *McClellan*, a judge may review several factors when determining whether an aggravation of a pre-existing condition is temporary or permanent: the nature and extent of the pre-existing condition and the extent of restrictions and disability resulting therefrom; the nature of the symptoms and extent of medical treatment prior to the aggravating incident; the nature and severity of the aggravating incident and the extent of the restrictions and disability resulting therefrom; and the nature of the symptoms and extent. These principles serve as a guide, not a requirement, to assist the compensation judge in determining the nature of an aggravation. *See Calbillo*. Overall, the evidence supported the judge's determination that the aggravation was temporary in nature.

APPEALS

***Gist v. Atlas Staffing, Inc.*, Case Nos. A17-0819 and A17-1096 (Minn. April 4, 2018).** For a summary of this case, please refer to the Interveners category.

APPORTIONMENT

Bolstad v. Target Center/Ogden Corporation, File No. WC16-5979, Served and Filed May 5, 2017. The employee worked as an audio technician and stage manager for Target Center and obtained jobs at other venues, through his union, when there were no events at Target Center. On November 28, 1990, he sustained a right shoulder injury while working for Target Center, insured by Broadspire. In 2000, he sustained a right shoulder injury after a skiing incident. On April 7, 2004, he sustained another right shoulder injury while working for Target Center, insured by Gallagher Bassett. On August 1, 2009, he sustained a third right shoulder injury while working for Target Center, insured by Sedgwick. As a result of the three separate right shoulder injuries he sustained while working for Target Center, he underwent three separate surgeries, received medical benefits, indemnity benefits, and permanent partial disability ratings. On October 2, 2009, the employee underwent an MRI of his left shoulder, which revealed a full-thickness rotator cuff tear. He alleged that this constituted a consequential *Gillette i*njury as a result of his three right shoulder surgeries. On January 23, 2010, he dislocated his left shoulder while working at Target Center, insured by Sedgwick. This injury was also admitted, and the employee received wage loss benefits and medical benefits. He subsequently dislocated his left shoulder while skiing. He was able to return to work for Target Center after his injuries, but there was a period of time when he was unable to perform the union jobs. He did not look for work outside of his union during that period of time. The employee underwent separate independent medical examinations by each insurer. Each IME opined something different regarding whether any of the right shoulder injuries were permanent injuries, the cause of the employee's left shoulder condition, and apportionment between the parties. In 2011, the employee filed a claim petition seeking various benefits. Sedgwick also filed a petition to discontinue, petition for contribution, and petition for joinder, seeking reimbursement for wage loss and medical benefits it paid to the employee under a 2012 temporary order. Compensation Judge Marshall denied the employee's claim that he suffered a *Gillette* injury to his left shoulder on October 2, 2009, and denied that the employee had sustained any consequential injury to his left shoulder as a result of the right shoulder injuries. The judge held that the employee's left shoulder treatment was causally related to the 2010 date of injury. He also held that medical treatment to the right shoulder should be equally apportioned among the 1990, 2004, and 2009 dates of injuries. All three insurers appealed. The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed as modified, holding that the compensation judge had substantial evidence to support his finding that the employee did not sustain a *Gillette* injury to the left shoulder consequential to his right shoulder injuries and that the ski accident following his January 2010 left shoulder injury was not a superseding, intervening left shoulder injury. The WCCA also affirmed the compensation judge's decision to apportion all three right shoulder injuries equally among the three insurers, but modified the award of TPD based on the laws in effect on the dates of each injury. With regard to the employee's claim for TPD when he was unable to perform the union jobs, there was substantial evidence that he had restrictions from his injuries, he had reduced earnings as a result of those injuries, and that he conducted a reasonable and diligent job search by relying exclusively on his union hiring hall in looking for work within his restrictions. The WCCA also noted that for those periods of time during which he used accrued vacation time, he was entitled to concurrent receipt of wage loss compensation while he received vacation pay pursuant to *Weigand v. Independent School District No. 2342.*

Oleson v. Independent School District #272 Eden Prairie Schools, File No. WC17-6034, Served and Filed July 7, 2017. (For additional information on this case, please refer to the Evidence category.) The WCCA (Judges Sundquist, Milun, and Stofferahn) affirmed Compensation Judge Grove's decision that Dr. Wicklund's IME report was well-founded and could be relied upon in determining causation and apportionment between two dates of injury, even though some of the medical treatment rendered was after the IME report.

ARISING OUT OF

***Hohlt v. University of Minnesota*, 897 N.W.2d 777 (Minn. June 28, 2017)**. The employee worked for the employer as a building painter, and had worked in a number of buildings on the University of Minnesota campus. On the date of injury, she was painting in the Mayo building, working the 3 PM to 11:30 PM shift. She parked in the Oak Street ramp, a public parking ramp owned and operated by the employer. She parked there because it offered a cheaper rate after 2 PM. The ramp was located four blocks away from the Mayo building. The employee punched out early at 10:30 PM. It was sleeting and snowing that evening, and she walked on the sidewalk between the Mayo building and the Oak Street ramp to get to her vehicle. The City of Minneapolis owned the sidewalk, but the employer had the responsibility to maintain the sidewalk, including keeping it clear of snow and ice, pursuant to city ordinance. The employee reached the intersection. As she walked forward onto the sidewalk curb ramp, not yet having reached the street, she slipped on the ice and fell, sustaining an injury. The employer denied primary liability. Compensation Judge Cannon determined that the injury did not arise out of the employment, as the hazard faced by the employee of falling on winter ice or snow was not unlike the hazard faced by the general public. He did not specifically decide the issue of whether the injury occurred in the course of employment, although he implied that the injury would likely have been found to be in the course of. Both parties appealed to the WCCA. The WCCA reversed the compensation judge, holding that the injury occurred in the course of employment, as at the time of the incident, the employee was on the premises of the employer, walking a short distance from where she worked on the most direct route to a parking ramp owned and operated by the employer. It also held that the injury arose out of the employment, as the employee's presence on the employer's premises was not due to her membership in the general public, but was because of her employment, and that is why she encountered the risk of the icy sidewalk.

The case was appealed to the Minnesota Supreme Court. In a 3-2 decision, with Justice Lillehaug writing for the majority, the Supreme Court affirmed the WCCA holding. The Court determined that the facts were essentially undisputed, so the appeal focused on a question of law, which the WCCA and the Supreme Court could consider *de novo*. In analyzing the legal issue, the Court affirmed its previous holdings that the "arising out of" and "in the course of" requirements are distinct, and each must be met for an injury to be compensable. With regard to the "arising out of" element, the Court held that a causal connection must exist between the injury and the employment. *See Gibberd*. The Court held that the causal connection exists because the employee's employment exposed her to a "hazard that originated on the premises as part of the working environment." *See Dykhoff; Nelson*. When "the employment creates a special hazard from which injury comes, then, within the meaning of the statute, there is that causal relation between employment" and the injury.

See Nelson; *Hanson*. That "hazard" was the employer-maintained sidewalk. It determined that the sidewalk was part of the employer's premises. The employee was exposed to the icy sidewalk (the hazard) on the employment premises because she was there, not as a member of the general public, but because of her employment. Citing to *Foley* and *Hanson*, the Court indicated that the test is not whether the general public is also exposed to the risk, but whether the employee was exposed to the risk because of the employment.

The Court distinguished the result in the *Dykhoff* case. In that case, the employee fell on a flat, dry, and clean floor on the employment premises. The *Dykhoff* Court determined that there was nothing about the floor that increased the employee's risk of injury. Ms. Dykhoff had failed to show any increased risk or hazard. The Court held that *Dykhoff* "is a case about an unexplained injury." In contrast, the employee in *Hohlt* had fully explained her injury, which was the result of an icy sidewalk, not a clean floor. With regard to the "in the course of employment" requirement, the Court reaffirmed its prior holdings that an employee is in the course of employment while providing services to the employer, and also for "a reasonable period beyond actual working hours if an employee is engaging in activities reasonably incidental to employment." It noted that the employee slipped and fell shortly after leaving work, which was a reasonable period beyond actual working hours. The direct walk to her car, only four blocks away, was reasonably incidental to employment. [In a footnote, the Court noted that an employee's walk to an employer parking lot that is "abnormally far" from the workplace would not be reasonably incidental to employment. It did not define what "abnormally far" is.]

Justice Anderson wrote a lengthy dissent on behalf of the minority. He would have determined that the employee did not satisfy either the "arising out of" or the "in the course of" requirements. With regard to "arising out of," Justice Anderson noted that a causal connection is met when the employment "peculiarly exposes the employee to an external hazard whereby he is subjected to a different and greater risk than if he had been pursuing his ordinary personal affairs." The employment must expose the employee to an increased risk or a special hazard. He would have determined that the employee did not establish that her injury was caused by the employment. She fell on a public sidewalk, and any member of the general public was equally at risk for falling on the same sidewalk due to the same conditions faced by the employee. The risk of falling on an icy sidewalk was not unique or peculiar to the employee's job as a painter, she was not exposed to any greater risk than if she had been walking on the same sidewalk in pursuit of personal activities, and she was not performing any work activities while on the public sidewalk. Also, Justice Anderson reasoned that it was the employee's personal choice to park in the parking ramp. Also, her injury did not occur in the parking ramp, but on a public sidewalk. Justice Anderson also would have determined that the injury did not occur "in the course of employment." The injury occurred four blocks from the building in which the employee worked, which was a significant distance, more significant than any case in which an injury had been awarded before. How far would the Court allow an employee to walk between two parts of the employment premises before it would not be compensable? The majority did not define what "abnormally far" is. The employee in *Hohlt* was not told by the employer where to park. The employee chose where to park, and indeed, the employer did not require the employee to even drive to work in the first place. Justice Anderson concluded that fundamentally, this case represented a "coming and going" dispute. Injuries that occur during a commute are typically not compensable. Here, the employee had punched out, was not performing work duties, and was walking on a public sidewalk, simply going home.

***Kubis v. Community Memorial Hospital Association*, 897 N.W.2d 254 (Minn. June 28, 2017)**. The employee injured her shoulder while allegedly rushing up a set of stairs at the end of her shift because she was concerned about working overtime and she needed to respond to the oncoming shift. The claim was denied on the basis that it did not arise out of her employment because there was no increased risk associated with her employment. Compensation Judge Baumgarth found the employee's testimony regarding "rushing" was not credible and held that the injury did not arise out of employment. The WCCA (*en banc*) reversed, holding that the employee was fatigued and hurrying because of the concern over overtime and her need to check in with the people on the next shift. According to the WCCA, being fatigued and hurrying rose to the level of an increased risk. The WCCA did not address the judge's finding that the employee's testimony was not credible. The case was appealed to the Minnesota Supreme Court. In a decision written by Justice Anderson, it reversed the WCCA's decision. The Supreme Court did not address whether the employee's subjective belief was enough to constitute an increased risk, or whether the WCCA misapplied *Dykhoff v. Xcel Energy*. Instead, the Minnesota Supreme Court reversed the WCCA's decision because the WCCA applied the wrong standard of review. The Supreme Court noted that the compensation judge made a credibility determination and found the employee's testimony regarding rushing was not credible. The compensation judge's decision was supported by substantial evidence that a reasonable mind would accept as adequate, and the WCCA was required to affirm the compensation judge's findings.

Justice Lillehaug wrote a dissenting opinion in which he indicated he would have given the WCCA deference and affirmed its decision. According to Justice Lillehaug, the compensation judge did not make a determination on the employee's credibility regarding whether she was rushing up the stairs to report to the incoming staff and that this finding was uncontroverted and supported the WCCA's determination that her injury arose out of her employment. Justice Lillehaug argued that the WCCA's decision was thorough, well-reasoned and correct and that the majority should have given deference to the WCCA, but instead substituted its own judgment. Justice Lillehaug also argued that *Kirchner v. County of Anoka* should have been applied to the facts of this case, because the facts were similar in all relevant ways and that the employee should have been awarded benefits. Justice Lillehaug noted that there was difficulty in applying the "increased risk test" and proposed the "positional risk test" as a better alternative.

Keltner v. Spartan Staffing, LLC, File No. WC17-6026, Served and Filed September 5, 2017. The employee died as a result of a fall off a ledge that was 18 or 19 feet off the floor. One side of the ledge was open with no barrier so that forklifts could put pallets in the open space. Hanging above the floor on the third tier were signs that read, "Do not go beyond this point. Wear fall protection." An OSHA investigation revealed that the employee's death was caused by a fall from the ledge. The employer denied primary liability and the matter went to a hearing. Compensation Judge Grove found that the death arose out of and in the course of the employee's work for the employer. The employer appealed and asserted three main arguments. First, the employer contested that this death arose out of the employee's work for the employer because he was not yet scheduled to start work at the time of the fall. The WCCA (Judges Stofferahn, Hall, and Sundquist) affirmed the compensation judge's findings that the employee's injury arose out of and in the course of his employment, agreeing that, although the injury occurred before he was to begin his shift, the employee had clocked in, was wearing the required clothing for the job, and was in the area where he previously worked. Second, the employer and insurer argued that the employee's death was not compensable because he was engaged in a prohibited act at the time of the fall. Specifically, he must have passed the point where the warning sign was hanging. The WCCA affirmed the compensation judge's determination that the requirements to prove a prohibited act were not met.

This defense requires an employer and insurer to meet a six part standard. *See Hassan*. Although the WCCA did not state what part of the standard was not met, it indicated that this was explained in the judge's memorandum. Interestingly, the WCCA then stated in a footnote that it was not making a determination as to the viability of this defense, such that it could be used in subsequent cases, noting that it is a common law defense and not part of the Workers' Compensation Act. Third, the employer and insurer argued that the employee's death was not compensable because it was self-inflicted. There were indications from the employee's girlfriend that the employee may have purposefully committed suicide and that he used methamphetamine. The compensation judge did not find this evidence persuasive for various reasons, including that the employee had put on all his gear that he needed for work, and the WCCA affirmed that finding.

Roller-Dick v. Centracare Health System, File No. WC17-6051, Served and Filed October 19, 2017. The employee was leaving work at the end of her workday. She used a stairway to go from the second floor to the first floor and then was going to exit near the parking lot to go to her car. The floor covering the stairs was rubber, and there were hand railings on both sides of the stairs; but she did not initially use the hand railings. She had a purse hanging from her elbow and was using both hands to carry a plant. (There was nothing in the decision about where the plant came from, whether she was required to take it home from work, and/or why she was taking it home, etc.) She was wearing rubber-soled shoes. On the second step, she "slipped" and fell to the bottom of the flight, fracturing her ankle. She dropped the plant and grabbed one of the railings as she fell down the stairs. She testified that, "I feel that the rubber on the bottom of my shoe stuck to the rubber surface of the stair material." There was no water on the stairs, nor were they otherwise defective or non-compliant with the building codes or OSHA standards. Compensation Judge Grove determined that the employee's injury did not arise out of her employment. The WCCA (Judges Stofferahn, Milun, and Hall) reversed. Pursuant to the *Dykhoff* holding, a causal connection must exist between the injury and the employment. A "causal connection" is supplied if the employment exposes the employee to a hazard which originates on the employment premises as a part of the working environment. Here, the compensation judge denied that the employee's injury arose out of employment because she failed to establish that her risk of injury on the stairs on the employer's premises was any greater than "she would face in her everyday life." The WCCA held that that was not the correct test. Because the injury occurred on the employer's premises, the question is whether the employee encountered an increased risk of injury from a hazard which originated on the employer's premises. A "hazard" is not defined as being *itself* a danger, but as a *possible source* of peril, danger, duress, or difficulty. In *Dykhoff*, the employer's premises constituted a neutral risk. In contrast, using stairs is not a neutral risk. If using stairs was a neutral risk, stairways would not have handrails. When someone falls on a flight of stairs, certainly the occurrence of an injury is more likely, as is an increase in the severity of the injury suffered. For these reasons, a flight of stairs cannot be considered a neutral condition. "A flight of stairs alone increases the risk of injury, as did the icy sidewalk in *Hohlt*, and it is not necessary to require a showing of 'something about' the staircase that further increased the risk." The WCCA held that this case was "virtually indistinguishable" from the facts in *Kirchner v. County of Anoka*. It noted the employee was not able to use the handrail because she was using both of her hands to carry the plant to her car. This case was appealed to the Minnesota Supreme Court and oral arguments occurred on March 8, 2018.

Comment: It will be interesting to see what the Supreme Court does with this case on appeal. In the *Kirchner* case, the employee was injured while walking down the stairs at work. In *Dykhoff*, when citing *Kirchner*, the Supreme Court indicated that "many workplaces have stairways and there is nothing inherently dangerous or risky about requiring employees to use them. But we recognized in *Kirchner* that if there is something about the stairway or other neutral condition that 'increases the employee's exposure to injury beyond that' the employee would face in his or her everyday non-work life, an injury causally connected to that condition could satisfy the 'arising out of requirement." In *Kirchner*, the Court determined that the injury arose out of the employment because the employee had to "negotiate the steps without the benefit of" a handrail. Without the protection of the handrail, the employee was at an increased risk of injury, and the requisite causal connection between the employment and the injury existed. In the *Roller-Dick* case, the WCCA is clearly going well beyond the previous decisions in *Kirchner* and *Dykhoff*. Further, pursuant to the *Kubis* case, summarized above, the Supreme Court did not determine that the injury arose out of the employment simply because it occurred on a stairway. There is a different group of judges on the Supreme Court at this time, so we will need to stay tuned as to how they may continue to evolve the "arising out of" increased risk test.

Lein v. Eventide, File No. WC17-6101, Served and Filed December 29, 2017. The employee was injured on January 19, 2015, when she fell and sustained injuries descending a flight of stairs on the employer's premises. The employer and insurer denied liability for the injury on the basis that the employee's injury did not arise out of her employment. At the hearing, the parties submitted expert opinions on the issue of whether or not something was wrong with the stairs. Compensation Judge Marshall concluded that the employee failed to establish she was exposed to an increased risk citing factors such as the lack of an OSHA investigation, the failure to show a defect in the stairs, and the employer's compliance with building codes. The employee appealed to the WCCA, which reversed, concluding the judge erred by importing general tort liability doctrine. The employer and insurer appealed to the Minnesota Supreme Court, which issued an Order vacating the WCCA's decision and remanding to the WCCA for reconsideration in light of the *Kubis* and *Hohlt* decisions. On remand, the WCCA (Judges Stofferahn, Milun, and Sundquist) reversed and remanded. Citing *Roller-Dick*, the WCCA found the employee's burden of proof to establish her injury arose out of her employment was met upon the showing that she fell and was injured on a stairway located on her employer's premises. The compensation judge improperly decided the case under a negligence theory, which is specifically prohibited under the Minnesota Workers' Compensation Act. As concluded in *Roller-Dick*, stairs themselves constitute an increased risk. Therefore, an injury on stairs is considered to have arisen out of the employment. This case does not contravene *Kubis*, as the WCCA has not exceeded its scope of review by rejecting the compensation judge's findings. The conclusion in this case relies solely on the compensation judge's finding that the employee was injured on the flight of stairs, which does not require substituting factual findings for those made by the compensation judge. This case also is in line with *Hohlt*, in that just like an icy sidewalk, stairs are not a neutral condition. Both stairs and an icy sidewalk are in and of themselves an increased risk as the condition is encountered on the employer's premises as the result of the employment. Therefore, because the employee fell on stairs at her work, her injury arose out of her employment.

ATTORNEY FEES

Weatherly v. Hormel Foods Corporation, File No. WC17-6038, Served and Filed June 13, 2017. The employee's attorney, Donaldson Lawhead, appealed from Compensation Judge Cannon's denial of *Roraff* and *Heaton* fees, and the WCCA (Judges Stofferahn, Hall, and Sundquist) affirmed. *Heaton* fees are awarded when there is a rehabilitation dispute and the employee is awarded rehabilitation benefits. However, there was no rehabilitation dispute in this case. Similarly, *Roraff* fees are awarded when there is a dispute regarding medical benefits, but it was found that there was no genuine dispute over medical benefits in this case. The employee attempted to supplement the record at the appellate level, but the WCCA denied the employee's motion to supplement the record based on Minn. Stat. §176.421, subd. 1, which indicates that appeals only deal with the record "as submitted," and not on anything that was not heard and considered by the compensation judge.

Hufnagel v. Deer River Health Care Center, File No. WC17-6057, Served and Filed December 5, 2017. The employee sustained an admitted work injury in 2009 and underwent significant medical treatment. She was able to return to work, and the employer was subsequently purchased by a different employer. The employee continued to work for the new employer, and alleged additional injuries in 2014 and 2015. The employee filed a claim petition for benefits and medical services. Both employers had independent medical evaluations performed. The 2009 injury was admitted, but the 2014 and 2015 injuries were denied. The defendants both maintained that none of the work injuries were substantial contributing causes of the employee's current condition and need for treatment. Apportionment was one of the issues. There were two medical interveners. Compensation Judge Kohl determined that the employee sustained injuries in 2014 and 2015, and that those injuries were temporary in nature. Benefits and medical treatment were ordered to be paid by the second employer during the period of the temporary aggravations, and the judge also found that the 2009 injury continued to be a substantial contributing factor to the current ongoing need for medical treatment. There was no apportionment. The decision was not appealed. The employee's attorney filed for attorney's fees, claiming almost $32,000 in fees pursuant to Minn. Stat. §176.191, subd. 1 and the *Roraff* case, based on 78.15 hours of time at hourly rates ranging from $405-$435, and after offsetting contingent fees. The employers objected, claiming that the excess fees were excessive and that .191 fees were not applicable. The compensation judge awarded $8,000 in *Roraff* fees, and assessed those against the second employer. The judge denied the .191 fees. The WCCA (Judges Hall, Stofferahn, and Sundquist) vacated and remanded. .191 attorney's fees are authorized where the primary issue is apportionment of benefits. The judge failed to consider the degree to which the two employers sought to place on each other the sole responsibility for payment of benefits. These efforts rendered apportionment a significant issue in the case and greatly increased the burden on the employee's attorney to provide effective representation. It remanded the case to the judge to determine the appropriate amount of .191 fees and the appropriate apportionment for those fees, noting that .191 fees can be apportioned differently from how the benefits were awarded. The WCCA also vacated the finding relative to the *Roraff* fee and remanded to the compensation judge. On remand, the judge is to consider whether the totality of fees awarded is adequate to compensate the employee's attorney for the representation provided. It also noted that the judge had inappropriately refused to award fees on a theory advanced by the employee's attorney, which had ended up being rejected. The WCCA noted that time must be spent on all issues, and the fact that some are unsuccessful does not make the time spent unreasonable. This case was appealed by the second employer to the Minnesota Supreme Court and oral argument occurred on April 10, 2018.

Wilson v. Twin Town Logistics, File No. WC17-6072, Served and Filed February 9, 2018. The employee sustained a work injury in 2013, and benefits were paid by the insurer. In January 2014, the employee filed a claim petition seeking attorney's fees and penalties for late payment of attorney's fees. The insurer was subsequently declared bankrupt. The claim petition was stricken from the calendar. The claims were submitted to MIGA, which determined that the claims were not covered. The claims were then borne by the employer directly. The claim petition was reinstated on the active trial calendar in 2015. The employee amended the claim petition to include claims for wage loss benefits, medical treatment, rehabilitation services, and penalties for late payment of wage loss. Compensation Judge Bouman awarded penalties for late payment of wage loss and medical bills. In November 2016, the employee's attorney filed for attorney's fees, including contingent fees based on the penalties, $2,368 in *Roraff* fees, and $30,572 in excess fees under *Irwin*, based on 186.1 hours of time at an hourly rate of $330. The employer objected. Judge Bouman determined that based on the prior litigation, the employee's attorney had been paid $11,200 in fees. She awarded the employee's attorney $3,000 as a combination of *Roraff*/*Heaton* fees and excess fees. The employee's attorney appealed. The WCCA (Judges Stofferahn and Sundquist) affirmed. Contingent attorney's fees are presumed to be adequate for the recovery of rehabilitation and medical benefits. Additional fees may be assessed if the attorney establishes that the contingent fee is inadequate to reasonably compensate the attorney for representation regarding the medical or rehabilitation disputes. Where the attorney fee requested is in excess of the statutory cap on fees, the judge must consider the request in light of the factors set out in *Irwin*. Those factors require consideration of the statutory guidelines on fees, the amount involved, the time and expense necessary to prepare for trial, the responsibility assumed by counsel, the experience of counsel, the difficulties of the issues, the nature of the proof involved, and the results obtained. In this case, the judge determined that contingent fees did not adequately compensate the employee's attorney and that excess fees of $3,000 were appropriate. The judge in this case examined the *Irwin* factors. She noted the total amount involved in the dispute. She noted that the employee's attorney is an experienced practitioner. She noted that he took full responsibility for securing the employee's benefits. She noted that the nature of the claims and the proof required was not particularly complex or unusual. Although the stay on litigation due to the insolvency of the insurer made the case complicated, the issues themselves were not complex or technically difficult. The judge carefully reviewed the extensive itemized statement submitted by the employee's attorney, showing $32,766 in attorney time and $4,544 in staff time. She found that some of the itemized time was excessive, duplicative, and included "secretarial-type services." The employee's attorney argues that the judge erred in not identifying with exactitude how the claimed time was excessive. The WCCA reviewed the itemized statement of time, noting hundreds of entries, and it determined that a detailed finding on each entry is not necessary or reasonable. While time expended by an attorney is a factor to be considered, an attorney is not automatically entitled to payment of all time set out in a fee statement. The WCCA generally gives deference to a judge's decision as to what constitutes a reasonable fee under the circumstances. The WCCA will examine whether the award by a judge amounts to an abuse of discretion. An abuse of discretion occurs when a judge makes "an erroneous legal conclusion or a clearly erroneous factual conclusion." *See Ansello*. In this case, the judge's findings did not rise to the level of clearly erroneous, and she did not abuse her discretion.

Judge Milun dissented. She would have determined that the factual findings made by the judge did not support the award. She would have determined that the award was inadequate compensation, and that it resulted in an abuse of discretion by the judge.

CAUSAL CONNECTION

Gist v. Atlas Staffing, Inc., File No. WC16-6019, Served and Filed June 21, 2017. (For additional information on this case, please refer to the Interveners and Jurisdiction categories.) There was no question in this case that the employee was exposed to silica as a result of his job duties. The issue was whether the exposure to silica caused the employee's kidney failure. Compensation Judge Bouman relied on the employee's expert medical opinion to find that the employee's kidney failure was caused by his exposure to silica and was work-related. The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed, finding that substantial evidence supported that position. Note: This case was appealed to the Minnesota Supreme Court. Please see that decision below.

Little v. Menards, Inc., File No. WC17-6036, Served and Filed July 27, 2017. The WCCA (Judges Hall, Stofferahn, and Sundquist) affirmed Compensation Judge Marshall's finding that the employee suffered a consequential left shoulder injury that arose out of his back injury (due to a fall attributed to radicular symptoms), despite the fact that the employee had prior left shoulder surgery that allegedly resolved prior to the work injury.

Kness v. Kwik Trip, File No. WC17-6048, Served and Filed August 11, 2017. The employee sustained a low back injury at work. She began treating with Dr. Sinicropi, who ultimately recommended surgery. The employer obtained an independent medical examination with Dr. Deal, who opined that the employee's injury resolved within six weeks post-injury. Dr. Sinicropi authored a narrative report in response to Dr. Deal's report. Based on Dr. Deal's IME report, as well as the fact that the employee refused a job offer, the employer filed a NOID to discontinue temporary total disability benefits. Compensation Judge Behounek allowed the discontinuance, relying on Dr. Deal's opinion that the employee's injury had resolved. The employee appealed. The employee mistakenly contended on appeal that the compensation judge made a specific finding that Dr. Sinicropi's opinion lacked foundation. The employee argued that, since Dr. Sinicropi had reviewed Dr. Deal's comprehensive report, Dr. Sinicropi had the same foundation upon which to base his opinion as did Dr. Deal. The WCCA (Judges Sundquist, Milun, and Hall) pointed out that the compensation judge did not make a finding on foundation, and instead found that the preponderance of the evidence supported the discontinuance of benefits. The WCCA, therefore, affirmed the compensation judge's finding that the employee's injury was resolved, finding that substantial evidence, including the adequately founded medical opinion of the independent medical examiner, supported the compensation judge's decision.

Allen v. Trailblazer Joint Powers Board, File No. WC17-6050, Served and Filed September 7, 2017. The WCCA (Judges Sundquist, Milun, and Stofferahn) found that there was substantial evidence, in the form of medical records from the employee's treating doctors, for Compensation Judge Tate to conclude that the employee's ongoing post-concussion symptoms were causally related to the work injury. The employer and insurer raised particular concern that the employee had not lost consciousness after the work-related head injury, but the WCCA found that proof of loss of consciousness is not a requirement for the existence of the employee's ongoing condition.

***Gist v. Atlas Staffing, Inc.*, Case Nos. A17-0819 and A17-1096 (Minn. April 4, 2018).** For a summary of this case, please refer to the Interveners category.

COMMON ENTERPRISE

***Kelly for Washburn v. Kraemer Construction, Inc.*, 896 N.W.2d 504 (Minn. June 7, 2017)**. Appellant Jessica Kelly, trustee for next-of-kin of Richard Washburn, sued respondent Kraemer Construction, Inc. in district court, alleging that Kraemer's negligence was the cause of Washburn's death by electrocution at a construction site. Washburn worked for Ulland Brother's, Inc., a general contractor. Ulland subcontracted for Kraemer to provide crane work for the repair of two bridges. The case centered on the placement of two concrete culverts at one of the bridges. For the work, Ulland employees worked on the rigging and Kraemer employees worked with a crane. Kraemer moved for summary judgment in district court, arguing that it was engaged in a common enterprise with Ulland, and therefore, the election of remedies provision in the Minnesota Workers' Compensation Act required dismissal of Kelly's lawsuit, as workers' compensation benefits had already been received. The district court denied summary judgment. The Minnesota Court of Appeals reversed and remanded for entry of summary judgment in favor of Kraemer. Kelly appealed to the Minnesota Supreme Court. In a 3-2 decision, with Justice Chutich writing for the majority, the Supreme Court affirmed, holding that Kraemer was in a common enterprise with Ulland as a matter of law, requiring dismissal of Kelly's lawsuit. Under Minn. Stat. §176.061, subds. 1, 4, when a worker is injured "under circumstances which create a legal liability for damages on the part of a party other than the employer . . . at the time of the injury," and the third party has workers' compensation insurance and was engaged in a "common enterprise" with the employer, the party seeking recovery "may proceed either at law against [the third] party to recover damages or against the employer for benefits, but not against both." There is a three-part test to determine whether the parties were engaged in a common enterprise. These factors include: (1) The employers must be engaged in the same project; (2) The employees must be *working together* (common activity); and (3) In such fashion that they are subject to the same or similar hazards. *See McCourtie v. United States Steel Corporation*, 253 Minn. 501, 93 N.W.2d 552, 556 (1958). The primary issues on appeal were whether there was a genuine issue of material fact regarding whether the employees were engaged in a common activity and subject to the same or similar hazards. Finding that neither crew could have accomplished the day's goal of setting the culvert sections without contemporaneous assistance of the other crew, the Court held that, as a matter of law, the Kraemer crew and the Ulland crew were working together in a common activity. The Court pointed out that the Kraemer crew could not have moved the culvert sections without the Ulland crew positioning, attaching, and maneuvering them, and the Ulland crew could not have placed the culvert sections without the Kraemer crew directing and operating the crane. The Court also found that, as a matter of law, looking at the circumstances surrounding the work, the Kraemer crew was subject to the same or similar hazards as the Ulland crew because members of both crews could have been injured by movement of the crane load, failure of the crane, collision with a bulldozer on site, or slipping and falling in the dewatered streambed. Therefore, the Court found that because all three factors were met, the parties were engaged in a common enterprise and the election of remedies applied.

Justice McKeig wrote the dissenting opinion finding that the majority misread the common enterprise jurisprudence, foreclosing a remedy for victims of work-related accidents. Specifically, Justice McKeig found that the majority misapplied the precedent on the issue of whether the workers were engaged in a common activity. In determining whether workers were engaged in a common activity, Justice McKeig pointed out that they have distinguished between work that is oriented toward a common goal and work that is truly a common activity.

Justice McKeig found that the Kraemer crew executed its duties independent of the Ulland crew, neither required nor requested the assistance of any Ulland employee to complete its function at the site, and that the two crews coordinated their work but did not collaborate. Because the majority's conclusion that the Ulland and Kraemer crews work was interdependent improperly weakens the "common activity" prong, Justice McKeig, joined by Justice Lillehaug, dissented.

CREDIT

Bruton v. Smithfield Foods, Inc., File No. WC17-6113, Served and Filed May 21, 2018. The employee sustained an injury in August 2016 while working for Smithfield. Smithfield has a high deductible on its insurance policy of $2 million. The third party administrator denied primary liability for the alleged injury, and the employee filed a claim petition for temporary total disability benefits, plus other benefits. Smithfield then authorized payment to the employee through its short-term disability policy, which is self-funded and administered by the employer. This paid 80% wage replacement. The STD payments are taxed. The employee also received PTO benefits from the employer. Subsequently, the employer admitted liability for the injury and admitted that the employee was TTD. It commenced payment of TTD, but did not pay TTD during the time that STD had been paid. It did pay a small amount which represented the underpayment between what would be payable as TTD and the after-tax STD benefits. The employer asserted its right to an offset, reducing TTD by the STD payments and the PTO benefits already paid during the same time frame. The employee objected to the offsets. The case was submitted to the judge on stipulated facts with a copy of the STD policy, an exhibit showing the payments made to the employee, and an exhibit showing the calculation as to what TTD would have been paid. Compensation Judge Hartman found that the employer was entitled to offset the TTD by the amount of the STD benefits paid to the employee, but not the payment of PTO. The employee appealed the offset of STD benefits. The WCCA (Judges Quinn, Milun, and Hall) reversed. The only entities, by law, that may make workers' compensation payments are: a self-insured employer; the State of Minnesota and its political subdivisions; the Special Compensation Fund; and a workers' compensation insurer. The employer agrees that the employee is entitled to TTD payments. Under such circumstances, the employer's insurer must make these payments. While there is a very high deductible, meaning the insurer might end up being paid back by the employer, the insurer still must make the payments. The STD plan is not one of these four types of entities. Payments made under the STD policy were not workers' compensation payments. The Act provides two routes by which an employer may seek to reduce an employee's benefits by the amount of other benefits the employee received. An employer may seek an offset from payment of full wages under a wage continuation program, or the employer may seek an offset as a result of an asserted right of intervention. If there is an intervention by another party, the employer does not technically get an offset, so much as the benefits are split between being paid partially to an employee and partially to an intervener. In this case, there was no wage continuation program. The employer, although self-funding the STD plan, is not the same as the plan. Therefore, the STD payments were not wage continuation. The second route is the intervention route. The WCCA agreed with the employer's argument that it is not necessary for an employer to intervene when it is already a party to the action. However, it is not clear from the record that the employer is the same entity as the STD plan. The STD plan was not an ERISA plan. There is no explanation in the stipulated facts as to whether the STD plan and the employer are the same entity, nor any explanation of the relationship between the two. The compensation judge treated them as if they were the same entity, but there are no findings in that regard. As such, we cannot conclude that an intervention claim by the STD plan was not necessary to assert a right to an offset. Without such an intervention, there can be no reduction of benefits otherwise owed to the employee. Because neither of the two

avenues potentially available for the employer to reduce the TTD payments owed are possible, no offset is allowable under the law. The employee is entitled to be paid the full amount of TTD benefits for his injury. In addition, even if we were to find the employer and the STD plan to be the same entity, and thus an intervener seeking recoupment of its paid out STD benefits, the decision would be the same. The STD plan did not assert any right of intervention. The employer's legal obligation is to pay TTD benefits, and if there had been an intervention, part of those would go to the employee and part would go back to the STD plan. If one were to assume that they are the same entity, this may seem like a difference without a distinction, but there are significant distinctions. The judge, in allowing the employer an offset, applied a public policy analysis disfavoring double recovery. Such an offset, however, must follow the requirements of the Act. The judge failed to address or analyze the contractual terms of the STD policy. In reviewing that policy language, it gives it no right to reimbursement. In fact, the policy specifically forbids payments when there is an entitlement to workers' compensation benefits. Yet, it creates no right to reimbursement when there is a denial of workers' compensation liability, payments of STD are made, and a later admission of workers' compensation liability results in STD payments that should not have been paid. In other words, the policy does not contain a "claw back" provision for reimbursement. Without a right to reimbursement under the policy language, there is a serious question as to whether the STD policy has the legal right to intervene. Since the policy does not provide for a right to reimbursement, the STD policy has no right to intervene.

Comment: This was Judge Quinn's first authored decision as a judge on the WCCA. Under the unique facts in this case, and based on the poorly drafted STD policy, it would appear that this employee will receive a double recovery of benefits, first having received extensive STD benefits, and now being awarded TTD benefits for the same exact period of time. An employer which is truly self-insured can still assert a right of an offset for STD benefits it pays instead of TTD benefits. It is recommended that employers which are not self-insured, but which self-fund STD plans, should examine the language of the STD policy and verify that it provides a right of reimbursement. It would then appear that the appropriate method for asserting an offset would be by way of a motion to intervene.

DEATH

Grieger v. Menards, File No. WC17-6091, Served and Filed April 10, 2018. The employee worked part-time at the employer. In November 2015, he slipped in the employer's parking lot, hitting his head. He died of the injury. He was survived by his wife. There were no dependent children. The employer accepted liability and paid dependency benefits based on an average weekly wage of $205.18. The wage was based on the calculation formula set forth in Minn. Stat. §176.011, subd. 6, so the employee's spouse was paid 50% of that amount. The spouse filed a claim petition, arguing that her benefits should be adjusted such that over the course of 10 years of payments, she would receive the $60,000 minimum death benefit. [Based on the average weekly wage used, if she was paid for 10 years, she would not reach the $60,000 minimum.] She also claimed that the insurer should have calculated the wage based on Minn. Stat. §176.011, subd. 18, which indicates that benefits should not be computed on less than the number of hours normally worked in the employment or industry in which the injury was sustained. Multiple experts testified regarding the number of hours normally worked in the employment or industry in which the employee worked at the time of his death. One expert indicated that the average number of hours worked was 32.3, whereas the defense expert testified that it was 21.07. A human resources individual from the employer testified that the average of all of the employer's casual part-timers was approximately 21 hours per week. Compensation Judge Marshall determined that the employer was properly

paying dependency benefits based on the average weekly wage at the time of death. He also determined that the benefits need not be prorated to reach the $60,000 death benefit. The WCCA (Judges Sundquist, Stofferahn, and Hall) issued a mixed decision. It determined that the use of the 26-week formula for calculating the average weekly wage has no application in computing the daily wage and weekly wage when the employee is not a full-time worker and compensation is for death benefits. *See Helmke*. Here, three vocational and employment witnesses testified as to what constituted the collective "number of hours normally worked in the employment or industry in which the injury was sustained." Had the judge adopted the least number of hours cited in the expert testimony of 20 hours per week, it would result in an average weekly wage of $217, more than the wage that was being paid. The judge is required to apply a different standard than the averaging of the employee's actual wages over the 26 weeks before the death. *See Crepeau*. Therefore, the WCCA vacated that portion of the decision and remanded the issue to the judge for a determination of the benefit payable using the number of hours normally worked in the employment. The WCCA affirmed the decision that the dependency benefits should not be prorated so as to allow for payment of $60,000 over the course of 10 years. Such a proration is premature. Dependency benefits are adjusted on October 1 of each year, and the amount of the adjustment cannot be predicted. It is conceivable that the spouse will ultimately reach or exceed the minimum of $60,000 paid out over the 10-year term of weekly payments. In the event that the payments do not reach the $60,000 minimum at the conclusion of the 10 year period, the difference will be payable by the employer at that time.

EVIDENCE

Oleson v. Independent School District #272 Eden Prairie Schools, File No. WC17-6034, Served and Filed July 7, 2017. (For additional information on this case, please refer to the Apportionment category.) The WCCA (Judges Sundquist, Milun, and Stofferahn) affirmed Compensation Judge Grove's decision that Dr. Wicklund's IME report was well-founded and could be relied upon in determining causation and apportionment between two dates of injury, even though some of the medical treatment rendered was after the IME report.

Bromwich v. Massage Envy Roseville, File No. WC17-6065, Served and Filed October 18, 2017. The employee alleged that she sustained a wrist injury as a result of performing a massage on a client. She initially treated with a chiropractor, whose notes stated, "Woke up with right wrist pain, fingers numb, pain with ROM." She later began treating with an orthopedic surgeon and underwent surgery. The employer and insurer had an IME, who opined that her wrist condition was not work-related. The employee underwent a second surgery. She asserted a claim for various benefits. The treating surgeon wrote a narrative report indicating that causation of the employee's condition by the work injury could not be answered with "absolute medical certainty," but that "certainly, it seemed to be an aggravating factor in the development of the employee's symptoms." Compensation Judge Daly found that the employee had sustained a work-related injury and awarded benefits. The employer and insurer appealed, arguing that the absence of corroboration in the initial chiropractic notes of a work injury precluded the compensation judge from finding that there was a work injury, and further, that he erred in adopting the treating surgeon's opinion regarding causation.

The WCCA (Judges Hall, Milun, and Stofferahn) affirmed. The WCCA found that reliance on a treating physician's opinion regarding causation where that opinion does not express absolute certainty does not constitute error. Pursuant to *Boldt v. Jostens, Inc.*, 261 N.W.2d 92 (Minn. 1977), "it is well established that the truth of the opinion need not be capable of demonstration, that an expert is not required to express absolute certainty in the matter which is its subject, and it is sufficient if it is probably true." The surgeon's opinion, when evaluated with the remaining medical records and the employee's testimony, met this standard.

GILLETTE INJURIES

Bolstad v. Target Center/Ogden Corporation, File No. WC16-5979, Served and Filed May 5, 2017. For a description of this case, please refer to the Apportionment category.

Nelson, Larry v. Smurfit Stone Container Corporation, File No. WC17-6053, Served and Filed October 9, 2017. The employee sustained a work-related right shoulder injury in 2009 and underwent an arthroscopic rotator cuff repair later that same year. He returned to work and continued to work until May 31, 2012, when he was laid off. At that time, he was asked to sign a document stating that he did not have a work-related injury. He soon thereafter applied for and was awarded Social Security retirement benefits. He testified that, when he was laid off, he had problems with his left shoulder. He did not begin treating for his left shoulder until late 2015, at which point he was recommended for left shoulder arthroscopic surgery. The employee claimed a *Gillette* injury to his left shoulder, culminating on May 31, 2012, as well as permanent total disability benefits beginning on that date. Compensation Judge Arnold denied the employee's claim for PTD benefits for lack of a diligent job search, but awarded temporary total disability benefits from the date of the left shoulder surgery in January 2016 through the date of the hearing. The employer and insurer appealed, arguing that the employee did not treat for his left shoulder until over three years after he stopped working for the employer and that he had signed a document stating that he did not have any work injury when he was laid off. However, the WCCA (Judges Milun, Stofferahn, and Hall) found that the compensation judge appropriately relied on the treating doctor's opinion that the employee had sustained a *Gillette* injury. It further found that case law supports the proposition that the last day the employee stops the employment can be concluded to be the date of injury, regardless of whether due to disability or layoff. As to the award of TTD benefits, the employer and insurer further argued that TTD benefits should not have been awarded, given that the compensation judge noted that there was not a diligent job search. However, the WCCA upheld the compensation judge's award of TTD benefits, finding that the job search finding was made only in the context of his denial of PTD benefits from and after May 31, 2012. It noted that the employee was taken entirely off-work after his January 2016 surgery, so the award of TTD benefits was appropriate.

IME

George v. Cub Foods, File No. WC17-6039, Served and Filed September 7, 2017. (For additional information on this case, please refer to the Maximum Medical Improvement, Medical Issues, and Rehabilitation categories.) The employee refused to allow the independent medical examiner to touch her arm and hand during an IME for a right upper extremity injury. Thus, the WCCA (Judges Sundquist, Stofferahn, and Hall) determined that there was substantial evidence to support Compensation Judge Daly's finding that the employee refused a reasonable request for examination and TTD was suspended until the employee complied with the examination, per Minn. Stat. §176.155, subd. 3.

INTERVENERS

Gist v. Atlas Staffing, Inc., File No. WC16-6019, Served and Filed June 21, 2017. (For additional information on this case, please refer to the Causal Connection and Jurisdiction categories.) The employee received medical treatment that was paid for by Medicare. A medical provider then intervened in the workers' compensation action for payment of a *Spaeth* balance. The employer argued that because the medical provider/intervener accepted payment from Medicare, the claims were deemed to have been paid in full and the intervener could not make a claim for additional payments. Compensation Judge Bouman found that she did not have subject matter jurisdiction to make a decision on this issue and apply federal Medicaid and Medicare law. The WCCA (Judges Milun, Stofferahn, and Sundquist) agreed. The medical intervener then argued that its acceptance of Medicare or Medicaid payments does not relieve the employer of its obligation to pay the *Spaeth* balance. The compensation judge ordered the employer to pay the *Spaeth* balance, and the WCCA affirmed that order. The WCCA reasoned that workers' compensation is primary and, if found liable, Medicare and Medicaid would step out of the process and let the workers' compensation insurer pay. Thus, even when there have been Medicare or Medicaid payments, the employer must still pay reasonable and necessary medical costs for an injured employee. Note: This case was appealed to the Minnesota Supreme Court. Please see the decision below.

Hemphill v. Soude Enterprises, File No. WC17-6046, Served and Filed August 1, 2017. The employee sustained an admitted injury, but the nature and extent of the injury was disputed and litigated in 2013. In 2013, the judge issued a decision finding that the employee sustained an avulsion fracture of the left thumb, but denied claimed injuries to her neck, back, and arm. In 2014, the employee filed another Claim Petition, and her attorney put a number of providers on notice of their possible rights to intervene. The 2014 Claim Petition was stricken from the active trial calendar. The employee filed a request for formal hearing after a medical conference, and her QRC filed a rehabilitation request, both of which were consolidated with the employee's Claim Petition. The WCCA opinion noted that it was not clear what entities may have filed motions to intervene. No interveners appeared at the hearing. At the end of the hearing, the attorney for the employer and insurer mentioned a letter from Mayo Clinic withdrawing its intervention claim. Compensation Judge Cannon awarded part of the employee's wage loss claim, denied the rehabilitation request, and denied the intervention claims because none of the interveners appeared in support of their claims. After the hearing, the attorney for the Teamsters Fund wrote a letter to the compensation judge asking for reconsideration because their motion to intervene complied with Minn. Stat. §176.361 and the Teamsters Fund was not ordered to appear at the hearing. The compensation judge issued an Amended Findings and Order ordering the self-insured employer to pay the intervention claims related to the employee's left thumb injury but did not specify the interveners. The employer appealed and the WCCA (Judges Stofferahn, Milun, and Sundquist) vacated and reversed. The WCCA held that employee's attorneys, attorneys for employers and insurers, and compensation judges should ensure that all parties' rights, including the rights of interveners, are addressed at the hearing. The matter was remanded to the compensation judge to determine whether intervention interests existed as a result of the work injury.

***Gist v. Atlas Staffing, Inc.*, Case Nos. A17-0819 and A17-1096 (Minn. April 4, 2018).** The employee was exposed to silica at his job with the employer, a known cause of end-stage renal disease. Shortly after leaving his job, he was diagnosed with end stage renal disease. He made a claim for workers' compensation benefits. The employer denied liability. The employee sought treatment with Fresenius Medical Care, which billed Medicaid, Medicare, and the employee's private insurer for the treatment, and it accepted payments from each. Fresenius intervened in the

case, seeking payment of its *Spaeth* balance, which was in excess of the amounts it had received from Medicaid, Medicare, and the private insurer. The compensation judge determined that the end-stage renal disease was work-related. She further determined that the Minnesota workers' compensation fee schedule applies to all charges for services provided to the employee for the work-related condition while in the state of Minnesota. For services which had been provided in Michigan, the Michigan fee schedule would apply. The judge further concluded that she lacked subject matter jurisdiction to interpret the Medicaid and Medicare laws, and ordered the employer to pay Fresenius in accordance with all other state and federal laws, its outstanding intervention interests associated with the end-stage renal disease. She also ordered the employer to reimburse the private insurer and the Minnesota Department of Human Services (Medicaid). The judge's Findings and Order were served on the parties on October 24, 2016. Fresenius' counsel, but not Fresenius itself, was served. On November 8, 2016, the employer filed a notice of appeal to the WCCA. That notice had been served on Fresenius the day before. Fresenius then served a notice of cross-appeal by mail on November 22, 2016, which was received by the OAH on November 28, 2016. On May 12, 2017, the WCCA dismissed Fresenius' cross-appeal for lack of subject matter jurisdiction, concluding that it should have been filed by November 23, 2016. Subsequently, the WCCA upheld the judge's decision that the employee's condition was work-related. The WCCA also affirmed the judge's determination that she lacked subject matter jurisdiction to interpret and apply Medicaid and Medicare statutes and rules. The WCCA also affirmed the judge's determination that Fresenius was entitled to its *Spaeth* balance pursuant to the Minnesota workers' compensation law, despite accepting payments from Medicaid and Medicare. The employer appealed to the Supreme Court, and Fresenius moved to lift the stay of its appeal.

The Supreme Court (Justice Lillehaug) affirmed in part, reversed in part, and remanded. First, the Supreme Court determined that substantial evidence supported the judge's determination that the employee's kidney condition was work-related, and it affirmed that decision.

The Supreme Court next addressed whether Fresenius was entitled to a *Spaeth* balance for its remaining bill after payment by Medicaid. The Court determined that the Medicaid regulation is unambiguous. It imposes a bright-line rule: when a provider participates in Medicaid, bills services to Medicaid, and accepts Medicaid payment for those services, it accepts the amount paid as "payment in full," and thus, cannot recover from third parties any unpaid amounts. As such, after accepting a payment from Medicaid for services, a provider is barred from recovering any additional amounts for those services from a liable employer. There is no exception for workers' compensation cases. The Court rejected Fresenius' argument that since DHS had now also been reimbursed for its Medicaid payments, that allows Fresenius to bill the full amount to the employer. The fact remains that Fresenius already accepted Medicaid payments, and that triggered the regulation's "in full" requirement. The Court concluded that the *Spaeth*-balance rule will not be extended in the Medicaid context. It noted that the Medicare regulation does not include "in full" language, although the Court did not specifically address whether medical entities which accept payment from Medicare may pursue their *Spaeth* balances. [It is possible that specific issue was not appealed.]

The Supreme Court next determined that Fresenius' appeal had been timely, as it had not personally been served with the original Findings and Order. Pursuant to Minn. Rule 1415.0700, service on the party's attorney is considered service on that party, except that all final orders, decisions, awards, and notices of proceedings must also be served directly on the party. Therefore, the Findings and Order needed to be directly served on Fresenius itself. Since that did not happen, Fresenius' time to cross-appeal had not expired by the time it filed its appeal.

The final issue was raised by Fresenius' cross-appeal, that being whether the Minnesota fee schedule applies to medical bills for treatment incurred prior to a finding of primary liability. The WCCA did not consider this issue, as it had determined that the cross-appeal was untimely. Therefore, this issue was remanded to the WCCA for consideration.

Comment: This decision clarifies certain issues, but has left the door open with other issues. It is now clear that a medical entity which accepts Medicaid payments for services rendered is precluded from seeking payment of its residual *Spaeth* balance. However, it would appear that the Supreme Court has also determined that the same rationale does not apply to a medical entity which accepts payment from Medicare. That entity may proceed with a claim for its residual *Spaeth* balance. The issue which is still to be determined is whether a medical provider is subject to the Minnesota fee schedule for services rendered before there is a finding of primary liability. Once liability is determined, it appears clear that the fee schedule will apply to all services after that date. The WCCA will now determine whether the fee schedule applies to services before a finding of primary liability. The assumption has always been that the fee schedule applies to all medical bills which are ultimately determined to be work-related, but we will have to wait and see what the WCCA says.

JURISDICTION

Gist v. Atlas Staffing, Inc., File No. WC16-6019, Served and Filed June 21, 2017. (For additional information on this case, please refer to the Causal Connection and Interveners categories.) The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed Compensation Judge Bouman's determination that a compensation judge does not have jurisdiction to interpret or apply laws designed specifically for the handling of claims outside the workers' compensation system. Note: This case was appealed to the Minnesota Supreme Court. Please see the decision below.

***Ansello v. Wisconsin Central, Ltd.*, 900 N.W.2d 167 (Minn. August 9, 2017)**. The employee sustained a low back injury in 2006 while performing longshoreman work for the employer. Benefits were paid by the employer and insurer under the Federal Longshore and Harbor Workers' Compensation Act (as opposed to the Minnesota Workers' Compensation Act.) The employee aggravated his back at work in 2014 and subsequently scheduled low back fusion surgery. He filed a Medical Request under the Minnesota Workers' Compensation Act to seek payment for medical treatment. The compensation judge held that the Longshore Act provides a basis for fully compensating the employee for medical treatment, and the medical expenses claimed by the employee under the Minnesota Workers' Compensation Act would "supplant, rather than supplement," benefits available under the Longshore Act. Therefore, he denied the employee's claim based on a lack of jurisdiction. The judge also invoked the doctrine of *forum non conveniens*, concluding that a Minnesota workers' compensation court is not a convenient venue to litigate his current medical claims, since benefits were previously submitted under the Longshore Act. The employee appealed. The WCCA reversed and remanded. The WCCA found that concurrent state coverage under the workers' compensation system is available for employees who receive benefits under the Longshore Act. The WCCA noted that, to avoid double recovery, federal and state benefits must be credited against one another. On appeal to the Minnesota Supreme Court, the WCCA was affirmed. The Minnesota Supreme Court (Justice Gildea) expounded on the *Sun Ship* case from the United States Supreme Court, which held that there is concurrent jurisdiction between the Longshore Act and state workers' compensation laws for *land-based* injuries covered under more than one law. Regarding the concept of *forum non conveniens*, the WCCA cited federal

case law that establishes a strong presumption in favor of the plaintiff's choice of forum. The WCCA determined that there is nothing inconvenient about the employee seeking benefits through the state system, given that he is a Minnesota resident, the injury occurred in Minnesota, and the employer's facility is located in Minnesota. The Minnesota Supreme Court upheld the WCCA on this point, as well, finding that the compensation judge abused his discretion. The Court pointed out that in every case in which the Minnesota Supreme Court has considered the doctrine of *forum non conveniens*, the two forums were in different states or in different nations. In this case, the choice was between a Minnesota compensation judge in Duluth and a federal compensation judge traveling to hear the case in Duluth.

Gerardy v. Anagram International, File No. WC16-6005, Served and Filed September 15, 2017. (For additional information on this case, please refer to the Temporary Total Disability category.) The WCCA (Judges Milun, Stofferahn, and Hall) affirmed the decision of Compensation Judge Behounek not to rule on the employer's alleged negligence, as liability for workers' compensation benefits is determined without regard to negligence. In determining that wage loss benefits were not owed, the Compensation Judge found that the employee was terminated for economic reasons versus his ability to work. The employee believed that he was wrongfully terminated and argued that the Compensation Judge did not have the subject matter jurisdiction to make this determination. However, the WCCA found that there was no error of law in determining the reason for the employee's termination for the purpose of determining eligibility for wage loss benefits. This case was summarily affirmed by the Supreme Court on April 19, 2018.

Hinkle v. Ruan Transportation, Inc., File No. WC17-6083, Served and Filed January 5, 2018. The employee was a Georgia resident, who was hired in Georgia in 2008 as an over-the-road truck driver, answering an ad out of a Georgia newspaper. He was assigned to an account with a home terminal in Georgia. In 2014, he was assigned to a different account with a home terminal in Minnesota, and that account also had a terminal in Georgia. He received his route assignments from his dispatcher in Minnesota. He attended mandatory training and safety meetings in Minnesota. He rented trucks from a facility in Georgia, and he picked up and delivered products in several states. He picked up or delivered products in 20 states, and he picked up and delivered in Minnesota 19 times in the 10 months before his injury, more than any other state. He traveled through Minnesota about eight times per month and would also pick up paperwork and attend classes in Minnesota. In October 2015, he was injured when he was adjusting the load on his truck in Georgia. He reported the injury by telephone, and the employer filed a first report of injury in Georgia, which listed its address in Minnesota. Initially, the claim was paid under Minnesota law, but in July 2016, the employer began paying benefits under Georgia's law. The employee filed for Minnesota benefits. Compensation Judge Hartman determined that the case was compensable under Minnesota law. The WCCA (Judges Hall, Milun, and Stofferahn) affirmed. Extraterritorial application of Minnesota's workers' compensation law is allowed under Minn. Stat. §176.041, subd. 2, which indicates that if an employee regularly performs primary duties of his employment in Minnesota and receives an injury outside of Minnesota in the employee of the employer, Minnesota law applies. The employer argued that the amount of time the employee spent and the amount of work performed in Minnesota were negligible compared to his overall employment activity. They argue that regularity implies majority and that the employee does not work "customarily, usually, or normally" in Minnesota. The WCCA disagreed. The statute does not require that more of the employee's time be spent in Minnesota than elsewhere, only that the employee regularly performs "primary" job duties in Minnesota. *See Gillund*. In this case, the employee's home terminal was located in Minnesota, he received his routes from a dispatcher in Minnesota, he made 19 trips to and from Minnesota in the 10 months before his injury, and he

picked up and delivered in Minnesota several times. As such, the statute was met. An employee temporarily out of the state may also be covered under Minnesota workers' compensation law pursuant Minn. Stat. §176.041, subd. 3, which indicates that if an employee hired in Minnesota by a Minnesota employer receives an injury while temporarily employed outside of Minnesota, such injury is subject to Minnesota law. Application of this section requires hiring of an employee in Minnesota by a Minnesota employer. The employer asserts that it is an Iowa employer, as its home office is located in Iowa. The WCCA disagreed. A determination of whether an employer is a Minnesota employer is based on the nature and degree of its activities in Minnesota, not the location of its home office. The employer has two terminals in Minnesota, and its employees perform services in Minnesota. The employer also maintained that the employee was not hired in Minnesota, as he was originally hired in Georgia in 2008. He had temporarily quit the employer in 2014 for 45 days, but then was rehired when the employer flew him to Minnesota in 2014 to fill out paperwork to become rehired. This was sufficient to show hiring in Minnesota. Based on the amount of time he spent in Minnesota, the evidence supported the decision that the employee's employment relationship remained centered in Minnesota, although he had no actual permanent situs of employment and could be considered always in a temporary location. *See Vaughn*.

***Gist v. Atlas Staffing, Inc.*, Case Nos. A17-0819 and A17-1096 (Minn. April 4, 2018).** For a summary of this case, please refer to the Interveners category.

MAXIMUM MEDICAL IMPROVEMENT

George v. Cub Foods, File No. WC17-6039, Served and Filed September 7, 2017. (For additional information on this case, please refer to the IME, Medical Issues, and Rehabilitation categories.) The WCCA (Judges Sundquist, Stofferahn, and Hall) affirmed Compensation Judge Daly's determination that the employee had reached maximum medical improvement, based on substantial evidence.

MEDICAL ISSUES

George v. Cub Foods, File No. WC17-6039, Served and Filed September 7, 2017. (For additional information on this case, please refer to the IME, Maximum Medical Improvement, and Rehabilitation categories.) The WCCA (Judges Sundquist, Stofferahn, and Hall) affirmed Compensation Judge Daly's determination that work hardening therapy and a functional capacities evaluation were reasonable and necessary, based on substantial evidence.

Colton v. Bloomington Plating, File No. WC17-6090, Served and Filed March 26, 2018. The employee worked for Bloomington Plating, insured by Federated. He sustained injuries in 1985 and 1986. In 1987, he settled with Federated with medical expenses left open. He then went to work for the State of MN/Department of Corrections. He had another injury in 2006 with that employer. In 2012, the employee, Federated, DOC, and the Special Compensation Fund agreed to a settlement which closed out all claims, except for certain future medical expenses. DOC was to be the paying agent, Federated agreed to reimburse DOC for 44% of medical treatment expenses, and the Fund was to reimburse Federated for the amount it paid to DOC. [The Fund was involved for Second Injury Fund reimbursement.] DOC has a contract with CorVel, which provides that CorVel will provide managed care services and medical bill payment services, will maintain a "statewide network of participating providers" for medical services to injured employees, and will provide "pharmacy benefit management services." DOC paid medical expenses on behalf of the employee in the amount of $55,386 between 2012 and 2014, and it submitted a request to Federated

for 44% of that amount. Federated paid DOC that amount and requested reimbursement from the Fund. The Fund refused to pay that amount, arguing that some of the prescriptions claimed exceeded the maximum allowable for those prescriptions. The Fund cited to Minn. Rule 5221.4070, subp. 4A(2), which sets the maximum fee for electronic transactions involving drug prescriptions as being the maximum allowable cost for that drug as established by the Department of Human Services, together with a professional dispensing fee of $3.65 per prescription. Federated maintained it should either be reimbursed by the Fund, or if the Fund was correct in its position, Federated should not have paid the disputed amount to DOC and should be reimbursed by DOC. Federated also asserted a claim for attorney's fees under Minn. Stat. §176.191, as well as a claim for penalties. DOC took the position that the rule did not apply in this case. It has a contract with CorVel, a certified managed care provider, which in turn has a contract with Caremark, a network of pharmacies which will provide medications at a specified amount. Under Minn. Rule 5221.4070, subp. 1aH(3), CorVel is defined as a workers' compensation payer because it has been designated by DOC to act on its behalf in paying drug charges. As such, DOC argued that Minn. Rule 5221.4070, subp. 5 applies, which indicates that subps. 3 and 4 do not apply "where a contract between a pharmacy, practitioner, or network of pharmacies or practitioners, and a workers' compensation payer provides for a different reimbursement amount." DOC argued that the maximum fee allowed provision under subp. 4 does not apply, and that the disputed amount of the claimed prescription expenses should be paid by the Fund. Compensation Judge Marshall determined that the Fund should reimburse Federated for the disputed amount on the prescriptions. It denied the claim for .191 fees to Federated, as well as penalties. The WCCA (Judges Stofferahn, Hall, and Sundquist) affirmed. Based on Minn. Rule 5221.4070, subp. 1aH(3), CorVel meets the definition of a workers' compensation payer. In turn, there is an agreement between CorVel and Caremark to pay the pharmacy network, and that meets the requirements of subp. 5. The Fund also argued that the disputed amount was a management fee for CorVel and is not medical services for which the Fund is partly responsible. The WCCA disagreed. It is correct that pharmacy or medical bills include an administrative component. Minn. Rule 5221.4070 specifically allows for payment of a drug cost as well as a "dispensing fee." The court noted that it could see no way that this dispensing fee could be categorized as anything other than an administrative cost of the provider.

PERMANENT TOTAL DISABILITY

Oseland v. Crow Wing County, File No. WC17-6120, Served and Filed May 1, 2018. Following a work injury in 1980, the employee was determined to be permanently and totally disabled as of July 1, 1987. PTD benefits were being paid, and pursuant to existing case law and rules, the insurer took an offset for Public Employees Retirement Association (PERA) benefits received by the employee. The employee ultimately died in February 2013, at which time PTD benefits stopped. In August 2014, the Minnesota Supreme Court issued its decisions in *Ekdahl* and *Hartwig*, clarifying that the PTD offset did not apply to PERA benefits. In September 2015, the Department of Labor and Industry (DOLI) alerted insurers that "time sensitive" correspondence would be sent out advising insurers as to DOLI's position on the effects of the new case law. In the letter, DOLI advised that the two cases applied prospectively and retroactively to all cases with dates of injury before and after October 1, 1995. As such, there were employees who had been underpaid PTD benefits. Further, the Special Compensation Fund would have been paying too much in supplementary benefit reimbursement. At that time, the Fund elected not to pursue collection of its overpayment. Insurers were advised to make payment of underpayments to the employees. The insurer advised DOLI that it was going to be reviewing its open files first, and then would turn to its closed files. On November 16, 2015, the insurer notified DOLI that it had identified two files that were impacted by the case law, and this employee's file was one of those. In June 2016, DOLI

sent the insurer its calculation of the amount of underpayment payable to the employee and the amount of over-reimbursement of supplementary benefits from the Fund. The insurer advised the employee's daughter-in-law in July 2016 that it was reviewing DOLI's calculations to see if there was agreement on the numbers. In September 2016, the insurer advised DOLI that its calculation of the underpayment of PTD benefits was about $10,000 less than the calculations of DOLI. DOLI responded, noting that it agreed with the insurer's calculations. At that time, the insurer contacted one of the employee's sons and notified him that there was an underpayment of approximately $159,000. The employee's son was told that the insurer needed the name of the estate, the name of the personal representative, and the estate tax number and address. The insurer asked again for this information one month later. At that time, the employee's heirs retained counsel, and a claim petition was filed in November 2016, claiming an underpayment of PTD benefits and claiming interest on that amount. The insurer admitted the underpayment of PTD, noting that it would make payment upon submission of the estate tax information. In January 2017, a decree of descent was issued by Crow Wing County District Court, naming the employee's heirs for purposes of the workers' compensation underpayment. Those heirs claimed the underpayment was the amount initially calculated by DOLI. The insurer, therefore, requested a settlement conference. The parties then entered into a partial stipulation for settlement in March 2017, in which the insurer agreed to pay the amount it acknowledged owing. The claim for the additional underpayment, interest, and penalties went to a hearing. Compensation Judge Tate determined that the insurer had appropriately calculated the underpayment, so no additional underpayment was due. Interest was allowed on the underpayment from the date the original benefits were owed, with the interest rate to be determined by the statute in effect at the time the benefit was to have been paid. The employee's claim for penalties was denied. The employee's claim for taxable costs associated with obtaining the decree of descent was denied. The WCCA (Judges Stofferahn, Milun, and Hall) vacated the determination and remanded the case to the judge. In 2017, the legislature enacted Minn. Stat. §1292 to clarify the holdings in *Hartwig* and *Ekdahl*. The Fund has subsequently issued guidance for its application to cases involving dates of injury prior to October 1, 1995, such as the current case. Application of the statute was not considered by the parties or by the judge. The case was remanded to the judge for further findings based on the new statute.

PROCEDURAL ISSUES

Carda v. State of Minnesota/Department of Human Services, File No. WC17-6030, Served and Filed July 11, 2017. Compensation Judge Tejeda expressly accepted the expert medical opinion of the self-insured employer that the employee was able to work full-time without restrictions, and this was sufficient grounds to discontinue temporary total disability compensation. The employee had a visit with her treating doctor one week before the hearing, and the treating doctor opined that the employee should remain off work, but the medical record was not produced at the hearing. No party requested that the compensation judge reopen the record for the receipt of this report. However, the employee asked the WCCA to vacate the compensation judge's findings and order, arguing that the judge committed an error of law. The WCCA (Judges Hall, Milun, and Sundquist) denied the request to vacate, holding, "[w]hile we have previously held that a compensation judge has the authority to hold the record open for post-hearing medical evidence, we cannot conclude that a compensation judge is compelled to do so on his own motion where no party has so requested. Accordingly, we decline to hold that the judge committed an error of law in this case." The employee went on to argue that even in the absence of an error of law, the interests of justice require that the judge's findings and order be vacated. The employee cited a Minnesota Supreme Court case, *Horan*, where that court considered a post-hearing affidavit "in the interests of justice."

The WCCA noted that it is a limited, administrative body, whereas the Minnesota Supreme Court has equitable powers that are inherent to the judiciary. Therefore, the WCCA did not deem itself to have the authority to vacate the compensation judge's findings and order in the absence of a factual or legal error.

Otterness v. Andersen Windows, File No. WC17-6063, Served and Filed December 5, 2017. The employee sustained injuries while working on January 12, 2012, and November 15, 2012. The employer admitted liability and paid benefits. The employer obtained an independent medical examination from Dr. Dick, who opined that the employee's 2012 injuries were temporary aggravations to the employee's pre-existing condition, that he had reached maximum medical improvement, and had a zero percent permanent partial disability (PPD) rating. Dr. Dick also opined the employee could do home exercises and walk as reasonable ongoing treatment for his condition. His treating doctor gave him a 10 percent PPD rating. The employee filed a Claim Petition seeking various benefits and payment of medical expenses. He also filed a rehabilitation request seeking retraining. The case was initially block assigned to Compensation Judge Grove. Prior to the hearing, the employee's attorney attempted to talk to the employee about inadequacies in the medical evidence he had to support his claimed injuries and claim for benefits. The employee's attorney had the case stricken from the active trial calendar. The employee then requested it be reinstated and it was assigned to Compensation Judge Wolkoff. The employee's attorney withdrew from representation, and the employee represented himself at the hearing. At the hearing, he attempted to introduce as an exhibit text messages between his attorney and him regarding possibly settling his claim and also getting additional medical evidence to support his claims. Judge Wolkoff ruled that the text messages were inadmissible and accepted the opinion of Dr. Dick that the employee's injuries were temporary in nature and had resolved. The employee filed an appeal requesting "a fair, impartial, non-bias (sic) review of this case/claim." The WCCA (Judges Hall, Milun, and Sundquist) affirmed the compensation judge's decision that the text messages were inadmissible. It also held that there was substantial evidence to support the compensation judge's decision to accept Dr. Dick's medical opinions regarding the nature and extent of the employee's injuries. With regard to the employee's objection to the change in the compensation judge assigned to hear his case, the WCCA held that the employee did not explain how the reassignment prejudiced him, and that the employee failed to formally object to the judicial re-assignment, so the procedural posture of the employee's claim was proper.

Devos v. Rhino Contracting, Inc., File No. WC17-6075, Served and Filed January 8, 2018. The employer was an uninsured entity which was based in North Dakota. The employee had worked for the employer in 2011 and 2012. The employee suffered an injury in September 2012 while working in Minnesota. The parties agreed that in 2012, the employee did not work 15 consecutive days in Minnesota, nor did he work more than 240 hours in Minnesota. However, a dispute existed as to whether he was recalled or rehired in 2012, and whether that occurred in North Dakota or in Minnesota, where the employee resided. A claim petition was filed, and the Special Compensation Fund filed a motion to dismiss, asserting that the employee's claim was barred by Minn. Stat. §176.041, subd. 5b and arguing that the employee was not entitled to benefits because he was an employee hired in North Dakota by a North Dakota employer, and his alleged injury arose out of his temporary work in Minnesota. The case had been stricken from the calendar at the employee's request for two years. Upon reinstatement, a special term conference was scheduled to consider the Fund's motion to dismiss. Compensation Judge Arnold held a special term conference via telephone. No witness testimony was received, but certain documentary exhibits were submitted and appearances were noted on behalf of the employee and the Fund. The employee's attorney indicated at the conference that he misunderstood and thought that it was a Pretrial Conference.

Arguments were presented. At the request of the employee's attorney, the record remained open for the submission of additional evidence on the issue of where the employee was hired. No additional evidence was submitted. Instead, the employee submitted a formal objection to the motion to dismiss. He argued that dismissal was not appropriate because factual disputes exist. The compensation judge granted the Fund's motion to dismiss, and the employee appealed. The WCCA (Judges Sundquist and Stofferahn) vacated the dismissal and remanded the case to the judge. In order for Minn. Stat. §176.041, subd. 5b to apply, various individual components of that statute need to be met. Although the judge determined that the statute had been met, there was no explanation or identification of evidence relied upon. The telephone conference was on the record, but the transcript of the proceeding was minimal. It is clear that the employee's attorney misunderstood the nature of the conference and was not prepared to present evidence to refute the motion to dismiss. He was clear, however, about his position that a factual dispute existed as to where the employee was hired. There was no stipulated set of facts presented to the judge, and it is unclear what evidence he considered. Under these circumstances, the dismissal was vacated and the matter remanded for a fact finding on the issues of when and where the employee was hired in 2012, and whether the employer is a North Dakota employer.

Judge Milun dissented. She would have determined that the evidence was sufficient in the record to support the judge's finding. Further, the employee had had two years in which to show jurisdiction existed. Although the employee's attorney made an argument as to a theory of the employee being hired, that was not evidence.

Murphy v. Riverview Healthcare Association, File No. WC17-6088, Served and Filed May 3, 2018. The employee worked for the employer on a part-time basis in a supply clerk position. On January 25, 2016, she and several co-workers were assigned an additional project to "redo" the storage room, which was a multi-week project in which all materials had to be removed, shelves torn down, new shelves set up, and the products replaced. For the first two weeks of the project, the employee went to full-time status, but due to stiffness and exhaustion from the extra work, she then chose to reduce her schedule to her normal part-time basis by the third week of the project. She was not scheduled to work on February 12, 2016. On that date, she awoke at home in bed noting that her left arm was raised overhead and that it felt numb. When she pulled it down with her other hand, she had the onset of pain in the left shoulder. The pain worsened as the day progressed, and she went to the hospital. She reported that she had been doing repetitive work recently, but that she had not had pain during her work activities. She underwent an MRI of the cervical spine on February 18, 2016, and was diagnosed with a large ruptured disc. Her treating surgeon saw her on February 25, 2016, and he recommended emergency surgery, which was performed on February 26, 2016. On March 17, 2016, the employee filed a report of injury, claiming an injury at work on or about January 25, 2016. The employer accepted primary liability and commenced payment of wage loss benefits and medical expenses. The employee did not have a good result from the surgery, and by June 2016, was diagnosed with complex regional pain syndrome. Her treating surgeon recommended additional cervical spine surgery. The employer had an IME performed in September 2016, and the IME concluded that the employee did not sustain any type of a work injury. On October 26, 2016, the employer filed a Petition to Discontinue benefits based on a defense of no primary liability and payment under a mistake of fact. The IME had also commented that the employee would reach maximum medical improvement one year post-surgery, and in January 2017, the employer filed an NOID seeking to discontinue temporary total disability benefits on the basis of MMI. That decision was decided separately from the Petition to Discontinue, and it is not part of this appeal. A hearing on the Petition to Discontinue was ultimately held on May 19, 2017. The employee's attorney objected

to the hearing on procedural grounds and on the basis that it would be unfair to determine primary liability and causation at an expedited hearing. He also sought to supplement the record with further medical evidence. Compensation Judge Rykken refused to hear the additional evidence, and she determined that the employee had not sustained a work-related injury. The WCCA (Judges Hall, Stofferahn, and Sundquist) affirmed. Pursuant to the statute, commencement of payment by an employer does not waive any rights to any defense the employer has on any claim either with respect to the compensability of the claim or the amount of compensation due. The Supreme Court has previously held that consideration of primary liability in an expedited discontinuance proceeding is not constitutionally improper so long as the opposing party has reasonable notice. *See Kulenkamp*. In this case, the hearing on the Petition to Discontinue did not take place for six months, which was ample time for the employee to prepare. The employee also asserted that the employer should have been barred from raising its primary liability defense in the hearing on the Petition to Discontinue, as it had not raised that issue at the expedited hearing on the issue of MMI. The WCCA noted that only issues that are specified on the NOID can be addressed at that time, and the issue of primary liability was not raised in the NOID. The employee also argued that the issues of primary liability and MMI were required to be combined into one pleading. The WCCA rejected that argument, noting that the statute provides various options for an employer to discontinue benefits, including a NOID and a Petition to Discontinue. Nothing makes these options mutually exclusive. The employee then contended that the employer should be estopped from raising the issue of primary liability. The employee asserted that she sustained further injury consequential to her surgery, and as such, there is an issue as to whether the employer should be permitted to cover the surgery, and then when it comes to light that the employee may have sustained a consequential injury as the result of that treatment, subsequently contest primary liability. Essentially, the employee argued that she may not have undergone the surgery but for the fact that the employer accepted liability and agreed to pay. The WCCA did not really address this estoppel issue, noting that the surgery had taken place on February 26, 2016, and that the employee did not even report the injury until March 17, 2016. As such, it was not possible that she could have relied on the acceptance of liability to undergo the surgery in the first place. The employee also argued that the employer should be precluded from asserting a primary liability defense in this case due to the extensive amount of benefits that it had already paid. The WCCA completely rejected that argument, noting that there was no prejudice to the employee from the payments already made. Finally, the WCCA held that the compensation judge did not abuse her discretion in not keeping the record open for another supplemental medical report.

PSYCHOLOGICAL INJURY

Nelson, Dale v. State of Minnesota/Department of Human Services, File No. WC17-6033, Served and Filed July 27, 2017. The employee appealed from Compensation Judge Marshall's determination that the employee did not suffer from PTSD as a result of his work injury, which resulted from an assault. The compensation judge chose between two conflicting medical opinions and sided with the medical expert of the self-insured employer that the employee did not have PTSD. In line with the *Hengemuhle* standard, the WCCA (Judges Milun, Stofferahn, and Hall) upheld the compensation judge, determining that his findings were supported by substantial evidence.

George v. Cub Foods, File No. WC17-6039, Served and Filed September 7, 2017. (For additional information on this case, please refer to the IME, Maximum Medical Improvement, and Medical Issues categories.) The WCCA (Judges Sundquist, Stofferahn, and Hall) affirmed Compensation Judge Daly's determination that the employee's restrictions were causally related to the work injury, and therefore, a rehabilitation consultation was appropriate.

***Halvorson v. B&F Fastener Supply*, 901 N.W.2d 425 (Minn. September 20, 2017)**. The employee injured multiple body parts while working for the employer and was unable to return to work with the employer. She underwent two surgeries. Eventually, she began working for a new employer within similar restrictions as prior to her latest surgery. The employer and insurer filed a request to terminate the employee's rehabilitation benefits because she was no longer a "qualified employee" under Minn. Rule 5220.0100, subp. 22, as her new job at McDonald's was suitable gainful employment, and there was "good cause" to terminate her rehabilitation under Minn. Rule 5220.0510, subp. 5, because she would not likely benefit from further rehabilitation services. At the hearing, however, the only issues the parties argued were: (1) whether the employee was still a qualified employee; and (2) whether she had returned to suitable gainful employment. Compensation Judge Behr held that the employee's new job was suitable gainful employment, and that she was not a qualified employee under Minn. Rule 5220.0100, subp. 22, and he allowed the rehabilitation plan to be terminated. The employee appealed arguing that the compensation judge committed an error of law by finding the employee's work was suitable gainful employment and that he improperly expanded the issues at hearing to include whether there was good cause to terminate her rehabilitation services. The WCCA reversed, holding that it was necessary to evaluate the plain language of the statute and rules for vocational rehabilitation services, that the compensation judge had improperly expanded the issues at hearing, and that the compensation judge also applied an incorrect standard to terminate rehabilitation benefits. The Minnesota Supreme Court (Justice Stras) agreed with the WCCA. Under Minn. Rule 5220.0100, subp. 22, the definition of "qualified employee" does not provide a specific provision to terminate rehabilitation benefits. In addition, Minn. Stat. §176.102, subd. 6(a), which addresses an employee's initial eligibility for rehabilitation services, does not provide an independent mechanism for an employer to terminate rehabilitation benefits. Instead, to terminate rehabilitation benefits, the standards are found under Minn. Rule 5220.0510, subp. 5 (stating that to terminate or suspend rehabilitation benefits, the employer and insurer can bring a rehabilitation request for good cause under one of four criteria), and Minn. Stat. §176.102, subd. 8 (stating that to terminate rehabilitation, one of five different criteria can be met to meet "good cause"), but none of the factors laid out in this rule or statute were raised at the hearing. Because the proper standards for terminating rehabilitation benefits were not before the compensation judge, the Minnesota Supreme Court upheld the WCCA's reversal of the judge's decision to terminate rehabilitation benefits.

Beguhl v. Supportive Living Solutions/Whittier Place, File No. WC17-6078, Served and Filed January 11, 2018. Prior to going to work for the employer, the employee had sustained previous injuries involving her spine, right shoulder, and left foot. While working for the employer, the employee sustained injuries in November 2015 and 2016. The employee sought ongoing benefits. Independent medical evaluations were performed, and the employer maintained that the effects of the work injuries had been temporary in nature. Subsequent to the work injuries, the employee had begun working with a QRC. The employer contested the billings of the QRC. Compensation Judge Tate determined that the work injuries remained substantial contributing factors of some, but not

all, of the employee's conditions, and she awarded benefits to the employee, as well as payment of the outstanding rehabilitation bills. The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed. With regard to causation and the award of benefits, those findings were supported by substantial evidence and were affirmed. With regard to the rehabilitation bills, the employer argued that some of the billings were not payable for a variety of reasons: QRC's frequent use of a standard billing amount (.2 of an hour) did not actually identify the reasonable time spent for services; the QRC's description of the service provided was inadequate; the billed time was not reasonable due to the particular service provided; the billed time was an administrative task not in furtherance of the rehabilitation plan; and the QRC failed to reduce the charged hourly fee as required by the rules. The WCCA has previously determined that adoption of a minimum time increment for timekeeping of QRC services, very close to the objected time in this matter, is in most cases reasonable. *See Boss*. The WCCA determined that the disputed descriptions of QRC activity were adequate to describe the services provided. The actual time spent appeared sufficient on the record to support the time billed. Several services were identified by the employer as unpayable under Minn. Rule 5220.1900, subp. 7, including leaving voicemail messages and providing services after a request to suspend services has been filed. The WCCA rejected this argument. The absence of the employer's consent shall not preclude a compensation judge from determining the reasonable value or necessity of case activities. The QRC takes the risk of nonpayment, but upon a showing of the need and reasonableness of the service, all appropriate services are compensable. *See Parker*. The WCCA did accept the employer's argument that certain administrative tasks were not in furtherance of the rehabilitation plan. The decision was modified to exclude those items. The WCCA also determined that the hourly reduction was applied. The employer had also argued that some of the QRC fees improperly included medical management services related to certain body conditions that were determined not to be compensable. The WCCA determined that one purpose of medical management is to ensure that the ultimate goal of the rehabilitation plan can be accomplished. Since the employee's ability to work is affected by her medical condition, regardless of the origin of any particular aspect of that condition, a qualified employee is entitled to reasonable medical management of her whole condition, not merely the portion identified as being a compensable work injury.

Dahl v. Rice County, File No. WC17-6093, Served and Filed March 5, 2018. The employee was a deputy sheriff for the employer from 1992 until 2006, with an average weekly wage of $1,168.53. During the years of his employment, he suffered four low back injuries, and ultimately, could not continue his work because the restrictions could not be accommodated. He underwent two low back fusion surgeries, resulting in permanent physical limitations. He was left with the ability to work in the light physical demand level. Following his severance from employment, he began working with a QRC. Numerous job leads were provided, and some of them led to extended periods of alternative employment. The evidence documented that the employee was engaged in job search, but at no time did he submit job logs. Some of the jobs which he held subsequent to severance from the employer paid well (in excess of his pre-injury wage), and others did not. Some required activities beyond his physical restrictions. Some required knowledge and skills beyond his capabilities. More recently, the jobs that he had been involved in were part-time or seasonal positions. In 2016, the QRC developed a retraining proposal for a three-year teaching degree at the University of Mankato with an occupational goal of high school teacher. The proposal was rejected at an Administrative Conference, and the employee appealed. The QRC testified in support of the retraining plan, and noted that although he had never seen any job logs, the fact that the employee had been employed in various capacities over 11 years since his severance from the employer shows that he was looking for work. He acknowledged that he had been frustrated over the years with the employee's lack of job logs, but nevertheless, felt that the employee had

reasonably cooperated with rehabilitation and that there was no barrier to retraining in this regard. The employee also had an independent vocational examiner, Mr. Askew, testify in support of the retraining plan, arguing that it met the *Poole* factors. The employer had an independent vocational evaluation by Ms. Schrot, who testified that the proposed retraining plan was not viable, as there are not an adequate number of positions open that would interest the employee following the completion of the plan, and jobs available would not restore the employee's economic status. She also commented that the job search was not diligent, and that the employee had not fully cooperated with rehabilitation. Compensation Judge Wolkoff approved the retraining plan. The WCCA (Judges Hall, Milun, and Sundquist) affirmed. The employer argued that the employee's job search was deficient. The compensation judge acknowledged that the job search activities were not perfect. However, a diligent job search is not necessarily required for retraining. *See Fisher*. While a well-documented job search may be preferred in the typical retraining case, there is no legal requirement that an employee complete and submit job logs. The evidence in the record details numerous employment positions that the employee sought and obtained over the years, and the QRC had testified that the employee had sufficiently cooperated with the rehabilitation process. The WCCA also determined that substantial evidence supported the judge's finding that the employee had the ability to succeed in the program. It also determined that the judge had considered the evidence appropriately, concluding that retraining to become a high school teacher is likely to restore the employee's economic status.

SETTLEMENT

Dahl v. AG Processing, Inc., File No. WC17-6032, Served and Filed June 21, 2017. The employee injured his right shoulder in October 2004. That injury was admitted. He underwent treatment, including shoulder surgery. The medical records also referenced pain in the cervical spine. The employer and insurer did not admit an injury to the cervical spine. An independent medical evaluator determined that there had been no injury to the cervical spine. The employee had subsequent right shoulder surgeries, which were paid. The employer and insurer maintained a denial of the cervical spine. In 2008, the parties entered into a stipulation for settlement, which provided for a full, final, and complete settlement of the 2004 date of injury, "except for certain future medical expenses which will remain open to the right shoulder." The stipulation referenced the IME report. Subsequently, the employee had ongoing treatment regarding the right shoulder with ongoing references to cervical spine symptoms, as well. The employee ultimately brought a medical request seeking payment of the medical treatment relating to the cervical spine. Another IME was performed, and the physician opined that the cervical spine condition was not related to the work injury. Compensation Judge Baumgarth determined that the stipulation for settlement closed out the employee's claim for treatment due to the contested cervical spine condition, and left open only certain types of treatment for the admitted right shoulder condition. The employee appealed at that time. Also at that time, the Minnesota Supreme Court had issued its decision in *Ryan v. Potlatch Corporation*. The WCCA had remanded the case to the compensation judge at that time for reconsideration of his findings based on the holding in *Ryan*. The judge maintained his decision, and the case was again appealed. The WCCA (Judges Sundquist, Stofferahn, and Hall) affirmed. The WCCA rejected the employee's argument pursuant to the *Sweep* case that the cervical spine must remain open, as it was not specifically referenced in the stipulation for settlement. The WCCA noted that prior to the settlement, the employee had asserted a claim relating to his cervical spine, and as such, that injury was among the "any and all claims" the employee settled. Pursuant to the holding in *Ryan*, a settlement agreement may close out conditions and complications that arise from the same injury and are within the reasonable contemplation of the parties at the time of the settlement agreement, even where those conditions or complications

were not yet fully realized at the time of the stipulation. The cervical spine injury claim was clearly within the reasonable contemplation of the parties at the time they entered into the stipulation. The WCCA also rejected the employee's alternative argument that the cervical spine symptoms were a consequential injury, as opposed to an independent condition. Even if that was true, under the current *Ryan* holding, a consequential condition which was within the reasonable contemplation of the parties could be foreclosed by a stipulation for settlement despite the fact that the condition only became compensable subsequent to the stipulation.

Allan v. Kolar Buick GMC, File No. WC17-6028, Served and Filed June 22, 2017. The WCCA (Judges Hall, Milun, and Stofferahn) affirmed Compensation Judge Arnold's interpretation of the stipulation for settlement concluding that the claim against a specific employer was closed out pursuant to an analysis under *Ryan v. Potlatch Corporation*. The WCCA held that the fact that the employee did not identify a separate date of injury until well after the settlement did not alter the analysis because the condition at issue was known to the parties at the time of the settlement.

STANDARD OF REVIEW

***Kubis v. Community Memorial Hospital Association,* 897 N.W.2d 254 (Minn. June 28, 2017)**. For a summary of this case, please refer to the Arising Out Of category.

***Mattick v. Hy-Vee Foods Stores,* 898 N.W.2d 616 (Minn. July 12, 2017)**. The employee initially fractured her right ankle in 2000, before starting to work for the employer, Hy-Vee. She had two surgeries following the 2000 fracture and was ultimately able to return to work for Hy-Vee, where she spent 40 to 45 hours per week on her feet. In 2004, the employee was diagnosed with post-traumatic arthritis after experiencing a month of pain in her ankle. From 2004 to 2014, she continued to experience minor pain and swelling, mostly related to changes in the weather. On January 18, 2014, the employee twisted her right ankle while working at Hy-Vee. Following the injury, she was diagnosed with a sprain and was able to continue working full-time. The employee's ankle improved somewhat but she continued to treat through March 2014, when she twisted her ankle again, outside of work. Ultimately, the employee's condition progressively worsened resulting in an ankle fusion. The rationale for the surgery was a diagnosis of advanced degenerative arthritis in her ankle. Hy-Vee denied payment for the surgery. At the hearing, the employee submitted expert reports from her treating providers, Dr. Collier and Dr. Ryssman, as well as reports from her independent expert, Dr. Bert. Dr. Collier opined that although the employee's work injury was not the primary cause of her arthritis, it led to the flare up along with the ankle sprain that she received. On the Health Care Provider Report, Dr. Collier checked "yes," that the employee's condition was caused, aggravated, or accelerated by her work. Dr. Ryssman declined to provide an opinion on whether the employee's work injury aggravated her arthritis but opined that the surgery was reasonable and necessary. Dr. Bert opined that the employee's work injury permanently aggravated her arthritis and substantially contributed to her need for surgery. The employer submitted its own independent medical examination report from Dr. Fey, who opined that there was no objective basis for finding that the work injury accelerated or in any way modified her arthritic condition. Dr. Fey opined that the work-related sprain was mild and temporary. Compensation Judge Dallner denied the employee's claim for the ankle surgery, finding Dr. Fey's report most persuasive. In a 2-1 decision, the WCCA reversed, finding that Dr. Fey's report lacked adequate foundation and that the compensation judge's finding was not supported by the evidence. Hy-Vee sought review of the WCCA's decision at the Minnesota Supreme Court. With Justice McKeig writing, the Supreme Court reversed the WCCA's decision, reinstating the compensation judge's decision. On appeal to the Supreme Court, the employer

argued that the WCCA exceeded the scope of its review, substituting its own findings for those of the compensation judge. The Supreme Court agreed, finding that the compensation judge did not abuse her discretion by relying on Dr. Fey's report and that the WCCA clearly and manifestly erred by overturning the compensation judge's finding that the work injury was not a substantial contributing cause of her ankle surgery which was performed to address a preexisting arthritic condition. The Court reiterated that, under *Nord*, a compensation judge's choice between conflicting expert opinions must be upheld unless the opinion relied on lacks adequate foundation. An expert opinion lacks adequate foundation when: (1) the opinion does not include the facts and/or data upon which the expert relied in forming the opinion; (2) it does not explain the basis for the opinion; or (3) the facts assumed by the expert in rendering an opinion are not supported by the evidence. *See Hudson*. In this case, Dr. Fey's opinion did not lack adequate foundation. The Court also stressed that, per the *Hengemuhle* standard, the WCCA's job is to review a compensation judge's decision in order to determine if the findings and order are supported by substantial evidence, or evidence that a reasonable mind might accept as adequate, based on the entire record.

SUPERSEDING INTERVENING INJURY

Bolstad v. Target Center/Ogden Corporation, File No. WC16-5979, Served and Filed May 5, 2017. For a description of this case, please refer to the Apportionment category.

TEMPORARY PARTIAL DISABILITY

Bolstad v. Target Center/Ogden Corporation, File No. WC16-5979, Served and Filed May 5, 2017. For a description of this case, please refer to the Apportionment category.

Petzel v. DS Agri Construction, File No. WC16-6020, Served and Filed May 16, 2017. The WCCA (Judges Sundquist, Milun, and Stofferahn) affirmed Compensation Judge Behounek's decision that the employee's work was sporadic and insubstantial and that the employee was not gainfully employed, so he was not entitled to temporary partial disability benefits.

TEMPORARY TOTAL DISABILITY

Bolstad v. Target Center/Ogden Corporation, File No. WC16-5979, Served and Filed May 5, 2017. For a description of this case, please refer to the Apportionment category.

Gerardy v. Anagram International, File No. WC16-6005, Served and Filed September 15, 2017. (For additional information on this case, please refer to the Jurisdiction category.) The WCCA (Judges Milun, Stofferahn, and Hall) found that there was substantial evidence in the record that supported Compensation Judge Behounek's determination that the employee was not entitled to temporary total disability benefits because the work injury resolved prior to the time period of the claimed benefits. This case was summarily affirmed by the Supreme Court on April 19, 2018.

Nelson, Larry v. Smurfit Stone Container Corporation, File No. WC17-6053, Served and Filed October 9, 2017. For a summary of this case, please refer to the *Gillette* Injuries category.

VACATING AWARDS

Holtslander v. Granite City Roofing, Inc., File No. WC16-6009, Served and Filed May 24, 2017. The employee sustained an admitted injury to numerous body parts, including his low back, on August 11, 1997. He sustained subsequent admitted injuries to numerous body parts, including his low back, on January 7, 1998, with the same employer and insurer. A few years later, in 2000, he again sustained various admitted injuries to various body parts, including his low back, while working for the same employer, which was then insured by a different insurer. The employee filed a claim petition for medical benefits and attorney's fees, and one of the insurers filed a petition for contribution. The parties eventually settled out his claims, except for limited medical benefits to his low back, right shoulder, right elbow, and cervical spine. At the time of the settlement, the employee was not working and the parties agreed he was not capable of returning to his pre-injury job as a roofer. After the settlement, the employee underwent three fusion surgeries, had hardware removed once, received a spinal cord stimulator, and it was also recommended he receive a replacement spinal cord stimulator. He filed a petition to vacate the award on stipulation. The employee argued at the time of the settlement he thought his condition was stable, that he would not require additional medical treatment, and that he would have fewer work restrictions and be able to obtain other employment. He argued that the stipulation should be vacated because of a mutual mistake of fact and because of a substantial change in his medical condition. The WCCA (Judges Milun, Stofferahn, and Hall) determined that there was no mutual mistake of fact. The WCCA held that there was a substantial change in the employee's condition because he had undergone numerous surgeries since the settlement, he had applied for and begun receiving social security disability benefits and was no longer able to work, he likely had additional permanent partial disability benefits, he had undergone extensive and costly treatment since the settlement, and the parties' initial settlement did not address the potential that he would become permanently and totally disabled as a result of his work injuries in the future. *See Fodness*. This case was summarily affirmed by the Supreme Court on February 13, 2018.

***Hudson v. Trillium Staffing*, 896 N.W.2d 536 (Minn. June 7, 2017)**. The employee was injured at work and the parties settled his claims. The employee's treatment was extensive prior to the settlement, but none of the doctors gave him a permanent partial disability rating. About one year later, the employee filed a petition to vacate the settlement, based on a new medical opinion from Dr. Ghelfi that he had a 75 percent permanent partial disability rating and was unable to work because of his injuries. The WCCA relied on Dr. Ghelfi's opinion, determined that the employee's condition had substantially changed, and vacated the award. The employer and insurer appealed to the Minnesota Supreme Court, arguing that the medical evidence from Dr. Ghelfi was insufficient to vacate the award. The Minnesota Supreme Court reversed the WCCA, holding that it abused its discretion in setting aside the award on stipulation. In a decision written by Justice Stras, the Supreme Court held that the WCCA did not scrutinize Dr. Ghelfi's factual foundation enough and that in order for an expert's opinion to be admissible, the expert must have adequate factual foundation. Dr. Ghelfi's opinion was flawed because she did not specify what facts led to her giving the employee a 75% PPD rating for his traumatic brain injury, and she did not explain how she calculated the rating. The Court also concluded that the facts as submitted were not sufficient to qualify for a 75% PPD rating under Minn. Rule 5223.0360, Subp. 7(D)(4), in that there was nothing to show that the employee needed to be sheltered and be supervised in all activities. In fact, the evidence showed that he was substantially independent.

Logan v. New Horizon Academy, File No. WC17-6031, Served and Filed June 30, 2017. The WCCA (Judges Stofferahn, Milun, and Hall) reversed Compensation Judge Tejeda's vacation of a portion of the stipulation addressing *Roraff* fees which was, allegedly, inadvertently included in the stipulation. The WCCA found that the compensation judge had no authority to issue an order vacating a portion of the stipulation.

Hartzell v. State of Minnesota, Department of Trial Courts, File No. WC17-6037, Served and Filed August 4, 2017. The WCCA (Judges Milun, Stofferahn, and Hall) found that the employee failed to demonstrate a causal relationship between her work injury and any current disability, or a substantial change in her medical condition. Therefore, the WCCA denied the employee's petition to vacate the award on stipulation.

Kellogg v. Phoenix Alternatives, Inc., File Nos. WC17-6035 and WC17-6047, Served and Filed September 14, 2017. The employee claimed that he settled his case under the assumption that he would receive SSDI benefits, but he did not. He sought to vacate the stipulation based on mutual mistake of fact. The WCCA (Judges Hall, Milun, and Stofferahn) denied the petition to vacate on this basis, given that there was no mistake of fact at the time of the stipulation. Instead, the employee was making a false assumption. A separate argument was made by the employee to vacate the stipulation based on a substantial change in medical condition. The employee's original injury was a low back injury, and he asked the WCCA to vacate his stipulation based on the assertion that he now had a sacroiliac (SI) joint condition. The WCCA refused to vacate the stipulation, determining that the SI joint condition was part and parcel of the low back, and therefore the SI joint condition was anticipated at the time of the settlement.

Rossbach v. Rossbach Construction, Inc., File No. WC17-6070, Served and Filed November 2, 2017. The employee petitioned to set aside an Award on Stipulation on the grounds of either fraud or mistake of fact. He sustained a work injury and the employer and insurer paid benefits in excess of $60,000. The adjuster obtained a quote regarding the projected cost of future vocational rehabilitation services, estimated to be $11,300. The adjuster wrote to the employee, who was not represented by an attorney, noting the projected cost of rehabilitation services and asking the employee whether he was open to settling his claim for $11,500 with medical benefits open. The employee accepted the offer. The stipulation was drafted, indicating it was a full, final, and complete settlement of all benefits, except future medical expenses. The proposed Award on Stipulation, which was submitted to the Office of Administrative Hearings with the executed Stipulation for Settlement, incorrectly stated that all parties were represented by counsel. In fact, neither party was represented by counsel. The compensation judge issued the Award on Stipulation, adopting the proposed Award as submitted. The employee later alleged that at the time of the settlement, he believed that he was only giving up his right to vocational rehabilitation benefits, not his right to future wage loss benefits. Thus, he filed a petition to vacate the Stipulation for Settlement with the WCCA. The WCCA (Judges Sundquist, Stofferahn, and Hall) found that the compensation judge made a mistake or error in issuing the Award on Stipulation, given that the parties were not actually represented by counsel as noted in the proposed Award on Stipulation; thus, the Stipulation was voidable. If both parties are represented by counsel, then the stipulation is presumed to be fair and reasonable and in conformity with the law. Upon receipt of such a settlement, the judge must immediately sign the award. However, if the parties are not both represented by counsel, a two-step process must be followed. First, the parties must establish that the stipulation is reasonable, fair, and in conformity with the Act. Second, the stipulation must be approved by a judge. Neither step was followed here.

The WCCA referred the parties' Stipulation for Settlement to the chief judge of the OAH for review to determine whether the settlement reflected the intent of the parties at the time of the stipulation and was fair, reasonable, and in conformity with the Workers' Compensation Act, and if appropriate, approve the stipulation. If the Award on Stipulation is approved, then the matter shall be returned to the WCCA to address the employee's petition to vacate.

MINNESOTA WORKERS' COMPENSATION 2017-2018 CASE LAW UPDATE
TABLE OF AUTHORITIES

2018 Minnesota Session Laws

Key: (1) ~~language to be deleted~~ (2) new language

CHAPTER 185--H.F.No. 3873

An act relating to workers' compensation; adopting recommendations of the Workers' Compensation Advisory Council; modifying workers' compensation provisions; modifying hospital outpatient fee schedules; modifying billing, payment, and dispute resolution; defining ambulatory surgical center payments; modifying covered benefits; amending Minnesota Statutes 2016, sections 175A.05; 176.011, subdivision 15; 176.101, subdivisions 2, 2a, 4; 176.102, subdivision 11; 176.136, subdivision 1b; 176.231, subdivision 9; 176.83, subdivision 5; Minnesota Statutes 2017 Supplement, section 15A.083, subdivision 7; Laws 2017, chapter 94, article 1, section 6; proposing coding for new law in Minnesota Statutes, chapter 176.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

WORKERS' COMPENSATION GENERAL

Section 1. Minnesota Statutes 2017 Supplement, section 15A.083, subdivision 7, is amended to read:

Subd. 7. **Workers' Compensation Court of Appeals and compensation judges.** Salaries of judges of the Workers' Compensation Court of Appeals are ~~98.52~~ 105 percent of the salary for ~~district court~~ workers' compensation judges of the Office of Administrative Hearings. The salary of the chief judge of the Workers' Compensation Court of Appeals is ~~98.52~~ 107 percent of the salary for ~~a chief district court judge~~ workers' compensation judges of the Office of Administrative Hearings. Salaries of compensation judges are 98.52 percent of the salary of district court judges.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 175A.05, is amended to read:

175A.05 QUORUM.

Subdivision 1. **Judges' quorum.** A majority of the judges of the Workers' Compensation Court of Appeals shall constitute a quorum for the exercise of the powers conferred and the duties imposed on the Workers' Compensation Court of Appeals except that all appeals shall be heard by no more than a panel of three of the five judges unless the case appealed is determined to be of exceptional importance by the chief judge prior to assignment of the case to a panel, or by a three-fifths vote of the judges prior to assignment of the case to a panel or after the case has been considered by the panel but prior to the service and filing of the decision.

Subd. 2. **Vacancy.** A vacancy shall not impair the ability of the remaining judges of the Workers' Compensation Court of Appeals to exercise all the powers and perform all of the duties of the Workers' Compensation Court of Appeals.

Subd. 3. **Retired judges.** Where the number of Workers' Compensation Court of Appeals judges available to hear a case is insufficient to constitute a quorum, the chief judge of the Workers' Compensation Court of Appeals may, with the retired judge's consent, assign a judge who is retired from the Workers' Compensation Court of Appeals or the Office of Administrative Hearings to hear any case properly assigned to a judge of the Workers' Compensation Court of Appeals. The retired judge assigned to the case may act on it with the full powers of the judge of the Workers' Compensation Court of Appeals. A retired

judge performing this service shall receive pay and expenses in the amount and manner provided by law for judges serving on the court, less the amount of retirement pay the judge is receiving under chapter 352 or 490.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 176.231, subdivision 9, is amended to read:

Subd. 9. **Uses ~~which~~ that may be made of reports.** (a) Reports filed with the commissioner under this section may be used in hearings held under this chapter, and for the purpose of state investigations and for statistics. These reports are available to the Department of Revenue for use in enforcing Minnesota income tax and property tax refund laws, and the information shall be protected as provided in chapter 270B.

(b) The division or Office of Administrative Hearings or Workers' Compensation Court of Appeals may permit the examination of its file by the employer, insurer, employee, or dependent of a deceased employee or any person who furnishes ~~written~~ signed authorization to do so from the employer, insurer, employee, or dependent of a deceased employee. Reports filed under this section and other information the commissioner has regarding injuries or deaths shall be made available to the Workers' Compensation Reinsurance Association for use by the association in carrying out its responsibilities under chapter 79.

(c) The division may provide the worker identification number assigned under section 176.275, subdivision 1, without a signed authorization required under paragraph (b) to an:

(1) attorney who represents one of the persons described in paragraph (b);

(2) attorney who represents an intervenor or potential intervenor under section 176.361;

(3) intervenor; or

(4) employee's assigned qualified rehabilitation consultant under section 176.102.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 4. **[176.2611] COORDINATION OF THE OFFICE OF ADMINISTRATIVE HEARINGS' CASE MANAGEMENT SYSTEM AND THE WORKERS' COMPENSATION IMAGING SYSTEM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the definitions in this subdivision apply unless otherwise specified.

(b) "Commissioner" means the commissioner of labor and industry.

(c) "Department" means the Department of Labor and Industry.

(d) "Document" includes all data, whether in electronic or paper format, that is filed with or issued by the office or department related to a claim-specific dispute resolution proceeding under this section.

(e) "Office" means the Office of Administrative Hearings.

Subd. 2. **Applicability.** This section governs filing requirements pending completion of the workers' compensation modernization program and access to documents and data in the office's case management system, the workers' compensation Informix imaging system, and the system that will be developed as a result of the workers' compensation modernization program. This section prevails over any conflicting provision in this chapter, Laws 1998, chapter 366, or corresponding rules.

Subd. 3. **Documents that must be filed with the office.** Except as provided in subdivision 4 and section 176.421, all documents that require action by the office under this chapter must be filed, electronically or in paper format, with the office as required by the chief administrative law judge. Filing a document that initiates or is filed in preparation for a

proceeding at the office satisfies any requirement under this chapter that the document must be filed with the commissioner.

Subd. 4. **Documents that must be filed with the commissioner.** (a) The following documents must be filed directly with the commissioner in the format and manner prescribed by the commissioner:

(1) all requests for an administrative conference under section 176.106, regardless of the amount in dispute;

(2) a motion to intervene in an administrative conference that is pending at the department;

(3) any other document related to an administrative conference that is pending at the department;

(4) an objection to a penalty assessed by the commissioner or the department;

(5) requests for medical and rehabilitation dispute certification under section 176.081, subdivision 1, paragraph (c), including related documents; and

(6) except as provided in this subdivision or subdivision 3, any other document required to be filed with the commissioner.

(b) The filing requirement in paragraph (a), clause (1), makes no changes to the jurisdictional provisions in section 176.106. A claim petition that contains only medical or rehabilitation issues, unless primary liability is disputed, is considered to be a request for an administrative conference and must be filed with the commissioner.

(c) The commissioner must refer a timely, unresolved objection to a penalty under paragraph (a), clause (4), to the office within 60 calendar days.

Subd. 5. **Form revision and access to documents and data.** (a) The commissioner must revise dispute resolution forms, in consultation with the chief administrative law judge, to reflect the filing requirements in this section.

(b) For purposes of this subdivision, "complete, read-only electronic access" means the ability to view all data and document contents, including scheduling information, related to workers' compensation disputes, except for the following:

(1) a confidential mediation statement, including any documents submitted with the statement for the mediator's review;

(2) work product of a compensation judge, mediator, or commissioner that is not issued. Examples of work product include personal notes of hearings or conferences and draft decisions;

(3) the department's Vocational Rehabilitation Unit's case management system data;

(4) the special compensation fund's case management system data; and

(5) audit trail information.

(c) The office must be provided with continued, complete, read-only electronic access to the workers' compensation Informix imaging system.

(d) The department must be provided with read-only electronic access to the office's case management system, including the ability to view all data, including scheduling information, but excluding access into filed documents.

(e) The office must send the department all documents that are accepted for filing or issued by the office. The office must send the documents to the department, electronically or by courier, within two business days of when the documents are accepted for filing or issued by the office.

(f) The department must place documents that the office sends to the department in the appropriate imaged file for the employee.

(g) The department must send the office copies of the following documents, electronically or by courier, within two business days of when the documents are filed with or issued by the department:

(1) notices of discontinuance;

(2) decisions issued by the department; and

(3) mediated agreements.

(h) Upon integration of the office's case management system and the department's system resulting from the workers' compensation modernization program, each agency will be provided with complete, read-only electronic access to the other agency's system.

(i) Each agency's responsible authority pursuant to section 13.02, subdivision 16, is responsible for its own employees' use and dissemination of the data and documents in the workers' compensation Informix imaging system, the office's case management system, and the system developed as a result of the workers' compensation modernization program.

Subd. 6. **Data privacy.** (a) All documents filed with or issued by the department or the office under this chapter are private data on individuals and nonpublic data pursuant to chapter 13, except that the documents are available to the following:

(1) the office;

(2) the department;

(3) the employer;

(4) the insurer;

(5) the employee;

(6) the dependent of a deceased employee;

(7) an intervenor in the dispute;

(8) the attorney to a party in the dispute;

(9) a person who furnishes written authorization from the employer, insurer, employee, or dependent of a deceased employee; and

(10) a person, agency, or other entity allowed access to the documents under this chapter or other law.

(b) The office and department may post notice of scheduled proceedings on the agencies' Web sites and at their principal places of business in any manner that protects the employee's identifying information.

Subd. 7. **Workers' Compensation Court of Appeals.** The Workers' Compensation Court of Appeals has authority to amend its rules of procedure to reflect electronic filing with the office under this section for purposes of section 176.421, subdivision 5, and to allow electronic filing with the court under section 176.285. The court may amend its rules using the procedure in section 14.389.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 5. Laws 2017, chapter 94, article 1, section 6, is amended to read:

Sec. 6. **WORKERS' COMPENSATION COURT OF APPEALS**	**$**	**1,913,000**	**$**	~~**1,913,000**~~ **1,946,000**

This appropriation is from the workers' compensation fund.

ARTICLE 2

HOSPITAL OUTPATIENT FEE SCHEDULE

Section 1. **[176.1364] WORKERS' COMPENSATION HOSPITAL OUTPATIENT FEE SCHEDULE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Addendum A" means the addendum entitled "OPPS APCs for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(c) "Addendum B" means the addendum entitled "OPPS Payment by HCPCS Codes for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(d) "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System. A HCPCS code is used to identify a specific medical service.

(e) "Hospital" means a facility that is licensed by the Department of Health under section 144.50.

(f) "HOFS" means the workers' compensation hospital outpatient fee schedule established under subdivision 3.

(g) "Insurer" includes workers' compensation insurers and self-insured employers.

(h) "Services" includes articles, supplies, procedures, and implantable devices provided by the hospital with the service. Services are identified by a code described in subdivision 3.

Subd. 2. **Applicability.** (a) This section only applies to payment of charges for hospital outpatient services if the charges include a service listed in the workers' compensation hospital outpatient fee schedule established by the commissioner under subdivision 3. If the charges do not include a service listed in the HOFS, payment shall be:

(1) the liability for each service that is included in the workers' compensation relative value fee schedule as provided in section 176.136, subdivision 1a, and corresponding rules adopted by the commissioner to implement the relative value fee schedule; or

(2) the liability as provided in section 176.136, subdivision 1b, paragraphs (b) and (c), for each service that is not included in the workers' compensation relative value fee schedule.

(b) This section does not apply to outpatient services provided at a hospital that is certified by Medicare as a critical access hospital. Outpatient services provided by these hospitals shall be paid as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 3. **Hospital outpatient fee schedule (HOFS).** (a) Effective for hospital outpatient services on or after October 1, 2018, the commissioner shall establish a workers' compensation hospital outpatient fee schedule (HOFS) to establish the payment for hospital bills with charges for services with a J1 or J2 status indicator as listed in the status indicator (SI) column of Addendum B and the comprehensive observation services Ambulatory Payment Classification (APC) 8011 with a J2 status indicator in Addendum A. The commissioner shall publish a link to the HOFS in the State Register before October 1, 2018, and shall maintain the current HOFS on the department's Web site.

(b) The amount listed for each of the procedures in the HOFS as described in paragraph (a) shall be the relative weight for the procedure multiplied by a HOFS conversion factor that results in the same overall payment for hospital outpatient services under this section as the actual payments made in the most recent 12-month period available before the effective date of this section. The commissioner must establish separate conversion factors to achieve the same overall payment for noncritical access hospitals of 100 or fewer licensed beds and hospitals with more than 100 licensed beds. The commissioner shall establish the two conversion factors according to the requirements in clauses (1) to (4) in consultation with insurer and hospital representatives.

(1) The commissioner shall obtain a suitable sample of de-identified data for Minnesota workers' compensation outpatient cases at Minnesota hospitals for the most recently available 12-month period. The commissioner may obtain de-identified data from any reliable source, including Minnesota hospitals and insurers, or their representatives. Any data provided to the commissioner by a hospital, insurer, or their representative under this subdivision is nonpublic data under section 13.02, subdivision 9.

(2) The sample must be divided into a data set for hospitals over 100 licensed beds, and 100 or fewer licensed beds, excluding critical access hospitals.

(3) For each data set the commissioner shall:

(i) calculate the total amount of the actual payments made in the most recent 12-month period available before the effective date of this section, adjusted for inflation to July 2018; and

(ii) apply all of the payment provisions in this section to each claim including, as applicable, payment under the relative value fee schedule or 85 percent of the hospital's usual and customary charge under section 176.136, subdivisions 1a and 1b, to determine the total payment amount using the Medicare conversion factor in effect for the OPPS in effect on July 1, 2018.

(4) The commissioner shall calculate the Minnesota conversion factor to equal the Medicare conversion factor multiplied by the ratio of total payments under clause (3), item (i), divided by the total payments under clause (3), item (ii).

(c) For purposes of this section:

(1) the relative weight is the amount in the "relative weight" column in Addendum B and Addendum A for comprehensive observation services.

(2) references to J1, J2, and H status indicators; Addenda A and B; APC 8011; and HCPCS code G0378 includes any successor status indicators, addenda, APC, or HCPCS code established by the Centers for Medicare and Medicaid Services.

(d) On October 1 of each year, the commissioner shall adjust the HOFS conversion factors based on the market basket index for inpatient hospital services calculated by Medicare and published on its Web site. The adjustment on each October 1 shall be a percentage equal to the value of that index averaged over the four quarters of the most recent calendar year divided by the value of that index over the four quarters of the prior calendar year.

(e) No later than October 1, 2021, and at least once every three years thereafter, the commissioner shall update the HOFS established under this subdivision by incorporating services with a J1 or J2 status indicator, and the corresponding relative weights, listed in the Addenda A and B most recently available on Medicare's Web site as of the preceding July 1. If Addenda A and B are not available on Medicare's Web site on the preceding July 1, the HOFS most recently published on the department's Web site remains in effect.

(1) Each time the HOFS is updated under this paragraph, the commissioner shall adjust the conversion factors so that there is no difference between the overall payment under the new HOFS and the overall payment under the HOFS most recently in effect, for services in both HOFSs.

(2) The conversion factor adjustments under this paragraph shall be made separately for each hospital category in paragraph (b).

(3) The conversion factor adjustments under this paragraph must be made before making any additional adjustment under paragraph (d).

(f) The commissioner shall give notice in the State Register of the adjusted conversion factor in paragraph (d) no later than October 1 annually. The commissioner shall give notice in the State Register of an updated HOFS under paragraph (e) no later than October 1 of the year in which the HOFS becomes effective. The notice must include a link to the HOFS published on the department's Web site. The notices, the updated fee schedules, and the adjusted conversion factors are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

Subd. 4. **Payment under the hospital outpatient fee schedule.** (a) Services in the HOFS, and other hospital outpatient services provided with or as part of service in the HOFS, are paid according to paragraphs (b) and (c).

(b) If a hospital bill includes a charge for one or more services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) If the bill includes a charge for only one service with only a J1 status indicator, payment shall be the amount listed in the HOFS for that service, regardless of the amount charged by the hospital.

(2) If the bill includes charges for more than one service with a J1 status indicator, the service with the highest listed fee in the HOFS shall be paid at 100 percent of the listed fee. Each additional service listed in the hospital outpatient fee shall be paid at 50 percent of the listed fee. Payment under this clause shall be based on the applicable percentage of the listed fee, regardless of the amount charged by the hospital.

(3) If the bill includes an additional charge for a service that does not have a J1 status indicator listed in the HOFS, no separate payment is made for the additional service. Payment for the additional service, including any service with a J2 status indicator, is packaged into and is not paid separately from the payment amount listed in the HOFS for the service with the J1 status indicator. Implantable devices are paid separately only as provided in subdivision 5.

(4) The insurer must not deny payment for any additional service packaged into payment for a service listed in the HOFS on the basis that the additional service was not reasonably required or causally related to an admitted work injury.

(c) If a hospital bill includes one or more charges for services with a J2 status indicator, and does not include any charges for services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) Except for services packaged into an observation service as provided in clause (4), payment for each service with a J2 status indicator shall be the amount listed in the HOFS, regardless of the amount charged by the hospital.

(2) If a service without a HCPCS code is billed with a service with a J2 status indicator, payment is packaged into the payment for the J2 service.

(3) Payment for drugs with a HCPCS code is separate from payment for the service with the J2 code as provided in this clause.

(i) If the drug is delivered by injection or infusion, payment for the drug is packaged into payment for the injection or infusion service.

(ii) If the drug is not delivered by injection or infusion, payment for the drug is paid at the Medicare Average Sales Price (ASP) of the drug on the day the drug is dispensed. No later than October 1, 2018, and October 1 of each subsequent year, the commissioner must publish on the department's Web site a link to the ASP most recently available as of the preceding July 1. If no ASP is available, the most recently posted ASP linked on the department's Web site remains in effect.

(4) If a bill includes eight or more units of service with the HCPCS code G0378 (observation services, per hour), and there is a physician's or dentist's order for observation, payment shall be the amount listed in the HOFS for the comprehensive observation services Ambulatory Payment Classification 8011, regardless of the amount charged by the hospital. All other services billed by the hospital, including other services with a J2 status indicator, are packaged into the payment amount and are not paid separately from the payment amount listed in the fee schedule for HCPCS code G0378.

(5) For any other service on the same bill as the service with a J2 status indicator, payment shall be as provided in subdivision 2, paragraph (a).

Subd. 5. **Implantable devices.** The maximum fee for any service in the HOFS includes payment for all implantable devices, even if the Medicare OPPS would otherwise allow separate payment for the implantable device. However, separate payment in the amount of 85 percent of the hospital's usual and customary charge for an implantable device is allowed if the implantable device:

(1) has an H status indicator in Addendum B;

(2) is properly charged on a bill with a service with a J1 status indicator in the HOFS; and

(3) is properly billed with another HCPCS code, if required by Medicare's OPPS system.

The commissioner shall update the HOFS each October 1 to include any HCPCS codes that are payable under this section according to the Addendum B most recently available on the preceding July 1.

Subd. 6. **Study.** (a) The commissioner shall conduct a study analyzing the percentage of claims with a service in the HOFS that were paid timely and the percentage of claims paid accurately. The commissioner must report the results of the study and recommendations to the Workers' Compensation Advisory Council and chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2021.

(b) Based on the results of the study, the WCAC shall consider whether there is a minimum 80 percent compliance in timeliness and accuracy of payments, and additional statutory amendments, including but not limited to:

(1) a maximum ten percent reduction in payments under the HOFS; and

(2) an increase in indemnity benefits to injured workers.

Subd. 7. **Rulemaking.** The commissioner may adopt or amend rules, using the authority in section 14.386, paragraph (a), to implement this section. The rules are not subject to expiration under section 14.386, paragraph (b).

EFFECTIVE DATE. This section is effective for hospital outpatient services provided on or after October 1, 2018.

ARTICLE 3

OUTPATIENT BILLING, PAYMENT, AND DISPUTE RESOLUTION

Section 1. Minnesota Statutes 2016, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a Critical Access Hospital certified by the Centers for Medicare and Medicaid Services~~, or while an outpatient at a hospital with 100 or fewer licensed beds,~~ shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by paragraph (a), subdivision 1a~~;~~ or 1c, ~~or~~ section 176.1362, 176.1363, or 176.1364, shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower, except as provided in paragraph (e). On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the

payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

(e) The limitation of the employer's liability based on 85 percent of prevailing charge does not apply to charges by an ambulatory surgical center as defined in section 176.1363, subdivision 1, paragraph (b), or a hospital as defined in section 176.1364, subdivision 1, paragraph (e).

(f) For purposes of this chapter, "inpatient" means a patient that has been admitted to a hospital by an order from a physician or dentist. If there is no inpatient admission order, the patient is deemed an outpatient. The hospital must provide documentation of an inpatient order upon the request of the employer.

EFFECTIVE DATE. This section is effective for treatment, articles, and supplies provided on or after October 1, 2018.

Sec. 2. **[176.1365] OUTPATIENT BILLING, PAYMENT, AND DISPUTE RESOLUTION.**

Subdivision 1. **Scope.** This section applies to billing, payment, and dispute resolution for services provided by an ambulatory surgical center (ASC) under section 176.1363 and hospital outpatient services under section 176.1364. For purposes of this section, "insurer" includes self-insured employer and "services" is as defined in section 176.1364.

Subd. 2. **Outpatient billing, coding, and prior notification.** (a) Ambulatory surgical centers and hospitals must bill workers' compensation insurers for services governed by sections 176.1363 and 176.1364 using the same codes, formats, and details that are required for billing the Medicare program, including coding consistent with the American Medical Association Current Procedural Terminology coding system and Medicare's Ambulatory Surgical Center Payment System, Outpatient Prospective Payment System, Outpatient Code Editor, Healthcare Current Procedural Terminology Coding System, and the National Correct Coding Initiative Policy Manual for Medicare Services and associated Web page and tables.

(b) All charges for ASC or hospital outpatient fee schedule services governed by sections 176.1363 and 176.1364 must be submitted to the insurer on the appropriate electronic transaction required by section 176.135, subdivisions 7 and 7a. ASCs must submit charges on the electronic 837P form. ASCs must not separately bill for the services and items included in the ASC facility fee under Code of Federal Regulations, title 42, section 416.164(a). Minnesota Rules, part 5221.4033, subpart 1a, does not apply to ASCs under this section, but does apply to hospital outpatient facility fees to the extent they are not covered by the hospital outpatient fee schedule under section 176.1364.

(c) Hospitals, ASCs, and insurers must comply with the prior notification and approval or authorization requirements specified in Minnesota Rules, part 5221.6050, subpart 9. Prior notification may be provided by either the hospital, ASC, or the surgeon. For purposes of prior notification under Minnesota Rules, part 5221.6050, subpart 9, "inpatient" has the meaning as provided under section 176.136, subdivision 1b, paragraph (d).

(d) ASC or hospital bills must be submitted to insurers as required by section 176.135, subdivisions 7 and 7a, and within the time period required by section 62Q.75, subdivision 3. Insurers must respond to the initial bill as provided in section 176.135, subdivisions 6 and 7a. Copies of any records or reports relating to the items for which payment is sought are separately payable as provided in section 176.135, subdivision 7, paragraph (a).

Subd. 3. **ASC or hospital request for reconsideration; insurer response; time frames.** (a) Following receipt of the insurer's explanation of review (EOR) or explanation of benefits (EOB), the ASC or hospital may request reconsideration of a payment denial or reduction. The ASC or hospital must submit its request for reconsideration in writing to the insurer within one year of the date of the EOR or EOB.

(b) The insurer must issue a written response to the ASC or hospital's request for reconsideration within 30 days, as provided in section 176.135, subdivision 6. The written response must address the issues raised by the request for reconsideration and not simply reiterate the information on the EOR or EOB.

Subd. 4. **Insurer request for reimbursement of overpayment; time frame.** If the payer determines it has overpaid an ASC or hospital's charges based on workers' compensation statutes and rules, the payer must submit its request for reimbursement in writing to the ASC or hospital within one year of the date of the payment.

Subd. 5. **Medical requests for administrative conference; time frame to file.** (a) An ASC, hospital, or insurer must notify the provider or payer, as applicable, of its intent to file a medical request for an administrative conference under section 176.106 at least 20 days before filing one with the department. The insurer, or the ASC or hospital if permitted by section 176.136, subdivision 2, must file the medical request for an administrative conference no later than the latest of:

(1) one year after the date of the initial EOR or EOB if the ASC or hospital does not request a reconsideration of a payment denial or reduction under subdivision 3;

(2) one year after the date of the insurer's response to the ASC or hospital's request for reconsideration under subdivision 3; or

(3) one year after the insurer's request for reimbursement of an overpayment from an ASC or hospital under subdivision 4.

(b) Paragraph (a) does not prohibit an employee from filing a medical request for assistance or claim petition for the payment denied or reduced by the insurer. However, the ASC or hospital may not bill the employee for the denied or reduced payment when prohibited by this chapter.

Subd. 6. **Interest.** (a) An insurer must pay the ASC or hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional ASC or hospital charges following a denial of payment. Interest is payable by the insurer on the additional amount owed from the date payment was due.

(b) An ASC or hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's request for reimbursement of an overpayment. Interest is payable by the ASC or hospital on the amount of the overpayment from the date the overpayment was made.

EFFECTIVE DATE. This section is effective for services provided on or after October 1, 2018.

ARTICLE 4

AMBULATORY SURGICAL CENTERS

Section 1. **[176.1363] AMBULATORY SURGICAL CENTER PAYMENT.**

Subdivision 1. **Definitions.** (a) For the purpose of this section, the terms defined in this subdivision have the meanings given them.

(b) "Ambulatory surgical center" or "ASC" means a facility that is: (1) certified as an ASC by the Centers for Medicare and Medicaid Services; or (2) licensed by the Department of Health as a freestanding outpatient surgical center and not owned by a hospital.

(c) "Conversion factor" means the Medicare ambulatory surgical center payment system (ASCPS) conversion factor used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the quality reporting requirements.

(d) "Covered surgical procedures and ancillary services" means the procedures listed in ASCPS, addendum AA, and the ancillary services integral to covered surgical procedures listed in ASCPS, addendum BB.

(e) "Insurer" includes workers' compensation insurers and self-insured employers.

(f) "Ambulatory surgical center payment system" or "ASCPS" means the system developed by the Centers for Medicare and Medicaid Services for payment of surgical services provided by federally certified ASCs as specified in:

(1) Code of Federal Regulations, title 42, part 416, including without limitation the geographic adjustment for the ASC and the multiple surgical procedure reduction rule;

(2) annual revisions to Code of Federal Regulations, title 42, part 416, as published in the Federal Register;

(3) the corresponding addendum AA (final ASC covered surgical procedures), addendum BB (final covered ancillary services integral to covered surgical procedures), addendum DD1 (final ASC payment indicators), and any successor or replacement addenda; and

(4) the Medicare claims processing manual.

(g) "Medicare ASCPS payment" means the Medicare ASCPS payment used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the Medicare quality reporting requirements.

Subd. 2. **Payment for covered surgical procedures and ancillary services based on Medicare ASCPS.** (a) Except as provided in subdivisions 3 and 4, the payment to the ASC for covered surgical procedures and ancillary services shall be the lesser of:

(1) the ASC's usual and customary charge for all services, supplies, and implantable devices provided; or

(2) the Medicare ASCPS payment, times a multiplier of 320 percent.

(i) The amount payable under this clause includes payment for all implantable devices, even if the Medicare ASCPS would otherwise allow separate payment for the implantable device.

(ii) The 320 percent described in this clause must be adjusted if, on July 1, 2019, or any subsequent July 1, the conversion factor is less than 98 percent of the conversion factor in effect on the previous July 1. When this occurs, the multiplier must be 320 percent times 98 percent divided by the percentage that the current Medicare conversion factor bears to the Medicare conversion factor in effect on the prior July 1. In subsequent years, the multiplier is 320 percent, unless the Medicare ASCPS conversion factor declines by more than two percent.

(b) Payment under this section is effective for covered surgical procedures and ancillary services provided by an ASC on or after October 1, 2018, through September 30, 2019, and shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services Web site as of July 1, 2018, and the corresponding rules and Medicare claims processing manual described in subdivision 1, paragraph (f).

(1) Payment for covered surgical procedures and ancillary services provided by an ASC on or after each subsequent October 1 shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services Web site as of the preceding July 1 and the corresponding rules and Medicare claims processing manual.

(2) If the Centers for Medicare and Medicaid Services has not updated addendum AA, BB, or DD1 on its Web site since the commissioner's previous notice under paragraph (c), the addenda identified in the notice published by the commissioner in paragraph (c) and the corresponding rules and Medicare claims processing manual shall remain in effect.

(3) Addenda AA, BB, and DD1 under this subdivision includes successor or replacement addenda.

(c) The commissioner shall annually give notice in the State Register of any adjustment to the multiplier under paragraph (a), clause (2), and of the applicable addenda in paragraph (b) no later than October 1. The notice must identify and include a link to the

applicable addenda. The notices and any adjustment to the multiplier are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

Subd. 3. **Payment for compensable surgical services not covered under ASCPS.** (a) If a surgical procedure provided by an ASC is compensable under this chapter but is not listed in addendum AA or BB of the Medicare ASCPS, payment must be 75 percent of the ASC's usual and customary charge for the procedure with the highest charge. Payment for each subsequent surgical procedure not listed in addendum AA or BB must be paid at 50 percent of the ASC's usual and customary charge.

(b) Payment must be 75 percent of the ASC's usual and customary charge for a surgical procedure or ancillary service if the procedure or service is listed in Medicare ASCPS addendum AA or BB and: (1) the payment indicator provides it is paid at a reasonable cost; (2) the payment indicator provides it is contractor priced; or (3) a payment rate is not otherwise provided.

Subd. 4. **Study.** The commissioner shall conduct a study analyzing the impact of the reforms, including timeliness and accuracy of payment under this section, and recommend further changes if needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the legislative committees with jurisdiction over workers' compensation by January 15, 2021.

Subd. 5. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.386, paragraph (a), to implement this section and the Medicare ASCPS for workers' compensation. The rules are not subject to expiration under section 14.386, paragraph (b).

EFFECTIVE DATE. This section is effective for procedures and services provided by an ASC on or after October 1, 2018, except subdivision 5 is effective the day following final enactment.

ARTICLE 5

WORKERS' COMPENSATION BENEFITS

Section 1. Minnesota Statutes 2016, section 176.011, subdivision 15, is amended to read:

Subd. 15. **Occupational disease.** (a) "Occupational disease" means a mental impairment as defined in paragraph (d) or physical disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follow as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard. A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of the employment.

(b) If immediately preceding the date of disablement or death, an employee was employed on active duty with an organized fire or police department of any municipality, as a member of the Minnesota State Patrol, conservation officer service, state crime

bureau, as a forest officer by the Department of Natural Resources, state correctional officer, or sheriff or full-time deputy sheriff of any county, and the disease is that of myocarditis, coronary sclerosis, pneumonia or its sequel, and at the time of employment such employee was given a thorough physical examination by a licensed doctor of medicine, and a written report thereof has been made and filed with such organized fire or police department, with the Minnesota State Patrol, conservation officer service, state crime bureau, Department of Natural Resources, Department of Corrections, or sheriff's department of any county, which examination and report negatived any evidence of myocarditis, coronary sclerosis, pneumonia or its sequel, the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. If immediately preceding the date of disablement or death, any individual who by nature of their position provides emergency medical care, or an employee who was employed as a licensed police officer under section 626.84, subdivision 1; firefighter; paramedic; state correctional officer; emergency medical technician; or licensed nurse providing emergency medical care; and who contracts an infectious or communicable disease to which the employee was exposed in the course of employment outside of a hospital, then the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment and the presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors which shall be used to rebut this presumption and which are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability.

(c) A firefighter on active duty with an organized fire department who is unable to perform duties in the department by reason of a disabling cancer of a type caused by exposure to heat, radiation, or a known or suspected carcinogen, as defined by the International Agency for Research on Cancer, and the carcinogen is reasonably linked to the disabling cancer, is presumed to have an occupational disease under paragraph (a). If a firefighter who enters the service after August 1, 1988, is examined by a physician prior to being hired and the examination discloses the existence of a cancer of a type described in this paragraph, the firefighter is not entitled to the presumption unless a subsequent medical determination is made that the firefighter no longer has the cancer.

(d) For the purposes of this chapter, "mental impairment" means a diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist. For the purposes of this chapter, "post-traumatic stress disorder" means the condition as described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. For purposes of section 79.34, subdivision 2, one or more compensable mental impairment claims arising out of a single event or occurrence shall constitute a single loss occurrence.

(e) If, preceding the date of disablement or death, an employee who was employed on active duty as: a licensed police officer; a firefighter; a paramedic; an emergency medical technician; a licensed nurse employed to provide emergency medical services outside of a medical facility; a public safety dispatcher; an officer employed by the state or a political subdivision at a corrections, detention, or secure treatment facility; a sheriff or full-time deputy sheriff of any county; or a member of the Minnesota State Patrol is diagnosed with a mental impairment as defined in paragraph (d), and had not been diagnosed with the mental impairment previously, then the mental impairment is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. This presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors that are used to rebut this presumption and that are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability. The mental impairment is not considered an occupational disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer.

EFFECTIVE DATE. This section is effective for employees with dates of injury on or after January 1, 2019.

Sec. 2. Minnesota Statutes 2016, section 176.101, subdivision 2, is amended to read:

Subd. 2. **Temporary partial disability.** (a) In all cases of temporary partial disability the compensation shall be 66-2/3 percent of the difference between the weekly wage of the employee at the time of injury and the wage the employee is able to earn in the employee's partially disabled condition. This compensation shall be paid during the period of disability except as provided in this section, payment to be made at the intervals when the wage was payable, as nearly as may be, and subject to the maximum rate for temporary total compensation.

(b) Temporary partial compensation may be paid only while the employee is employed, earning less than the employee's weekly wage at the time of the injury, and the reduced wage the employee is able to earn in the employee's partially disabled condition is due to the injury. Except as provided in section 176.102, subdivision 11, paragraphs (b) and (c), temporary partial compensation may not be paid for more than ~~225~~ 275 weeks, or after 450 weeks after the date of injury, whichever occurs first.

(c) Temporary partial compensation must be reduced to the extent that the wage the employee is able to earn in the employee's partially disabled condition plus the temporary partial disability payment otherwise payable under this subdivision exceeds 500 percent of the statewide average weekly wage.

Sec. 3. Minnesota Statutes 2016, section 176.101, subdivision 2a, is amended to read:

Subd. 2a. **Permanent partial disability.** (a) Compensation for permanent partial disability is as provided in this subdivision. Permanent partial disability must be rated as a percentage of the whole body in accordance with rules adopted by the commissioner under section 176.105. The percentage determined pursuant to the rules must be multiplied by the corresponding amount in the following table:

Impairment Rating (percent)	Amount
less than 5.5	$ ~~75,000~~ 78,800
5.5 to less than 10.5	~~80,000~~ 84,000
10.5 to less than 15.5	~~85,000~~ 89,300
15.5 to less than 20.5	~~90,000~~ 94,500
20.5 to less than 25.5	~~95,000~~ 99,800
25.5 to less than 30.5	~~100,000~~ 105,000
30.5 to less than 35.5	~~110,000~~ 115,500
35.5 to less than 40.5	~~120,000~~ 126,000
40.5 to less than 45.5	~~130,000~~ 136,500
45.5 to less than 50.5	~~140,000~~ 147,000
50.5 to less than 55.5	~~165,000~~ 173,300
55.5 to less than 60.5	~~190,000~~ 199,500
60.5 to less than 65.5	~~215,000~~ 225,800
65.5 to less than 70.5	~~240,000~~ 252,000
70.5 to less than 75.5	~~265,000~~ 278,300
75.5 to less than 80.5	~~315,000~~ 330,800
80.5 to less than 85.5	~~365,000~~

	383,300
85.5 to less than 90.5	~~415,000~~
	435,800
90.5 to less than 95.5	~~465,000~~
	488,300
95.5 up to and including 100	~~515,000~~
	540,800

An employee may not receive compensation for more than a 100 percent disability of the whole body, even if the employee sustains disability to two or more body parts.

(b) Permanent partial disability is payable upon cessation of temporary total disability under subdivision 1. If the employee requests payment in a lump sum, then the compensation must be paid within 30 days. This lump-sum payment may be discounted to the present value calculated up to a maximum five percent basis. If the employee does not choose to receive the compensation in a lump sum, then the compensation is payable in installments at the same intervals and in the same amount as the employee's temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid.

Sec. 4. Minnesota Statutes 2016, section 176.101, subdivision 4, is amended to read:

Subd. 4. **Permanent total disability.** For permanent total disability, as defined in subdivision 5, the compensation shall be 66-2/3 percent of the daily wage at the time of the injury, subject to a maximum weekly compensation equal to the maximum weekly compensation for a temporary total disability and a minimum weekly compensation equal to 65 percent of the statewide average weekly wage. This compensation shall be paid during the permanent total disability of the injured employee but after a total of $25,000 of weekly compensation has been paid, the amount of the weekly compensation benefits being paid by the employer shall be reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are occasioned by the same injury or injuries which give rise to payments under this subdivision. This reduction shall also apply to any old age and survivor insurance benefits. Payments shall be made at the intervals when the wage was payable, as nearly as may be. In case an employee who is permanently and totally disabled becomes an inmate of a public institution, no compensation shall be payable during the period of confinement in the institution, unless there is wholly dependent on the employee for support some person named in section 176.111, subdivision 1, 2 or 3, in which case the compensation provided for in section 176.111, during the period of confinement, shall be paid for the benefit of the dependent person during dependency. The dependency of this person shall be determined as though the employee were deceased. Permanent total disability shall cease at age ~~67 because the employee is presumed retired from the labor market~~ 72, except that if an employee is injured after age 67, permanent total disability benefits shall cease after five years of those benefits have been paid. ~~This presumption is rebuttable by the employee. The subjective statement the employee is not retired is not sufficient in itself to rebut the presumptive evidence of retirement but may be considered along with other evidence.~~

Sec. 5. Minnesota Statutes 2016, section 176.102, subdivision 11, is amended to read:

Subd. 11. **Retraining; compensation.** (a) Retraining is limited to 156 weeks. An employee who has been approved for retraining may petition the commissioner or compensation judge for additional compensation not to exceed 25 percent of the compensation otherwise payable. If the commissioner or compensation judge determines that this additional compensation is warranted due to unusual or unique circumstances of the employee's retraining plan, the commissioner may award additional compensation in an amount not to exceed the employee's request. This additional compensation shall cease at any time the commissioner or compensation judge determines the special circumstances are no longer present.

(b) If the employee is not employed during a retraining plan that has been specifically approved under this section, temporary total compensation is payable for up to 90 days after the end of the retraining plan; except that, payment during the 90-day period

is subject to cessation in accordance with section 176.101. If the employee is employed during the retraining plan but earning less than at the time of injury, temporary partial compensation is payable at the rate of 66-2/3 percent of the difference between the employee's weekly wage at the time of injury and the weekly wage the employee is able to earn in the employee's partially disabled condition, subject to the maximum rate for temporary total compensation. Temporary partial compensation is not subject to the ~~225-week~~ 275-week or 450-week limitations provided by section 176.101, subdivision 2, during the retraining plan, but is subject to those limitations before and after the plan.

(c) Any request for retraining shall be filed with the commissioner before 208 weeks of any combination of temporary total or temporary partial compensation have been paid. Retraining shall not be available after 208 weeks of any combination of temporary total or temporary partial compensation benefits have been paid unless the request for the retraining has been filed with the commissioner prior to the time the 208 weeks of compensation have been paid.

(d) The employer or insurer must notify the employee in writing of the 208-week limitation for filing a request for retraining with the commissioner. This notice must be given before 80 weeks of temporary total disability or temporary partial disability compensation have been paid, regardless of the number of weeks that have elapsed since the date of injury. If the notice is not given before the 80 weeks, the period of time within which to file a request for retraining is extended by the number of days the notice is late, but in no event may a request be filed later than 225 weeks after any combination of temporary total disability or temporary partial disability compensation have been paid. The commissioner may assess a penalty of $25 per day that the notice is late, up to a maximum penalty of $2,000, against an employer or insurer for failure to provide the notice. The penalty is payable to the commissioner for deposit in the assigned risk safety account.

Sec. 6. Minnesota Statutes 2016, section 176.83, subdivision 5, is amended to read:

Subd. 5. **Treatment standards for medical services.** (a) In consultation with the Medical Services Review Board or the rehabilitation review panel, the commissioner shall adopt rules establishing standards and procedures for health care provider treatment. The rules shall apply uniformly to all providers including those providing managed care under section 176.1351. The rules shall be used to determine whether a provider of health care services and rehabilitation services, including a provider of medical, chiropractic, podiatric, surgical, hospital, or other services, is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate under section 176.135, subdivision 1, based upon accepted medical standards for quality health care and accepted rehabilitation standards.

(b) The rules shall include, but are not limited to, the following:

(1) criteria for diagnosis and treatment of the most common work-related injuries including, but not limited to, low back injuries and upper extremity repetitive trauma injuries;

(2) criteria for surgical procedures including, but not limited to, diagnosis, prior conservative treatment, supporting diagnostic imaging and testing, and anticipated outcome criteria;

(3) criteria for use of appliances, adaptive equipment, and use of health clubs or other exercise facilities;

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization;

(6) criteria for treatment of chronic pain; ~~and~~

(7) criteria for the long-term use of opioids or other scheduled medications to alleviate intractable pain and improve function, including the use of written contracts between the injured worker and the health care provider who prescribes the medication~~.~~; and

(8) criteria for treatment of post-traumatic stress disorder. In developing such treatment criteria, the commissioner and the Medical Services Review Board shall consider the guidance set forth in the American Psychological Association's most recently

adopted Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. The commissioner shall adopt such rules using the expedited rulemaking process in section 14.389, including subdivision 5, to commence promptly upon final enactment of the legislation enacting this clause. Such rules shall apply to employees with all dates of injury who receive treatment after the commissioner adopts the rules. In consultation with the Medical Services Review Board, the commissioner shall review and update the rules governing criteria for treatment of post-traumatic stress disorder each time the American Psychological Association adopts a significant change to their Clinical Practice Guideline for the Treatment of PTSD in Adults, using the expedited rulemaking process in section 14.389, including subdivision 5.

(c) If it is determined by the payer that the level, frequency, or cost of a procedure or service of a provider is excessive, unnecessary, or inappropriate according to the standards established by the rules, the provider shall not be paid for the procedure, service, or cost by an insurer, self-insurer, or group self-insurer, and the provider shall not be reimbursed or attempt to collect reimbursement for the procedure, service, or cost from any other source, including the employee, another insurer, the special compensation fund, or any government program unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency, or cost was not excessive under the rules in which case the insurer, self-insurer, or group self-insurer shall make the payment deemed reasonable.

(d) A rehabilitation provider who is determined by the rehabilitation review panel board, after hearing, to be consistently performing procedures or providing services at an excessive level or cost may be prohibited from receiving any further reimbursement for procedures or services provided under this chapter. A prohibition imposed on a provider under this subdivision may be grounds for revocation or suspension of the provider's license or certificate of registration to provide health care or rehabilitation service in Minnesota by the appropriate licensing or certifying body. The commissioner and Medical Services Review Board shall review excessive, inappropriate, or unnecessary health care provider treatment under section 176.103.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 7. **EFFECTIVE DATE.** Unless otherwise specified, this article is effective for employees with dates of injury on or after October 1, 2018.

Presented to the governor May 18, 2018

Signed by the governor May 20, 2018, 3:32 p.m.

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REHABILITATION: REQUIREMENTS OF STATUTE AND RULE

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REHABILITATION: REQUIREMENTS OF STATUTE AND RULE
TABLE OF CONTENTS

I. INTRODUCTION

A. Evolution of Rehabilitation

The concept of state-regulated and monitored rehabilitation assistance to injured workers came into existence in 1979. Prior to that time, there was no statutory requirement for the provision of rehabilitation services. Retraining was allowed, but only if the Division of Vocational Rehabilitation had certified a retraining plan for an injured worker.

In 1979, the Legislature enacted Minn. Stat. §176.102, which provided for a mandatory system of rehabilitation assistance. This assistance included direct job placement, on-the-job training, or formal retraining. Once an injured worker was off work for more than 60 days, or more than 30 days if the injury was to the low back, the employee was entitled to receive rehabilitation benefits and the assignment of a qualified rehabilitation consultant (QRC).

Effective October 1, 1992, the system of mandatory rehabilitation was changed. The same types of rehabilitation services are still potentially available to injured workers. However, the employee is not necessarily entitled to rehabilitation assistance in every case. Rather, the employee is entitled to a *rehabilitation consultation* upon request or upon the establishment of certain requirements. *See* Minn. Stat. §176.102, subd. 4(a) (1992). This change has been interpreted by the Workers' Compensation Court of Appeals ("WCCA") to be "procedural" in nature. Therefore, the 1992 changes, entitling the employee to a rehabilitation consultation by request, apply to all cases regardless of the date of injury. *Henrich v. Crane Creek Asphalt of Owatonna*, slip op. (WCCA 1995).

B. Goal of Rehabilitation

Minn. Stat. §176.102, subd. 1(b) provides the guiding principle for the rehabilitation process. That provision states:

> Rehabilitation is intended to restore the injured employee so the employee may return to a job related to the employee's former employment or to a job in another work area which produces an economic status as close as possible to that the employee would have enjoyed without the disability. Rehabilitation to a job with a higher economic status than would have occurred without disability is permitted if it can be demonstrated that this rehabilitation is necessary to increase the likelihood of reemployment. Economic status is to be measured not only by opportunity for immediate income but also by opportunity for future income.

The general purpose of rehabilitation is to "arm injured workers who are disabled from returning to their pre-injury jobs with the skills required to return them to jobs related to their former employment or to jobs that produce an economic status as close as possible to that which the employee would have enjoyed without

the disability and also to encourage injured workers to increase their employability by acquiring such skills through training or retraining." *Jerde v. Adolfson & Peterson*, 484 N.W.2d 793 (Minn. 1992), *quoting Langa v. Fleischmann-Kurth Malting Company*, 481 N.W.2d 35 (Minn. 1992).

II. ELIGIBILITY FOR REHABILITATION

Prior to the 1992 legislative changes, an employee was entitled to rehabilitation assistance after remaining off work for a certain period of time following an injury. Such automatic and mandatory rehabilitation is no longer required. Instead, the State has devised a system by which it claimed an intent to look at cases more individually and determine whether rehabilitation assistance is necessary in a given case. This monitoring by the State requires, in return, a level of reporting by employers, insurers, and employees that had not been required previously.

When the Commissioner has received notice or information that an employee has sustained an injury that may be compensable under the chapter, the Commissioner is to notify the injured employee of the right to request a rehabilitation consultation to assist in return to work. Minn. Stat. §176.102, subd. 4(a). This notice may be included in other information the Commissioner gives to the employee under Minn. Stat. §176.235 and must be highlighted in a way to draw the employee's attention to it.

An employee is not eligible for a rehabilitation consultation or rehabilitation services if he or she has been able to return to former employment without residual disability or restrictions. *Lewis v. Honeywell, Inc*., slip op. (WCCA 1995); *see Kautz v. Setterlin Company*, 410 N.W.2d 843 (Minn. 1987). The WCCA has held, consistently, that "[r]ehabilitation assistance is available so long as the employee is precluded from engaging in the same work that [s]he was engaged in at the time of the injury." *Richardson v. Unisys Corp.*, 44 W.C.D. 199 (WCCA 1990); *Schramel v. Belgrade Nursing* Home, No. WC14-5749 (WCCA 2015). Likewise, the employee may not be entitled to a rehabilitation consultation or services if employers and insurers successfully assert other defenses with regard to threshold liability issues such as complete recovery from the injury, lack of causal relationship, lack of notice, the expiration of the Statute of Limitations, and refusal of suitable employment. *Judnick v. Sholom Home Rest*, slip op. (WCCA 1995); *Simonsen v. University of Minnesota*, slip op. (WCCA 2000); *Del Rio v. Luiginos, Inc.*, slip op. (WCCA 2000). *See also Brew v. College of St. Scholastica*, slip op. (WCCA 2003) (initial rehabilitation consultation was denied on the basis that the employee's work injury was no longer a substantial contributing factor in his ongoing condition or alleged disability — the employee's complaints related to his deconditioned status and postural fatigue); *DeRosier v. Albrecht Co., Inc.*, slip op. (WCCA 1999) ("an employee's request for a rehabilitation consultation may be challenged on the basis that the employee has no underlying entitlement to benefits...Possible defenses and threshold liability issues include allegations of complete recovery from injury, lack of notice, and the expiration of the statute of limitations...The employer and insurer's contention that the employee has fully recovered from a temporary injury, and has been released to return to work with no residual disability or restrictions, is such a defense.")

A. Disability Status Report

1. Statute: Minn. Stat. §176.102, subd. 4(b) (1992)

In order to assist the Commissioner in determining whether to request a rehabilitation consultation for an employee, an employer is required to notify the Commissioner whenever the employee's temporary total disability will likely exceed 13 weeks. The notification must be made within 90 days from the date of the injury, or when the likelihood of at least a 13-week disability can be determined, whichever is earlier. The notice must include a "current physician's report." Minn. Stat. §176.102, subd. 4(b) (1992).

2. Rule: Minn. R. 5220.0110, subp. 7 (1993)

The method established by the Department of Labor and Industry to notify it of the potential need for rehabilitation is the Disability Status Report ("DSR"). A copy of the current report is included in the Appendix to these materials.

The insurer is required to file a DSR to notify the Commissioner of a referral for rehabilitation or to request a waiver of rehabilitation services. When the employee has *not* returned to work following an injury, the insurer *shall* complete a DSR, file it with the Commissioner, and serve a copy on the employee in the following instances:

1. Within 14 calendar days after it becomes known that the temporary total disability will likely exceed 13 cumulative weeks;

2. Within 90 calendar days of the date of injury when the employee has not returned to work following a work injury; or

3. Within 14 calendar days after receiving a request for rehabilitation consultation, whichever is earlier.

Further, when a waiver of rehabilitation services has been granted, the insurer shall complete, serve, and file another DSR within 14 days of the expiration of the waiver. The requirement for an insurer to file a DSR 180 days after the injury if no party has requested a rehabilitation consultation and the employee has not returned to work has been removed from the statute. A DSR is also required following each request for a rehabilitation consultation. Minn. R. 5220.0110, subp. 7(A)(2005).

The DSR must contain certain information. The information required by Minn. R. 5220.0110, subp. 7(B)(1993) is as follows:

1. Identifying information on the employee, employer, and insurer;

2. Information about the duration of disability and the likelihood that the disability will extend beyond 13 weeks;

3. The current work status of the employee;

4. An indication of whether the employer will return the employee to work (for waiver purposes);

5. Information about accommodations or services being provided to the employee to assist in the return to the date-of-injury employer;

6. An indication of whether a rehabilitation consultation is occurring or a request for a waiver of consultation is being made;

7. If a rehabilitation consultation is indicated, the name of the qualified rehabilitation consultant who will conduct the rehabilitation consultation; and

8. A current treating physician's work ability report must be attached to the form.

The WCCA has determined that an insurer is also required to file a DSR when the employee *is* working and the employee has requested a rehabilitation consultation. *See Cortez v. Heartland Foods*, slip op. (WCCA 1995). An insurer *may* file a DSR when the employee is working and may or may not return to suitable gainful employment within 180 days of the date of injury. This latter aspect is voluntary and, once again, it is apparently designed to inform the Commissioner of the status of the employee and whether a rehabilitation consultation should be ordered.

B. Rehabilitation Consultation

A rehabilitation consultation must be provided by the employer to an injured employee upon request of the employee, the employer, or Commissioner. Minn. Stat. §176.102, subd. 4(a) (1992).

This provision requires the provision of a rehabilitation consultation upon request. However, an employer may be exempt from the requirements of that provision if a *timely* request for waiver is filed. *Wagner v. Bethesda Hospital*, slip op. (WCCA 1995). A request for a waiver can be made after the employee requests a rehabilitation consultation by submitting a DSR and requesting a waiver.

It is *not* a defense to a request for a rehabilitation consultation that the employee is not a qualified employee for rehabilitation services. *Id*. *See also Gibbs v. The Duluth Clinic, Ltd.*, slip op. (WCCA 1998). However, as indicated above, an employee is not eligible for a rehabilitation consultation or rehabilitation services if:

- The employee has been able to return to former employment without residual disability or restrictions. *Lewis v. Honeywell, Inc.*, slip op. (WCCA 1995); *see Kautz v. Setterlin Company*, 410 N.W.2d 843 (Minn. 1987)

- The employers and insurers can successfully assert other defenses with regard to threshold liability issues such as complete recovery from the injury, lack of causal relationship, lack of notice, the expiration of the Statute of Limitations, and refusal of suitable employment. *Judnick v. Sholom Home Rest*, slip op. (WCCA 1995); *DeRosier v. Albrecht Co., Inc.*, slip op. (WCCA 1999); *Simonsen v. University of Minnesota*, slip op. (WCCA 2000); *Del Rio v. Luiginos, Inc.*, slip op. (WCCA 2000); *Brew v. College of St. Scholastica,* slip op. (WCCA 2003); *Hoffman v. Timberline Sports N Convenience*, slip op (WCCA 2015)

The WCCA has, on several occasions, addressed the requirement for a rehabilitation consultation:

- In *Dobson v. Northwest Mechanical Service*, slip op. (WCCA 1999), the employee complained of injuries to his knees, and, on a couple of occasions he was restricted from work. His treating physician then wrote a report indicating that he did not think restrictions were "justified." However, the doctor also indicated that the employee should consider a vocational change to a job involving less repetitive squatting and kneeling activities. The WCCA affirmed Compensation Judge Mesna's award of a rehabilitation consultation. The WCCA rejected the insurer's argument that a consultation was not justified as the employee had been released to work without restrictions and was working without a wage loss. The WCCA held that "the question of whether an employee has sufficient restrictions on his activities to justify the need for a rehabilitation consultation is a fact question that is left to the compensation judge." Further, it held that formal medical restrictions are not necessary, and that a judge may rely on the employee's testimony regarding the ability to perform work following an injury.

- In *Dahl v. Homecrest Industries, Inc.*, slip op. (WCCA 1999), the employee sustained an injury and was disabled for a couple of months. He returned to work for the employer, and he was given rehabilitation assistance to help with that return to work. The employer was willing to accommodate the restrictions, and the QRC closed her file. Sometime later, the employee sought a rehabilitation consultation, although he was still working at the employer. Compensation Judge Kelly awarded the rehabilitation consultation, and the WCCA affirmed. An injured employee is entitled to a rehabilitation consultation upon the request of the employee as a matter of law. Minn. Stat. §176.102, subd. 4(a). The WCCA rejected the employer's argument that since the employee had returned to work in his pre-injury job with the employer, he did not meet the criteria for a "qualified employee." The employee's eligibility for statutory rehabilitation services was not at issue in determining entitlement to a

rehabilitation consultation. *See Wagner*. Since the employee was continuing to have symptoms and had restrictions, the fact that he had returned to work in his pre-injury job does not mean that he may not be entitled to rehabilitation services.

- In *Frazier v. RNW Associates*, slip op. (WCCA 1999), the employee sustained an injury, underwent treatment, was taken off work for a time, and was eventually released to work without restrictions. No modifications were made to his pre-injury job. He continued to have symptoms. He then quit his job and testified that he did so due to a denial of a requested raise and the physical demands of the job aggravating his injury. He continued to have symptoms while working for a new employer. He sought a rehabilitation consultation. The insurer denied the claim, arguing that the employee was not entitled to the consultation as his treating doctor released the employee to return to work without restrictions, the employee returned to work with the employer and worked at his pre-injury job for seven months, and he voluntarily terminated his employment to work as an independent contractor with another employer. Compensation Judge Knight awarded a rehabilitation consultation and the WCCA affirmed, observing that the question of whether an employee has sufficient restrictions or limitations on his activities to justify a rehabilitation consultation is a fact question for the compensation judge. The judge can rely on evidence from a health care provider who has issued formal restrictions on the employee's ability to work. The assignment of formal restrictions, however, is not a prerequisite to an award of a rehabilitation consultation. A lack of specific restrictions does not mean the employee has made a complete recovery from the injury. The compensation judge may rely on the testimony of the employee about his ability to work following the injury.

- In *Sether v. Wherley Motors, Inc.*, slip op. (WCCA 1999), the employee had an admitted work-related injury in the form of a heart attack in 1994. He had treatment, which was paid by the employer and insurer. He again had symptoms and treatment between 1997 and 1998. The medical records cast doubt as to whether the injury was a substantial contributing cause of the employee's symptoms and need for treatment. The employee filed medical requests for coverage of the treatment and a rehabilitation request seeking a rehabilitation consultation. Compensation Judge Bonovetz denied the employee's request for a rehabilitation consultation, specifically finding that the work injury was not a substantial contributing cause of the employee's need for treatment in 1997-1998, and therefore, it was not a substantial contributing cause for the need for a rehabilitation consultation. The WCCA affirmed the denial of medical treatment in 1997-1998, but remanded on the rehabilitation consultation issue. The WCCA noted that the employer had not filed a request for waiver of the rehabilitation consultation and on that basis alone, the employee should be allowed to undergo the consultation. The employer and insurer argued that the compensation judge did not find that the employee was restricted or unable to continue in his normal job duties as a result of the injury. The

WCCA noted that while the employee had returned to work in his normal job duties as of 1994, the record showed adjustments the employee personally had to make to cope with his job-related stress and psychological counseling the employee had to undertake as a result of that stress. The employer and insurer further argued that it was appropriate for the judge to deny a rehabilitation consultation in situations in which the employee has not shown any underlying entitlement to benefits. The WCCA, however, observed that the judge did not specifically state that the employee was not entitled to any workers' compensation benefits, and did not specifically address whether the employee had any residual effects from his 1994 injury, which could constitute a need for a rehabilitation consultation at this point. The WCCA remanded.

- Most recently, in *Hoffman v. Timberline Sports N Convenience*, slip op. (WCCA 2015), the employee sustained a right knee injury in the form of an aggravation of a preexisting degenerative condition and a temporary consequential injury to her left foot. Compensation Judge Wolkoff held that the employee had no employment restrictions from the work injury and, on that basis, denied the employee's claim for a rehabilitation consultation. The WCCA affirmed, holding that an employee must at least have restrictions to be entitled to a rehabilitation consultation, and "[a] determination that the employee has completely recovered from the work injury or has no employment restrictions from the injury may defeat a claim for a rehabilitation consultation."

C. Rehabilitation Services

Provision of rehabilitation services, other than the initial rehabilitation consultation, is required only if the employee is eligible for rehabilitation assistance under Minn. Stat. §176.102 and rules adopted by the Commissioner. *Pelland v. Gillette Company*, slip op. (WCCA 1995). *See* Minn. Stat. §176.102, subd. 4; Minn. R. 5220.0100, subp. 22.

In order for rehabilitation services to be compensable, the employee must be found to be a qualified employee. Pursuant to Minn. R. 5220.0100, subp. 22, a qualified employee is an employee who, because of the effects of a work-related injury or disease, whether or not combined with the effects of a prior injury or disability, meets the following requirements:

1. The employee is permanently precluded or is likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury;

2. The employee cannot reasonably be expected to return to suitable gainful employment with the date-of-injury employer; and

3. The employee can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability.

The issue of the employee's eligibility for rehabilitation services has been the subject of numerous court decisions. In situations in which the employer has continually cooperated with the employee's treatment and accommodated physical restrictions, allowing the employee to work with minimal time loss, the WCCA has generally concluded that a determination regarding whether the employee is a qualified employee for rehabilitation services is premature. *See Lopez v. Best Western Northwest Inn*, slip op. (WCCA 1995); *Cortez v. Heartland Foods*, slip op. (WCCA 1995). Once again, however, each case must be viewed on its own merits to determine whether the employee can meet the requirements of the rule and, therefore, be eligible for rehabilitation services. For example:

- In *Jordan v. Howard Lumber Company*, slip op. (WCCA 1997), the employee sought rehabilitation benefits. Compensation Judge Barnett did not permit submission of the employer/insurer's IME report. Pursuant to Minn. Rule 5220.0100, subp. 22(C), a qualified employee is an injured employee who can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, *considering the treating physician's opinion of the employee's work ability*. The compensation judge determined that the IME report was irrelevant based on that rule. The WCCA reversed. There is nothing in the rule that limits the evidence *solely* to the treating doctor's records, nor does the rule require the exclusion of an opinion from a medical provider other than the treating physician. Based on the rule, it is the employee's burden to initially establish eligibility for rehabilitation services by showing that based on the treating doctor's opinion of the employee's work ability, a return to suitable gainful employment is likely with the provision of rehabilitation services. The employer and insurer may then present evidence to rebut the employee's claim, including the submission of medical evidence inconsistent with or contrary to the treating doctor's opinions.

- In *Cornejo v. Release Coatings of Minneapolis*, 58 W.C.D. 348 (WCCA 1998), Compensation Judge Dallner ruled that the employee was a qualified employee and found him eligible to receive rehabilitation services. The WCCA ruled that the decision was "premature" and vacated the judge's decision. It found that although the effects of the work injury most likely would result in an inability to return to the employee's pre-injury job, it was unclear whether the other requirements of the eligibility rule (Minn. Rule 5220.0100, subp. 22) had been met. That is, it was uncertain whether the employee would be able to return to suitable employment with the date-of-injury employer and whether the employee could reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services. The WCCA cited the fact that the record provided neither an indication as to what the employee's permanent restrictions were likely to be nor any physician's opinion as to

the employee's probable post-surgery ability to perform the various job assignments available in the employer's plant. It ruled, therefore, that the award of rehabilitation assistance was premature. The Minnesota Supreme Court affirmed the result, but remanded at the end of the appellate process to determine if the rehabilitation was appropriate at that time. *See Cornejo v. Release Coatings of Minneapolis*, 582 N.W.2d 549 (Minn. 1998) (a rehabilitation determination should be made when the nature and extent of permanent disability and its effect on the employee are known). *See also Langa v. Fleischmann-Kurth Malting Co.*, 481 N.W.2d 35 (Minn. 1992).

- In *Dvorak v. Lutheran Home and Church*, slip op. (WCCA 1998), the employee was working as a part-time nurse's aide while still in high school when she sustained a chronic spine strain. Her treating doctor put her on restrictions of no more than four hours per day, work no more than two days in a row, and additional physical restrictions. The employer accommodated the restrictions. The employee sought a rehabilitation consultation which was allowed, and the QRC recommended provision of rehabilitation services. Compensation Judge Jansen approved the rehabilitation plan. The QRC had determined that although the employee was only working part-time at the time of her injury, her aspiration for full-time employment should be considered in determining her entitlement to rehabilitation services. The WCCA reversed, noting that the employee was likely to be permanently precluded from performing the job she held at the time of her injury, which is one of the criteria for allowing rehabilitation services. However, the notion that the employee would benefit from rehabilitation services based on her prior aspirations was not supported by the record. The employer had provided the employee with as many hours as she could work within her restrictions and noted they could accommodate the employee up to 40 hours a week even if she couldn't lift more than five pounds; however, the treating doctor's restrictions severely limited the employee's work hours. The employee testified that the employer accommodated her medical restrictions in every respect and her current employment situation is ideal. Although part-time employment may not be considered suitable gainful employment for the employee indefinitely, for now it is all that she is capable of performing.

- In *Keaveny v. Hennepin County*, slip op. (WCCA 2000), the employee sustained an admitted work injury on June 30, 1994. The employer provided a disability case manager and was able to keep the employee working in modified capacities without wage loss until January 1999. At that time, the employee's job was changed, but her salary remained in excess of the pre-injury wage. The employee sought a rehabilitation consultation, which was granted. The QRC opined that the employee was a qualified employee for rehabilitation services. The employer objected. Thereafter, the employee sustained a flare-up of her condition and was kept working in a modified, part-time basis until the hearing in October 1999. The compensation judge determined that the employee was a qualified employee entitled to statutory rehabilitation services, and the WCCA affirmed. The employer argued pursuant to Minn. Rule

5220.0100, subp. 22 that the employee was not a qualified employee, as she failed to meet the requirement that she could not reasonably be expected to return to suitable gainful employment with the date-of-injury employer. The employer pointed out that it had continued to employ the employee for over five years after the injury, and that it was willing to provide a disability case manager to assist in making appropriate modifications to the job. The WCCA determined that rehabilitation services in the form of medical management were necessary to coordinate the employee's work efforts with the treating physician's restrictions. "The fact that it is the express desire of the parties and the goal of the rehabilitation plan to return the employee to employment with her date-of-injury employer does not automatically render the employee ineligible for statutory rehabilitation services." At a point five years after the original injury, the employee was still having physical problems, and she was only employed in a part-time capacity. Questions still existed as to whether the job was "suitable."

- In *Hanson v. Bagley Hardwood Products, Inc.*, slip op. (WCCA 2002), the employee sustained an admitted injury to her right hand on July 18, 1997. She underwent two surgeries and follow-up therapy. She was released to return to work by her treating surgeon without restrictions. She was rated and paid PPD for her injury. She was evaluated by two other physicians, one on referral of her treating surgeon and another at the request of the insurer. Both doctors concluded that she could return to work without restrictions. The employee sought rehabilitation services. The insurer allowed a consultation, but denied the request for ongoing rehabilitation services, contending that she was not a qualified employee. Compensation Judge Kelly awarded rehabilitation services, despite the absence of written restrictions and relying primarily on the employee's testimony of her symptoms. The WCCA affirmed. It ruled that based on prior case law, an employee's testimony alone can be the basis for finding that the employee has a disability which restricts or limits his or her ability to work. It also ruled that Minn. Rule 5220.0100, subp. 22(C), which requires the "treating physician's opinion of the employee's work ability," only states that it is to be "considered" in determining whether an employee can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services. The WCCA ruled that the provision does not explicitly state that an employee cannot be found eligible for rehabilitation services in the absence of specific written restrictions.

  See also Medlock v. Masterson Personnel, No. WC14-5732 (WCCA 2015).

- In *Hussein v. University of Minnesota*, File No. WC04-141 (WCCA 2004), the WCCA observed that the rehabilitation eligibility rules require something more than a mere uncertainty as to an employee's prospects for suitable work in the absence of rehabilitation services for those proposed services to be compensable. In *Hussein*, the employee sustained an admitted injury which resulted in a claim for a deQuervain's release. An

IME opined that there was no evidence of any ongoing injury, that the proposed surgery was not reasonable or necessary, and that the employee could return to work without restrictions. The employee retained a QRC, who filed a rehabilitation request seeking approval of a rehabilitation plan outlining a goal of obtaining the recommended surgery, post-surgery disability, and return to work with the date of injury employer. Compensation Judge Culnane awarded the rehabilitation plan and surgery. The WCCA reversed, holding that the employee was not a qualified employee pursuant to Minn. R. 5220.0110, subp. 22. That rule provides that a qualified employee means an employee who, because of the effects of a work-related injury or disease, whether or not combined with the effects of a prior injury or disability: (1) is permanently precluded or likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of the injury; (2) cannot reasonably be expected to return to suitable gainful employment with the date-of-injury employer; and (3) can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability. The WCCA held that the employee was not a qualified employee because he had been working at his usual and customary occupation with the employer since the injury and because the QRC testified the job was suitable, notwithstanding the fact that the employee performed his work duties with pain and restrictions. The WCCA noted that while the QRC was concerned about the employee's long-term prospects to continue working at the job because of his symptoms, the rehabilitation eligibility rules require something more than a mere uncertainty as to the employee's prospects for suitable work.

- In *Holt v. Ford Motor Company*, File No. WC07-181 (WCCA 2007), the employee sustained injuries to his right shoulder, which were accepted as compensable. Following the injuries, the employee began a work conditioning program and was working with his QRC. He eventually returned to work for the employer. He subsequently requested a change of QRC. However, the employee signed a special termination of employment agreement. He took a buyout in anticipation of the employer's eventual closing of the plant. Following that, he began working as a car salesman. The employee requested ongoing rehabilitation services. At hearing before Compensation Judge Culnane, it was determined that the employee remained a qualified employee for rehabilitation services. The WCCA affirmed. The WCCA indicated that it was undisputed that the employee continued to have restrictions affecting the use of his right arm. It was further noted that he could not return to the job he was performing at the time of the injury. The WCCA indicated that there was no reason to distinguish a case such as this (where the employee accepted a buyout) from those who terminated employment or were terminated for misconduct. The WCCA had previously held that "whether an employee is employed, voluntarily terminates its employment, retires or relocates, does not terminate his or her entitlement to rehabilitation services." *Erickson v.*

City of St. Paul, File No. WC06-258 (WCCA 2007). Therefore, the award of rehabilitation services was affirmed.

- In *Farnsworth v. Northwest Airlines Corp.*, File No. WC08-107 (WCCA 2008), the employee suffered repeated injuries with the employer, the last of which was to his elbows and occurred in December 1986. He was given restrictions that precluded him from returning to his regular job, but the employer provided him a job within his restrictions until he was laid off in June 2005 (the layoff was unrelated to the restrictions). After trying unsuccessfully to find suitable gainful employment, the employee met with a QRC for a rehabilitation consultation. The employee's treating physician indicated that the employee should have permanent restrictions. However, after a review of the medical records and an examination of the employee, an IME opined that the employee did not require restrictions for his upper extremities. At a formal hearing the compensation judge adopted the opinions of the IME doctor and found that the employee was not a qualified employee because he did not have restrictions secondary to his work injury, and therefore was not entitled to rehabilitation services. The employee appealed, arguing that the judge can only consider the treating physicians opinion as to the employee's work ability. The WCCA affirmed the decision stating that in resolving this issue the compensation judge may consider all evidence, including the opinions of the IME.

- In *Conklin v. Becker County Developmental Achievement Center*, slip op. (WCCA 2011), the WCCA affirmed Compensation Judge Behounek's determination that the employee was not a qualified employee and therefore not eligible for rehabilitation services. The WCCA held that, implicit in a determination of whether an employee is likely to be permanently precluded form a customary occupation or pre-injury job, is a determination of whether or not the employee has restrictions. The WCCA specifically held that, absence restrictions, an employee is not a qualified employee. Here, the employee's only restriction was "no jumping." The employee's pre-injury job and customary occupation did not require jumping.

- In *Goetzinger v. K-Mart Corp.*, File N. WC13 (WCCA 2013), the employee sustained an injury in 1983, which prohibited her from returning to her pre-injury employment and resulted in permanent restrictions. Between 1983 and 2012, the employee held various jobs, quitting her last full-time position in 2012 because she felt it was outside her restrictions. She then sought a rehabilitation consultation and rehabilitation services, and then found a part-time job. The WCCA agreed with the compensation judge that the employee was eligible for rehabilitation services. One of the employer/insurer's arguments was that the employee was not entitled to rehabilitation services because no wage replacement was due, as the employee's current earnings exceeded her pre-injury wage. The WCCA held that, while wage replacement is based on mathematical calculations, when looking at eligibility for rehabilitation services, the issue is analyzed differently and involves a comparison of the employee's pre- and post-

injury economic status. *See Tottenham.* The WCCA emphasized that the fact that the employee was making more than she did in 1983 was not dispositive. Rather, the WCCA indicated that the issue required analysis of the employee's wages, benefits, opportunity for income and advancement, and other employment-related factors, as a whole, put the employee in a satiation as close as possible to that she would have enjoyed without disability. In this case, lack of employer-funded health insurance and consideration of cost of living increases were factors considered in finding her eligible for services. Further, the WCCA confirmed that the fact that the employee voluntarily quit her last job did not preclude her from receiving rehabilitation benefits. *See Johnson v. State, Dep't of Veterans Affairs.*

- In *Huderle v. Sanford Clinic Bemidji*, No. WC15-5837 (WCCA 2016), the employee's pre-injury job for the employer was as a nursing assistant working directly in patient care. Post-injury, she worked in a clerical position, for the date of injury employer, that was within her restrictions and resulted in no wage loss. The employee sought rehabilitation services. The WCCA found that the compensation judge conducted a proper analysis under *Keklah* and *Gackstetter*, and that there was no evidence as to any differences in opportunity for future income or advancement between the positions or that the fringe benefits differ. The court noted that while the employee might prefer working directly with patients, her pre-injury job was not available to her because it was not within her restrictions. The court affirmed the judge's determination that the employee was not a qualified employee for rehabilitation services. *Citing Adams v. Marvin Windows*, 52 W.C.D. 585 (WCCA 1995).

III. WAIVER OF REHABILITATION

The statute allows for a waiver of rehabilitation. Minn. Stat. §176.102, subd. 4(h) (1992) provides: "The commissioner or compensation judge may waive rehabilitation services under this section if the commissioner or compensation judge is satisfied that the employee will return to work in the near future or that rehabilitation services will not be useful in returning an employee to work." Likewise, the rehabilitation rules allow for a waiver. Minn. R. 5220.0120, subp. 1 (1993) provides: "A rehabilitation waiver is used to defer the initiation of rehabilitation services including the consultation."

A. Procedural Requirements

In order for a waiver of rehabilitation to be effective, it must be filed in a timely manner. *See Wagner v. Bethesda Hospital*, slip op. (WCCA 1995). In other words, the employer and insurer must follow the requirements of statute and rule in order to be able to argue that a waiver is appropriate. The proper form to be used for a request for a waiver of rehabilitation services or a rehabilitation consultation is the disability status report. As described above in Section II(A), the DSR *must* be filed at certain specified times, and it must include certain information in order for the Department of Labor and Industry to grant the waiver.

The Department of Labor and Industry reviews DSRs very carefully. For example, it requires the documentation demanded on the form, including the "treating doctor's restrictions" as contained in a Report of Work Ability, as well as an offer of suitable gainful employment signed by the date-of-injury employer. The statute simply requires that the notification "must include a current physician's report." *See* Minn. Stat. §176.102, subd. 4(b) (1992). Therefore, the requirement for a "treating" physician's report, along with a job offer, does not have a basis in the statute.

Requests for a waiver typically generate a response from the Department. A letter will be issued from the Department indicating whether the waiver is granted or denied. The Department presumes that if a waiver is denied that a rehabilitation consultation will be scheduled immediately. If one is not scheduled, the Department will order one.

Presumably, if the employer and insurer disagree with the denial of the waiver, a Rehabilitation Request or a Request for Formal Hearing can be filed, seeking further review of the decision.

The Department carefully monitors compliance with the filing of forms and uses computer runs to identify those cases in which the employee has not been returned to work in 90 days and there has been no provision of a rehabilitation consultation or request for waiver. The Department will send insurers a notice giving them 14 days to file a disability status report requesting either a waiver or agreeing to provide a consultation. The Department may issue an order to perform a consultation or, in some cases, refer the case to compliance for possible assessment of a $500 penalty.

B. Substantive Reasons for Waiver

A rehabilitation consultation will not be required where the employee has returned to work to former employment, without residual disability or restrictions. *See Lewis v. Honeywell*, slip op. (WCCA 1995).

The most disputed issue is whether a waiver will be granted because it can be seen that the employee will be able to return to suitable gainful employment within 90 days after the injury, as required by Minn. R. 5220.0120, subp. 2 (1993). The Department requires a job offer signed by the date-of-injury employer. However, the courts have considered situations in which a waiver was requested without such documentation. For example, the WCCA authorized a waiver in a situation in which the employee had lost no time from work except for medical treatment, was working full-time in jobs that were partly light duty jobs and partly his pre-injury job, and the employee was expected to return to his regular job following physical therapy. *See Cortez v. Heartland Foods*, slip op. (WCCA 1995).

C. Effect of Waiver

If a waiver is granted, the waiver shall not be effective for more than 90 days following the injury and may not be renewed. Minn. R. 5220.0120, subp. 2 (2005).

In *Cleven v. Marvin Windows*, slip op. (WCCA 2000), the employee sustained an injury on November 17, 1997, but did not lose time from work, except for some arguable loss of overtime. On the 181st day following the date of injury, the employee filed a Rehabilitation Request for a rehabilitation consultation. Four days after the Rehabilitation Request was filed, the employer and insurer filed a DSR requesting a waiver of the rehabilitation consultation. Compensation Judge Mesna ruled that the employee was entitled to a rehabilitation consultation, citing Minn. Rule 5220.0120, subp. 2, which provides that a waiver is not effective more than 180 days after the injury unless a renewal of the waiver is granted. The judge ruled that "since a waiver, if granted, does not remain effective more than 180 days after the injury, it obviously follows that a waiver may not be requested more than 180 days after the injury. If a waiver was granted in such circumstances, it would become ineffective the moment it was issued." The WCCA agreed. While the amount of time in which a waiver is effective has changed since the decision of this case, the principle remains good law. A waiver cannot be granted more than 90 days after the date of injury because it is only effective for 90 days from the injury date.

One issue that has arisen relates to Minn. Rule 5220.0120, subp. 6, which indicates: "If 90 calendar days have passed since the waiver was granted and the employee has not returned to suitable gainful employment, the insurer shall provide a rehabilitation consultation. The insurer shall also provide a rehabilitation consultation if requested by the employee at any time even if a waiver has been granted." The last sentence of this provision seemingly renderers the concept of a waiver meaningless. It also seems to conflict with Minn. Rule 5220.0120, subp.1, which indicates that: "A rehabilitation waiver is used to defer the initiation of rehabilitation services including the consultation." Currently, there is no case law addressing this discrepancy in language.

D. Effect of Failure to File Disability Status Report

If a DSR is not filed according to the requirements of the rules, the Commissioner may order a rehabilitation consultation by a qualified rehabilitation consultant at the insurer's expense, pursuant to statute. Minn. R. 5220.0110, subp. 8 (1993).

In addition, if 90 days have passed since the date of injury and the employee has not returned to work, no rehabilitation consultation has taken place, and no waiver of rehabilitation services has been granted, the Commissioner *shall* order a rehabilitation consultation at the insurer's expense to be provided by the Vocational Rehabilitation Unit of the Department of Labor and Industry, if appropriate. Minn. R. 5220.0120, subp. 5 (2005).

IV. REHABILITATION CONSULTATION

A. Purpose

A rehabilitation consultation is used to determine whether an employee is a qualified employee for rehabilitation services. Minn. R. 5220.0130, subp. 1 (1993); *Mlnarik v. Normandy Motor Hotel*, slip op. (WCCA 1995).

B. Procedure

The employee *may* request a rehabilitation consultation by giving *written* notice to the insurer requesting a rehabilitation consultation. Notification of the request shall be filed with the Commissioner. Minn. R. 5220.0110, subp. 6. At least one judge in a lower court setting has determined that a written notice is not *required*.

If the employee, employer, or Commissioner requests a rehabilitation consultation, the insurer *shall* arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within 15 calendar days of the insurer's receipt of the request. Minn. R. 5220.0130, subp. 2.

If the insurer requests a waiver of rehabilitation services which is denied by the Commissioner, the insurer *shall* arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within 15 calendar days of the notification that the waiver request has not been granted. *Id*.

The rehabilitation consultation shall be held at a location not more than 50 miles from the employee's residence. *Id*.

Prior to the consultation, a copy of the First Report of Injury, the Disability Status Report, and accompanying current treating physician's Reports of Work Ability shall be sent by the insurer to the assigned qualified rehabilitation consultant. Minn. R. 5220.0130, subp. 3(A) (1993).

During the first in-person meeting with the employee for purposes of conducting a rehabilitation consultation, the assigned qualified rehabilitation consultant must do the following:

1. Meet with the employee and explain the responsibilities of the QRC as required by Minn. R. 5220.1803, explain the employee's rights and responsibilities regarding rehabilitation, including the employee's right to choose a qualified rehabilitation consultant; and

2. Gather information which will permit a determination of the employee's eligibility for rehabilitation. Minn. R. 5220.0130, subp. 3(B) (1993).

C. Reporting Requirements

The rehabilitation consultation shall be documented by the assigned qualified rehabilitation consultant on a rehabilitation consultation report form prescribed by the Commissioner. The form must contain the following information:

1. Identifying information of the employee, employer, insurer, and qualified rehabilitation consultant;

2. The rehabilitation consultation date;

3. An indication of the likelihood that the employee will return to the date-of-injury employer or date-of-injury occupation; and

4. A determination of whether or not the employee is a qualified employee for rehabilitation services and a narrative report explaining the basis for this determination. Minn. R. 5220.0130, subp. 3(C) (2005).

The rehabilitation consultation report must be completed by the assigned rehabilitation consultant in all cases and must be filed within fourteen days of the first in-person meeting with the employee and concurrently mailed to the employer, the employee, any attorney for the employee, and the insurer. Minn. R. 5220.0130, subp. 3(D) (2005). Failure to file a report in a timely fashion could give rise to a basis for a change of QRC at a later time. *See Kerber v. Farmington Ford*, slip op. (WCCA 1996).

Following the consultation and the issuance of a report, the employee or the insurer may object to the assessment of the qualified rehabilitation consultant by filing a rehabilitation request for assistance with the Commissioner. Minn. R. 5220.0130, subp. 3(E) (2005). The employer and insurer may also object by filing a rehabilitation request. Minn. R. 5220.0950, subp. 1 (1993).

V. REHABILITATION PROCESS

The Commissioner or a compensation judge shall determine eligibility for rehabilitation services and shall review, approve, modify, or reject rehabilitation plans. Minn. Stat. §176.102, subd. 6.

Once it is determined that the employee is eligible for rehabilitation services, a Rehabilitation Plan must be filed. The statute provides that the plan must be provided to the parties within 30 days of the rehabilitation consultation and shall be submitted to the Commissioner within 15 days after it has been developed. Minn. Stat. §176.102, subd. 4(e) (1992). Failure to timely file such reports can lead to a change of QRC. *See Kerber v. Farmington Ford*, slip op. (WCCA 1996).

The employee then is eligible to receive a number of "rehabilitation services" provided under the statute and rules. Rehabilitation services means a program of vocational rehabilitation, including medical management, designed to return an individual to work consistent with Minn. Stat. §176.102, subd. 1(b). The program begins with the first in-

person visit of the employee by the assigned qualified rehabilitation consultant, including a visit for purposes of a rehabilitation consultation. The program consists of a sequential delivery and coordination of services by the rehabilitation providers under an individualized rehabilitation plan. Specific services under this program may include, but are not limited to, vocational evaluation, counseling, job analysis, job modification, job development, job placement, labor market survey, vocational testing, transferable skills analysis, work adjustment, job seeking skills training, on-the-job training, and retraining. Minn. R. 5220.0100, subp. 29 (1993). This section will focus on the requirements of a Rehabilitation Plan and the rehabilitation benefits available to the employee.

Recently, in 2018, in *Beguhl v. Supportive Living Solutions/Whittier Pl.*, No. WC17-6078 (WCCA 2018), the WCCA found that the employer/insurer should pay for medical management services provided to the employee for conditions that were not compensable. The WCCA concluded that [s]ince the employee's ability to work is affected by her medical condition regardless of the origin of any particular aspect of that condition, a qualified employee is entitled to reasonable medical management of her whole condition, not merely the portion identifiable as treating a compensable work injury."

A. Rehabilitation Plan, Progress Reports, and Plan Amendments

The purpose of the Rehabilitation Plan is to communicate to all interested parties the vocational goal, the rehabilitation services, and the projected amounts of time and money that will be needed to achieve the vocational goal. Minn. R. 5220.0410, subp. 1 (1993). A Rehabilitation Plan is a written document completed by the assigned qualified rehabilitation consultant on a form prescribed by the Commissioner describing a vocational goal and the specific services by which the qualified employee will be returned to suitable gainful employment. Minn. R. 5220.0100, subp. 27 (1993).

In developing a Rehabilitation Plan, consideration shall be given to the employee's qualifications, including but not limited to, age, education, previous work history, interests, transferable skills, and present and future labor market conditions. Minn. Stat. §176.102, subd. 4(g) (1992).

As indicated above, if rehabilitation services are found to be appropriate, a Rehabilitation Plan must be completed and provided to the parties within 30 days of the rehabilitation consultation. Minn. Stat. §176.102, subd. 4(e) (1992); Minn. R. 5220.0410, subp. 3 (1993). A copy of the R-2 Rehabilitation Plan is included in the Appendix to these materials.

The assigned qualified rehabilitation consultant shall file the Rehabilitation Plan with the Commissioner within 45 days of the first in-person contact between the qualified rehabilitation consultant or within 15 days of circulation to the parties, whichever is earlier. Minn. R. 5220.0410, subp. 5 (1993).

Upon receipt of the proposed plan each party must, *within 15 days*, do one of the following two things:

1. Sign the plan, signifying agreement, and return it to the assigned qualified rehabilitation consultant; or

2. Promptly notify the assigned qualified rehabilitation consultant of any objection to the plan and work with the assigned qualified rehabilitation consultant to resolve the objection by agreement.

If the objection is not resolved, the objecting party must file a Rehabilitation Request within 15 days of receiving the proposed plan. If such a Rehabilitation Request is not filed within 15 days, the plan approval process will occur, and it will be presumed that the party is in substantial agreement with the plan's vocational objective and the services that are proposed. Minn. R. 5220.0410, subp. 4 and 6 (1993). *See Thompson v. Menasha Corporation*, slip op. (WCCA 1995).

A party's failure to sign the plan shall not constitute a waiver of any right to subsequently dispute the plan or to dispute payment of rehabilitation fees. Minn. R. 5220.0410, subp. 6 (1993).

All rehabilitation services provided by rehabilitation providers *shall* be provided pursuant to an approved Rehabilitation Plan. Minn. R. 5220.0410, subp. 8 (1993).

The QRC must complete plan progress reports on a periodic basis. Minn. R. 5220.0450, subp. 2 (2005) requires that a plan progress report be submitted six months after the QRC has filed an approved Rehabilitation Plan with the Commissioner. This is not required if a plan amendment has already been submitted. Further, at least every thirty days, a QRC must send a progress report to the parties. Minn. R. 5220.1802, subp. 4 (2008).

The QRC must file the six-month plan progress report with the Commissioner and provide copies to the employee, employer, and insurer within 15 days after six months have passed from the date of the filing of the Rehabilitation Plan. Subsequent plan progress reports are to be filed with the Commissioner within 15 days after the Commissioner's written request, with copies to the employee, employer, and insurer. Minn. R. 5220.0450, subp. 3 (2005).

In addition to the plan progress reports, whenever circumstances indicate that the Rehabilitation Plan objectives are not likely to be achieved, proposals for Rehabilitation Plan amendment may be considered by the parties. A Rehabilitation Plan may be amended for good cause, including, but not limited to:

1. A new or continuing physical limitation that significantly interferes with the implementation of the plan;

2. The employee is not participating effectively in the implementation of the plan;

3. A need to change the vocational goal of the Rehabilitation Plan;

4. The projected rehabilitation cost or duration, as stated in the original Rehabilitation Plan, will be exceeded; or

5. The employee feels ill-suited for the type of work for which rehabilitation is being provided.

Minn. R. 5220.0510, subp. 1 (1993).

- In *Rine v. City of Minnetonka*, File No. WC08-174 (WCCA 2008), the employee sought to amend the rehabilitation plan to include exploration of retraining. The WCCA affirmed Compensation Judge LeClair-Sommer's denial of the request to amend the rehabilitation plan. The employee had an admitted injury with permanent restrictions. The employee had been out of the labor market, voluntarily, for five years. When she decided to re-enter the labor market, a plan was developed calling for job seeking skills training and direct job placement. While this plan was in place, and without engaging in these activities, the employee sought to amend the plan for exploration of retraining, and specifically, to consider being retrained as a French interpreter. An independent vocational opinion was obtained, and that expert concluded that the employee should pursue a full-time job search utilizing her past experience and skills. The WCCA noted that, while the employee's high pre-injury wage might be difficult to replace, there was no evidence that the current plan was substantially inadequate to achieve the rehabilitation plan objectives and, therefore, denied the request to amend the plan.

- However, in *Budke v. St. Francis Medical Center*, slip op. (WCCA 2010), the WCCA affirmed Judge Olson's determination that it was reasonable to allow a change of a rehabilitation plan to permit a QRC to perform a labor market survey to explore whether retraining as a nurse practitioner would be reasonable. The *Poole* factors do not apply when the issue is not approval of a retraining plan, but instead whether the rehabilitation plan should be amended to permit the QRC to conduct a labor market survey and take other appropriate steps to explore and investigate retraining as a reasonable rehabilitation option.

- In *Petermeier v. Centimark Corp.*, slip op. (WCCA 2014), the employee sustained an admitted injury as a roofer and was unable to return to his same job. His date of injury employer had accommodated his scheduling needs because the employee had custody of his child on certain weekends. The employee subsequently accepted a flooring job with a subsidiary of the employer, which required travel and work on the weekends. The employee testified he gave notice to the flooring employer that he would need certain weekends off to be with his child. However, the flooring employer was not always able to accommodate this. The employee then filed a Rehabilitation Request seeking a change in his rehabilitation plan to include a job search in Minnesota on the basis that his flooring job was

separating him from his son. The WCCA reversed Compensation Judge Rykken's decision that the date of injury employer provided suitable skilled labor work. The WCCA held the judge did not address whether the flooring position was suitable, gainful employment and remanded the case to have that addressed. The WCCA noted Minnesota courts have "long recognized that an injured employee is not required to dramatically alter a reasonable and responsible pattern of living to be eligible for workers' compensation benefits." The WCCA remanded for a determination as to whether the employee was entitled to revision of the rehabilitation plan, to include job placement assistance, on the basis that his post-injury job prevented him from maintaining established, regular weekend visitation with his son.

It is the responsibility of the assigned qualified rehabilitation consultant to facilitate discussion of proposed amendments. Minn. R. 5220.0510, subp. 2 (1993). Upon preparation of the proposed plan amendment, the qualified rehabilitation consultant shall provide a copy to all parties. Minn. R. 5220.0510, subp. 2a (1993). Upon receipt of the proposed plan amendment, each party must, *within 15 days*, either:

1. Sign the plan amendment signifying agreement and return it to the assigned qualified rehabilitation consultant; or

2. Promptly notify the assigned qualified rehabilitation consultant of any objection to the plan amendment and work with the assigned qualified rehabilitation consultant to resolve the objection by agreement.

Similar to the process involved with the original Rehabilitation Plan, if the objection is not resolved, the objecting party must file a Rehabilitation Request within 15 days of receipt of the proposed plan amendment. If no Rehabilitation Request is filed within 15 days, the plan amendment approval process will occur and it will be presumed that the party is in substantial agreement with the amendment. A party's failure to sign the plan shall not constitute a waiver of any right to subsequently dispute the amendment or to dispute payment of rehabilitation fees relative to it. Minn. R. 5220.0510, subp. 2b (1993).

Where an employer or insurer contests an employee's entitlement to rehabilitation services, a QRC is not required to file rehabilitation plan amendments while continuing rehabilitation services during the pendency of the rehabilitation dispute. In *Parker v. University of Minnesota*, slip op. (WCCA 2003), a *Parker/Lindberg* hearing was held to determine the intervention claim of the QRC. The employer argued it had made a suitable job offer to the employee, and that he had rejected it. The WCCA rejected the employer's argument that even though the QRC services were reasonable and necessary, the services must be in compliance with the rehabilitation plan in order for the QRC to be paid. When the QRC sought to change rehabilitation efforts to focus on job search after the employee rejected the job offer, no rehabilitation plan amendment was filed. The WCCA held that because the employer disputed any entitlement to rehabilitation services, the filing of a rehabilitation plan amendment would have served no

purpose. The QRC was entitled to continue providing services during the dispute without a rehabilitation plan amendment.

B. Choice of QRC

Prior to 1992, the employee had the ability to change a qualified rehabilitation consultant on two occasions. One period of choice came within 60 days of the first in-person meeting and the second ability was any time thereafter. That rather expansive right to the employee was limited by the 1992 legislative changes. Minn. Stat. §176.102, subd. 4(a) (1992) provides that an employee has the right to choose a qualified rehabilitation consultant once at any time in the period beginning before the rehabilitation consultation and ending 60 days after filing of the rehabilitation plan.

The employee's choice of a qualified rehabilitation consultant must be in writing and must notify the insurer of the name, address, and telephone number of the qualified rehabilitation consultant chosen.

When rehabilitation has been completed and a rehabilitation plan closed due to an employee's return to work, an employee may be entitled to choose a different QRC when that job position is subsequently terminated and vocational rehabilitation services are reinitiated, even before a subsequent rehabilitation consultation is conducted. *See McQuillen v. Jelan Products,* slip op. (WCCA 2003).

A change of assigned qualified rehabilitation consultant necessitated by circumstances outside the control of the employee is not a choice by the employee and, therefore, does not exhaust the employee's right of choice. Further, if the assigned qualified rehabilitation consultant leaves a firm to work for another firm, the employee may either choose to continue with the assigned firm or remain with the QRC at their new firm. Neither option will exhaust the employee's right to choice of a QRC. Minn. R. 5220.0710, subp. 5 (1993).

1. Change of QRC Within First 60 Days After Filing Rehabilitation Plan

The Department of Labor and Industry has interpreted the statute to allow the employee to choose a qualified rehabilitation consultant "once at any time in the period beginning before the rehabilitation consultation and ending 60 days after filing of the rehabilitation plan." Minn. R. 5220.0710, subp. 1 (1993). This period includes the time prior to the initial rehabilitation consultation. *See Volcke v. Stuarts, Inc.*, 55 W.C.D. 283 (WCCA 1996); *Reaney v. Weyerhaeuser,* slip op. (WCCA 1998).

In *Reaney v. Weyerhaeuser*, slip op. (WCCA 1998), the attorney for the employer wrote to the employee's attorney indicating that a rehabilitation consultation was going to be arranged with a particular QRC. The employee's attorney filed a rehabilitation request seeking a change of QRC, and had the employee complete a rehabilitation consultation with a different QRC. The WCCA held that the employee was entitled to request

a change of QRCs. The WCCA's decision includes a careful review of Minn. Stat. §176.102, subd. 4(a) and 4(d), and Minn. R. 5220.0710, subp. 1. The WCCA interpreted these provisions to provide an employee with a right to make a change of QRC from a QRC selected by the employer to one selected by the employee. The WCCA held that this change may be made at any time following the employer's initial selection of a QRC, even before a rehabilitation consultation has been conducted, but no later than 60 days after the filing of the rehabilitation plan. The WCCA held that this is a *right* and that the employee does not need to provide a reason or justification for this change. The WCCA noted that an employee may later request another change of QRC, but that a further change can only be made subject to a determination that the change is in the best interests of the parties.

2. Change of QRC for the Best Interests of the Parties

Once the employee has exhausted the choice to a qualified rehabilitation consultant, any subsequent determinations shall be made according to the "best interests of the parties." *See Reaney v. Weyerhaeuser*, slip op. (WCCA 1998). The parties may, of course, agree at any time to change and select a new qualified rehabilitation consultant. Minn. R. 5220.0710, subp. 3 (1993). A change of QRC may be requested by any party. Again, the WCCA has addressed change of QRC issues on several occasions:

- In *Kerber v. Farmington Ford*, slip op. (WCCA 1996), the QRC had failed to file a timely rehabilitation consultation report and failed to file a timely Rehabilitation Plan. The WCCA concluded that the proposed QRC delayed the efficient delivery of rehabilitation services in contradiction to rule and statute. Therefore, the WCCA ruled that it was reasonable for the compensation judge to determine that the choice of the QRC was not in the best interest of the parties and that a change of QRC could take place.

- In *Owens v. New Morning Windows*, slip op. (WCCA 2000), the employee sustained an injury on July 8, 1998. The employer voluntarily provided the employee with a QRC. A rehabilitation plan was filed in December 1998 contemplating the employee's continuing employment with the employer. In May 1999, the employee filed for a change of QRCs, indicating in his request that he no longer trusted the first QRC. A rehabilitation specialist denied the request, and the employee requested a formal hearing. The compensation judge denied the request to change QRCs, and the WCCA affirmed. The WCCA rejected the employee's argument that he has an unqualified right under the statute and rules to choose a QRC at least once and that that right had never been exhausted. Pursuant to Minn. Stat. §176.102, subd. 4(a), the employee has an unqualified right to choose a QRC within 60 days following the filing of a rehabilitation plan. *See Reaney*. Thereafter, any change must be in the "best interest of the parties." The WCCA also rejected

the employee's argument that a change of QRC was in the "best interests" of the parties. It determined that one prior working relationship between the QRC and the employer did not make the original QRC a "company QRC." The WCCA acknowledged that the QRC had some issues with communication with the employee, but did not find them so egregious as to constitute bias. Finally, the WCCA acknowledged that there may be some lack of trust on the part of the employee in the first QRC, but noted that a certain reasonable efficiency and practicality is expedient in rehabilitation matters, and concluded that effective work remains effective even in cases where the relationship and communication are less than optimum. The initial QRC had the employee working at an economic status in excess of what he had at the time of the injury. *See also Lemke v. ISD #112*, slip op. (WCCA 2003).

- In *Gombold v. Metal Craft Machine & Engineering*, File No. WC07-132 (WCCA 2007), the QRC failed to inform the employer and insurer that the employee had been ordered to perform 200 hours of community service in connection with a DUI offense. To fulfill this sentence, the employee began working at Goodwill for five hours a day, which the QRC also did not disclose to the employer and insurer. The employer and insurer filed a Request for Formal Hearing to have the QRC changed. The compensation judge stated that it is in the best interest of the parties that both the employee and employer and insurer trust that the QRC working on the case will be forthright in providing all information relevant to the employee's rehabilitation to all parties. The WCCA affirmed stating that since the employer and insurer no longer trusted the QRC, it was in the best interests of the parties that the employee be reassigned to a new QRC.

- The WCCA has determined that it is not in the best interests of the parties to change a QRC simply because the QRC works for the insurer or one of its subsidiaries. In *Stutelberg v. Kelleher Construction, Inc.*, File No. WC08-250 (WCCA 2009), the employee met with a QRC who worked for Zurich Services, a division of the insurer. At the rehabilitation consultation, the QRC disclosed her relationship with the insurer and the employee signed a Rehabilitation Rights and Responsibilities of the Injured Worker form. Then the employee filed a Rehabilitation Request for a change of QRC after the statutorily prescribed 60-day limit had run. The compensation judge found that the QRC had provided appropriate rehabilitation services to the employee and that the preponderance of the evidence failed to establish that a change in QRC was in the best interests of the parties. On appeal, the employee argued that there is an inherent conflict of interest when the QRC is an employee of the insurer or one of its subsidiaries. Therefore, the employee wanted the WCCA to fashion a remedy of law to combat this inherent conflict of interest by lowering the burden upon the employee to show that it

is in the best interest of the parties to allow the change of QRC in these situations. The WCCA declined to lower the burden, citing the statutory safeguards in place for the employee. The legislature promulgated rules that allow the employee to choose a different QRC within 60 days after a filing of the rehabilitation plan; if the employee is not comfortable with a QRC that works for the insurance provider, he has the opportunity to switch to a different QRC. If the employee does not change a QRC within the first 60 days, then any subsequent request for a change will be determined by the best interests of the parties standard.

- In *Bode v. 3M Co.*, No. WC16-5910 (WCCA 2016), the WCCA reversed a judge's denial of a change of QRC, reviewing the issue on a *de novo* basis and determining that the QRC failed in her duty to take due care to ensure that a rehabilitation client is placed in a job that is within the client's physical condition. In this case, the employee had complained numerous times about her job assignments, and this was documented by the QRC and the providers, however, the QRC did not take what the WCCA would consider to be reasonable action, such as requesting a rehabilitation conference, suggesting that the employee be taken off work for a period of time to allow for recovery, or conducting an on-site job evaluation. WCCA also determined that the QRC engaged in adversarial communications, in violation of Minn. R. 5220.1801, subp. 9K, when the QRC included in her report information from the QRC regarding a job that the employee decided not to apply for because she did not feel capable of doing it, and information about the employee's husband taking a new job. The WCCA found that neither of these communications had any bearing on the rehabilitation plan to return the employee to work with her pre-injury employer, and therefore, including this information in her report was a violation of the rule against engaging in adversarial communication.

STRATEGY TIP: If you are seeking to change QRCs based on the "best interests of the parties," one suggested strategy is to have a replacement QRC already identified and ready to step in immediately. If this replacement QRC can articulate in a brief letter ideas s/he has for furthering the rehabilitation process, that can also be used to foster your argument for the change.

C. Return to Work with the Same Employer

One of the services provided by the qualified rehabilitation consultant is assisting in a return to work with the pre-injury employer. Usual methods include meeting with the employee, employer, and treating physician in order to effectuate a prompt and effective return to work.

D. On-the-Job Training

On-the-job training means training while employed at a work place where the employee receives instruction from an experienced worker and which is likely to result in employment with the on-the-job training employer upon its completion. Minn. R. 5220.0100, subp. 21 (1993).

The primary objective of on-the-job training is suitable gainful employment with the on-the-job training employer that is likely to restore the employee as close as possible to pre-injury economic status. Minn. R. 5220.0850, subp. 1 (1993).

The controlling rule with regard to on-the-job training is Minn. R. 5220.0850. It contains significant elements as to what a plan is to include that encompasses on-the-job training.

Once an on-the-job training plan is submitted to the Commissioner, the Commissioner has 30 days to approve or reject the plan. The Commissioner has a right to pursue resolution of questions regarding the on-the-job training plan by means of an administrative conference. Minn. R. 5220.0850, subp. 4 (1993). Any party requesting resolution of a dispute about an on-the-job training plan may file a request for rehabilitation assistance. Minn. R. 5220.0850, subp. 5 (1993).

E. Job Placement

One of the most common rehabilitation services provided is that of job placement. An issue that often arises with regard to job placement is who is allowed to select the job placement vendor. The roles of the qualified rehabilitation consultant and the job placement vendor are usually separate. However, qualified rehabilitation consultants are increasingly seeking to retain job placement services as part of their activities on a file.

Minn. R. 5220.0410, subp. 9 (1993) provides that "the insurer may select the vendor of job development or job placement services." Litigation has ensued over whether this is a mandatory directive. The Department of Labor and Industry issued a pronouncement in 1994 indicating that this was not mandatory.

The WCCA has adopted the position of the Department. It has ruled that the right to select the job vendor is not mandatory, but is optional. It has also ruled that it is the QRC who determines the direction and course of the employee's rehabilitation plan, including a job search, subject to the employer and insurer's right to object by filing a Rehabilitation Request. If the QRC determines that a vendor will be needed for job placement, the insurer may select who it will be. However, if the QRC decides to provide the job placement or development services through the QRC's firm and this is incorporated into an approved Rehabilitation Plan, the QRC may do so. *See Taylor v. Pine County,* slip op. (WCCA 1995).

If the employer and insurer object to the QRC or the QRC's firm performing job placement, the insurer must have a "credible rationale" for its position. The burden of proof on this issue is on the employer and insurer. *Id. See also Thompson v. Menasha Corporation*, slip op. (WCCA 1995).

Another issue, which can arise relative to job search, concerns the types of employment pursued. The WCCA has held that although an employee may express dislike for a specific profession, that alone is not a determinative factor for an adequate job search. In *Wessel v. 3M Company*, File No. WC04-163 (WCCA 2004), the employee sustained multiple injuries while employed with the employer over 35 years in various warehouse and factory positions. She worked with restrictions until the plant closed. Rehabilitation services were commenced, and the employee was working with a job placement vendor. At the onset, the employee expressed a dislike for "office work." By the fall of 2002, the employee was interested in retraining as a sign language interpreter. The WCCA affirmed the determination that the employee is entitled to retraining, but rejected the specific retraining plan. The rejection of the plan centered on the employee's refusal to look for office work. The WCCA noted that even though an employee expresses a dislike for a specific profession, that alone is not a determinative factor for an adequate job search. Because of the employee's high average weekly wage at the time of her injury, the WCCA determined she was entitled to some retraining, but also indicated that she should pursue some skills enhancement and conduct a job search that included office work.

Effective May 17, 2013, Minn. Stat. 176.102, subd. 5 places a limitation on the extent of job placement service that can be performed on a case. Job development services provided by a QRC firm or registered vendor cannot exceed 20 hours per month or 26 consecutive or intermittent weeks. Once 13 weeks of job development services have been provided, the QRC must consult with the parties and file a plan amendment reflecting an agreement by the parties to extend job development services for up to an additional 13 consecutive or intermittent weeks or file a request for a rehabilitation conference. The commissioner or compensation judge can issue an order modifying the rehabilitation plan but must not order more than 26 total consecutive or intermittent weeks of job development services.

F. Retraining

Retraining is a formal course of study in a school setting that is designed to train an employee to return to suitable gainful employment. Minn. Stat. §176.011, subd. 17a. The purpose of retraining is to return the employee to suitable gainful employment through a formal course of study. Retraining is to be given equal consideration with other rehabilitation services, and proposed for approval if other considered services are not likely to lead to suitable gainful employment. Minn. Rule 5220.0750, subp. 1 (1993). *See Anderson v. Sheehy Construction Company*, slip op. (WCCA 1995) ("the rule does not require other rehabilitation services, such as job search, to be unsuccessful before retraining may be considered and proposed, if other services are not likely to lead to suitable gainful employment").

Retraining is not only available to injured workers, but also to the surviving spouse of an employee who died as a result of a work-related incident. Minn. Stat. §176.102, subd. 1a. This provision states that a "qualified dependent surviving spouse" is someone in "need of rehabilitation assistance to become self-supporting." A surviving spouse would not receive rehabilitation wage loss benefits during any period of retraining, but would continue to receive any dependency benefits to which they were entitled. In *Wirtjes v. Interstate Power Co.*, 479 N.W.2d 713, 46 W.C.D. 95 (Minn. 1992), the Minnesota Supreme Court determined that the standard for determining whether a surviving spouse is qualified for retraining is different than the standard for an injured employee. The Supreme Court held that "it is the individual talents, skills, experience, earning capacity, and employability of the surviving spouse . . . that determine whether the surviving spouse is in need of rehabilitation assistance and, if so, the kind of rehabilitation services required." In *Wirtjes*, the court determined that a 25 year old widow, who was "young, intelligent and employable" and had a current degree and training in a marketable field, was not qualified for retraining services. The court noted that with a few years' experience and long before compensation payments ceased, the widow would be capable of being "fully-self-supporting," and although she might need placement assistance, she had not demonstrated the need for retraining. In contrast, in *Grage v. ACME Elec. Motor, Inc.*, No. WC15-5898 (WCCA 2016), the court determined that a 54 year old widow, with limited work experience, with dependent benefits running out in 6 years, and who was struggling with licensing requirements to secure and maintain employment was qualified for assistance pursuant to Minn. Stat. §176.102, subd. 1a.

Retraining is limited to 156 weeks, during which time the employee will receive temporary total disability benefits (or temporary partial disability if the employee is working during the retraining program). Minn. Stat. §176.102, subd. 11.

An employee who has been approved for retraining may petition the Commissioner or a compensation judge for additional compensation not to exceed 25% of the compensation otherwise payable. Minn. Stat. §176.102, subd. 11 (a). In order to qualify, the employee will have to show "unusual or unique circumstances." *See Fettig v. ABB Combustion Engineering*, 52 W.C.D. 338 (WCCA 1994)(the "unusual or unique circumstances" contemplated by the statute must be (1) circumstances of the plan itself, *citing Breiwick v. Brix & Sons*, 45 W.C.D. 58 (WCCA 1991) and *Caruso v. Statewide Services*, slip op. (WCCA 1991); and (2) circumstances that result in a financial burden for the employee. *Breiwick*, 45 W.C.D. at 60.) The employee has the burden of proving the existence of such circumstances. *See Stasica v. Olympic Wall Systems*, 47 W.C.D. 271 (WCCA 1992), *citing Anderson v. Creamette Co.*, 44 W.C.D. 262 (WCCA 1990). The employee should provide evidence of "specific amounts, purposes and dates of any expenditures." *Anderson*, 44 W.C.D. at 267-68. *See also Stasica*, 47 W.C.D. at 274. To succeed on a claim for additional retraining benefits under Minn. Stat. §176.102, subd. 11(a), the employee should provide "evidence of specifically attributable expenses flowing from particular aspects of the plan itself." *Breiwick*, 45 W.C.D. at 60.

1. Eligibility

The Minnesota Supreme Court has held that retraining is necessary if it will materially assist the employee in restoring an impaired earning capacity. *Nordby v. Arctic Enterprises, Inc.*, 232 N.W.2d 773 (Minn. 1975). Factors to be considered in determining eligibility for retraining include:

a. The reasonableness of retraining compared to the employee's return to work with the employer or through job placement activities;

b. The likelihood of the employee succeeding in a formal course of study given the employee's abilities and interests;

c. The likelihood that retraining would result in reasonably attainable employment; and

d. The likelihood that retraining would produce an economic status as close as possible to that which the employee would have enjoyed without the disability. *Poole v. Farmstead Foods*, 42 W.C.D. 970 (WCCA 1989).

In reviewing the reasonableness of retraining as compared with other options, cost can be considered. In *Rovinsky v. Paulson Super Valu*, slip op. (WCCA 1993), a $50,000.00 retraining plan was denied as the cost was considered excessive given the employee's minimal lost earning capacity. If the cost of the retraining program is a primary basis for objecting to the plan, proposing an alternative plan is an option. In *Kundferman v. Ford Motor Company*, 55 W.C.D. 464 (WCCA 1996), the court noted that when alternative plans are proposed, the compensation judge should perform a comparative analysis of the plans.

- The importance of cost as a consideration in assessing the appropriateness of a proposed retraining plan is outlined in the Supreme Court of Minnesota's decision in *Varda v. Northwest Airlines Corporation*, 692 N.W.2d 440 (Minn. 2005). In *Varda*, the employee was a reservation agent, living in the Hibbing area, who sustained a bilateral carpal tunnel syndrome condition culminating in August 2000. The employer could not accommodate the restrictions, and rehabilitation assistance was provided. A four-year retraining plan was proposed in order to obtain a Bachelor of Arts degree in nursing, with an estimated cost of $144,388. A two-year plan was also considered, which would permit her to seek licensure as a registered nurse, with a total cost of $9,500. Only the four-year plan was proposed for approval. Expert vocational evidence was provided in support of each plan. The compensation judge awarded the more expensive plan. The WCCA reversed and substituted the two-year plan, noting that the record failed to

establish that the employee would gain any significant economic advantage by attending the four-year program sufficient to outweigh the immense additional cost of that program. It determined that the two-year plan would provide the employee with the ability to earn a wage that exceeded her pre-injury wage.

The Supreme Court affirmed the WCCA decision. It held that the issue of which of the two plans was most appropriate and reasonable was a question of law, as opposed to a question of fact, and therefore, that the WCCA was able to apply a broader standard of appellate review. The Court cited to the various *Poole* factors. When each party submits alternative retraining plans, the compensation judge is to compare the plans by evaluating the various *Poole* factors. *See Kunferman*. The Court determined that the evidence showed that each of the plans proposed would provide a job that would return the employee to an economic status higher than what she would have had without the disability. Although the evidence supported the conclusion that the four-year program would be "better," it did not support the conclusion that the two-year program would not be appropriate or reasonable. The critical question was whether the more costly program is "necessary to increase the likelihood of re-employment" within the meaning of Minn. Stat. §176.102, subd. 1(b). Because both programs are appropriate and reasonable, the deciding factor in determining which program is necessary becomes the cost.

Justices Anderson and Meyer dissented. They would have held that the WCCA exceeded its appropriate standard of appellate review and should have determined that substantial evidence existed to support the original decision of the compensation judge. In essence, they would have determined that the issue was a question of fact, not law, and that the WCCA was confined by a more stringent standard of review.

The *Varda* decision establishes that cost can be a relevant consideration in determining the appropriateness of a proposed retraining plan. It also demonstrates the importance of alternative defense strategies in retraining claims. On the one hand, the strategy can be to defend against any type of retraining plan whatsoever. Alternatively, if it appears that retraining of some sort is going to be permitted, then the better strategy may be to propose a less expensive plan which will allow the employee to recoup an earning capacity consistent with the pre-injury earning capacity. Even though the employee's proposed plan may be "better," it may not be "necessary."

- In *Polecheck v. State of Minnesota, Department of Natural Resources*, slip op. (WCCA 2009), the WCCA affirmed Compensation Judge Cannon's approval of a program at University of Wisconsin-Superior over a program at the College of St. Scholastica. The WCCA cited *Varda* in its determination. The programs had a $25,000 difference in cost and both were accredited and would provide a bachelor's degree in social work. Therefore, the less costly program was appropriate because it would accomplish the statutory purpose of retraining.

- However, in *Koppen v. Knowlan's Super Market*, slip op. (WCCA 2011), the WCCA affirmed Compensation Judge LeClair-Sommer's approval of a retraining plan for a four year degree. The WCCA concluded both the four year degree proposed by the employee and the insurer's alternative proposal of a two year program, were likely to result in reasonably attainable employment. Despite the insurer's argument that the two year plan was mandated by *Varda*, the WCCA held that, where the compensation judge ruled a four year retraining plan was more likely to realize the goal of returning the employee as closely as possible to his pre-injury economic status than an alternative two year program, the judge's award was to be affirmed.

- In *Grunzke v. Seaboard Farms, slip op.* (WCCA 2000), the WCCA had an opportunity to address several of the *Poole* factors. The employer appealed from the determination that the employee is entitled to retraining. The WCCA affirmed. The employee worked for the employer for 32 years. In 1994 and 1995, he sustained admitted injuries. Following a number of surgeries, he was released to work with restrictions, and the employer provided him with light-duty work, although at a wage loss. The employee underwent a rehabilitation consultation and was found to be a qualified employee, eligible for selective placement or retraining. The employer contested the employee's eligibility for rehabilitation assistance and did not sign the rehabilitation plan. The QRC filed a rehabilitation request and conducted aptitude testing over the employer's objection, ultimately recommending that the employee complete a retraining program as a transport refrigeration technician at a local community college. The employer had an independent vocational assessment performed, which concluded that the retraining program was not appropriate, as the potential employment would be beyond the employee's restrictions, he was currently in a job he was capable of doing, the fact that it was a new program, and that there were only two employers in the Albert Lea area that hire program graduates. The compensation judge held that while the employee's present job was physically suitable, it was not economically suitable, and the proposed retraining plan would produce an economic status as

close as possible to that which he would have enjoyed without his work related injuries.

The employer went on to argue that the QRC should have explored both direct job placement with the current employer and on-the-job training before pursuing retraining. The employer also argued that the QRC made no effort to assist the employee with any job search with other employers in the area and, therefore, did not demonstrate that other services, including direct job placement or on-the-job training would not lead to suitable gainful employment. Finally, the employer argued that the employee's current wages were comparable to that which he would earn post-retraining. The WCCA disagreed, citing the four-factor test established in *Poole*. The WCCA found that the employee's QRC had compared retraining to job search or continued employment with the employer and concluded that a job search would not be successful in locating a higher paying job for the employee, in view of the employee's physical work restrictions, his limitation to eight hours of work per day, and his lack of transferable skills. While there was evidence that the employee's initial wages in the post-retraining labor market would be essentially equal to that which he currently earned with the employer, the future advancement within three to five years of being in the field would produce an increased economic status. The WCCA held that economic status is to be measured not only by opportunity for immediate income, but also by opportunity for future income.

Finally, while the employer argued that the post-retraining work would be beyond the employee's abilities and restrictions, the WCCA found more persuasive the QRC's testimony that in interviewing one potential employer, that employer advised that there were other employees that were available to assist with heavier objects. The WCCA held that the judge could have reasonably concluded that the proposed retraining plan was within the employee's physical restrictions.

Therefore, in *Grunzke*, the WCCA seemed to indicate that a plan which would require 3-5 years to produce an increased economic status is acceptable. However, in *Olson v. Kleinhuizen*, 50 W.C.D. 427 (WCCA 1994), the WCCA denied a retraining plan which predicted that it would take 5-7 years after completion of the plan for the employee to regain the lost earning capacity.

- The importance of future economic status as a consideration in determining whether retraining is appropriate is also underscored in *Johnson, Ryan v. Arctic Cat, Inc.*, slip op. (WCCA 2004). The employee was a field test driver for personal watercraft manufactured by the employer. Following an injury, he was unable to return to work in his pre-injury job, but was able to return to

work for the employer at only a $.60 per hour decrease in wage. However, the post-injury job did not allow him to access 600-900 hours of overtime per year available to test drivers. The employee sought an amendment to the rehabilitation plan to allow exploration of retraining. The WCCA allowed the amendment on the basis that the employee's earning capacity had been impaired by the injury.

- In *Weme v. Independent School District #94*, slip op. (WCCA 2000), the employee sustained two work injuries, the first being in 1993 and the second in 1997. She was eventually allowed to return to work full-time with restrictions. The employer did not provide work within her restrictions, but provided rehabilitation assistance in the nature of job placement assistance. After approximately four months of job search, and approximately one year of working with the QRC, the employee refused to sign a rehabilitation plan amendment extending job development and placement due to frustration over the job placement activities. She opted to continue job search on her own and vocational rehabilitation services were placed on hold. After approximately four months of these efforts, she requested and was granted approval of a change in QRC, who submitted a rehabilitation plan calling for retraining and continued job search. The employee then filed a Rehabilitation Request for approval of a retraining plan to obtain a bachelor of science in social work, requiring four years of college. The proposed retraining plan was approved via an administrative conference. It was concluded that further job search would be fruitless. The employer appealed.

  Compensation Judge Bonovetz approved the retraining plan. The employer argued on appeal that the employee was capable of sustained gainful employment without retraining, that she did not cooperate with rehabilitation, and that she was not physically or mentally capable of handling the rehabilitation plan. The employer also argued that the proposed retraining plan did not meet the requirements of Minn. Rule 5220.0750, subp. 2. The WCCA affirmed. While there was evidence that the employee's potential wage on entry into the labor market as a social worker would be comparable to what she could earn without retraining, the WCCA observed that, according to Minn. Stat. §176.102, subd. 1(b), economic status is to be measured not only by the opportunity for immediate income, but also by the opportunity for future income.

- In *Ascher v. Bill Dentinger, Inc.*, slip op. (WCCA 2001), the WCCA held that in reviewing the issue of the reasonableness and necessity of retraining as compared to other job placement activities, the scope and effectiveness of the employee's job search is relevant. In this case, over the course of time relevant to the inquiry, the employee had followed up on only 18 of 45 suitable

job leads, and obtained only four interviews. An independent vocational consultant testified that the employee had not actively sought potentially higher paying employment, and the job search to-date had been only cursory in terms of the employee's involvement. The independent vocational expert concluded that there were actual jobs available in the labor market, which would provide the employee with a wage similar to that anticipated after retraining. The WCCA denied the retraining claim, although it cautioned that a job search is not an absolute prerequisite to a retraining plan.

- *Stotts v. Polaris Industries, LP, slip op.* (WCCA 2003), similarly underscores the relevance of an employee's job search activities in addressing the issue of the reasonableness and necessity of retraining as compared to other job placement activities. In *Stotts*, the employee contended she was entitled to retraining benefits following a compensable bilateral upper extremity injury that left her with a permanent lifting restriction of ten pounds. Her work history was exclusively industrial in assembly line positions. She had attended school through the eleventh grade and subsequently obtained a GED. She resided in a remote area of northern Minnesota and relied upon her mother for all her financial needs. The retraining program proposed sought a two-year degree in sales. The employee testified that she was willing to move anywhere within the state to attend a retraining program, and would also move anywhere, within reason, if she had a guaranteed position. However, she admitted that she never conducted any type of job search outside of a 50 mile radius from her very rural residence. An independent vocational evaluator opined that the employee conducted a poor job search within the fifty mile radius of her residence, and she identified numerous positions that would have duplicated or exceeded the date of injury wage. She further opined the retraining program proposed was premature because the employee had failed to conduct a job search in larger communities. Lastly, she opined the retraining program did not improve the employee's employability. She specifically noted that sales positions are usually obtained or awarded from within an employer. In terms of reasonableness, she felt that a broadened job search to include larger communities would be far more beneficial than a retraining program. The WCCA denied the retraining program.

- Conversely, the WCCA has held that an employee may not be required to expand a job search outside of his own community even when a proposed retraining program contemplates education and post-retraining employment outside of the employee's community. *See Schmidt v. Arrowhead Electric*, slip op. (WCCA 2004.) In *Schmidt*, the employee had three injuries at the employer that precluded him from doing his job as a lineman. His wage at

the time of the last injury was $929 per week. He lived in Grand Marais, MN. He commenced a job search in the Grand Marais area with the assistance of a QRC. He was able to find temporary, part-time work at a golf course and as a school bus driver. The QRC then prepared a retraining plan in a 143-week radiologic technician program at a college in Duluth. The anticipated economic status following the program would be $780 per week. The insurer contended that the employee should perform a job search in Duluth area before retraining. The employee admitted at the hearing that he would be willing to relocate to Duluth, St. Cloud, Menomonie, WI or Ashland, WI following completion of his retraining program. The compensation judge denied the retraining program as premature, and found that it was no more reasonable than a job search in the Duluth area, located 100 miles away from the employee's home. The WCCA reversed. The two rehabilitation options presented for comparison were additional job placement or retraining. If the rehabilitation plan calls for job placement, an employee may not be required to job search outside his own community. The WCCA also determined that the judge erred in only comparing the entry-level wages for the retraining position to the wages the employee could theoretically earn by way of job search. The potential for future income in the retraining position should also have been considered.

Judge Pederson dissented. He found that the decision did not require the employee to seek work outside of his home community. The judge noted that the retraining program would not result in employment within the employee's home community. Therefore, neither vocational option would produce an economic status as close as possible to the pre-injury wage in the employee's home community. In order to arrive at that economic status, the employee would have to relocate. He had expressed a willingness to relocate. Judge Pederson argued that comparison of placement opportunities in the extremely limited Grand Marais job market with post-retraining opportunities in the significantly larger Duluth market is not a fair or reasonable comparison.

It should be noted that although the first *Poole* factor addresses a consideration of the reasonableness of retraining as compared to the employee's return to work with the employer or through job placement activities, the WCCA has affirmed approvals of retraining programs under circumstances in which no formal job placement activities were undertaken. The key considerations appear to be whether it can be determined prior to undertaking job placement activities, that those activities will be inferior to retraining in restoring a pre-injury earning capacity, and whether the employee lacks transferable skills.

- *Sever v. Radotich Heating & Sheet Metal*, File No. WC04-177 (WCCA 2004.) The WCCA approved a proposed retraining plan. Following a foot injury, the employee was unable to return to work in his construction job, which was fairly high paying. He lived on the Iron Range. After investigating various rehabilitation opportunities, the employee's QRC recommended a four-year Bachelor of Accounting program with a cost of almost $50,000. The employer denied the plan, noting that none of the *Poole* factors were met. The WCCA concluded that all four factors were met. Although direct job placement was not attempted, the WCCA noted that the employee had very few transferrable skills and that the labor market on the Iron Range was extraordinarily tight. To the extent that the employee could do any sedentary jobs, they would in no way restore his pre-injury earning capacity. It was reasonable to proceed directly towards retraining.

- The last *Poole* factor was established in *Yonke v. Continental Machines, Inc.*, slip op. (WCCA 2001). The WCCA affirmed an award of retraining. The employer argued that the employee's average weekly wage of $456.40 and his weekly earnings of $420 at the time of trial were close enough to make retraining unnecessary. The WCCA disagreed, finding that rehabilitation is intended to restore an injured employee so that the employee may return to a job related to the employee's former employment, or to a job in another work area which produces an economic status as close as possible to that the employee would have enjoyed without the disability. The employer relied on *Stadick*, in which the WCCA held that the average weekly wage on the date of injury controls and the wages the employee expected to earn in the future are speculative and cannot be used in determining the employee's benefit rate or the employee's entitlement to retraining. However, the WCCA noted that unlike *Stadick*, there is concrete evidence in the present case concerning the employee's post-injury earning capacity in his pre-injury occupation. Specifically, following the employee's injury at the time of his lay-off, the employee was working as a machinist earning $18 per hour with substantial fringe benefits (i.e., much more than at the actual time of the injury.) However, he was subsequently laid off and the security job he held after the lay-off only paid $10.50 per hour with one week of paid vacation as the only fringe benefit. The WCCA noted that the evidence was not speculative and clearly demonstrates the substantial economic disparity between a machinist's work and security work. *See also Siltman*.

- *Custer v. I.S.D. No. 2154*, File No. WC06-219 (WCCA 2007). The WCCA affirmed compensation Judge Arnold's approval of the employee's request for retraining. The employee sustained an admitted injury when she slipped and fell while working as a junior high school art teacher. At the time of the injury, the

employee also worked part-time weekday evenings (4:00 - 9:00 p.m.), 25 hours per week in a sedentary position for the billing department of Fingerhut Corporation. Her job duties involved talking to customers on the telephone. Following the work injury, the employee was released to work with restrictions. The school district accommodated the employee's need to lie down during breaks to relieve her back pain. Due to budget cuts within the school district, the employee's hours were cut to 3/4 time, but she was then able to return to work on a full-time basis by transferring from the junior high school to the senior high school, replacing a retiring full-time high school art instructor. The employee attempted to return to her part-time job at Fingerhut, but was later removed from that work by her treating physician, who opined that she was unable to tolerate static sitting or standing activity associated with her position at Fingerhut. He restricted the employee to working 40 hours per week. In addition to limiting the employee to lifting 10 pounds only occasionally, the permanent restrictions also required that the employee be able to sit, stand, walk, and change positions frequently, as needed, with 30 minutes duration for static positions of sitting. The restrictions required that the employee be able to lie down for 30 to 45 minutes every few hours during the day. Thereafter, the employee discontinued work at Fingerhut, but continued to work on a full-time basis as a high school art teacher for the school district where she attained weekly earnings which exceeded her combined pre-injury average weekly wages at the school district and Fingerhut. The employee requested retraining to obtain a Master of Arts degree. The school district refused, arguing that the employee was not entitled to retraining because her post-injury weekly wages exceeded those which she earned on the date of injury and, therefore, she had sustained no loss of earning capacity. The employer also argued that even if the employee was deemed entitled to retraining benefits, the retraining plan submitted by the employee was not appropriate, in that the 90-mile, one-way commute to school exceeded her restrictions. The employer also argued that the proposed course-work would require long periods of sitting, which the employee had testified she could not do.

Judge Arnold concluded that because the employee's restrictions precluded her from returning to her part-time position at Fingerhut, her economic status related to her Fingerhut position was not as close as possible to that which she would have enjoyed without her disability and injury, and therefore, she was entitled to proceed with the proposed retraining program. In response to the employer's concerns that the employee would be physically unable to complete the retraining program, the judge concluded that while the employee's physical impairments placed barriers on her completing the retraining program, the employee credibly testified that she believed she would be able to overcome those barriers.

The WCCA noted that "a loss of earning capacity is not synonymous with a loss of actual earnings. *See Jerabek v. Teleprompter Corporation* 255 N.W.2d 377 29 W.C.D. 612 (Minn. 1977), and *Siltman v. Partridge River, Inc.*, 523 N.W.2d 491, 51 W.C.D. 282 (Minn. 1994)." The WCCA noted that even though the employee's earnings from teaching steadily increased over the years, her injury-related restrictions have resulted in an overall loss of earning capacity and loss of "future opportunity" because she was unable to continue employment at Fingerhut, where she earned $159.22 per week, or approximately $8,280 per year, prior to the work injury. Because her work restrictions precluded her from returning to work at Fingerhut, and restricted her from working more than five days per week for more than seven hours per day, the employee was no longer able to supplement her teaching employment with her part-time Fingerhut employment. The WCCA determined that under those facts, Judge Arnold reasonably concluded that the employee was entitled to retraining benefits to restore her lost earning capacity.

The remainder of the WCCA's decision then addressed the factors outlined in *Poole v. Farmstead Foods*, 42 W.C.D. 90, 978 (WCCA 1989) for determining whether a retraining program is appropriate. The WCCA found that each of the four *Poole* factors had been substantially satisfied, however, the WCCA focused its decision primarily on three of the *Poole* factors.

The WCCA noted that although the judge recognized that the potential physical demands on the employee's low back condition in traveling from her residence to the proposed school for retraining were "troubling," the judge ultimately believed that the employee and her physician were credible in their beliefs that the employee could complete the proposed retraining program, especially because she could complete it over a seven-year period of time. The employer argued that the employee's treating physician never formally reviewed the retraining plan to determine whether it would be physically suitable. The WCCA noted that the employee's treating physician "evidently discussed the proposed retraining program with the employee and her QRC, and suggested practical accommodations such as taking breaks, standing while in the classroom as opposed to sitting, and taking classes during summer months when the employee was not teaching at the high school." The WCCA held that substantial evidence supported the judge's determination that the employee had the physical and academic capability to succeed in the retraining program.

- A common issue is the request to amend the rehabilitation plan to request retraining. This was the issue addressed by the WCCA in *Graves v. Virginia Regional Medical Center*, File No. WC06-296 (WCCA 2007). The WCCA affirmed Compensation Judge Olson's determination that the plan should be amended for an award of retraining. Factors taken into consideration were the length of time since the injury (4 years), the fact that the employee was still working at a wage loss admittedly related to the injury, and the lack of evidence that the employee was expected to return to her pre-injury earning capacity at any time in the near future. The WCCA emphasized that this was not a determination of entitlement to retraining, merely exploration of retraining. The Court found this case to be similar to its decision in *Johnson v. Artic Cat, Inc*., where it concluded that exploration of retraining is appropriate if the employee has a loss of earning capacity causally related to the employee's work injury.

- The WCCA affirmed a determination by Special Master Pustarino that the *Poole* factors are not meant to be exclusive. In *Lardani v. Lardani Stucco,* slip op. (WCCA 2010), the employee obtained full time employment, post injury, at a wage loss. The QRC prepared a retraining plan for a construction project management program. The insurer's vocational expert concluded there was little likelihood of successful employment after retraining, and that the employee would not be able to reach the anticipated average weekly wage suggested in the retraining plan because of the depressed labor market in construction. The WCCA determined it is speculation to say whether the labor market with be as dismal in the future as it was at the present. The employee's family had contacts in the construction industry. The placement rate was at 82% and the government statistics anticipated a 10.7% increase in construction jobs before 2016. There were a lack of viable alternatives if the retraining plan was disapproved.

- In *Fisher v. Jim Lupient Auto Mall*, No. WC16-5976 (WCCA 2017), the WCCA reversed a compensation judge's denial of a proposed retraining plan, substituting its own factual determinations and judgement. The WCCA concluded that a diligent job search is not necessarily required for retraining. The employee was employed as an automobile repair technician from 1983 to 2013. On August 5, 2011, he sustained an admitted injury to his low back. Following the injury he was provided medium duty permanent restrictions and began working with a qualified rehabilitation consultant and with a job placement specialist. The employee underwent a job search for six months, at which time the QRC recommended exploration of retraining options. A Retraining Plan was developed, indicating the goal of obtaining a bachelor's degree in Operations Management at St. Thomas University. At the request of the employer, the employee also underwent an

independent vocational evaluation with rehabilitation consultant Berdahl. Mr. Berdahl contacted four universities/colleges and completed a labor market survey before concluding that the employee never properly conducted a serious job search and that the retraining plan was not appropriate. Mr. Berdahl recommended a less costly two-year associates degree with possible transfer to a four-year degree or another less costly business degree program at a college such as Metropolitan State University. Compensation Judge Kohl found that the evidence failed to support the reasonableness of the proposed retraining plan to attend St. Thomas University as compared to continued job placement activities or less costly retraining options, the likelihood that the proposed plan would result in reasonably attainable employment, and the likelihood that the proposed plan would produce an economic status as close as possible to that which the employee would have earned without his disability. The WCCA reversed. In reviewing the record, the WCCA found that the evidence showed that despite Mr. Berdahl's conclusion that the employee did not conduct a diligent job search, the evidence was that the employee spent 29 months conducting an extensive job search. The WCCA also found that the record supported the reasonableness of the retraining proposed by the employee as compared to the less costly retraining options, as the employer failed to demonstrate that suggested alternatives would be equally viable and effective in restoring the employee to suitable, gainful employment. The WCCA found that gainful employment was likely reasonably attainable upon completion of the operations management degree at St. Thomas with wages producing an economic status as close as possible to that the employee would have earned without the disability.

- In *Dahl v. Rice Cnty.*, No. WC17-6093 (WCCA 2018), the WCCA again reported that a diligent job search is not necessarily required for retraining. The court acknowledged that the evidence in the record reflected lengthy periods of time during which the employee was dealing with medical and mental health issues, familial issues, and an out-of-state relocation, and that both the QRC and employee testified that there was not a consistent level of participation and cooperation over the years. However, the WCCA concluded that, overall, and under the circumstances, the employee had sufficiently cooperated with rehabilitation. Interestingly, and in contrast to the decision in *Fischer*, in *Dahl*, the WCCA found that the issue of a diligent job search is a question of fact, and, because they agreed with the judge, the affirmed the judge on this issue.

2. Procedural Requirements

Prior to the 1995 legislation, there were no time limits as to when an employee could bring a claim for retraining. Any time the employee satisfied the eligibility requirements created by case law, the employee could potentially file a claim for retraining. Effective October 1, 1995, a request for retraining must be filed with the Commissioner *before* 104 weeks of any combination of temporary total or temporary partial disability benefits have been paid. Minn. Stat. §176.102, subd. 11(C). (The DOLI has indicated its position that the employee's request for retraining must be made by Rehabilitation Request or Claim Petition, rather than by letter — COMPACT, February 1998.) In *Grunzke v. Seaboard Farms*, slip op. (WCCA 2000), the WCCA held that the statutory amendment, Minn. Stat. §176.102, subd. 11(C), is not retroactive and applies only in cases in which the employee's injury was sustained on or after October 1, 1995.

For dates of injury after October 1, 2000, the statute has been amended to extend the time for requesting retraining to 156 weeks of any combination of temporary total or temporary partial disability benefits having been paid. For dates of injury after October 1, 2008, the time for applying for Retraining was extended to 208 weeks of payment of a combination of TTD and/or TPD benefits. Minn. Stat. §176.102, subd. 11(c).

In *Davidson v. Northshore Manufacturing*, slip op. (WCCA 1999), the employee sustained an injury on May 15, 1996 that resulted in surgery. He filed a Rehabilitation Request in September 1998, stating that "the employee requests retraining." No specific retraining plan was put forth. An administrative conference was held, and a judge ruled that the Rehabilitation Request was "not ripe for adjudication," but also ruled that by filing the request, the employee had "indefinitely tolled any statute of limitations imposed by Minn. Stat. §176.102, subd. 11(C)." At a subsequent hearing following the filing of a Request for Formal Hearing, Compensation Judge Donald Erickson concluded that the employee's filing of a Rehabilitation Request "indefinitely preserved his right to request retraining." The WCCA, considering the issue *en banc*, vacated the decision. It ruled that the issue was not ripe and no benefits were at stake. It stated that the circumstances of retraining may well never come to pass and that "while it is understandable for the parties to want guidance as to how the requirements of Minn. Stat. §176.102, subd. 11(C) may be satisfied, nothing in the Workers' Compensation Act allows for either advisory opinions or declaratory judgments." Therefore, the decisions of both compensation judges were vacated as premature. The WCCA noted that the employee filed his Rehabilitation Request, notifying the employer and insurer of his request for retraining and a decision as to whether "that filing satisfies the statute may be made if and when the employee actually seeks approval of some specific retraining plan in the future." *See also Wirrer v. Bostrom Sheet Metal Works*, slip op. (WCCA 2001) (decision on retraining not appropriate in absence of an actual present dispute over employee's entitlement to retraining benefits.)

Certain requirements were placed on the employer and insurer by the 1995 legislation. The employer and insurer must do the following in connection with the limitation on retraining:

a. The employee must be notified in writing of the 104-week limitation for filing a request for retraining [Note: effective for dates of injury after October 1, 2000, it is extended to 156 weeks and effective for dates of injury after October 1, 2008, it is extended to 208 weeks];

b. The written notice must be given *before* 80 weeks of temporary total disability or temporary partial disability benefits have been paid, regardless of the number of weeks that have elapsed since the date of injury;

c. If the notice is not given before 80 weeks, the period of time to file a request for retraining is extended by the number of days the notice is late, but in no event may a request be filed later than 225 weeks after the combination of temporary total disability or temporary partial disability benefits have been paid;

d. A fine may be assessed against the employer or insurer in the amount of $25 per day that the notice is late, up to a maximum penalty of $2,000. The fine is payable to the Commissioner for deposit in the Assigned Risk Safety Account. Minn. Stat. §176.102, subd. 11(d) (1995).

In *Schug v. City of Hibbing*, slip op. (WCCA 2003), the employee sustained an injury on August 26, 1998. On October 30, 1998, the employer sent a letter to the employee, together with the primary liability determination form, which advised the employee that any requests for retraining shall be filed before 104 weeks of any combination of TTD or TPD have been paid. On September 18, 2001, after 104 weeks of TTD and TPD had been paid, the employee's QRC filed a request for retraining. The Compensation Judge held that the notice to the employee of when he must request retraining was legally ineffective, as it was not reasonably calculated to inform the employee at a meaningful time that his right to retraining might expire. The WCCA reversed. The statutory notice was provided to the employee two months after the work injury. The WCCA noted that it may have been more preferable for the employer to have provided the notice later in the claim, but there was no statutory requirement as to when the notice must be given, other than it must be given before a combination of 80 weeks of TTD and TPD has been paid. The WCCA also concluded that Minn. Stat. §176.102, subd. 11(C) is unambiguous, and the plain meaning of the statute requires a denial of consideration of a retraining claim if an employee does not file a request for retraining before 104 weeks of any combination of TTD or TPD benefits have been paid, even though in its application the statute may yield unreasonable results.

- In *Clegg v. Winona Health Services,* slip op. (WCCA 2009), the WCCA affirmed Compensation Judge Patterson's determination that the employee's claim for retraining benefits was not barred by Minn. Stat.§ 176.102, subd. 11(c). The employee brought a claim for retraining benefits after she had been paid 181 weeks of combined temporary total and temporary partial disability benefits. The WCCA determined that the employer and insurer had failed to prove that they gave the employee the requisite notice regarding the limit of retraining as required by Minn. Stat. §176.102, subd. 11(d), and therefore, the claim for retraining was timely. While it was the claims adjuster's practice to attach a form benefit explanation letter, including the discussion of retraining limitations, there was no such letter in the insurer's file and no such letter attached to the documentation filed with the Department of Labor and Industry. There was no evidence offered by the insurer regarding the mailing procedures or evidence regarding proper service of the notification letter. Just because the letter was generated on the computer system does not establish that it was placed in an envelope, properly addressed and mailed.

3. Elements of a Retraining Plan

In order to formulate a retraining plan, it is generally assumed that vocational testing, including aptitude testing, should be conducted to determine whether the injured employee will meet the eligibility requirements established by case law. Once the requisites have been carried out, a proposed retraining plan must be developed and filed with the Commissioner that contains the information set forth in Minn. R. 5220.0750, subp. 2 (1993). The information required by that subpart is substantial and is as follows:

a. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

b. the retraining goal;

c. information about the formal course of study required by the retraining plan, including:

(1) the name of the school;
(2) titles of classes;
(3) the course's length in weeks, listing beginning and ending dates of attendance;
(4) an itemized cost of tuition, books, and other necessary school charges;
(5) mileage costs; and
(6) other required costs;

d. starting and completion dates;

e. pre-injury job title and economic status, including, but not limited to pre-injury wage;

f. a narrative rationale describing the reasons why retraining is proposed, including a summary comparative analysis of other rehabilitation alternatives and information documenting the likelihood that the proposed retraining plan will result in the employee's return to suitable gainful employment;

g. dated signatures of the employee, insurer, and assigned qualified rehabilitation consultant signifying an agreement to the retraining plan; and

h. an attached copy of the published course syllabus, physical requirements of the work for which the retraining will prepare the employee, medical documentation that the proposed training and field of work is within the employee's physical restrictions, reports of all vocational testing or evaluation, and a recent labor market survey of the field for which the training is proposed.

The Commissioner has 30 days within which to review the retraining plan and notify the parties of approval or denial. The employer and insurer have the right to contest a retraining plan by filing a Rehabilitation Request. Minn. R. 5220.750, subp. 5. That will initiate the review process, with the scheduling of an Administrative Conference and a Hearing before a compensation judge, if necessary.

Although the procedure established for retraining claims appears to anticipate that the plan be developed and certified before commencing the program, that is not a necessary requirement. In *Reitan v. Kurt Manufacturing Company*, slip op. (WCCA 1997), the WCCA affirmed a decision of a compensation judge which provided for a retroactive certification of a retraining program. In so doing, the WCCA specifically rejected the argument of the insurer that the retraining program could not be retroactively approved because the employee had failed to submit a Retraining Plan pursuant to Minn. R. 5220.0750, subp. 2. The WCCA found that the compensation judge had appropriately set forth the factors in *Poole v. Farmstead Foods*, 42 W.C.D. 970 (WCCA 1989) in awarding retraining benefits. Therefore, the fact that the employee had commenced the program prior to receiving certification was not a defect in approving the plan. *See also Lund v. Metropolitan Transit Commission*, 45 W.C.D. 479 (WCCA 1991) (a retraining plan can be retroactively approved where the employee completes a retraining program but did not obtain certification or follow the appropriate procedures for certification at the time of the initiation of training.)

The court has also held that it is important that the retraining plan substantially contain the information required in Minn. Rule 5220.0750, subp. 2. In *Tschudi v. Lakewood Entertainment*, slip. op. (WCCA 2011), the WCCA reversed an award of three year training program on the basis that the proposed retraining plan did not substantially contain the specific information required by Minn. Rule 5220.0750, subp. 2. The plan was not submitted on the required form, did not include a rehabilitation goal, and did not provide detailed information regarding the proposed normal course of study. There were also no starting and completion dates, a comparative analysis of other rehabilitation alternatives, information documenting the likelihood that the proposed plan would result in an employee's return to suitable gainful employment or any syllabus, rehabilitation testing, or market surveys. Most of the *Poole* factors weighed against approval of the plan. The WCCA determined the employee did not meet the burden of proof in establishing entitlement to retraining.

4. Discontinuance of a Retraining Plan

There are instances in which the employee does not make the grade in a retraining program. A number of potential scenarios could arise, such as failure to attend sufficient classes, receiving poor grades, or outright failure. The question becomes what facts are necessary in order to discontinue retraining benefits. The WCCA addressed this issue in *Erickson v. City of Proctor*, slip op. (WCCA 1997). The WCCA indicated that the issue presented is whether there is "good cause" to suspend, terminate, or alter a retraining plan pursuant to Minn. Stat. §176.102, subd. 8 and Minn. R. 5220.0510, subp. 5 (1993). In *Erickson*, the employer had alleged that the employee's performance level indicated that the plan could not be successfully completed. It sought to discontinue benefits for failure to cooperate with the plan. The WCCA indicated, however, that the issue was not non-cooperation with the retraining plan, but rather whether the employee would be able to successfully complete the retraining program. The case was remanded to the compensation judge for a resolution of that issue.

G. Other "Rehabilitation" Benefits

On rare occasions other types of claims are allowed as compensable rehabilitation expenses under Minn. Stat. 176.102, subd. 9(a)(2), which provides that an employer is liable for the "cost of all rehabilitation services and supplies necessary for implementation of the [rehabilitation] plan." In *Wong v. Won Ton Foods*, 50 W.C.D. 289 (WCCA 1993), *summarily aff'd* (Minn. 1994), the court upheld, as a compensable vocational rehabilitation benefit, the cost of a handicap accessible van to an employee whose work injury rendered him a quadriplegic. In *Wong*, it was specifically determined that the van would enable the employee to function independently and seek and engage in employment. The employee had demonstrated a physical capability of returning to his pre-injury vocation, as he was highly educated and had strong transferable skills. In contrast, in *Washek v. New Dimensions Home Health*, No. WC15-5861 (WCCA 2016), a request for a

handicap accessible vehicle was denied as there was no evidence that the request was part of a rehabilitation plan, in fact there was no rehabilitation plan, the employee was not physically capable of returning to her pre-injury vocation, and the employee had not been capable of working for almost 10 years.

VI. TERMINATION/CLOSURE OF REHABILITATION

In most instances, the rehabilitation plan is terminated when the employee returns to work and has achieved the goal of rehabilitation as stated at the outset. The Statute and Rules lay out very specific guidelines to be followed for closure or termination a rehabilitation plan. The Supreme Court's decision in *Halvorson v. B&F Fastener Supply*, 901 N.W.2d 425 (Minn. 2017) make it clear that specifically following these procedures is required.

Although not specifically addressed by any particular Statutory provision or Rule, a judicial adoption of an IME report finding no restrictions is a sufficient basis for termination of the rehabilitation plan. *Wiggin v. Marigold Foods*, No. WC04-136 (WCCA 2004); *Myers v. Super 8*, No. WC16-5908 (WCCA 2016).

A. Required Closure of the Plan

The assigned qualified rehabilitation consultant *shall* file a rehabilitation plan closure report with the Commissioner's office within 30 calendar days of one of the following events:

1. The employee has been steadily working at suitable gainful employment for 30 days or more, or the time provided for in the plan;

2. The employee's rehabilitation benefits have been closed out by an award on stipulation or award on mediation;

3. The employee and insurer have agreed to close the rehabilitation plan;

4. The qualified rehabilitation consultant has been unable to locate the employee following a good faith effort to do so;

5. The employee has died; or

6. The commissioner or a compensation judge has ordered that the rehabilitation plan be closed and there has been no timely appeal of that order.

Minn. R. 5220.0510, subp. 7 (1993).

When the employee has returned to suitable gainful employment, it should be argued that the qualified rehabilitation consultant may not keep the rehabilitation case open to provide continued medical management. Medical management is defined as "services that assist communication of information among parties about the employee's medical condition and treatment, and rehabilitation services

that coordinate the employee's medical treatment with the employee's vocational rehabilitation services. Medical management refers *only* to those rehabilitation services necessary to facilitate the employee's return to work." Minn. R. 5220.0100, subp. 20 (1993) (emphasis added). Once the employee returns to work, the goal of medical management has been accomplished and there is no further need for the QRC to keep their file open. *But See Schramel v. Belgrade Nursing Home*, WC14-5749 (WCCA 2015), where the WCCA held that the QRC's medical management activities even when the employee was off were "reasonably focused" on providing medical management with the goal of enabling a return to work, and that, therefore, the employer/insurer had to pay for these services.

B. "Good Cause" Closure of the Plan

Under the rehabilitation rules, the employer or insurer or the employee may at any time request the closure of rehabilitation services by filing a Rehabilitation Request with the Commissioner. If good cause is established, the Commissioner or compensation judge may terminate rehabilitation services. Good cause under the rules includes, but is not limited to:

1. A new or continuing physical limitation that significantly interferes with the implementation of the plan;

2. The employee's performance indicates that the employee is unlikely to successfully complete the plan;

3. The employee is not participating effectively in the implementation of the plan; or

4. The employee is not likely to benefit from further rehabilitation services.

Minn. R. 5220.0510, subp. 5 (1993).

Additionally, under Minn. Stat. 176.102, subd. 8(a), "upon request to the commissioner or compensation judge by the employer, the insurer, or employee, or upon the commissioner's own request, the plan may be suspended, terminated, or altered upon a showing of good cause, including:

1. a physical impairment that does not allow the employee to pursue the rehabilitation plan;
2. the employee's performance level indicates the plan will not be successfully completed;
3. an employee does not cooperate with a plan;
4. that the plan or its administration is substantially inadequate to achieve the rehabilitation plan objectives;
5. that the employee is not likely to benefit from further rehabilitation services.

An employee may request a change in a rehabilitation plan once because the employee feels ill-suited for the type of work for which rehabilitation is being provided. If the rehabilitation plan includes retraining, this request must be made within 90 days of the beginning of the retraining program."

- In *Moats v. Miltona Custom Meats*, No. WC13-5632 (WCCA 2014), the WCCA affirmed the denial of an employer/insurer's request to close rehabilitation services. The employer/insurer argued that the employee was in a physically and economically suitable position. Her current earnings resulted in weekly wage loss of between $0 and $88.00, and the employer/insurer argued that this was an economically suitable position. The court agreed that the job was physically suitable, but found that it was not economically suitable because the earnings varied from week-to-week, and because a wage loss of $88.00 per week is not insignificant to someone earning between $282 and $338.40 per week.

- In *Halvorson v. B&F Fastener Supply*, 901 N.W.2d 425 (Minn. 2017), the employee injured multiple body parts while working for the employer in an assembly position. She was unable to return to work for the date of injury employer. After extensive medical treatment, including several surgeries (with some minimal employment between the surgeries, under restrictions) she then began working for McDonald's within similar restrictions as prior to her last surgery. The employer and insurer filed a request to terminate the employee's rehabilitation benefits because she was no longer a "qualified employee" under Minn. Rule 5220.0100, subp. 22, because her job at McDonalds was suitable gainful employment. The employer and insurer initially also asserted there was "good cause" to terminate her rehabilitation under Minn. Rule 5220.0510, subp. 5, because she would not likely benefit from further rehabilitation services. At the hearing, however, the only issues the parties argued were: (1) whether the employee was still a qualified employee; and (2) whether she had returned to suitable gainful employment. The issue of whether "good cause" existed to terminate rehabilitation services pursuant to Minn. Rule 5220.0510, subp. 5, was withdrawn by the employer and insurer. The compensation judge held that the employee's job at McDonald's was suitable gainful employment and that she was not a qualified employee under Minn. Rule 5220.0100, subp. 22. The judge allowed the rehabilitation plan to be terminated. The WCCA reversed, holding that it was necessary to evaluate the plain language of the statute and rules for vocational rehabilitation services. The WCCA held that the compensation judge had improperly expanded the issues at hearing and also applied an incorrect standard to terminate rehabilitation benefits. Under Minn. Rule 5220.0100, subp. 22, the definition of "qualified employee" does not provide a specific provision to terminate rehabilitation benefits. Instead, to terminate rehabilitation benefits, the standards are found under Minn. Rule 5220.0510, subp. 5 (stating that to terminate or suspend rehabilitation benefits, the employer and insurer can bring a rehabilitation request for good cause under one of four criteria), and Minn. Stat. §176.102, subd. 8 (stating that to terminate rehabilitation, one of five different criteria can be

met to meet "good cause"). However, none of the factors laid out in the rule or statute were raised at the hearing. Because the definition of a "qualified employee" does not provide a basis to terminate rehabilitation benefits, and the proper standards under Minn. Rule 5220.0510, subp. 5, and Minn. Stat. §176.102, subd. 8, were not before the compensation judge, the compensation judge's decision was reversed.

This case was appealed to the Minnesota Supreme Court, which conducted a thorough review of the statute and rules and agreed with the WCCA that the employer/insurer failed to seek file closure under the correct provisions in the Statute. Therefore, the Supreme Court affirmed the WCCA decision.

C. Closure for Failure to Cooperate

The rehabilitation plan can also be terminated or suspended if the employee does not make a good faith effort to participate and cooperate in a rehabilitation plan. Minn. Stat. §176.102, subd. 13 provides that "all" workers' compensation benefits may be discontinued or forfeited during the time that the employee refuses to participate in a rehabilitation evaluation or does not make a good faith effort to participate in a rehabilitation plan. In order to establish grounds for discontinuance on this basis, the employer or insurer must show evidence of the Rehabilitation Plan and establish the employee's non-cooperation.

VII. QRC STANDARD OF CONDUCT

An often overlooked section of the Rehabilitation Rules is the section governing the conduct of the QRC. QRCs are held to a standard of objectivity. Good faith disputes may arise among parties about rehabilitation services or about the direction of a rehabilitation plan. However, the Rules require that a rehabilitation provider remain professionally objective in conduct and in recommendation on all cases. Minn. R. 5220.1801, subp. 4a (1993).

The Rules further indicate that the role and functions of a claims agent and a rehabilitation provider are separate. A QRC shall engage only in those activities designated in Minnesota Statute §176.02 and rule adopted thereunder. Minn. R. 5220.1801, subp. 8 (A) (1993).

Additionally, a QRC cannot provide any medical, rehabilitation or disability case management services related to an injury that is compensable under Minnesota Statute §176 when those services are part of the same claim, unless the case management services are part of an approved rehabilitation plan. Minn. Stat. §176.102, subd. 10 (2013). Basically, effective October 2013, a QRC can no longer operate in the capacity of a Disability Case Manager in a consultative role, without an approved plan.

The QRC cannot act as an advocate for or advise any party about a claims or entitlement issue. Minn. R. 5220.1801, subp. 8B. This Rule indicates that a QRC cannot engage in any of the following activities regarding any claim for workers' compensation benefits:

1. Claims adjustment;

2. Claims investigation;

3. Determining liability or setting reserves for a claim;

4. Authorizing or denying provision of future medical or rehabilitation services;

5. Recommending, authorizing, or denying payment of medical or rehabilitation bills;

6. Making recommendations about the determination of workers' compensation monetary benefits;

7. Arranging for medical examinations not recommended by the treating doctor; or

8. Arranging for or participating in surveillance or investigative work.

Minn. R. 5220.1801, subp. 9 (1993) goes on to state that the following conduct is specifically prohibited and is grounds for discipline:

a. Reporting or filing false or misleading information or a statement in connection with a rehabilitation case or in procuring registration or renewal of registration as a rehabilitation provider, whether for oneself or for another.

b. Conviction of a felony or a gross misdemeanor reasonably related to the provision of rehabilitation services.

c. Conviction of crimes against persons.

d. Restriction, limitation, or other disciplinary action against the rehabilitation provider's certification, registration, or right to practice as a rehabilitation provider in another jurisdiction for offenses that would be subject to disciplinary action in this state, or failure to report to the department the charges which have been brought in another state or jurisdiction against the rehabilitation provider's certification, registration, or right to practice.

e. Failure or inability to perform professional rehabilitation services with reasonable skill because of negligence, habits, or other cause, including the failure of a qualified rehabilitation consultant to monitor a vendor or qualified rehabilitation consultant intern, or

the failure of a rehabilitation provider to adequately monitor the performance of services provided by a person working at the rehabilitation provider's direction.

f. Engaging in conduct likely to deceive, defraud, or harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a rehabilitation client.

g. Engaging in conduct with a client that is sexual or may be reasonably interpreted by the client as sexual or in any verbal behavior that is seductive or sexually demeaning to a client or engaging in sexual exploitation of a client or a former client.

h. Obtaining money, property, or services other than reasonable fees for services provided to the client through the use of undue influence, harassment, duress, deception, or fraud.

i. Engaging in fraudulent billing practice.

j. Knowingly aiding, assisting, advising, or allowing an unqualified person to engage in providing rehabilitation services.

k. Engaging in adversarial communication or activity. Adversarial communication includes, but is not limited to:

(1) requesting or reporting information not directly related to an employee's rehabilitation plan;
(2) deliberate failure or delay to report to all parties pertinent information regarding an employee's rehabilitation including, but not limited to, whether the employee is a qualified employee;
(3) misrepresentation of any fact or information about rehabilitation; or
(4) failure to comply with an authorized request for information about an employee's rehabilitation.

l. Providing an opinion on settlement and recommending entering into a settlement agreement.

m. Making a recommendation about retirement; however, a rehabilitation provider may assist an employee in contacting resources about a choice of retirement or return to work.

n. Failure to take due care to ensure that a rehabilitation client is placed in a job that is within the client's physical restrictions.

o. Failure to maintain service activity on a case without advising the parties of the reason why service activity might be stopped or reduced.

p. Failure to recommend plan amendment, closure, or another alternative when it may be reasonably known that the plan's objective is not likely to be achieved.

q. Unlawful discrimination against any person on the basis of age, gender, religion, race, disability, nationality, or sexual preference, or the imposition on a rehabilitation client of any stereotypes of behavior related to these categories.

VIII. REHABILITATION SERVICE FEES AND COSTS

Historically, the rates for rehabilitation services performed by QRCs and placement vendors have been determined by the DOLI. The initial rates were set in 1993, and since then have been adjusted, according to rule, by the adjustment percentage established by Minn. Stat. §176.645. The $10 per hour reduction in the rates after rehabilitation services have been performed for more than 39 weeks or in excess of $3,500 remains intact. In addition, the rules contain requirements for the form and timing of billings. Minn. R. 5220.1900.

Pursuant to statute and rules, the employer/insurer has the primary responsibility for monitoring and the sole responsibility for paying the cost of necessary rehabilitation services provided. Minn. Stat. §176.102, subd. 9; Minn. R. 5220.1900, subp. 1 (1993). The statute also provides that an employer is not liable for charges for services provided by a rehabilitation consultant or vendor unless the employer or its insurer receive a bill for those services within 45 days of the provision of services. Minn. Stat. §176.102, subd. 9(c). This requirement may be waived if the rehabilitation consultant or vendor can prove that the failure to submit the bill as required by this paragraph was due to circumstances beyond the control of the rehabilitation consultant or vendor. *Id*. The rehabilitation consultant or vendor may not collect payment from any other person, including the employee, for bills that an employer is relieved from liability for paying under this paragraph. *Id*. Additionally, a QRC who continues to provide rehabilitation services during the pendency of a dispute over rehabilitation eligibility runs the risk of non-payment in the event that the employer prevails at a hearing on the merits. *Breeze v. FedEx Freight, Inc.*, slip op. (WCCA 2014)(interpreting *Parker v. University of Minnesota*, slip op. (WCCA 2003)); *Sebghati v. Life Time Fitness, Inc.*, No. WC14-5740 (WCCA 2015).

A. *Billings*. All rehabilitation provider billings shall be on the "vocational rehabilitation invoice" prescribed by the Commissioner. Minn. R. 5220.1900, subp. 1a (1993).

B. *Fees*. Please refer to the discussion at the beginning of this section.

C. *Consultants' Rates*. Please refer to the discussions at the beginning of this section. A rehabilitation provider shall bill one-half of the hourly rate for wait time and ¾ of the hourly rate for travel time. Minn. R. 5220.1900, subp. 1c (1993). The current hourly rate is $108.78 as of October 1, 2017.

D. *Interns*. When billing on an hourly basis, the upper billing limit for a QRC intern shall be $10 per hour less than the hourly rate charge for services provided by QRCs employed by the same firm. Minn. R. 5220.1900, subp. 1d (1993).

E. *Job Development and Placement Services*. When billed on an hourly basis, job development and placement services shall be billed at an hourly rate not to exceed $50 per hour, subject to the above adjustments. Minn. R. 5220.1900, subp. 1e (1993). The current rate, as of October 1, 2016, is $82.58.

F. *Fee Reduction*. Billing services provided by the QRC or QRC intern based upon an hourly rate shall be reduced by $10 per hour when:

1. the duration of the rehabilitation case exceeds 39 weeks from the date of the first in-person visit between an assigned QRC and the employee; or

2. the cost of rehabilitation services billed by the QRC has exceeded $3,500, whichever comes first.

Minn. R. 5220.1900, subp. 1f (1993).

G. *Payment*. Within 30 days after receiving a rehabilitation provider's bill, the employer or insurer must pay the charge or any portion of the charge that is not denied, deny all or part of the charge stating the specific service charge and the reason it is excessive or unreasonable, or specify the additional data needed, with written notification to the rehabilitation provider. Minn. R. 5220.1900, subp. 1g (1993).

H. *Billing Limits*. A QRC cannot bill more than eight hours for a rehabilitation consultation and the development, preparation, and filing of a rehabilitation plan, unless the QRC has to travel over 50 miles to visit the employee, employer, or health care provider, or an unusually difficult medical situation is documentable. Minn. R. 5220.1900, subp. 6b (1993). A QRC cannot bill more than two hours in a 30-day billing cycle during job placement unless the QRC is performing job placement services. Minn. R. 5220.1900, subp. 6a (1993).

APPENDIX

Appendix
A-1

Disability Status Report

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

Disability Status Report

Filed as required by Minn. Rules 5220.0110, subp. 7

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DS 01

DO NOT USE THIS SPACE

1. WID or SSN	2. DATE OF INJURY
3. EMPLOYEE NAME	
4. EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	5. EMPLOYEE PHONE #

6. EMPLOYER	7. EMPLOYER CONTACT PERSON	8. PHONE #

9. INSURER/SELF-INSURER/TPA	12. TITLE OF JOB AT DATE OF INJURY	
10. INSURER ADDRESS	13. AVERAGE WEEKLY WAGE AT DATE OF INJURY	14. JOB AT DATE OF INJURY ☐ FULL TIME ☐ PART TIME
CITY STATE ZIP CODE	15. NUMBER OF DAYS OF DISABILITY	16. IS THE EMPLOYEE CURRENTLY WORKING? ☐ YES ☐ NO
11. INSURER CLAIM NUMBER	17. WILL THE DISABILITY LIKELY EXTEND BEYOND 13 WEEKS? (see instructions on back) ☐ YES ☐ NO	

18. REASON FOR FILING THE DISABILITY STATUS REPORT: **(Check A or B)**

Was a consultation requested? ☐ NO ☐ YES If yes, consultation requested by:

☐ Insurer ☐ Employer ☐ Employee on _____ (date of request)

☐ A. The employee is being referred for a rehabilitation consultation. (Insurer must send a copy of this Disability Status Report, the First Report of Injury, and the treating physician's Report of Work Ability to the QRC before the rehabilitation consultation.)

Name of QRC _____

☐ B. A waiver of the rehabilitation consultation is being requested. (An offer of suitable gainful employment signed by the date-of-injury employer and the Report of Work Ability must be attached.)

Projected return to work date _____

Name of insurer representative completing form	Phone number	Extension	Date served on employee

Distribution: Workers' Compensation Division, Employee

Instructions to Insurer

The Disability Status Report (DSR) is used to notify parties that you are either referring the injured worker for a rehabilitation consultation or requesting a waiver of the consultation. The DSR, with a Report of Work Ability (RWA), must be mailed to the injured worker and filed with the Department of Labor and Industry:

- Within 14 calendar days of knowledge that the employee's temporary total disability is likely to exceed 13 cumulative weeks; or
- Within 90 calendar days of the date of injury when the employee has not returned to work following a work injury; or
- Within 14 calendar days after receiving a request for a rehabilitation consultation, whichever is earlier; or
- Within 14 calendar days of expiration of an approved waiver of rehabilitation services.

To Refer for a Rehabilitation Consultation:

If you are referring the injured worker for a rehabilitation consultation, check Box 18A. Send a copy of the DSR form, the First Report of Injury and the treating physician's Report of Work Ability to the QRC prior to the consultation. Fill in the name of the QRC on the form and indicate which party requested the consultation. If the employee requested the consultation, fill in the date of the request.

To Request a Waiver of a Rehabilitation Consultation:

M.S. § 176.102, subd. 4 and Minn. Rules 5220.0110 and 5220.0120 provide that the commissioner may grant a waiver of a rehabilitation consultation to an otherwise qualified employee if there is documentation that the employee will return to suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for waiver is filed. A waiver will not be granted unless documentation is submitted that a suitable job offer within the treating doctor's restrictions has been made.

If you are requesting a waiver, check Box 18B and attach the following documentation:

- Report of Work Ability or other medical report with the same information from the treating doctor which indicates that the employee will be released to return to work within 90 calendar days after the request for waiver is filed and specifying the employee's work restrictions in functional terms.
- Written offer of suitable gainful employment signed by the employer that is within the treating doctor's restrictions to which the employee will return within the timeframe indicated above. Include <u>one</u> of the following:
    - If the employer is offering the employee his/her date-of-injury job, any modifications of the job to accommodate the employee's restrictions must be noted.
    - If the written offer of suitable gainful employment (which does not include temporary, light-duty) is for a different job with the date-of-injury employer, the offer must include the job title, job environment, work tasks, weekly wage, physical, mental and educational demands of the job, and/or employer modifications of the job to accommodate the employee's restrictions.

Instructions to Employee

If you do not agree with the insurer's recommendation for a rehabilitation consultation or a waiver of rehabilitation consultation, you may file a Rehabilitation Request with the Department of Labor and Industry. If you have questions call the Benefit Management and Resolution Unit at 1-800-342-5354 or 651-284-5032.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-2

Rehabilitation Consultation Report

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

Rehabilitation Consultation Report

Enter dates in MM/DD/YYYY format.

RC01

DO NOT USE THIS SPACE

1. WID or SSN	2. DATE OF INJURY
3. EMPLOYEE NAME	
4. EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	5. EMPLOYEE PHONE #

6. EMPLOYER NAME	7. EMPLOYER CONTACT PERSON	8. ER PHONE #

9. INSURER CLAIM NUMBER	14. QRC NAME
10. INSURER/SELF-INSURER/TPA	15. QRC FIRM
11. INSURER ADDRESS	16. QRC ADDRESS
CITY STATE ZIP CODE	CITY STATE ZIP CODE

12. CLAIM REPRESENTATIVE	13. CLAIM REP PHONE #	17. QRC #	18. QRC FIRM #	19. QRC PHONE #

20. Is the employee permanently precluded or likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury? ☐ Yes ☐ No

21. Can the employee reasonably be expected to return to suitable gainful employment with the date-of-injury employer? ☐ Yes ☐ No

22. Can the employee reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability? ☐ Yes ☐ No

23. I have consulted with the date-of-injury employer regarding the above issues. ☐ Yes ☐ No

24. **Check Box A, B or C as applicable:**

☐ A. It is my opinion that the employee is a qualified employee and eligible for rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.

☐ B. It is my opinion that the employee is not a qualified employee and is not eligible to receive rehabilitation services at this time according to Minn. Rules 5220.0100, subp. 22.

☐ C. The parties have informed me that they wish to initiate statutory rehabilitation services at this time.

ATTACH A NARRATIVE REPORT EXPLAINING THE BASIS FOR YOUR DETERMINATION

25. Date of rehabilitation consultation	QRC Signature	QRC Intern Signature (if applicable)

QRC: File this form with the Department of Labor and Industry within 14 days of date in Box 25 (the first in-person meeting or the first telephone conference) as required by Minn. Rule 5220.0130. If the employee is eligible for rehabilitation services, a Rehabilitation Plan (R-2) must be developed and circulated to the parties within 30 days of the initial meeting and filed with the Department within 45 days of the initial meeting as required by Minn. Rule 5220.0410.

Employee: If you disagree with or have questions about the information provided on this form, you are encouraged to contact the QRC and insurer to discuss any concerns. If your concerns are not resolved, you may call the Department's Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354 or request a determination by filing a Rehabilitation Request with the Department.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

cc: Employee, Employer, Insurer, and Attorney(s)

Appendix
A-3

R-2 Rehabilitation Plan

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

R-2
Rehabilitation Plan

PRINK IN INK or TYPE
Enter dates in MM/DD/YYYY format.

RE01

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

1. WID or SSN	2. DATE OF INJURY
3. EMPLOYEE NAME	
4. EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	5. EMPLOYEE PHONE NUMBER / 6. DATE OF BIRTH
7. EMPLOYER NAME	8. EMPLOYER CONTACT PERSON / 9. PHONE #
10. INSURER CLAIM NUMBER	15. QRC NAME
11. INSURER/SELF-INSURER/TPA	16. QRC FIRM
12. INSURER ADDRESS	17. ADDRESS
CITY STATE ZIP CODE	CITY STATE ZIP CODE
13. CLAIM REPRESENTATIVE / 14. PHONE NUMBER	18. QRC # / 19. QRC FIRM # / 20. QRC PHONE NUMBER
21. Occupation at time of injury / 22. Pre-injury AWW	25. Highest grade completed (select one)

23. Job at date of injury: ☐ Part time ☐ Full time

24. Employee's work status

- ☐ a. Off work from DOI to start of rehabilitation
- ☐ b. Some work between DOI and start of rehabilitation, not working at start of rehabilitation
- ☐ c. Working at start of rehabilitation

25. Highest grade completed (select one)

- ☐ a. No high school diploma or GED
- ☐ b. High school diploma or GED
- ☐ c. Some post secondary course work
- ☐ d. Post secondary vocational/technical program
- ☐ e. Bachelor's degree
- ☐ f. Master's, PhD or professional degree

26. Employee may require an interpreter: ☐ Yes ☐ No

27. Date of rehabilitation consultation (start date)

28. Vocation goal

☐ a. RTW same employer ☐ b. RTW different employer

Comments:

VOCATIONAL REHABILITATION PLAN

SERVICE CATEGORY and CODE (from VRI)	DESCRIPTION	SERVICE START DATE	SERVICE END DATE	ESTIMATED DAYS	ESTIMATED COST
			TOTALS		

Employee Comments:

STATEMENT OF EMPLOYER/INSURER RESPONSIBILITY: The employer/insurer understands its responsibility to pay for services reasonably required and to monitor the costs and timelines of the services. M.S. § 176.102, subd. 9 and Minn. Rules 5220.1900, subp. 1g.

STATEMENT OF QRC RESPONSIBILITY: I understand that I am responsible for the timely delivery of the above specified services pursuant to M.S. § 176.102 and Minn. Rules 5220.0100-.1900 and agree to conscientiously carry out my professional duties as a Qualified Rehabilitation Consultant in the interest of the employee's rehabilitation. Should the estimated cost of this plan be exceeded or if additional time is required for completion of the plan, I will notify the Department and the parties by submitting a Rehabilitation Plan Amendment (R-3) in accordance with M.S. § 176.102, subd. 8 and Minn. Rules 5220.0510.

STATEMENT OF EMPLOYEE RESPONSIBILITY: I understand that it is my responsibility to cooperate with all parties involved in my rehabilitation and I agree to make a good faith effort to participate in this plan. This includes attendance at scheduled activities and appointments, and adherence to reasonable medical advice.

TO THE PARTIES: If you disagree with the plan, you have 15 days from the receipt of the proposed plan to resolve the disagreement or object to the proposed plan. The objection must be filed with the Department on a Rehabilitation Request form.

Send a copy of this plan to the employee's treating health care provider if permitted by Minn. Rules 5220.1802, subp. 5 (Minn. Rules 5220.0410, subp. 7).

Attach a copy of your initial evaluation report (Minn. Rules 5220.1803, subp. 5).

☐ Employee has read and signed the form "Rights and Responsibilities of the Injured Worker"

☐ Employee has read and declined to sign the form "Rights and Responsibilities of the Injured Worker"

Employee Signature	Date
Claim Representative Signature	Date
QRC Signature	Date

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-4

R-3 Rehabilitation Plan Amendment

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

R-3
Rehabilitation Plan Amendment

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

RP01

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

1. WID or SSN	2. DATE OF INJURY	3. DATE OF REHABILITATION CONSULTATION: (#27 on R-2)
4. EMPLOYEE NAME		8. QRC NAME
5. INSURER/SELF-INSURER/TPA		9. ADDRESS
6. INSURER CLAIM NUMBER		CITY STATE ZIP CODE
7. EMPLOYER NAME		10. QRC # / 11. QRC FIRM # / 12. PHONE NUMBER
13. CHANGE OF QRC ☐ Yes ☐ No		PREVIOUS QRC # / NEW QRC #
14. WITHDRAWAL OF QRC? ☐ Yes ☐ No		
15. PROPOSED AMENDMENT/RATIONALE (attach separate sheet as necessary)		
16. EMPLOYEE COMMENTS		

	Plan costs to date		Other costs necessary to complete plan		Estimated total cost
17. Costs		+		=	
18. Plan duration from plan filing date (in weeks)	Duration to date	+	Expected additional duration to plan completion	=	Estimated total duration

19. Specify any additional rehabilitation services or changes to the current plan that will be required:

SERVICE CATEGORY and CODE (from VRI)	DESCRIPTION	PROJECTED COMPLETION DATE	PROJECTED COST

20. Is this form being filed in lieu of a Plan Progress Report? ☐ Yes ☐ No If yes, complete #21-23.
See Minn. Rule 5220.0450, subp. 3.A.

21. Is the employee released to return to work? ☐ Yes, with restrictions ☐ Yes, without restrictions ☐ No	Medical report date
22. Current work status: ☐ Not working ☐ Part time ☐ Full time ☐ Seasonal layoff	If working, is this a temporary job? ☐ Yes ☐ No
23. Do barriers to successful completion of the rehabilitation plan exist? ☐ Yes ☐ No If yes, list these on a separate sheet along with the measures to be taken to overcome those barriers, and attach it to this form.	
Employee Signature	Date
Claim Representative Signature	Date
QRC Signature	Date

cc: Employee, Insurer, Attorney(s) or other parties

Instructions to QRC

Proposed plan amendment without a change of QRC:

The QRC or other parties may propose amendments to current rehabilitation plans. It is the QRC's responsibility to facilitate discussion of proposed amendments and file the Rehabilitation Plan Amendment (R-3) form when appropriate. Once an amendment has been proposed, the QRC shall provide copies of the R-3 to the employee, insurer, and any attorneys representing the employee or insurer. The QRC shall also send a copy of the R-3 to the date of injury employer if the goal is to return the employee to work with that employer.

Proposed plan amendment including a change of QRC:

1. If the employee has the right to change QRC's without approval per Minn. Rule 5220.0710, subpart 1, the new QRC must file an R-3 with the Department of Labor and Industry within 15 calendar days of receipt of the information transferred by the former QRC. However, it is not necessary to circulate for signatures. Copies must be sent to the parties listed on the form.
2. If approval of a change of QRC is required per Minn. Rule 5220.0710 and the insurer has approved the change, the new QRC must circulate the R-3 for signatures and file with the Department of Labor and Industry within 15 days of obtaining the signatures.
3. If approval of a change of QRC is required and the insurer objects to the change, the insurer should file a Rehabilitation Request form with the Department of Labor and Industry within 15 days of the receipt of the R-3.

Proposed plan amendment for withdrawal of QRC when insurer has denied further liability for the injury for which rehabilitation services are being provided:

If a claim petition, objection to discontinuance, request for administrative conference, or any other document initiating litigation has been filed on the liability issue, a QRC who elects to withdraw must file the R-3 with the Department of Labor and Industry and send copies to the parties, including a separate copy to the Department's Vocational Rehabilitation Unit. If no litigation is pending on the liability issue, the QRC may withdraw by filing an R-8 Plan Closure form if permitted by Minn. Rule 5220.0510, subp. 7.

Instructions to Other Parties

Within 15 days of receiving a proposed amendment:

1. If you agree with the amendment, sign the R-3 and return to the QRC; or
2. If you disagree with the amendment, notify the QRC of your objections and try to work with the QRC to resolve them. If the issues are not resolved, the objecting party must file a Rehabilitation Request with the Department of Labor and Industry within 15 days of the receipt of the R-3.

NOTE: If a party fails to sign or object to a proposed amendment within 15 days of receiving the R-3, the amendment is deemed approved.

This material can be made available in different forms, such as large print, Braille, or on a tape. To request call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-5

Plan Progress Report

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

Plan Progress Report

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

PR01

DO NOT USE THIS SPACE

1. DATE OF THIS REPORT			
2. WID or SSN	3. DATE OF INJURY		
4. EMPLOYEE NAME			
5. EMPLOYEE ADDRESS			
CITY STATE ZIP CODE		6. DATE OF REHABILITATION CONSULTATION: (#27 on R-2)	
7. EMPLOYER NAME		8. EMPLOYER CONTACT PERSON	9. PHONE NUMBER
10. INSURER CLAIM NUMBER		15. QRC NAME	
11. INSURER/SELF-INSURER/TPA		16. QRC FIRM	
12. INSURER ADDRESS		17. ADDRESS	
CITY STATE ZIP CODE		CITY STATE ZIP CODE	
13. CLAIM REPRESENTATIVE	14. PHONE NUMBER	18. QRC # / 19. QRC FIRM #	20. PHONE NUMBER

21. Is the employee released to return to work? ☐ Yes, with restrictions ☐ Yes, without restrictions ☐ No — Medical report date

22. Current work status: ☐ Not working ☐ Part time ☐ Full time ☐ Seasonal layoff — If working, is this a temporary job? ☐ Yes ☐ No

23. Is the plan still current? ☐ Yes ☐ No

	Plan costs to date		Other costs necessary to complete plan		Estimated total cost
24. Costs		+		=	

	Duration to date		Expected additional duration to plan completion		Estimated total duration
25. Plan duration from plan filing date (in weeks)		+		=	

26. Do barriers to successful completion of the rehabilitation plan exist? ☐ Yes ☐ No

If yes, list these on a separate sheet along with the measures to be taken to overcome those barriers, and attach it to this form.

This form is required to be filed 6 months after filing the R-2 (unless an R-3 is filed 15 days before or after 6 months have passed since the R-2 filing date). See Minn. Rules 5220.0450, subp. 3 A. Send copies to the employee, insurer, and attorney(s). Send to the date-of-injury employer if the goal of the rehabilitation plan is to return to work with that employer.

This material can be made available in different forms, such as large print, Braille, or on a tape. To request call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-6

On the Job Training Plan

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

On the Job Training Plan

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

JA04

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	
INSURER/SELF-INSURER/TPA	

INSURER CLAIM NUMBER	OJT JOB TITLE
OJT EMPLOYER NAME	OJT BEGINNING DATE
OJT EMPLOYER ADDRESS	OJT ENDING DATE
CITY STATE ZIP CODE	OJT PLAN PROGRESS EVALUATION DATE(S)

Does this OJT employer intend to hire the employee upon completion of the OJT? ☐ Yes ☐ No

JOB DESCRIPTION (attach a job analysis, or describe the nature of the work, giving examples of duties)

Job must be within the employee's physical restrictions. ATTACH MEDICAL REPORT.

List the skills the employee will acquire through this training:

List supplies and tools needed during training (itemize costs):

	TOTAL COSTS	
WEEKLY WAGES AND WORKERS' COMPENSATION BENEFITS	**Start of OJT**	**End of OJT**
Weekly wages paid by OJT Employer		
Weekly workers' compensation benefits paid by Insurer		

RATIONALE FOR OJT: see Minn. Rule 5220.0850, subp. 2(N)
[NOTE: Justification is required for plans EXCEEDING 6 months: see Minn. Rule 5220.0850, subp. 3]

ACCEPTED PLAN: If all parties are in agreement with (and have signed) this OJT Plan, submit it to the Department with the required attachments for approval or denial (see Minn. Rule 5220.0850, subp. 4).

Employee Signature	Print or type name	Phone number	Date
Insurer Representative Signature	Print or type name	Phone number	Date
OJT Employer Signature	Print or type name	Phone number	Date
OJT Trainer Signature	Print or type name	Phone number	Date
QRC Signature	Print or type name	Phone number	Date
QRC Number			

INSTRUCTIONS TO QRC

DISPUTED PLAN: To resolve a disputed OJT Plan, call the Department's Benefit Management and Resolution Unit at (651) 284-5032, and/or file a Rehabilitation Request (see Minn. Rule 5220.0850, subp. 5). **DO NOT SUBMIT A DISPUTED PLAN to the Department without attaching it to a Rehabilitation Request, unless a Rehabilitation Request has been filed or will be filed by another party.**

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

For Department Use Only

☐ Approved ☐ Denied			
DLI Representative Signature	Print or type name	Phone number	Date
Reason for denial:			

Appendix
A-7

Insurer's Notice to Employee: Request for Retraining

Insurer's Notice to Employee: Request for Retraining

Date

Claimant Name
Claimant Address
City, State, Zip

Re: Request for Retraining Notice

Dear Claimant Name:

In accordance with MN Stat. §176.102, subd. 11(d)(1995), you are hereby notified that any request that you may make for retraining benefits pursuant to MN Stat. §176.102, subd. 11 and Minn. Rules Part 5220.0750 must be filed with the Commissioner of the Department of Labor and Industry before you have been paid 104 weeks of any combination of temporary total disability and/or temporary partial disability benefits.

As of the date of this notice, ____/_____/_____, you have been paid ____ weeks of temporary total disability benefits and ____ weeks of temporary partial disability benefits, for a combined total of ____ weeks of disability benefits.

The Department of Labor and Industry recommends that you file a Rehabilitation Request form or a Claim Petition with the department if you wish to request retraining. You may obtain a Rehabilitation Request form by calling the Minnesota Department of Labor and Industry at (612) 296-2432.

Sincerely,

Claims Management Specialist

Appendix
A-8

Retraining Plan

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

Retraining Plan

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

EP04

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	
EMPLOYER NAME	
INSURER/SELF-INSURER/TPA	

INSURER CLAIM NUMBER	CLAIM REPRESENTATIVE	PHONE NUMBER

Pre-injury job title		Pre-injury wage	Current compensation rate
Occupational goal(s)		Anticipated wage (from Labor Market Survey) to	
Certificate/Degree program title	Program length (weeks)	Program start date	Program completion date
School name		City, State	

ITEMIZED COSTS:

Tuition/Lab/Activity fees	
Books/Tools	
Special/Unique costs*	
Custodial Day Care	
Travel/Parking	
Total retraining costs (excluding wage benefits)	

* Explain (for example, tutoring, board and lodging)

REQUIRED ATTACHMENTS: Pursuant to Minn. Rule 5220.0750, subp. 2(H), the following items MUST BE ATTACHED.

a. Course syllabus/class titles.

b. Physical requirements of the job for which the employee is being trained. (On-site job analysis is preferred.)

c. Medical information that the training and the occupational goals are within the employee's restrictions.

d. Test results which support course choice.

e. Recent labor market survey.

RETRAINING RATIONALE: see Minn. Rule 5220.0750, subp. 2(F)

ACCEPTED PLAN: If all parties are in agreement with (and have signed) this Retraining Plan, submit it to the Department with the required attachments for approval or denial (see Minn. Rule 5220.0750, subp. 5).

Employee Signature	Print or type name	Phone number	Date
Insurer Representative Signature	Print or type name	Phone number	Date
QRC Signature	Print or type name	Phone number	Date
QRC Number			

INSTRUCTIONS TO QRC

NOTE: Retraining is limited to 156 weeks.

DISPUTED PLAN: To resolve a disputed Retraining Plan, call the Department's Benefit Management and Resolution Unit at (651) 284-5032 and/or file a Rehabilitation Request (see Minn. Rule 5220.0950). **DO NOT SUBMIT A DISPUTED PLAN to the Department without attaching it to a Rehabilitation Request, unless a Rehabilitation Request has been filed or will be filed by another party.**

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

For Department Use Only

☐ Approved ☐ Denied			
DLI Representative Signature	Print or type name	Phone number	Date
Reason for denial:			

Appendix
A-9

R-8 Notice of Rehabilitation Plan Closure

Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

R-8
Notice of
Rehabilitation Plan Closure

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NR01

DO NOT USE THIS SPACE

1. DATE OF REHABILITATION CONSULTATION: (#27 on R-2)		
2. WID or SSN	3. DATE INJURY	8. QRC NAME
4. EMPLOYEE NAME		9. ADDRESS
5. DATE-OF-INJURY EMPLOYER		CITY STATE ZIP CODE
6. INSURER/SELF-INSURER/TPA		10. QRC NUMBER / 11. QRC FIRM # / 12. QRC PHONE #
7. INSURER CLAIM NUMBER		13. NAME OF LAST REGISTERED REHAB VENDOR / 14. VENDOR #

15. EMPLOYMENT STATUS AT PLAN CLOSURE (check one)

- ☐ a. Employee RTW with DOI employer
- ☐ b. Employee RTW with different employer
- ☐ c. Employee not employed (Skip to item 21)

COMPLETE #16-20 IF EMPLOYEE RETURNED TO WORK

16. EMPLOYER AT PLAN CLOSURE

17. JOB TITLE AT PLAN CLOSURE

18. Gross weekly wage at RTW

19. RTW DATE

20. RETURN TO WORK JOB:
☐ Same job ☐ Modified job ☐ Different job

21. REASON FOR REHABILITATION PLAN CLOSURE (check one)
(see instructions on back)

- ☐ a. Plan completed (employee returned to suitable gainful employment)
- ☐ b. Award on Stipulation/Mediation
- ☐ c. Commissioner or Compensation Judge Order
- ☐ d. Employee and insurer have agreed to close the plan
- ☐ e. Unable to locate employee
- ☐ f. Death of employee
- ☐ g. QRC withdrawal

22. Did employee have an attorney?
☐ Yes ☐ No

23. PLAN CLOSURE DATE

24. Check if services provided:
☐ On-the-job training ☐ Retraining

25. Cost of **prior** QRC Firm services other than placement	$
26. Cost of **current** QRC Firm services other than placement	$
27. Cost of any job placement and job development provided by **prior** QRC Firm	$
28. Cost of any job placement and job development provided by **current** QRC Firm	$
29. Cost of job placement and job development by Registered Rehabilitation Vendor(s) (including CARF accredited)	$
30. Cost of other rehabilitation services (retraining, on-the-job training, relocation, testing, etc.)	$
31. Total cost of rehabilitation services (add 25-30)	$

By signing this form, I certify that copies of this form and attachments are being sent to the insurer, any attorney(s), the Department of Labor and Industry , and if required to the VRU, and to the employee at the following address:

32. QRC signature	33. Date form completed

EMPLOYEE: IF YOU HAVE QUESTIONS ABOUT THE CLOSURE OF THIS REHABILITATION PLAN, CALL THE DEPARTMENT OF LABOR AND INDUSTRY AT 651-284-5032 OR 1-800-342-5354.

Instructions to QRC

The Notice of Rehabilitation Plan Closure (R-8) form must be filed with the Department of Labor and Industry within 30 calendar days of knowledge that: (see Minn. Rules 5220.0510, subps. 7 and 7a)

a. the employee has been steadily working at suitable gainful employment for 30 days or more, or the time period provided for in the plan
b. the employee's rehabilitation benefits have been closed out by an award on stipulation or award on mediation
c. the commissioner or a compensation judge has ordered that the rehabilitation plan be closed and there has been no timely appeal of that order
d. the employee and insurer have agreed to close the rehabilitation plan
e. the QRC has been unable to locate the employee following a good faith effort to do so
f. the employee has died
g. the QRC decides to withdraw after the insurer has provided written notice to the employee, the employee's attorney, the commissioner, and the QRC that the insurer is denying further liability for the injury for which rehabilitation services are being provided. **In this situation, the QRC must file the R-8 and attach a copy of the insurer's notice of denial, copying appropriate parties, including a separate copy to the Department's Vocational Rehabilitation Unit.**

NOTE: This does not apply if a claim petition, objection to discontinuance, request for an administrative conference, or other document initiating litigation has been filed on the liability issue. If one of these documents has been filed and the QRC decides to withdraw, the QRC shall document the withdrawal by filing a Rehabilitation Plan Amendment (R-3).

ATTACH A CLOSURE REPORT SUMMARIZING SERVICES PROVIDED. (see Minn. Rule 5220.0510, subp. 7(4))

Send copies of the R-8 to the employee, insurer, and attorney(s). If the insurer is denying further liability, send a separate copy addressed to the Department's Vocational Rehabilitation Unit.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

Appendix
A-10

Rehabilitation Job Placement Plan and Agreement (JPPA) (Decertified)

Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155
WHEN COMPLETED, MAIL TO ABOVE ADDRESS

REHABILITATION JOB PLACEMENT PLAN AND AGREEMENT (JPPA)

Employee: _____ S.S.#: _____
Address: _____ DOI: _____
_____ Insurer: _____
QRC: _____ Ins. Cl. # _____
PS: _____ Target Date: _____
Starting Date: _____

Vocational Areas of Job Search

Checklist of data submitted by QRC:

_____ medical release defining physical limitations
_____ list of transferable skills
_____ vocational testing or evaluation if appropriate
_____ training in job seeking skills
_____ labor market analysis

The job placement plan contains the following items, which reflect the optimum expectations of the employee during the job seeking effort. These items can be modified to reflect varying abilities to perform and the job market reality.

The Employee:

_____ full-time job seeking, 6-8 hours/day, 5 days/week
_____ 2-3 applications submitted daily
_____ 2-3 contacts with placement specialist weekly
_____ immediate follow-up on job leads
_____ 4-5 cold call job searches daily
_____ 2 interviews weekly
_____ job search up to a 50 mile radius
_____ legible daily log of activities available for review

The Placement Specialist (PS):

_____ 2-3 contacts with employee weekly
_____ 10 job leads provided weekly
_____ 2 interviews arranged weekly
_____ daily log of activities

The Insurer:

_____ Reimbursement for reasonable travel expenses

the Job Placement Plan and Agreement should reflect the reality of the employee's ability to eng age in job seeking and the service provider's ability to perform in the current labor/job market. A disagreement with the items of responsibility does not necessarily mean non-cooperation, and each may be negotiated and modified.

Comments or exceptions to the plan:

Date	Employee's Signature	
Date	Employee's Representative (if any)	
Date	Qualified Rehabilitation Consultant	Reg. #
Date	Placement Specialist (QRC or Vendor)	Reg.
Date	Insurer	

Appendix
A-11

Rehabilitation Request

CHECK BOX IF THIS REQUEST ADDS REHABILITATION ISSUES TO A PENDING REHABILITATION REQUEST ☐

Rehabilitation Request

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NOTE: Before filing this form, call the workers' compensation insurer. If that does not resolve the issue, call Workers' Compensation Benefit Management and Resolution Unit at (651) 284-5032 (or 1-800-342-5354).

RQ03

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
EMPLOYER NAME	
EMPLOYER ADDRESS	
CITY STATE ZIP CODE	

INSURER/SELF-INSURER/TPA		
INSURER ADDRESS		
CITY STATE ZIP CODE		
CLAIM REPRESENTATIVE NAME		
INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- This form must be filled out **completely**; otherwise, it may be **returned** to you.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- This form may not be used to request wage loss, medical, or permanent partial disability benefits.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ **YES** ☐ **NO**

1. **THIS REQUEST IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ QRC/ Vendor

2. **REHABILITATION ISSUES (check only those that apply)**
I request:

☐ a. that rehabilitation services/consultation be provided. Attach medical report which lists restrictions.

☐ b. a change of QRC (qualified rehabilitation consultant):

FROM	
	NAME
	FIRM NAME
	ADDRESS
	PHONE # (include area code)

TO	
	NAME
	FIRM NAME
	ADDRESS
	PHONE # (include area code)

☐ c. that the rehabilitation plan be changed.

☐ d. retraining or exploration of retraining.

☐ e. that the rehabilitation plan be terminated.

☐ f. that the rehabilitation plan be suspended.

☐ g. that the employee's rehabilitation expenses be reimbursed. Attach itemized bills and supporting documentation.

☐ h. that QRC/vendor bills be paid. Attach supporting QRC/vendor reports and itemized bills.

☐ i. other (explain)

(over)

3. Explain the details of your request. Attach all documents, such as medical reports and rehabilitation reports/bills, which support your request. A decision may be based solely on these documents, the Workers' Compensation Division file, and the response to this form.

4. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, QRC/vendor and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #4 on _____ (date)

PRINT NAME OF PERSON FILING THIS REQUEST			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, SEND IT AND ALL ATTACHMENTS TO:

Benefit Management and Resolution Unit
Workers' Compensation Division
Department of Labor and Industry
PO Box 64218
St. Paul, MN 55164-0218

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-12

Rehabilitation Response

Rehabilitation Response

RR03

DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

THIS FORM RESPONDS TO ISSUES RAISED ON THE REHABILITATION REQUEST FORM WHICH WAS SIGNED ON _____(date)

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	PHONE # (include area code)

EMPLOYEE ADDRESS			INSURER/SELF-INSURER/TPA		
CITY	STATE	ZIP CODE	INSURER ADDRESS		
EMPLOYER NAME			CITY	STATE	ZIP CODE
EMPLOYER ADDRESS			CLAIM REPRESENTATIVE NAME		
CITY	STATE	ZIP CODE	INSURER CLAIM #	INSURER PHONE #	EXT

INSTRUCTIONS:

- All parties are expected to try to resolve issues themselves, using the Department of Labor and Industry to settle disputes only when these attempts fail.
- This form must be filled out completely.
- The injured worker's name, WID or social security number, and date of injury must be written on all attached documents.
- Insurers must file this form with the Department of Labor and Industry, and serve this form on the other parties, within 10 days after service of the Rehabilitation Request. All others should file this form with the Department of Labor and Industry, and serve it on all parties, within 20 days after service of the Rehabilitation Request.

I AM INTERESTED IN TRYING TO RESOLVE ISSUES INFORMALLY THROUGH MEDIATION.
For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354. ☐ YES ☐ NO

1. **THIS RESPONSE IS BEING COMPLETED BY:**

☐ Employee ☐ Employee's Attorney ☐ Employer ☐ Insurer/TPA Self-insured ☐ Insurer's Attorney ☐ QRC/ Vendor

2. **RESPONSE TO ISSUES RAISED ON REQUEST FORM (check only those that apply)**

a. I ☐ agree ☐ disagree with the request for rehabilitation consultation/services.

IF A QRC IS BEING ASSIGNED, GIVEN NAME AND ADDRESS AND INDICATE WHO SELECTED THE QRC.

NAME	FIRM NAME	ADDRESS	SELECTED BY

b. I ☐ agree ☐ disagree with the request to change QRCs.

c. I ☐ agree ☐ disagree that the rehabilitation plan should be changed.

d. I ☐ agree ☐ disagree with the request for retraining/exploration of retraining.

e. I ☐ agree ☐ disagree that the rehabilitation plan should be terminated.

f. I ☐ agree ☐ disagree that the rehabilitation plan should be suspended.

g. I ☐ agree ☐ refuse to reimburse the employee for rehabilitation expenses.

h. I ☐ agree ☐ refuse to pay the requested QRC/vendor bills. Attach list of service charges disputed and reasons for dispute.

i. Response to "Other":

YOU MUST COMPLETE # 3 BELOW IF YOU DISAGREE WITH ANY PART OF THE REQUEST.

3. Explain why you disagree with the request and why it should not be granted. Attach extra sheets if necessary. You must attach medical reports, QRC/vendor reports or other documents which are needed to support your position. A written decision may be based solely upon review of this form, its attachments, the Workers' Compensation Division file, and the Rehabilitation Request form.

4. Send a copy of this form and all attachments to all parties, including the employee, employer, insurer, QRC/vendor, and attorneys. Provide the names and addresses below. Attach extra sheets if necessary.

NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE
NAME	ADDRESS	CITY, STATE, ZIP CODE

I sent a copy of this form and all attachments to the parties listed in #4 on _____ (date)

PRINT NAME OF PERSON FILING THIS RESPONSE			SIGNATURE		
ADDRESS			ATTORNEY REGISTRATION #		
CITY	STATE	ZIP CODE	PHONE # (include area code)	EXT	DATE SIGNED

WHEN YOU HAVE FULLY COMPLETED THIS FORM, SEND IT AND ALL ATTACHMENTS TO:

Benefit Management and Resolution Unit
Workers' Compensation Division
Department of Labor and Industry
PO Box 64218
St. Paul, MN 55164-0218

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Appendix
A-13

Rehabilitation Rights and Responsibilities of the Injured Worker

Rehabilitation Rights and Responsibilities of the Injured Worker

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

IW 0 5

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	

The purpose of vocational rehabilitation is to assist you (the injured worker) so that you may return to your former job, to a job related to your former employment, or to a job in another work field. The job should be physically appropriate and produce an economic status as close as possible to that which you would have enjoyed without disability.

The first step in this return to work process is a Rehabilitation Consultation with a Qualified Rehabilitation Consultant (QRC) to determine if you qualify for rehabilitation services. If the QRC determines that you are qualified, the next step is the development of a rehabilitation plan. Your QRC will help you develop and implement this plan. Consideration will be given to your former employment, the current labor market and your qualifications, including transferable skills, previous work history, age, education and interests.

YOUR RIGHTS

Under the provisions of the Minnesota Workers' Compensation Law, you (the injured worker) ***have certain rehabilitation rights. These rights include:***

- Selection of your own Qualified Rehabilitation Consultant (QRC). The employer/insurer will generally refer you to a QRC. You may choose your own QRC up to 60 days after a written rehabilitation plan is filed with the State. Any further change of QRC must be mutually agreed upon or determined to be in the best interest of the parties by the Commissioner or a compensation judge.

- When a QRC first meets or writes to contact you, he or she is required to disclose to you in writing, any affiliation or ownership interest between the QRC (or the QRC firm) and your employer/insurer or adjusting company. The QRC is also required to disclose to you and all parties to a case, any affiliation or business referral arrangement between the QRC (or the QRC firm) and any other parties to the case, including attorneys and doctors.

- If the QRC determines that you are eligible for vocational rehabilitation, a rehabilitation plan, which may include training if needed, will be developed. The rehabilitation services required to carry out the plan will be provided at no cost to you.

- The right to request a change in your rehabilitation plan.

- The right to receive a copy of your rehabilitation plan. The right to obtain a copy of any required progress records upon request.

- The right to request assistance from the Workers' Compensation Division of the Minnesota Department of Labor and Industry. If you have questions about your rehabilitation plan, call 651-284-5032 or 800-342-5354. If there is a dispute about your eligibility for statutory rehabilitation services or the rehabilitation plan, you may file a Rehabilitation Request and the Department may schedule an administrative conference in order to resolve the dispute.

(over)

WID or SSN	DATE OF INJURY	EMPLOYEE NAME

IW 05

YOUR RESPONSIBILITIES

In addition to the above rights, you (the injured worker) have certain rehabilitation responsibilities under the workers' compensation law. ***These responsibilities include the following:***

- You must cooperate with reasonable medical and rehabilitation examinations and evaluations as ordered by the Commissioner.
- You must make a good faith effort to participate in your rehabilitation plan. Failure to do so may result in suspension or termination of your rehabilitation or monetary benefits.
- You must advise your QRC and insurance company of your wage, hours, employer and job title when you return to work with any employer and when your hours or wages change. This is necessary to accurately calculate your wage loss benefits and to ensure rehabilitation services are appropriate. Failure to accurately report wages earned while receiving workers' compensation benefits may result in civil or criminal consequences.

The statements below are requested to verify whether you received the documents listed and that the information on this form has been explained to you. You are not required to provide the information requested below or sign this form. Your workers' compensation benefits will not be affected if you choose not to provide the information or sign the form. This form will be filed with the Minnesota Department of Labor and Industry, and may also be provided to the Office of Administrative Hearings and law enforcement agencies.

Employee, check any that apply:

☐ The above information has been explained to me and I have been provided with a copy of this form.

☐ I have received written notification from the QRC disclosing any affiliation or business referral arrangement the QRC or QRC firm may have with any parties to my case and a written explanation of any affiliation or ownership interest the QRC or QRC firm may have with my employer/insurer, and any other insurer or adjusting company.

☐ The QRC has informed me that he/she and the QRC firm have no affiliation or ownership interest or business referral arrangement with any parties to my case or any other insurer or adjusting company.

EMPLOYEE SIGNATURE		DATE
QRC SIGNATURE	QRC NUMBER	DATE

PROVIDING THE INFORMATION ON THIS FORM TO THE INJURED WORKER IS REQUIRED BY MINNESOTA STATUTES SECTION 176.102, SUBD. 4C AND MINNESOTA RULES, PART 5220.1803, SUBP. 1 AND 1A.

THIS MATERIAL CAN BE MADE AVAILABLE IN DIFFERENT FORMS, SUCH AS LARGE PRINT, BRAILLE OR ON TAPE. TO REQUEST, CALL (651) 284-5030 OR 1-800-342-5354 (DIAL-DLI)/VOICE OR TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

The QRC must sign and date this form at the first in-person contact with the employee, and must provide a copy to the employee and the insurer. The QRC must also provide a copy of this form to the Department of Labor and Industry.

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032
1-800-342-5354 (DIAL-DLI)

Appendix
A-14

Report of Work Ability

Report of Work Ability

See Instructions of Reverse Side

RW 01

DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410,I subd. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

WID or SSN	DATE OF INJURY
EMPLOYEE	
EMPLOYER	
INSURER/SELF-INSURER-TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office _____

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☐ Employee is able to work with restrictions, from _____(date) to _____(date)

The restrictions are:

3. ☐ Employee is unable to work from _____ (date) to _____(date)

The next scheduled visit is: ☐ as needed OR _____

NAME (Type or Print)			SIGNATURE		DEGREE
ADDRESS			STATE	LICENSE #/REGISTRATION #	
CITY	STATE	ZIP CODE	PHONE # (include area code)		DATE SIGNED

MN RW01(5/08)

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent that one every two weeks;
2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and
3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, WID or social security number, and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third-party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2, or 3.
    1. If the employee is able to work without restrictions, fill in the beginning date.
    2. If the employee is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).
    3. If the employee is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.
- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Wisconsin – Wis. Stat. §102.29

The proceeds will be distributed according to the provisions of 102.29, Wisconsin Statutes, as follows:

1. $100,000.00 total amount of third party settlement.
2. $40,000.00 to employee's attorney as cost of collection (fee and costs).
3. $20,000.00 one-third of balance to employee.
4. $20,000.00 to worker's compensation insurance carrier or self-insured employer as reimbursement for payment of
    a. $10,000.00 in compensation, and
    b. $10,000.00 in medical expenses.
5. $20,000.00 balance to employee which shall constitute a cushion or credit against any additional claim under worker's compensation.

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Wisconsin Worker's Compensation Quick Reference Guide

1. Third-party situations.

Every time a worker is injured at work, there are at least two parties, namely, the worker and the employer, for purposes of workers' compensation litigation. However, when the worker is injured through the fault or negligence of someone who is not an agent of his employer, issues of workers' compensation subrogation and employer liability arises as a result of claims that may be brought against the negligent third party. These situations typically arise in automobile accidents, construction accidents, product liability accidents, premises accidents, and medical malpractice claims.

2. Workers' compensation subrogation.

The employer by statute has an opportunity to separately pursue reimbursement of workers' compensation benefits paid and payable or let the injured worker do so before the statute of limitations runs. Wis. Stat. § 102.29. If either the injured worker or the employer bring suit, they must provide "reasonable notice" to the other and presumably this is done by naming and serving the suit on the other as an involuntary plaintiff. *See,* Wis. Stat. § 803.03; *Anderson v. Garber,* 466 N.W.2d 721 (Wis. App. 1991); *Employers Mut. Liability Ins. Co. of Wisconsin,* 388 N.W.2d 658 (Wis. App. 1986). The court has discretion to enforce a global settlement when either the injured worker or the employer is unwilling to consent to a reasonable settlement. *Dalka v. American Family Mutual Ins. Co.*, 799 N.W.2d 923 (Wis. Ct. App. 2011); *Bergren v. Staples*, 263 Wis. 477, 57 N.W.2d 714 (1953).

3. Workers' compensation as an exclusive remedy.

Under Wis. Stat. § 102.03(2), an injured worker cannot sue his employer for anything other than workers' compensation benefits unless the employer has independent liability under a collective bargaining agreement, a local ordinance, or something similar to the dual capacity doctrine. *See,* Wis. Stat. § 102.03(2); *Houlihan v. ABC Ins. Co.*, 542 N.W.2d 178 (Wis. App. 1995), *review denied*, 546 N.W.2d 470 (Wis. 1995). Similarly, an injured worker cannot sue a co-worker unless that co-worker committed "an assault intended to cause bodily harm," was negligently operating "a vehicle not owned or leased by the employer" or has breached some independent duty to the coworker. *See,* Wis. Stat. § 102.03(2); *Ortman v. Jensen & Johnson,* 225 N.W.2d 635 (Wis. 1975); *Luppovici v. Hunzinger Construction Co.*, 255 N.W.2d 590 (Wis. 1997). In a loaned servant situation, an injured worker is precluded from pursuing claims against either the special or borrowing employer or the general or lending employer. *See, Braun v. Jewett,* 85 N.W.2d 364 (Wis. 1957).

4. No Employer liability or Coverage B exposure.

In *Anderson v. Garber, 466 N.W.2d 721 (Wis. App. 1991)*, the Wisconsin courts confirmed that they are unwilling to recognize any employer liability under the exclusive remedy provisions cited above. However, an employer can be liable to a third-party tortfeasor if they have contractually agreed to indemnify them.

5. Statutory distribution under Wis. Stat. § 102.29

Upon recovery from a third-party tortfeasor, either by way of trial or settlement, generally, the worker's attorney takes the first third or contingent fee agreed, and then the employee receives one third of the settlement or verdict amount received by the

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injured worker. Out of the remaining two thirds, the employer is paid 100% of their lien less and the remainder is then given back to the worker and is available as a credit against future workers' compensation benefits. The employer has no discount for the cost of collection on past or future benefits. This statutory distribution is required unless the parties consent to do otherwise. *See, Nelson v. Rothering*, 496 N.W.2d 87 (Wis. 1993); *Skirowski v. Employers Mut. Cas.*, 462 N.W.2d 245 (Wis. 1990) *review denied*, 465 N.W.2d 656 (Wis. 1990); *Huck v. Chicago, St. Paul, M&O Ry. Co.*, 111 N.W.2d 434 (Wis. 1963). The court is allowed to deviate to some degree or at least exclude portions of a settlement from the formula distribution in circumstances that involve a spouse's loss of consortium claim, a wrongful death claim where some next of kin are not workers' compensation beneficiaries. See *generally, Brewer v. Auto-Owners Ins. Co*, 418 N.W.2d 841 (Wis. App. 1987).

6. Uninsured and underinsured motor vehicle.

The employer has no right to recover workers' compensation paid and payable from an underinsured or uninsured motor vehicle policy. *Berna; Mork v. Jones*, 498 N.W.2d 221 (Wis. 1993).

7. Statutes of Limitations and Repose (Generally).

TYPE OF CLAIM	APPLICABLE LAW	TIME PERIOD
Personal injury	Wis. Stat. § 893.54	Three years
Wrongful death	Wis. Stat. § 893.54	Three years
Contract	Wis. Stat. § 893.43	Six years
Medical malpractice	Wis. Stat. § 893.54 Wis. Stat. § 893.80(1)(m)	Three years, however, notice of injury must be given within 180 days of discovery
Statute of Repose	Wis. Stat. § 893.89	Ten years for improvements to real property

8. Helpful Internet Links:

NAME/SUBJECT	WEB ADDRESS TO LINKS	NOTE
Wisconsin State Legislature, Statutes and Legislative History	http://www.legis.state.wi.us/RSB/STATS.HTML	Workers' Compensation Statute: Chapter 102; Subrogation § 102.29.
Wisconsin Department of Workforce Development	http://www.dwd.state.wi.us/wc/	General Information. Advisory Council
Workers' Compensation Office of the Commissioner of Insurance	http://oci.wi.gov/workcomp.html	
State Bar of Wisconsin	http://www.wisbar.org	

Contact Information

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Blake W. Duerre, Co-Chair	612 375-5932	*bwduerre@ArthurChapman.com*
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Wisconsin – Wis. Stat. §102.29(1) Formula – Example

Assumptions:

1. $550,000.00 = Total Gross settlement;
2. $4,263.20 = Total costs incurred by Plaintiff's counsel;
3. $50,542.88 = WC Carrier's Total to-date lien (to-date workers' compensation benefits "paid")

***Wis. Stat. §102.29(1)* – Formula:**

Reduce Gross Recovery by "Reasonable" Cost of Collection (includes attorney's fees and costs): First, "reasonable" attorney's fees are subtracted from the gross recovery. What precisely constitutes "reasonable" contingent fees can be subject to debate and is ultimately determinable by the court. *Meyer v. Michigan Mut. Ins. Co.*, 609 N.W.2d 167 (Wis. App. 2000). If workers' compensation carrier and the injured worker both have counsel who jointly press the claim, the attorney fees allowed as part of the costs of collection shall be, unless otherwise agreed upon, divided between the attorneys for those parties as directed by the court or by the Department. Wis. Stat. §102.29(1)(d).

After attorney's fees are subtracted from the gross recovery, reasonable costs associated with the recovery effort are also deducted.

Standard 1/3 Contingent Fee on Gross Recovery = $550,000.00 x 1/3 = $183,333.33

	$550,000.00	Gross Recovery
-	$183,333.33	(Employee's Counsel's Contingent Fees)
-	$4,263.20	(Employee's Attorney's Costs)
	$362,403.47	

Calculation of Employee's 1/3 Share of the Recovery Remaining *After* Reduction for Costs/Fees: Wis. Stat. §102.29(1)(b)(1) provides that, "[a]fter deducting the reasonable cost of collection, one-third of the remainder shall in any event, be paid to the injured employee or the employee's personal representative or other person entitled to bring an action." Wis. Stat. §102.29(1)(b)(1).

$362,403.47 x 1/3 = $120,801.15 = (Employee's 1/3 share of the *net* recovery)

Calculation of Worker's Compensation Carrier's "Cash" Subrogation Recovery

Out of the balance remaining after the deduction and payment of the reasonable costs of collection and the injured worker's 1/3 share, the employer or workers' compensation carrier, if applicable, shall be reimbursed for *all* payments made by the employer/workers' compensation carrier or which the employer/workers' compensation carrier may be obligated to make in the future. Wis. Stat. §102.29(1)(b)(2).

	$362,403.47	(Amount remaining after reduction of reasonable costs of collection)
-	$120,801.15	(Employee's statutory 1/3 share)
	$241,602.32	(Balance Remaining *after* payment of Employee's statutory 1/3 share)
-	$50,542.88	(WC Carrier's Total WC Benefits Paid To-Date)
	$191,059.44	(Excess – Paid to Employee and Workers' Compensation Carrier's "Cushion")

Calculation of the Worker's Additional Share and Workers' Compensation Carrier's "Cushion"/ "Future Credit": Any balance remaining after reimbursement of the workers' compensation benefits to the employer/workers' compensation carrier under Wis. Stat. §102.29(1)(b)(2), shall be paid to the employee or the employee's personal representative or other person entitled to bring an action and shall operate as a "cushion" or "credit" against future workers' compensation benefits payable under the Act. Wis. Stat. §102.29(1)(b)(3); *Rightman v. Honkamp*, 245 Wis. 68, 13 N.W.2d 597 (Wis. 1944); *Sutton v. Kaarakka*, 168 Wis. 2d 160, 483 N.W.2d 259 (Wis. Ct. App. 1992). If the cushion is paid to the employee, it is a credit against future workers' compensation payments. If it is escrowed or reserved by the workers' compensation carrier, the insurer generally retains the interest as part of the cushion. *See Sutton v. Kaarakka*, 168 Wis. 2d 160, 483 N.W.2d 259 (Wis. Ct. App. 1992). The cushion is generally taken in a dollar-for-dollar, up-front manner that amounts to a "holiday" against future workers' compensation benefit payments until such time as the credit is exhausted.

	$550,000.00	Gross Recovery
-	$183,333.33	(Employee's Counsel's Contingent Fees)
-	$4,263.20	(Employee's Attorney's Costs)
	$362,403.47	(Amount remaining after reduction of reasonable costs of collection)
-	$120,801.15	(Employee's statutory 1/3 share)
	$241,602.32	(Balance Remaining *after* payment of Employee's statutory 1/3 share)
-	$50,542.88	(WC Carrier's Total WC Benefits Paid To-Date)
	$191,059.44	(Excess – Paid to Employee and Workers' Compensation Carrier's "Cushion")

Summary

	$550,000.00	**(Gross Settlement)**
-	**$187,596.53**	**(WC Carrier &Worker underwrite cost of collection reduction from gross settlement)**
-	**$50,542.88**	**(WC Carrier's *net* cash recovery)**
-	**$311,860.59**	**(Employee's total cash recovery is $120,801.15 = statutory 1/3 share plus**
-	**$191,059.44,**	**in excess paid to Employee after cash subrogation reimbursement to carrier and this amount operates as a "cushion" in WC Carrier's favor, against future workers' compensation benefits payable.)**

$000,000.000

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Bradley L. Idelkope

Minnesota Workers' Compensation Subrogation Distribution Worksheet Minn. Stat. §176.061, Subd. 6

WCRA SubroCalc Web page: http://www.wcra.biz/newcalcs/Subro_Calc.aspx

Variables: **A: Total recovery**		$ *150,000*	$ *100,000*	$ *60,000*
B: Atty's fees plus costs *a + Z2,000*		$ *52,000*	$ *35,333*	$ *22,000*
C: W.C. benefits paid to date		$ *60,000*	$ *60,000*	$ *60,000*
D: Cost of collection percentage				
B: $ *52,000* $ *35,333* $ *22,000*		35 %	35 %	35 %
A: $ *150,000* $ *100,000* $ *60,000*				

Minn. Stat. §176.061, Subd. 6

"The proceeds of all actions for damages or of a settlement of an action under this section ... shall be divided as follows:	A:	$ *150,000*	$ *100,000*	$ *60,000*
(Attorney's share)				
(a) After deducting the reasonable cost of collection, including, but not limited to, attorney fees and burial expenses in excess of the statutory liability, then !	B:	$ *52,000*	$ *35,333*	$ *22,000*
(remainder) =		$ *98,000*	$ *64,667*	$ *38,000*
(Worker's share)				
(b) One-third of the remainder shall, in any event, be paid to the injured employee or the employee's dependents, without being subject to any right of subrogation. !		$ *32,667*	$ *21,556*	$ *12,667*
(balance remaining) =		$ *65,333*	$ *43,111*	$ *25,333*
(Employer's share)				
(c) Out of the balance remaining, the employer ... shall be reimbursed in an amount equal to all benefits paid (C:$*60,000*) less the product of the costs deducted under clause (a) (B:$*52,000*) divided by the total proceeds received by the employee or his dependents from the other party (A:$*150,000*) multiplied by all benefits paid by the employer ... (C:$*60,000*) to the employee or the employee's dependents.				
[C:$*60,000* x (1-D:*35*%) or (*.65*)] [C:$*60,000* x (1-D:*35*%) or (*.65*)] [C:$*60,000* x (1-D:*37*%) or (*.63*)] !		$ *39,000*	$ *39,000*	$ *25,333*
(balance remaining) =		$ *26,333*	$ *4,111*	$ *-0-*
(Future credit)				
(d) Any balance remaining shall be paid to the employee or the employee's dependents and shall be a credit to the employer…for any benefits which the employer ... is obligated to pay, but has not paid, and for any benefits that the employer ... is obligated to make in the future."				

Algebraic Formula:
C - [(B) A) x C] = Employer Share

Short Cut:
C x (1 ! D) = Employer Share

DISCLAIMER: This summary is intended as an educational resource and is not intended to provide definitive answers. Consultation with the applicable laws and/or competent counsel should always be obtained.

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MINNESOTA WORKERS' COMPENSATION SUBROGATION DISTRIBUTION WORKSHEET MINN. STAT. §176.061, SUBD. 6

WCRA SubroCalc Web page: http://www.wcra.biz/newcalcs/Subro_Calc.aspx

Variables:	**A:**	**Total recovery**	$____	$____	$ _____
	B:	**Atty's fees plus costs** $____	$____	$ _____	
	C:	**W.C. benefits paid to date**	$____	$____	$ _____
	D:	**Cost of collection percentage**			
	B:	**$** _____ $ _____ $ _____	____%	____%	____%
	A:	**$** _____ $ _____ $ _____			

Minn. Stat. §176.061, Subd. 6

"The proceeds of all actions for damages or of a settlement of an action under this section ... shall be divided as follows:

A: $____ $____ $_____

(Attorney's share)

(a) After deducting the reasonable cost of collection, including, but not limited to, attorney fees and burial expenses in excess of the statutory liability, then (remainder)

! B: $____ $____ $____
= $ $ $

(Worker's share)

(b) One-third of the remainder shall, in any event, be paid to the injured employee or the employee's dependents, without being subject to any right of subrogation. (balance remaining)

! $____ $____ $____
= $ $ $

(Employer's share)

(c) Out of the balance remaining, the employer ... shall be reimbursed in an amount equal to all benefits paid (C:$____) less the product of the costs deducted under clause (a) (B:$____) divided by the total proceeds received by the employee or his dependents from the other party (A:$____) multiplied by all benefits paid by the employer ... (C:$__) to the employee or the employee's dependents.
[C:$ _____ x (1-D: _%) or (. _)]
[C:$_____ x (1-D: _%) or (.__)]
[C:$_____ x (1-D: _%) or (.__)]

Algebraic Formula:
C - [(B) A) x C] = Employer Share

Short Cut:
C x (1 ! D) = Employer Share

! $____ $____ $ _____
(balance remaining) = $ $ $

(Future credit)

(d) Any balance remaining shall be paid to the employee or the employee's dependents and shall be a credit to the employer ... for any benefits which the employer ... is obligated to pay, but has not paid, and for any benefits that the employer ... is obligated to make in the future."

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Minnesota – Minn. Stat. §176.061, Subd. 6 Formula – Example

Assumptions:

1. $550,000.00 = Total Gross settlement;
2. $4,263.20 = Total costs incurred by Plaintiff's counsel;
3. $50,542.88 = WC Carrier's Total to-date lien (to-date workers' compensation benefits "paid")

Factors impacting recovery under the formula:

A. Gross Recovery $550,000.00

B. Employee Fault % 0 $ 0.00

C. Cost of Collection/Attorney's fees $187,596.53

(Cost of Collection Percentage x Gross or Net Recovery, No.'s 1 or 2 below, depending upon whether there is employee fault)

($183,333.33 in Contingent Fees + $4,263.20 in Costs = $187,596.53)

D. Percentage Cost of Collection

Attorney's Fees, plus costs, if any = .3410846
÷ Total Recovery
↓
(Gross or Net Recovery (Nos. 1or 2, below), depending upon whether there is employee fault)

E. Workers' Compensation benefits paid to date $50,542.88

Allocation under the formula:

1. Gross recovery **$550,000.00**

2. Reduce gross recovery by employee's fault, if any.

The calculation:

Gross recovery – amount correlating with Employee's % of fault, if any = **Net Recovery**
$550,000.00 – $0.00 = $550,000.00 **$550,000.00**

3. Deduct cost of collection

Statutory Authority:

Deduct the reasonable costs of collection including, but not limited to, attorney's fees and burial expenses in excess of the statutory liability. *Minn. Stat.* §176.061, Subd. 6(a).

Cost of collection includes attorney's fees, which generally range between 33% and 35% of the gross/net recovery. Additionally, cost of collection includes the employee's attorney's costs, if any, and other possible expenses, such as burial expenses.

The Calculation:

a. If no employee fault, the calculation will be:

Gross recovery – cost of collection = Net Net Recovery

$550,000.00 – $187,596.53 = $362,403.47 **$362,403.47**

b. If employee fault, the calculation will be:

Net recovery (No. 2, above) – [(percentage cost of collection X net recovery (#2))] = Net Net Recovery

$_____ – $_____ = $_____ **$**_____

4. Employee's Statutory 1/3 Share

Statutory Authority:

One-third of the remainder shall, in any event, be paid to the injured employee or the employee's dependents without being subject to any right of subrogation. *Minn. Stat.* §176.061, Subd. 6(b).

The Calculation:

Amount arrived at in No. 3, above, X 1/3 = Employee's statutory 1/3 share

$362,403.47 X 1/3 = $120,801.15 **$120,801.15**

5. Balance remaining for subrogation

The Calculation:

Amount arrived at in No. 3, above – Amount arrived at in No. 4, Above = Balance remaining for subrogation

$362,403.47 – $120,801.15 = $241,602.32 **$241,602.32**

6. Employer's Share of the proceeds

Statutory Authority:

Out of the balance remaining, the employer...shall be reimbursed in an amount equal to all benefits paid under this chapter to or on behalf of the employee or the employee's dependents by the employer..., less the product of the costs deducted under clause (a) of (this Section) divided by the total proceeds received by the employee or dependents from the other party multiplied by all benefits paid by the employer…to the employee or the employee's dependents. *Minn. Stat.* §176.061, Subd. 6(c).

The Calculation:

WC paid – [(cost of collection ÷ gross recovery) x WC benefits paid] = Employer's share

$50,542.88 – [($187,596.53 ÷ $550,000) x $50,542.88] = $33,303.48 **$33,303.48**

Short-cut: WC paid – (% Cost of Collection x WC Paid) = Employer's share

$50,542.88 – (.3410846 X $50,542.88) = $33,303.48
$50,542.88- ($17,239.398) = $33,303.48

Note: There may be situations in which the employer/insurer's share of the proceeds by operation of the above-noted calculation will be more than the amount of money actually available for subrogation after the employee's statutory 1/3 share is allocated (No. 5, above) (This often occurs when there is a high percentage of employee fault and/or when the percentage of workers' compensation benefits paid to-date is high, as compared with the total verdict). In those situations, the employer/insurer will receive, as its share of the proceeds, the full amount of the balance remaining for subrogation (No. 5, above) as a cash recovery. There is generally no future credit available. *See Kealy v. St. Paul Housing and Redevelopment Authority*, 303 N.W.2d 468 (Minn. 1981). *See also* No. 7, below.

7. Balance Remaining for employee

Statutory Authority:

Any balance remaining shall be paid to the employee or the employee's dependents, and shall be a credit to the employer . . . for any benefits which the employer . . . is obligated to pay, but has not paid, and for any benefits that the employer . . . is obligated to make in the future. *Minn. Stat.* §176.061, Subd. 6(d).

The Calculation:

Balance remaining for subrogation (No. 5, above) – Employer's share (No. 6, above) = Balance remaining for employee

$241,602.32 – $33,303.48 = **$208,298.84** **$208,298.84**

Note: There may be no balance remaining. In those cases, e.g., where the amount available for subrogation after the employee receives her 1/3 share is less than or equal to the workers' compensation benefits paid, less the cost of collection, the employer/insurer recovers its full share of the proceeds, under No. 6, above, without the opportunity for a future credit. *See Kealy v. St. Paul Housing and Redevelopment Authority*, 303 N.W.2d 468 (Minn. 1981). On the other hand, where there is a balance remaining after running the calculation in No. 7, the employee generally receives the balance in cash form and the employer/insurer receives a future credit for the sum, less reduction for costs of collection. *See* No. 8, below.

8. Future Credit

Statutory Authority

Any balance remaining shall be paid to the employee or the employee's dependents, and shall be a credit to the employer . . . for any benefits which the employer . . . is obligated to pay, but has not paid, and for any benefits that the employer . . . is obligated to make in the future. *Minn. Stat.* §176.061, Subd. 6(d).

Nature of the future credit

The future credit is not a pure credit in the exact amount of the balance paid over to the Employee. Rather, it is also subject to a cost of collection discount, requiring the insurer to pay one-third (or the particular percentage of cost of collection applicable to the particular case) of all future compensation benefits until the credit is used up. *Cronen v. Wegdahl Coop. Elevator Assn.*, 278 N.W.2d 102 (Minn. 1979). Thus, under *Cronen*, for every dollar of benefits paid in the future, the Subdivision 6(d) credit should be reduced by 33% (or the applicable percentage cost of collection derived in the Subdivision 6 calculation). *See Kealy v. St. Paul Housing and Redevelopment Authority*, 303 N.W.2d 468 (Minn. 1981).

As a practical matter, the future credit has an actual net value to the employer/workers' compensation insurer, which is 33% (or the applicable percentage cost of collection utilized in the particular case) less than the gross figure derived through mathematical operation of the formula. For every dollar of future workers' compensation liability incurred, the employer will actually pay the employee 33 cents (or the applicable amount derived from the cost of collection ratio under the formula) and reduce its credit by one dollar.

The literal language of *Minn. Stat.* §176.061, Subd. 6(d), provides that the future credit extends to "any benefits which the employer...is obligated to pay, but has not paid, and for any benefits that the employer...is obligated to pay in the future." *Minn. Stat.* §176.061, Subd. 6(d). The only limitation the Statute places on the future credit is that it may not be applied to interest or penalties. Case law interpreting the Statute appears to acknowledge that the future credit applies to future medical expenses as well as indemnity benefits. *See S.B. Foot Tanning Company, et. al. v. Leo Piotrowski, et. al.*, 554 N.W.2d 413 (Minn. App. 1996). However, in at least one situation, the Workers' Compensation Court of Appeals has held that an employer or workers' compensation insurer cannot use the future credit to defeat a no-fault insurer's right to reimbursement as against the workers' compensation insurer. *Womack v. Fikes of Minnesota*, 61 W.C.D. 574 (W.C.C.A. 2001).

The Calculation for the "net" value of the future credit

Balance remaining to employee (No. 7, above) – (Balance remaining to Employee (No. 7 above)) x % Cost of Collection (No. 2, above) = Net value of Future Credit

$208,298.84 – ($208,298.84 X $.3410846) = $137,251.31
$208,298.84 - $71,047.53 = $137,251.31

Summary

$550,000.00 **(Gross Settlement)**

- **$187,596.53** **(WC Carrier &Worker underwrite cost of collection reduction from gross settlement)**
- **$ 33,303.48** **(WC Carrier's *net* cash recovery)**
- **$329,099.99** **(Employee's total cash recovery - $120,801.15 = statutory 1/3 share; $208.298.84 Excess paid to Employee after cash subrogation reimbursement to carrier and this amount operates as a "gross future credit" in WC Carrier's favor, against future workers' compensation benefits payable. However, the gross future credit *cannot* be undertaken on a "holiday/freeze-out" basis. The carrier must continue to pay workers' compensation benefits at a rate of .3410846 for every dollar of workers' compensation benefits payable and reduce its gross future credit by $1.00, until the future credit is exhausted, at which time, benefit payments, if any, resume at their normal rate. In reality, the gross future credit is worth $137,251.31, after reduction for the cost of collection.)**

$000,000.000

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QUICK TAKE: MEDICARE SECONDARY PAYER COMPLIANCE

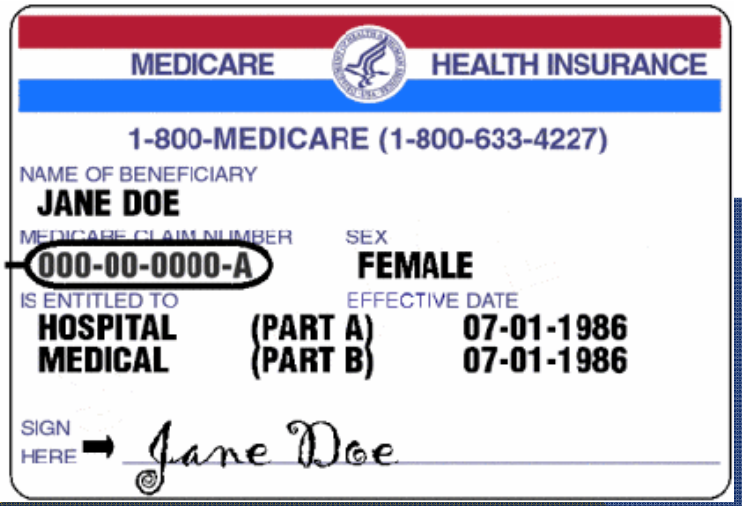
ANNIE M. DAVIDSON JD, CMSP, MSCC

CARE. COMPLIANCE. CONTROL

WHO QUALIFIES FOR MEDICARE?

- Age 65+
- Social Security Disability Insurance for 2 years +
- End-stage renal disease/Lou Gehrig's disease

Part A – Hospital Coverage
Part B – Non-hospital medical services
Part C – Medicare Advantage Plan
Part D – Prescription Drug Plan



WHO IS ENROLLED IN MEDICARE?

Area of Medicare	Number of enrollees
Original Medicare only	37,728,156
Part C	21,448,250
Part D	Approx. 42 Million
Grand total	59,176,406

Sample of some key states	Number of enrollees
Minnesota	980,304 (58% Part C enrollees)
Wisconsin	1,125,958 (42% Part C enrollees)
North Dakota	126,302
South Dakota	168,167
Iowa	605,872
Illinois	2,176,409

THE TRIPLE THREAT

Section 111 Reporting	Conditional Payments	Medicare Set Asides
Statute and policy driven compliance (42 USC 1395y(b)(8))	Statutory and regulatory compliance (42 USC 1395y(b)(2)) and 42 CFR 411.20 et. seq.	Policy and regulatory (42 CFR 411.46)
Coordination of benefits and recovery vehicle	Recovery vehicle	Coordination of benefits vehicle
Penalty: "Up to $1,000 per day, per claim"	$ for $ recovery, up to total settlement; no requirement that settlement take place	Medicare can "not recognize" the underlying workers' compensation settlement

SO WHAT DO WE NEED TO THINK ABOUT?

- The Medicare Secondary Payer Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under liability insurance (including self-insurance), no-fault insurance or workers' compensation

- Past: Conditional payments, Medicare Advantage Plan recovery, and Part D Plan recovery. Also Section 111 reporting.

- Present: Terms to incorporate into the general release or settlement documents.

- Future: Medicare Set-Asides, zero allocations, and workload review thresholds to participate in voluntary CMS submission process.

IDENTIFYING MEDICARE BENEFICIARIES

MANDATORY INSURER REPORTING

Claims involving Medicare eligible injured parties that meet certain requirements must be submitted to CMS in the form and format specified:

- Medicare eligibility must first be confirmed.
- Claims must be reported quarterly.

<u>When to report:</u>

- Acceptance of Ongoing Responsibility for Medical (ORM): Applies to Workers' Compensation and No-Fault claims.
- Occurrence of a Total Payment Obligation to the Claimant (TPOC):
  - Applies to Liability, Workers' Compensation and No-Fault claims.
  - Settlement, judgment, award or any other payment releasing medicals must be reported.
    - WC minimum TPOC threshold >$750* (amounts ≤$750 are still reportable if entity has open ORM)
    - Liability minimum TPOC threshold >$750

WHAT IS A CONDITIONAL PAYMENT?

"A primary plan's responsibility for such payment may be demonstrated by a [1] judgment, [2] 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 [3] by other means."

What does the statute say?	What does it mean in practice
Judgment	Judge's decision or jury verdict
Payment conditioned upon . . . compromise, waiver, or release of payment	Settlement
For items or services included in a claim against the primary plan or the primary plan's insured	Medical treatment incurred by the beneficiary
By other means	Section 111 reporting, WC medical payments, PIP medical, etc.

RECOVERY BY ORIGINAL MEDICARE

Current landscape:

- Commercial Repayment Center (CRC) is Federal contractor assigned to handle all “ORM Recovery” claims
- Benefits Coordination and Recovery Contractor (BCRC) is the Federal contractor assigned to handle all post-settlement recovery

Characteristics:

- CRC relies upon information generated almost ***entirely*** from Section 111 Mandatory Insurer Reporting
- BCRC relies upon a combination of information sources; some of it is Section 111 Mandatory Insurer Reporting and other information is based upon beneficiary, insurer and/or attorney voluntary reporting

Types of recoveries:

- CRC performs “rolling recovery,” meaning they will recover on open ORM claims whenever there is a potential recovery opportunity (regardless of insurer claims status)
- BCRC performs “once-and-only-once” recovery, meaning they will only recover one time per settlement and will hold off on issuing demands until the moment when they are most likely to receive reimbursement

INTEREST ASSESSMENT

- If payment is not made within 60 days from the date of the Initial Determination, then interest is assessed for each 30 day period the debt remains unresolved.
- A party may choose to pay the demand amount in order to avoid the accrual and assessment of interest.
- Even if appeal or waiver is pending. If the waiver/appeal is granted, CMS will issue a refund.
- Interest typically falls between 10% and 11%.

FORMAL APPEALS PROCESS

- Redetermination: request within **120 days** of the Demand (i.e. initial determination).
- Reconsideration: request within **180 days** of the Redetermination decision.
- Administrative Law Judge hearing: request within **60 days** of Reconsideration decision.
- Department Appeals Board review: request within **60 days** of the ALJ decision.
- Federal Court Review: file within **60 days** of the DAB decision.

REFERRAL TO DEPARTMENT OF TREASURY (AND SOMETIMES JUSTICE)

- Notice of Intent to Refer (ITR) letter is sent 90 days after the demand letter if full payment or valid documented defense is not received.
- If full repayment is not received within 60 days of ITR (150 days after demand letter), the debt is referred to Treasury once any outstanding correspondence is worked.
- CMS may also refer debts to the Department of Justice for legal action if it determines that the required payment or a properly documented defense has not been provided.

MEDICARE ADVANTAGE AND PART D PLANS

- Each entity's correspondence will vary, but should contain same demographic information about the beneficiary and explain who they are and where they derive their rights.
- Correspondence must contain a statement of reimbursement outlining the dates of service, ICD codes, and amounts.
- Appeal rights apply to these entities?
- They do not have access to the Federal Government's recovery options; therefore, they frequently sue carriers for double damages.

FUTURE MEDICAL CONSIDERATIONS & MSAS

Problem: How does one comply with the MSP Act such that the burden of future medical is not shifted to Medicare *after a case settles*?

Solution: Medicare Set-Aside Arrangements (MSAs) which were first created by attorneys in workers' compensation cases for the purpose of helping the parties set-aside a certain amount of money for causally related medical treatment that would otherwise be paid by Medicare.

Medicare Review: 2001 memo from Medicare formalized a voluntary MSA review and approval process for workers' compensation cases.

WORKERS' COMPENSATION MEDICARE SET-ASIDE ALLOCATIONS

- Monies allocated to cover anticipated costs of future care related to the claim injury.
- Priced over employee's life expectancy (can use rated age).
- WC fee scheduled used, if applicable.
- Can be self administered or custodially administered, and can be funded via lump-sum or annuity.
- Stipulations for Settlement must be submitted to CMS to finalize any approved MSA.

WORKERS' COMPENSATION MEDICARE SET-ASIDE ALLOCATIONS

When to get a WCMSA allocation:

- Employee is a Medicare beneficiary OR
- Employee is reasonably expected to become a beneficiary within 30 months of the date of settlement…
  - ✓ On SSDI for less than 2 years
  - ✓ Applied for SSDI
  - ✓ Denied SSDI, but appealing
  - ✓ Present intention to apply for SSDI
  - ✓ 62.5 years old
  - ✓ Catastrophic injury

CMS REVIEW IS VOLUNTARY

- CMS developed a voluntary review process to help parties determine whether their MSA allocations adequately protect Medicare's future interest. CMS doesn't have person-power to review all MSAs, so established workload review thresholds.
- AGAIN, MSAs are voluntary AND submission to CMS is voluntary too. Carriers may have developed their own policies, which require submission when thresholds are met.
- If parties wish to participate in the voluntary review process, then need to have all documentation necessary according to Medicare's guidelines and the proposed settlement amount must exceed the applicable workload review thresholds.
- Note, parties are not bound to fund any amount approved by CMS.

WORKLOAD REVIEW THRESHOLDS FOR SUBMISSION TO CMS

- If Medicare beneficiary, then proposed settlement amount (including any MSA funds) must exceed $25,000.
- If employee has a reasonable expectation of Medicare eligibility within 30 months, then the proposed settlement (including any MSA funds) must exceed $250,000.
- What if under threshold?

THRESHOLDS ARE NOT A "SAFE HARBOR"

Medicare has advised that these thresholds are workload review thresholds, not a "safe harbor."

Options to demonstrate consideration of Medicare's interests in future medical without CMS approval:

- Obtain an MSA, even if unapproved.
- Obtain report from treating physician stating no need for future medical treatment and/or prescription medication.
- Obtain court order documenting no need for injury related future medical care.
- Make the entire settlement available for future medical.

SETTLEMENT/RELEASE LANGUAGE CONSIDERATIONS

Medicare Conditional Payment Resolution

- Identifying conditional payment amounts
- Explaining how conditional payments will be resolved
- Identifying and resolving Medicare Advantage plan liens

Future medical considerations

- Proper releases of responsibility for future medical
- If MSA completed, indicating amount set-aside
- Responsibilities of claimant in administering the MSA or information on custodial/professional administration

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QUESTIONS?

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ANATOMY ESSENTIALS FOR WORKERS' COMPENSATION CLAIMS HANDLERS

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MEDICAL TERMINOLOGY

Workers' compensation cases always require the review of medical records in order to assess issues of causation and the nature and extent of an alleged injury. Oftentimes, however, doctors, nurses, certified personal care assistants, and other medical professionals fail to use layman terms in describing their observations. In addition, different practitioners may use different terminology when describing the same medical condition or part of anatomy. As a result, having a basic understanding of common medical terminology can be useful to understand the sometimes cryptic and confusing medical records. This article is intended to introduce the reader to commonly used medical terminology. It also provides methods that can be used for the general understanding of medical terminology that may be less commonly used.

I. Basic Principles

The evolution of medical terminology has been largely influenced by the Latin and Greek terminology. Because of this it can be helpful to understand how the word roots and prefixes/suffixes are used to be better able to identify and understand unknown medical terminology.

A **"word root"** is the main part of the word. In the context of medical terminology, the word root is the foundation of a medical term and typically refers to the body part. Generally speaking, word roots from Greek describe a disease, condition, treatment, or medical diagnosis. In contrast, Latin word roots usually describe anatomical structures. Because of the use of both Latin and Greek terminology, there are also different roots that have the same meaning. Examples of common word roots are:

Greek	Latin	Meaning
Dermatos	Cutane	Skin
Nephros	Ranes/Nephr	Kidneys
Stomatos	Oris	Mouth
Kardia	Cardi	Heart
Gaster	Gastro	Stomach
Hepat	Hepat	Liver
Osteon	Oste	Bone

A **"prefix"** is something that is placed in front of the word root that changes the meaning of a medical term. It is important to note that not all medical terms have a prefix. For example, **"cardiologist**" (someone who works with heart patients) does not have a prefix. A prefix usually refers to a: (1) number; (2) time; (3) position; (4) direction; or (5) negation. Some common examples of prefixes are:

Prefix +	Word Root +	Suffix =	Medical Word	Meaning
An -	Esthes	- ia	Anesthesia	Condition of not feeling
Hyper -	Therm	- ia	Hyperthermia	Condition of excess heat
Intra -	Muscul	- ar	Intramuscular	Within the muscles
Macro -	Gloss	- ia	Macroglossia	Condition of a large tongue
Micro -	Card	- ia	Microcardia	A condition of a small heart

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A **"suffix**" is something that is placed behind the word root. Similar to a prefix, a suffix changes the meaning of a medical term. Suffixes typically describe symptoms, surgical or diagnostic procedures, pathology, such as disease or an abnormality, or a part of speech. Some common suffixes are below:

Combining form +	**Suffix=**	**Medical word**	**Meaning**
Arthr/o	- centesis (puncture)	Arthrocentesis	Puncture of joint
Thorac/o	- tomy (incision)	Thoracotomy	Incision of the chest
Gastro/o	- megaly (enlargement)	Gastromegaly	Enlargement of the stomach
Erythr/o	- cyte (cell)	Erythrocyte	Red blood cell
Cyt/o	- -logy (study)	Cytology	Study of a cell

A "combining form" is created when a medical term is created by using a vowel. The "equation" for a combining form is:

Word root + vowel = Combining Form

The vowel has no meaning, but helps connect the word to form the term. As shown by the suffix chart above, other elements can be added to the combining form to create a medical term.

II. The steps to defining a medical term.

A three-step process can be typically used to define an unknown medical word. Those steps are:

1. Define the suffix.
2. Define the prefix.
3. Define the middle word or word root.

Below are a few examples of how to apply this process to some common medical terms.

Example 1: Osteochondritis

1. Define Suffix	**2. Define prefix**	**3. Define middle part or word root**	**4. Meaning**
"itis" (inflammation)	"osteo" (bone)	"chondri" (cartilage)	Inflammation of bone and cartilage

Example 2: gastroenteritis

1. Define Suffix	**2. Define prefix**	**3. Define middle part or word root**	**4. Meaning**
"itis" (inflammation)	"gastro" (stomach)	"enter" (intestin)	Inflammation of the stomach and intestine

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III. Pronunciation Guidelines

Because of the large Latin and Greek influence in medical terminology, pronouncing medical words can be confusing and can also be a challenge. There are a few guidelines we like to use in medical terminology:

1. "ae" and "oe": only the second vowel is pronounced.

Examples: "bursae" or "pleural"

2. "e" and "es" are often pronounced as separate syllables.

Examples: "syncope" or "systole"

3. "ch" is sometimes pronounced like a "k"

Examples: "cholesterol" or "cholemia" or "trachea"

4. "I" at the end of the word is pronounced "eye"

Examples: "bronchi" or "fungi" or "nuclei"

5. "ps" at the beginning of the word is pronounced "s"

Examples: "psychology" or "psychiatry"

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BODY STRUCTURE AND MEDICAL CONDITION TERMS

- **Abdominal and pelvic cavity:** The lower part of the ventral (abdomino pelvic) cavity can be further divided into two portions: abdominal portion and pelvic portion. The abdominal cavity contains most of the gastrointestinal tract as well as the kidneys and adrenal glands.
- **Abdomino pelvic cavity**: The closed, membrane-lined sterile anatomical space which houses various internal organs, particularly those of the digestive system; its lining is a serous membrane, the peritoneal membrane, located medially on the anterior of the trunk, inferior to the thoracic cavity, and housed within the confines of the trunk musculature; it is arbitrarily subdivided into: (1) abdominal cavity containing the stomach, liver, intestines, and spleen (2) pelvic cavity containing some of the reproductive organs, the urinary bladder, and the distal colon; it provides a protected space for those organs.
- **Anterior cruciate ligament**: also called the "ACL." It is the ligament in the knee that crosses from the femur (thigh bone) to the top of the tibia (bigger bone in lower leg.)
- **Arthritis**: inflammation of a joint.
- **Atrophy**: a decrease in size or a wasting away of a body part or tissue.
- **Bone cyst**: a sac on a bone that contains liquid or semisolid material.
- **Bursa**: a small serous (fluid filled) sac between a tendon and bone.
- **Bursitis**: inflammation of a bursa
- **Cardiac muscle**: Found in the heart.
- **Carpal bones**: eight small bones located at the wrist, which are the: trapezium, trapezoid, capitate, hamate, scaphoid, lunate, triquetrum, and pisiform.
- **Carpal Tunnel Syndrome**: a medical condition caused by compression of the median nerve where it passes through the wrist into the hand. Symptoms include: weakness, pain, and disturbances of sensation in the hand and fingers
- **Cartilage:** a somewhat elastic tissue that is between bones and joints.
- **Caudal or Caudad:** Tail, tail end.
- **Cephalad or Cranial:** Head.
- **Chondromalacia:** cartilage that is abnormally soft and or is degenerative in nature.
- **Comminuted Fracture:** a bone fracture where the bone is broken into more than one piece.
- **Compound Fracture:** also known as an "open fracture". It is a fracture where the bone sticks through the skin.
- **Congenital:** something existing at birth.
- **Connective tissue**: Generally provides structure and support to the body. There are two types of connective tissue: loose connective tissue and fibrous connective tissue.
- **Contusion**: another word for a bruise.
- **Cranial cavity**: The partially closed, membrane-lined sterile anatomical space, a subdivision of the dorsal body cavity, which houses the superior portion of the central nervous system, i.e., the brain; its lining are the three connective tissue layers known as the cerebral meninges, i.e., the dura mater, arachnoid, and pia mater; it is located medially on the posterior of the head and housed within the confines of the skull; it contains the brain, various cerebral blood vessels, the pituitary gland, and the roots of the cranial nerves; it provides a protected space for the brain.
- **Degenerative Disc Disease**: also spelled "degenerative disk disease" and it is the normal changes or "normal wear or tear" that take place in the disks of someone's spine.
- **Developmental**: the opposite of "congenital." Something "developmental" is something that develops at some point after birth.

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BODY STRUCTURE AND MEDICAL CONDITION TERMS *continued…*

- **Disc:** Sometimes also spelled "disk" and it is the soft "pad" in between each vertebrae of the spine.
  - **Bulging Disc:** a disc that is weakened or deteriorated and it swells through a crevice in the spine beyond where it would normally be.
  - **Fragmented disc**: it is when fragments of the disc migrate away from a damaged disc structure.
  - **Herniated disc:** also called a slipped disk or a ruptured disk. It occurs when the inside "soft jelly" pushes through the tougher exterior of the disk.
  - **Protruding disc:** also called a "slipped disc." It is a "catch-all" term for medical problems related to discs in the spine
- **Dislocation**: the displacement of one or more bones at a joint.
- **Dorsal cavity:** the body cavity situated near the back of the human body, and includes the cranial cavity and vertebral cavity.
- **Dorsal body cavity:** The closed, membrane-lined sterile anatomical space which houses the central nervous system; its lining are the three connective tissue layers known as the meninges; it is located medially on the posterior of the head and trunk and housed within the confines of the skull and vertebrae; it is arbitrarily subdivided into a cranial cavity containing the brain and a vertebral cavity containing the spinal cord and the roots of the spinal nerves.
- **DVT:** Deep vein thrombosis. It is a condition in which there is a blood clot in a deep vein, usually in the legs.
- **Epithelium tissue**: Protects your body from moisture loss, bacteria, and internal injury. There are two kinds of epithelium tissue: covering and lining. Epithelium covers/lines most of your internal and external body surfaces; for example, the outermost layer of your skin and the internal surface lining of your lymph vessels and digestive tract. Glandular epithelium secretes hormones or other products such as stomach acid, sweat, saliva, and milk.
- **Femur**: also known as the thighbone, it is the "proximal bone" of the lower extremity that extends from the hip to the knee.
- **Fibromyalgia**: a chronic disorder characterized by widespread pain, tenderness, and stiffness of muscles and associated connective tissue structures that is typically accompanied by fatigue, headache, and sleep disturbances.
- **Fibrous connective tissue**: Also holds body parts together, but its structure is a bit more rigid than loose connective tissue. Fibrous connective tissue is found in ligaments, tendons, cartilage, and bone.
- **Fibula**: the outer or "smaller" bone in the lower leg between the knee and ankle.
- **Fracture**: broken bone.
- **Ganglion cyst**: they are non-cancerous fluid-filled cysts that can be found on the hand or back of the wrist.
- **Glenoid labrum:** fibrocartilaginous rim attached around the margin of the glenoid cavity.
- **Humerus**: long bone of the upper arm that extends from the shoulder to the elbow.
- **Inflammation**: characterized by redness, swelling, warmth and pain, inflammation is a way for the body to respond to infection, irritation or some other type of injury.
- **Joint**: where two or more bones meet.
- **Kyphosis**: an exaggerated outward curvature of the thoracic region of the spine, can be called a "humped back."
- **Lateral Collateral Ligament**: abbreviated as the "LCL". It is the ligament that stabilizes the outer knee.
- **Lateral Epicondylitis**: also known as tennis elbow. It is a condition of the extensor tendon on the outer side of the elbow that can be caused by repetitive twisting of the wrist or forearm, which leads to inflammation and irritation.

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BODY STRUCTURE AND MEDICAL CONDITION TERMS *continued…*

- **Latrogenic**: is "due to the activity of a physician or therapy."
- **Ligament**: a tough fibrous band of tissue that connects the ends of bones.
- **Loose connective tissue**: holds structures together. For example, loose connective tissues hold the outer layer of skin to the underlying muscle tissue. This tissue is also found on your fat layers, lymph nodes, and red bone marrow.
- **Malunion**: an incomplete or faulty healing of something such as a fractured bone.
- **Medial Collateral Ligament**: abbreviated as the "MCL." It is the ligament that stabilizes the inner knee.
- **Metacarpal**: the middle or "intermediate" part of the skeletal hand that is located between the phalanges and the carpal bones.
- **Metatarsal**: of, relating to, or being the part of the human foot or of the hind foot in quadrupeds between the tarsus and the phalanges that in humans comprises five elongated bones which form the front of the instep and ball of the foot.
- **Muscular Dystrophy**: a degenerative disorder for muscles that causes weakness and atrophy.
- **Muscle tissue**: Differs from other tissue types in that it contracts. Muscle tissues are made up of muscle fibers. The muscle fibers contain many myofibrils, which are the parts of the fiber that actually contract. There are three kinds of muscle tissue: skeletal muscle, cardiac muscle, and smooth muscle.
- **Myofascial treatment**: treatment of a hyperirritable spot in a muscle.
- **Nerve tissue**: Forms the nervous system, responsible for coordinating the activities and movements of your body through its network of nerves. Parts of the nervous system include: the brain, spinal cord, and nerves that branch off those two key parts.
- **Neuralgia:** intense, typically intermittent pain along a nerve, especially in the head or face.
- **Neuroglia or glial cells**: Provide support functions for the neurons, such as insulation or anchoring neurons to blood vessels.
- **Neurons**: Are the basic structural unit of the nervous system. Each cell consists of the cell body, dendrites, and axons.
- **Nonunion**: when a broken bone is not healing.
- **Osteoarthritis**: a common type of progressive/degenerative arthritis with the onset during middle or old age.
- **Osteomyelitis**: an infectious inflammatory disease of the bone marked local death and separation of tissue.
- **Osteonecrosis**: dead bone tissue.
- **Osteoporosis**: a decrease in bone mass with decreased density and enlargement of bone spaces.
- **Patella:** knee cap.
- **Peritoneum**: A serous membrane that lines the peritoneal cavity and covers the surface of the viscera within it. Like other serous membranes of the body, the peritoneum has a parietal layer, which covers the wall of the abdomen, a visceral layer, which covers the individual parts of the intestine. A small amount of fluid lies between these two layers in an extensive potential space, allowing free movement of the organs over each other. Although the peritoneum is formed in much the same way as the pericardium, the intestine is so much more complicated in shape than the heart that there are many folds and layers of the visceral peritoneum. One particularly important part of the visceral peritoneum is a fold attached to the rear wall of the abdomen, called the mesentery; between the two layers of this fold lie the coils of the small intestine. Inflammation of the peritoneum is called peritonitis.
- **Phalanges**: one of the digital bones of the hand or foot. (The fingers or toes.)

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BODY STRUCTURE AND MEDICAL CONDITION TERMS *continued…*

- **Posterior Cruciate Ligament**: abbreviated as the "PLC" and it is the ligament located in the center of the knee that controls the tibia's backward movement.
- **Radius**: the shorter of the two bones in the forearm. It is located on the thumb side of the arm.
- **Refractory**: resistant to ordinary treatment.
- **Rotator Cuff:** a capsule with fused tendons (the subscapularis, supraspinatus, infraspinatus and teres minor) that supports the arm at the shoulder joint.
- **Sacrum**: the part of the spinal column that directly connects with the pelvis.
- **Scoliosis**: a lateral curvature of the spine.
- **Serous membrane**: the mesothelial tissue that lines certain internal cavities of the body, forming a smooth, transparent, two-layered membrane lubricated by a fluid derived from serum. The peritoneum, pericardium, and pleura are serous membranes.
- **Skeletal muscle**: Attached to bones and causes movements of the body.
- **SLAP lesion**: also known as a "superior labral tear from anterior to posterior" and it is an injury to the glenoid labrum.
- **Smooth muscle**: Lines the walls of blood vessels and certain organs such as the digestive and urogenital tracts.
- **Soft-tissue:** body tissue that is not hardened or calcified and that typically supports or surrounds bones or internal organs, such as muscles, tendons, fat, skin, and fascia.
- **Spina bifida**: birth defect where there is incomplete closing of the backbone and membranes around the spinal cord
- **Spondylolisthesis**: a spinal condition in which a bone vertebra slips forward onto the bone below it.
- **Sprain**: an injury to a ligament that resulted from overuse or trauma.
- **Strain**: an injury to a tendon or muscle that resulted from overuse or trauma.
- **Synovium:** lining of a joint.
- **Synovectomy:** a procedure to remove the synovium.
- **Tarsals:** also referred to as the "tarsus and they are the seven bones in the intermediate part of the foot closest to the ankle/leg. The seven bones are the calcaneus, talus, cuboid, navicular and the medial, middle and lateral cuneiforms.
- **Tendon:** the tissue that connects muscles to bone.
- **Tendonitis:** inflammation or irritation of a tendon.
- **Tibia:** the inner and larger of the two bones in the lower leg that goes from the knee to the ankle.
- **Thoracic cavity**: The closed, partially membrane-lined sterile anatomical space, a subdivision of the ventral body cavity, which houses the lungs, heart, and the organs of the mediastinum; its linings are the three serous membranes known as the pleural membranes and the pericardial membrane; located medially on the anterior of the trunk and housed within the confines of the rib cage; it provides a protected space for those organs. The thoracic cavity is bound laterally by the ribs (covered by costal pleura) and the diaphragm caudally (covered by diaphragmatic pleura).
- **Trigger finger**: a condition in which a finger gets stuck in a bent position and then snaps straight.

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BODY STRUCTURE AND MEDICAL CONDITION TERMS *continued…*

- **Ventral body cavity**: The closed, membrane-lined sterile anatomical space which houses various internal organs; its lining are various serous membranes, located medially on the anterior of the trunk and housed within the confines of the rib cage and trunk musculature; it is subdivided into: (1) thoracic cavity containing the lungs, heart, and the organs of the mediastinum, (2) an abdominopelvic cavity with two partially separated subcompartments: (a) abdominal cavity containing the stomach, liver, intestines, and spleen, and (b) a pelvic cavity containing some of the reproductive organs, the urinary bladder, and the distal colon; this cavity provides a protected space for those organs.

DIAGNOSTIC AND PROCEDURURAL TERMS

- **Arthrodesis**: a bone fusion usually done in the ankles, wrists, fingers or thumbs.
- **Arthrogram**: an x-ray image of the inside of a joint after a contrast medium is injected into the joint.
- **Arthroscopy**: a minimally invasive surgical procedure that includes a visual examination of the interior of a joint with an arthroscope to diagnose/treat various conditions or injuries of a joint, and especially to repair or remove a damaged or diseased tissue or bone.
- **Arthroplasty**: the restoration of a joint through surgery.
- **CT Scan**: also known as a computed tomography scan. It is a cross-sectional, three-dimensional image of an internal body part produced by computed tomography chiefly for diagnostic purposes. CT scans can look at bones and tissue.
- **Decompression**: a procedure to remove pressure on something (such as a decompression of the spinal cord.)
- **Discogram:** a diagnostic test that involves injecting a special dye into an injured disc or series of discs in the spine and then takes x-rays to examine the intervertebral discs of the spine.
- **Diskectomy**: surgical removal of an intervertebral disk.
- **EKG**: also known as "electrocardiogram" and also referred to as an "ECG" it collects information from the 12 different areas of the heart.
- **EMG**: also known as "Electromyography." EMGs look at muscle and nerves.
- **Gadolinium enhanced CT**: gadolinium is a heavy metal that shows up on medical imaging such as CT scans, which enhances the CT scan. Gadolinium is used in some patients who are allergic to the more commonly used iodine.
- **MRI**: also called "Magnetic Resonance Imaging." It is an image that can get quite detailed and can look at soft tissues/muscles.
- **MRI Arthrogram**: an imaging study that takes detailed pictures of joints. It involves an arthrogram and an MRI.
- **Myelogram**: an x-ray that uses a dye or contrast material that is injected into the spinal canal to be able to evaluate the spinal canal and nerve roots.
- **PET scan**: a positron emission tomography scan. It is a medical image that uses a special dye with radioactive tracers to check for disease in the body.
- **Osteotomy:** a surgical procedure that changes the alignment of bone.
- **Spinal fusion**: a surgical procedure to the spine that is essentially a "welding" process.
- **X-ray**: x-radiation or a type of electromagnetic radiation. X-rays look at the bones.

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INJECTIONS

- **Botox Injection:** also known as a "Botulinum toxin injection." These types of injections use botulinum toxin to temporarily paralyze muscle activity. They are **not** permitted under the Minnesota workers' compensation treatment parameters. (Low Back: Minn. R. 5221.6200, subpart 5(C); Neck: Minn. R. 5221.6205, subpart 5(C); Thoracic Spine: Minn. R. 5221.6210, subpart 5 (C).)
- **Epidural Steroid Injection:** these injections deliver steroids directly into the epidural space and are used to try to reduce inflammation. (Low Back: Minn. R. 5221.6200, subpart 5(A)(5); Neck: Minn. R. 5221.6205, subpart 5(A)(4); Thoracic Spine: Minn. R. 5221.6210, subpart 5(A)(4); CRPS: Minn. R. 5221.6305, subpart 2(A).)
- **Facet Joint Injection:** also known as facet nerve blocks or nerve injections. It injects a small amount of local anesthetic or numbing agent and/or a steroid medication to anesthetize a facet joint and block pain. (Low Back: Minn. R. 5221.6200, subpart 5(a)(3); Neck: Minn. R. 5221.6205, subpart 5(A)(2); Thoracic Spine: Minn. R. 5221.6210, subpart 5(A)(2).)
- **Nerve Block Injection**: a medical procedure in which some sort of anesthetic injection is performed near a nerve to try to block pain. (Low Back: Minn. R. 5221.6200, subpart 5(A)(4); Neck: Minn. R. 5221.6205, subpart 5(A)(3); Thoracic Spine: Minn. R. 5221.6210, subpart 5(A)(3).)
- **Permanent lytic or sclerosing injections**: this includes radio frequency denervation of the facet joints. (Low Back: Minn. R. 5221.6200, subpart 5(B); Neck: Minn. R. 5221.6205, subpart 5(B); Thoracic Spine: Minn. R. 5221.6210, subpart 5(B).)
- **Sacroiliac Joint Injections**: it injects local anesthetics such as lidocaine into the sacroiliac joint and is used to confirm whether there is a sacroiliac joint dysfunction. (Minn. R. 5221.6200, subpart 5(A)(2).)
- **Stellate Ganglion Block Injection**: it is a local anesthetic that is injected deep into the nerve tissue of the neck.
- **Synvisc Injection**: it is an injection that injects fluid into your knee to try to lubricate and cushion the joint, typically for osteoarthritis. It is a type of viscosupplementation injection.
- **Trigger Point Injections**: also abbreviated as "TPI" and is an injection to treat a painful area of a muscle. (Low Back: Minn. R. 5221.6200, subpart 5(a)(1); Neck: Minn. R. 5221.6205, subpart 5(a)(1); Thoracic Spine: Minn. R. 5221.6210, subpart 5(A)(1).)
- **Viscosupplementation Injections**: injections typically used to treat painful and arthritic joints that involves injecting viscous fluid onto a synovial joint.

PHARMACOLOGY TERMS

- **Addiction:** A compulsive uncontrollable dependence on a substance.
- **Bolus:** A single dose of drug usually injected into the blood vessel over a short period of time.
- **Brand Name:** A drug sold under the name given by the drug manufacturer.
- **Contraindication:** A factor in the patient's condition that makes the use of a medication or a specific treatment dangerous or ill-advised.
- **Compliance:** Patient's consistency and accuracy in following the regiment prescribed by a physician or other healthcare professional.
- **Generic Drug:** Usually named for its structure and not protected by a brand name or trademark.
- **Idiosyncratic Reaction:** An unexpected reaction to a drug that is peculiar to the individual.
- **Inhalation Administration:** Vapors and gases taken through the nose or mouth and absorbed in the blood stream through the lungs.
- **Intradermal Injection:** Made into the middle layers of the skin.

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PHARMACOLOGY TERMS *continued…*

- **Intramuscular Injection (IM):** Made directly into the muscular tissue.
- **Oral Administration:** Medications taken by mouth to be absorbed through the walls of the stomach or small intestine.
- **Palliative:** A substance that eases the pain or severity of the symptoms of the disease, but does not cure it.
- **Paradoxical Reaction:** The result of medical treatment that yields the exact normal and expected results.
- **Parenteral:** Administration of medication by injection through hypodermic syringe.
- **Percutaneous Treatment**: A procedure that is performed through the skin.
- **Pharmacist:** Licensed specialist who formulates and dispenses prescribed medications.
- **Pharmacology:** The study of the nature, uses, and effects of drugs for medical purposes.
- **Placebo:** An inactive substance, administered for suggestive effects.
- **Potentiation:** Drug interaction that occurs when the effect of one drug is increased by another drug, herbal remedy, or other treatment.
- **Rectal Administration:** Insertion of medication in the rectum either in the form of a suppository or a liquid.
- **Subcutaneous Injection (SC):** Made into the fatty layer just below the skin.
- **Sublingual Administration:** Placement of medication under the tongue where it is allowed to dissolve slowly.
- **Topical Application:** Liquid or ointment that is rubbed into the skin on the area to be treated.
- **Transdermal Medication:** Administered from a patch that is applied to unbroken skin.

TERMS USED DURING MEDICAL EXAMS

- **Abduction**: movement of a limb away from the middle of the body.
- **Active range of motion**: joint motion that patient carries out.
- **Adduction**: movement of a limb towards the midline of the body.
- **Anterior or ventral**: Front (example, the kneecap is located on the anterior side of the leg).
- **Avulsion**: "tearing" away.
- **Axial Plane (Transverse Plane)**: A horizontal plane; divides the body or any of its parts into upper and lower parts.
- **Coronal Plane (Frontal Plane)**: A vertical plane running from side to side; divides the body or any of its parts into anterior and posterior portions.
- **Distal**: Away from or farthest from the trunk or the point or origin of a part (example, the hand is located at the distal end of the forearm).
- **Dorsal**: the back or posterior of a structure.
- **Dorsal recumbent:** Patient lies flat on back with knees bent and feet flat on exam table. Often used in the examination of the rectum, vagina or both. Drape placed in diamond-shaped fashion.
- **Dorsiflexion:** flexion in the dorsal direction, for example flexion of the foot in an upward direction.
- **Eversion:** tilt away from the midline of the body or away from the median plane.
- **Extension:** an unbending movement around a joint in a limb that increases the angle between the bones of the limb at the joint.
- **Flexion**: bending.
- **Inferior or caudal**: Away from the head; lower (example, the foot is part of the inferior extremity).
- **Inversion**: to turn inward or toward the midline of the body.

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TERMS USED DURING MEDICAL EXAMS *continued…*

- **Knee/chest position**: Patient rests on the knees and chest with head turned to one side, arms extended on the bed, and elbows flexed and resting so they personally bear the person's weight; abdomen remains unsupported, though a small pillow may be place under the chest.
- **Lachman's test**: this is a clinical test used to diagnose an injury of the ACL. In the test, the knee is flexed between 20 and 30 degrees and the tibia is displaced anteriorly relative to the femur. When the test is positive (abnormal) there is a soft endpoint greater than 4 mm that is displaced.
- **Lateral**: Away from the midline of the body (example, the little toe is located at the lateral side of the foot).
- **Lithotomy position**: Patient lies on the back with the legs well separated, thighs acutely flexed on the abdomen, and legs on the thighs; stirrups may be used to support the feet and legs. Prone position – a position with the patient lying face down with arms bent comfortably at the elbows and padded with the arm boards position forward.
- **Medial**: toward the midline of the body (example, the big toe is located at the medial side of the foot).
- **Median plane**: Sagittal plane through the midline of the body; divides the body or any of its parts into right and left halves.
- **Passive range of motion:** movement by someone other than the patient of a specific joint.
- **Pronation:** rotation of a body part towards the midline.
- **Prone position**: Patient lies face down with arms bent comfortably at the elbows and padded with the arm boards position forward.
- **Posterior or dorsal**: Back (example, the shoulder blades are located on the posterior side of the body).
- **Proximal**: Toward or nearest the trunk or the point of origin of a part (example, the proximal end of the femur joins with the pelvic bone).
- **Reverse Trendelenberg position:** A supine position with the patient on a plane incline with the head higher than the rest of the body and appropriate safety device such as a foot board.
- **Sagittal Plane (Lateral Plane)**: A vertical plane running from front to back; divides the body or any of its parts into right and left sides.
- **Sims Position**: Patient lies on the left side with the left thigh slightly flexed and the right thigh acutely flexed on the abdomen; the left arm is behind the body with the body inclined forward, and the right arm is positioned according to the patient's comfort period.
- **Straight leg raise**: this can also be called a "lasègue" or "Lazarević" sign. It is a test done to assess whether a patient with low back pain has a disc herniation. The patient begins by lying down (supine) with both knees extended. The examiner stands at the patient's side with the distal arm supporting the heels and the proximal hand on the patient's thighs. The examiner slowly raises the leg until tightness or pain is noted.
- **Superior or cranial**: Toward the head end of the body; upper (example, the hand is part of the superior extremity).
- **Supination**: rotation of the forearm or hand so that the palm faces upward or forward.
- **Supine position**: Patient lies flat on back with arms to the side, and legs extended. This position is used for an examination of front of body, breast, palpation of internal organs. Draping extends from under the armpits to the toes.
- **Trendelenberg's Position:** Patient's back is on a table or bed, whose upper section is lowered to 45º so that the head is lower than the rest of the body; the adjustable lower section of the table or bed is bent so that the patient's legs and knees are flexed. There is support to keep the patient from slipping.

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TERMS USED DURING MEDICAL EXAMS *continued…*

- **Two Point Discrimination Test:** a test in which the examiner touches to parts of the skin with pressure to identify them as discrete sensation. The point of this test is used to determine sensory loss, such as following disease or trauma affecting the nervous system.
- **Waddell's signs:** a group of clinic tests used to determine whether a patient's back pain is not organic, or, in other words, to determine if the reported pain is psychological in origin.

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SHOULDER HYPO:

Employee works as a cell machinist. He has had this job for about 8 years. In this period of time he has had three separate jobs as a pillar, a machinist #1 and a machinist #2. He alleges that "spinning" parts on the Machinist #2 position has injured his bilateral shoulders. This job involved putting a metal basket full of parts on a forklift, putting the basket next to the conveyor belt and taking a 25 pound gate off the basket. A mechanical arm would then push the parts out of the basket onto the conveyor belt. The Employee would monitor the parts going down the conveyor belt and, if necessary, pick up parts if they fell off the conveyor belt onto the ground. He also might flip switches on the machine if there was a jam in the machine. Sometimes he would have to check the "chuma" to make sure it was not loose. This involved reaching up overhead with two wrenches to tighten the "chuma." The machine then automatically brushed the parts and put the parts through a pressure machine before the parts came out onto table. The Employee would manually inspect the parts. This required him to pick up a part, roll it by hand to inspect it/check it for defects. It then went down the conveyor belt to either be oiled or not. The Employee would then pick up the parts – two parts in each hand and set them in a basket on the floor beside him. At some point the company increased the speed of the machines so that he had to work faster. He says that it was the "spinning" or hand in section of the parts that caused his bilateral shoulder issues.

He underwent a right shoulder arthroplasty and was diagnosed with advanced right shoulder glenohumeral arthritis. A subsequent x-ray of his right shoulder reveals degenerative changes in the acromioclavicular joint. About one year later he began treating for his left shoulder. An x-ray of the left shoulder revealed degenerative changes. An MRI of his left shoulder revealed a near full thickness focal tear involved the anterior, superior, distal supraspinatus tendon fibers that measured about 8mmx7mm. There was also attenuated cross-sectional volume involving the myotendinous junction of the conjoined portion of the supraspinatus tendon that could be sequela of subacute tear of about 40% loss of cross sectional volume and also very slight atrophy of the supraspinatus muscle. He underwent a left shoulder diagnostic arthroscopy, diagnostic bursoscopy, arthroscopic acromioplasty with an open distal claviculectomy, biceps tendinosis and rotator cuff tendon repair. Are his bilateral shoulder conditions related to his job hand inspecting the parts?

HAND/WRIST HYPO:

Employee is 58 years old and has worked as a machine operator for 31 years. He has reported that his left wrist becomes "worse and swollen" when he lifts 36 inch sheets of material at the machine to prepare for cutting them. He allegedly has to grab the end of the material and pull it to the front of the machine for approximately 40 to 50 feet and that he does this activity three to four times a day. He also alleges his wrist swells up when he drives forklift. At his deposition, he testified that on his DOI, he was working with three other people to lift sheets up and three sheets of material broke that day. When the third sheet of material broke that day, his left wrist was sore. He went to the ER and they took out fluid from his wrist area. The Employee continued to treat and was diagnosed with mild scapholunate degeneration that is allegedly related to his "work injury" as a machine operator. His wrist condition is also described in his records as "chronic in nature." Through the course of his treatment, the Employee is also diagnosed with arthritis. Is the Employee's injury work related or not?

KNEE HYPO:

The Employee is a 55-year-old woman. Her medical history included the fact that in 2002 she underwent gastric bypass surgery. Prior to the surgery she weighed 340 pounds. She lost approximately 150 pounds. She was a smoker and had smoked for approximately 30 years. She had prior problems with her right knee following a fall. She claimed to have injured her left knee on November 11 and November 12, 2014 while at work. The "injury" of November 11, 2014 was when she was kneeling while performing CPR. On November 12, 2014, she slipped in the driveway of her place of employment. She did not fall, but claimed to have twisted her left knee. Diagnostic studies following the claimed incident revealed tricompartmental osteoarthritis with full thickness chondral defects and hypertrophic changes. Five days prior to the claimed injuries, the employee had been seen for medical treatment for left knee pain and received Percocet for her symptoms. The employee underwent arthroscopic surgery in February 2015 and was recommended to undergo a total left knee replacement due to "severe end stage osteoarthritis." Is her left knee condition related to the incidents of November 11 and 12, 2014? Was the arthroscopic procedure of February 2015 reasonable and necessary? Is the total knee replacement related to the incidents of November 11 and 12, 2014?

FOOT/ANKLE HYPO

The employee works as a carpenter with a company that puts on educational/entertainment shows, such as shows about animals, etc. The animals are animatronic. The employee's job is to set up the scenic displays and setting up black curtains where they do not want the customers to see things. On his date of injury, the employee was setting up the black curtains, which are between 13 and 30 feet high. They were understaffed. Setting up the black curtains required him to set up piping to hold the black curtains and then to place the black curtains on the pipe frames. This required him to climb up/down a ladder several times. He was wearing steel-toed boots. The Employee had installed about 400 feet of black curtains, when he felt pain and a burning sensation in his left ankle/shin area. It was on the outside and inside of his ankle/shin. He alleges that he twisted his ankle while coming down the ladder. The Employee's records reflect he was diagnosed with a sprain, but, six months later, asserts his sprain is not healing. He has not, however, sought additional treatment. The employee reports ongoing pain in his ankle/shin area. Are his alleged symptoms related to a work injury or not?

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Minnesota Workers' Compensation Subrogation Quick Reference Guide

1. Third-party situations.

Every time a worker is injured at work, there are at least two parties, namely, the worker and the employer, for purposes of workers' compensation litigation. However, when the worker is injured through the fault or negligence of someone who is not an agent of his employer, issues of workers' compensation subrogation and employer liability arises as a result of claims that may be brought against the negligent third party. These situations typically arise in automobile accidents, construction accidents, product liability accidents, premises accidents, and medical malpractice claims.

2. Workers' compensation subrogation.

The employer by statute has its own "separate additional cause of action against the third party to recover amounts payable for medical treatment or for other compensation payable under the section resulting from the negligence of the third party *regardless of whether such benefits are recoverable by the employee or the employee's dependents at common law or by statute*. Minn. Stat. §176.061, Subd. 7. (*See also* Subds. 3, 5, and 10). However in *Zurich American Ins. Co. v. Bjelland*, 710 N.W.2d 64 (Minn. 2006) the Supreme Court determined an employer is limited to those damages the employee could recover under the wrongful death act, thus thwarting the purpose of the 2000 amendment incorporating the highlighted language to correct the Supreme Court's prior holdings that the statute only grants the employer a right to share in the worker's common law negligence action. *Tyroll v. Private Label Chemicals*, 505 N.W.2d 54 (Minn. 1993); M.W. *Ettinger Transfer v. Shaper Mfg.*, 494 N.W.2d 29 (Minn. 1992). The employer has the option of intervening in the worker's cause of action, initiating its own cause of action, or just sitting back and letting the worker pursue the claim. However, the employer's claim cannot be settled without the employer's consent. Minn. Stat. §176.061, Subd. 8.a., *Jackson v. Zurich American Ins.*, 542 N.W.2d 621 (Minn. 1996).

3. Workers' compensation as an exclusive remedy.

Under Minn. Stat. §176.061, Subd. 1 and Subd. 4, an injured worker cannot sue his employer for anything other than workers' compensation benefits. Similarly, an injured worker cannot sue a co-worker unless that co-worker had a duty that was independent of his employer's duty to keep a safe work place and that co-worker either was grossly negligent or intentionally inflicted the injury. Minn. Stat. §176.061, Subd. 5(c). A third party may also be able to avoid liability to a worker if acting in a "common enterprise" with the employer. *McCourtie v. U.S. Steel Corp.*, 93 N.W.2d 552 (Minn. 1959). However, the third party, if negligent, may then owe workers' compensation subrogation plus costs and fees to the employer. *Minnesota Brewing Co. v. Eagan & Sons*, 574 N.W. 2d 54 (Minn. 1998).

4. Employer liability or Coverage B exposure created by the *Lambertson* case and codified in Minn. Stat. §176.061, subd. 11(2000).

In *Lambertson v. Cincinnati Corp.*, 257 N.W.2d 679 (Minn. 1977), the Supreme Court overruled the state's long-standing bar against employer contribution holding that a third party could, in fact, recover "contribution against (the negligent employer) in an amount proportional to its percentage of negligence, but not to exceed its workers' compensation liability to (the worker)". The right to contribution has now been codified in Minn. Stat. §176.061, subd. 11 (2000). This amendment limits the contribution to the net subrogation recovery, but their still may new money exposure to the employer if a substantial part of the recovery is future credit that will be used. A contractual indemnity agreement would create more potential exposure to the employer.

5. Statutory distribution formula, Minn. Stat. §176.061, Subd. 6.

Upon recovery from a third-party tortfeasor, either by way of trial or settlement, if the proceeds include both amounts recoverable and not recoverable under the Workers' Compensation Act, allocations of the proceeds are normally run through the formula contained in Minn. Stat. §176.061, Subd. 6. The exact language of the distribution formula is on the attached worksheet. Generally, however, the worker's attorney takes the first third, and then the worker receives a third of whatever remains, and the remainder is then given to the employer or is given back to the worker and is available as a credit against future workers' compensation benefits. The employer must still pay or discount for the cost of collection on

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future benefits. *Cronen v. Wegdahl*, 278 N.W.2d 102 (Minn. 1979).

6. Court allocation of proceeds in accordance with *Henning*.

If the parties agree that the total settlement is reasonable, the worker can request the court to allocate the proceeds of the settlement between the amounts recoverable and not recoverable under the Workers' Compensation Act in accordance with *Henning v. Wineman*, 306 N.W.2d 550 (Minn. 1981). Generally, workers choose to do this when the policy limits are small relative to the worker's pain and suffering damages. However, if the employee fails to give notice of a trial or settlement with the negligent third-party tortfeasor as required by Minn. Stat. §§176.061, subd. 8(a), he is not entitled to request a *Henning* allocation of the recovery from a verdict or settlement. *Womack v. Fikes of Minnesota*, 636 N.W.2d 795 (Minn. 2001) (summarily affirming 61 W.C.D. 574).

7. *Naig* settlements.[1]

A *Naig* settlement is a settlement of all damages that are not compensated by workers' compensation. *Naig v. Bloomington Sanitation*, 258 N.W.2d 81 (Minn. 1977). If there is a *Naig* settlement, the worker will be taken out of the lawsuit as an interested party, and the employer and insurer are left on their own to pursue their workers' compensation lien. Because of the possibility of prejudice to the employer and insurer, the Supreme Court requires the worker intending to enter into a *Naig* settlement to give *reasonable* notice to an employer and insurer prior to entering into this agreement. *Easterlin v. State of Minnesota*, 330 N.W.2d 704 (Minn. 1983). Further, the employee's penalty for failing to give the required notice is the loss of his right to protect that one-third interest allowed under Minn. Stat. §§176.061, subd. 6 (b) in the net recovery. *Womack v. Fikes of Minnesota,* 636 N.W.2d 795 (Minn. 2001)(summarily affirming 61 W.C.D. 574).

8. Reverse *Naig* settlements.

An employer may settle its workers' compensation lien separately with the third-party tortfeasor and avoid the formula allocation. Notice to the worker of such a settlement is not required. *Folstad v. Eder*, 467 N.W.2d 608 (Minn. 1991). Where the employer's negligence is substantial, it is generally advisable to enter into a reverse *Naig* settlement in which the employer agrees to waive or assign its subrogation interest to the third party or worker in exchange for the dismissal of and/or indemnification from the third-party contribution claim of the third-party tortfeasor. There is some question whether the third-party-tortfeasor will be willing to risk having the burden to prove future workers' compensation after *Schlichte v. Kielan,* 599 N.W.2d 185 (Minn. App. 1999) *rev. denied* (Minn. Nov. 17, 1999). However, under Minn. Stat. §176.061, subd. 11 (2000) *at the trial court will deduct any awarded damages that are duplicative of workers' compensation benefits paid or payable.@* It should be kept in mind that if the Workers' Compensation Reinsurance Association (WCRA) has an interest, approval for a waiver should be obtained.

9. Waive and walk motion.

When neither the worker nor the third party are willing to settle with the employer, the employer has the right to waive its right to recover workers' compensation paid and payable to avoid employer liability under Minn. Stat. §176.061, subd. 11 (2000). This amendment codifies the intent of *Lambertson*, because the waiver removes workers' compensation from the lawsuit and limits the lawsuit to the worker's claim for non-workers' compensation damages for which there is no right of contribution. *See, Folstad, supra*; Kempa *v. E.W. Coons Co.*, 370 N.W.2d 414, 417-418 (Minn. 1985). Following the logic of *Lambertson*, if the employer is willing to give up any possibility of being reimbursed by the third party, the employer should be entitled to avoid any new money exposure beyond its workers' compensation obligation.

10. Employer's claim for increased insurance premiums.

In addition to the employer and insurer's right to recover workers' compensation paid and payable, the employer has an independent claim for damages due to increased workers' compensation insurance premiums. Minn. Stat. §176.061, Subd. 5(b). Generally, if the insured's premiums are based upon experience modifications, a given injury will not affect the insurance premiums until a year or two after the date of the injury, and then the premiums will be affected for only three years. Attorneys and insurers should be conscious of not waiving the employer's right for increased insurance premiums.

[1] Not to be confused with *Pierringer* settlements in which a plaintiff settles with one defendant leaving open claims against other non-settling defendants.

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WISCONSIN WORKER'S COMPENSATION 2018 CASE LAW UPDATE

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WISCONSIN WORKER'S COMPENSATION 2018
CASE LAW UPDATE

TABLE OF CONTENTS

WISCONSIN WORKER'S COMPENSATION 2018 CASE LAW UPDATE

APPEALS

Chancellor v. Tandem Staffing of Appleton, Claim No. 200-058759 (LIRC March 28, 2018). The applicant originally filed an application for hearing in August 2003 as a result of an alleged November 2000 injury. A prehearing occurred in May 2005. The parties determined the applicant's deposition should be taken because he was incarcerated. Arrangements were not made and the applicant did not respond to department inquiries. The claim was dismissed without prejudice in September 2005. The applicant refiled a claim in November 2012. He indicated a Certificate of Readiness would follow. In September 2013, the applicant was asked to provide a Certificate of Readiness in 60 days or an explanation for failure to do so. Another such letter was sent in December 2013. The applicant was given another 60 days. He was advised that failure to respond could result in dismissal of the claim. In February 2014, the applicant's attorney wrote to the department and advised the necessary medical opinions should be completed by July 1, 2014. On August 6, 2014, the applicant was provided another 60 days to respond, subject to dismissal of the claim. The same types of letters were sent again on April 3, 2015 and July 2, 2015. On August 20, 2015, the applicant's attorney indicated the parties were continuing to gather documentation. He anticipated filing a Certificate of Readiness before November 15, 2015. On November 18, 2015, another warning letter was sent. On December 7, 2015, the applicant's letter indicated he had recently provided employment authorizations and requested suspension of the claim for 90 days. This letter was not provided to the attorney for the employer and insurer. On February 2, 2016, the attorney for the employer and insurer asked for the claim to be dismissed because of failure to prosecute the claim. On June 2, 2016, the department set a deadline for filing the Certificate of Readiness for August 2016. The attorney for the employer and insurer again requested the claim be dismissed for failure to prosecute on October 24, 2016. The applicant's attorney wrote on December 5, 2016 and indicated the Certificate of Readiness would be filed within the week, to indicate readiness for hearing no earlier than March 2017. On May 17, 2017, the department provided the applicant's attorney another 30 days to submit the Certificate of Readiness. The letter indicated the claim would be dismissed with prejudice absent this submission. The applicant's attorney submitted the Certificate of Readiness on June 17, 2017. The applicant indicated they would not be available for hearing in the next 120 days except for a few specific dates in October, November and December. The judge issued a final dismissal of the claim on August 22, 2017. The judge was unaware of the Certificate of Readiness at that time because it was not yet connected to the file. Twenty-two days later, the applicant submitted a Petition for Commission Review of the dismissal. The Labor and Industry Review Commission denied the appeal of the dismissal with prejudice. The applicant's attorney acknowledged that he received the dismissal three days after it was issued. The attorney asserted that the petition was prepared and processed for mail on the last date of the appeal period. He indicated the mail did not go out for an unidentified reason. The attorney indicated the appeal paperwork was immediately filed the day after (on the 22nd day), once the mail was discovered on the table. The attorney also asserted the appeal right document was not included in the dismissal order. Attorneys are held to the knowledge of statutory law. The attorney's statement that it was prepared for submission on the last day of the appeal period verifies the attorney was aware of the 21 day appeal period. The late filing may have occurred due to negligence of the attorney or his staff, but nothing beyond the applicant's control was established. The attorney was well aware of the appeal period and the ramifications of the dismissal. The history of delay in failure to respond to department requests reflects that there were repeated failures to make reasonable efforts to adhere to relevant deadlines.

ARISING OUT OF

Welch v. Griffiths Corp., Claim No. 2013-020601 (LIRC June 7, 2017). The applicant testified, and told his physicians, that he injured his head when the forklift he was operating tipped, and his face slammed into the cage. He testified clearly and without doubt that this was on the second occasion when the forklift tipped. However, the applicant had told other people, including the person who took the recorded statement, that he jumped from the forklift before it actually tipped a second time. The applicant specifically asserted that he must have sustained a work-related injury as claimed because it was unlikely that he would have been able to fool two psychologists, a neurologist, and a chiropractor, all of whom submitted records in support of his claim. Administrative Law Judge Angela McKenzie denied benefits. The Labor and Industry Review Commission affirmed. The applicant was not credible. He was unable to recall events frequently and offered inconsistent version of the facts. The video of the accident did not demonstrate clearly that he hit his head, and if so, that there was not sufficient force to cause him any injury. The video did not reveal he appeared seriously injured after the incident. [Editor's note: This case stands for the proposition that claimants can fool some doctors all of the time.]

Goodman v. Bartlein Barrels, Inc., Claim No. 2015-009026 (LIRC June 30, 2017). The applicant alleged he "tweaked" his back on December 5, 2014 at work while he was running tests on a 50 caliber barrel. The work injury was not reported until after the applicant came back to work on December 29, 2014, at which time he was walking with a limp. Many of the radiological tests were interpreted as showing degenerative problems in the spine as opposed to any recent physical injury. Further, sometime after December 5, 2014, the applicant was found trying to reprogram the drive on his lathe so as to make it reflect that he was working on 50 caliber barrels on December 5, 2014, when he was not actually doing so. The applicant also took photos at work of the job station and a 50 caliber barrel. By contract, the employer agreed with the federal government that no photographs would ever be allowed in their plant. The employer discovered the photographs were taken. The applicant later signed an affidavit saying he had destroyed and deleted the photographs. He then sent such photographs to the worker's compensation insurer in an attempt to pursue the worker's compensation claim. Administrative Law Judge William Phillips denied applicant's request for benefits. The judge outlined detailed credibility concerns he had with the applicant's testimony and reports of symptoms, etc. as the basis for his denial of the claim. The Labor and Industry Review Commission affirmed with modification. The Commission indicated specifically that it rewrote the decision to reflect the rationale for the dismissal of the claim to more accurately reflect the factual and legal basis for the decision. Specifically, the Commission held there was no competent medical evidence to link the applicant's back condition to the alleged work-related injury. The credibility concerns as it relates to the applicant and whether the applicant in fact ran tests on the date claimed, or another date, were not relevant. The employer credibly testified there was no reported injury. There was no mention of back symptoms to the employer until the applicant returned to work from vacation, after which he would have had time to rest and recover. The applicant continued to work full time (and overtime) for two weeks post alleged injury without medical treatment. Additionally, the applicant presented no expert evidence regarding diagnosis or causation. There was no WKC-16b expert report or testimony from a physician presented at the hearing.

Maldonado v. Exel Logistics, Inc., Claim No. 2013-029011 (LIRC June 30, 2017). The applicant operated a battery operated forklift. The battery died, and he attempted to fix the forklift. He alleged that he sustained an injury to his back when he attempted to move the battery. The applicant underwent a discectomy at L4-5 and L5-S1. He also, later, underwent a fusion. The

surgery was not successful. He sought a second opinion, but his treating physician would not provide him with a recommendation. Dr. Aschliman performed an independent medical examination. He initially opined that he could not provide a causation opinion because he needed to review an actual MRI from prior to the alleged injury, in order to determine whether there were any actual structural changes. After review of the actual scan, Dr. Aschliman opined the applicant's scans were essentially the same, and there was no objective structural breakage post injury. Dr. Ford, a radiologist, provided a similar opinion. Dr. Aschliman opined, prior to the surgery, that it would not likely be successful. The administrative law judge awarded the benefits sought. The Labor and Industry Review Commission reversed. Dr. Aschliman and Dr. Ford are more credible. The failure of the surgery and refusal of the treating surgeon to provide a recommendation for a second opinion reduces the physician's credibility. Dr. Aschliman's opinion was more credible, particularly in light of his initial refusal to provide a causation opinion without reviewing the actual pre-injury MRI scan.

Musial v. City of Green Bay, Claim No. 2014-004700 (LIRC June 30, 2017). The applicant was a referee for city league basketball games. The first game was canceled when one team did not have enough players show up. The referees were paid per game. Therefore, they were paid for the first game because it was scheduled. The referees had a second game scheduled. They were free to do whatever they liked until the time the second game started. They did not need to remain on the employer's premises. The people who had shown up for the first game decided to play a "pickup game" before the second game was scheduled to start. The people asked the two referees to play so that they would have enough players. The applicant agreed and was injured during that basketball game. The unnamed administrative law judge found that playing in a pickup basketball game was in the course of employment. The Commission reversed. The applicant was not performing services growing out of and incidental to his employment at the time of the injury. The applicant's job duties had ended. He made a personal decision to play basketball, and as such, was engaged in a personal pursuit at the time of the injury. There was no clear benefit to the employer from the applicant's engaging in the unofficial pickup basketball game. Further, even if the employer experienced some benefit, this would bring social and recreational pursuits into the course of employment.

Rentas v. Aurora Health Care, Inc., Claim No. 2015-009517 (LIRC June 30, 2017). The applicant had a significant pre-existing history of back symptoms and medical treatment. She alleged that she sustained an injury when she was assisting a co-worker with moving a patient from one wheelchair to another wheelchair. She reported the patient grabbed the applicant by the neck and pulled her down. She reported similar symptoms pre and post injury. The MRI scans reflected only minimal progression of her degenerative condition. There was no diagnostic evidence of breakage or structural changes. The treating physician's post injury diagnoses existed pre-injury. The treating physician did not provide explanation regarding any alleged breakage that occurred on the date of injury or that there was any precipitation, aggravation, and acceleration beyond normal progression. The administrative law judge denied the applicant's claims. The Labor and Industry Review Commission affirmed. An employee's pre-existing issues alone do not preclude a finding of compensability. However, an employee has the burden of demonstrating that there was a direct breakage (a letting go or structural change) or a precipitation, aggravation and acceleration beyond normal progression of a progressively deteriorating or degenerative condition. An employer is not liable for any condition that coincidentally comes or manifests itself while an employee is working.

Bach v. Bach, Claim No. 2011-032333 (LIRC July 21, 2017). The applicant's son, due to a brain tumor, required 24 hour care. The applicant was previously her son's guardian. She was removed as guardian, and a corporate guardian was appointed. In October 2010, a Circuit Court ordered the son's placement to continue in the applicant's home until an unlocked community-based residential facility had an opening, and the facility was willing and able to accept the son. That order remained in effect at the time of the claimed injury. Shortly before the alleged injury, the employer advised the applicant her wage would be reduced from $340.00 per day to $100.00 per day. She believed that if her son was only present at her home during the day, her payment would increase back to $340.00 because the care would be a "day program." She started taking her son to his grandparent's home to spend the night in the basement. While her son was entering the grandparent's home one evening, he tripped and fell. She sustained a shoulder injury as she tried to hold him. The unnamed administrative law judge denied the benefits claimed. The Commission affirmed. The applicant had no legal right or authority to decide that her disabled son could or should spend the night at his grandparents. Rather, pursuant to the Circuit Court order, he was to sleep at the applicant's home. The moving of the son to the grandparents in the evening had nothing to do with the applicant's job responsibilities. Instead, these activities were solely personal to the applicant as she tried to collect more money. Her deviation from the course of employment for personal reasons was completed. The applicant's assertion that her actions in taking her son to the grandparents involved a service that was at least in part for her employer's benefit, because it would enable her to have fair, legal compensation to pay for her son's many high needs that no one else paid for, was not reasonable. The employer would not have benefit from the increase of pay to the applicant. The applicant's remedy for her perceived improper reduction in pay was to pursue a grievance with her employer through normal channels, and not to unilaterally take illegal action (as she was not her son's guardian) to try and increase her daily pay. The applicant's son was placed in a residential home two days later because the court guardian determined the applicant violated the court's order with her illegal actions of attempting to move her son to his grandparent's home.

Weck v. Joy Global Surface Mining, Inc., Claim No. 2016-0034 (LIRC September 27, 2017). The applicant alleged he sustained a shoulder injury in November 2012. The applicant did not miss work or reduce his work duties. He did not seek any medical treatment until after another injury occurred in February 2013. He did not report to anyone at work or a medical provider, within a reasonable amount of time after the 2012 injury, that he had any ongoing disability. The administrative law judge (unnamed) awarded benefits. The Labor and Industry Review Commission reversed and dismissed the claim. The only direct testimony regarding the effects of the injury was an affirmative response to the question "this particular injury did not work itself out." There was no credible, corroborating evidence of any residual disability attributable to the injury. In contrast, Dr. Weiss opined the injury caused no disability or need for medical treatment. Dr. Weiss' opinion was supported by medical evidence and by the lack of medical treatment, lack of report of ongoing disability, and lack of time off from work in the immediately period post injury. This was controverted only by a WKC-16b from the treating physician, which indicated the work event directly caused the applicant's disability and surgery. There was no medical support or explanation additionally provided to support that opinion. There were no other post injury medical records filed or presented.

***Employers Assurance Corp. v. Schue-Nilles*, 380 Wis. 2d 282 (Ct. App. 2018).** The applicant had finished her work day but had not yet punched out. She fell and twisted her knee while putting on her snow boots in the backroom of her workplace. The employer did not prohibit its workers from changing their footwear on the employer's premises. The Labor and Industry Review Commission held that the injury arose out of her employment and awarded benefits. This decision was based upon the applicant not having punched out, not sustaining an idiopathic or unexplained fall, and the injury occurring while the applicant was engaged in an everyday activity, and for her personal comfort, while still at work. Further, she would have been in the course of employment under the coming and going rule even if she had punched out. Her actions arose out of employment because actions only need to be usual or normal in the sense of exertion and effort, and not unusual or extraordinary, in order for such activity to cause a compensable injury. The Circuit Court of Barron County reversed. The Court of Appeals reversed the Circuit Court. The Commission's decision was reinstated. The employer asserted that the positional risk doctrine results in an injury arising out of employment only if the workplace conditions subject the employee to a zone of danger or hazard of employment. This assertion misstated the case law. The Wisconsin Supreme Court has held that the positional risk doctrine is negated by a determination that an injury was not of an idiopathic nature. (*See Cmelak v. Industrial Commission*, 135 N.W.2d 304 (1965) *and Jenson v. Employers Mut. Cas. Co.* 468 N.W. 2d 1 (1991)). Once the Commission determined that the injury was not idiopathic, the conclusion that the injury arose out of employment is straightforward because the employment does not have to proximately cause the injury. All that was required was that the circumstances of the employment put the applicant at the particular place where the injury occurred, and it was not an idiopathic injury.

Culver v. Francois Oil Co., Inc., Claim No. 2016-015343 (LIRC January 31, 2018). The applicant worked as a full-time cashier for the employer, which is a company locally known as Milton Travel Center. On Easter Sunday, the video showed the following events. An unidentified customer stepped away from a car and proceeded to the store. He went through the center of the store and approached the restroom hallway. He moved off camera. The applicant looked up as though responding to something at the right center of the store. The applicant moved around to the front of the counter and to the right. He then stepped off camera and entered the restroom hallway. The customer then reappeared from the hallway, walked backward toward the restroom, stepped back into the hallway, turned and scoped out the store, and walked the perimeter of the store, between product shelving units, and to the cigarette display. He grabbed cartons of cigarettes, tried to open the cash drawer, and opened the unlocked cabinet. He then stepped around the counter and exited the store. Thirty minutes passed, and a co-worker entered the restroom and found the applicant seated on the toilet, pants down, disoriented, and only partially responsive. There was a pool of blood on the floor just outside what would be the threshold to the door of the toilet stall. There was a bloody smeared handprint on several walls. The applicant alleged he was injured as a result of an assault. The employer and insurer allege that the applicant sustained head injuries as a result of an idiopathic cardiac event, which caused the applicant to fall and strike his head, or, alternatively, as an unexplained event. Administrative Law Judge Shore awarded benefits. The Labor and Industry Review Commission affirmed. The applicant sustained relatively severe injuries to the back of his head and the front of his head. The assertion that these injuries could be explained by tripping and falling and then getting back up again and falling is extremely unlikely given the severity of the injuries. There is no assertion of a preexisting idiopathic heart condition that could have caused the fall twice that is supported by credible medical evidence. The initial emergency department records reference the applicant was evaluated after a fall, and that he was suffering a possible syncopal episode versus assault,

etc. on several occasions. These reflected the physicians' preliminary and inconclusive conjectures regarding how the applicant was injured. The physicians were primarily and appropriately concerned with treating the applicant rather than determining whether or not he had been physically attacked at work. The credible inference from the videotape, the applicant's injuries, and the physical evidence is that the thief on the videotape did physically attack the applicant. The nature of the injuries is most reasonably explained by the thief physically attacking the applicant. The record was reopened to allow an on-site inspection of the employer's premises to permit better evaluation of the photographic and video evidence.

Bergson v. Aurora HealthCare of Southern Lakes, Claim No. 2016-027590 (LIRC February 20, 2018). The applicant worked in registration in an emergency department. He sustained an injury when he climbed over his desk to return an insurance card to a patient. He asserted that he climbed over the desk because he believed it was imperative to return a forgotten insurance card to a couple visiting from Georgia. The couple had previously indicated they had inadvertently left their other insurance card at a different hospital, and the applicant was concerned the couple would not be able to receive additional medical treatment on their return trip home without the card. The applicant believed that climbing over the desk was necessary because the couple was already out the hospital doors when the applicant realized that he had not returned the card. He had previously been advised to climb over a desk in a different department if he was locked into the area. This was the first time he had tried to climb over the desk in this department. The applicant crawled over the top of his desk. His foot caught on the desk, and he went forward. There was video of the incident. The applicant was two weeks status post wrist surgery at the time of this incident. The unnamed administrative law judge awarded benefits. He determined that the applicant did not deviate from his employment when he crossed the desk to attempt to return the insurance card. The judge held the applicant was trying to carry out his responsibilities to the patient and was in the course of his employment. The Labor and Industry Review Commission affirmed. Upon entering an employer's premises and beginning work, an employee is presumed to be continuing to work as long as he or she is on the employer's premises, absent evidence to the contrary. After an employee has entered the course of employment, the test to be applied in determining if he has removed himself is one of deviation. The question becomes whether the employee has engaged in some activity of his own which has no relation to the employer's business. An act is not a deviation, even if in violation of the employer's directives, if it furthers the employer's interests and not merely the employee's own personal ends. An impulsive, momentary, and insubstantial deviation will not bar recovery. The *Nigbor* criteria are to be considered; specifically, the extent and seriousness of the deviation, the completeness of the deviation, the extent to which the practice of horseplay has become an accepted part of the employment, and the extent to which the nature of employment may be expected to include such horseplay. Here, the applicant was on duty and on the employer's premises. He was attempting to return an insurance card to a patient which is part of his job responsibilities. The injury occurred because he was trying to do his job. He did not benefit in any way, and so the deviation cannot be considered done for personal reasons. There is a strong nexus between the applicant's actions and the employer's interests. Going over the desk was foolish. However, he was not disciplined for that, and, in fact, was taught to do that in a different department. While he performed his employment in an unwise manner, he did not deviate.

Senesac v. Cabela's Inc., Claim No. 2014-026180 (LIRC April 30, 2018). The applicant last recalled moving boxes. He could not recall where he was located. He next recalled waking up in a hospital room. The applicant was found by a co-worker on the floor with one leg bent under him and one leg straight out. He was on the mat in front of the area where he normally worked. There were no witnesses to the fall. The applicant was trying to hold the cut on the back of his head where he was bleeding. The co-worker noticed a box was askew and put it out of the way. That box had a dent in one corner. A lead worker filled out an incident report and noted the mechanism of injury as "tripped" because the emergency medical technician told her to do so. The technician had not witnessed the fall. There was no evidence the applicant hit his head on anything other than the floor. The applicant was not on medication at the time he fell. He had some benign essential tremors, but only in his hands prior to the fall. After the fall, the applicant also had them in his legs. The emergency room physician concluded the applicant had an unknown event. He noted it was not clear whether it was a trip and fall or a syncopal episode of a seizure. The applicant stayed in the hospital for a period of time because of a potential seizure or syncopal episode. His blood pressure was reduced for a period of time. This improved with intravenous fluids. The applicant's treating physician subsequently opined that the fall caused the applicant's disability. Next to the box on a 2015 WKC-16b regarding whether the incident precipitated, aggravated, and accelerated a pre-existing condition, the treating physician wrote "it is possible; probability uncertain." This qualification was removed on the same form that was completed in 2017. The applicant was provided permanent restrictions. His vocational expert opined he was *odd lot* permanently and totally disabled as a result of the injury and assigned restrictions. Dr. Burgarino performed an independent medical examination. He opined the unwitnessed fall may have been associated with postural instability which was a cardinal feature of idiopathic/constitutional Parkinson's disease. He opined the applicant required additional evaluation for possible early idiopathic Parkinson's disease based upon other findings on examination. Dr. Burgarino opined the applicant returned to his baseline and required no ongoing restrictions or permanent disability. The unnamed administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The applicant sustained an injury because of an idiopathic fall. That fall did not arise out of employment. The first step is to determine whether the fall was idiopathic. An idiopathic fall is a fall due to a personal condition that is not caused or aggravated by employment. Such falls are not compensable. These falls can occur when an individual falls while walking on non-slippery, level surfaces not because of any hazard or danger of employment, but instead because of a disease, physical disability, or condition personal to the individual. The applicant has the burden to prove the cause was not solely idiopathic. The medical records show the applicant was dehydrated and responded positively to rehydration. His blood pressure normalized after hydration. Further, the fall may have been related to postural instability from early Parkinson's disease. This demonstrates the fall was idiopathic. Further, even if the fall was not idiopathic, it would need to be explained by evidence of a cause related to employment. Unexplained falls are not compensable even if the individual is in the course of employment. There is no presumption that the unexplained fall arises out of employment. The applicant had no memory of what happened, and no one witnessed the fall. There is no evidence the applicant tripped, and no witnesses stated they had ever tripped on the mat where the applicant was located at the time of the fall. Therefore, the fall was also an unexplained, non-compensable injury. The mere existence of a floor mat does not create a hazard or zone of special danger. The applicant has the burden of showing a special hazard exists. This burden was not met. There was contradictory evidence regarding how the mats were positioned. There was no expert testimony about the use of anti-fatigue mats. The Commission will not speculate that the mat could have caused the applicant to fall.

BAD FAITH

Schmelzer v. Zurich American Insurance Company, Claim No. 2011-019555 (LIRC September 27, 2017). The parties entered into a compromise agreement. The employer and insurer agreed to indemnify and hold the applicant harmless for unpaid medical expenses itemized on a specific WKC-3 up to a specific maximum amount. The parties indicated it was understood and agreed that the employer and insurer could negotiate with any healthcare provider, carrier, or other party claiming a lien for such unpaid medical expenses to secure waiver or reduction of the claims. This was approved on October 27, 2015. On November 6, 2015, a new adjuster took over the file on behalf of the insurer. All of the medical expenses were negotiated and settled with the exception of two Aurora Health Care charges. Two collection agencies represented Aurora for the bills. The adjuster contacted both collection agencies in January 2016 and informed them of the insurer's responsibility for the bills. The collection agencies indicated they could not discuss the bills without the applicant's permission. The applicant and her attorney agreed to provide permission. The adjuster subsequently left voicemails for the collection agencies to attempt to negotiate the respective bills. The collection agencies indicated Aurora's policy was not to allow negotiations of the bills until the applicant provided information regarding her monthly income, employment status, dependents, and assets. The applicant was asked, by the adjuster, to provide this information. This was requested on two occasions, in April and May 2016. In June 2016, the collection agency again indicated this information was needed. The adjuster offered payment to resolve the case, but the collection agency indicated it could not consider the same until the paperwork was completed. The applicant contacted the collection agency in April to seek an itemized statement. The collection agency did not ask her any of the personal information it indicated was needed to continue settlement negotiations with the insurer. After the applicant's home loan application was denied, the applicant's attorney requested the insurer to resolve the bills. The applicant again contacted the collection agencies to seek itemized bills for her attorney. The cover letter providing the bills requested that the applicant contact the collection agency. The applicant did not receive the letter. The applicant's attorney did not provide the document to the applicant. The applicant did not provide the personal information to the collection agency. The administrative law judge awarded bad faith penalties. The Labor and Industry Review Commission reversed. There was no credible case for a bad faith penalty. There was a lack of comity between the parties; however, the applicant's failure to respond to the reasonable request of the collection agencies to provide specific personal information precludes a finding of bad faith. The insurer had a reasonable basis for the delay in payment of the two medical bills at issue. The insurer informed the applicant of specific personal information needed from the applicant in order to proceed with negotiations of the unpaid bills. The applicant did not respond to the requests. While there was no specific term in the compromise agreement that obligated the applicant to assist the insurer in reducing the medical bills or to require the providers to actually agree to reduce the bills, the agreement did impliedly obligate the applicant to cooperate with reasonable requests made by the respondents to assist in negotiating resolution of the medical bills. The request made by the insurer to the applicant was reasonable. The judge's characterization of the insurer's pursuit of a negotiated settlement of the bills as "selfish, malicious, and unconscionable" finds no support in the objective terms of the compromise agreement or the facts which occurred after the agreement was approved.

CAUSAL CONNECTION

Vallier v. Aurora Health Care, Inc., Claim No. 2010-033148 (LIRC June 30, 2017). The applicant alleged she was walking out of a room while looking at paperwork and accidentally ran into the corner of a hallway. She reported that she made hard contact with a door frame, somewhere between her right elbow and right shoulder. She reported tingling in her right hand and pain in her elbow. There was no bruising on her arm. She continued to experience pain and tingling in her arm. She was referred for an EMG and diagnosed with cervical radiculopathy. She reported later that she had been experiencing neck and right upper extremity pain ever since the work injury. Additionally, later records reflect she reported that she hit her neck and shoulder on the corner of a wall or door frame. Her surgeon opined a cervical disc herniation was most likely related because the applicant was asymptomatic prior to the injury. Dr. Lyons performed an independent medical examination. He opined the mechanism of bumping into a door jam could not have contributed to the onset or progression of degenerative disc condition. The unnamed administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The mechanism of injury was not sufficient to have caused any bruising. The applicant did not report any cervical symptoms until after the disc herniation was identified by the MRI. Yet, she reported to subsequent physicians that she had reported ongoing symptoms ever since the work-related injury occurred. The treating physicians' foundation was, therefore, flawed. Dr. Lyons' opinion is more credible than the treating physicians' opinions, and no compensation is owed.

Taylor v. Tradesmen International, Inc., Claim No. 2013-002491 (LIRC December 15, 2017). The applicant was standing on a platform. He was wearing a hard hat. A co-worker raised the platform. The applicant's head struck the ceiling. The applicant initially reported some neck pain. Approximately one week post injury, the records indicated he had considerable reduction in that pain. Three months later, the applicant reported radiating pain and numbness. Medical providers initially indicated the applicant hit his head on the ceiling. Later records reflected he struck his head on the ceiling. Other records reflected that he rammed his head into the ceiling, and another report reflected the event was "neck crunching." Dr. Soriano performed an independent medical examination. He opined that a temporary soft tissue injury was sustained, and that did not require the claimed treatment or disability. Administrative Law Judge Nancy Schneiders denied the applicant's claim. The Labor and Industry Review Commission affirmed. While medical providers might choose their own words, they are unlikely to use such dramatic words to describe an incident unless that is what they were told by the applicant. The records vary as to the degree of force with which he reported that he hit his head. The applicant's testimony regarding the mechanism of injury and nature of the symptoms is not consistent with the medical records. Dr. Soriano's opinions are well founded, thorough and persuasive.

***O'Brien v. Labor & Industry Review Commission*, 380 Wis. 2d 509 (Ct. App. 2018).** The applicant underwent a neck fusion for a personal condition. This was performed by Dr. Pennu. The fusion eventually failed. The applicant was sitting at work when the back rest of his chair broke, causing the applicant to begin falling backward. He put his head at a downward angle and experienced a sudden jerking motion. This immediately caused him severe pain in his neck. He alleged this work-related injury caused the fusion failure. (The incident occurred approximately five months before the fusion failure was diagnosed.) Dr. Pennu opined the failure was related to that fall. Dr. Boco performed an independent medical examination. He opined that the work-related injury did not have any connection to the failure of the fusion. Instead, Dr. Boco opined that the fusion failed because the applicant was a heavy smoker and never quit smoking. He

opined continuation of smoking puts an employee at further risk for pseudo arthritis after initial surgery and re-surgery. The Labor and Industry Review Commission denied the claimed benefits. The Commission held the treating surgeon's opinion, in part, was unconvincing because it was so conclusory. Further, the Commission noted the treating surgeon's opinion was not clear as to whether the surgeon stated his own causation opinion or merely related the applicant's causation opinion. The surgeon had affirmatively answered a question "describe the accidental event or work exposure to which the patient attributes his or her condition." The Circuit Court reversed the Commission's decision. The Court of Appeals reversed the Circuit Court. The Commission's decision was reinstated. The Commission's decision was based on sufficient credible evidence and, therefore, must be affirmed. This is the standard applied in reviewing the Commission's decision in this type of situation. The Commission reasonably concluded the treating physician provided no convincing reason to choose his opinion over Dr. Boco's opinion.

Kasarsky v. Aurora Health Care, Inc., Claim No. 2014-028038 (LIRC January 12, 2018). The applicant sustained a compensable left foot injury. She asserted that altered gait resulted in a compensable right hip condition, necessitating surgery for her hip. The administrative law judge denied the claim for prospective surgery. This was the only claim addressed at the hearing by agreement of the parties. The Labor and Industry Review Commission affirmed. A treating physician completed a WKC-16b indicating there was precipitation, aggravation, and acceleration of the pre-existing hip condition beyond normal progression. The only explanation was reference to office notes from the prior year. The office notes reflected the doctor opined it is *possible* that the foot injury may have caused more compensatory stress on the right hip. The opinion was not stated to a reasonable degree of medical probability. A different physician, who treated for the left foot condition, referred to medical records wherein the doctor noted the applicant had recently treated for a hip condition. There was no causation opinion included in the medical records. The other medical records do not include any type of causation opinion. Dr. Friedel performed an independent medical records review and subsequent physical examination. Dr. Friedel opined there was a longstanding degenerative change of the right hip which necessitated the need for surgery. He opined this was not casually related to the work-related foot injury. The order was left interlocutory because the only issue was the entitlement to payment for the prospective right hip surgery. There was no final determination regarding the overall compensability of the right hip condition. The administrative law judge has the discretion to leave an order interlocutory or make the order final. The issue of the existence of a causal connection between the left foot injury and the right hip condition was not finally determined. Jurisdiction over that issue was appropriately reserved on an interlocutory order.

Cruz v. Five Star Fabricating, Inc., Claim No. 2015-028405 (LIRC January 31, 2018). The applicant sustained a compensable lumbar injury. The nature of that injury was in question as well as the applicant's entitlement to prospective medical treatment in the nature of low back surgery. The medical records reflect some discrepancies regarding the mechanism of injury. These involved how the applicant fell off a two by four, how his feet landed on the floor, and whether any other part of his body landed on the floor. The administrative law judge (unnamed) dismissed the application. The Labor and Industry Review Commission reversed. The applicant sustained a compensable low back injury which resulted in an L4-5 protrusion. The employer and insurer are liable for prospective coverage of the proposed lumbar fusion surgery at L4-5. The inconsistencies in the medical records regarding the mechanism of injury are relatively minor and not determinative. The Commission has long recognized that busy medical providers, who are primarily concerned with medical diagnosis and treatment, often write inaccurate descriptions of exactly how a work injury occurred. The Commission carefully examines the

record in each case to determine the weight to be given particular medical record inconsistencies or inaccuracies. Further, English is a second language for the applicant. He requires an interpreter to communicate in English. The likelihood in these situations is certainly higher for misinterpretation of a description or particular word. This also holds true for the administrative law judges concern with the difficulty she experienced when questioning the applicant through an interpreter at the hearing. The treating physician's opinions were more credible than the independent medical examiner in light of the applicant's testimony and the medical records.

Grimmer v. Young Men's Christian Assn. of Eau Claire, Claim No. 2014-021899 (LIRC February 20, 2018). The applicant had a history of knee problems and dislocations. Most were not work related. The final was related to his employment. The independent medical examiner opined that, when an initial knee dislocation damages the MPFL, all subsequent dislocations are attributable to that damaged MPFL. Therefore, when the surgery repairs the MPFL, it is not surgery caused by the subsequent dislocation, it is surgery caused by the torn MPFL. The Labor and Industry Review Commission awarded benefits. The fact that the applicant may have benefit from a surgical repair to the MPLF after an initial dislocation does not mean that surgical repair after a subsequent dislocation at work cannot be related to that subsequent dislocation. The court cited *Klemp v. United Parcel Rhinelander* for support for the Commission's determination that the employer and insurer were liable for benefits despite medical opinions that the employee would have eventually needed the same surgery to treat the pre-existing condition even if the work injury had not occurred. Further, the surgery was performed to treat potential loose bodies, and the decision to repair the MPFL was made during the procedure. The work injury precipitated, aggravated, and accelerated, beyond normal progression, the applicant's deteriorating knee condition. The surgery was needed to address the accelerated deterioration.

COMPROMISE AGREEMENT

Felber v. GKN Sinter Metals Inc., Claim No. 2013-015981 (LIRC May 2, 2018). An administrative law judge handwrote a compromise agreement, including a stamped notation that denied attorney fees but allowed attorney costs. The applicant testified, and the compromise language supported, the applicant had concern that his hearing application was not received within the 12 year statute of limitation. The attorney asserted the application was timely filed but the department records did not show that it was received. The applicant asserted that this stress was such unusual stress that it constitutes duress. Administrative Law Judge Falkner dismissed the request to re-open the compromise agreement. The Labor and Industry Review Commission affirmed. The applicant may well have had stress regarding whether the hearing application was timely filed. The applicant chose his attorney and chose to proceed with the compromise agreement without a final determination regarding whether a hearing application was timely received. This stress was not so unusual as to constitute duress. The employer and insurer were also still contesting substantial elements of the applicants claim. Contested claims almost always involve substantial emotional stress for an applicant. This is not uncommon. The applicant asserted mutual mistake because there was no discussion regarding the alleged traumatic brain injury claim at the time of the compromise. The applicant had the burden to raise and identify specific claims and provide evidence. The failure to do so cannot be attributed to the employer and insurer. The applicant was on notice that a physician had opined that there was no post traumatic brain injury attributable to the work injury. The applicant was on notice that this was an issue to be addressed at the hearing. There was no mutual mistake when the parties agreed to a full and final compromise that addressed all issues related to the work injury. The administrative law judge who presided over the compromise did not allow a grossly inequitable

result. The applicant's attorney may have had incentive to see the applicant compromise his claim, so the attorney could avoid the issue of whether he failed to properly submit or monitor delivery of the hearing application. However, the applicant also knew he was at risk regarding this issue. The two shared the risk. If the applicant believes he can prove his interests were undercut by his attorney's actions, the recourse is against the attorney and not via a reopen of the compromise agreement.

DISFIGUREMENT

Breitzman v. Airpro Fan & Blower Company, Claim No. 2012-019990 (LIRC June 7, 2017). The applicant got his left hand caught in a machine and sustained a severe crushing injury. The middle, ring, and little fingers of his left hand had to be amputated. His left index finger had to be fused at an unnatural angle. The unnamed administrative law judge awarded the maximum disfigurement award of one year's wages. She opined the injury had precluded the applicant from returning to work as a welder and had impaired his ability to return to work. The Labor and Industry Review Commission modified the award and reduced the amount in half. Consideration of the actual physical limitations caused by the applicant's injury is inapplicable to the question of the disfigurement award. That consideration is built into the scheduled award for permanent physical disability. Potential wage loss due to disfigurement contemplates the cognitive and emotional effects that visualization of the disfigurement may have on potential employers and co-workers and, thus, the likelihood that an applicant may not be hired or may be discharged due to the appearance of the disfigurement. The applicant's left hand disfigurement was severe However, he had significant personal health problems which were also part of the reason he was receiving social security disability benefits, and which impacted his ability to physically perform other available jobs. He also self-limited his income, so he did not lose his eligibility for social security and to care for his wife. [*See also* Permanent Partial Disability.]

DUE PROCESS

Weck v. Joy Global Surface Mining, Inc., Claim No. 2016-0034 (LIRC September 27, 2017). The applicant alleged he sustained a shoulder injury in November 2012. The administrative law judge (unnamed) awarded benefits. The Labor and Industry Review Commission reversed and dismissed the claim. This was based upon the lack of medical evidence. There was no due process violation with respect to events that took place at the hearing. The attorney for the employer and insurer attempted to question the applicant at the hearing regarding several issues, including a potential prior shoulder injury/treatment and alternative cause of the symptoms. The judge interrupted the questioning to ask the applicant questions. The judge further limited the attorney's line of questioning upon objection by the applicant's attorney and on his own accord. The attorney for the employer and insurer alleged a due process violation and bias against the judge for failure to allow the attorney to question the applicant regarding these items. The judge could have allowed more leeway. However, there were no documents or evidence submitted (or any offer of submission) to support the line of questioning regarding a prior injury, despite the attorney indicating that he had seen such evidence. (For further discussion on this case please also refer to the Arising Out Of category.)

EMPLOYMENT RELATIONSHIP

Opperman v. Let Mikey Do It LLC, Claim No. 2015-018063 (LIRC March 16, 2018). The applicant brought a claim against the uninsured employer's fund. Benefits were paid to her. The employer filed a reverse hearing application asserting that there was no employer-employee relationship because the applicant was never hired. The owner of the handyman business indicated approximately 50% of his business was insulation. He found laborers with ads on Craigslist. He screened people via email and phone calls. If his criteria for hiring are met, then he has the individual come to his house for a meet and greet. The employer then told the individual about the business and asked questions about their experience, etc. The employer and applicant agreed to meet and did so. There was no agreement regarding pay. There was no job application or W-4 that was provided to the applicant. The employer asked the applicant to shadow another individual to see if the job would work out. This other individual was present for the meeting and had observed other similar meetings. This other individual considered himself to be a sole proprietor as were the others who met with the employer. The applicant went to two job sites. He did not perform any work. The applicant did not need to stand on a ladder to observe. The other individual was in the attic and heard a thud. He found the applicant on the floor intertwined with the ladder. This other individual observed that the way everything was laid out was unusual. Other people had shadowed in the past. If the person was hired then he was paid for hours spent shadowing. The administrative law judge (unnamed) awarded benefits. The Labor and Industry Review Commission reversed. There was no implied contract of hire between the employer and the applicant. The applicant was in a pre-employment observation period and not an employee at the time of the alleged injury. There was no employer-employee relationship. The employer was, therefore, not liable for any compensation. The applicant (and the uninsured employer fund, standing in his shoes) had the burden of proof even though the employer filed the reverse hearing application. The *Kress* test generally provides the primary test for determining whether the work done by a worker establishes an employer-employee relationship by examining the level of control over the work by an employer. However, where there is a dispute regarding whether the worker was even hired, the Commission first has to decide whether there was an express or implied contract of hire and if the applicant was working in the service of the employer. The presumption that a person was an employee and that a relationship of employer and employee exists arises only when the person was rendering service for the alleged employer. This is a presumption that can be rebutted. An implied contract for hire requires the element of mutual meeting of the minds and a mutual intention to contract. This can be demonstrated by considering the conduct of the parties. There was no objective meeting of the minds in this case and, thus, no implied contract for hire. The applicant was not in the service of the employer. Service is essentially aiding the principle in the regular conduct of the business. The applicant did nothing but lift a tarp on his own initiative. He performed no work on the job site. Merely observing work performed by another before hire is not in the service of an employer. Additionally, under the *Kress* test, there was no work by the applicant for the employer to control. Even though the applicant would have been paid for the time spent shadowing if he had been hired, this was not sufficient to establish an employer-employee relationship. The word "hire" connotes prepayment of some kind, and wages are a necessary part of an employment relationship. The actions of shadowing are more in the nature of a voluntary pre-employment screening before employment, which is not part of or establishing an employment relationship.

END OF HEALING

***Wittmann v. Consolidated Lumber Co.*, 376 Wis. 2d. 526 (Ct. App. 2017).** The applicant fell and fractured his fibula while working as a salesperson. He was not provided any restrictions and worked without a wage loss. He treated conservatively for many years. He was terminated from his position approximately one year post injury. The records reflect the termination occurred due to lack of business. A few months later, he was advised surgery would be an appropriate treatment for his condition. The applicant declined the recommendation for surgery. Another physician opined he reached the end of healing approximately 13 months after he declined surgery. The applicant sought temporary disability benefits between the date of termination and the date he reached end of healing. Dr. Thomas O'Brien performed an independent medical examination of the applicant. He opined the applicant had reached the end of healing a few months after the injury occurred, when the fibula fracture healed. An unnamed administrative law judge denied the claim. The applicant was not placed under work restrictions and lost no wages prior to his termination. The Labor and Industry Review Commission adopted the administrative law judge's decision. The Circuit Court and Court of Appeals affirmed. Just because an applicant continues to treat for other symptoms and conditions in the same extremity injured in the work-related incident, does not mean an applicant has not reached end of healing for that injury. The applicant returned to work for the employer without restrictions and worked for one year. There were significant delays in the visits to the medical doctors to evaluate the potential that any ligament injuries occurred during the fall. The applicant also refused to undergo surgery when that was recommended. The more credible opinion is that he reached the end of healing when the fracture healed and before the termination.

EVIDENCE

***American Family Mutual Insurance Company v. Haas*, 904 N.W.2d 830 (Ct. App. 2017)**. Dr. White prepared a WKC-16B, which was filed pursuant to Wis. Stat. 102.17(1)(d)(1). Dr. White opined the applicant's surgeries were necessitated because of prior surgeries and injuries, which were previously determined to be work related. One month after Dr. White completed a second WKC-16B regarding the issues at hand, Dr. White's ability to practice medicine was limited by the State of Wisconsin Medical Examining Board. Dr. White voluntarily surrendered his license to practice in Wisconsin the following month. Dr. White's reports were introduced into evidence 13 months after Dr. White voluntarily surrendered his license. The employer asserted that, because Dr. White was not licensed when the hearing took place (even though he was licensed when the report was prepared), the report was not admissible. Wis. Stat. 102.17 and DWD 80.22 permit a WKC-16B report to serve as prima facie evidence at a hearing, as to the matter contained in the report, if the doctor consents to and is available for Crosby's examination. The Labor and Industry Review Commission held the most reasonable reading of the statute and rules is that the licensure requirements apply when the report is certified, and that any opinion in the report should be viewed as given when the report is certified, versus an arbitrary date of a hearing that might occur at some future point. The Circuit Court and Court of Appeals affirmed. To disallow a report because the doctor's license was not valid at the time of a hearing results in a party risking having a report, which was originally obtained in good faith, rejected because of acts beyond the party's control (such as a delay in a hearing date or a doctor's decision not to practice any longer). There is no support in the statute or rule to require a physician who properly certified a WKC-16B report at the time it was prepared, to be licensed at the time of the hearing. The employer and insurer could have sought to discredit the doctor's opinions and credentials as a result of the later loss of licensure, via cross examination, but they chose not to do so.

Bruton v. Service Master by Berger, Claim No. 2011-003574 (LIRC June 30, 2017). The applicant alleged she sustained a right lower extremity injury that was a compensable consequence of a conceded left lower extremity. The applicant alleged her left leg buckled and caused her to fall down steps, resulting in a right lower extremity injury. The medical records had some discrepancies regarding the actual mechanism of injury. However, the administrative law judge awarded benefits. The Labor and Industry Review Commission affirmed. The Commission is routinely presented with medical records describing the circumstances of an injury that are arguably or directly inconsistent with the applicant's description of the incident. The Commission must weigh the significant of the inconsistencies with the other evidence, including the medical records which are consistent with the applicant's version. The Commission must also be mindful of the fact that medical providers are often pressed for time and are generally more focused on the treatment of an injury than on the precise details of how the injury occurred. The Commission frequently sees medical records that contain obvious errors reflecting a lack of attention to the details of an injury event, including misinterpretations of verbal descriptions given to the provider. Obvious and/or repeated inconsistencies in a description given by an applicant may raise a legitimate doubt as to the truthfulness of the description of the incident. The totality of the evidence supports the applicant's description of the incident. The inaccuracy in the initial records was attributable to the applicant's emotional state at the time of the report of the injury.

Kucan v. WFH Lab – Elmbrook Memorial, Claim No. 2014-013792 (LIRC March 16, 2018). The applicant alleged that he sustained a low back injury as a result of a specific incident. The administrative law judge (unnamed) awarded benefits sought by the applicant. The Labor and Industry Review Commission affirmed in part and reversed in part. The Commission adopted the treating physician's opinion regarding causation and the extent of permanent physical disability. However, the Commission adopted the independent medical examiner's (Dr. Krug's) opinion regarding the nature of permanent restrictions required [rather than the treating physician, as did the administrative law judge]. The applicant's vocational expert's opinion was adopted, based upon the permanent restrictions required by the independent medical examiner. The treating physician's opinions were adopted with respect to the need for future medical treatment. [Editor's note: This case shows that the judges and Commission will sometimes pick and choose different parts of different expert's opinions and not just adopt one entire opinion.]

EXCLUSIVE REMEDY

Fitzgerald v. Capezza,* 900 N.W.2d 344 (Ct. App. 2017)(*unpublished). The applicant was involved in a single vehicle accident while traveling to a work site in Iowa for her employer, All Star Catering, LLC. Ms. Capezza was driving, and the applicant was a passenger. The applicant asserted Ms. Capezza was a volunteer and not an employee. She conceded that she was an employee, and her employer was subject to the Wisconsin Worker's Compensation Act. The applicant commenced a worker's compensation proceeding in Minnesota, where the majority of her employer's business was located. That claim was resolved via mediation. The terms of the settlement outlined that she was employed by All Star, and that her injuries arose out of and in the course of that employment. A separate assignment of subrogation agreement was executed, whereby she specifically agreed she would not seek recovery of any award or settlement amount from her employer, the owner of that employer, or Ms. Capezza personally, regardless of the amount of the award or settlement by any insurer. One year after this agreement was entered into, the applicant filed a personal injury action in Wisconsin against Ms. Capezza personally and Secura as the insurer of the truck involved in the accident. The Circuit Court granted a

motion for summary judgement, on the basis that the claim was precluded by the exclusive remedy provision of the Worker's Compensation Act. The Court of Appeals affirmed. Ms. Capezza met the definition of an "employee" under Wis. Stat. 102.07(4)(a). The employer had the right to exercise control over the details of Ms. Capezza's work. The employer selected locations for the events. The employer required Ms. Capezza to travel to the work site the day before the event. Ms. Capezza worked 20 weekends for the employer over the year of the accident. She received compensation, albeit not cash wages. Ms. Capezza performed work that one might expect to normally be performed by an employee under a contract for hire, and therefore, Ms. Capezza meets the definition of an employee. There is no dispute regarding this issue based upon the facts presented. Wis. Stat. 102.03(2) provides that worker's compensation is an employee's exclusive remedy against an employer, co-employee, and carrier for a work-related injury. The vehicle Ms. Capezza was driving was titled in the name of the owner of the employer. However, the employer paid for the vehicle expenses and listed the vehicle on tax documentation. Therefore, the vehicle was considered owned by the employer. There was no basis for a separate theory of recovery against the insurer of the vehicle merely because it was titled in the name of the owner of the employer. Finally, the applicant also executed a legally binding agreement that stated she would not seek recovery from Ms. Capezza. Any potential third party claim was, therefore, waived.

***In re Estate of Rivera,* 908 N.W.2d 486 (Ct. App. 2018).** Mr. Rivera was killed in an automobile accident on August 21, 2014. He was a passenger in a vehicle driven by an employee of a temporary agency, which had assigned the driver to work for Alpine Insulation. The accident occurred because of the driver's negligence. Mr. Rivera was employed by Alex Drywall. Alex Drywall had provided Mr. Rivera to perform work for Alpine Insulation. Alpine Insulation paid Alex Drywall for Mr. Rivera's services. Alex Drywall paid Mr. Rivera for his work. This accident arguably arose out of and in the course of his employment. However, Mr. Rivera's estate did not file a worker's compensation claim. Instead, his estate brought a civil claim against the temporary agency. Alpine Insulation asserted Alex Drywall was a temporary help agency, and that, therefore, Mr. Rivera's estate was prohibited from bringing a tort action against Alpine Insulation under Wis. Stat. 102.29(6)(b)(1). Summary judgment was granted on behalf of Alpine Insulation. The Court of Appeals reversed and remanded. Wis. Stat. §102.24(2m) provides that the Worker's Compensation Act applies to temporary help agencies. The statute specifically provides the temporary help agency is the employer of an employee whom the temporary help agency places with or leases to another employee that compensates the temporary help agency for the employee's services. The exclusive remedy provision of the Act applies and a tort claim, therefore, could not have been maintained against Alex Drywall. Wis. Stat.§102.29(6)(b)(1) provided that no employee of a temporary help agency *who makes a claim for compensation* may make a claim or maintain an action in tort against any employer that compensates the temporary help agency for the employee's services. Under the plain language of the statute, because a worker's compensation claim had not been made, the tort action was not barred against Alpine Insulation. The phrase "who makes a claim for compensation" refers to a claim for compensation under the Worker's Compensation Act. No such claim was brought in this situation. Alpine Insulation also alternatively asserted that Mr. Rivera was a loaned employee and not a temporary employee, and therefore, barred under *Bauernfeind v. Zell,* 528 N.W.2d 1 (1995). However, Wis. Stat. §102.29(7) was created after the injured involved in the *Bauernfeind* case. Under Wis. Stat. §102.29(7), no employee who is loaned by his or her employer to another employer, and who makes a claim for compensation under Chapter 102, may make a claim or maintain an action in tort against the employer who accepted the loaned employee's services. This statute has the same qualifying language of "who makes a claim."

[The statutory language for temporary and loaned employees was changed this past legislative session. The language now prevents claims from employees who have the right to make a claim instead of just those who have made a claim. The language was also amended in multiple other areas of the statute where similar language existed. This change was effective March 2, 2018.]

***Thiele v. Robinson*, 380 Wis. 2d 282 (Ct. App. 2018)(*unpublished*).** The plaintiff/employee brought a civil case in Circuit Court against Bootz Saloon and its general liability insurer, Auto-Owners, as a result of actions of a fellow employee (a bartender named Mr. Robinson). Mr. Robinson was the plaintiff's direct supervisor and also had an ownership interest in the company. The alleged actions can generally be classified as sexual harassment, sexual assault, physical assault, and all around disgusting behavior. The plaintiff alleged the bar failed to properly supervise and train Mr. Robinson, failed to provide a safe work environment, and for negligent infliction of emotional distress. There were several charges brought against Mr. Robinson as well for assault, false imprisonment, etc. The Auto-Owners policy had two types of policies in effect. These provided coverage for bodily injuries caused by an accident, including continuous or repeated exposure to substantially the same general harmful conditions. There was an exclusion for any claims falling under the Worker's Compensation Act. There was also coverage for personal injuries caused by an offense arising out of your business (Coverage B) with several exclusions. The trial court granted Auto-Owners judgment dismissing the complaint. The Court of Appeals affirmed. There was no coverage for any of the claims. The plaintiff's exclusive remedy against Bootz Saloon was under the Worker's Compensation Act. The courts have long held that negligence claims against a co-employee or employer are precluded by the exclusivity provision of the Worker's Compensation Act. Further, Mr. Robinson's actions stemmed from intention acts, which were not covered under the policy. Mr. Robinson's conduct was outside the scope of his employment as a manager or owner of the company. Employees were only considered insureds for acts within the scope of employment while performing duties related to the conduct of the business under the Coverage B portion of the policy.

HEARING LOSS

Yanke v. ATI Ladish, LLC, Claim No. 2014-029742 (LIRC February 20, 2018). The applicant underwent an exit audiogram, performed by an employee of the company, on the plant grounds on his last date of employment. He had previously undergone a number of prior audiograms on the facility grounds. He worked for the company for 41 years. The location was loud. The audiogram performed on the last date of employment (July 31, 2014) revealed a binaural hearing loss of 1.07%. The applicant treated with Dr. Harney and underwent an audiogram in his office. That audiogram revealed a bilateral hearing loss of 18.12%. Dr. Harvey opined this was more credible than the audiogram on the last date of employment because it was performed in a sound proof certified booth. Dr. Dankle performed an independent medical examination on February 11, 2015. At that time, an audiogram was performed and revealed a loss of 18.13%. Dr. Dankle opined the exit audiogram revealed a 1.1% loss and that it should control. Dr. Harvey opined the reason for the difference in ratings so close together was that the occupational screening audiograms do not always remove all environmental noise. The exit audiogram was consistent with prior years. Administrative Law Judge Lake awarded 1.1% loss because the policy of the court is to use the audiogram performed most contemporaneously with the last date of employment. She determined there was no compelling evidence to deviate from the past practice. The Labor and Industry Review Commission affirmed. A hearing loss caused by noise exposure at work does not worsen after the employee is removed from the noisy employment.

Hearing tests taken at the time of retirement, so long as they are done properly, provide a good measurement of hearing loss due to work exposure. DWD 80.25(4) specifically addresses the test to be used to determine hearing impairment. Bone conduction audiometry is not mentioned in this section. The Commission has previously held that, if hearing loss is purely sensorineural, air conduction audiometry is equally as accurate as bone conduction audiometry. The applicant's hearing loss was only sensorineural, not mixed. Hearing loss tests performed by air and bone conduction after the exit audiogram does not make them more accurate than the exit audiogram. The test performed in the office is not more accurate than the exit audiogram. The person who conducted the exit audiogram was qualified even though he was not a licensed audiologist. There is nothing in the statute or rules that prohibit use of tests performed by someone with the same qualifications. Further, any lack of soundproofing in the exit audiogram should have overstated the hearing loss, not understated it, because the outside noises would have made it harder to perform well.

HERNIA INJURIES

Fogeltanz v. County of Manitowoc, Claim No. 2016-002914 (LIRC July 13, 2017). On July 15, 2015, the applicant moved a 55 gallon barrel filled with liquid. The barrel weighed approximately 450 pounds. While moving it, he did not feel any major pain. The applicant later indicated he did feel strain from the barrel. Several days later, he started to feel a bulge. He eventually was diagnosed with a right inguinal hernia. The unnamed administrative law judge opined the applicant was believable and awarded benefits. The Labor and Industry Review Commission agreed with the credibility determination. However, benefits were still denied. This decision was based upon the medical experts' opinions, and those experts did not testify. Therefore, the credibility determination did not impact the outcome. The independent medical examiner's opinion was adopted. The hernia did not result at the time of the barrel moving. There was no immediate report of major pain. The bulge was not noticed until several days after the barrel moving incident. The hernia was the result solely of the congenital condition which was pre-existing and not due to any work activities.

INSURANCE COVERAGE

***Acuity v. Property Image, LLC*, 2018 WI App 28 (Ct. App. 2018)*(unpublished)*.** Acuity filed a small claims suit to collect an increased premium for the second year of worker's compensation coverage for a company. After the completion of the first year, Acuity had performed an audit. The audit found that an employee, who should have been classified as a carpenter, had been classified in a less expensive job classification. The auditor informed the company's agent that the employee would be reclassified for the second policy year. The premium charged per hour worked for that particular employee increased. The agent had not informed the company of the reclassification. The court held the company was not responsible for the increased premium. The company must be given notice by somebody of a change in classification before the increased rate could be charged.

ISSUE PRECLUSION

Adamowicz v. Old Carco LLC, Claim No. 2005-018339 (LIRC October 19, 2017). The applicant sustained a right knee injury on September 6, 2012. The claim was litigated and an order issued in October 2006, awarding indemnity benefits to the applicant. This included an award of 4% permanent partial disability to the knee. The Labor and Industry Review Commission affirmed that 2006 order. The applicant had ongoing symptoms. He underwent additional medical treatment. The applicant retired prior to undergoing a partial knee replacement surgery in 2015. Dr. Bartlett performed an independent medical examination in July 2016. He opined the work-related injury was temporary in nature and that the applicant had fully recovered from the effects of that injury. The unnamed administrative law judge denied the applicant's claims for permanency benefits and temporary benefits following the knee replacement procedure. The Labor and Industry Review Commission reversed with respect to the award of permanency benefits. The Department and Commission previously determined the applicant sustained a permanent injury to the knee. Dr. Bartlett's opinion, that only a temporary injury was sustained, sought to re-litigate the issue of the nature of the work injury. These issues were previously resolved by the Commission's 2007 decision. When an issue of fact or law is actually litigated and determined by a valid judgement, and that determination is essential to that judgement, the determination is conclusive in a subsequent action, whether on the same or a different claim. Any application of issue preclusion must comply with the principles of fundamental fairness. There are five factors which a court is to consider when making the decision to involve issue preclusion. These include whether the party against whom preclusion is sought could have obtained review of the judgment, whether the question is one of law that involves two distinct claims or intervening contextual shift in law, if significant differences even in the quality or extensiveness of proceedings between the two courts warrant re-litigation of the issue, if the burdens of persuasion shifted such that the party seeking preclusion had a lower burden of persuasion in the first trial than in the second, and if matters of public policy and individual circumstances involved would render the application of collateral estoppel to be fundamentally unfair, including inadequate opportunity or incentive to obtain a full and fair adjudication in the initial action. Here, the issue preclusion was appropriate. Dr. Bartlett's opinions cannot be adopted because the Commission had already determined that a permanent injury was sustained. Dr. Bartlett's opinion rests on the conclusion that the applicant fully recovered from the injury without permanent disease. Therefore, the opinions of the treating physician regarding causation were adopted. *See also Temporary Total Disability Benefits.*

LOSS OF EARNING CAPACITY

Janssen v. Monode Steel Stamp, Inc., Claim No. 2013-007952 (LIRC June 7, 2017). The applicant sustained an admitted back injury. He was assigned permanent restrictions following a functional capacity evaluation. Shortly thereafter, the employer closed its plant in Wisconsin and moved the facility to Ohio. The applicant worked at the Ohio plan for several months. He then quit because he did not want to make the 475 mile, one-way commute from his home in Wisconsin. The applicant applied for several positions before obtaining employment a few months later at a wage loss. Dr. Hsu performed an independent medical examination. He agreed with the permanent restrictions outlined in the functional capacity evaluation. The vocational expert differed regarding the extent of loss of earning capacity sustained as a result of the work-related injury. The Commission modified, and reduced the extent of loss of earning capacity awarded by the administrative law judge. Opinions stated by the vocational experts are relevant, but not dispositive, in determining loss of earning capacity. The Commission independently

assesses reports from vocational experts in conjunction with the factors in Wis. Admin. Code DWD 80.34(1) to arrive at its own estimate of loss of earning capacity. The applicant's choice to quit his job with the employer and being unwilling to relocate to Ohio does not prevent the applicant from entitlement to loss of earning capacity benefits. Willingness to change residences is a factor to consider. An award of loss of earning capacity can be barred if an employee refuses, without reasonable cause, an offer of employment that pays over 85% of the pre injury wage. However, refusing to relocate from Wisconsin to Ohio is not acting without reasonable cause particularly when the applicant was able to obtain employment back in Wisconsin. This was a factor considered in the reduction of the award but did not support a complete denial. The displaced worker theory also does not eliminate entitlement to benefits. This theory arises from the situation where the business where the applicant was employed closes after his or her injury. Employers often assert the loss of earning capacity should not be based on pre-injury wages which do not reflect the applicant's likely future depressed earnings in light of the plant closing. However, neither vocational expert provided much basis for the displaced worker theory in this situation. The expert's opinions that the applicant could fully replace the wages he earned do not support the assertion that the employer's plant closure depressed wages in the city where the applicant resided.

McGonigle v. A W Oakes & Son, Claim No. 2015-018458 (LIRC May 3, 2018). The applicant sustained an admitted low back injury. The parties obtained medical expert opinions regarding permanent restrictions. These opinions were different sufficiently that the extent of loss of earning capacity was impacted. Additionally, a different treating physician provided restrictions based upon a functional capacity evaluation which was 'in between' the other assigned restrictions. The vocational experts agreed the applicant was *odd lot* permanently and totally disabled if the treating physician restrictions were adopted. The vocational experts' opinions ranged from 0% loss of earning capacity to 75% loss of earning capacity if the independent medical examiner's (Dr. Hsu's) restrictions were adopted. The parties submitted documentation reflecting the applicant's Social Security Disability application was pending. Administrative Law Judge Martin awarded 65% loss of earning capacity benefits. Administrative Law Judge Martin left the decision interlocutory for a potential higher award, depending on whether the applicant would obtain some type of employment. The Labor and Industry Review Commission modified and affirmed in part, reversed in part, and remanded the decision for further determination regarding loss of earning capacity, the impact of the applicant's status as a Social Security Disability recipient, and updated vocational opinions regarding the same. The medical experts' opinions regarding restrictions were not supported by the evidence. Instead, the list of restrictions based upon the functional capacity evaluation (and a different treating physician's adoption of the same) was the most reasonable. Further, the employer and insurer requested an offset calculation because the applicant was awarded social security disability benefits after the original hearing. Additionally, the applicant provided the Commission with a letter indicating that DVR could not help the applicant because of his age and restrictions. This was not submitted into evidence. The Commission remanded the case to determine whether the applicant would receive training from DVR, and/or if he had effectively removed himself from the labor market with the social security disability determination. The vocational experts need to reconsider all of this information and provide opinions regarding loss of earning capacity.

MEDICAL ISSUE

***Flug v. Labor and Industry Review Commission,* 898 N.W.2d 91 (Wis. 2017).** The applicant was diagnosed with two conditions (a soft tissue strain and a degenerative disc disease). She underwent surgery for her degenerative disc disease. The applicant believed the surgery was being performed to treat the work-related injury at the time it was completed, based upon her treating physician's opinion. Following a hearing, it was judicially determined that the effects of the work-related injury resolved prior to the surgery, and that the surgery was performed solely to treat the applicant's personal condition. The applicant did not dispute the administrative law judge's causation opinion. The applicant asserted that the respondents were responsible to compensate her for her permanent partial disability because, at the time surgery was performed, she believed, in good faith, that the disability causing surgery was necessary to treat the work-related condition. The Labor and Industry Review Commission denied her claims in their entirety. The Circuit Court affirmed. The Court of Appeals reversed and remanded. The Court of Appeals held that an employee need only have a good faith belief that treatment being undertaken was related to the work-related injury at the time the treatment is performed. This opinion was based upon the Court of Appeal's interpretation of Wis. Stat. 102.42(1m). The statute provides, "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 shall pay disability indemnity for all disability incurred as a result of that treatment." The Supreme Court reinstated the Commission's dismissal of the applicant's claims in their entirety. The dispute focused on what it meant for treatment to be generally medically acceptable, but unnecessary. The parties agreed the applicant sustained a compensable injury, underwent invasive medical treatment, and sustained permanent partial disability as a direct result of that treatment. The medical treatment was not unnecessary because the treatment improved the applicant's condition. The medical treatment in question must treat the compensable work-related injury in order to qualify an employee for additional benefits. This is consistent with past decisions, including *Spencer*, *the City of Wauwatosa and Honthaners Restaurant.* To decide otherwise would be a sharp break from the legislatively enacted compromise between employers and employees for the payment of expenses and benefits consequent upon a work-related injury, and it would also represent a significant step towards making the Worker's Compensation system a blank insurance policy to provide benefits for disabilities which may manifest while on the job, but which are in no way caused by or related to the employment. The court is not the proper branch of the government to prescribe such a momentous change. The Supreme Court, therefore, declined to adopt an understanding of the statute which would extend employer liability to injuries and disease that have nothing to do with the workplace.

Chaulkin v. Midwest Airlines Inc., Claim No. 1999-063367 (LIRC January 31, 2018). The applicant sustained a conceded low back injury in November 1999. In 2005, the court determined that an L4-S1 fusion surgery in November 2000 was causally related to the 1999 work-related injury. The applicant had a mixed result and continued to experience symptoms. In 2014, a right sacroiliac joint fusion surgery was performed. This was revised in 2015. Liability for these two surgeries was not at issue at the time of the hearing. Subsequently, the applicant continued to have ongoing symptoms. She underwent additional surgery in March 2016, in the nature of revision of the L4-S1 fusion and an extension of the fusion to L3-4. She reported ongoing pain. Revision surgery was performed a few weeks later, which included replacement of loose screws and fragment removal. These surgeries had limited but beneficial effect on her symptoms. She could sleep six (versus four) hours each night and did not need to lie down all day. The surgeon

opined the March 2016 surgeries were medically necessary as a result of the 1999 injury. Dr. Robbins performed a medical records report. He opined the SI joint surgeries were not causally related to the 1999 injury. He also opined the L3-4 symptoms were degenerative and the result of normal aging and prior surgical intervention. He opined the then anticipated surgery at this level was not warranted. Dr. Brown also performed multiple independent medical examinations. He agreed with Dr. Robbins' opinions in general, but also opined the March 2016 fusion extension was caused by the prior lumbar fusion because of fusion adjacent level disease. He did not specifically opine whether the surgery was medically necessary. A supplemental report included an opinion that the treatment was not medically necessary. The administrative law judge dismissed the applicant's claim for additional medical expense. The Labor and Industry Review Commission reversed. The applicant faulted the insurer for not invoking the reported mandatory procedure of evaluating medical necessity under Wis. Stat. 102.16(2m). This statute specifies that the department has jurisdiction over the alternative dispute resolution process and outlines the details for the actual operation of that process. Wis. Stat. 102.16(1m)(b) outlines the department's discretion to order resolution of disputes by the alternative resolution process or to resolve the dispute through the findings of an administrative law judge at a hearing. Wis. Admin. Code 80.73(9) implements the provisions of Wis. Stat. 102.16(2m) and allows providers, insurers, and the injured workers the opportunity to request alternative dispute resolution process. The applicant could have applied to the department to initiate this process prior to going to a hearing. The employer and insurer cannot dispute the fact that the March 2016 surgeries were at least in part causally related to the effects of the work-related November 2000 lumbar fusion surgery. The determination regarding whether or not a proposed surgery is medically necessary is, in the first instance, a decision to be made by the treating physicians. The employer and insurer could obtain a medical opinion disputing the treating physician's opinion. This was to be obtained timely. The first opinion disputing the proposed surgery was in a written report issued the day before the scheduled surgery. The timing of this report and subsequent additional report at the employer and insurer's request would not preclude a finding of no medical necessity if the credible evidence were to support the finding. Neither physician, however, directly disputed the medical necessity of the decision to redo the fusion. The dispute was regarding the extension of the fusion. The employer and insurer's position was undercut by the independent medical examiner's opinions. Disregarding the medical judgment of the treating physician to perform the surgery would be unreasonable.

Luksic, Jr. v. Joy Global Surface Mining, Inc., Claim No. 1997-000124 (LIRC January 31, 2018). The applicant sustained a conceded work-related injury. The applicant sought payment of continued opioid medical treatment. Administrative Law Judge McKenzie determined that continued opioid medication were reasonably necessary because the applicant testified the medication eased his pain. The Labor and Industry Review Commission affirmed. The insurer must notify the affected health service provider under Wis. Stat. 102.16(2m)(b) that the necessity of continued opioid medical treatment is in dispute. The insurer must pay ongoing medical expenses as prescribed, pending the outcome of the process under the statutory provision. The employer is liable for all expenses, including medications, which may be reasonably required to cure and relieve the effects of the injury under Wis. Stat. 102.42(1). The two questions to be addressed generally are whether the claimed expenses are related to the work injury (incurred for the purpose of curing and reliving the effects of the work injury as opposed to some other condition), and, if so, whether the expense was reasonably necessary. There is no dispute the narcotic medication prescribed was intended to relieve the effects of the work injury. The only dispute is whether the expenses were reasonably necessary. Medical treatment is not unnecessary just because it is provided after the applicant reached the end of healing or because the only

purpose is palliative. Within those guidelines, it is a matter of expert opinion regarding whether a treatment is reasonably necessary. The treating physician asserted the medication was effective and the applicant did not have any sign of drug abuse or other aberrant behavior from taking the drugs. This opinion was not contested. The employer and insurer obtained medical opinions that long term use of Hydrocodone and Diazepam for chronic pain provided little or no pain relief or improved quality of life and were associated with negative effects. Opioids have been widely over prescribed. There is a general consensus that, after a certain length of time, the risk of prescribing opioids outweighs the benefits. That general consensus is difficult to be taken down to a specific case and a rule that specific use of opioids is unnecessary in the face of a treating physician's opinion that the balance of risks and benefits weighs in favor of continued drug therapy. There is reasonable dispute, however, regarding the necessity of ongoing medical treatment. There was little engagement between the doctors on the merits of their conflicting opinions. The process under DWD 80.73 provides a process by which the insurer and health care provider can respond directly to each other as to why the treatment is necessary or not and puts the question of necessity in the hands of an impartial expert or panel of experts. The issue is appropriate for resolution through that process.

Powers v. Fresh Brands Distribution, Inc., Claim No. 2001-009553 (LIRC January 31, 2018). The applicant sustained a work-related injury in 2000. She felt something "pop" in her hip when the incident occurred. The parties submitted expert opinions that conflicted regarding whether ongoing medical treatment after a particular date was reasonable, necessary, and causally related to the injury. The parties entered into a limited compromise agreement which left open medical expenses after March 22, 2002. The administrative law judge held the additional medical treatment was causally related to the work injury and ordered all medical expenses paid. The Labor and Industry Review Commission affirmed in part and reversed in part. The initial fusion procedure was necessary to cure and relieve the effects of the injury. The treating physician's foundation was more detailed than the independent medical examiner's, who did not appear to entirely understand the mechanism of injury. The second fusion, in 2007, was also directed at symptoms related to the work-related injury. The 2007 fusion procedure included a revision of the 2001 fusion. There is a credible inference that the second procedure would not have been performed had it not been for the first. The applicant must provide itemized bills identifying the date of treatment, the name of the provider, and treatment involved. The applicant has the burden of proving the amount of the treatment expenses. The independent medical examiner's opinion that the indication for the 2007 procedure is "quite dubious" raises a question of the medical necessity for the fusion procedure. However, the record is not sufficient to allow that issue to be decided. Instead, the applicant should produce the bills. If the insurer continues to dispute the medical necessity of the treatment, the process under Wis. Stat. 102.16(2m) should be utilized.

Zuiker v. Cub Foods, Claim No. 1990-061069 (LIRC March 16, 2018). The applicant filed a claim for payment of ongoing prescription narcotic medical expenses related to a 1990 work-related injury. The issues addressed were whether the applicant's opioid treatment should be reduced or ended, at least on a trial basis; and whether the applicant's refusal to participate in a program designed to wean her from the use of opioids, has aggravated her condition and constituted a violation of Wis. Stat. §102.42(6) justifying termination of payment for opioid medication. The insurer obtained a medication review by Dr. Weg. In 2013, Dr. Weg recommended weaning from the prescribed medication (morphine) over a period of three months, with appropriate medical support. The applicant and her physician discussed this proposed reduction in medication but no action was taken. Another records review was performed by Dr. Brown, at the insurer's request. He opined the applicant was overusing

narcotic medication. He opined the applicant had refused to follow reasonable medical advice by not following through with physical therapy and psychological treatment recommendations. He agreed with another opinion that the applicant's overuse of narcotics had aggravated, caused, or continued her disability. Dr. Brown also agreed with the weaning proposed by Dr. Weg. On December 16, 2013, the insurer advised the applicant, via a letter, that the insurer agreed with Dr. Weg and Dr. Brown, and that the applicant should undertake the weaning program. The applicant did not open the letter upon receipt and did not recall if she ever opened the letter. On April 24, 2014, another letter was sent by the insurer indicating that the insurer would no longer pay for the narcotic medication because the applicant had unreasonably refused or neglected to follow reasonable medical advice regarding the overuse of narcotics under Wis. Stat. 102.42(6). The applicant then indicated she was interested in pursuing the weaning program. She subsequently chose not to enter the program because her treating physician was not in agreement. The treating physician's deposition was taken. He indicated that he had not prescribed a weaning program because he, together with the applicant, felt that the pain medication had been helpful in improving her pain level and level of function. They discussed the weaning, but believed the risk of continuing the pain medication was outweighed by the benefit of that medication. He did acknowledge that he would agree with the proposal if there were clear signs that the medication was causing harm to the applicant or if the applicant wished to consider a trial of the same. The Labor and Industry Review Commission ordered the applicant to enter and complete a narcotic weaning program proposed by the insurer on the date the insurer arranged for the program to begin. Any unreasonable delay would result in the cessation of the insurer's liability for the prescription medication under Wis. Sta. §102.42(6). The documentation reflected that the several times, over the past twenty years, that the applicant reduced her narcotic use, her condition improved. Her condition rapidly deteriorated each time she resumed heavy doses of narcotics. The evidence supported the opinions that the applicant would benefit from a substantial weaning program for narcotic medication. The applicant was entitled to payment for the medication obtained prior to the Commission's decision because the applicant was relying upon the treating physician's opinion during that period of time. These benefits were awarded despite the Commission's determination that the prescription regime could no longer be medically justified on an ongoing and future basis.

MENTAL INJURY

***Burt-Redding v. Labor and Industry Review Commission*, 377 Wis. 2d. 729 (Ct. App. 2017).** The applicant was a patrol officer in the Grand Chute Police Department. She shot an individual while in the line of duty. The individual was threatening motorists, wielding a knife, and belonged to a street gang. Following the shooting, she received threats to herself and to her son. Her police chief also warned her that the victim's family had threatened the applicant's life. The police chief and a police science instructor testified that the threats were not unusual or atypical in the law enforcement profession. Threats are a common experience and most police officers accept the possibility of threats go with the territory. The unnamed administrative law judge noted that the events caused the applicant stress. However, the administrative law judge held that the threats did not amount to extraordinary stress of greater dimension than the day to day emotional strain and tension experienced by a similarly situated patrol officer. The Labor and Industry Review Commission adopted the administrative law judge's decision. The Commission, therefore, denied the applicant's entire claim for benefits. The Circuit Court and Court of Appeals affirmed. The threats perceived by the applicant were not unusual or atypical for a police officer. There was no evidence any threat was acted upon. The treats were investigated and deemed unfounded. The applicant continued working as a police officer for five years post

shooting without taking any steps to seek prosecution of those people who were threatening or harassing her. She also never sought assistance from any of the employee assistance programs available to police officers. She received acceptable employee reviews during her continued employment.

OCCUPATIONAL/REPETITIVE INJURIES

Vara v. Southwest Airlines, Claim No. 2015-020808 (LIRC July 28, 2017). The applicant was employed as a baggage handler for approximately seven years. She lifted bags that weighed, at times, more than 50 pounds. Her work was strenuous. On the date of injury, she downloaded about 30 bags from a plane onto a luggage cart. The applicant reported she twisted her knee while unloading the bags. She reported that she then turned, took a few steps, and noticed a pulled muscle sensation in her right knee. The applicant reported the symptoms first appeared while she was walking away and not while she was unloading bags. The treating surgeon opined that the downloading of the bags caused a meniscal tear. The treating physician did check the box indicating the work activities were direct cause, and checked the box indicating the work incident precipitated, aggravated, and accelerated a pre-existing condition beyond normal progression. The applicant indicated that she had been in the process of moving her home prior to the injury. She testified that she did not injure her knee while moving. Dr. Bartlett performed an independent medical examination. He opined that the work event of merely walking could not cause the pathology observed in the applicant's knee. He also opined the workplace exposure was not the sole cause or material contributory causative factor in the condition's onset or progression. Administrative Law Judge Sherman Mitchell awarded benefits. The Commission affirmed. The treating physician's opinions were not inconsistent. The applicant had preexisting osteoarthritis in her knee. The surgical notes reflect she sustained a traumatic complex tear. The applicant had no prior problems or treatment. She reported the injury shortly after it occurred. Insinuation of an alternative cause, such as an injury the prior weekend, is not persuasive when there is no evidence in the record to support such a conclusion.

N'Gegba v. Integrity Staffing, Claim No. 2016-014330 (LIRC March 16, 2018). The applicant alleged she sustained a repetitive work-related injury. The surgeon originally opined that the applicant's condition was caused by her work exposure for the employer. The description overstated the number of days worked and did not articulate that he understood how much the applicant worked. The attorney for the employer and insurer sent a pre-printed question to the surgeon. The surgeon affirmatively agreed that, given that the applicant had only been employed for 11 days, it was not probable that the occupational exposure was causative of bilateral carpal tunnel syndrome. The applicant's attorney then sent another preprinted question to the surgeon. He was asked whether the occupational exposure "described above' was at least a material contributory causative factor in the onset or progression of the condition. He answered in the negative. This repeated the opinion that there was no occupational causation. Dr. Barron then performed an independent medical examination. He opined the 11 days of work were of insufficient magnitude, duration, and frequency to be material contributory causative factor of the condition. However, Dr. Barron did not articulate the knowledge of the number of hours of work or the work duties. The applicant's own treating physician, unambiguously, opined on two occasions that the surgery was not causally related to the job duties. This was after he had been informed of her actual number of work days.

The only support for her claim was from a physician who did not reflect he accurately understood how much she worked prior to the development of symptoms. Administrative Law Judge O'Connor denied the applicant's claim. The Labor and Industry Review Commission affirmed and dismissed the application. She did not meet her burden of proof.

Maki v. Department of Transportation, Claim No. 2014-005610 (LIRC March 28, 2018). The applicant worked in the Division of Motor Vehicles as a customer service representative. She began working at the Kenosha site in May 2012. Her job duties included processing drivers licenses, taking photos, making sure applications were filled out correctly, handling title work, registering cars, and issuing tags. In June or July 2012, customer service representatives began to have to punch holes in plastic voided driver's licenses with a hand held punch if they were to be returned to the customer. In September 2012, the staff was allowed to use one of the holes of a three hold punch for this purpose. In February 2013, the staff was also allowed to use a hand held punch that spelled out the word VOID. The applicant alleged she began to develop wrist and forearm pain in fall 2012. She reported the shoulder pain began when she started using the three hold punch. She reported experiencing pain shooting into her shoulder with use of this punch. She reported the pain and was told another staff member could be asked to do the hole punching. Customer service representatives punched five to six holes per day, depending on the station assigned. She underwent three shoulder surgeries. Her treating physician opined that she sustained bilateral shoulder problems because of overuse while working at the Department of Motor Vehicles. Dr. Siegert opined that there was no incident which precipitated, aggravated, or accelerated any pre-exiting condition. He also opined that her symptoms were a mere manifestation of a pre-existing condition. The administrative law judge (unnamed) awarded benefits. The Labor and Industry Review Commission reversed. The applicant testified that she had difficulty and pain with punching holes in the driver's licenses. She did not testify there was any incident of "popping" in her shoulders that occurred when she suddenly felt pain. She continued to have pain when she used the hole punch. Her treating physician did not provide any explanation for how bilateral rotator cuff tears would be caused by hole punching. Using a hole punch five to six times per day cannot be credibly characterized as "overuse." The use of this term suggests the doctor may not have had an accurate understanding of the job duties. She has not met her burden to prevail on her claim and her application must, therefore, be dismissed.

PENALTY

Vosters v. Vosters Custom Brick Paving LLC, Claim No. 2015-014969 (LIRC January 31, 2018). The applicant was employed by the employer. This business was solely owned by the applicant's father. The applicant was working on a job site when his right thumb was pinched and ultimately amputated. The employer's insurer paid indemnity benefits. The applicant worked 20 hours the week before the injury and 23 hours the week of the injury. The employer paid the applicant $7.75 per hour. The applicant was 16 years old at the time of the injury. The employer did not have a work permit for the applicant. This was obtained after the injury. The administrative law judge awarded a $7,500.00 penalty. The Labor and Industry Review Commission affirmed. Wis. Stat. 103.70 and DWD 270.05 require a permit in certain situations for minor workers. Wis. Stat. 102.60(1m) provides for a penalty when an injury is sustained by a minor who is illegally employed. The amount is to be equal to the amount recovered by the employee but not to exceed $7,500.00. The applicant was required to have a permit, and he did not. He was injured while illegally employed. The employer is responsible for paying a penalty of $7,500.00. The employer asserted it was not aware the applicant required a permit. Ignorance of the law is no excuse, nor is it an exception to the permit requirement. The employer asserts the applicant was not engaged

in gainful employment. That term is not defined. However, his employment as a part time, summer only, employee, who makes minimum wage, does not mean he was not gainfully employed. There is no exception to the permit requirement that applies in this case. There is no statutory provision permitting reduction or forgiveness of the penalty amount. The statutory provision requiring the permit for 16 and 17 year olds was repealed two years post injury but was in existence on the date of injury and, thus, was required.

PERMANENT PARTIAL DISABILITY

Breitzman v. Airpro Fan & Blower Company, Claim No. 2012-019990 (LIRC June 7, 2017). The applicant got his left hand caught in a machine and sustained a severe crushing injury. The middle, ring, and little fingers of his left hand had to be amputated. His left index finger had to be fused at an unnatural angle. All of the medical records reflected that the applicant was right hand dominant. The applicant admitted that he wrote with his right hand. He asserted, however, that he believed his left hand was dominant because he did, or preferred to do all other physical tasks (other than writing) with his left hand. The applicant asserted that he should receive a 25% increase to the ratings for the amputations on his left hand because it was his dominant hand. The Commission held that the applicant's testimony in regards to that claim was not credible and denied the same. His testimony was unclear on the issue of what he told doctors that would lead them to indicate that he was right hand dominant. For further discussion of this case, please also refer to the Disfigurement category.

Goman v. Tutor-Perini Corp., Claim No. 2015-011682 (LIRC July 28, 2017). The applicant fell 15 feet from a bridge he was building for the employer. He landed on a mix of construction materials. He required a five level percutaneous intersegmental pedicle screw fixation from T1to L3. The records demonstrated he had sustained a burst fracture at L1. The surgeon's records reflected the procedure performed was not a fusion, but more of an internal bracing without fusion. The applicant was assigned permanent 25 pound lifting restrictions post-surgery. The applicant was also restricted from working in high places or on ladders or lifts. His treating physician opined he sustained 55% permanent partial disability, based upon a 10% rating per level fused and a 5% rating for a vertebral compression fracture. Dr. Barron opined the applicant sustained no permanent disability. He based this opinion on a physical examination and surveillance videos. The videos demonstrated the applicant engaging in physical activities including frequent bending, kneeling, pulling a wheeled garbage bin, carrying a bucket of water, and netting fish. The applicant opened his own fishing guide business post injury. The administrative law judge awarded the benefits sought. The Labor and Industry Commission modified the award. The applicant did not actually undergo a fusion, and the minimum ratings did not apply. The Commission determined he sustained only 3% permanent partial disability, per level, and an additional 5% permanent partial disability for the burst fracture.

Millen v. Tradesmen International Inc., Claim No. 2015-003060 (LIRC August 18, 2017). The applicant sustained an admitted elbow injury. After recovery, he underwent a functional capacity evaluation. Dr. Konkol opined the applicant sustained 50% permanent partial disability to the right elbow. The basis for that was noted as pain, weakness, and impaired ability to return to work previous duties. Dr. Siegert performed an independent medical examination. He rated the applicant's strength initially at 23 pounds. However, after rapid, repetitive gripping, the capacity was 93 pounds. Dr. Siegert assessed a 10% permanent partial disability to the right elbow. The administrative law judge (unnamed) held the 50% permanency rating was appropriate. The administrative law judge indicated that she accepted Dr. Konkol's rating because he was the

treating physician. The Labor and Industry Review Commission modified the decision and awarded 15% permanent partial disability. The 50% rating was excessive in light of the relatively good range of motion and elbow strength measurements. The discrepancy in performance during Dr. Siegert's independent medical examination (27 pounds vs. 93 pounds) undercuts the applicant's claim and questions the credibility of his subjective symptoms of pain. The treating physician's opinion contained a vocational component in that Dr. Konkol noted "impaired ability to return to work previous duties." This did provide ambiguity into the opinion. However, there was an inference that Dr. Konkol based the permanency assessment on medical versus vocational considerations because, elsewhere, he wrote 50% permanent partial disability compared to amputation at the level of the elbow. That being said, the assessment was not adopted entirely. There is no treating physician rule in Wisconsin, and conflicts of expert medical opinions must be based upon the credibility of the relevant opinions and circumstances of the case without special deference to the treating physician's opinion.

Coppage v. Midwest Labor, Claim No. 2012-007424 (LIRC October 11, 2017). The applicant sustained an admitted right foot injury when she was working at a car wash. An employee drove a car onto her foot and trapped it for some time. She underwent extensive treatment. She was diagnosed with complex regional pain syndrome and arthritis of the foot. Her treating physician rated permanent partial disability based upon pain in the foot, the ability to stand, and the ability to wear shoes. Video surveillance was taken during several trips to and from physical therapy. The applicant moved very slowly, used crutches, and put little to no weight on her right foot when she moved from the car to the building where the physical therapy took place, from the building back to the car, and then from the car to her home. She wore a protective boot on at least one occasion. The surveillance also showed her walking outside of her home briskly in regular shoes and without crutches, shortly after she returned home. The administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The surveillance shows the applicant walking much differently after she returned home from physical therapy. The applicant testified that she took medicine right after physical therapy per Dr. Holz's instructions, and that was the reason for differences in her walking ability. This explanation lacks credibility. She did not begin to treat with Dr. Holz until three months after the surveillance. Further, the dramatic difference in the walking ability within minutes of arriving home, as evidenced on the video, is not only difficult to accept on its face, but also does not square with the months of medical documentation in which the applicant failed to appreciate any benefit from her medication. She also told the independent medical examiner (Dr. Wojciehoski) that she had never been able to walk normally after the injury occurred. The medical opinions finding symptom magnification and pain out of proportion to expected findings are consistent with the conclusion the applicant was exaggerating her pain. The applicant was shown the video well before the hearing and had time to have her treating physician comment on the video and provide an updated opinion regarding permanency. However, this was not done, and the physician's opinion regarding the permanency cannot be accepted. The only other medical evidence is that the applicant did not sustain any permanency.

PROCEDURAL ISSUES

Jacquet v. Allstar Exteriors, Claim No. 2016-005631 (LIRC June 7, 2017). The applicant and the uninsured employer's fund entered into a compromise agreement of the applicant's claim. The alleged employer filed a petition to set aside the compromise agreement on the basis it was not the applicant's employer and that the applicant was actually a subcontractor. The Labor and Industry Review Commission held the proper procedure would be for the alleged employer to file a reverse petition with the Commission to seek a determination that the alleged employee was a subcontractor and not an actual employee.

Flores v. New Creation Home Rehabilitation, Claim No. 2014-001417 (LIRC September 27, 2017). This case was brought against the employer and the uninsured employer's fund. The employer submitted a Petition for Commission Review alleging the employer's copies of the application for hearing and notice of hearing were sent to an incorrect address, and the employer never received those. The attorneys for the applicant and the uninsured employer's fund could not in good faith argue the notice of hearing had been sent to the employer's correct address. The Labor and Review Commission remanded the case for a determination as to whether the employer received copies of the application for hearing and notice of hearing. If the employer did not receive those documents, then a new hearing addressing the merits of the case would be appropriate.

Simonich v. SMJB, Inc., Claim No. 2016-011807 (LIRC February 20, 2018). The Labor and Industry Review Commission held the administrative law judge has the discretion to determine whether a case should be dismissed with or without prejudice.

SECOND INJURY FUND

Grande v. Lange Drywall, Claim No. 1980-000416 (LIRC September 14, 2017). The applicant filed a claim against the Second Injury Fund under Wis. Stat. §102.59(1) related to injuries from 1978 and 1979. The applicant sustained a conceded left knee injury in 1978. He was assigned 10% permanent partial disability to the knee, which has a value of 42.5 weeks of benefits. The applicant sustained compensable cervical injuries in 1979 and 1980. Following a hearing, the applicant was awarded 40% loss of earning capacity benefits. This totaled 400 weeks of benefits. These benefits were not apportioned between the two dates of injury because there was a pre-hearing agreement between the parties regarding apportionment. In 1987, the applicant underwent additional surgery for his knee. His rating was increased to 15% permanent partial disability for the 1978 injury, which totaled 63.75 weeks of benefits. The applicant again required surgery for the knee injury, in the nature of a total knee replacement. This occurred in 1994. The applicant was provided the statutory minimum rating in 1978 for this procedure, which equated to 170 weeks of permanent partial disability. Another revision to the total knee was completed in 2009, which entitled the applicant to another 170 weeks of benefits. Yet another revision was completed to the knee in 2011. The applicant was entitled to additional permanency, which resulted in a total payout of the maximum of 425 weeks of permanent partial disability over the years for a knee injury. The administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The current version of Wis. Stat. 102.59(1) provides:

> "if at the time of injury an employee has permanent disability that if it had resulted from that injury would have entitled the employee to indemnity for 200 weeks and if as a result of that injury the employee incurs further disability that entitles the employee to indemnity for 200 weeks, the employee shall be paid from the funds provided in this section additional compensation equivalent to the amount that would be payable for that previous disability if that previous disability had resulted from that injury or the amount that is payable for that further disability, whichever is less, except than an employee may not be paid that additional compensation if the employee has already received compensation under this subsection."

In 1979, the applicant did not yet have any permanent disability from the 1978 injury that would result in payment of 200 weeks of benefits. Instead, he had a claim for only 42.5 weeks. The applicant did not provide any entitlement for permanency that equaled or exceeded 200 weeks until the knee replacement was initially performed in 1994. The wording of the statute requires the first injury to have resulted in over 200 weeks permanency by the time the second injury occurred. The language in the statute is different regarding the timing of the 200 weeks for the second injury. The disability from the second injury must just eventually reach the 200 week threshold in order for the statute to apply. The choice of different words is significant and means the legislature intended for the first injury to have already resulted in 200 weeks of disability before the second injury occurred. This did not occur here and, therefore, no benefits are owed.

TEMPORARY DISABILITY

Villareal v. SPX Corp., Claim No. 2014-031662 (LIRC June 30, 2017). The employer and insurer initially denied the applicant's claim for benefits. The applicant received short term disability benefits during the period of time the claim was denied. The short term disability benefits paid full wages for eight weeks and 70% of wages thereafter. The administrative law judge determined the applicant sustained a work-related injury, and that temporary total disability benefits were owed. The judge ordered the employer and insurer to repay the short term disability benefit insurer for all benefits it had paid to the applicant. The Labor and Industry Review Commission modified the determination. An employer and its worker's compensation insurer is responsible only to pay benefits due under the Worker's Compensation Act. The order was modified to require the worker's compensation insurer to repay the short term disability insurer in the amount of worker's compensation temporary disability benefits that were determined to be owed. The employer and insurer were not required to repay the short term disability insurer for all amounts the short term disability insurer paid to the applicant.

Mueller v. Ashley Furniture, Claim No. 2013-027631 (LIRC July 13, 2017). The applicant retired from the employer in March 2014. She did not work again until January 2015. She then began working part time. She worked 12.25 to 26.25 hours biweekly. She could work full time if she wanted, but she chose to work part time and not look for work elsewhere. The applicant described the work as a great retirement job. An unnamed administrative law judge dismissed the applicant's claims on the basis that she had voluntarily resigned. The Labor and Industry Review Commission affirmed. The Circuit Court remanded for a determination regarding whether the applicant had returned to the workforce following her retirement, and if so, if she was, therefore, entitled to temporary disability benefits post-surgery. The Commission concluded she was not entitled to such benefits. Generally an employee who voluntarily retires after a work injury cannot receive temporary disability compensation after his or her retirement because the employee cannot establish loss of earnings or actual wage loss caused by the injury. Once the

applicant voluntarily retired, any wage loss the injury might have caused became theoretical. The applicant in this case returned to the labor force in a limited fashion in January 2015. That is not sufficient to establish an actual wage loss due to the work-related injury post-surgery. The applicant chose to limit her hours, did not wish to work more hours, was not working elsewhere, and considered the employment an ideal retirement job. If the applicant testified she was looking for full time work elsewhere or wanted to work more hours than were available, she might have been able to establish actual wage loss supporting an award for temporary partial disability benefits.

Adamowicz v. Old Carco LLC, Claim No. 2005-018339 (LIRC October 19, 2017). The applicant sustained a right knee injury on September 6, 2012. The claim was litigated and an order issued in October 2006, awarding indemnity benefits to the applicant. This included an award of 4% permanent partial disability to the knee. The Labor and Industry Review Commission affirmed that 2006 order. The applicant had ongoing symptoms. He underwent additional medical treatment. The applicant retired prior to undergoing a partial knee replacement surgery in 2015. Dr. Bartlett performed an independent medical examination in July 2016. He opined the work-related injury was temporary in nature, and that the applicant had fully recovered from the effects of that injury. An unnamed administrative law judge denied the applicant's claims for permanency benefits and temporary benefits following the knee replacement procedure. The Labor and Industry Review Commission affirmed the denial of temporary disability benefits. Temporary disability is meant to cover wage loss during the healing period. A retired worker is generally not eligible for temporary total disability if the worker has no wage loss during the healing period. If the work injury is the reason for the retirement, then the applicant is eligible for temporary total disability. The difference in these situations is the applicant's attachment to the labor market. The receipt of social security benefits will not necessarily preclude an applicant from receiving temporary total disability. The applicant is not precluded from obtaining temporary disability simply because he entered into an early retirement agreement. The applicant was not precluded from working elsewhere. He would not have lost the financial benefit of the buyout if he worked elsewhere. He was physically able to work despite restrictions. At the time of the hearing, the applicant had not worked for approximately six months (he was released to work with restrictions during that period of time). The applicant had opened his own business post retirement. For approximately 18 months he worked as a hunting guide. He made far less than his average weekly wage. He received a pension and social security. The applicant testified that he stopped working, and worked fewer hours, because of his work-related symptoms. However, pheasant hunting season is short and the applicant would have only been able to work for three months per year, even without the injury being taken into consideration. This work was more in the nature of a hobby than employment showing attachment to the labor market. He also listed his occupation as "retired." *See also Issue Preclusion.*

UNREASONABLE REFUSAL TO REHIRE

***Amalga Composites v. Labor and Industry Review Commission*, 377 Wis. 2d 730 (Ct. App. 2017).** The applicant was released to full duty work on December 12, 2012. The employer did not return the applicant to work until July 29, 2013. One month after the applicant returned to work, the employer notified the applicant that there was an issue with the validity of her social security number. She was given one month to clear this up. She did not, and the employer terminated the applicant's employment. The applicant sought back wages under Wis. Stat. 102.35(3) for the period between her release to full duty and return to work for the employer (pre-termination). The employer asserted the wage claim was barred under federal law because payment of back wages would violate federal immigration policy because the applicant was an undocumented worker. The employer did not deny that it refused to rehire the applicant; instead, the employer asserted that it could not rehire the applicant because of federal immigration statutes (Immigration Act). The Labor and Industry Review Commission held that the applicant was entitled to payment of past wages. The Commission noted the employer offered a Social Security Award report stating the social security number did not match the applicant's name. The Commission held that was not sufficient to demonstrate the applicant was undocumented. The applicant did not testify that she was undocumented. Her attorney objected to the quasi on regarding whether she could provide proper documentation of her employment, on relevance grounds, and the attorney for the employer withdrew the question. The circuit court affirmed the decision awarding benefits but also did not make a finding that the applicant was an undocumented worker. The Court of Appeals reversed and remanded for a determination regarding whether the applicant was undocumented, in order to determine whether the Immigration Act even applied in this case. The court held the employer had the burden of demonstrating that the applicant was an undocumented worker. If the employer could not meet its burden, the Immigration Act issues, and associated defenses raised by the employer were moot.

Neitzke v. Miron Construction Co., Inc., Claim No. 2013-003481 (LIRC December 15, 2017). The applicant sustained a work-related injury. He was released back to work. He previously brought a previous claim arguing unreasonable/wrongful refusal to rehire. In that claim, the administrative law judge had decided in his favor. The employer petitioned for review to the Commission. In May 2016, the Commission reversed the administrative law judge. The applicant appealed to Circuit Court. In December 2016, the Circuit Court reversed the Commission's decision. The Circuit Court remanded the matter back to the Commission for further determination as to its reasons for rejecting the administrative law judge's findings regarding credibility of testifying witnesses and for further explanations of its findings. On remand, the Commission outlined that the standard for these cases holds that the burden shifts to the employer to show reasonable cause why the worker had not been rehired once the applicant demonstrated he sustained a compensable work-related injury, and that he was not rehired. Here, the burden was met. The employer demonstrated that it universally hired employees by contacting the union hall and asking for workers, who were then assigned by the union hall according to its procedures. The employer followed a reasonable business practice and did not unreasonably refuse to rehire the applicant.

Allison v. Ashley Furniture Industries Inc., Claim No. 2013-025801 (LIRC January 12, 2018). The applicant began to work for the employer in 1992. He was considered a good employee with respect to knowledge and performance of work duties. He developed a history of difficulty relating to his co-workers and supervisors. In May 2012 the applicant was called into a meeting with a supervisor, superintendent, and human resources representative to discuss concerning issues with respect to the applicant's treatment of others and management. The focus was on the applicant's argumentative behavior toward coworkers and supervisors. The applicant became loud and argumentative during the meeting. There was no specific disciplinary action taken. On the evening of December 2012, the superintendent heard a loud verbal confrontation between the applicant and a co-worker. The direct supervisor had already informed the applicant it would be considered insubordination if he continued to argue. The superintendent explained to the applicant why he was wrong, and the applicant continued to argue loudly. The applicant asked to speak with human resources. The applicant was told that the contact would be made via email and the applicant should return to work to keep the machines running. Instead, the applicant went to his desk and sat down. Production was halted because a co-worker had to go perform the applicant's job. Human resources met with the applicant and superintendent shortly after. The applicant was given a written disciplinary warning. Future violations would result in additional discipline including up to discharge. The applicant refused to sign the document. On March 2013, the applicant's female coworker filed a written complaint and indicated the applicant verbally badgered her regarding her work performance, including being sarcastic. The applicant met with human resources. The applicant was initially sarcastic. The applicant was told his tone was inappropriate. He was counseled about his behavior. No written disciplinary report was issued. The applicant sustained a work-related injury on January 11, 2013. He received medical treatment but did not miss any work. On August 15, 2013, the applicant got into an argument with a co-worker. The co-worker indicted he had enough of the applicant yelling at him and telling him what to do. The co-worker physically attacked the applicant. The co-worker was terminated immediately for the physical assault. The applicant met with human resources and was then told to go home. Shortly afterward, the superintendent determined the applicant should be discharged. The superintendent was unaware of the work-related injury, or that surgery was recommended for that injury. Administrative law judge held the employer had unreasonably refused to rehire the applicant. A full year's wages were ordered paid to the applicant. The Labor and Industry Review Commission reversed. The applicant repeatedly demonstrated an unacceptable level of antagonistic and provocative behavior toward his co-workers. The applicant had been warned that future instances of behavior could result in discharge. The applicant, yet still again, initiated conflict with a co-worker. The discharge determination was made based upon the cumulative record of the applicant's workplace disruption including his verbal badgering of the co-worker leading up to the discharge itself. The employer had reasonable cause to make this decision. The superintendent's testimony that the discharge was made on the basis of the applicant's behavior, and that he was then unaware of the work injury and surgery, was credible.

Dobbert v. Carew Trucking Inc., Claim No. 2013-032080 (LIRC April 30, 2018). The applicant alleged that Carew Trucking and Carew Concrete Supply unreasonably refused to rehire him. The applicant was hired by Carew Trucking in 1998. He was employed as a dump truck driver. The two companies named herein were related businesses. He was not employed by Carew Concrete. His job duties did not cross over into the other company. His paychecks and tax accounting was under Carew Trucking's name. His supervisor was a Carew Concrete employee. However, a written agreement existed, which required Carew Trucking to pay Carew Concrete for supervisory services. Other employees were permitted to change their employment status

from one company to another. An application for employment and position opening was required. Formal employment paperwork was completed for each such change. The companies share the same business address, telephone, and website, as well as the same management staff and registered agent. The 100% owner of Carew Trucking owns 92% of Carew Concrete. After the applicant sustained a compensable work-related injury, the applicant was restricted from driving professionally. Carew Trucking wrote to the applicant and indicated that, based upon these restrictions and the applicant's acceptance of the same, the company assumed the applicant was terminating employment. The applicant was advised to contact the company if his driving restrictions should change. Carew Concrete later had positions open which did not involve driving a vehicle. The applicant did not apply for these positions, and they were not offered to the applicant. The administrative law judge (unnamed) denied the applicant's claim. The Labor and Industry Review Commission affirmed. The only positions available at Carew Trucking were driving jobs. These were offered and declined because of the applicant's restrictions. Wis. Stat. 102.35(3) provides recovery when the employer unreasonably refuses to rehire an employee when that employer has suitable employment available within the applicant's restrictions. Carew Trucking did not have any such suitable employment. Therefore, the application must be dismissed. The applicant was not employed by Carew Concrete and, therefore, cannot have a claim against that company. The companies were legally established as separate corporations and legally operated as separate businesses. There was contractual arrangement for provision of management services from one company to another. The applicant was not jointly employed by both companies. There are circumstances where joint employment exists; however, the employee must be under an employment contract with each of the joint employers, the employers must maintain simultaneous control over the worker, and the worker's services for each employer must be the same or closely related. There was no evidence of an employment contract between the applicant and Carew Concrete.

VOCATIONAL REHABILITATION

Wein v. AD Roofing, LLC, Claim No. 2011-024653 (LIRC June 30, 2017). The applicant was 19 years old at the time of the work-related injury. He was driving his employer's pickup truck. He was involved in a head-on collision with a semi. The applicant sustained very substantial brain injuries that left him with substantial depression. Vocational testing demonstrated that he had quite good mathematical and mechanical intellectual abilities. Two separate counselors at DVR, on two separate occasions, recommended against attempts at vocational rehabilitation because of his substantial limitations. An unnamed administrative law judge awarded permanent total disability benefits. The Commission affirmed. The applicant was not required to wait for some period of time to see if he could undertake and complete a retraining program. This type of case did not require or justify postponing a decision on whether or not the claimant was permanently and totally disabled.

WISCONSIN WORKER'S COMPENSATION 2018
CASE LAW UPDATE

TABLE OF AUTHORITIES

Cases

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MISCONDUCT AND SUBSTANTIAL FAULT IN WISCONSIN

TABLE OF CONTENTS

MISCONDUCT AND SUBSTANTIAL FAULT IN WISCONSIN

OVERVIEW

For about 20 years, employers and insurers in Wisconsin were often required to pay an employee temporary disability wage loss benefits after the employee was terminated. This was a very frustrating situation for many employers because of the increased claim costs as well as the "principle of the matter." This requirement arose out of the infamous *Brakebush* case.[1] In *Brakebush*, surveillance revealed the employee was bow hunting and playing pool. The employee did not mention those activities to the employer or the doctors. The employee was released to work light duty. The employer terminated the employee for gross misconduct. This was on the basis that the company policy prohibited misrepresentation of facts or giving false or misleading information regarding a work injury. The Wisconsin Supreme Court held that there is no exception to an employer's liability for wage loss during a healing period when the employee is terminated for misrepresentations relating to his or her medical condition.

The *Brakebush* holding was expanded into other types of discharge. In *Wellsandt v. Chippewa County*,[2] the Commission awarded temporary total disability benefits despite termination for a legitimate reason. The applicant in *Wellsandt* had returned to work prior to the discharge. He was discharged for failing to replace the oil in a sheriff's deputy's car while working under a last chance agreement. The court conceded that, presumably, had the applicant not been fired, he would have continued to work within his restrictions. The court determined that the exception to the *Brakebush* standard would need to rest on the conclusion that the applicant's conduct was the analytic equivalent to refusing an offer of work. The Commission refused to make that conclusion. The Commission interpreted the *Brakebush* decision to reflect that the Supreme Court held the Commission lacked authority to eliminate temporary disability wage loss based on misconduct discharges, regardless of the circumstances. The *Wellsandt* court based this on the Court of Appeal's general statement that, "compensation continues during the healing period even if the employee is fired for cause."

Following these decisions, the employer and insurer were essentially required to concede payment of temporary disability benefits to an employee in these situations or face a potential penalty claim. The legislature did provide three exceptions, about ten years after *Brakebush.* Effective April 1, 2006, Wis. Stat. §102.43(9) was amended to add three exceptions to an employee's otherwise entitlement to receive temporary disability benefits during the healing period. These exceptions included (1) an employee's unreasonable refusal of a suitable employment offer, (2) an employee's violation of an employer's drug policy, and (3) an employee's suspension or termination after being charged with a commission of a crime. These exceptions were construed very narrowly. There was no "for cause" or "good cause" or any similar type of exception provided by the legislature in 2006. Instead, the employers and insurers continued to pay an employee temporary disability benefits after the employee was terminated for misconduct during the healing period.

The legislature finally provided some relief for employers and insurers in 2016. Effective March 2, 2016, Wis. Stat. §102.43(9) was again amended. This amendment provided an employee was not entitled to payment of temporary disability benefits during the healing period when an employee could otherwise return to work, and the employee's employment with the employer had been suspended or terminated due to misconduct as defined in Wis. Stat. §108.04(5) or for substantial fault as defined in Wis. Stat.§108.04(5g)(a).

[1] *Brakebush Bros., Inc. v. Labor and Industry Review Comm'n,* 210 Wis. 2d 623, 563 N.W.2d 512 (1997).
[2] *Wellsandt v. Chippewa County,* Claim No. 93-00745 (LIRC November 28, 1997)

CHAPTER 108 STATUTORY PROVISIONS

Chapter 108 contains the unemployment benefit provisions. The unemployment provisions related to misconduct and substantial fault, referenced in the Worker's Compensation Act, became effective January 4, 2014. Disputes regarding the interpretation of language in unemployment statutes are addressed by the Labor and Industry Review Commission, Circuit Court, the Court of Appeals, and the Supreme Court of Wisconsin. This is the same process used in Wisconsin worker's compensation disputes. The Labor and Industry Review Commission decisions are not dispositive or binding on unemployment benefit claims or worker's compensation benefit claims. However, the Labor and Industry Review Commission decisions regarding unemployment benefits will provide some guidance as to how the Commission will interpret the same type of situations and facts, regardless of the type of claim pending.

In *Dufour v. Sweet House of Madness, LLC*, Hearing No. 14600226 (March 19, 2014), the Labor and Industry Review Commission held that there is a three step evaluation in unemployment disputes that must be addressed in order to determine whether an employee is ineligible for unemployment benefits. The first step requires the court to determine whether the employee was discharged for misconduct by engaging in any of the actions enumerated in Wis. Stat. Section 108.04(5)(a)-(g). If the provisions do not apply, the next step is determining whether the employee's actions constitute misconduct as originally defined by the Wisconsin Supreme Court in *Boynton Cab. Co. v. Neubeck*, 237 Wis. 249 (1941) (now codified in the introduction to Wis. Stat. Section 108.04(5)). The third step is determining whether the discharge was for substantial fault under Wis. Stat. Section 108.04(5g). While the steps do not need to be evaluated in order under the worker's compensation statute, there is certainly some logic to applying that course of evaluation and considering whether the specific enumerated situations apply before determining whether more general, or broad, definitions are applicable. In applying the process used by the *Dufour* court, we would look at a situation in the following manner:

Step One

The first step is determining whether the employee was discharged for misconduct by engaging in any of the actions enumerated in Wis. Stat. § 108.04(5) (a)-(g). These provisions are as follows:

> "(a) A violation by an employee of an employer's reasonable written policy concerning the use of alcohol beverages, or use of a controlled substance or a controlled substance analog, if the employee:
>
> 1. Had knowledge of the alcohol beverage or controlled substance policy; and,
> 2. Admitted to the use of alcohol beverages or a controlled substance or controlled substance analog or refused to take a test or tested positive for the use of alcohol beverages or a controlled substance or controlled substance analog in a test used by the employer in accordance with a testing methodology approved by the department.
>
> (b) Theft of an employer's property or services with intent to deprive the employer of the property or services permanently, theft of currency of any value, felonious conduct connected with an employee's employment with his or her employer, or intentional or negligent conduct by an employee that causes substantial damage to his or her employer's property.

(c) Conviction of an employee of a crime or other offense subject to civil forfeiture, while on or off duty, if the conviction makes it impossible for the employee to perform the duties that the employee performs for his or her employer.

(d) One or more threats or acts of harassment, assault, or other physical violence instigated by an employee at the workplace of his or her employer.

(e) Absenteeism by an employee on more than two occasions within the 120-day period before the date of the employee's termination, unless otherwise specified by his or her employer in an employment manual of which the employee has acknowledged receipt with his or her signature, or excessive tardiness by an employee in violation of a policy of the employer that has been communicated to the employee, if the employee does not provide to his or her employer both notice and one or more valid reasons for the absenteeism or tardiness.

(f) Unless directed by an employee's employer, falsifying business records of the employer.

(g) Unless directed by the employer, a willful and deliberate violation of a written and uniformly applied standard or regulation of the federal government or a state or tribal government by an employee of an employer that is licensed or certified by a governmental agency, which standard or regulation has been communicated by the employer to the employee and which violation would cause the employer to be sanctioned or to have its license or certification suspended by the agency.**"**

Theft of an employer's property or services was addressed by the Labor and Industry Review Commission in *DuFour v. Sweet House of Maddness, LLC*. Hearing No. 14600226 (Mar. 19, 2014). In this case, an employee worked as a cashier for a bakery for about six months. The bakery had a policy that employees could only take pastry items and/or soda home if the employees obtained permission from the manager or owner. In this case, the employee took a soda and a pastry item home one day without asking for permission from either her manager or the owner. She was terminated for theft. The employee's actions were considered to constitute theft under Wis. Stat. §108.04(5)(b). The Commission also noted that her conduct would have also constituted misconduct under the *Boynton Cab. Co.* standard.

If any of these statutory enumerated situations applies, the employee would be considered discharged for misconduct. Under the new statutory language for worker's compensation claims, the employee would, therefore, not be entitled to ongoing temporary disability benefits while in the healing period. However, if those situations do not specifically apply, the evaluation would need to continue.

Step Two

Based upon the *Boynton Cab Co.* case, Wis. Stat. §108.04(5)(intro) defines misconduct as: "one or more actions or conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violations or disregard of standards of behavior which an employer has a right to expect of his or her employees, or in carelessness or negligence of such degree or recurrence as to manifest culpability, wrongful intent, or evil design of equal severity to such disregard, or to show an intentional and substantial disregard of an employer's interests, or of an employee's duties and obligations to his or her employer."

The *Boynton Cab. Co.* standard has been considered numerous times since that case was decided in 1941. Relatively recently, in *Spencer v. LIRC,* 359 Wis. 2d 677, (Ct. App. 2014)(*unpublished),* the applicant worked as a delivery driver for Coca-Cola. The applicant was first written up when he called his supervisor to inquire about his delivery route for the next work day. When he heard which route he had been assigned, he started swearing at the supervisor. The supervisor asked him to meet the supervisor at the employer's building. The applicant went to the building but left without speaking to the supervisor. The applicant was called and asked to return. The applicant indicated he was not going to waste his breath anymore, and then continued to swear at the employer. During this process, the applicant walked past a conference room where a manager was standing. The manager asked him how he was doing. The applicant responded by again swearing and indicating he was ready to quit. The applicant then stormed out. A customer also called to complain about the applicant not stocking product properly in the customer's store. The applicant's supervisor asked him to go back to the store. The applicant did so. However, he told the customer that it was ridiculous that he had to come back to the store. The applicant also complained to his supervisor when he returned to the employer's location. The applicant was, thereafter, discharged. The Labor and Industry Review Commission held that the applicant's behavior was (1) deliberate and (2) demonstrated a substantial disregard to the employer's interests in customer service and written company policies. The Commission held the applicant's behavior reached misconduct under the *Boynton Cab Co.* standard. The Wisconsin Court of Appeals affirmed.

Additionally, and most recently, the Wisconsin Court of Appeals affirmed the Labor and Industry Review Commission's decision that an applicant was ineligible for unemployment benefits after the employer installed a GPS tracker device on their company owned vehicle that the applicant used and discovered the applicant was falsifying his hours worked. *Lord v. LIRC,* 367 Wis. 2d 748 (Ct. App. 2016)(*unpublished).*

These are several recent examples; however, the case law is rather extensive on what constitutes 'misconduct' under this standard. This case law is very fact specific, and the result will depend greatly on small changes in details regarding the situation. This case law provides guidance to employers and insurers with situations that may suffice to reach the general *Boynton Cab. Co.* misconduct standard codified in Wis. Stat. §108.04(5).

Step Three

If the situation does not fall into one of the potential misconduct situations, the next evaluation is whether an employee was discharged for substantial fault. If this standard is met, an employee will similarly not be entitled to temporary total disability benefits during the healing period.

Wis. Stat. §108.04(5g)(a) outlines the definition of substantial fault. This statutory provision was newly enacted in 2014. This statutory provision specifically states:

"An employee whose work is terminated by an employing unit for substantial fault by the employee connected with the employee's work is ineligible to receive benefits until 7 weeks have elapsed since the end of the week in which the termination occurs and the employee earns wages after the week in which the termination occurs equal to at least 14 times the employee's weekly benefit rate under s. 108.05 (1) in employment or other work covered by the unemployment insurance law of any state or the federal government. For purposes of requalification, the employee's benefit rate shall be the rate that would have been paid had the discharge not occurred."

Unlike the definition for "misconduct," which provides specific examples of what constitutes "misconduct," the substantial fault provision provides specific examples of what does not constitute "substantial fault" in Wis. Stat. §108.04(5g)(a)(1)-(3). These examples include:

1. One or more minor infractions of rules unless an infraction is repeated after the employer warns the employee about the infraction.
2. One or more inadvertent errors made by the employee.
3. Any failure of the employee to perform work because of insufficient skill, ability, or equipment.

CASE LAW

The courts in Wisconsin have just recently started to address situations falling under the post 2014 provisions of Chapter 108 which address misconduct and substantial fault situations. The Labor and Industry Review Commission has addressed several different scenarios, as has the Wisconsin Court of Appeals. The Wisconsin Supreme Court has provided its opinion on one set of facts, and another case is currently pending before the court.

In 2016, the Court of Appeals held that insubordination amounted to misconduct. In *Cockrell v. Labor and Industry Review Commission,*[3] the court addressed an applicant's entitlement to unemployment benefits. The applicant sustained a work-related injury in October 2014. He was provided restrictions on January 13, 2015. A transitional duty plan was in place. On January 14, 2015, the applicant's supervisor instructed the applicant not to report for work in the morning until after his follow-up medical appointment scheduled for 8:30 a.m., so they could discuss his schedule in accordance with the restrictions. The supervisor indicated this was because the applicant was scheduled to put away stock, which would violate his restrictions. He understood those instructions and did not indicate he had any concerns about not beginning work on January 15, 2015 at his normal time. The applicant reported to work the following day at 5:11 a.m. The applicant testified he reported to work knowing his supervisor had instructed him not to do so because he did not want to lose his wages for the day. His supervisor arrived at 7:45 a.m. and asked him to return after his doctor's

[3] *Cockrell v. Labor and Industry Review Commission,* 2016AP448 (Wis. Ct. App. 2016)(slip copy/summary disposition order).

appointment. When he returned, he was suspended. He was later discharged for insubordination for having reported to work when he was told not to so report. The Labor and Industry Review Commission held that the insubordination was misconduct. The Commission indicated that it generally holds that refusal to follow a reasonable employer directive is misconduct unless an employee has a defensible reason for refusing to follow the directive. The Commission determined the alleged reason in this case was not a defensible reason. The Circuit Court and Court of Appeals affirmed. The Court of Appeals agreed that the applicant was insubordinate when he reported for work the morning of January 15, 2015. The court held that insubordination amounts to "misconduct" under Wis. Stat. 108.04(5) because it is conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violations or disregard of standards of behavior, which an employer has a right to expect of his or her employees.

The facts in the *Cokrell* case are easily analogized to situations that occur regularly in worker's compensation cases. Based upon the *Cockrell* decision, an employer could arguably assert that an employee's failure to follow restrictions when instructed to do so would be failure to follow a reasonable employer directive and qualify as misconduct. There are a number of other very common situations in worker's compensation cases which would arguably rise to this level. The court did not outline what would qualify as a defensible reason for failure to follow a directive. We can anticipate future litigation and very fact dependent analysis from the courts on these issues.

The Court of Appeals analyzed a situation involving an employee who was discharged for not following safety rules under the substantial fault provision in *Josellis v. Labor and Industry Review Commission.*[4] In *Josellis,* the applicant received a copy of the employer's employment relations act. This contained a provision stating an employee may be suspended or terminated for unacceptable conduct. As defined in the act, this included violation or neglect of safety rules. The applicant received written counseling reports for confrontational behavior in August 2014. In February, the applicant received another report for driving at a high speed and failing to observe a stop sign in the parking lot. He was placed on a performance improvement plan. This plan required him to follow all safety precautions while performing duties. Three months later, the employee was suspended for three days for failing to properly place wet floor signs when mopping a restroom floor, in violation of safety rules. The following month, he was discharged after going without a hard hat into an area that was undergoing construction, despite posted signs saying hard hats were required. The Court of Appeals agreed with the Labor and Industry Review Commission's determination that the applicant was ineligible for unemployment benefits under Wis. Stat. §108.04(5g). The applicant's failure to comply with the safety requirement of wearing a hard hat was the only action considered to constitute substantial fault. The court did not consider the earlier actions to rise to this level. This was the final safety violation preceding the applicant's discharge and claim for unemployment benefits. The court held that the applicant entered a restricted area without wearing a hard hat despite knowledge that a hard hat was required and in violation of the employer's safety rules. The court determined the applicant's decision to enter the area was not inadvertent. The court outlined that this decision was not attributable to a lack of skill, ability, or equipment.

[4] *Josellis v. Labor and Industry Review Commission*, 2015AP2532 (Wis. Ct. Ap. 2016)(*not reported).*

While the violation of safety rules might not be as common practice as violation of restrictions, the Court of Appeals has determined that these actions would qualify as substantial fault. These safety rule violations can be significant and result in very dangerous situations. However, the court does appear to believe that some limitation is required based upon the analysis of the facts in *Josellis*. We can anticipate that minor violations, even if those would result in a termination, may not suffice to rise to the level of substantial fault.

The Court of Appeals addressed a similar type of situation, where the applicant's actions impacted the safety of others, in *Easterling v. Labor and Industry Review Commission*.[5] However, the court came to the opposite conclusion in this case. The applicant was employed as a driver of a van, which transported individuals with special needs. The employer had a wheelchair tip policy. This policy provided that failure to properly secure a wheelchair, which then caused the wheelchair to tip during transport, would result in termination of the driver's employment. The applicant failed to secure a wheelchair, the wheelchair tipped over, and the applicant was terminated the following day. Her claim for unemployment benefits was denied because the examiner determined she was discharged for substantial fault. The Labor and Industry Review Commission also determined she was discharged for substantial fault and held she was, therefore, ineligible for unemployment benefits under Wis. Stat. §108.04(5g). The Circuit Court affirmed. However, the Court of Appeals reversed. The Commission had determined that the applicant had mistakenly failed to secure a passenger's wheelchair in place on the floor of the van. The Commission further had determined she had made sure the wheelchair was positioned properly and the brakes were applied, but determined that, in her haste to attend to other passengers, she forgot to secure the straps of the floor mount to the wheelchair. The Commission further held that contributing factors included the lack of an experienced volunteer, the presence of three additional passengers who were not expected, a feeling of pressure to hurry because the passengers were eager to get onto the van, and the van was parked in a crosswalk. However, the Court of Appeals determined that there was no evidence that the applicant had intentionally or willfully disregarded the wheelchair policy. In *Operton*, the Court of Appeals (predating the Supreme Court's decision, but which was consistent with the Court of Appeals' decision) held the term "inadvertent" meant "failing to act carefully or considerately, inattentive; resulting from heedless action, unintentional." The Court of Appeals held there was no pattern of conduct and no admission or action inconsistent with inadvertence on the part of the applicant. There was no other substantial evidence that could support a finding that the applicant acted intentionally. The inference was that the applicant's failure to secure the wheelchair was not an affirmative decision, but was the result of heedless action and unintentional. She mistakenly failed to secure the wheelchair and forgot to do so, which is an inadvertent error. Substantial fault does not include one or more inadvertent errors.

These cases will likely turn on whether the specific facts can be more properly classified as inadvertent errors or substantial fault. Generally, the egregiousness of the action will be taken into consideration. Further, we can anticipate that the patterns of employees' conduct will be important to the Court of Appeals' determination, even if the earlier events did not result in the discharge or termination.

[5] *Easterling v. Labor and Industry Review Commission*, 374 Wis. 2d 312 (Ct. App. 2017).

The Wisconsin Court of Appeals considered another misconduct situation in the summer of 2017, in *Wisconsin Department of Workforce Development v. Wisconsin Labor and Industry Review Commission.*[6] The Supreme Court is currently considering this case. Oral arguments were scheduled in December 2017. However, the court has not yet issued a decision. In this case, the employer had a policy, in its manual, that employees in their probationary period may have their employment terminated for one instance of no call/no show. The applicant did not show up for work once while in her probationary period because of flu-like symptoms. Her employment was terminated. She filed for unemployment benefits. An administrative law judge held the applicant violated the employer's policy and, thus, met the definition of misconduct. The Labor and Industry Review Commission adopted the position that the intent of the language regarding "otherwise specified…in an employment manual" was intended to allow a manual to provide that an employee could be absent on a more frequent basis without threat of discharge. It interpreted the two absences in 120 days to be a statutory minimum below which an employer could not go and still have a situation be considered misconduct. The Court of Appeals affirmed the Commission's interpretation of the statute. Thus, the court held that, an employer, by its manual, cannot provide that one absence in a 120 day period is "excessive" for purposes of meeting the misconduct definition in Wis. Stat. §108.04(5).

The only decision issued by the Wisconsin Supreme Court, thus far, interpreting either of the two post-2014 unemployment statutes, is *Operton v. Labor and Industry Review Commission.*[7] In this case, the Wisconsin Supreme Court considered whether an employee had been terminated for substantial fault. This case was an issue of first impression. The applicant in *Operton* worked as a cashier and was well liked and always on time. She participated in training regarding policies and procedures, including training on processing WIC program checks. She made eight cash handling errors with respect to transactions involving WIC checks during her twenty months with the employer. The applicant was terminated for her repeated errors and failure to improve upon those. The violations were considered to be "cash handling errors" or "mistakes" pursuant to the discipline records of the employer. The employer acknowledged the errors were not intentional or performed because of any ill will by the applicant. The *Operton* court held that, an employee's multiple inadvertent errors, even if the employee had been warned about the errors, do not necessarily constitute substantial fault to disqualify an employee from receiving unemployment benefits. An employee does not lose his or her unemployment benefits for making unintentional errors. The court also held that inadvertent errors, warning or no warnings, never meet the statutory definition of substantial fault.

[6] *Wisconsin Department of Workforce Development v. Wisconsin Labor and Industry Review Commission,* No. 375 Wis. 2d 183 (Wis. Ct. App. 2017)

[7] *Operton v. Labor and Industry Review Commission*, 894 N.W.2d 426 (2017)

CONCLUSION

The 2016 worker's compensation statutory changes regarding misconduct and substantial fault were very employer friendly. For twenty years, employers and insurers were frustrated by the need to continue paying temporary disability benefits when an employee was terminated for cause. The statutory changes provide at least a potential for a defense to such ongoing payments.

A few important things need to be considered in evaluating the actual benefit from this statutory change. These provisions essentially only apply when an employee is released to work and would be eligible to work for the date of injury employer within restrictions, but for the termination. If an employee is completely taken off work and then terminated, the new statutory provision will not apply regardless of the reason for the termination. Additionally, there is no change to the employee's ability to seek loss of earning capacity benefits, permanent total disability benefits, and/or retraining benefits. An employer still needs to keep in mind these potential additional claims that could be brought, post end of healing, if an employee does not return to work for an employer at 85% to 90% of the average weekly wage. The considerations for the potential increased exposure for worker's compensation benefits post end of healing will need to be balanced by the employment and business considerations of terminating an employee for actions that could arguably amount to misconduct or substantial fault. If the determination is made that a termination is necessary, then the new statutory provisions provide some relief to the additional temporary disability exposure that existed prior to two years ago.

Finally, it is important to keep in mind that the statute was not entirely clear as to whether it applied to situations involving dates of injury after March 2, 2016 or terminations after March 2, 2016. The court has not addressed this in any reported cases. Practitioners agree that the provisions apply for dates of injury after March 2, 2016. The bar is split over whether there is an argument to be made that the provisions should also apply to terminations occurring after March 2, 2016. Presumably, an employer and insurer will decide, at some point, to push the envelope and take such a case to hearing to address this issue. Such a case may ultimately make its way to the Labor and Industry Review Commission and, then, potentially all the way up to the Court of Appeals. At that point, there may be a definitive answer to this question.

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INVESTIGATION OF MECHANISMS OF INJURY

TABLE OF CONTENTS

INVESTIGATION OF MECHANISMS OF INJURY

I. INTRODUCTION

The mechanism of injury is the precise manner in which an employee's alleged injury occurred. Mechanisms of injury can be traumatic and specific in nature, or repetitive over time. Given the potentially significant costs associated with a workers' compensation claim, the employer and insurer must complete a thorough investigation at the inception of each claim with regard to the alleged mechanism of injury. It is critical to obtain as much information and documentation as possible with regard to the employee's precise, alleged mechanism of injury, so as to determine whether an injury truly occurred and whether an employee's ongoing condition or diagnosis actually arose out of the work activities.

These materials focus on techniques for completing an investigation of a mechanism of injury, how to evaluate a mechanism of injury versus an employee's medical diagnosis, using findings on mechanisms of injury to make primary liability determinations, and effectively presenting those findings to medical experts.

II. INVESTIGATION TECHNIQUES

A. First Report of Injury

When a work injury is reported to an employer, the First Report of Injury form should be completed. For the employer and insurer, the First Report of Injury is often the first account of the alleged mechanism of injury. As a case progresses and investigation and discovery are completed, it is important to keep track of how the mechanism of injury was initially reported on the First Report of Injury so that any inconsistencies with regard to the mechanism of injury can be documented. For example, a mechanism of injury may be described in a specific way on a First Report of Injury, but medical records or an employee's statement may provide a different account. Inconsistencies can be key in determining whether primary liability should be denied.

B. Accident Reports

In addition to the First Report of Injury, many employers complete independent accident reports regarding claimed mechanisms of injury. Accident reports sometimes contain more detail regarding the mechanism of injury than the First Report of Injury, given that the First Report of Injury form contains limited space for the narrative regarding the injury. Any accident reports completed by the employer should be promptly forwarded to the adjustor.

C. Statement of Employee

Information regarding the mechanism of injury can be obtained directly from the employee through the use of an interview or recorded statement. Direct communication with the employee is valuable, especially in the period of time before the employee retains an attorney. Use recorded statements strategically. If the statement will clarify the incident, take the statement. If it will only reiterate the obvious, then avoid taking the statement.

When completing the employee's statement, obtain as much detail as possible regarding the mechanism of injury, including detail about the date, location, and precise physical movements of the employee and/or objects involved. With repetitive, *Gillette*-type injuries, obtain extensive details about the job duties, what specific duties led to pain, and when the employee attributed his or her pain to the job duties. It can be helpful to outline the questions to ask the employee, and then ask as many follow-up questions as possible during the interview.

D. Central Index Bureau Check

An inquiry to the Central Index Bureau (CIB or ISO report) should be made to determine whether the employee has ever made claims of injuries previously. If an employee is making a claim about a particular mechanism of injury, it can be helpful to determine whether he or she has made any similar claims in the past, especially for the purpose of establishing that there are preexisting or underlying medical issues at play. This information can also assist with making credibility determinations about the employee.

E. Obtain Authorizations

1. Medical Authorizations

In order to determine whether an alleged mechanism of injury is the cause of an employee's medical condition or diagnosis, it is imperative to determine what preexisting medical issues exist. A list of all medical providers who have treated the employee in the past should be obtained. Medical records, including hard copies of any scans or x-rays, from these providers can then be obtained. Since this does require a cost, a determination should be made as to whether the case is worth the expense of obtaining the records. However, spending a few hundred dollars to obtain prior medical records could well be worth the cost since it could potentially save thousands of dollars in exposure for workers' compensation benefits.

2. Minnesota Department of Labor and Industry Records

Authorizations directed to the Minnesota Department of Labor and Industry should be obtained so that an employee's workers' compensation case records can be obtained. These records can contain medical records and independent medical examination reports, evidence of past workers' compensation cases and payments, and various reports regarding prior mechanisms of injury, such as First Reports of Injury.

F. Surveillance

In a case in which a particular mechanism of injury is in question, especially when there are no witnesses, surveillance can be a useful investigative tool. For example, if an employee is claiming that she fell, hit her head, and sustained a concussion, then it can be helpful to conduct surveillance to determine whether the employee is active. While surveillance evidence alone usually cannot allow for an automatic denial of primary liability, it can be particularly helpful for independent medical examiners in making determinations about whether an employee actually suffered an injury as reported.

Utilize a reputable private investigator. Avoid employer-sponsored/conducted surveillance, but coordinate surveillance with any employer tips. Make sure you have the correct individual purported to be the employee. Surveillance is most useful when it shows a pattern of behavior. Thus, it is wise to budget for three consecutive days of surveillance. Consider preset meetings for surveillance, such as IME or QRC appointments.

G. Witness Statements

Secure written, signed, and dated statements from any relevant co-employees or witnesses to an employee's injury, especially when the alleged mechanism of injury is in question. Witness statements are useful in making primary liability determinations, as they can confirm or differ from a claimed mechanism of injury.

H. Job Site Video

When it comes to a report of a specific injury, one of the easiest ways to confirm that the alleged injury actually took place is to obtain any video that has been captured of the incident in question, if available. Since some video evidence can be destroyed relatively quickly after an incident occurs, it is important that the employer coordinate the retrieval of video evidence as soon as possible.

On the other hand, with regard to repetitive, *Gillette*-type injuries, it can be helpful to create a video of a particular employee's exact job activities as an illustrative exhibit for an independent medical examiner, especially if a particular job is complex and/or difficult to describe or visualize. This illustrative exhibit can also be impactful in the courtroom if the intention is to try to show that a particular job

or alleged mechanism of injury did not result in a particular diagnosis. In creating these types of videos, it is critical to use a person of similar height and body habitus to act out the job duties because, for example, it may be easier for a taller person to do the job being shown.

I. Job Site Photographs

If no video evidence is available regarding an alleged injury, then the next best thing to do is to obtain photographs, as soon as possible after the incident, of the precise location where an alleged injury occurred, any tools or objects involved, any contusions or physically-apparent wounds on the employee's body, and the like.

J. Timing and Work Schedule

In rare circumstances, an employee may make an assertion that she sustained an injury at a particular time and place, but her work schedule may not comport with her account of the incident. It is important to know what the employee's work schedule is so that it can be confirmed that she was physically present for the mechanism of injury to have actually taken place. For example, an employee may claim that she was injured at 3:00pm while working with a particular machine on a factory line, but it could be the case that she was not scheduled to use that machine in question at that specific time, or it could be the case that the machine in question would not be in operation at that specific time.

K. Production Data

When an alleged mechanism of injury involves a particular process over the course of time, any relevant production data should be obtained, if possible. There are a number of ways that this scenario could play out. It is critical to obtain data on work output when an employee is asserting a *Gillette* injury claim or asserting that he was overworked during a particular number of hours or days. A more specific example would be if an employee asserts that he has developed carpal tunnel from using a nail gun, and he asserts that he would go through 100 nails per product and create five products per hour, then any logs regarding the actual work output for the period of time in question should be obtained.

L. Social Media Investigation

In the course of completing an initial investigation of an employee, it can be helpful, and sometimes case-altering, to perform a social media investigation of the employee on outlets such as Facebook, Instagram, and Twitter. Any information that is publicly listed on social media profiles is "fair game" and can be used at the disposal of the employer and insurer. In the same way that surveillance can be useful in determining whether a particular mechanism of injury occurred, it can also be useful to obtain evidence from an employee's social media account. For example, if an employee is asserting that the mechanism of injury was a debilitating

fall resulting in incapacitating low back pain, but that same employee can be seen on Facebook taking a vacation the weekend after, then screenshots of these pictures on an employee's profile should be preserved.

M. Accident Reconstruction

In particularly high-value cases where the mechanism of injury is in question, it may be beneficial for the employer and insurer to obtain an accident reconstruction report from an accident reconstruction expert, biomechanical engineer, or other similar scientific expert. When a mechanism of injury simply does not sound physically possible (*i.e.*, an employee claims to have been thrown to the right side of a car when the car was rear-ended in the center, or an employee claims to have broken a leg when falling from a short height, etcetera) it can be highly impactful to bring scientific evidence into the picture.

III. COMPARING MECHANISMS OF INJURY WITH MEDICAL DIAGNOSES

Once the facts are established and the alleged mechanism of injury has been fully-investigated, the employer and insurer must take the analysis to the next level and determine whether an alleged mechanism of injury comports with an employee's post-injury medical diagnosis or diagnoses. In other words, *does it make sense*?

This step is critical in determining whether an injury actually occurred, whether an ongoing diagnosis is causally related to the incident in question, and what the long-term exposure may be in terms of both indemnity and medical benefits given the severity of the injury.

The key questions in this analysis are as follows:

- In light of the investigation on the alleged mechanism of injury, did the injury actually occur?
- Could the alleged mechanism of injury have caused a specific medical diagnosis?
- If an injury occurred, what are the specific body parts involved and what is the specific injury as to each of those body parts?
- Is an employee's ongoing condition causally related to the alleged mechanism of injury or an underlying/degenerative condition? Remember that, for liability to attach, the alleged mechanism of injury must be a "substantial contributing factor" with regard to an ongoing condition. This is a determination that must be confirmed by medical experts.
- Even if an employee has known prior injuries and/or a history of degenerative issues, did the mechanism of injury aggravate or accelerate the underlying issue?
- How long will the effects of the mechanism of injury last? In other words, when will the employee recover from the injury?

While the employer and insurer cannot act as its own medical expert, one of the best ways to analyze mechanisms of injury versus medical diagnoses is to become familiar with conditions that are underlying or degenerative in nature, and what types of conditions can come on as a result of an employee's claimed mechanism of injury. The best way to explore this concept is by way of examples for both specific/traumatic injuries and repetitive, *Gillette*-type injuries.

The examples below are illustrative. Any similarity to actual cases is purely coincidental.

A. Examples – Specific Injuries

On a snowy, winter day, an employee sustains a work-related slip-and-fall while walking into the building. He claims that this slip-and-fall resulted in low back pain with radicular symptoms into the right leg. However, an MRI is obtained that shows no impingement of the sciatic nerve that affects the right leg. Video evidence of the slip-and-fall is captured, so the mechanism of injury is confirmed. However, the lack of nerve impingement is a clue that the mechanism of injury may be less severe than the employee asserts.

An employee is working with a patient in a healthcare setting, and must lift that patient into a wheelchair. The employee asserts that, while lifting the patient, he heard a "pop" in his neck. The claim is admitted and payment of benefits is initiated. A MRI is obtained and shows that there is a herniated disc in the cervical spine. However, the employer and insurer gather the employee's prior medical records, including a prior MRI of the cervical spine that was taken two years prior to the alleged mechanism of injury. The two MRIs match. In this type of situation, the matching MRIs from before and after the claimed mechanism of injury can help a medical expert determine that the mechanism of injury only resulted in a temporary strain or sprain, as opposed to the disc herniation itself. The medical expert determines the employee has fully recovered from the effects of the injury, so the employer and insurer have a basis to discontinue payment of benefits.

There are several low beams in an employer's warehouse area. An employee claims that he hit his head on a low beam and sustained a concussion. He now has vision problems and constant headaches, and goes off-work. The employer and insurer conduct an investigation. They note that the employee is five feet, ten inches tall, but the beam is six feet, three inches off the ground. Additionally, they gather the employee's medical records, which note that he was seen in an emergency room the past weekend after a physical altercation in which he was hit in the head. The employer and insurer appropriately deny the claim.

B. Examples – *Gillette* Injuries

An employee has felt pain in her left shoulder for a number of weeks and believes that this pain is caused by her work activities. Specifically, she works on an assembly line and makes boxes. She reaches to the side with her left arm, grabs a sheet of cardboard, assembles a box at waist level, and uses the right arm to put the box on a pallet. Eventually, her shoulder pain becomes so unbearable that she reports a work injury with the employer. The employee claims that the mechanism of injury with regard to her left shoulder is repetitively reaching to the side with her left arm and assembling boxes. She goes to see her doctor, who confirms that her left symptoms are consistent with a rotator cuff tear. Surgery is recommended to repair the torn rotator cuff. The employer and insurer deny the claim, noting that the alleged mechanism of injury does not comport with the rotator cuff tear, given that all of the employee's work activities are done at waist level as opposed to overhead. Note that this primary denial of liability would need to be confirmed by a medical expert if the employee contested it.

A delivery driver reports an injury to his employer. He claims that he must repetitively climb in and out of his truck, and he has had to do additional routes in the last three weeks, which has caused left knee pain. The claim is initially admitted. The employee begins to treat with an orthopedist, who recommends surgery and opines that the employee's work activities are the substantial contributing cause for his need for surgery. The employer gathers all of the employee's time cards, as well as specifics about where he has made deliveries in the several weeks before he made his injury claim, and what he was delivering. They discover that the employee has not actually had to exit his truck upon making his deliveries. The employer and insurer have the employee see an independent medical examiner, who points out that the treating doctor did not have correct information upon making his determination that the employee had sustained a work injury. In addition, the independent medical examiner finds that the employee has chondromalacia, which is a degenerative condition. Due to the investigation and expert report, the employer and insurer have a basis to deny primary liability and cease payment of benefits.

An employee works at a factory where she uses her hands and fingers to assemble small parts for medical equipment. She begins to complain to her co-workers that she has carpal tunnel symptoms in her right wrist. A couple weeks later, she reports an injury to her supervisor and goes to see a doctor. The medical record confirms that the employee is pregnant and has been diagnosed with uncontrolled diabetes, and the record notes that both pregnancy and diabetes are associated with carpal tunnel symptoms. The employee's treating doctor does not specifically opine that her carpal tunnel symptoms are causally related to her work activities. Nevertheless, the employee continues to vehemently assert that her symptoms are work-related and stops coming to work. The employer and insurer appropriately deny the claim, based on the lack of medical evidence that links her alleged injury to her work activities.

IV. UTILIZING FINDINGS ON MECHANISMS OF INJURY

There are two key reasons for exploring the alleged mechanism of injury to the fullest extent possible – to make primary liability determinations and to effectively present findings to medical experts. By using the investigation techniques described above at the onset of a claim, the employer and insurer can save money in the long-term.

A. Making Primary Liability Determinations

The investigation of the mechanism of injury should be commenced as soon as possible after the alleged injury occurs or is reported, given that the statute imposes strict timelines on making the primary liability determination.

Pursuant to Minn. Stat. §176.221, subd. 1, within 14 days of notice to or knowledge by the employer of an injury compensable under this chapter, the payment of temporary total compensation shall commence. Liability for compensation under this chapter may be denied by the employer or insurer by giving the employee written notice of the denial of liability. If liability is denied for an injury which is required to be reported to the commissioner under Minn. Stat. §176.231, subd. 1 (the First Report of Injury provision), the denial of liability must be filed with the commissioner and served on the employee within 14 days after notice to or knowledge by the employer of an injury which is alleged to be compensable under this chapter. A notice of denial of liability must state in detail the facts forming the basis for the denial and specific reasons explaining why the claimed injury or occupational disease was determined not to be within the scope and course of employment, and shall include the name and telephone number of the person making this determination.

Therefore, for injuries with claimed disability extending more than three calendar days, the insurer must make a determination regarding liability within 14 days of the first day of disability or the date the employer was aware of disability, whichever is later. Essentially, the insurer must pay or deny a claim within 14 days. Additionally, if a First Report of Injury is filed (even though it may not have been necessary), a Notice of Primary Liability Determination must be filed.

Overall, it is critically important to investigate each claim promptly so that, if primary liability should be denied, the denial can be timely filed. Doing so can help put the employer and insurer in a good position to control the costs of a claim.

B. Obtaining Expert Medical Opinions

Obtaining a well-timed and well-founded independent medical examination can be a key component to posturing a workers' compensation matter for the desired result. Providing the IME doctor with as much information as possible regarding the precise mechanism of injury, whether specific or *Gillette* in nature, is of the utmost importance. The IME doctor must have the correct facts so that the IME report is adequately founded.

In some cases, there can be a consensus amongst the parties that an alleged mechanism of injury is legitimate, but when the IME doctor obtains the employee's testimony and the medical records, it can be determined that there are other issues at play with regard to the employee's ongoing condition. For example, an employee may complain of various symptoms that his doctor linked to the mechanism of injury, but the IME doctor may link those symptoms to a specific disease (*i.e.*, rheumatoid arthritis, forms of cancer, or other nonwork-related genetic conditions) as opposed to the mechanism of injury.

A strong IME report can help the employer and insurer take a wide array of actions, including discontinuing wage loss benefits, denying medical expenses, establishing liability of another employer or insurer, evaluating apportionment, evaluating permanent partial disability, and determining whether the employee's current condition is causally related to the alleged work injury. The cornerstone of a strong IME is a solid account of the mechanism of injury, including any and all inconsistencies in reporting or as noted in the medical records.

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Office Visit

Encounter Information

	Provider	Department	Encounter #
12/18/2015 10:15 AM	Jody C Epstein, MD	Achc Wingra Park Fish Fam Med Center	51689460

Progress Notes

Progress Notes signed by Sarah J Boyd, C-MA at 12/18/15 1019

Author: Sarah J Boyd, C-MA Filed: 12/18/15 1019 Note Time: 12/18/15 1014
Status: Signed Editor: Sarah J Boyd, C-MA (Medical Assistant)

Patient agenda items: Back Pain

s is a 37 year old female is here today for a follow up on low back pain was seen on 12/14/2015. Reports intermittent aching in low back.

Would like to trazodone medication

States her eye pain and "foggy brain" have subsided.

Medications list reviewed:
NO refills are needed.
There are NO medication changes.

Health Maintenance addressed, NO updates needed

Care Everywhere: No

Electronically signed by Sarah J Boyd, C-MA at 12/18/15 1019

Progress Notes signed by Jody C Epstein, MD at 12/18/15 1107

Author: Jody C Epstein, MD Filed: 12/18/15 1107 Note Time: 12/18/15 1025
Status. Signed Editor: Jody C Epstein, MD (Resident Physician)

ACHC WINGRA FAMILY MEDICAL CENTER

SUBJECTIVE:

is here to follow up on 2 issues

1. Back pain s/p bus accident
Bus bottomed out on Dec 2, she bounced and hit very hard in the driver's chair

Immediate pain
Now getting much better
Chiropractic adjustments have been helpful in the last week
Was given work excuse but they made her ride the bus, not drive, which has been very painful
Improved sciattic pain on left but intermittent pain in right leg
Occasional arms go numb - was more frequent immed after the accident, now only rarely and better if she hugs a pillow at night
Xray showed mild T11 compression fracture of indeterminate age and DDD throughout

2. Sleep medicatiom
has long hx insomnia, improved with 100mg trazadone (50 mg did not work), started many months ago. Since then, she has had brian fog which she attributes to the medication.
Then she also developed eye pain, which started a few weeks before bus accident
Worse with bright light and small print - both eyes affected
Left eye also felt slightly blurry
She had normal eye exam and got updated contacts before this started
This all went away when she stopped trazadone
Now using flexeril to help with sleep, working well
Ambien worked well for sleep in past as well
Mood was down with the change of seasons, started Vit D which has helped, overall thinks mood is very good

ROS: See HPI for pertinent ROS
No saddle antestesia
No difficulty urianting or with BM

PREVENTIVE HEALTH
Declines flu shot

OBJECTIVE
BP 118/88 mmHg | Pulse 80 | Resp 16 | Wt 227 lb (102.967 kg)
General appearance: Alert, well-groomed, appears comfortable. Good eye contact. Full affect
Resp: Non labored
Back: No spinous process tenderness, mild tenderness to palpation over SI joints and sacrum
Neuro: Sensation intact in LE, 5/5, 1+ patellar DTR

ASSESSMENT AND PLAN
1. Insomnia
- Discussed multiple therapies that are available: she can continue flexeril for sleep, try trazadone again to see if fogginess and eye pain recur, or restart ambien. Given refill of both ambien and flexeril, advised to use one at a time, not both

2. Bilateral low back pain with sciatica, sciatica laterality unspecified s/p MVA: She has thoracic compression fracture but her pain is distinctly lumbar. Unsure acuity of thoracic fracture but if it is acute and caused by this accident, it is not the main driver of her pain. Overall improving, neuro intact. Still with pain while riding the bus, so she should be off the bus completely for 1-2 weeks
- Work excuse given through Jan 4
- Flexeril PRN
- Stretching
- Will discuss thoracic fracture with Chiropractor, avoid mid-back manipulation

***Recommend follow up*: 3 weeks**

Seen and discussed with Dr. Martonffy

.....

Jody Epstein, MD
Family Medicine Resident

Electronically signed by Jody C Epstein. MD at 12/18/15 1107

Progress Notes signed by Andrea Martonffy I, MD at 12/18/15 1107

Author. Andrea Martonffy I, MD Filed: 12/18/15 1107 Note Time: 12/18/15 1046
Status: Signed Editor: Andrea Martonffy I, MD (Physician)

Supervision Documentation:
I saw and evaluated the patient and agree with the resident's findings and plan. See resident's note for details.

Back pain: small compression fracture in thoracic area, but pain is low back. Doing well with chiropractic care now. Off work until January due to school break.
Anxiety, insomnia: ocular Sx possibly related to trazodone. Off of it now. Has had up to date eye exam. Ambien PRN.

Electronically signed by Andrea Martonffy I. MD at 12/18/15 1107

Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Patient Instructions

Jody C Epstein, MD at 12/18/15 1044

Status: Signed
Discuss T11 fracture with your chiropractor
Continue Flexeril (muscle relaxant) as needed
For sleep: you can continue Flexeril, try ambien again or try trazodone again and monitor for eye pain

Encounter Status

Closed by Jody C Epstein, MD on 12/18/15 at 11:07 AM

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Appointment

Result Information

Report Date and Time	Status	MyChart	Pt Viewed
3/7/2016 2:33 PM	Final result	Not Released	No

MRI THORACIC SPINE W/ O CONTRAST (Acc# UWMF22038988) (Order 234938800)

Status: Final result

Result Information

Date of Service	MyChart	Pt Viewed
3/7/2016 1:40 PM	Not Released	No

Impression

Impression:
1. Multilevel disk bulges and disk protrusions the largest is a a the level of T7-T8. Details of each level are in the body the report.
2. Chronic appearing mild compression of the T11 vertebral body.
3. On the sagittal scout image multiple disk bulges are seen in the cervical spine.

Narrative

MRI of thoracic spine.

History: Midline thoracic back pain

Comparison x-ray of the lumbar spine 12/14/2015

Sagittal and axial MR images were obtained through the thoracic spine.

Findings:

The thoracic spinal cord has normal signal. The conus medullaris terminates at the level of L1.

No acute bony abnormality is identified. There is mild anterior wedging of the T11 vertebral body which is thought to be a chronic finding given that there is no associated edema. There is a rounded area of increased T1 and T2 signal in the posterior aspect of the T11 vertebral body consistent with a hemangioma.

T2-T3 and T3-T4: There are very small left central protrusions seen on the sagittal images but not included on the axial images. There is no neural foraminal narrowing or central spinal stenosis.

T4-T5: There is no disk bulge or disk protrusion. There is no neural foraminal narrowing or central spinal stenosis.

T5-T6: There is a small left central disk protrusion causing some mild effacement of the thecal sac. There is no neural foraminal narrowing or central spinal stenosis.

T6-T7: There is some minimal central bulging of the disk. There is no neural foraminal narrowing or central spinal stenosis.

T7-T8: There is a moderate-sized posterior fairly broad-based protrusion of the disk which effaces the ventral thecal sac but does not displace the central spinal cord. There is no neural foraminal narrowing.

T8-T9: There is a very small central protrusion of the disk. There is no central spinal stenosis or neural foraminal narrowing.

T9-T10: There is a bilobed of bulge of the disk worse on the right than the left with some effacement of the right ventral thecal sac. There is no significant neural foraminal narrowing.

T10-T11: There is a small left central disk protrusion with some effacement of the thecal sac but the disk material does not touch the spinal cord. There is no neural foraminal narrowing.

T11-T12: There is no significant disk bulge or disk protrusion. There is no neural foraminal narrowing or central spinal stenosis.

T12-L1: This level was included on the sagittal images and there is some minimal bulging of the disk but no neural foraminal narrowing or central spinal stenosis.

On the sagittal scout image multiple disk bulges are seen in the cervical spine.

Electronically signed by: Elizabeth Teigen on 03/07/2016 02:33PM

Procedure Note Dx Info

Interpreting Radiologist

Signed By	Signed On
Elizabeth L Teigen, MD	Mon Mar 7, 2016 2:33 PM

Order: MRI THORACIC SPINE W/ O CONTRAST [R72146] (Order 234938800) Status: Final result

Patient Information

Patient Name	Sex	DOB
	Female	

Order Information

Date and Time	Department	Order Released By	Order Authorized By
3/7/2016 12:40 PM	ONE S PARK DIAGNOSTIC RADIOLOGY	Pamela A Christensen	Jonas J Y Lee, MD

Associated Diagnoses

Midline thoracic back pain

Order Questions

8498215 17:45

Question	Answer	Comment
Reason for Exam	Vertebral collapse, painful or hx malignancy ^3073998	
What specific question(s) would you like answered by this exam?	?pathologic fracture, nerve impingement	
Relevant recent/ past history?	bus accident, T11 wedging, persistant pain	
Is patient pregnant?	No	
Does patient have a pacemaker or defibrillator?	No	
Note: If yes, exam may not be scheduled.		
Allergy to Gadolinium (MRI) contrast?	No	
Relevant Surgical History (Select all applicable or None)	None	
Implanted Devices? (Select all applicable or None)	None	
History of Metal in Body? (Select all applicable or None)	None	
Has patient had a colonoscopy/endoscopy in the last 8 weeks?	No	
Note: If yes, please call to see if exam can be scheduled		
For Scheduling purposes, is the patient claustrophobic or require any form of sedation? Note: ordering provider is responsible for prescribing oral anxiolytic or ordering sedation services.	No	
Is the patient currently on dialysis?	No	
Note: If yes, Patient needs to be scheduled for dialysis 24 hours after MRI		
Last patient weight?	242 lbs	2/25/16
Last patient height?	5' 1"	12/14/15
(UWMF only) Does the patient have a history of cancer?	No	
(UWMF only) Previous US/CT/MR of area being imaged? Y/N (Please specify date and facility in comments box at bottom)	No	
(UWMF only) Appropriate use of contrast?	DETERMINED BY RADIOLOGIST	
Note: specify contrast instructions if needed		

Testing Performed By

Lab - Abbreviation	Name	Address
908 - MAIN	UWHC CSC LABORATORY	600 Highland Ave. Madison WI 53792

RESULTS: IMAGE

Results

X-RAY CHEST PA & LAT VIEWS DUAL ENERGY [213882438] Resulted: 05/14/15 0736, Result status: Final result

Ordering provider:	James E Svenson, MD 05/14/15 0305	Resulted by:	Jeffrey P Kanne, MD Andrew J Scarano, MD
Performed:	05/14/15 0311 - 05/14/15 0315	Collected by:	05/14/15 0324
Resulting lab:	UWHC RADIOLOGY		

Results (continued)

X-RAY CHEST PA & LAT VIEWS DUAL ENERGY [213882438] (continued) Resulted: 05/14/15 0736, Result status: Final result

Narrative:
Comparison: None

Findings: Lungs are well-expanded and clear. No pleural effusion or pneumothorax. Cardiomediastinal silhouette within normal limits.

As the teaching physician, I personally examined the radiologic study, reviewed the findings with Dr. Andrew Scarano and arrived at this interpretation.

Electronically signed by: Jeffrey Kanne on 05/14/2015 07:36AM
Impression:
Impression: Normal chest.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
59 - UWHCRADIANT	UWHC RADIOLOGY	Unknown	Unknown	07/01/11 0820 - Present

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Appointment

Result Information

Report Date and Time	Status	MyChart	Pt Viewed
12/14/2015 4:09 PM	Final result	Not Released	No

X-RAY LUMBAR SPINE 2-3 VIEWS (Acc# UWMF21931692) (Order 213882477)

Status: Final result

Result Information

Date of Service	MyChart	Pt Viewed
12/14/2015 1:08 PM	Not Released	No

Impression

IMPRESSION:
1. Mild T11 wedging of indeterminate age which was not present on 5/14/15. Further evaluation with MR may be helpful to evaluate for acuity.
2. Diffuse multilevel degenerative disk height loss and facet joint arthropathy.

Narrative

Examination: 2 view (AP, lateral) radiographs of the lumbar spine with lateral single view radiograph of the pelvis.

COMPARISON: Chest radiograph dated 5/14/15.

CLINICAL INDICATION: 37-year-old female with injury on December 2 with persistent pain including shooting pain down the left leg per chart review.

FINDINGS: When compared to 5/14/15 chest radiograph, there has been interval development of mild T11 wedging. Multilevel intervertebral disk height loss and facet joint arthropathy is present. No significant traumatic subluxation is identified. The lumbar spine, sacroiliac joints, and pubic symphysis remain in anatomic alignment.

As the teaching physician, I personally examined the radiologic study, reviewed the findings with Dr. Will Larison and arrived at this interpretation.

Electronically signed by: Kenneth Lee on 12/14/2015 04:09PM

Result Notes

Notes Recorded by Beth E Potter, MD on 12/15/2015 at 10:30 AM
Message left with patient

Procedure Note Dx Info

Interpreting Radiologist

Signed By	Signed On	Prelim By	Prelim On
Kenneth S Lee, MD	Mon Dec 14, 2015 4:09 PM	Will G Larison, MD	Dec 14, 2015

Order: X-RAY LUMBAR SPINE 2-3 VIEWS [R72100] (Order 213882477) Status: Final result

Patient Information

Patient Name	Sex	DOB
	Female	

Order Information

Date and Time	Department	Order Released By	Order Authorized By
12/14/2015 12:56 PM	ACHC WINGRA FAMILY MEDICINE CENTER	Shereen T Vakili, Rad Technologist	Beth E Potter, MD

Associated Diagnoses

Bilateral low back pain with left-sided sciatica

Order Questions

Question	Answer	Comment
What specific question(s) would you like answered by this exam?	hx of pain since 12/2/15 - low back pain radiating down left leg	
Relevant recent/ past history?	low back pain	
Is patient pregnant?	No	

Note: If yes, exam is not performed unless life-threatening.

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Appointment (EPIC MRN: , PPD MRN: , UWHC MRN:)
DOB: AGE at DOS: 37 year old, SEX: F

Result Information

Report Date and Time	Status	MyChart	Pt Viewed
1/9/2016 9:31 AM	Final result	Not Released	No

X-RAY CHEST PA & LAT VIEWS (Acc# UWMF21965062) (Order 213882484)

Status: Final result

Result Information

Date of Service	MyChart	Pt Viewed
1/8/2016 9:48 AM	Not Released	No

Impression

Impression: The lungs remain clear. No pleural effusion, pneumothorax, or pulmonary edema. The cardiomediastinal silhouette is unchanged.

Narrative

Comparison: 5/14/2015

As the teaching physician, I personally examined the radiologic study, reviewed the findings with Dr. Amanda Smolock and arrived at this interpretation.

Electronically signed by: Scott Nagle on 01/09/2016 09:31AM

Procedure Note Dx Info

Interpreting Radiologist

Signed By	Signed On	Prelim By	Prelim On
Scott K Nagle, MD	Sat Jan 9, 2016 9:31 AM	Amanda R Smolock, MD	Jan 8, 2016

Order: X-RAY CHEST PA & LAT VIEWS [R71020] (Order 213882484) Status: Final result

Patient Information

Patient Name	Sex	DOB
	Female	

Order Information

Date and Time	Department	Order Released By	Order Authorized By
1/8/2016 9:38 AM	ACHC WINGRA FAMILY MEDICINE CENTER	Shereen T Vakili, Rad Technologist	Kirsten S Rindfleisch, MD

Associated Diagnoses

Shortness of breath

Order Questions

Question	Answer	Comment
What specific question(s) would you like answered by this exam?	infiltrate?	
Relevant recent/ past history?	recnet back injury now with dyspnea on exertion	

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

CHARLES B. HARRIS
Attorney at Law
Direct (715) 808-0513
cbharris@ArthurChapman.com

April 26, 2018

[redacted]

RE: [redacted]
WI Case No: [redacted]
D/I: 2/10/2016
Our File No.: [redacted]

Dear [redacted]:

Thank you for agreeing to review this matter for me. I would appreciate it if you would review the factual information. If there is additional information you would like me to obtain for you, please let me know.

Once you have completed your investigation, there may be some more detailed information I would like to get from you. However, I'd basically like to know whether or not you are able to express an opinion as to the nature of the force of the impact between the two vehicles and the nature of the forces to which [redacted], the driver of the front vehicle, would have been subjected. Finally, I would also like to know what, if any, conclusions you might be able to reach in regards to whether or not the involved forces would be significant enough to cause any sort of physical injury to [redacted] and if so, the nature and extent of the injuries that this accident would be capable of causing.

I enclose to you the following information regarding the accident and vehicles:

1. The involved police report;
2. Four photographs of the vehicles identified as photos 1712 through 1715;
   i. Photograph 1712 is a photo taken from the rear looking forward at the trailer being pulled by [redacted] at the time of the accident.
   ii. Photograph 1713 is a photograph of the door to the vehicle to the tractor being operated by the claimant, [redacted].
   iii. Photograph 1715 is a photograph of the front license plate of the vehicle being operated by [redacted].

iv. Photograph 1714 is a photograph of the front of the vehicle being operated by [redacted]. [redacted] of [redacted]. I also attach copies of the repair information for the vehicle of [redacted].

It is my understanding that the vehicle driven by [redacted] was empty at the time of the accident and that the truck itself weighs 23,000 pounds. The truck is 35 feet long by 8 feet wide. I am informed that the weight of the tractor and trailer operated by [redacted] was 36,500 pounds and that that vehicle suffered no visible damage and had no repairs performed to it.

As far as injuries go, the claimant is claiming to have some psychological residuals from the accident. For your background information, I enclose to you the reports that have been filed with the Department to date from [redacted], claimant's psychologist. I also enclose the copy of the report from [redacted], who I asked to see the claimant. As further background, I enclose the reports of [redacted], who has filed a report at the request of claimant's counsel, as well as the reports of [redacted], who saw the claimant at the request of my clients. I also enclose a copy of a chronology entitled "Subsequent Treatment", which my office put together as a reduced summary of plaintiff's treatment after the accident. I attach with that copies of pages 137-138; 172-174 as they relate to the 2/11/2016 visit. I also attach a copy of pages 134-136 as they relate to the 2-15-2016 visit, and a copy of page 128-131 as it relates to the 2-17-2016 visit. I also attach copies of pages 88-97 as they relate to neuropsychological testing and office visit on 4-21-2016, at which time [redacted] was tending towards the view that the complaints of dizziness and off balance symptoms were likely due to frustration with pain as opposed to being caused by any possible concussion. I also attach pages 1,032-1,034 which are from [redacted]'s office visit of 5-26-2016, in which he concludes the symptoms were not really post-concussive. He noted the patient had mild pain in the cervical paraspinal muscles and that when he walked, he seemed to purposefully sway from one side to the other.

Very truly yours,

Charles B. Harris

CBH/vll
Enc.

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MINNESOTA TABLE OF RATES AND BENEFITS

MAXIMUM COMPENSATION RATE
MINN. STAT. §176.101, SUBD. 1

04/28/1957	$45.00	**10/01/1987**	$376.00
09/01/1967	60.00	**10/01/1988**	391.00
09/01/1969	70.00	**10/01/1989**	413.00
PP/TP	63.00		
09/01/1971	80.00	**10/01/1990**	428.00
PP/TP	73.00		
09/01/1973	100.00	**10/01/1991**	443.00
08/01/1975	135.00	**10/01/1992**	481.95
10/01/1975 (Dep Bens)	135.00	**10/01/1993**	508.20
10/01/1977	197.00	**10/01/1994**	516.60
10/01/1978	209.00	**10/01/1995 – 9/30/2000**	615.00
10/01/1979	226.00	**10/01/2000 – 9/30/2008**	750.00
10/01/1980	244.00	**10/01/2008 – 9/30/2013**	850.00
10/01/1981	267.00	**10/01/2013 – 9/30/2014**	963.90
10/01/1982	290.00	**10/01/2014 – 9/30/2015**	980.22
10/01/1983	313.00	**10/01/2015 – 9/30/2016**	1,008.78
10/01/1984	329.00	**10/01/2016 – 9/30/2017**	1,046.52
10/01/1985	342.00	**10/01/2017 – Present**	1,061.82
10/01/1986	360.00		

SUPPLEMENTARY BENEFITS
MINN. STAT. §176.132 AND
PERMANENT TOTAL MINIMUM
MINN. STAT. §176.101, SUBD. 4

01/01/1972	$ 60.00	**10/01/1994**	$320.00
07/01/1974	73.00	**10/01/1995**	*329.00
01/01/1975	80.00	**10/01/1996**	*341.00
01/01/1976	85.00	**10/01/1997**	*360.00
01/01/1977	91.50	**10/01/1998**	*377.00
07/01/1977	109.80	**10/01/1999**	*400.00
01/01/1978	118.20	**10/01/2000**	*418.00
01/01/1979	125.40	**10/01/2001**	*442.00
10/01/1979	135.85	**10/01/2002**	*457.00
01/01/1980	146.90	**10/01/2003**	*467.00
10/01/1980	158.60	**10/01/2004**	*481.00
10/01/1981	173.55	**10/01/2005**	*504.00
10/01/1982	188.50	**10/01/2006**	*509.00
10/01/1983	204.00	**10/01/2007**	*526.00
10/01/1984	214.00	**10/01/2008**	*553.00
10/01/1985	223.00	**10/01/2009**	*571.00
10/01/1986	234.00	**10/01/2010**	*565.00
10/01/1987	245.00	**10/01/2011**	*583.00
10/01/1988	255.00	**10/01/2012**	*596.00
10/01/1989	269.00	**10/01/2013**	*615.00
10/01/1990	279.00	**10/01/2014**	*625.00
10/01/1991	288.00	**10/01/2015**	*643.00
10/01/1992	299.00	**10/01/2016**	*667.00
10/01/1993	315.00	**10/01/2017**	*677.00

Supplementary benefits abolished for injuries occurring after 10/01/1995.

* For dates of injury after 10/01/1995, this figure is also used as the minimum rate for payment of PTD benefits.

MINIMUM COMPENSATION RATE
MINN. STAT. §176.101, SUBD. 1

07/01/1953	$17.50		
08/01/1975	$34.00 -20% of Statewide Average Weekly Wage		
01/01/1977	$36.60 -20% of Statewide Average Weekly Wage		
10/01/1977	New Computation: 50% of Statewide Average Weekly Wage or Gross Wage, whichever is **less**, but in no case less than 20% of Statewide Average Weekly Wage.		
	50%	**Gross Wage**	**20%**
10/01/1977	$98.50	$147.75	$39.40
10/01/1978	104.50	156.75	41.80
10/01/1979	113.00	169.50	45.20
10/01/1980	122.00	183.00	48.80
10/01/1981	133.50	200.25	53.40
10/01/1982	145.00	217.50	58.00
10/01/1983	156.50	234.75	62.60
10/01/1984	164.50	246.75	65.80
10/01/1985	171.00	256.50	68.40
10/01/1986	180.00	270.00	72.00
10/01/1987	188.00	282.00	75.20
10/01/1988	195.50	293.23	78.20
10/01/1989	206.50	309.75	82.60
10/01/1990	214.00	321.00	85.60
10/01/1991	221.50	332.25	88.60

(Example of application of minimum compensation rate using an injury date between 10/01/1991 and 09/30/1992: If gross wage above $332.25, use 2/3 as compensation rate, subject to the maximum. If gross wage less than $332.25, then use $221.50 as compensation rate. If gross wage less than $221.50, use actual wage as minimum. If gross wage less than $88.60, use $88.60 anyway.)

10/01/1992	New computation: 20% of Statewide Average Weekly Wage or Gross Wage, whichever is **less**.		
10/01/1992	-	-	$91.80
10/01/1993	-	-	96.80
10/01/1994	-	-	98.40
10/01/1995	New computation: statutory amount or gross wage, whichever is **less**.		
10/01/1995 - 9/30/2000	-	-	$104.00
10/01/2000 - Present	-	-	130.00

RELATIVE VALUE FEE SCHEDULE
(Effective for services provided after 10/01/1993)

10/01/1993	$52.05	**10/01/2010**	
10/01/1994	52.91	Medical; Path/Lab	67.23; 39.60
10/01/1995	54.31	Chiro; Physical Med	53.48; 52.35
10/01/1996	56.35	**10/01/2011**	
10/01/1997	59.47	Medical; Path/Lab	68.84; 40.55
10/01/1998	62.27	Chiro; Physical Med	54.76; 53.61
10/01/1999	66.14	**10/01/2012**	
10/01/2000	69.04	Medical; Path/Lab	69.87; 41.16
10/01/2001	73.13	Chiro; Physical Med	55.58; 54.41
10/01/2002	**75.18**	**10/01/2013**	
10/01/2003	75.18	Medical; Path/Lab	64.69; 55.68
10/01/2004	76.31	Chiro; Physical Med	48.83; 48.88
10/01/2005		**10/01/2014**	
Medical; Path/Lab	76.31; 63.72	Medical; Path/Lab	64.73; 55.75
Chiro; Physical Med	48.08; 66.16	Chiro; Physical Med	48.80; 48.89
10/01/2006		**10/01/2015**	
Medical; Path/Lab	76.87; 64.19	Medical; Path/Lab	65.12; 56.08
Chiro; Physical Med	55.35; 66.64	Chiro; Physical Med	49.09; 49.18
10/01/2007		**10/01/2016**	
Medical; Path/Lab	77.56; 64.77	Medical; Path/Lab	69.48; 56.70
Chiro; Physical Med	55.85; 67.24	Chiro; Physical Med	49.34; 55.57
10/01/2008		**10/01/2017**	
Medical; Path/Lab	80.74; 67.43	Medical; Path/Lab	69.62; 56.81
Chiro; Physical Med	58.14; 70.00	Chiro; Physical Med	49.44; 55.68
10/01/2009			
Medical; Path/Lab	81.63; 68.17		
Chiro; Physical Med	58.78; 70.77		

ADJUSTMENT OF COMPENSATION - MINN. STAT. §176.645

(Effective for injuries occurring **after** 10/01/1975.)

10/01/1976	7.65%	**10/01/1997**	* 5.53%
10/01/1977	6.00%	**10/01/1998**	* 4.70%
10/01/1978	6.00%	**10/01/1999**	* 6.00%
10/01/1979	6.00%	**10/01/2000**	* 4.39%
10/01/1980	6.00%	**10/01/2001**	* 5.92%
10/01/1981	6.00%	**10/01/2002**	* 3.24%
10/01/1982	6.00%	**10/01/2003**	* 2.28%
10/01/1983	6.00%	**10/01/2004**	* 3.06%
10/01/1984	5.11%	**10/01/2005**	*4.59%
10/01/1985	3.95%	**10/01/2006**	*1.03%
10/01/1986	5.26%	**10/01/2007**	*3.32%
10/01/1987	4.44%	**10/01/2008**	*5.2%
10/01/1988	3.99%	**10/01/2009**	*3.29%
10/01/1989	5.63%	**10/01/2010**	*-1.14%
10/01/1990	3.63%	**10/01/2011**	*3.23%
10/01/1991	3.50%	**10/01/2012**	*2.23%
10/01/1992	3.61%	**10/01/2013**	*3.17%
10/01/1993	* 5.45%	**10/01/2014**	*1.69%
10/01/1994	* 1.65%	**10/01/2015**	*2.91%
10/01/1995	* 2.64%	**10/01/2016**	*3.74%
10/01/1996	* 3.76%	**10/01/2017**	*1.46%

Note: For injuries between 10/01/1975 and 9/30/1981, benefits are adjusted on October 1 of each following year. For injuries on or after 10/01/1981, benefits are adjusted on each successive anniversary date of the injury. For injuries occurring 10/01/1992 and thereafter, the first adjustment occurs on the second anniversary date of the injury. For injuries occurring 10/01/1995 and thereafter, the first adjustment occurs on the fourth anniversary date of the injury. For injuries occurring 10/01/2013 and thereafter, the first adjustment occurs on the third anniversary date of the injury. Subsequent adjustments occur on an annual basis.

***Note**: For injuries from 10/01/1977 to 9/30/1992, adjustments are capped at 6%. Effective 10/01/1992, adjustments are capped at 4%. The WCCA has determined that this cap only applies to dates of injury on and after 10/01/1992. *See Charley v. FMC Corporation.* For injuries after 10/01/1995, adjustments are capped at 2%. For injuries on and after 10/01/2013, adjustments are capped at 3%, and cannot be less than 0%.

INTEREST CALCULATIONS - MINN. STAT. §176.221, SUBD. 7

Before 10/01/1995	8%
10/01/1995 8% rate repealed. Current rate may be obtained by calling Hennepin County Courts, Judgments, Civil Division at 612-348-3169.	
10/01/1995 - 12/31/1995	6%
01/01/1996 - 12/31/1998	5%
01/01/1999 - 12/31/1999	4%
01/01/2000 - 12/31/2000	5%
01/01/2001 - 12/31/2001	6%
01/01/2002 - 12/31/2002	2%
01/01/2003 - 12/31/2006	4%
01/01/2007 - 12/31/2007	5%
01/01/2008 - Present	4%

MAXIMUM REHABILITATION CHARGES

QRC		PLACEMENT VENDORS	
10/01/1993	$65.00/hr	**10/01/1993**	$50.00/hr
10/01/1994	68.72/hr	**10/01/1994**	53.00/hr
10/01/1995	70.09/hr	**10/01/1995**	53.92/hr
10/01/1996	71.49/hr	**10/01/1996**	55.00/hr
10/01/1997	72.92/hr	**10/01/1997**	56.10/hr
10/01/1998	74.38/hr	**10/01/1998**	57.22/hr
10/01/1999	75.87/hr	**10/01/1999**	58.36/hr
10/01/2000	77.39/hr	**10/01/2000**	59.53/hr
10/01/2001	78.94/hr	**10/01/2001**	60.72/hr
10/01/2002	80.52/hr	**10/01/2002**	61.93/hr
10/01/2003	82.13/hr	**10/01/2003**	63.17/hr
10/01/2004	83.77/hr	**10/01/2004**	64.43/hr
10/01/2005	85.45/hr	**10/01/2005**	65.72/hr
10/01/2006	86.33/hr	**10/01/2006**	66.40/hr
10/01/2007	88.06/hr	**10/01/2007**	67.73/hr
10/01/2008	91.00/hr	**10/01/2008**	69.08/hr
10/01/2009–09/30/2011	92.82/hr	**10/01/2009–09/30/2011**	70.46/hr
10/01/2011–09/30/2012	94.68/hr	**10/01/2011–09/30/2012**	71.87/hr
10/01/2012–09/30/2013	96.57/hr	**10/01/2012–09/30/2013**	73.31/hr
10/01/2013 – 09/30/2014	99.47/hr	**10/01/2013 – 09/30/2014**	75.51/hr
10/01/2014 – 09/30/2015	101.15/hr	**10/01/2014 – 09/30/2015**	76.79/hr
10/01/2015 – 09/30/2016	104.09/hr.	**10/01/2015 – 09/30/2016**	79.02/hr
10/01/2016– 09/30/2017	107.21/hr.	**10/01/2016 – 09/30/2017**	81.39/hr.
10/01/2017 – Present	108.78	**10/01/2017 – Present**	82.58/hr.

ECONOMIC RECOVERY COMPENSATION
MINN. STAT. §176.101, SUBD. 3a

(Effective for injuries **between** 01/01/1984 and 10/01/1995)

% OF DISABILITY	WEEKS OF COMPENSATION
0-25	600
26-30	640
31-35	680
36-40	720
41-45	760
46-50	800
51-55	880
56-60	960
61-65	1,040
66-70	1,120
71-100	1,200

IMPAIRMENT COMPENSATION
MINN. STAT. §176.101, SUBD. 3b

(Effective for injuries **between** 01/01/1984 and 09/30/2000)

% OF DISABILITY	AMOUNT	% OF DISABILITY	AMOUNT
0-25	$75,000	61-65	$160,000
26-30	80,000	66-70	180,000
31-35	85,000	71-75	200,000
36-40	90,000	76-80	240,000
41-45	95,000	81-85	280,000
46-50	100,000	86-90	320,000
51-55	120,000	91-95	360,000
56-60	140,000	96-100	400,000

PERMANENT PARTIAL DISABILITY

(Effective for injuries occurring **after** 10/01/2000)

% OF DISABILITY	AMOUNT	% OF DISABILITY	AMOUNT
0 - <5.5	$75,000	50.5 - <55.5	$165,000
5.5 - <10.5	80,000	55.5 - <60.5	190,000
10.5 - <15.5	85,000	60.5 - <65.5	215,000
15.5 - <20.5	90,000	65.5 - <70.5	240,000
20.5 - <25.5	95,000	70.5 - <75.5	265,000
25.5 - <30.5	100,000	75.5 - <80.5	315,000
30.5 - <35.5	110,000	80.5 - <85.5	365,000
35.5 - <40.5	120,000	85.5 - <90.5	415,000
40.5 - <45.5	130,000	90.5 - <95.5	465,000
45.5 - <50.5	140,000	95.5 - 100	515,000

Note: Permanent partial disability is payable upon cessation of temporary total disability. If the employee requests payment in a lump sum, then the compensation must be paid within 30 days. This lump sum payment may be discounted to the present value calculated up to a maximum five percent basis. If the employee does not request a lump sum, payment is in installments at the same interval and same amount as the employee's temporary total disability at the date of injury. Minn. Stat. §176.101, subd. 2a.

MILEAGE EXPENSES
MINN. RULE 5221.0500, SUBP. 2E

01/1/2001 - 12/31/2001	$.345 per mile
01/1/2002 - 12/31/2002	$.365 per mile
01/1/2003 - 12/31/2003	$.36 per mile
01/1/2004 - 12/31/2004	$.375 per mile
01/01/2005 - 09/01/2005	$.405 per mile or employer's rate
09/01/2005 - 01/01/2006	$.485 per mile or employer's rate
01/01/2006 - 12/31/2006	$.445 per mile or employer's rate
01/01/2007 - 12/31/2007	$.485 per mile or employer's rate
01/01/2008 – 06/30/2008	$.505 per mile or employer's rate
07/01/2008 – 12/31/2008	$.585 per mile or employer's rate
01/01/2009 – 12/31/2009	$.55 per mile or employer's rate
01/01/2010 – 12/31/2010	$.50 per mile or employer's rate
01/01/2011 – 06/30/2011	$.51 per mile or employer's rate
07/01/2011 – 12/31/2012	$.555 per mile or employer's rate
01/01/2013 – 12/31/2013	$.565 per mile or employer's rate
01/01/2014 - 12/31/2014	$.56 per mile or employer's rate
01/01/2015 – 12/31/2015	$.575 per mile or employer's rate
01/01/2016 – 12/31/2016	$.54 per mile or employer's rate
01/01/2017 – 12/31/2017	$.53.5 per mile or employer's rate
01/01/2018 – Present	$.54.5 per mile or employer's rate

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WISCONSIN TABLE OF RATES AND BENEFITS

PRIVATE REHABILITATION COUNSELOR FEE FOR SERVICES	
1994	$1,000.00
1995	$1,000.00
1996	$1,028.00
1997	$1,058.00
1998	$1,083.00
1999	$1,109.00
2000	$1,133.00
2001	$1,169.00
2002	$1,193.20
2003	$1,211.00
2004	$1,239.00
2005	$1,270.00
2006	$1,312.00
2007	$1,361.00
2008	$1,392.00
2009	$1,453.00
2010	$1,449.00
2011	$1,474.00
2012	$1,509.00
2013	$1,548.00
2014	$1,585.00
2015	$1,611.00
2016	$1,616.00
2017	$1,631.00

MILEAGE EXPENSES	
11/15/69	$.10 per mile
07/01/73	$.11 per mile
07/01/75	$.14 per mile
07/01/77	$.15 ½ per mile
07/01/78	$.17 per mile
07/01/79	$.18 per mile
07/01/80	$.19 per mile
07/01/81	$.20 ½ per mile
07/01/82	$.21 ½ per mile
01/01/91	$.24 per mile
01/01/94	$.26 per mile
01/01/98	$.29 per mile
01/01/02	$.32 ½ per mile
01/01/06	$.38 ½ per mile
05/01/06	$.42 ½ per mile
12/01/07	$.46 ½ per mile
07/01/08	$.48 ½ per mile
07/01/12	$.51 per mile

MEAL EXPENSES				
Current Rates:				
In-State			Out-of-State	
Breakfast	$ 8.00		Breakfast	$10.00
Lunch	10.00		Lunch	15.00
Dinner	20.00		Dinner	25.00
* These rates include tax and tip. The maximum allowable tip is 15% of the meal claim. ** The meal rates follow that which is allowed for state employees and changes only when state employee rates are changed.				

Effective Date	Maximum Weekly Wage For Temporary, Permanent Total & Death Benefits	Maximum Temporary, Permanent Total & Death Benefits Weekly Rate	Maximum Temporary, Permanent Total & Death Benefits Daily Rate	Maximum Wage for Permanent Partial Only	Maximum Permanent Partial Monthly Rate	Maximum Permanent Partial Weekly Rate	Maximum Payment from Children's Fund Monthly Rate	Maximum Payment from Children's Fund Weekly Rate	Death Benefits to Unestranged Parents
1/1/2004	$1,030.50	$687.00	$114.50	$348.00	$1,005.33	$232.00	$297.70	$68.70	$6,500.00
3/30/2004	$1,030.50	$687.00	$114.50	$348.00	$1,005.33	$232.00	$297.70	$68.70	$6,500.00
1/1/2005	$1,066.50	$711.00	$118.50	$363.00	$1,048.67	$242.00	$308.10	$71.10	$6,500.00
1/1/2006	$1,014.00	$676.00	$112.67	$363.00	$1,048.67	$242.00	$292.93	$67.60	$6,500.00
4/1/2006	$1,116.00	$744.00	$124.00	$378.00	$1,092.00	$252.00	$322.40	$74.40	$6,500.00
1/1/2007	$1,165.50	$777.00	$129.50	$393.00	$1,135.33	$262.00	$336.70	$77.70	$6,500.00
1/1/2008	$1,207.50	$805.00	$134.17	$393.00	$1,135.33	$262.00	$348.83	$80.50	$6,500.00
4/1/2008	$1,207.50	$805.00	$134.17	$408.00	$1,178.67	$272.00	$348.83	$80.50	$6,500.00
1/1/2009	$1,212.00	$808.00	$134.67	$423.00	$1,222.00	$282.00	$350.13	$80.80	$6,500.00
1/1/2010	$1,222.50	$815.00	$135.83	$423.00	$1,222.00	$282.00	$353.17	$81.50	$6,500.00
5/1/2010	$1,222.50	$815.00	$135.83	$438.00	$1,265.33	$292.00	$353.17	$81.50	$6,500.00
1/1/2011	$1,230.00	$820.00	$136.67	$453.00	$1,308.67	$302.00	$355.33	$82.00	$6,500.00
1/1/2012	$1,281.00	$854.00	$142.33	$453.00	$1,308.67	$302.00	$370.07	$85.40	$6,500.00
4/17/2012	$1,281.00	$854.00	$142.33	$453.00	$1,352.00	$312.00	$370.07	$85.40	$6,500.00
1/1/2013	$1,318.50	$879.00	$146.50	$483.00	$1,395.33	$322.00	$380.90	$87.90	$6,500.00
1/1/2014	$1,338.00	$892.00	$148.67	$483.00	$1,395.33	$322.00	$386.53	$89.20	$6,500.00
1/1/2015	$1,366.50	$911.00	$151.83	$483.00	$1,395.33	$322.00	$394.77	$91.10	$6,500.00
1/1/2016	$1,404.00	$936.00	$156.00	$483.00	$1,395.33	$322.00	$405.60	$93.60	$6,500.00
3/2/2016	$1,404.00	$936.00	$156.00	$513.00	$1,481.89	$342.00	$405.60	$93.60	$6,500.00
1/1/2017	$1,441.50	$961.00	$160.17	$543.00	$1,568.67	$362.00	$416.43	$96.10	$6,500.00
1/1/2018	$1,491.00	$994.00	$165.67	$543.00	$1,568.67	$362.00	$430.73	$99.40	$6,500.00

Effective Date	Maximum Burial Expense	Payment into State Fund (§102.59, Wis. Stats.)	Maximum Annual Wage (weekly wage x 50)	Maximum Death Benefit (annual wage x 4)	Maximum Payment to Spouse Monthly Rate	Maximum Payment to Spouse Weekly Rate	Payment into State Fund Total Dependency (§102.49, Wis. Stats.)	Payment into State Fund No Dependency (§102.49, Wis. Stats.) Per Installment maximum	Payment into State Fund No Dependency (§102.49, Per Installment Wis. Stats.) If Parents Receive $6,500
1/1/2004	$6,000.00	$7,000.00	$51,525.00	$206,100.00	$2,977.00	$687.00	$5,000.00	$41,220.00	$39,920.00
3/30/2004	$6,000.00	$10,000.00	$51,525.00	$206,100.00	$2,977.00	$687.00	$10,000.00	$41,220.00	$39,920.00
1/1/2005	$6,000.00	$10,000.00	$53,325.00	$213,300.00	$3,081.00	$711.00	$10,000.00	$42,660.00	$41,360.00
1/1/2006	$6,000.00	$10,000.00	$50,700.00	$202,800.00	$2,929.33	$676.00	$10,000.00	$40,560.00	$39,260.00
4/1/2006	$6,000.00	$20,000.00	$55,800.00	$223,200.00	$3,224.00	$744.00	$20,000.00	$44,640.00	$43,340.00
1/1/2007	$6,000.00	$20,000.00	$58,275.00	$233,100.00	$3,367.00	$777.00	$20,000.00	$46,620.00	$45,320.00
1/1/2008	$6,000.00	$20,000.00	$60,375.00	$241,500.00	$3,488.33	$805.00	$20,000.00	$48,300.00	$47,000.00
4/1/2008	$6,000.00	$20,000.00	$60,375.00	$241,500.00	$3,488.33	$805.00	$20,000.00	$48,300.00	$47,000.00
1/1/2009	$6,000.00	$20,000.00	$60,600.00	$242,400.00	$3,501.33	$808.00	$20,000.00	$48,480.00	$47,180.00
1/1/2010	$6,000.00	$20,000.00	$61,125.00	$244,500.00	$3,531.66	$815.00	$20,000.00	$48,900.00	$47,600.00
5/1/2010	$10,000.00	$20,000.00	$61,125.00	$244,500.00	$3,531.66	$815.00	$20,000.00	$48,900.00	$47,600.00
1/1/2011	$10,000.00	$20,000.00	$61,500.00	$246,000.00	$3,553.33	$820.00	$20,000.00	$49,200.00	$47,900.00
1/1/2012	$10,000.00	$20,000.00	$64,050.00	$256,200.00	$3,700.66	$854.00	$20,000.00	$51,240.00	$49,940.00
4/17/2012	$10,000.00	$20,000.00	$64,050.00	$256,200.00	$3,700.66	$854.00	$20,000.00	$51,240.00	$49,940.00
1/1/2013	$10,000.00	$20,000.00	$65,925.00	$263,700.00	$3,808.00	$879.00	$20,000.00	$52,740.00	$51,440.00
1/1/2014	$10,000.00	$20,000.00	$66,900.00	$267,600.00	$3,865.33	$892.00	$20,000.00	$53,520.00	$52,220.00
1/1/2015	$10,000.00	$20,000.00	$68,325.00	$273,300.00	$3,947.66	$911.00	$20,000.00	$54,660.00	$53,360.00
1/1/2016	$10,000.00	$20,000.00	$70,200.00	$280,800.00	$4,056.00	$936.00	$20,000.00	$56,160.00	$54,860.00
3/2/2016	$10,000.00	$20,000.00	$70,200.00	$280,800.00	$4,056.00	$936.00	$20,000.00	$56,160.00	$54,860.00
1/1/2017	$10,000.00	$20,000.00	$72,075.00	$288,300.00	$4,164.33	$961.00	$20,000.00	$57,660.00	$56,360.00
1/1/2018	$10,000.00	$20,000.00	$74,550.00	$298,200	$4,307.33	$994.00	$20,000.00	$59,640.00	$58,340.00