# 2019 Minnesota and Wisconsin Workers Compensation Seminar

# *2019 Minnesota and Wisconsin Worker's Compensation Seminar*

Thursday, June 13, 2019 | Oak Brook, Illinois

## Agenda

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| 7:45 - 8:15a.m. | **Registration** |
| 8:15 – 8:30 a.m. | **Welcome and Introductions** |
| 8:30 – 9:15 a.m. | **Minnesota Workers' Compensation Case Law Update – Rick Nelson and Chris Tuft**<br>This update will provide you with a review of 2018-2019 cases that impact workers' compensation claims, as well as techniques for how to utilize the results on a day-to-day basis. In addition, this course will provide an overview of legislative changes pertinent to workers' compensation. |
| 9:15 – 10:00 a.m. | **Wisconsin Worker's Compensation Case Law Update – Susan Larson**<br>This update will provided you with an overview of Wisconsin case law impacting worker's compensation claims, along with recommendations for utilizing this information in handling claims. In addition, Susan will review Wisconsin legislative changes that are significant to worker's compensation matters. |
| 10:00 – 10:15 a.m. | **Refreshment Break** |
| 10:15 – 11:15 a.m. | **QRC's Gone Wild? Developing an Understanding of Minnesota Statutory Vocational Rehabilitation - Rob Otos**<br>This program will help the participant develop an understanding of Minnesota Statutory Vocational Rehabilitation (QRC) service, Disability Case Management Services and the difference between the two. Additionally, we will discuss the nuances of Minnesota rehabilitation, and what adjusters and employers can do to be an active participant in the process. |
| 11:15 – 11:45 a.m. | **Tips and Techniques for Managing Vocational Rehabilitation in Minnesota – Ray Benning**<br>This presentation will address selection to termination of QRC services and your rehabilitation plan obligations from opening to closure. Ray will discuss coordinating the relationship between Employer, Insurer/TPA and Employee to maximize outcomes and manage expenses. |
| 11:45 – 12:00 p.m. | **Questions and Answers** |
| 12:00 – 1:00 p.m. | **Lunch** |
| 1:00 – 2:00 p.m. | **Don't SHOULDER the Burden of KNEEDLESS Workers' Compensation Claims – Dr. Summerville**<br>Dr. Summerville brings a primer on compensable and non-compensable shoulder and knee disorders and injuries in the workplace. He will share personal experience and practice patters as a guide to medicolegal medicine. He will also discuss case examples and their various outcomes. |
| 2:00 – 2:30 p.m. | **Updates on Complex Medical Issues in Minnesota and Wisconsin Workers' Compensation: Medical Marijuana, TBIs, Concussions, PTSD and Opioids – Jim Pikala and Susan Larson**<br>Jim and Susan will focus on some of the most challenging and costly medical causation and treatment issues encountered in workers' compensation cases, including medical marijuana, TBI/concussions, opioids and PTSD. |
| 2:30 – 2:45 p.m. | **Questions and Answers** |

# Arthur Chapman

## Workers' Compensation Team

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ROBERT OTOS
MA, OTR/L, CDMS, SHRM-CP
Chief Human Resource Officer
St. Louis Park, MN 55426

**Credentials**

Bachelor of Arts in Health Science, College of Saint Scholastica
Master of Arts in Occupational Therapy, College of Saint Scholastica
Registered/Licensed Occupational Therapist
Qualified Rehabilitation Consultant (inactive)
Certified Disability Management Specialist
Society of Human Resource Management- Certified Professional

**Professional Experience**

Senior Vice President of Operations, ALARIS/Paradigm Complex Care Solutions 2017-present

- Responsible for the strategic leadership of the field case management services
- Responsible for the development and achievement of the field case management financial plan, including revenue and profitability goals
- Provide leadership to the regional Directors to develop and achieve the strategic goals of their regions
- Responsible for revenue and productivity optimization across the field case management division.
- Provide leadership development to all operational managers and directors
- In collaboration with the CEO and CFO, develop the financial plan for the field case management divisions.
- Collaborate with all members of the senior executive team as needed to develop strategy and to promote cross functional implementation of operations initiatives and operational support of other team's strategic initiatives
- Promote and support the Quality Management Program across the field case management operations
- Strongly support and promote the enterprise culture across the field case management divisions.

Chief Human Resource Officer, The ALARIS Group, Inc.® 2014-2017

- Develop and implement HR strategies that support the organizations mission, vision, core values and strategic plan
- Develop and implement the strategic recruitment and retention plan to support the talent needs of the organization within each department
- Develop and implement a cost-effective comprehensive benefits and compensation plan for the talent within the organization
- Develop, implement and monitor all corporate training initiatives
- Develop and implement any local or federal governmental affairs program as needed, as well as track any state or federal initiatives that may impact the organization
- Facilitate the Performance Management process with managers and supervisors in a way that can effectively monitor employee performance and engagement
- Evaluate employee engagement on a continual basis to determine the health and well being of the corporate culture, mission, vision and core values
- Develop and lead corporate social media initiative to promote means of internal and external communications
- Manage and understand any applicable departmental audit reviews
- Fulfill the Senior Clinical Staff responsibility to validate that qualified case managers are competent and accountable for decisions affecting consumers

Vice President Corporate Relations: The ALARIS Group, Inc.® 2012 - 2014

- Developed and implemented HR strategies that support the overall success of the organization
- Established HR plans that supported the organizations mission, vision and core values
- Developed and implemented the strategic recruitment and retention plan to support the talent needs of the organization within each department
- Developed and implemented a cost-effective and comprehensive benefits and compensation plan for the talent within the organization
- Developed, implemented and monitored all corporate training initiatives
- Developed and implemented any local or federal governmental affairs program as needed, as well as tracked any state or federal initiatives that may impact the organization
- Facilitated the Performance Management process with managers and supervisors in a way that could monitor employee performance as well as engagement
- Evaluated employee engagement on a continual basis to determine the health and well being of the corporate culture, mission, vision and core values
- Developed and led corporate social media initiative to promote means of internal as external communications

Director of Operations, MN, CO, NM, El Paso, The ALARIS Group, Inc.®, 2002- 2012

- Hired, trained and mentored new case managers in Statutory Vocational Rehabilitation and Disability Case Management processes, techniques and application
- Oversaw expansion into new territories to insure success
- Provided Information Technology training and support
- Managed daily operations of the case management product in Minnesota, Colorado, New Mexico and El Paso, Texas
- Managed case management staff and supervisors in assigned geographical areas
- Managed and fostered the staff development program at The ALARIS Group, Inc.®
- Provided support for business growth, human resources, marketing/sales and internal operations in Minnesota
- Continued to function as a case manager in a limited capacity and lead the Ergonomic Team

Case Manager, The ALARIS Group, Inc.®, 2000 - 2016

- Provided Statutory Vocational Rehabilitation services to claimants within the Minnesota workers compensation system
- Provided case management services within Minnesota and Wisconsin for workers compensation, short-term disability auto cases and catastrophic case management
- Provide expert testimony for litigated rehabilitation files
- Developed and implemented ergonomic and job analysis program
- Ergonomic expert for The ALARIS Group, Inc.®
- Developed and implement return to work plans for injured workers
- Consultant for job analysis and return to work programs for employers

Case Manager, Concentra Manager Care, 1997 - 2000.

- Designed, negotiated and implemented return-to-work plans for injured workers
- Provided vocational and medical case management services to claimants within the workers compensation system Minnesota and Wisconsin

- Provided vocational and medical case management in long and short-term disability auto cases and catastrophic case management
- Designed and implemented ergonomic and job analysis program

Staff Occupational Therapist, Iron Range Rehabilitation Center, 1997- 1997

- Worked with acute inpatient, home health, outpatient, workers compensation and job site analysis

**Professional Associations**

Minnesota Association of Rehabilitation Providers
Board Member 2004-2012
Annual Conference Representative 2005-2006
Board Member, Membership 2006-2008
President 2009-2010
International Association of Rehabilitation Providers
IARP Annual Conference Committee Member 2005-2006

**Professional Committees**

Minnesota RTW/SAW Summit Sponsorship Chair
Labor Management Policy Committee- MN Chamber of Commerce
Health Policy Committee Chair- MN Chamber of Commerce
Minnesota Health Care Exchange Measurement and Reporting Technical Task Force

**Boards**

SFM Foundation/Kids Chance of America MN/IA
Kids Chance of America National- Marketing Committee Member
St Louis Park Hockey Association
St. Louis Park Youth Football Association

**Accomplishments/Awards**

2010 Best Places to Work #11 Small Business Category
2011 Top Workplaces, Star Tribune #5 Small Business Category
2012 Top Workplaces, Star Tribune #8 Small Business Category
2011-2012 Leadership MN- MN Chamber of Commerce

**CURRICULUM VITAE**

**BRUCE C. SUMMERVILLE, M.D.**
Illinois Bone and Joint Institute, LLC

| | | |
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| 350 S. Greenleaf, Ste 405<br>Gurnee, IL 60031 | 101 Waukegan Rd, Ste 990<br>Lake Bluff, IL 60044 | 1025 Red Oak Ln, Ste 100<br>Lindenhurst, IL 60046 |

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**EDUCATION:**

**Undergraduate:** Northwestern University, Evanston, IL 9/81 - 6/85

**Graduate:** Rush Medical College, Chicago, IL 8/86 - 6/90

**Post Graduate:** General Surgery Internship
Northwestern University, Chicago IL 6/90 - 6/91

Orthopaedic Surgery Residency
Northwestern University, Chicago, IL 6/91 - 6/95

**Fellowship Training:** Orthopaedic Adult Reconstruction/Total Joint Replacement
Thomas Jefferson University, Philadelphia, PA 8/95- 8/96

**CERTIFICATION AND LICENSE:**

American Board of Orthopaedic Surgeons 1999, Recertified 2008

Diplomate National Board of Medical Examiners

Illinois Medical License, May 1994

Certified in the AMA Guides to the Evaluation of Permanent Impairment 6$^{th}$ Edition by the AADEP, March 14, 2012

Wisconsin Medical License, September 2014

**EMPLOYMENT:**

Elmhurst Clinic
172 Schiller Street
Elmhurst, IL 60126
630-834-1120
8/96 to 3/99

Illinois Bone and Joint Institute
(Formerly Lake Shore Orthopaedics & Sports Medicine, S.C.)
350 South Greenleaf Avenue, Suite 405
Gurnee, Illinois 60031
847-336-3335
4/99 to Present

**HOSPITAL APPOINTMENTS:**

Hawthorn SurgiCenter, Libertyville, IL
Northwestern Lake Forest Hospital, Lake Forest, IL
VISTA Health Systems, Waukegan, IL

United Hospital System, Kenosha WI
(October 2014 through January 2015)

**SOCIETY MEMBERSHIPS:**

American Academy of Orthopaedic Surgeons (AAOS)
American Association of Hip and Knee Surgeons (AAHKS)
Lake County Medical Society
American Medical Association (AMA)

**ACTIVITIES & INTERESTS:**

Medical Director VISTA Joint and Orthopedic Center
Waukegan High School Team Physician, Waukegan, IL
Zion-Benton High School Team Physician, Zion,IL
Chicago Bears Football assistant examiner, Lake Forest, IL; 1995
NBA Combine assistant and site physician, Chicago, IL; 1994
Midlands Wrestling Tournament site physician, Evanston, IL; 1993
Shoot the Bull 3-on-3 Tournament site physician, Chicago, IL; 1992-93

**RESEARCH AND PRESENTATIONS:**

"Latest Approaches in Hip and Knee Replacement", Presented February 2009 VISTA Health Systems, Waukegan, IL

"Innovations and Advances in Hip and Knee Replacement", Presented April 2008 Lake Forest Hospital, Lake Forest, IL

"What's New in Arthritis Treatment", Presented May 2006 Highland Park Senior Center, Highland Park, IL

"Treatment of Arthritis in the 21st Century", Presented April 2006 Lake Forest Hospital, Lake Forest, IL

"Treatment of Arthritis in the 21st Century" Presented February 2006 Vista Community Health, Lake County, IL

The Female Athlete. Presented 5/19/98 as part of the Community Education Series at Elmhurst Memorial Hospital.

Bone and Joint Disease Seminar. Presented 4/2/97 as part of the Community Education Series at Elmhurst Memorial Hospital.

Acute Management of Cervical Spine Injuries. Presented 3/25/97 as part of the Trauma Series Lectures at Elmhurst Memorial Hospital.

Summerville, BC; Goldstein, WM; Comparison of an Inset v. Resurfacing Patella in Total Knee Arthroplasty. Scientific Exhibit AAOS 1996.

Summerville, BC; Goldstein, WM; Clinical Comparison of an Inset v. Resurfacing Patella in Total Knee Arthroplasty. Poster Exhibit AAOS 1996.

Tanner, CM; Summerville, BC, et al; Dietary Antioxidant Vitamins and the Risk of Developing Parkinson's Disease. Poster Exhibit AAON 1989.

**REFERENCES:** Available Upon Request.

# ...Did you Know?

## Myotomes:
## The Relationship between the Spinal Nerve and Muscles

Each muscle in the body is supplied by a particular level or segment of the spinal cord and by its corresponding spinal nerve. The muscle and its nerve make up a myotome. This information is approximately the same for every person.

**C3, 4 and 5** supply the diaphragm (the large muscle between the chest and the belly that we use to breathe).

**C5** also supplies the shoulder muscles and the muscle that we use to bend our elbow.

**C6** is for bending the wrist back.

**C7** straightens the elbow.

**C8** bends the fingers.

**T1** spreads the fingers.

**T1-T12** supplies the chest wall and abdominal muscles.

**L2** bends the hip.

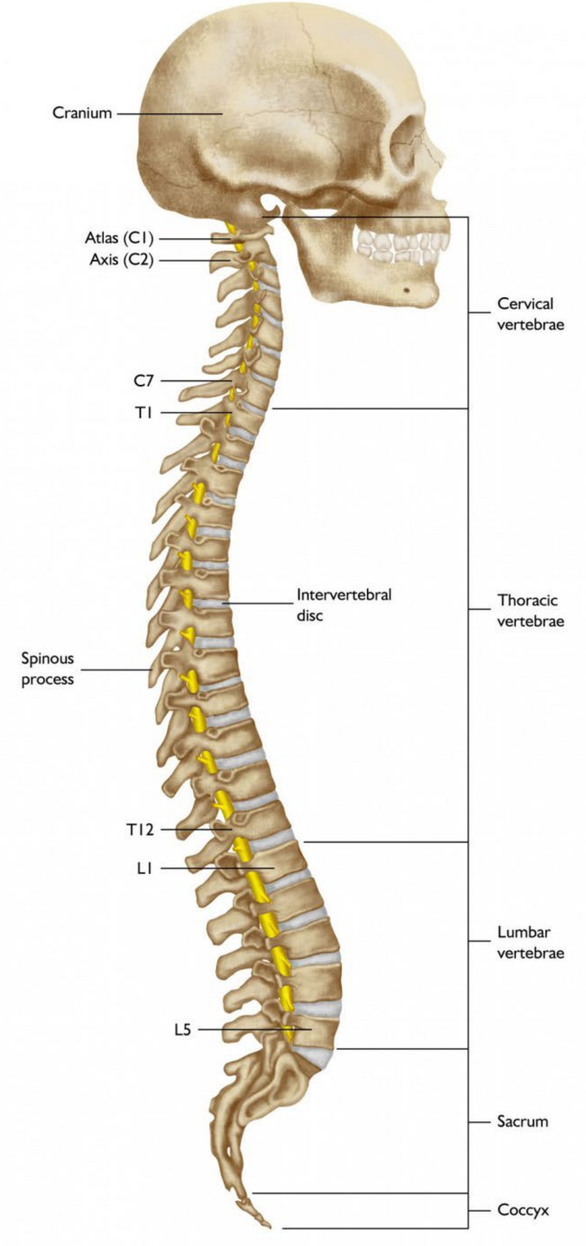
**L3** straightens the knee.

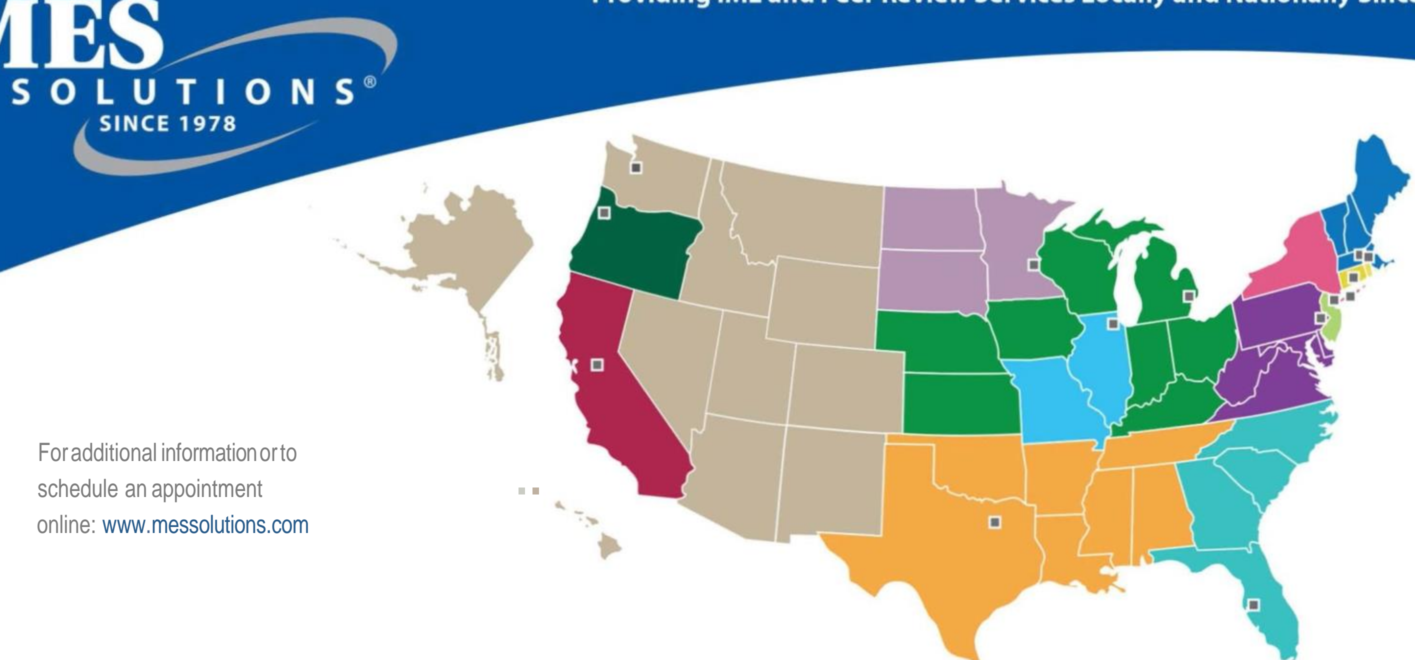
**L4** pulls the foot.

**L5** wiggles the toes.

**S1** pulls the foot down.

**S3, 4 and 5** supply the bladder, bowel, sex organs, and the anal and other pelvic muscles.



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### Southwestern Region

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### Midwestern Region

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### Eastern Region

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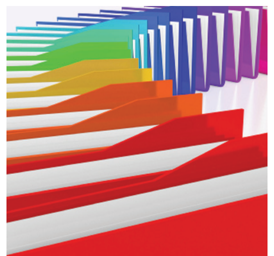
**Get started…move the work from your desk to ours!**

## *What happens after I make an IME referral to MES Solutions?*



The processing of your referral begins **within 24 hours** of receipt.

- MES collects the medical records from you, sorts and organizes your file and prepares it for the IME physician's office.
- MES handles all pre-payments required by the physician prior to the IME.
- MES processes and mails all appointment notification letters to the injured party or their attorney via your preferred mailing service: USPS Regular Mail, Certified Receipt, FedEx or UPS. Overnight services are available.
- MES prepares a physician cover letter on our letterhead outlining in detail the reasons for the examination including your specific questions.
- MES calls the injured party or their attorney 48-72 hours prior to the exam and reminds them of the examination date, time and location. In addition, MES can:
  - Process mileage reimbursement checks upon request;
  - Arrange transportation and translation services; and
  - Coordinate overnight lodging.
- Show or No-Show Confirmation: MES confirms with the examining physician's office if the injured party attended the IME. Once we know, you are notified.
- Procurement of the completed IME report: MES follows-up daily with the examining physician's office to obtain the completed report.
- Quality Control: Once MES receives the report, it is scrutinized for quality and accuracy through our Quality Assurance process. If the physician's report requires clarification, MES will work directly with the examiner to resolve them.

- **Payment and Invoicing:** You pay one invoice for all services rendered and only when the IME report is delivered to your desk!

Another benefit: Your choice of referral method via the web, e-mail, phone or fax.

***Setting the Standard for IME and Peer Review Services Nationwide***

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Consult the checklist below to identify common issues that an independent medical evaluation can address.

## Physician and Allied Healthcare Professional

- Extensive duration of treatment that remains constant in terms of modality, type, frequency, duration, and approach
- No improvement or worsening in symptoms reported
- No clear treatment plan submitted; no clear definition of diagnosis and/or prognosis
- No expected case resolution discussed by treating physician or claimant
- Lack of correlation between reported subjective complaints/symptoms and documented objective findings
- Unexplained gap in treatment
- Suspicion of a psychological overlay; reports of high stress level, depression, marital difficulties, family problems, etc., in conjunction with medical issues
- Lack of correlation between accepted diagnosis and appropriate medical specialty
- Lack of timely referral for required secondary medical consultation
- Claimant receiving treatment methods not commonly accepted by medical community
- Need for an independent reading of radiological studies
- Lack of cooperation from providers in regard to case update, submission of progress reports, etc.
- Treatment by a pain management specialist within first 6-8 weeks
- Continued treatment with opioid analgesics and muscle relaxants beyond Official Disabilities Guidelines (ODG) recommendations. See: www.disabilitydurations.com

## Claimant

- Claimant visiting many different providers or quickly switching providers within a short duration
- Claimant refusing diagnostic testing
- Claimant's noncompliance with recommended treatment
- Suspicion of malingering: The physician is able to administer specific tests to detect exaggerating during the course of an independent evaluation.
- The claimant has seen several different providers of either the same or varying specialties, whose diagnosis differ and/or conflict.
- The claimant's current medical status needs to be determined
- A need for validation of diagnosis rendered, based on individual case dynamics and symptoms reported
- Failure to return to work (RTW) within Medical Disability Advisor (MDA) time frames www.mdguidelines.com
- High risk claims: lumbar spine and multiple body areas
- Claimant non-compliance with scheduled provider visits
- Treatment by numerous physicians or increasing number of specialist referrals
- Polypharmacy: Claimant on numerous medications
- History of frequent injury claims and recurrent similar injuries
- Significant pre-existing conditions and/or co-morbidities
- Pain behaviors reflected in treatment notes
- Frequent emergency room visits
- Emergence of psychiatric issues within first six weeks post injury such as depression and anxiety

## Testing

- Excessive diagnostic testing
- Diagnostic tests do not support diagnosis; Subjective complaints not supported by objective findings.

## Surgery

- Excessive diagnostic testing
- Diagnostic tests do not support diagnosis; Subjective complaints not supported by objective findings.

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# 2019 Minnesota and Wisconsin Workers Compensation Seminar

June 13, 2019

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

## Agenda

- Minnesota Workers' Compensation Case Law Update
- Wisconsin Worker's Compensation Case Law Update
- QRC's Gone Wild? Developing an Understanding of Minnesota Statutory Vocational Rehabilitation
- Tips and Techniques for Managing Vocational Rehabilitation in Minnesota
- Don't Shoulder the Burden of Kneedless Workers' Compensation Claims
- Updates on Complex Medical Issues in Minnesota and Wisconsin Workers Compensation



## Minnesota Workers' Compensation Case Law Update

Richard C. Nelson

Christine L. Tuft

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

## Questions?

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Christine L. Tuft
612 375-5923
CLTuft@arthurchapman.com



# Wisconsin Worker's Compensation Law Update

Susan E. Larson

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

Paradigm MES Solutions Since 1978

## Bad Faith

*Andres v. County of Juneau c/o Minute Men HR Management of Wisconsin, Inc.*, Claim No. 2006-033350 (LIRC April 9, 2019)

## Bad Faith

*Tomasini v. Classic Concrete*, Claim No. 2016-014312 (LIRC November 20, 2018)



## Claim and Issue Preclusion

*Russell v. Trek Bicycle Corp.,* Claim No. 2016-008163 (LIRC August 31, 2018)



## Disfigurement

*Vang v. Pro Metal Works,* Claim No. 2014-00776 (LIRC October 31, 2018)

## Employment Relationship

*Glowacki v. Lakeview Neurorehab Center Midwest,* 383 Wis. 2d 602 (Wis. Ct. App. 2018) (unpublished)



## Evidence

*Rowe v. Milwaukee Transport Service, Inc.,* Claim No. 2015-029225 (LIRC April 26, 2019)



## Exclusive Remedy

*Payton-Myrick v. Labor and Industry Review Commission*, 384 Wis. 3d 270 (Wis. Ct. App. 2018)(unpublished)

## Loss of Earning Capacity

*William Hyde v. LIRC, Daimler Chrysler Motors Company*, 382 Wis. 2d 832 (Wis. Ct. App. 2018)(unpublished)

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## Medical Issue (Narcotics)

*Liegakos v. Old Carco, LLC*, Claim No. 1999-062505 (LIRC July 31, 2018)

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## Medical Treatment

*Forster v. AIF Leasing, LLC*, Claim No. 2010-019559 (LIRC January 31, 2019)

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## Mental Injury

*Mattson v. Aurora Healthcare, Inc.*, Claim No. 2015-011429 (LIRC June 29, 2018)



## Occupational Injury

*Suprise v. Pierce Mfg., Inc.*, Claim No. 2016-030358 (LIRC July 31, 2018)



## Occupational Injury

*Posey v. Reindl Bindery, Co, Inc.*, Claim No. 2017-017096 (LIRC March 11, 2019)

## Penalty

*Rouse III v. Milwaukee Transport Services Inc.,* Claim No. 2013-013536 (LIRC August 31, 2018)



## Permanent Partial Disability

*Overman v. Marinette Marine Corp.*, Claim No. 2016-008107 (LIRC January 31, 2019)



## Permanent Total Disability

*Barnes v. Bremner Food Grp, Inc.*, Claim No. 2015-010274 (LIRC June 19, 2018)

## Retraining

*Karpes v. Tradesman Int'l, Inc.*, Claim Nos. 2013-027630, 2015-000831 (LIRC June 19, 2018)



## Standard of Review

***Tetra Tech EC, Inc. v. Wisconsin Department of Revenue,*** **382 Wis. 2nd 496 (Wis. 2018)**



## Standard of Review

***Wisconsin Bell, Inc. v. LIRC and Charles E. Carlson,*** **283 Wis. 2d 624 (Wis. 2018)**

## Unreasonable Refusal to Rehire

*Riech v. SM & P Utility Resources, Inc.*, Claim No. 2016-029538 (LIRC November 30, 2018)



## Unreasonable Refusal to Rehire

*Torres v. RP's Pasta Co.*, Claim No. 2015-027890 (LIRC November 30, 2018)



## Questions?

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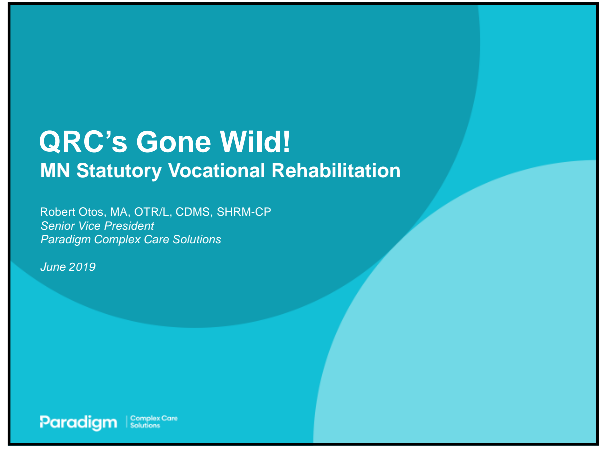


## What will you learn today?

- Statutory Vocational Rehabilitation Services vs Disability case management services
- Form, Form and more Forms
- Vocational Services- Placement and Retraining
- Why can't you just.....Misc Topics
- Cost, and how you can control them
- Questions

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## Evolution of DCM and Statutory Vocational Rehabilitation

Prior to 1979, vocational rehabilitation was provided by counselors from the State of MN.

Case managers worked for insurance companies in the private sector.

The creation of the QRC designation occurred in 1979.

Mandatory rehabilitation prior to 1992:

- Referral to QRC within 30 days for a back claim.
- Referral to QRC within 60 days for a non-back claim.
- No definition of Qualified Employee.
- Employee choice.
- 85% of filed plans returned employee to pre-injury employer.

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## Evolution of DCM and Statutory Vocational Rehabilitation

In 1992 the Minnesota Department of Labor and Industry developed and passed new rehabilitation rules.

Referral to QRC at 13 weeks of temporary total disability, or if temporary disability is expected to exceed 13 weeks. (Tracked through Disability Status Report).

Employee must be a "Qualified Employee"
- Cannot or probably cannot return to the former job, and
- Can reasonably be expected to return to suitable employment through provision of rehabilitation services, or
- Cannot reasonably be expected to return to suitable employment with the date-of-injury employer without rehabilitation services.

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## Evolution of DCM and Statutory Vocational Rehabilitation

- Due to changes, most employees were found to be ineligible for Statutory Vocational Rehabilitation.
- Decrease in rehabilitation plans by 85%.
- Rule change came as an effect of an insurer outcry - had little control of rehabilitation services, as it was the employee's choice.
- Insurers and case management firms knew the benefits of effective case management, thus the evolution of the Disability Case Manager.
- The MN DOLI stated that the rules were to be "interpreted" differently. Most employees should be determined eligible for Statutory Vocational Rehab services.
- In 1997 the MN DOLI indicated that the rule change in 1992 gave an "unanticipated outcome" of the evolution of the unregulated industry of Disability CM.

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## Definitions

**Statutory Rehabilitation Services:**

A program of vocational rehabilitation, including medical management, designed to return an injured worker to work consistent with Minnesota Statutes, section 176.102, subd. 1, paragraph (b).

**Disability Case Management**

Process by which an agent of the insurer/employer assists the injured worker in the coordination of medical care and actively pursues a safe, timely, and cost-effective return to work with the pre-injury employer.

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## Services

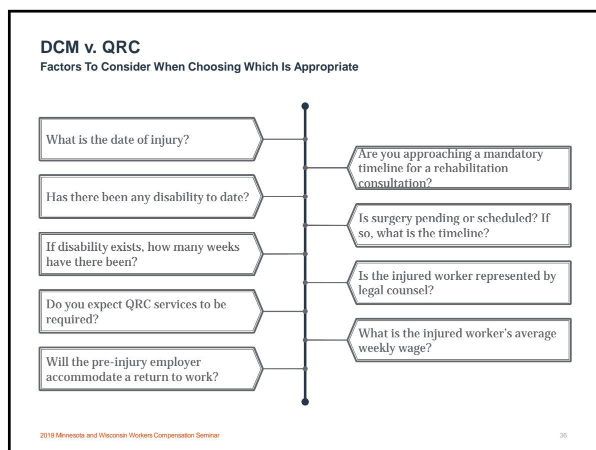
| QRC Services | DCM Services |
|---|---|
| Medical case management | Medical case management |
| Return to work coordination | Return to work coordination |
| Job analysis | Job analysis |
| Job modification | Job modification |
| Transferable skills analysis | Ergonomic consultation |
| Job placement/development | Medical record reviews |
| Job seeking skills training | Life care planning |
| Vocational counseling/guidance | |
| Vocational testing | |
| Labor market survey | |
| Retraining | |
| Vocational expert testimony | |

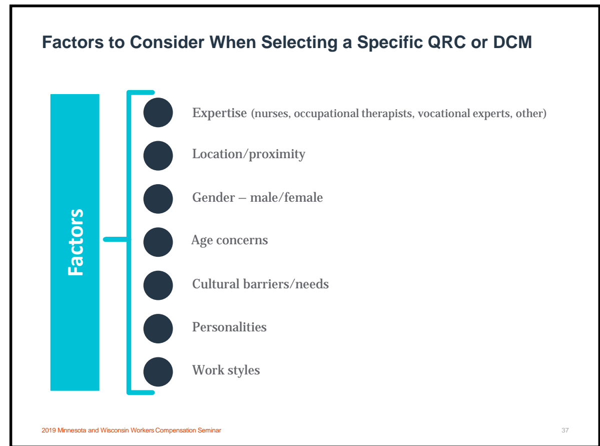


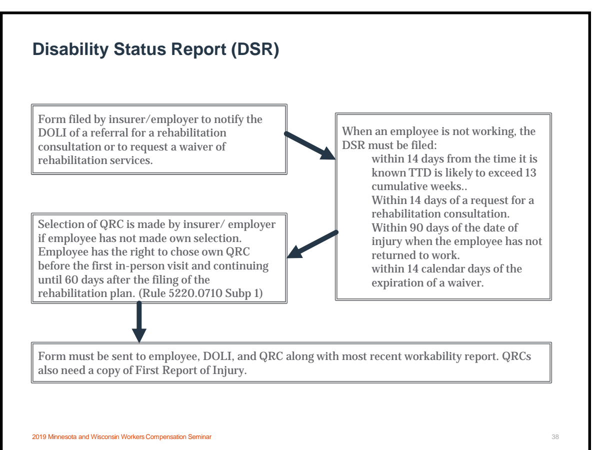
## Comparisons

| QRC Services | DCM Services |
|---|---|
| Regulated by DOLI pursuant to MS176.102; defined by MN Rules Chapter 5220. | NOT regulated by DOLI. |
| Criteria for eligibility. | No criteria for eligibility. |
| Injured worker has limited right to make selection of QRC provider. | Employer/insurer makes selection of DCM provider. |
| QRC must remain objective. | DCM works as agent of employer/insurer. |
| Services provided under a formal plan agreed upon by all parties. | No formal plan required; can be limited or task based assignments. |
| Injured worker required to cooperate with formal plan. | Injured worker not required to cooperate with DCM. |
| Certain criteria must be met prior to file closure. | File can be closed at any time. |
| Fees regulated by statute. | Fee set by market conditions. |








### Disability Status Report (DSR)

Waiver of rehabilitation may be requested in lieu of rehabilitation consultation if return to work is imminent. Documentation of job offer and workability report must be included. DOLI reviews and determines if waiver is appropriate. (Refer to Rule 5220.0120)

↓

A waiver is granted when the employer documents that the otherwise qualified employee will return to the date-of-injury job or other suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for the waiver is filed. The waiver shall not be effective more than 90 calendar days after the waiver is granted. A waiver of consultation and rehabilitation services may not be renewed.

↓

If 90 calendar 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.

↓

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.

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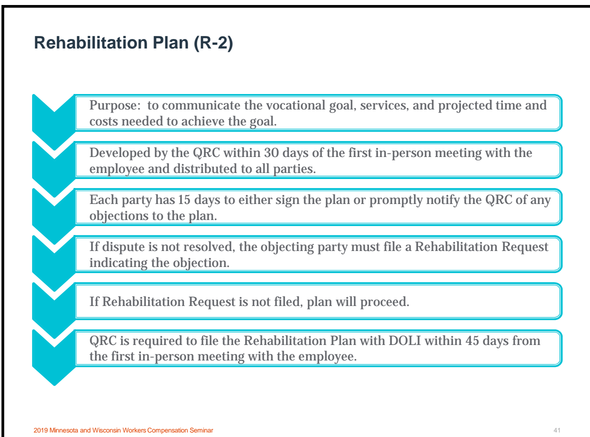
## Rehabilitation Consultation

- A meeting of the employee and the QRC to determine whether the employee is qualified to receive rehabilitation benefits considering the treating physician's opinion of the employee's work ability.
- Qualifying criteria as set forth in MN Rule 5220.0100, Subp. 22:
  - Employee is or is likely to be permanently precluded from employee's usual and customary job or job held at the time of injury.
  - Employee cannot reasonably be expected to return to suitable gainful employment with date-of-injury employer.
  - Employee can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services.
- QRC Actions:
  - Review DSR, First Report and medical information.
  - Must meet with employee to explain rights & responsibilities (including right to choose QRC) and gather information to determine eligibility.
  - Determine eligibility based on MN Rule 5220.0100, Subp. 22.
  - Complete a Rehabilitation Consultation Report and file with all parties within 14 days of in-person meeting with employee.



## Rehabilitation Plan (R-2)





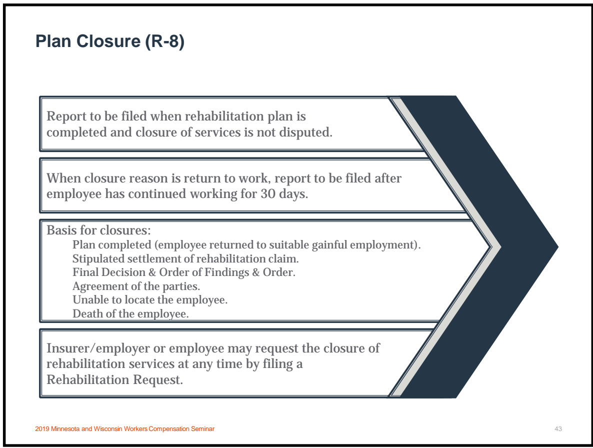

## Plan Amendments (R-3)

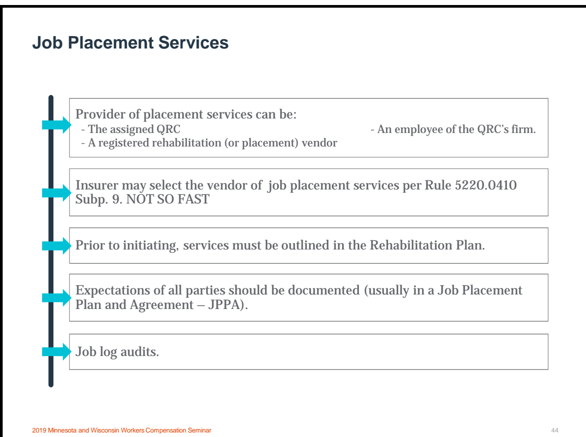
Plans can be amended for good cause which can include but are not limited to:

- New restrictions that interfere with current plan.
- Employee is not participating effectively.
- Change of vocational goal.
- Change in projected time frame or costs.
- Employee feels ill-suited for type of work in plan (may be requested once).
- Change of QRC.

Process for development and filing is similar to Rehabilitation Plan (R-2).

If dispute over amendment cannot be resolved, objection must be filed on Rehabilitation Request.




## Retraining

MN Rule 5220.0750, Subp. 1: The purpose of retraining is to return the employee to suitable 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.

Insurer must notify employees of their right to request retraining prior to 80 weeks of combined temporary disability.

Employee requests for retraining consideration must be made:
- prior to 104 weeks of combined temporary disability (TTD + TPD) for injuries occurring between October 1, 1995 and October 1, 2000.
- prior to 156 weeks of combined temporary disability (TTD + TPD) for injuries occurring on or after October 1, 2000.
- Prior to 208 weeks of combined temporary disability (TTD + TPD) for injuries occurring on or after October 1, 2008.
  - Hallum v Potlatch

Retraining is limited to 156 weeks (based on school calendar).

Poole factors.

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## Employer/Insurer Obligation for Retraining Notification

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.

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## Miscellaneous Topics

**QRC's Role in the IME Process**

- Required to follow the recommendations of the treating physician.
- Required to maintain "separate roles and functions" from that of a claims agent per MN Rule 5220.1801, Subp. 8. (e.g., cannot arrange or attend IMEs).
- Shall engage only in activities designated in MS 176.102.

**File Closures**

- Upon plan completion (return to suitable gainful employment).
- Per stipulated settlement of rehabilitation claim.
- Per Final Decision & Order or Findings & Order.
- Per agreement of the parties.
- Unable to locate the employee-diligent effort.
- Death of the employee.

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## Miscellaneous Topics Continued

- Objectivity of QRCs.
- Services available to a qualified dependent surviving spouse upon request.
- Independent vocational evaluations.
  - Allowed on cases in litigation or when retraining is at issue
- Only one QRC can perform services on each file (exceptions).
- Relocation of employee.

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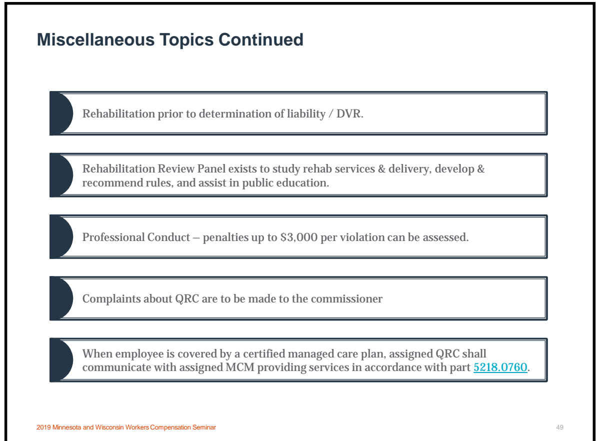


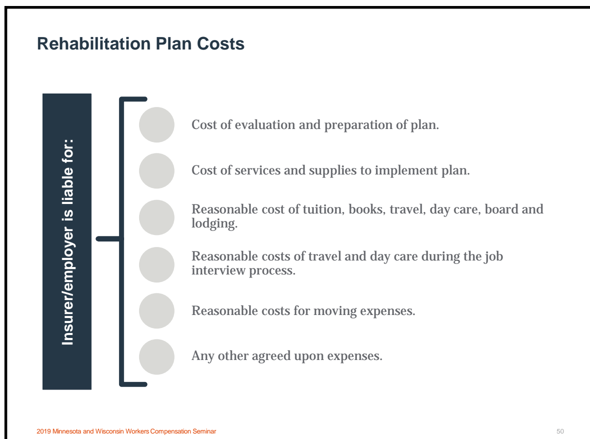


### Fees are Controllable

- Employer is not liable for charges unless a bill is received within 45 days of services.
- Job placement has limitations as well: Job development is limited to 26 weeks and 20 hours/month
- QRC can not bill more than 8 hours for the consultation, inclusive of the development and filing of the plan. MR 5220.1900 subp 6b
- QRC cannot bill more than 2 hours time in a 30 day period when Job Placement is provided by someone other than the QRC. Approval of the insurer is needed for additional time, or approval by the commissioner or compensation judge. MR 5220.1900 Subp6a
- Travel by the QRC over 50 miles to visit the employee, employer, or HCP, not allowed without consent of the parties or determination by compensation judge. MR 5220.1900 Subp 6b

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## Statutory Rehabilitation Rates
**(effective 10/1/18)**

| Service | Rate |
|---|---|
| QRC Professional time | $106.19/hour |
| QRC Travel | $79.64/hour |
| QRC Wait time | $54.39/hour |
| QRC-Intern Professional time | $96.19/hour ($10.00 < QRC rate) |

**Notes:**

QRCs limited to 2 6 hours of billable time in any 30 day calendar period when placement activities. EXCLUDING travel and wait time
- ▹ Additional may be requested by QRC and can be authorized by adjuster. Good issue to discuss upon initiation of placement.

Rates are adjusted on 10/1 each year pursuant to MS 176.645.



## Rates Continued

| Service |
|---|
| Placement Services effective 10/1/18:<br>Placement time = $85.06<br>Rates are adjusted on 10/1 each year pursuant to MS 176.645. |
| Disability Case Management<br>Rates are set by market conditions. |



## Rates Continued

Data tracked for outcomes is primarily as a result of Statutory Vocational Rehabilitation - compiled by MN DOLI.

Average case cost in 2014- $8450.

Time from DOI to start of Rehabilitation in 2014 – 5.5 months.

Service duration in 2014 – 13.2 months.

Return to work outcomes:
- 40.2% - job with same employer.
- 16.8% - job with different employer.
- 42% - “JOB NOT REPORTED”

Best outcomes come from early intervention.

Coordinate appropriate medical services and referral from the onset of the injury.

Promote early RTW.

Build a rapport early on with the employee.

Front line management

## Case Example

Tom is a 44 year old employee with a history of a right knee injury. Tom was working as a farm laborer, when he was kicked by a cow on 2/23/00 causing the injury. The employee and insurer were told that the pre-injury employer would not be returning the employee to work. This case was sent for a Rehabilitation consultation on 6/29/00. Services included, medical management, as the employee eventually had surgery total knee replacement. Following approximately 2 months of recovery, the employee was released with permanent restrictions and job placement services were initiated. Through the provision of rehabilitation services, the employee was employed within 3 weeks, at $1.50 more per hour than his pre-injury position.

- This employee lived in a small community approximately 90 miles west of MPLS.
- The employee has a history of repetitive DWI's, thus making is impossible for him to drive to work (a job lead was developed at a local manufacturing facility approximately 2 blocks from the employee's home).
- Total Duration of this claim was 5 months.
- Total cost $4,005.55.
- Cost savings: $14,379 lost wages (approximate based on Medial Disability Advisor), possible TPD exposure of approximately $16,640 (labor market in the area was supportive of approximately $6/hour).
- ROI of approximately 7.7 to 1.



## Case Example

Jon is a 23 year old employee who works at a local food manufacturing facility. The employee injured his back while loading semi-trailers with packaged potato chips. The employee was evaluated by an orthopedic physician and an MRI showed degeneration of L4-S1 with a moderate bulge at L5-S1. A spinal fusion was recommended, authorized and performed. Following a recovery time of approximately 3 months, the employee was to be placed on permanent restrictions and a FCE was ordered. The FCE gave specific physical parameters, though concluded that the employee should pursue a job/career change. The physician was in agreement with this, as his decision was based on the FCE and job description given by the employee. This case was referred for a case management task assignment of a job analysis to compare with the FCE and present to the physician. The job analysis vs. FCE comparison concluded that the employee's pre-injury position was within the employee permanent physical restrictions and the employee was placed on a graduated return to work program in his pre-injury position.

- Cost savings- Vocational rehabilitation services of: job placement, vocational counseling, vocational testing, and possible retraining.
- Lost wages for an undetermined amount of time.
- File cost was $480 (about one week of TTD).



## Questions?

Paradigm | Complex Care Solutions

# Tips and Techniques for Managing Vocational Rehabilitation in Minnesota

Raymond J. Benning

Arthur Chapman Kettering Smetak & Pikala, P.A.

## Eligibility for Rehabilitation

- Rehabilitation services, including medical management, is designed to return an individual to work
- Employee may request a rehabilitation consultation by giving written notice to the insurer
- Insurer must file a disability status report to notify commissioner of rehab referral for consult or waiver of services



## Not Eligible

- Able to return to former employment without residual disability or restrictions
- When insurer asserts defenses such as:
  - Threshold liability
  - Complete recovery
  - Lack of causal relationship
  - No notice
  - Statute of limitations
  - Refusal of suitable employment

## Disability Status Report

- Insurer must complete and file with Commissioner and serve on employee within 14 days of knowing that TTD will likely exceed 13 weeks
- Within 90 days of injury if employee not returned to work
- Within 14 days of rehabilitation request for consultation

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## Waiver of Rehabilitation

A waiver of rehabilitation is used to defer the initiation of rehabilitation services, including a rehabilitation consult

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## Criteria

- Must be filed on the disability status report within time frames as noted before
- When granted, insurer must file another disability status report within 14 days of the expiration of the waiver

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## Waiver Granted

- Employer documents otherwise qualified employee will return to date of injury job or other suitable gainful employment with employer
- Within 90 days of request of waiver
- Waiver effective 90 days
- It may not be renewed

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## Rehabilitation Consultation

**Purpose** is to determine if employee is a qualified employee for rehabilitation services

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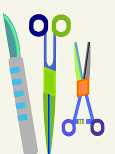
## Procedure

- Employee may request a rehabilitation consultation by giving written notice to the insurer
- Employee must also file request with Commissioner



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## What Must Insurer Do?

Arrange for a rehabilitation consultation by a QRC to occur within 15 days of insurer's receipt of request

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## Insurer Should

- Arrange the consultation to be held within 50 miles of employee's residence
- Send a copy of the first report of injury, the disability status report, and the physician's current reports of workability to the QRC

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## Initial Meeting

- The QRC **must**:
  - Meet with employee and explain rights and responsibilities regarding rehabilitation
  - Employee's right to choose QRC
  - Gather information to determine employee's eligibility for rehabilitation

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## Reporting Requirements

Form must contain the following:

- Date of consult
- Identifying information of employee, employer, insurer, and QRC
- Indication of likelihood that employee will return to date of injury employer or occupation
- Whether employee is a qualified employee and explain basis
- This report must be filed within 14 days of meeting



## Rehabilitation Plans and Amendments

- Evaluation of proposed plan
- Objecting to proposed plan
- Plan amendments



## Choice of QRC

- Initial selection
- Change within 60 days
- Change for the “bests interests” of the parties

## Rehabilitation Options

- Return to work same employer
- On-the-job training
- Job placement

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## Retraining Benefits

- Tuition, supplies, room and board, day care expenses, mileage, etc.
- Wage loss during retraining
- Surviving spouse may seek retraining

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## Eligibility for Retraining

- Equal consideration
- Cost of retraining as compared to other types of rehabilitation
- Proposing alternative plans
- Economic status considerations

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## Procedural Requirements

- Employer/insurer obligations
- Employee's "statute of limitations" to make request



## Elements of a Retraining Plan

## Termination of Retraining Plan

## Discontinuing Rehabilitation

- Required plan closure
- "Good cause" plan closure
- Closure for failure to cooperate



## QRC Standard of Conduct

- Minn. R. 5220.1801, subp. 8B
- Establishes distinction between role of QRC versus role of claims professional
- QRC cannot act as an advocate for any party
- QRC cannot act in adversarial manner



## Fees and Costs

## QUESTIONS?

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# DON'T SHOULDER THE BURDEN OF KNEEDLESS WORKERS' COMPENSATION CLAIMS

DR. BRUCE SUMMERVILLE

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

Paradigm MES SOLUTIONS SINCE 1978

## Bruce Summerville, MD

- B.A., Northwestern University
- M.D., Rush Medical College
- Orthopedic Post-graduate Residency, Northwestern Memorial Hospital
- Total Joint Fellowship, Thomas Jefferson University

RUSH UNIVERSITY CHICAGO, IL

ROTHMAN INSTITUTE

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## Bruce Summerville, MD

- General Orthopedist
- Subspecialty interest in degenerative conditions of the Hip/Knee/Shoulder
- Shoulder and knee arthroscopy
- Joint Replacement
- Fracture care
- >3000 patient visits and 365 surgeries in 2018
- Licensed in Wisconsin and Illinois
- Performs IMEs in Gurnee, IL and Waukesha, Madison, Green Bay, Schofield and Eau Claire, Wisconsin



## Effect of WC on outcomes

*The Effects of WC status on outcomes of Cervical Disc Arthroplasty*; 20 January 2016, volume 98, issue 2, p. 93-99

*With Hand and Wrist Disorders Effects of Workers Compensation on the Diagnosis and Surgical Treatment of Patients* ; 06 October 2010, volume 92, issue 13, p. 2294-2299

*Disability, Impairment, And Physical Therapy Utilization After Arthroscopic Partial Meniscectomy in Patients Receiving Workers' Compensation*; 21 March 2012, Volume 94, issue 6, p. 523-530



## Introduction

- Sprains
- Strains
- Overuse/Tears
- Fracture
- Dislocation
- Other

## Common Themes

- Minor injuries/mechanism
- Preexisting conditions
- Evolution of complaints over time
- Inadequate conservative treatment
- Inadequate diagnostic workup/imaging
- Temporal relationship/association considered causation

## Causes

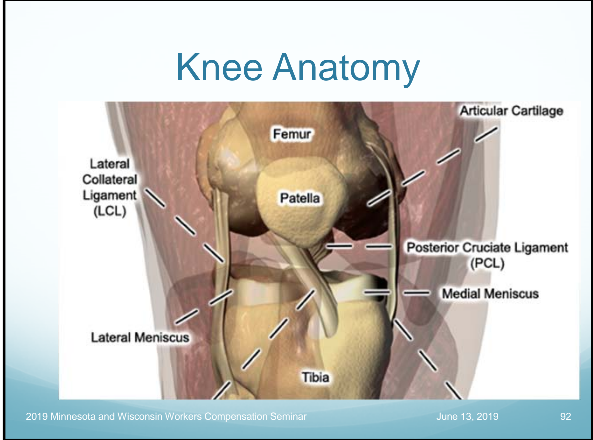
- Repetitive motion and overuse
- Falls
- Aggravation of preexisting conditions

# KNEE ANATOMY

- Ligaments: connects bones to bones
- Bones: supporting structure for muscles
- Cartilage: gliding surface between joints
- Tendons: connects muscles to bone

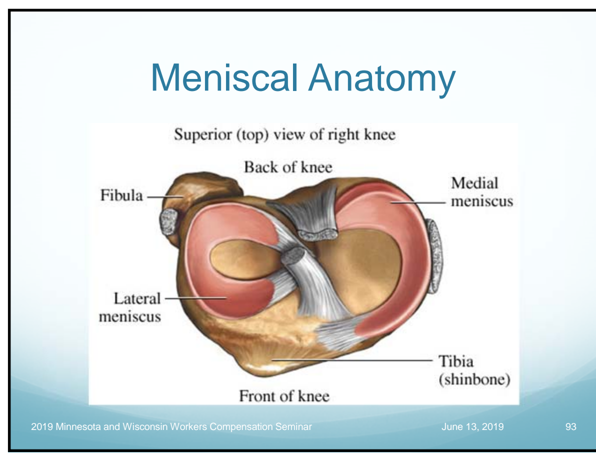


# Knee Anatomy






# Meniscal Anatomy



## Meniscal Anatomy

- Medial and lateral structures; medial larger than lateral and better vascularized
- Peripheral third poorly vascularized
- Fibrocartilaginous with parallel longitudinal fibers
- Medial less 'mobile' than lateral and subject to more stress



## Collateral Ligaments

femur
patella
tendon of gastrocnemius
fibular collateral ligament
popliteus tendon
fibula
lateral meniscus
patellar ligament
tibia
tibial tuberosity

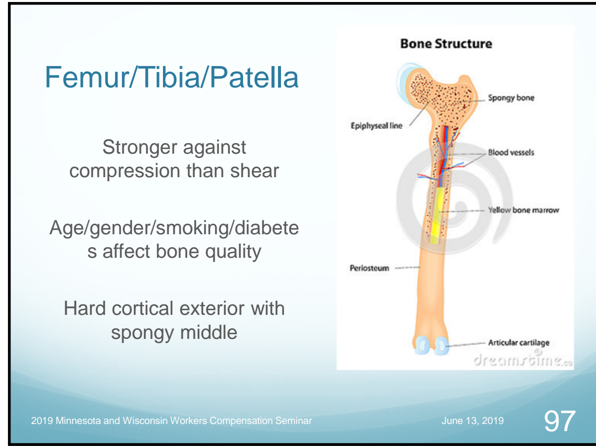
- Hinges between femur and tibia
- Fibrous tissue with minimal elasticity but high load to failure
- Medial or inner side subject to more stress and potential injury



## Cruciate Ligaments

Posterior Cruciate Ligament
Medial Femoral Condyle

- Histologically like collateral ligaments
- Much more complex function; resists sideways/anterior/posterior/pivoting stresses
- Poorly vascularized thus reconstruction instead of repair after injury


Femur/Tibia/Patella
Stronger against compression than shear
Age/gender/smoking/diabetes affect bone quality
Hard cortical exterior with spongy middle
Bone Structure
Spongy bone
Epiphyseal line
Blood vessels
Yellow bone marrow
Periosteum
Articular cartilage
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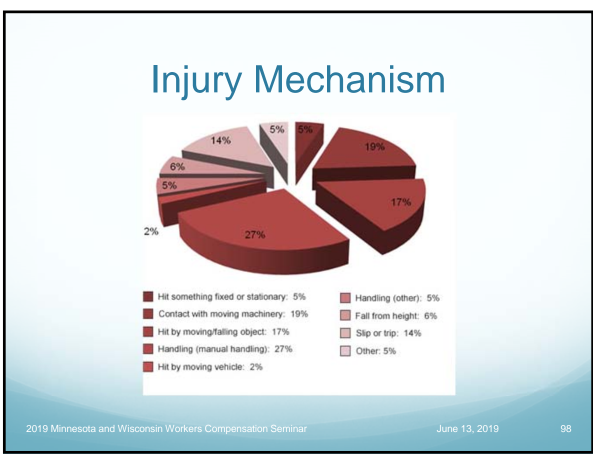
Injury Mechanism
Hit something fixed or stationary: 5%
Contact with moving machinery: 19%
Hit by moving/falling object: 17%
Handling (manual handling): 27%
Hit by moving vehicle: 2%
Handling (other): 5%
Fall from height: 6%
Slip or trip: 14%
Other: 5%
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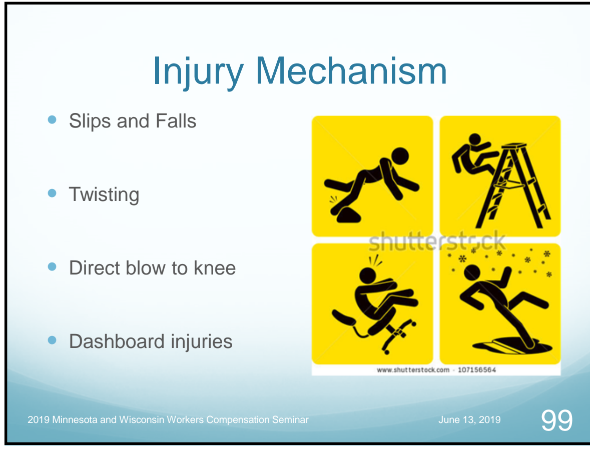
Injury Mechanism
Slips and Falls
Twisting
Direct blow to knee
Dashboard injuries
shutterstock
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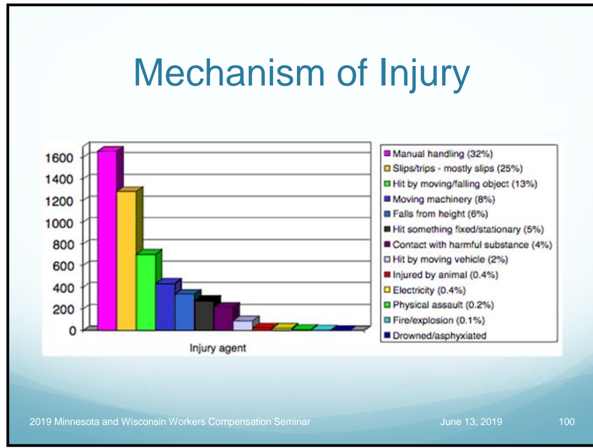
Mechanism of Injury
1600
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400
200
0
Injury agent
Manual handling (32%)
Slips/trips - mostly slips (25%)
Hit by moving/falling object (13%)
Moving machinery (8%)
Falls from height (6%)
Hit something fixed/stationary (5%)
Contact with harmful substance (4%)
Hit by moving vehicle (2%)
Injured by animal (0.4%)
Electricity (0.4%)
Physical assault (0.2%)
Fire/explosion (0.1%)
Drowned/asphyxiated
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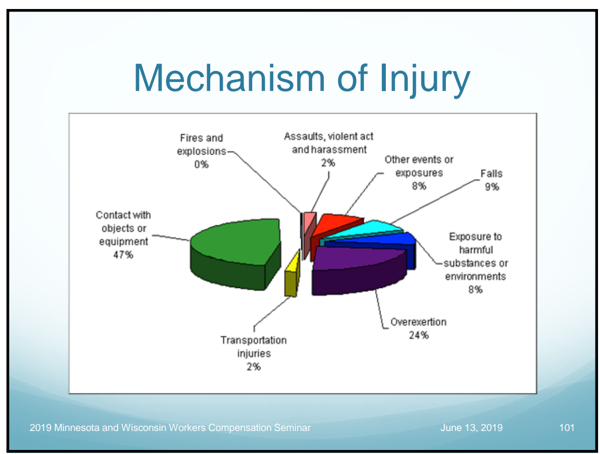
Mechanism of Injury
Fires and explosions 0%
Assaults, violent act and harassment 2%
Other events or exposures 8%
Falls 9%
Exposure to harmful substances or environments 8%
Overexertion 24%
Transportation injuries 2%
Contact with objects or equipment 47%
2019 Minnesota and Wisconsin Workers Compensation Seminar
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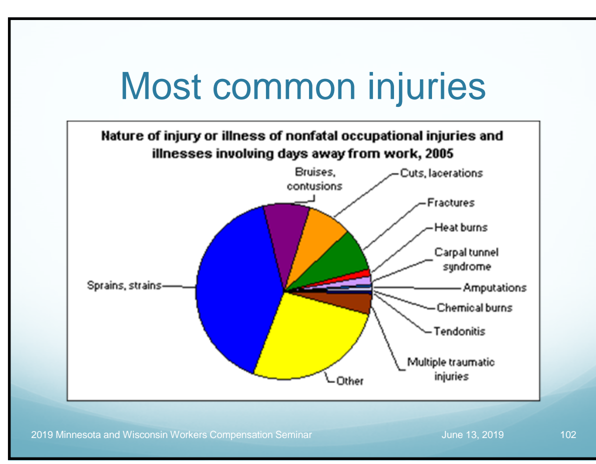
Most common injuries
Nature of injury or illness of nonfatal occupational injuries and illnesses involving days away from work, 2005
Bruises, contusions
Cuts, lacerations
Fractures
Heat burns
Carpal tunnel syndrome
Amputations
Chemical burns
Tendonitis
Multiple traumatic injuries
Other
Sprains, strains
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## Mechanism of injuries

- Meniscal tears- due to twisting or hyperflexion injury
- Medial collateral ligament tears- caused by sideways stress to the knee
- Anterior cruciate ligament tears-; due to deceleration or twisting
- Posterior cruciate ligament tears; dashboard injuries
- Tibia, femur, and patella fractures-falls/direct blow to knee/



## Mechanism of Injury

**Table 1. Hints For Linking Mechanism To Type Of Knee injury**

| Mechanism | Type Of Knee Injury |
|---|---|
| Motor vehicle accidents (high energy trauma) | Knee dislocation, distal femur physis, PCL |
| Knee "went out of joint" after non-contact pivot | Patellar dislocation with possible osteochondral fracture |
| Fall from bicycle/twisting force with hyperextension | Tibial spine fracture |
| Jumping activities (high jumping, basketball, etc) | Tibial tubercle avulsion or patella sleeve fractures |
| Blow to outside of knee (valgus stress) | MCL injury or physeal fracture |
| Blow to inside of knee (varus stress) | LCL injury or physeal fracture |
| Hyperextension (non-contact), twisting, or deceleration | ACL injury, tibial spine fractures |
| Direct blow or fall on flexed knee | Patellar or osteochondral fracture |
| "Pop" heard | Patellar dislocation or ACL injury |



## History

**Table 3. Significant Historical Points In Knee Injuries.**

- Acute onset of pain within 72 hours of injury
- Audible pop and immediate swelling with twisting or forced hyperextension
- Direct blow to anterior tibia, forced hyperextension, or axial load
- Direct blow to the medial or lateral aspect of the knee
- Varus or valgus stress to knee
- Twisting injury—painful popping and catching, delayed swelling
- Direct blow to patella or hyperflexion
- Prior knee surgery

Source: Beatty JH, ed. *Orthopaedic Knowledge Update 6: Home Study Syllabus.* Rosemont, IL: American Academy of Orthopaedic Surgeons; 1999.

## Significant exam findings

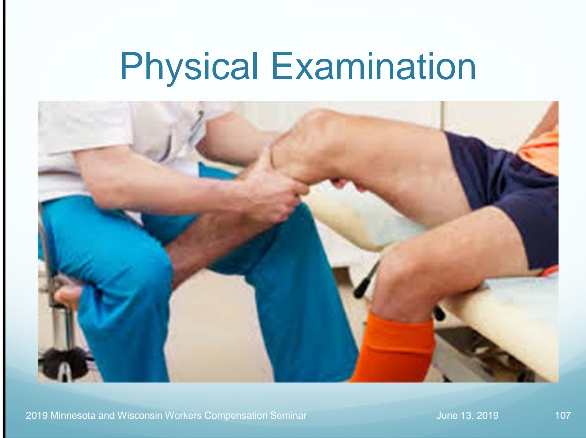
**Table 4. Significant Physical Examination Findings In Knee Injuries.**

- Effusion or acute swelling
- Positive Lachman test
- Patellar tenderness or abnormal position
- Tenderness of the lateral or medial aspect of the knee or head of fibula
- Joint line tenderness or positive McMurray's test
- Inability to straighten or flex the knee greater than 90°
- Inability to perform straight-leg raise
- Positive posterior drawer test
- Valgus or varus joint instability
- Inability to bear weight for four steps without assistance

Adapted from: Beatty JH, ed. *Orthopaedic Knowledge Update 6: Home Study Syllabus.* Rosemont, IL: American Academy of Orthopaedic Surgeons; 1999.

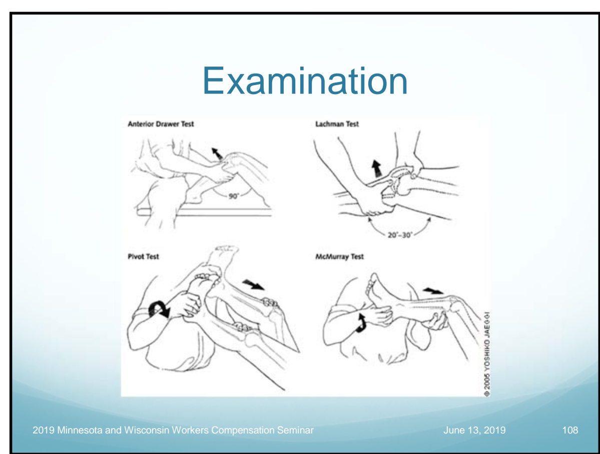


## Physical Examination





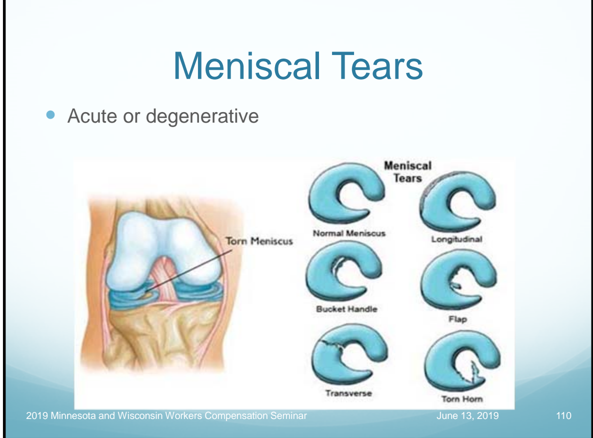
## Examination



## Meniscus Tears

- Fibrocartilage present both medial and lateral
- Medial more likely to tear acutely/with trauma
- Limited spontaneous healing potential
- Unlikely to heal even with repair in persons >40 yo
- Most significant factor in development of OA later
- Repair/healing likely to prevent future OA





## Meniscal Tears

- Very common orthopedic knee injury
- Acute v. degenerative
- MRI grading system; I,II, or III correlates likelihood MRI images show a clinically relevant tear noted at arthroscopy (specificity and positive predictive value)

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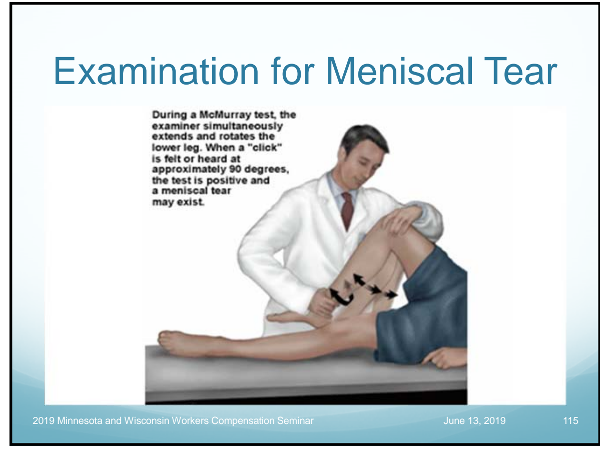
Examination for Meniscal Tear
During a McMurray test, the examiner simultaneously extends and rotates the lower leg. When a "click" is felt or heard at approximately 90 degrees, the test is positive and a meniscal tear may exist.
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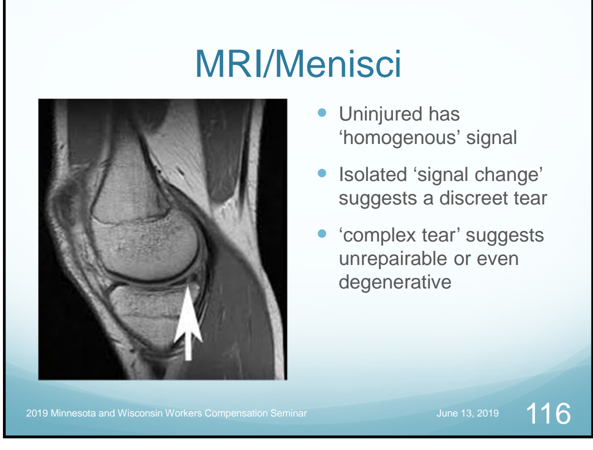
MRI/Menisci
Uninjured has 'homogenous' signal
Isolated 'signal change' suggests a discreet tear
'complex tear' suggests unrepairable or even degenerative
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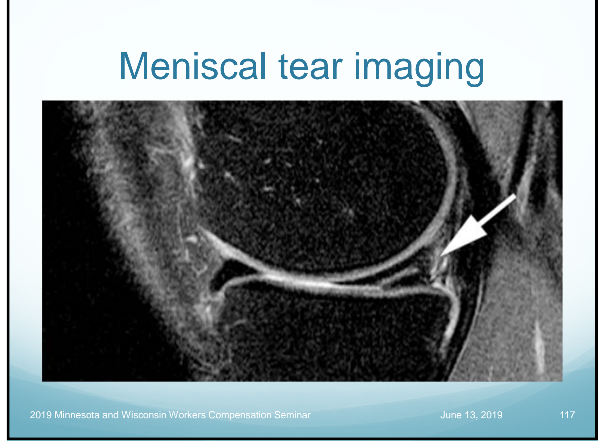
Meniscal tear imaging
2019 Minnesota and Wisconsin Workers Compensation Seminar
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## MRI Grading

| Grade | Meniscus |
|---|---|
| Grade 1 | Presence of amorphous or high signal shadow but not reaching the meniscal articular surface |
| Grade 2 | Presence of linear high signal on the image, continuation of Grade 1 and reaching the margin of the articular surface |
| Grade 3 | Linear or diffuse high signal extending to the joint surface |

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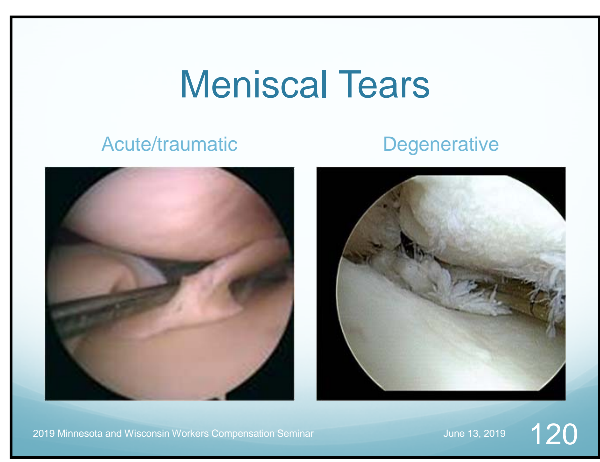

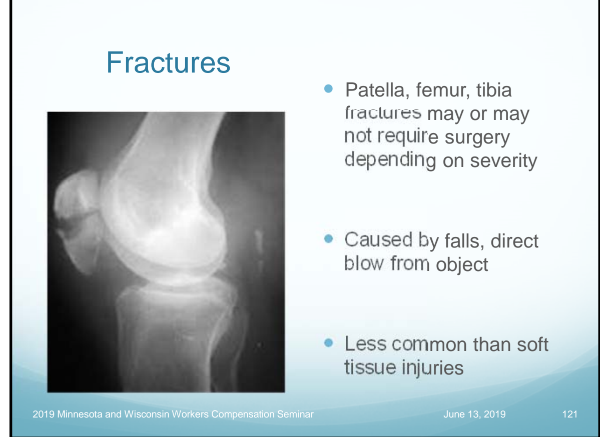


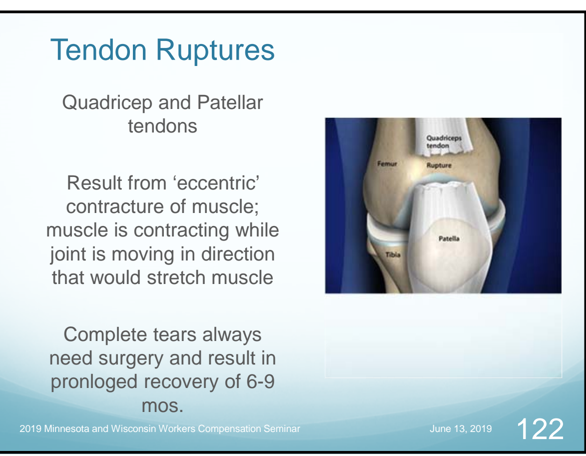


## Tendon Rupture

- Partial could be treated nonoperatively
- Complete requires surgical repair
- Pronlonged recovery may lead to permanent stiffness

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## Collateral Ligament Tear

- Injury occurs due to a sideswipe or blow to side of knee
- Treatment with hinged brace for 4-6 weeks
- Normal functional recovery expected without future sequelae
- Never require surgery when occur in isolation
- Not common as isolated injury in WC setting

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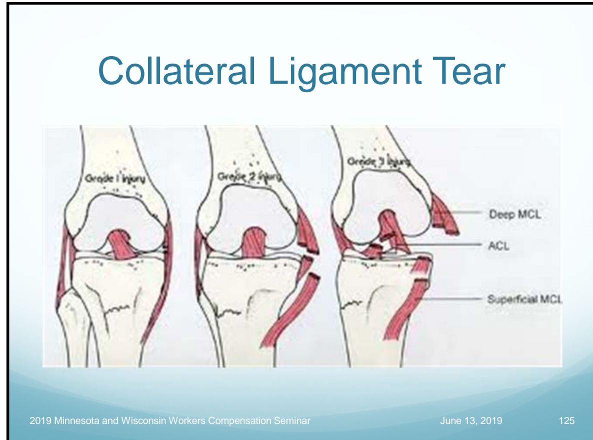
## Collateral Ligament Tear

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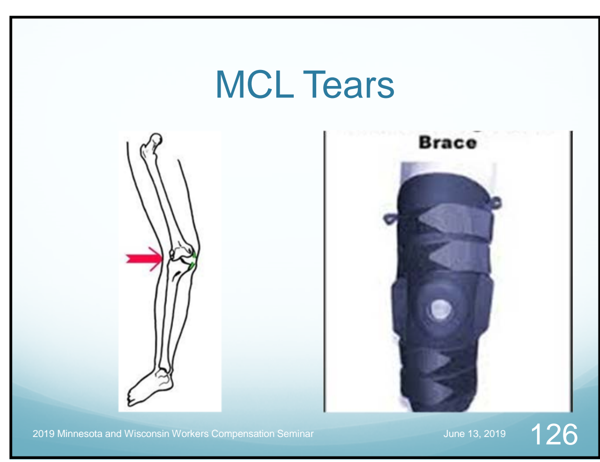
## MCL Tears

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## Cruciate Ligaments

**ACL**

- Occurs from twisting/pivoting injury
- Not common as result of industrial accident
- May/may not require surgery

**PCL**

- Direct blow to front of knee
- Rarely require surgery in isolation
- Full functional recovery expected even without surgery

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## ACL tear mechanism

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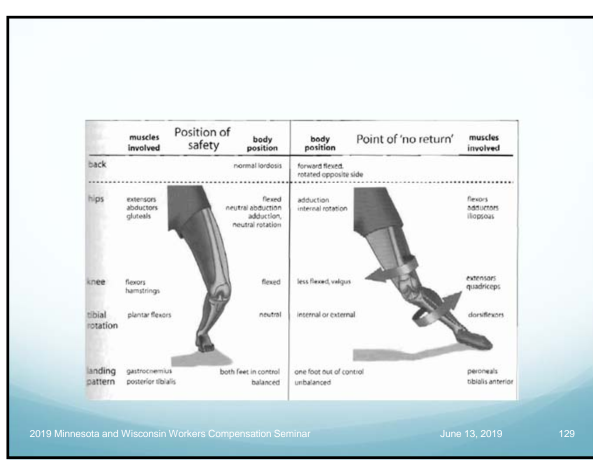

| | Position of safety: muscles involved | Position of safety: body position | Point of 'no return': body position | Point of 'no return': muscles involved |
|---|---|---|---|---|
| back | | normal lordosis | forward flexed, rotated opposite side | |
| hips | extensors abductors gluteals | flexed neutral abduction adduction, neutral rotation | adduction internal rotation | flexors adductors iliopsoas |
| knee | flexors hamstrings | flexed | less flexed, valgus | extensors quadriceps |
| tibial rotation | plantar flexors | neutral | internal or external | dorsiflexors |
| landing pattern | gastrocnemius posterior tibialis | both feet in control balanced | one foot out of control unbalanced | peroneals tibialis anterior |

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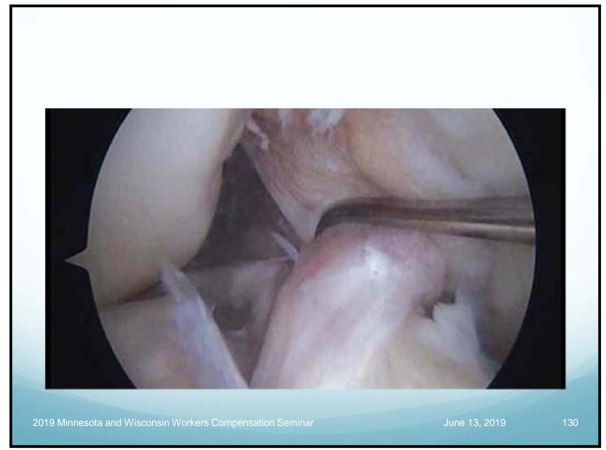
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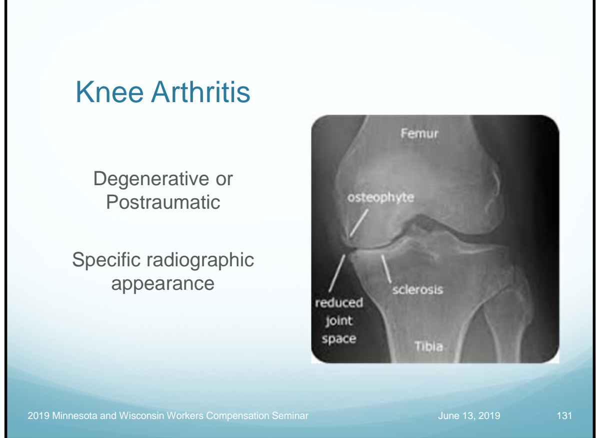
Knee Arthritis
Degenerative or Postraumatic
Specific radiographic appearance
Femur
osteophyte
sclerosis
reduced joint space
Tibia
2019 Minnesota and Wisconsin Workers Compensation Seminar
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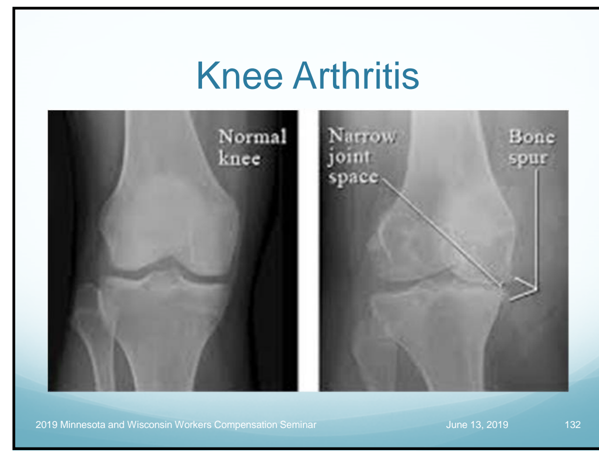
131


Knee Arthritis
Normal knee
Narrow joint space
Bone spur
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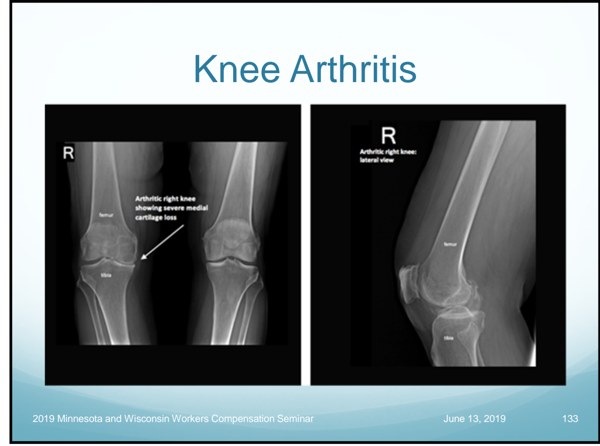
## Knee Arthritis

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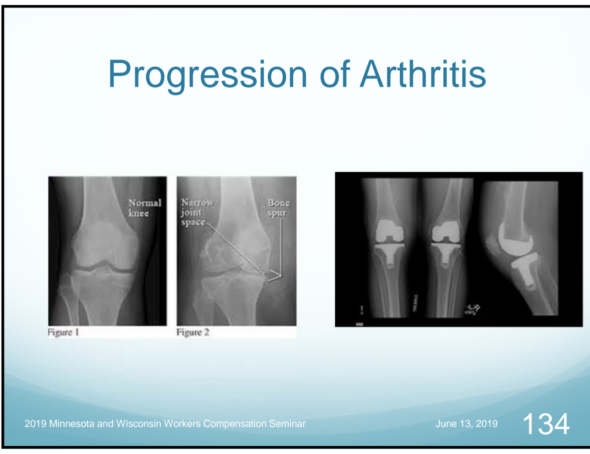
## Progression of Arthritis

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## Permanent Partial Disability

- Ankylosis 40%
- ROM <135 degrees 25%
- ROM < 90 degrees 10%
- Prosthesis Total 50%
- Partial Prosthesis 45%
- Total or Partial Meniscectomy 5%
- ACL Repair 10%

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## Causation

- Preexisting complaints/medical records
- Objective exam findings
- Diagnostic imaging
- Discrepancies in the history
- Physicians experience and knowledge



## Lewellyn Standards

- 1968 court decision regarding causation
- Causation can be determined even in cases of preexisting pathology
- Subject in part to physician interpretation of injury and relationship to current pathology and potential for future worsening of preexisting pathology



## Scenarios

- Direct Causation
- Precipitate, Aggravate, and Accelerate Preexisting
- Appreciable Period of Workplace Exposure
- Manifestation of a Preexisting Condition
- Temporary Aggravation of a Preexisting Condition

## Direct Causation

- R.S. is 42 y.o. in good health without preexisting knee problems
- He twists his knee at work after he missteps in a ditch
- He experiences acute medial knee pain, an effusion, and decreased ROM of his knee
- Xrays show no degenerative changes or other injury; MRI shows a grade III signal in the medial meniscus without other abnormality



## Direct Causation

- He undergoes arthroscopy/partial medial meniscectomy without other pathology noted at the time of arthroscopy
- He remains off work 1-2 weeks and returns to light duty thereafter for 4-6 weeks
- At about 8 weeks postoperative and after 4-6 weeks of Physical Therapy he is ready to return to moderate duty employment without restriction



## Precipitate, Aggravate, and Accelerate

- JC is a 55 yo with mild degenerative knee arthritis who tolerates his medium level work until he twists his knee on the job and tears his medial meniscus
- Xrays and MRI confirm the arthritis and meniscal tear and his new onset of symptoms, lack of previous knee c/o and failure to improve with conservative treatment leads to a knee arthroscopy
- He returns to work months later but over a year later returns to MD with worsening pain and xrays which demonstrate worsening knee arthritis

## Precipitate, Aggravate, and Accelerate

- He is treated with injections/NSAIDS
- After failure of conservative treatment and progression of OA on radiographs he undergoes TKA
- He is able to return to work with vocational change and limits to his activities



## Appreciable Period of Workplace Exposure

- T.S. is a 55 yo employed in heavy construction; job description includes frequent squatting/kneeling/carrying loads up to 100 lbs.
- After 30 years in the same employment he develops anterior knee pain
- Xrays demonstrate PF arthritis; he has no other h/o injury or athletic endeavors which place him at risk
- The unique and isolated nature of his pathology makes this compensable



## Manifestation of a Preexisting Condition

- S.T. is 45 yo with longstanding knee instability due to chronic ACL insufficiency and works a medium/light job description
- His knee buckles/swells monthly at home; he manages this with ice/rest/NSAIDS
- Arising from chair at work his knee gives and way and is a similar to episodes he experiences at home
- After several days of rest/off work he returns to full duty

## Temporary Aggravation of Prexisting Injury

- RN is a 45 yo with mild degenerative knee arthritis who tolerates his medium level work until he falls on his knee at work
- Xrays and MRI confirm the arthritis but no other pathology
- After several weeks off work and/or on light duty he returns to his pre-injury status
- Without further pathology this is compensable only for the short term aggravation of preexisting pathology



## Malingering

- J.C. is a 42 yo female who fell at work on a wet floor landing directly on her knee
- After failing to respond to rest/ice she undergoes MRI scan which shows no appreciable pathologic findings; xrays show now abnormalities
- She feels unable to go to work in spite of minimal physical objective findings; she displays 'symptom magnification' and c/o of entire leg pain and now back pain



## Malingering

- Because of lack of appreciable objective exam findings and inconsistencies as well as negative diagnostic imaging she is sent back to work without restrictions
- Back pain which is not initially reported within a reasonable time post injury is not considered part of the initial claim
- She is released from the physician's care at MMI 3 mos. Post injury

## Malingering

- No objective findings by history, on examination, or diagnostic studies support any pathologic diagnosis
- Pure malingering uncommon; symptom exaggeration and extension more common
- Waddell's Signs- examination inconsistencies
- Inconsistencies in history



## Waddel's Signs

**Table.**
Waddell's Nonorganic Signs*

| Type of Nonorganic Sign | Nonorganic Sign | Description |
|---|---|---|
| Tenderness | | Tenderness not related to a particular skeletal or neuromuscular structure; may be either superficial or nonanatomic. |
| | Superficial | The skin in the lumbar region is tender to light pinch over a wide area not associated with the distribution of a posterior primary ramus. |
| | Nonanatomic | Deep tenderness, which is not localized to one structure, is felt over a wide area and often extends to the thoracic spine, sacrum, or pelvis. |
| Simulation tests | | These tests give the patient the impression that a particular examination is being carried out when in fact it is not. |
| | Axial loading | Low back pain is reported when the examiner presses down on the top of the patient's head; neck pain is common and should not be considered indicative of a nonorganic sign. |
| | Rotation | Back pain is reported when the shoulders and pelvis are passively rotated in the same plane as the patient stands relaxed with the feet together; in the presence of root irritation, leg pain may be produced and should not be considered indicative of a nonorganic sign. |
| Distraction tests | | A positive physical finding is demonstrated in the routine manner, and this finding is then checked while the patient's attention is distracted; a nonorganic component may be present if the finding disappears when the patient is distracted. |
| | Straight leg raising | The examiner lifts the patient's foot as when testing the plantar reflex in the sitting position; a nonorganic component may be present if the leg is lifted higher than when tested in the supine position. |
| Regional disturbances | | Dysfunction (eg, sensory, motor) involving a widespread region of body parts in a manner that cannot be explained based on anatomy; care must be taken to distinguish from multiple nerve root involvement. |
| | Weakness | Demonstrated on testing by a partial cogwheel "giving way" of many muscle groups that cannot be explained on a localized neurologic basis. |
| | Sensory | Include diminished sensation to light touch, pinprick or other neurologic tests fitting a "stocking" rather than a dermatomal pattern. |
| Overreaction | | May take the form of disproportionate verbalization, facial expression, muscle tension and tremor, collapsing, or sweating; judgments should be made with caution, minimizing the examiner's own emotional reaction. |

* Adapted from Waddell G, McCulloch JA, Kummel E, Venner RM. Nonorganic physical signs in low-back pain. *Spine*. 1980;5:117–125.



## IMEs

*schedule an*

**independent medical examination**

## Independent Medical Exam

- Causation based on mechanism, exam, and imaging studies
- Preexisting factors/injury
- Malingering and symptom magnification
- Objectivity
- Permanency



## IMEs

- Thorough history
- Thorough record review
- Diagnostic image review
- Complete and thorough physical exam
- Does it make sense? Tying the history, record/imaging review, and clinical exam together along with clinical experience



## Medical Records

- Any previous complaints to any former health care provider
- Previous diagnostic images; MRI or xray
- Consistency among providers and from patient

## Patient history

- Consistently told by patient
- Consistent mechanism of injury to resultant pathology
- Response to treatment



## Diagnostic Imaging

- Correctly performed and interpreted
- Good quality
- No previous pathology



## End Of Healing

- Important for determining potential impairment and need for any further treatment
- Injured has met expected/average timeframe for recovery and no further improvement is expected
- Specific to pathologic diagnosis and treatment

## Conclusions

- Based on history and mechanism of injury/physical examination/diagnostic images
- Clinical experience with non-Workmans Compensation patients
- Common experiences/outcomes happen commonly

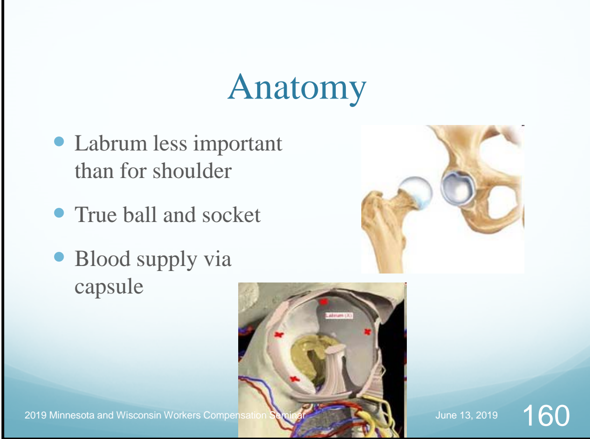


## Introduction - Hip Injuries

- Less common than shoulder/knee
- Many require only conservative management
- Surgical cases generally due to major trauma

## Traumatic Hip Injuries

- Fractures
- Sprains and Strains
- Dislocations
- Contusions




## Hip Anatomy-Bones

- Hip Joint a true ‘ball and socket’
- Hip stability related to bony structure
- Significant trauma needed to fracture or dislocate hip in non-osteoporotic bone

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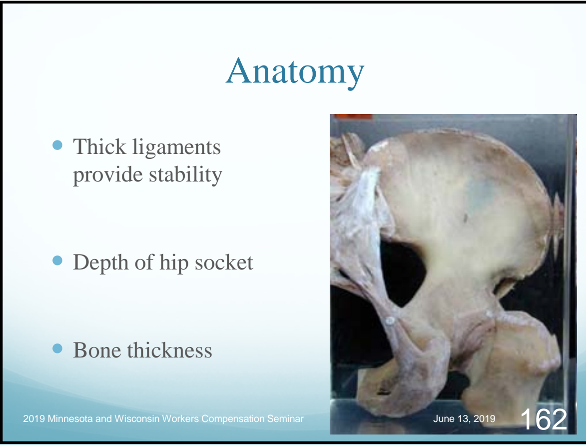
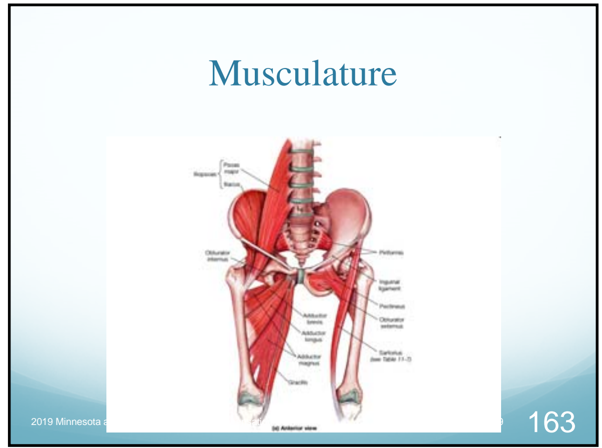
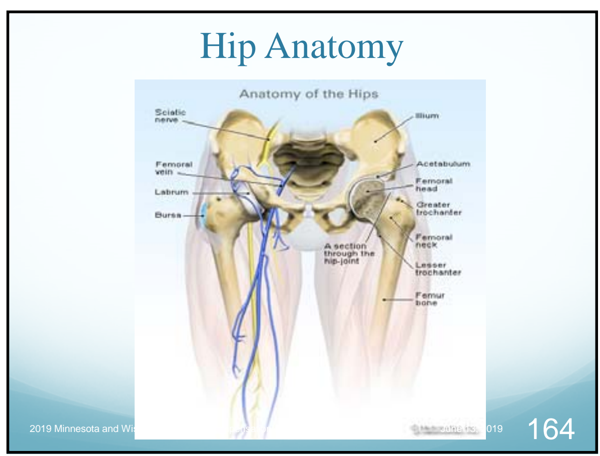
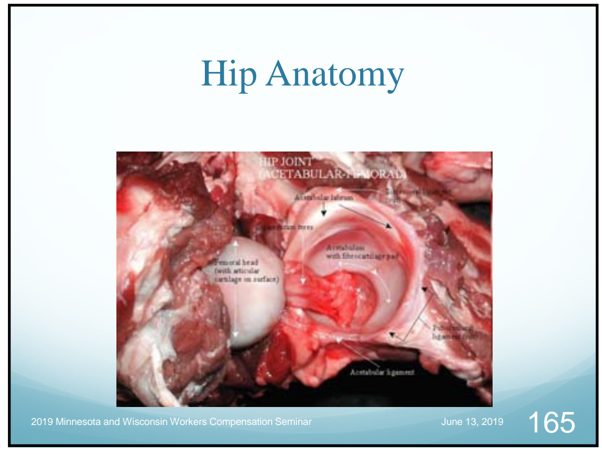



Musculature
163


Hip Anatomy
Anatomy of the Hips
Sciatic nerve
Femoral vein
Labrum
Bursa
Ilium
Acetabulum
Femoral head
Greater trochanter
Femoral neck
A section through the hip-joint
Lesser trochanter
Femur bone
164


Hip Anatomy
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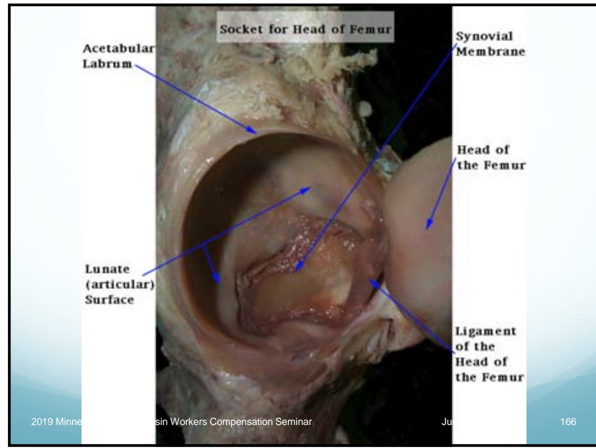
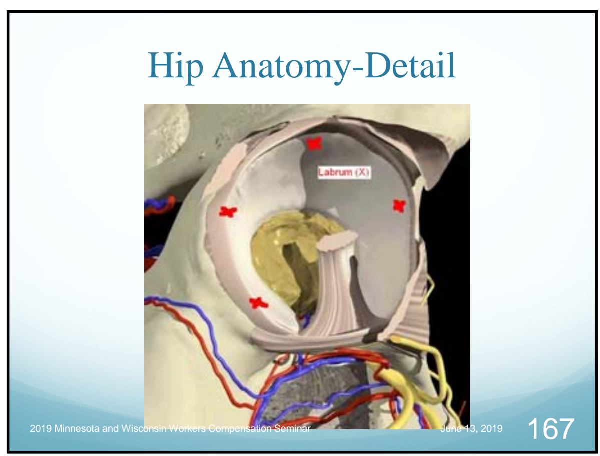

Socket for Head of Femur
Acetabular Labrum
Synovial Membrane
Head of the Femur
Lunate (articular) Surface
Ligament of the Head of the Femur
166


Hip Anatomy-Detail
Labrum (X)
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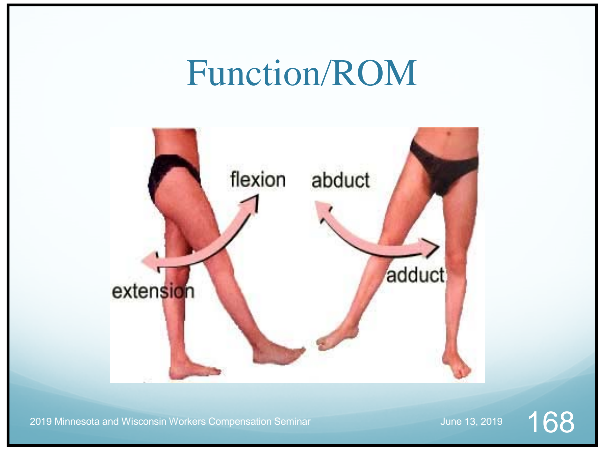
Function/ROM
flexion
abduct
extension
adduct
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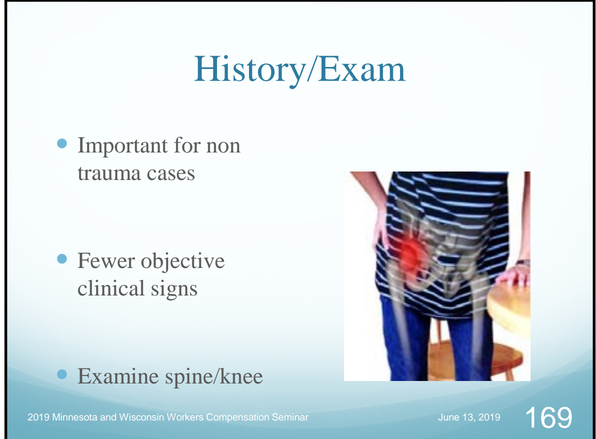


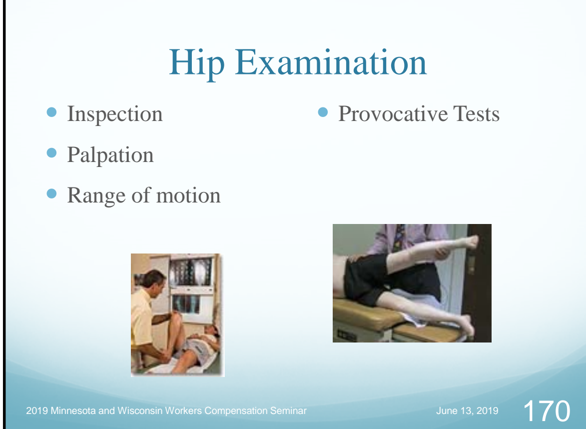


## Provocative Tests

- FAbER: flexion, abduction, external rotation
- Ober: extension/abduction followed by adduction
- Stinchfield: straight leg raise
- Trendelenberg: stand on one leg

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## Faber Test

- Labral tears
- Pain elicited in groin

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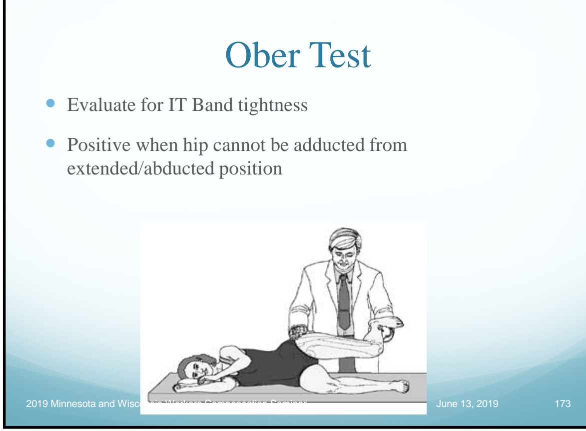


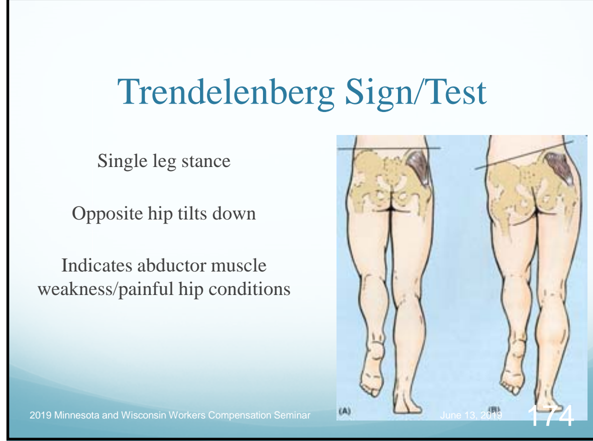

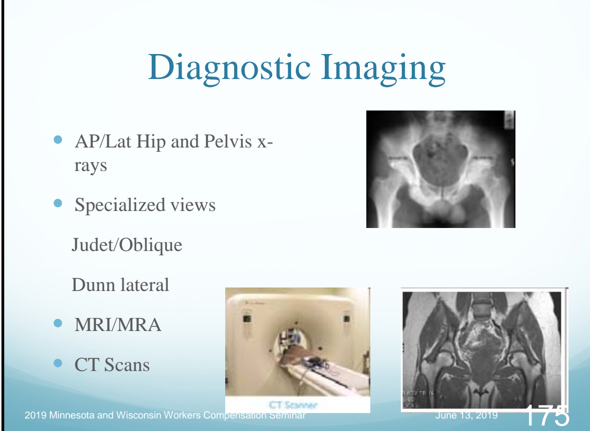
Diagnostic Imaging
AP/Lat Hip and Pelvis x-rays
Specialized views
Judet/Oblique
Dunn lateral
MRI/MRA
CT Scans
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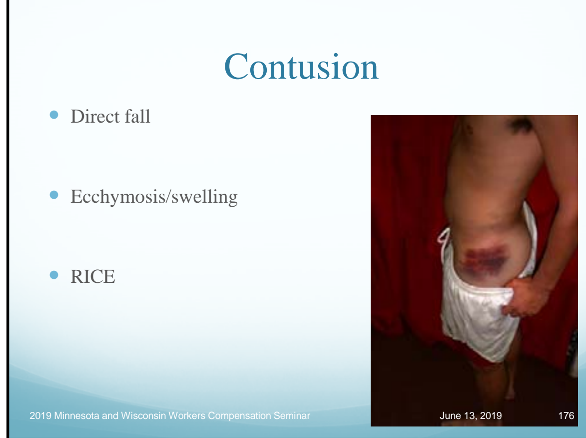
Contusion
Direct fall
Ecchymosis/swelling
RICE
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Hamstring Strain
Complex muscle action
RICE/limited treatment
Semitendinosis
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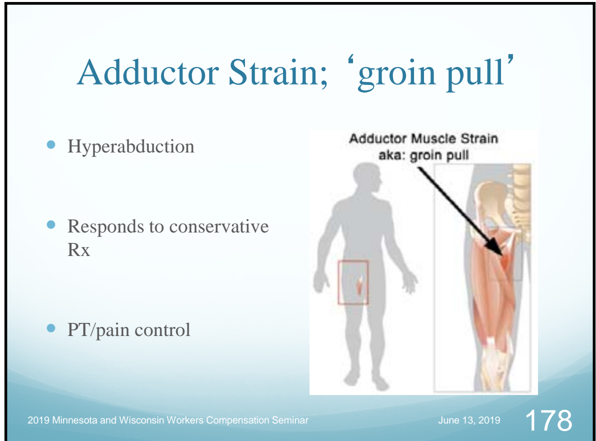
Adductor Strain; 'groin pull'
Hyperabduction
Responds to conservative Rx
PT/pain control
Adductor Muscle Strain
aka: groin pull
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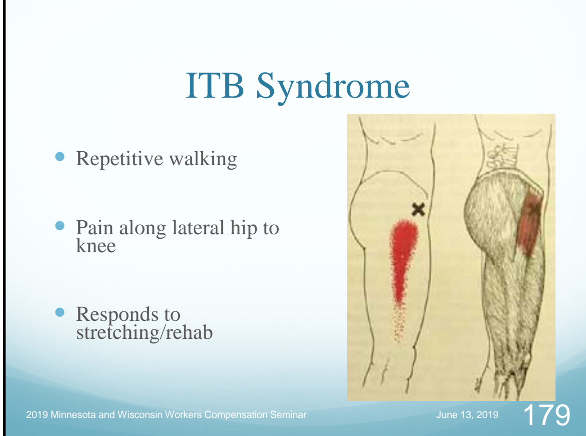
ITB Syndrome
Repetitive walking
Pain along lateral hip to knee
Responds to stretching/rehab
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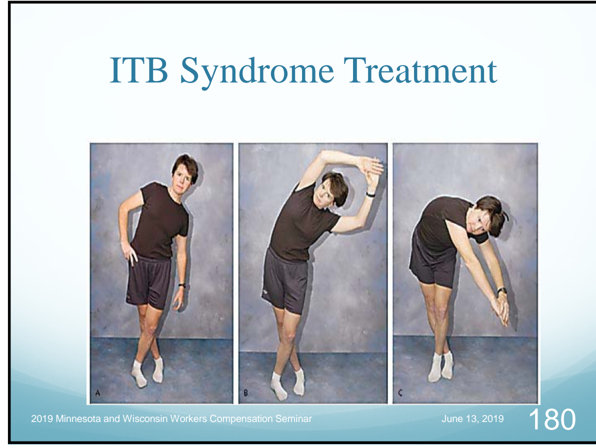
ITB Syndrome Treatment
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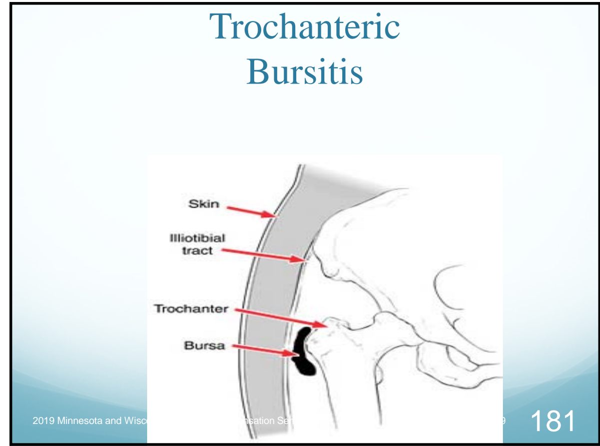
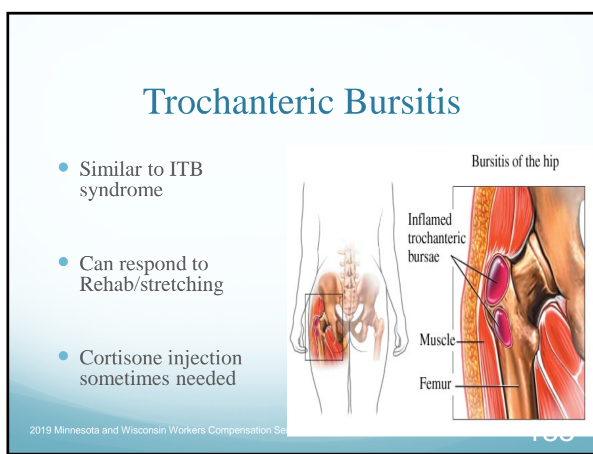
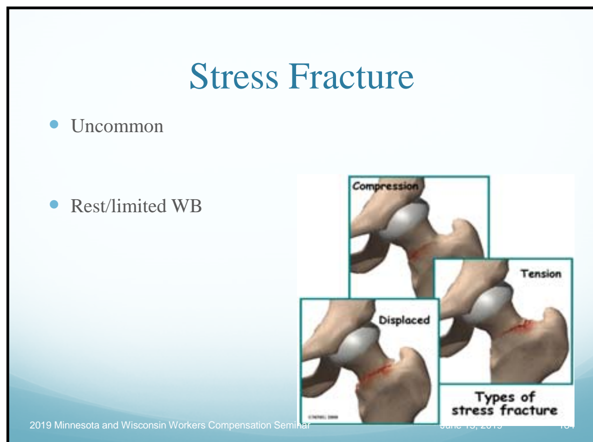

Trochanteric
Bursitis
Skin
Illiotibial
tract
Trochanter
Bursa
181

Pain area in
trochanteric
bursitis
182


Trochanteric Bursitis
Similar to ITB syndrome
Can respond to Rehab/stretching
Cortisone injection sometimes needed
Bursitis of the hip
Inflamed
trochanteric
bursae
Muscle
Femur


Stress Fracture
Uncommon
Rest/limited WB
Compression
Tension
Displaced
Types of stress fracture
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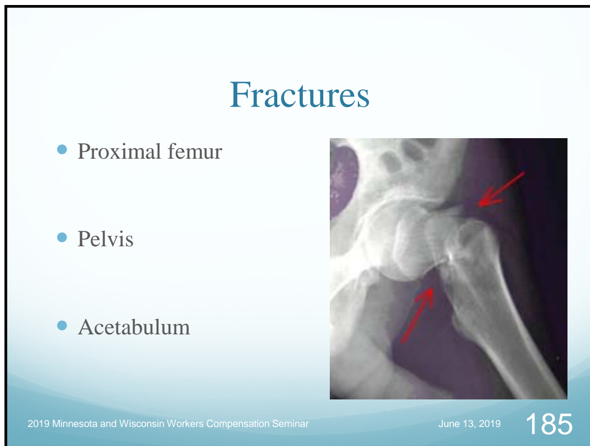
Fractures
Proximal femur
Pelvis
Acetabulum
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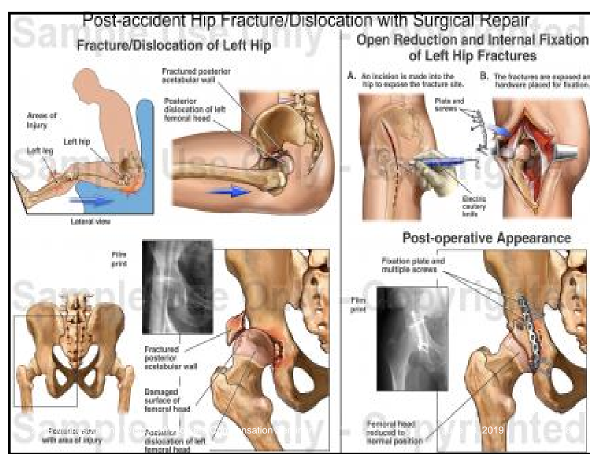
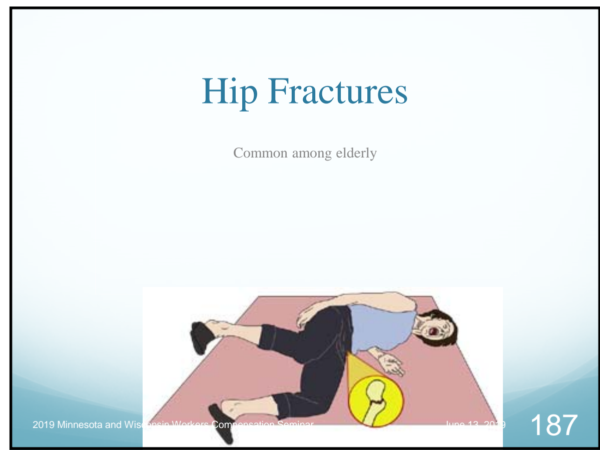
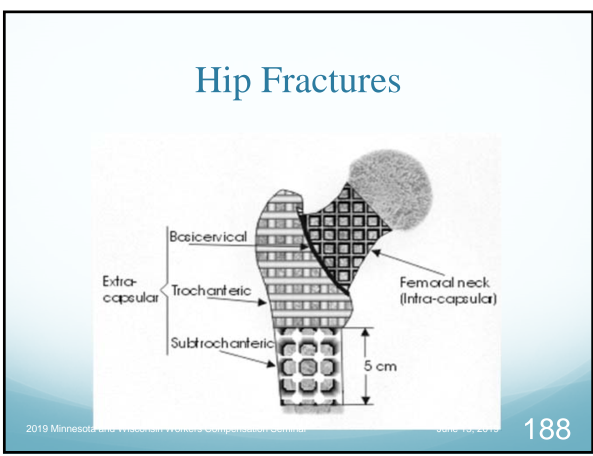
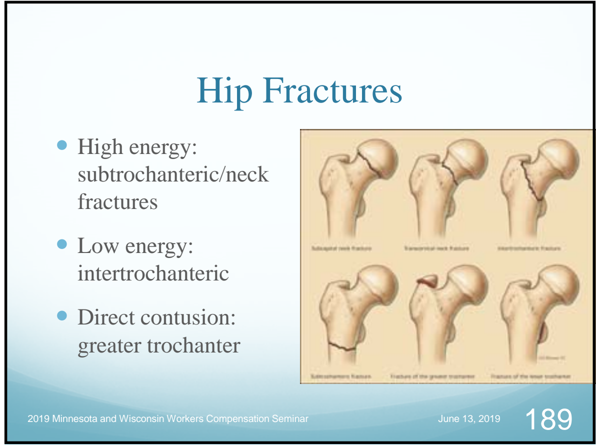

Post-accident Hip Fracture/Dislocation with Surgical Repair
Fracture/Dislocation of Left Hip
Open Reduction and Internal Fixation of Left Hip Fractures
Post-operative Appearance


Hip Fractures
Common among elderly
187


Hip Fractures
Basicervical
Extra-capsular
Trochanteric
Subtrochanteric
Femoral neck (Intra-capsular)
5 cm
188


Hip Fractures
High energy: subtrochanteric/neck fractures
Low energy: intertrochanteric
Direct contusion: greater trochanter
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## Neck Fractures

- Surgical emergency if displaced in patients under 60
- Closed reduction/open reduction
- Pinning or hemiarthroplasty

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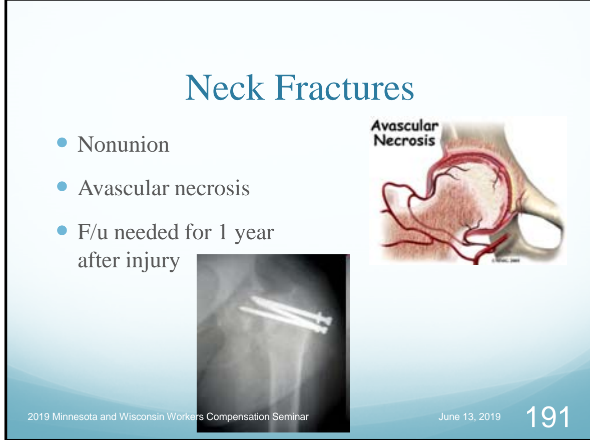

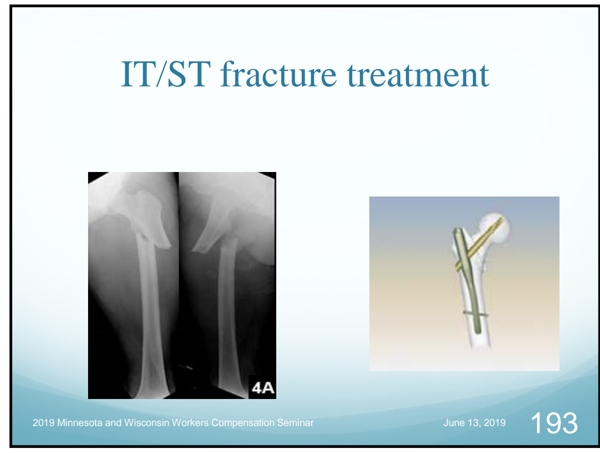


## Pelvic/Acetabular Fractures

- Significant trauma/fall
- Work population often require surgery
- Can lead to long-term complications/arthritis

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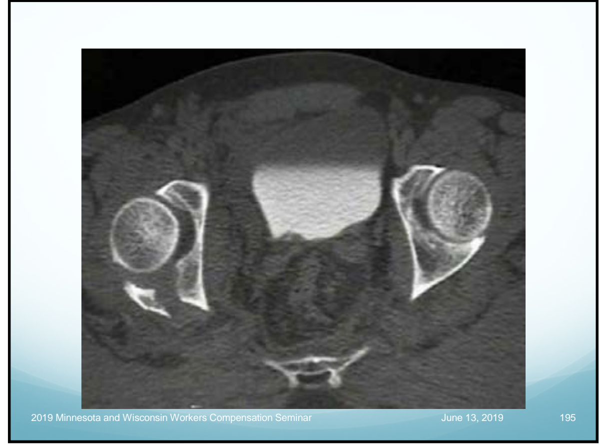

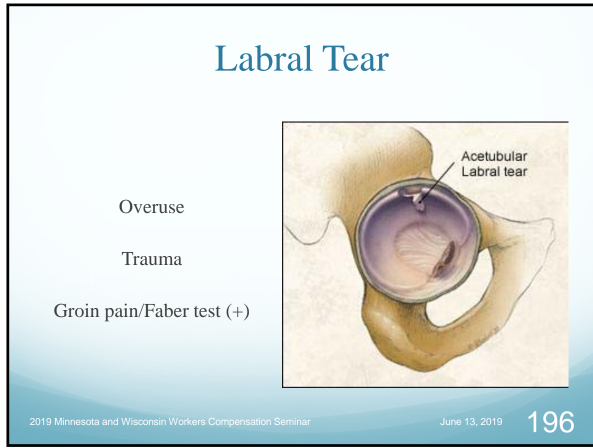


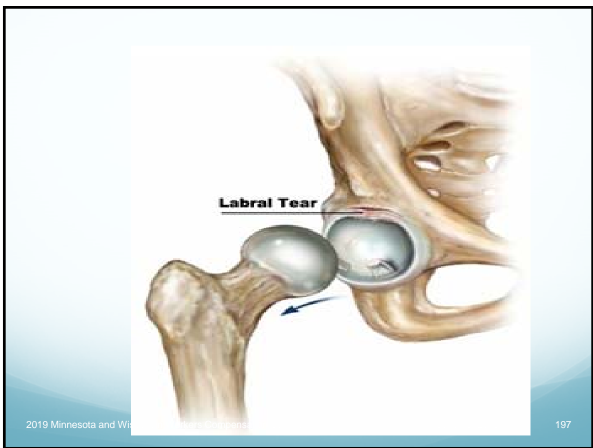


## Labral tears

- More prevalent as diagnosis
- Not related to trauma unless posterior and secondary to hip dislocation or subluxation
- Most tears related to FAI (femoral acetabular impingement); a congenital morphologic disorder of the hip and less severe form of hip dysplasia
- Increasing as cause of litigation following traumatic injuries to hip

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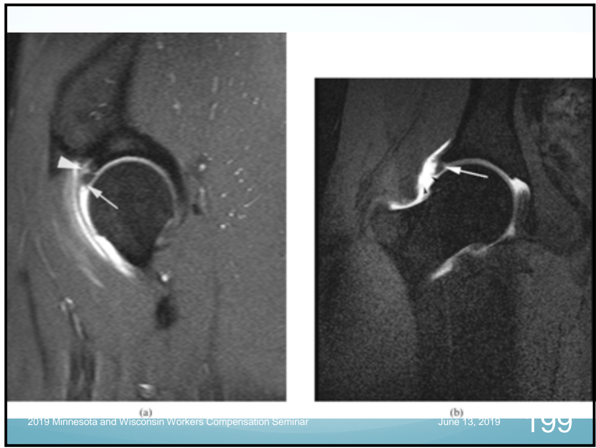
(a)
(b)
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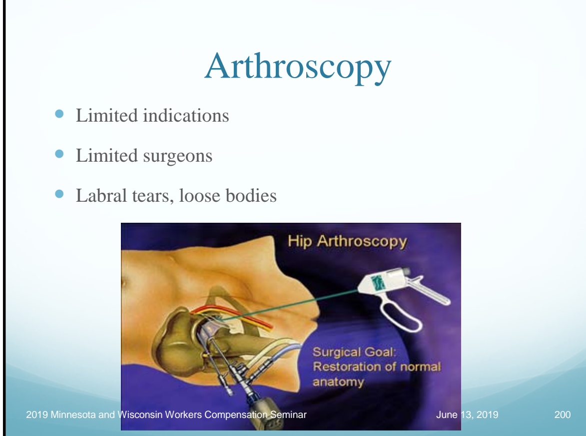
Arthroscopy
Limited indications
Limited surgeons
Labral tears, loose bodies
Hip Arthroscopy
Surgical Goal: Restoration of normal anatomy
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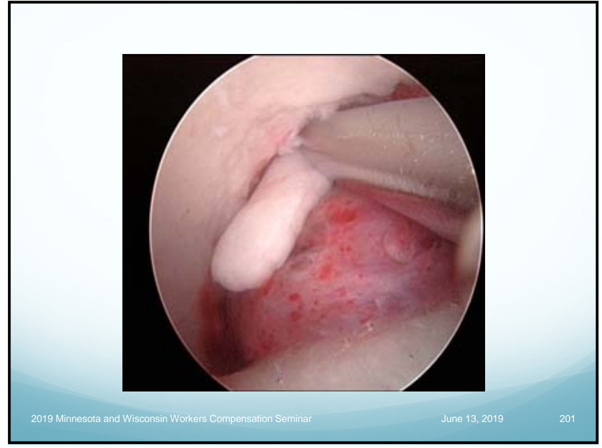
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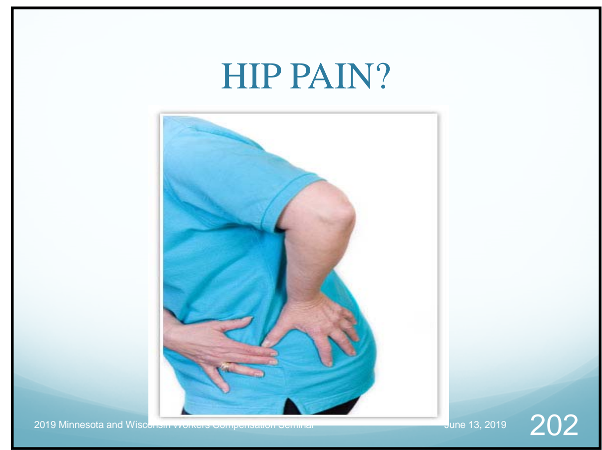
HIP PAIN?
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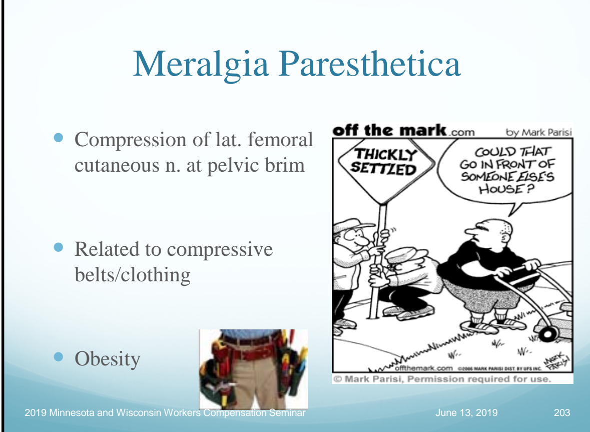
Meralgia Paresthetica
Compression of lat. femoral cutaneous n. at pelvic brim
Related to compressive belts/clothing
Obesity
off the mark.com
by Mark Parisi
THICKLY SETTLED
COULD THAT GO IN FRONT OF SOMEONE ELSE'S HOUSE?
© Mark Parisi, Permission required for use.
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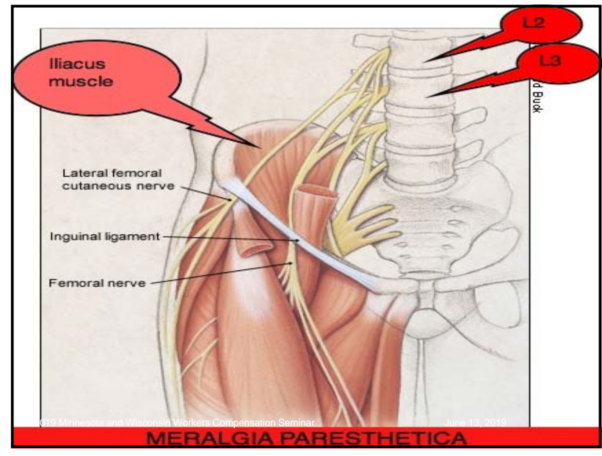
L2
L3
Iliacus muscle
Lateral femoral cutaneous nerve
Inguinal ligament
Femoral nerve
MERALGIA PARESTHETICA

## Meralgia Paresthetica

- Confused with radiculopathy
- Selective Xylocaine injection
- Steroid injection for treatment
- Remove compression

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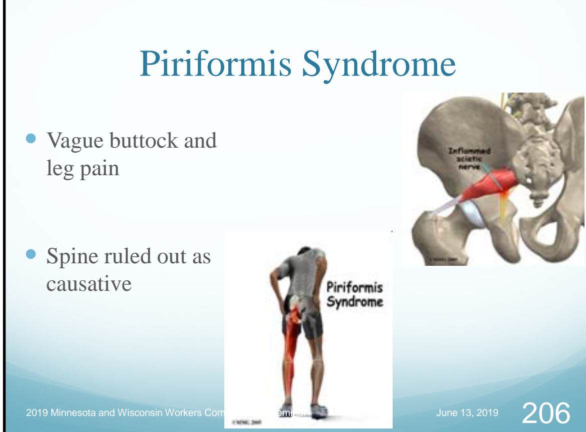

Overuse/Strain/Sprain
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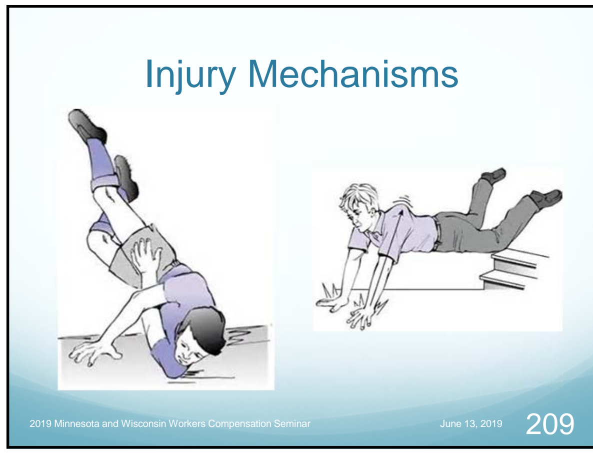
Injury Mechanisms
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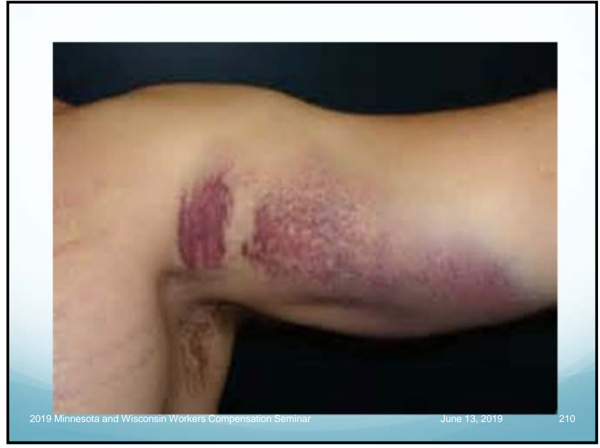
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## Shoulder Anatomy

- Ball and socket joint
- Tremendous range of motion
- Stability based on soft tissues
- Complex interactions



## Bone Structure

- Humeral head
- Glenoid
- Scapula and Acromion
- Clavicle

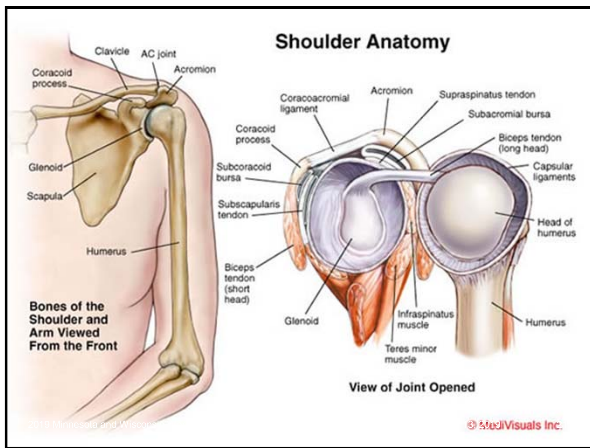


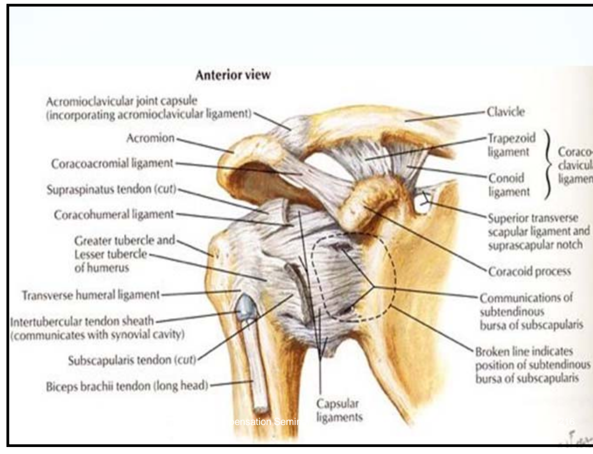
## Bone Anatomy

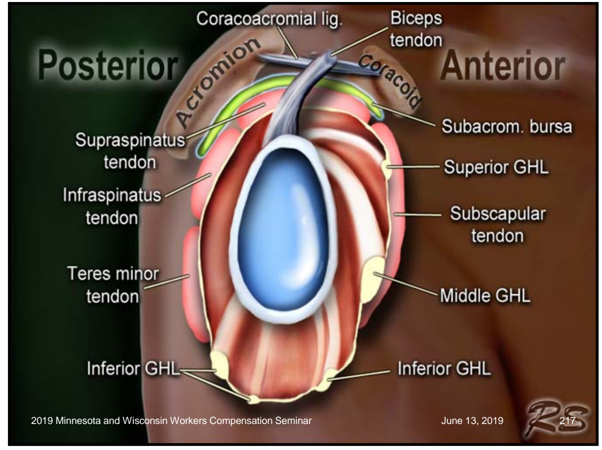
## Soft Tissues

- Glenoid labrum
- Biceps tendon
- Rotator cuff tendons
- Glenohumeral ligaments








## Glenoid Labrum

- Fibrocartilaginous similar to meniscus of knee
- Increases depth/stability of shoulder
- Subject to stress and injury from repetition and/or acute injury
- SLAP/Bankart tears most common



## BicepsTendon

- Long head enters joint/attaches to superior labral
- Subject to repetitive stress/traction
- Rupture/instability/degeneration
- Previously unappreciated source of shoulder pain

## Rotator Cuff

- Suprinspinatous/subscapularis/infraspinatous/teres minor
- 3 muscles bellies form common tendon
- Subscapularis separated by others because of biceps tendon
- Degeneration common
- Acute tears often the result of trauma



## Glenohumeral ligaments

- Capsular thickenings provide stability to joint
- Torn secondary to trauma
- Can stretch out over time with repetitive stress



## Humerus and Glenoid

- Fractures in various anatomic locations
- Fracture location and displacement/angulation affects treatment
- Glenoid fxs rare and usually associated with shoulder dislocation

## Acromion and Clavicle

- AC joint ligaments maintain stability
- AC joint may degenerate with repetitive stress
- Acromial fractures rare
- Clavicle fractures common



## Shoulder Exam

RC: HAWKINS. NEER

SLAP: OBRIEN

INSTABILITY: APREHENSION, FULCRUM, SHIFT-LOAD

BICEP: YERGASON, SPEED

Range of motion | Impingement signs | Strength



## Bony Injuries

- Proximal humerus fractures
  - Head, shaft, and/or tuberosities
- Clavicle fractures
- Scapula and glenoid fractures

## Proximal Humerus Fractures

- Direct fall on arm
- Proximal humerus anatomy and blood supply
- Neer classification
- Angulation/displacement
- Nonoperative v surgical treatment

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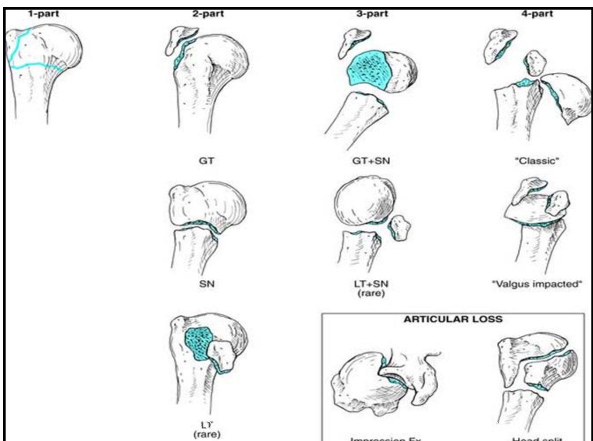


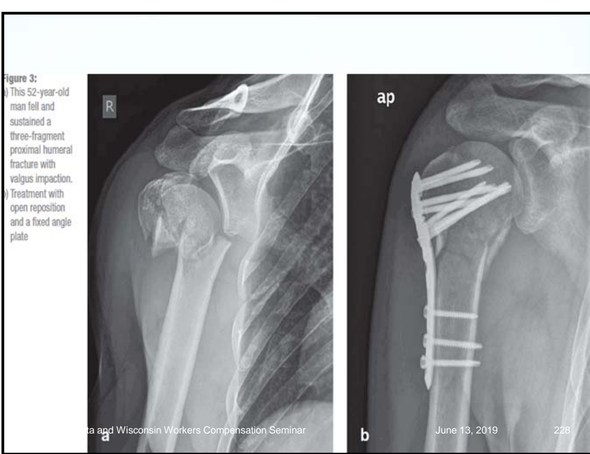


igure 3:
) This 52-year-old man fell and sustained a three-fragment proximal humeral fracture with valgus impaction.
) Treatment with open reposition and a fixed angle plate

## Clavicle Fractures

- Midshaft most common
- Controversy regarding treatment
- Displaced fx >> nonunion?
- Comorbidities; smoking
- Cosmetic deformity v functional deficit

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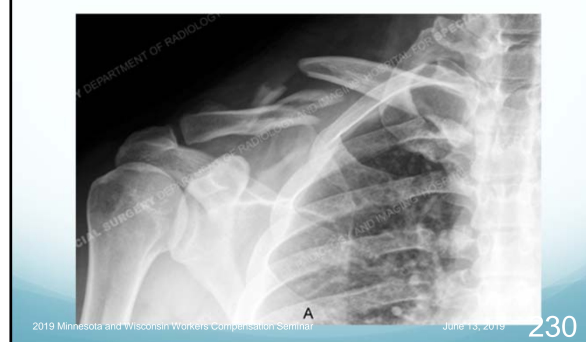
## Clavicle Fracture

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## Clavicle ORIF

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## Glenoid and Scapula fractures

- Scapula fxs caused by direct blow
- Glenoid fxs associated with shoulder dislocation
- Surgery for glenoid fx to restore shoulder stability
- Scapular body fxs rarely need surgery



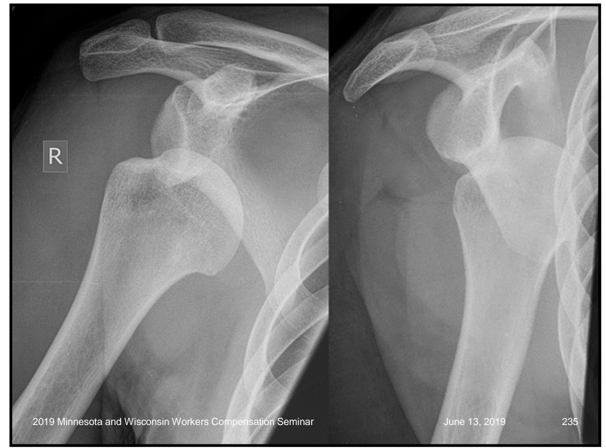
## Soft Tissue Injuries

- LABRAL TEARS
  - Bankart and SLAP
- BICEP TENDON TEARS/DISLOCATION
- ROTATOR CUFF TEARS
- GLENOHUMERAL DISLOCATIONS
- AC (ACROMIOCLAVICULAR DISLOCATIONS)
- HAGL/PASTA TEARS



## GH Dislocations

- Fall on outstreched/extended shoulder
- Most commonly anterior
- 85% associated with labral tear
- Younger patients more likely to have recurrent instability without labral repair


R
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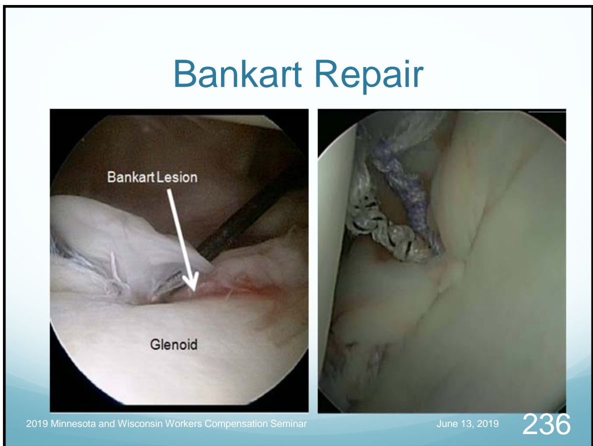
Bankart Repair
Bankart Lesion
Glenoid
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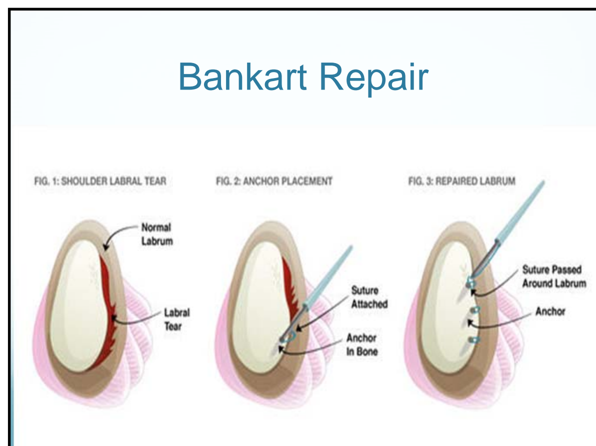
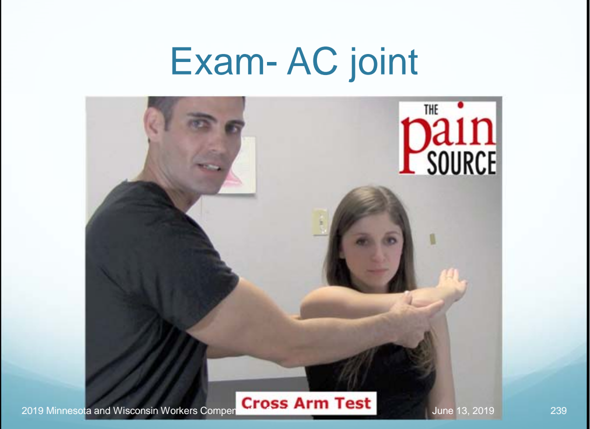

Bankart Repair
FIG. 1: SHOULDER LABRAL TEAR
Normal Labrum
Labral Tear
FIG. 2: ANCHOR PLACEMENT
Suture Attached
Anchor In Bone
FIG. 3: REPAIRED LABRUM
Suture Passed Around Labrum
Anchor

## AC joint separation

- Fall directly on superior shoulder
- Immediate deformity and/or pain
- Treatment guided by severity and graded I-VI
- Cosmetic deformity v functional deficit/pain
- Degeneration due to previous grade I or II separation or repetitive stress

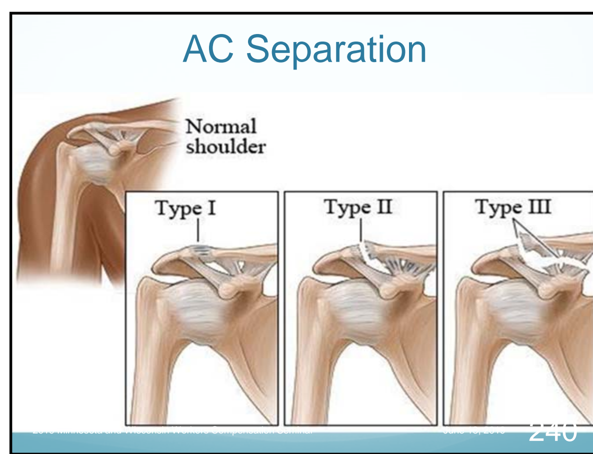


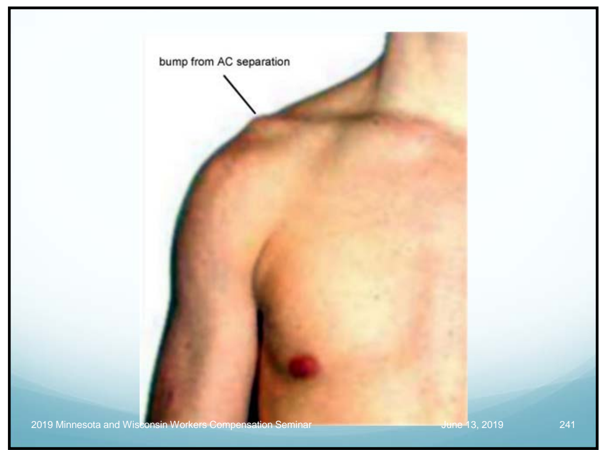
## Exam- AC joint






## AC Separation




bump from AC separation
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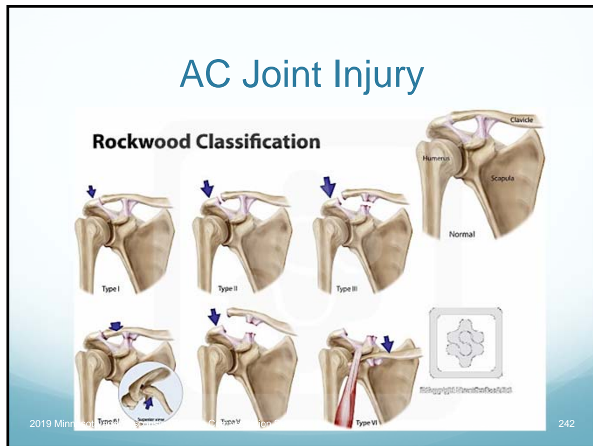
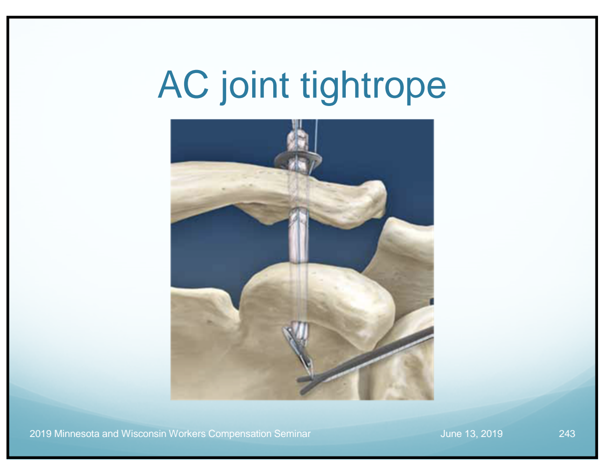

AC Joint Injury
Rockwood Classification
Clavicle
Humerus
Scapula
Normal
Type I
Type II
Type III
Type VI
242


AC joint tightrope
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## SLAP (superior labrum anterior posterior)

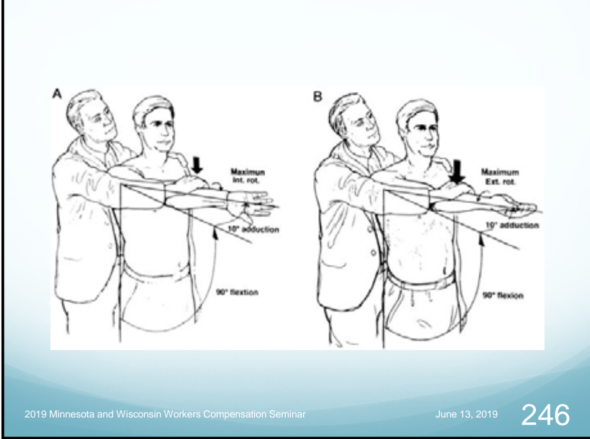
- Axial load or distraction-acute injury
- Chronic- repetitive use/stress
- c/o anterior/superior shoulder pain
- Clicking/catching mechanical symptoms
- Absence of swelling/overt PE signs



## SLAP Tears

- High index of suspicion
- Obrien's Test; specificity/sensitivity
- MRI Arthogram;
- <50 yo MRI should be done as arthrogram
- Surgery v Rehab
- Based on grade/symptoms/age of patient





## SLAP Tears

- Grade I-IV
- Surgery for II-IV
- All arthroscopic technique
- 4-6 mos recovery
- ROM allowed/lifting restriction 5# up to 6 weeks postop
- 90% successful

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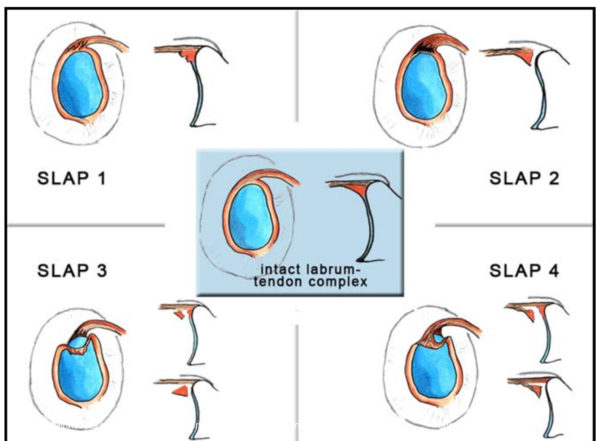


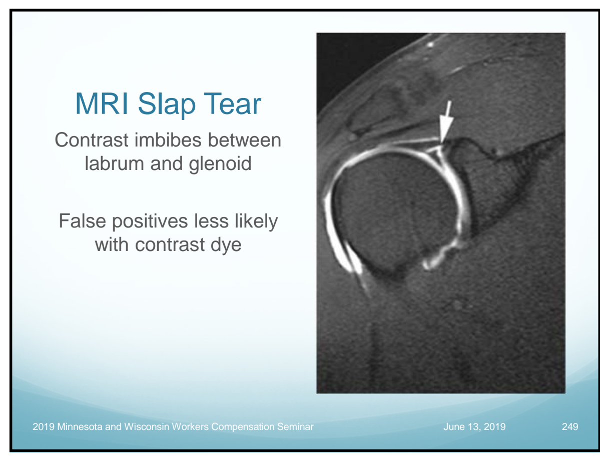

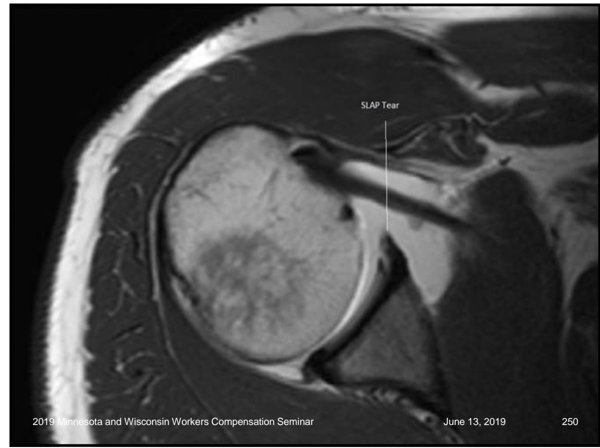
SLAP Tear
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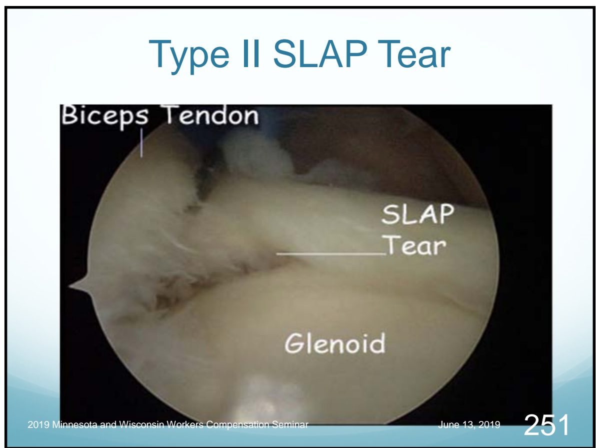
Type II SLAP Tear
Biceps Tendon
SLAP
Tear
Glenoid
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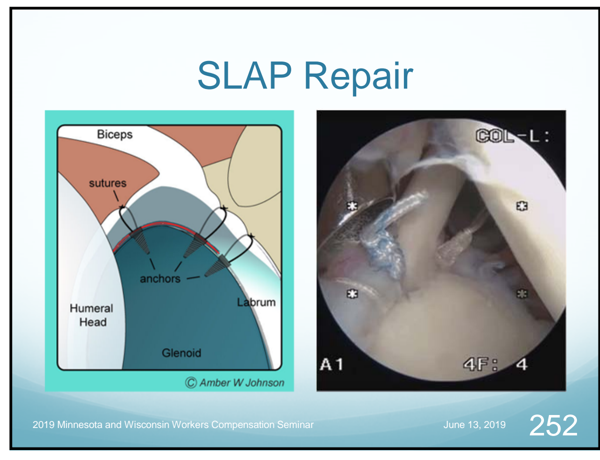
SLAP Repair
Biceps
sutures
anchors
Labrum
Humeral Head
Glenoid
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## Bicep Tendon

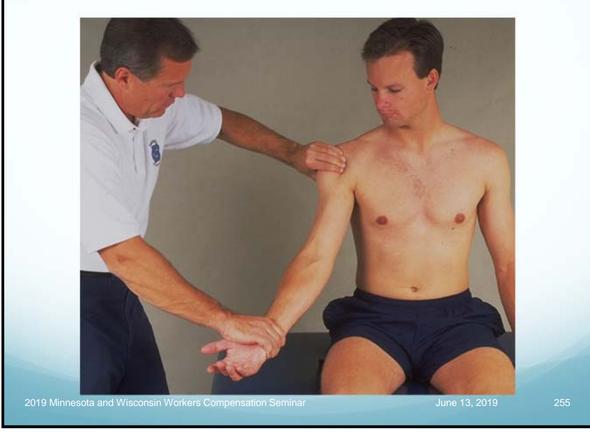
- Symptoms similar to SLAP tears
- Acute rupture in older population
- Subluxation/instability often associated with subscapularis tears
- Degeneration from repetitive stress

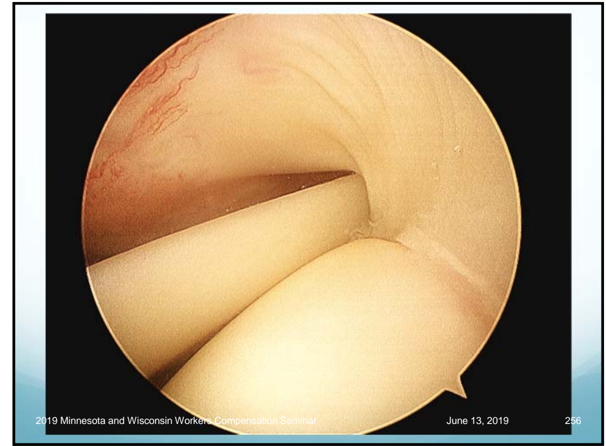


## Bicep Tendon

- Conservative treatment for isolated ruptures
- Initial rehab/injections etc. for isolated degeneration
- Debridement v tenodesis for failed nonoperative care; 30-50% degeneration guidelines
- Location of tenodesis
- Treat bicep pathology simultaneously with RC/labral pathology



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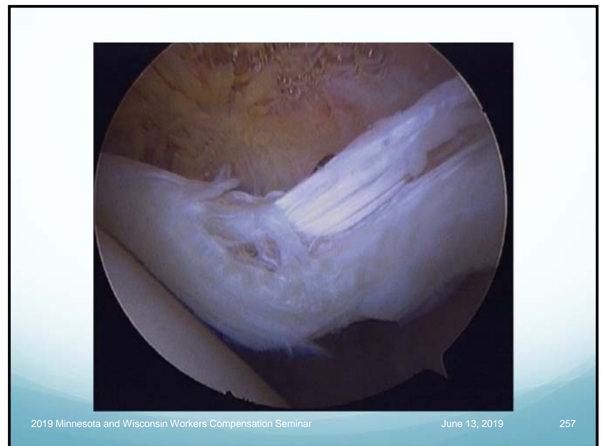
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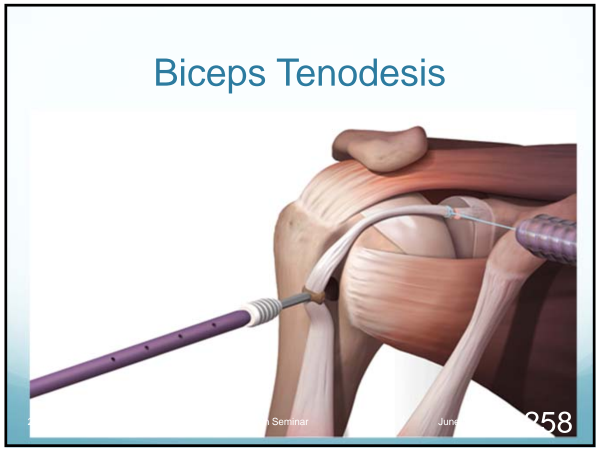
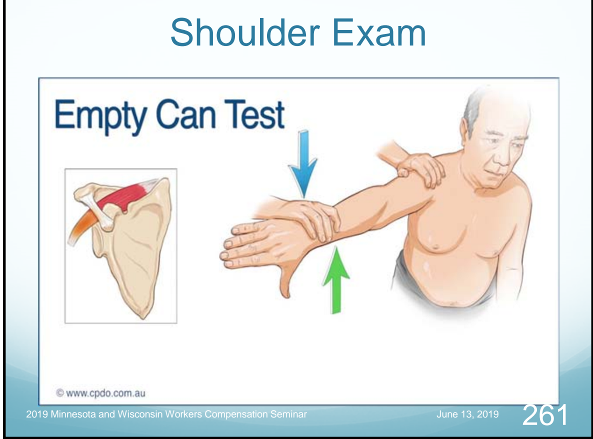
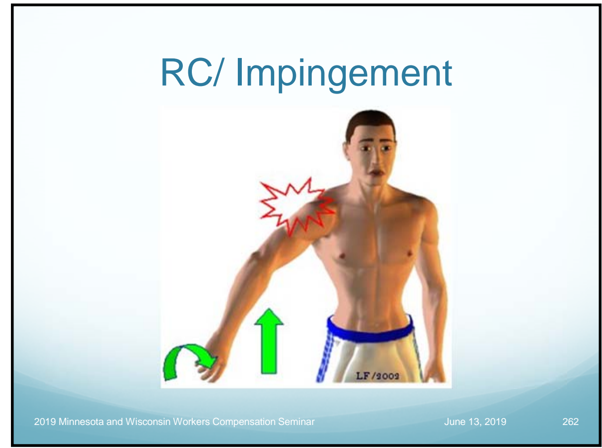

Biceps Tenodesis
258

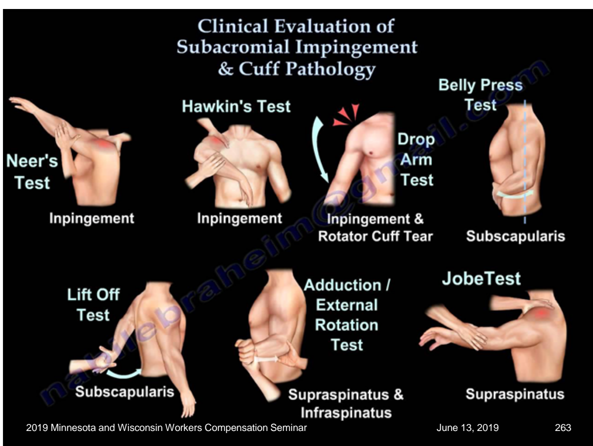
## Rotator Cuff

- Supraspinatous most common
- Tear propagates just posterior to Bicep tendon
- Associated pathology
- Chronic v acute
- More aggressive treatment with younger patients
    - concern for progression/weakness








## Shoulder MRI

- Arthrogram increases sp./sens. for SLAP/labral tears
- Not necessary for RC diagnosis
- Arthrogram indicated for < 50 yo
- Delayed diagnosis with trial of conservative care does not compromise later surgical outcome

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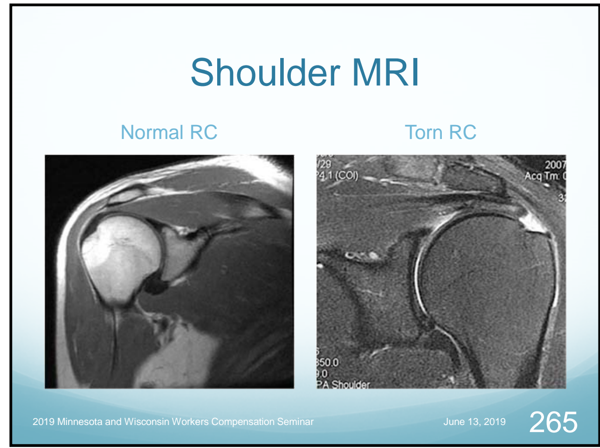
Shoulder MRI
Normal RC
Torn RC
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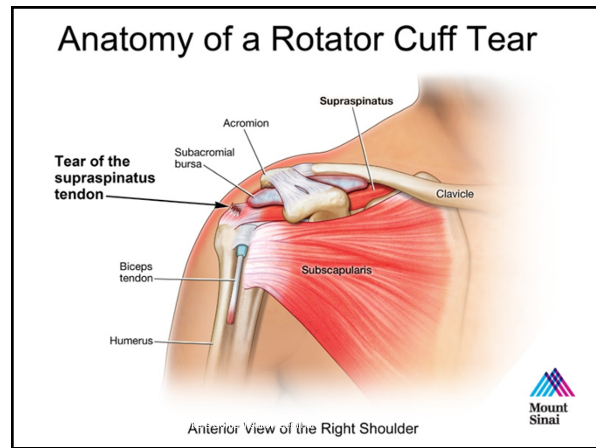
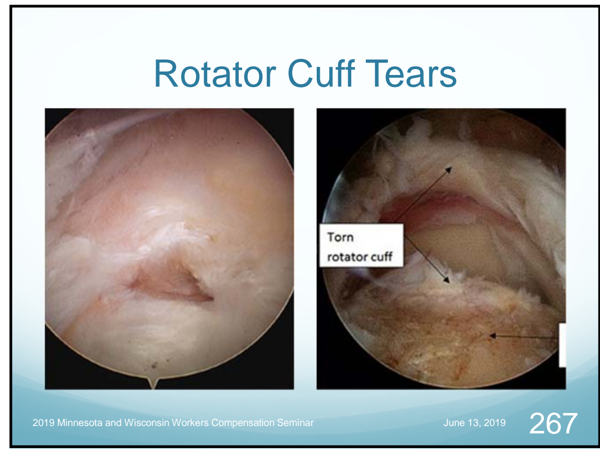

Anatomy of a Rotator Cuff Tear
Supraspinatus
Acromion
Subacromial bursa
Tear of the supraspinatus tendon
Clavicle
Biceps tendon
Subscapularis
Humerus
Anterior View of the Right Shoulder
Mount Sinai


Rotator Cuff Tears
Torn rotator cuff
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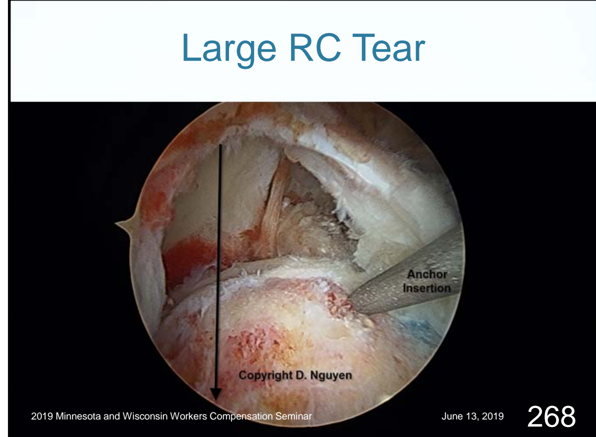


## RC Tear treatment

- Arthroscopic repair
- Single v double row
- Absorbable anchors
- 90% success
- comorbidities; smoking/Diabetes

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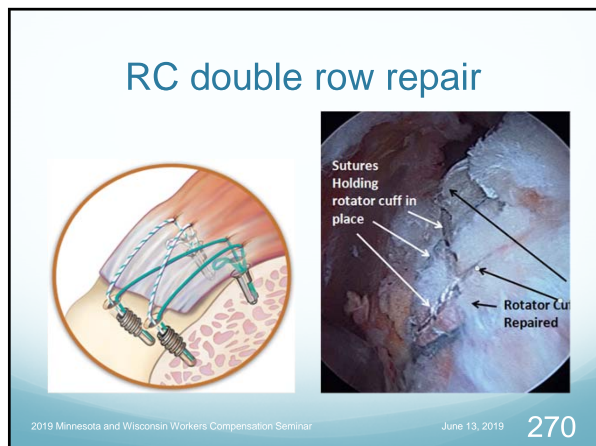

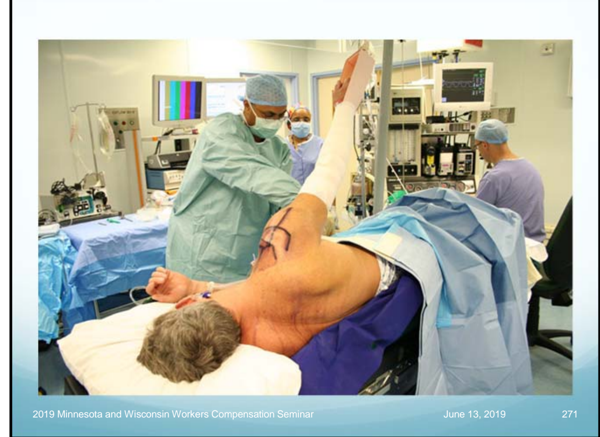


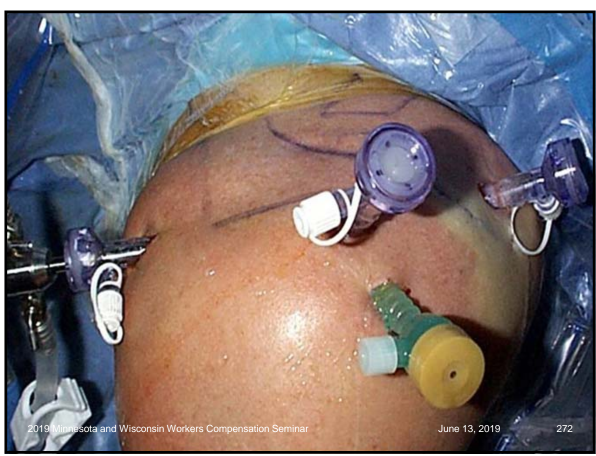


## Independent Medical Exam

- Causation based on mechanism, exam, and imaging studies
- Recovery and return to work timeframe
- Preexisting factors/injury
- Malingering and symptom magnification
- Objectivity
- Permanency

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## IMEs

- Thorough history
- Thorough record review
- Diagnostic image review
- Complete and thorough physical exam
- Does it make sense? Tying the history, record/imaging review, and clinical exam together along with clinical experience



## Diagnostic Imaging

- Correctly performed and interpreted
- Good quality
- No previous pathology



## Patient history

- Consistently told by patient
- Consistent mechanism of injury to resultant pathology
- Response to treatment

## Medical Records

- Any previous complaints to any former health care provider or employer
- Previous diagnostic images; MRI or xray
- Consistency among providers and from patient



## Causation

- Preexisting complaints/medical records
- Objective exam findings
- Diagnostic imaging
- Discrepancies in the history
- Physicians experience and knowledge



## Conclusions

- Shoulder pathology diagnosis based on history of injury, PE, and diagnostic studies
- Many individuals have (+) preexisting pathology or false positive diagnostic imaging not clinically relevant
- PE may be more subtle than knee pathology
- Overlap with cervical spine pathology
- Proceed cautiously with diagnostic imaging and treatment

# Updates on Complex Medical Issues in MN and WI Workers' Compensation:

## Medical Marijuana, TBIs, Concussions, PTSD and Opioids

James S. Pikala

Susan E. Larson

Arthur Chapman Kettering Smetak & Pikala, P.A.

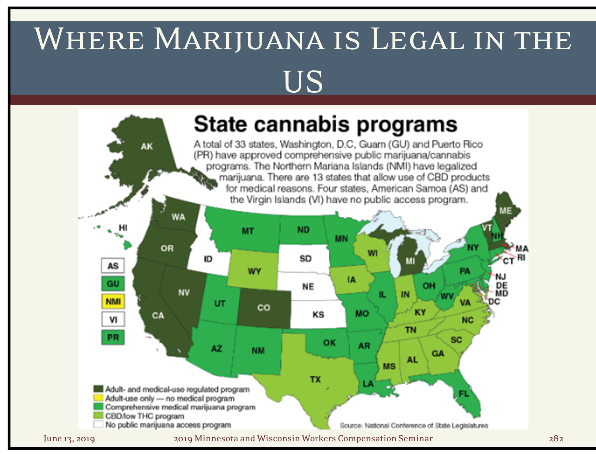
Paradigm MES Solutions Since 1978

# Medical Marijuana Update

Arthur Chapman Kettering Smetak & Pikala, P.A.

Paradigm MES Solutions Since 1978

# Where Marijuana is Legal in the US

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## Minnesota

In May 2014, Minnesota became the 22nd state to legalize medical marijuana



## Minn. Stat. § 152.22, Subd. 6 Qualifying Conditions

"Medical cannabis" any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, delivered in the form of:

1) liquid, including, but not limited to, oil;
2) pill;
3) vaporized delivery method with use of liquid or oil but which does not require the use of dried leaves or plant form; or
4) any other method, excluding smoking, approved by the commissioner.



## Minn. Stat. § 152.22, Subd. 14 Qualifying Medical Conditions

"Qualifying medical condition" means a diagnosis of any of the following conditions:

1) Cancer, if associated with:
   I. severe or chronic pain;
   II. nausea or severe vomiting; or
   III. cachexia or severe wasting;
2) Glaucoma;
3) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDs);
4) Tourette syndrome;

## Minn. Stat. § 152.22, Subd. 14 Qualifying Medical Conditions

5) Amyotrophic Lateral Sclerosis (ALS);
6) Seizures, including those characteristic of Epilepsy;
7) Severe and persistent muscle spasms, including those characteristic of Multiple Sclerosis;
8) Inflammatory bowel disease, including Crohn's disease;
9) Terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
   i. severe or chronic pain;
   ii. nausea or severe vomiting; or
   iii. cachexia or severe wasting; or
10) Any other medical condition or its treatment approved by the commissioner.



## Additional Qualifying Conditions

11) Intractable Pain – effective date July 1, 2016
    - Health care practitioners can start certifying intractable pain patients. August 1, 2016 – patients certified eligible to receive medical cannabis.
12) Post-Traumatic Stress Disorder – PTSD – effective date August 1, 2017
13) Autism – effective date August 1, 2018
14) Obstructive Sleep Apnea – effective date August 1, 2018



## Qualified Patients

Distribution in oil or liquid form (non-leaf) to qualified patients began July 1, 2015.

## Definition - Intractable Pain

"Pain whose cause cannot be removed and according to generally accepted medical practice, the full range of pain management modalities appropriate for this patient has been used without adequate result or with intolerable side effects."

M.S. 152.125



## Statistics

Patients using medical marijuana has increased, especially adding intractable pain category.

- From August 1, 2016 to December 31, 2016 2,245 people enrolled in medical marijuana for intractable pain. Of this group, 2,174 patients purchased medical cannabis. Study showed pain reduction of 30% but a decrease in opiate use. Minnesota Department of Health, March 2018 newsletter.
- *See also*, University of Michigan, study finds a 64% reduction in opiates.



## Statistics

The most frequently certified conditions are:

- Intractable pain;
- Cancer; and
- PTSD

# Emerging Issues in Workers' Compensation Medical Marijuana

## Federal Law

## Medical Marijuana History

In 1970, President Nixon repealed the Marijuana Tax Act and listed it as a Schedule I drug along with Heroin, LSD, and Ecstasy, noting no **medical uses and a high potential for abuse**. Controlled Substance Act, 21 USC § 812 (b)(1) (1970).



## Current Status of Federal Law

- Marijuana is still illegal at the Federal level as a Schedule I controlled substance.
- March 2009 ("Ogden" memo), 2010, 2011 ("COLE" memos) under President Obama and Attorney General Eric Holder – those complying with state laws are not an enforceable priority.
- 2011 back-tracked – larger scale providers could be targeted, but patients not a priority.
- DEA requested the FDA evaluate re-scheduling.
- January 2018 "Session" memo rescinded the prior policies.

## Insurers / Employers Obligation to Pay for Medical Marijuana

- Evolving issue
- New Mexico, in a Court of Appeals decision, *Vialpando v. Ben's Automotive Services and Redwood Fire & Casualty*, upheld the WCJ's decision to **reimburse the Employee** for his medical marijuana expense. It focused on whether it was a prescription drug or services versus reasonableness and necessity.



## New Mexico

- New Mexico Court of Appeals in January 2015 confirmed that "medical" marijuana was reasonable and necessary
  - *Maez v. Riley Industrial*
- The patient tested positive for **recreational** use of marijuana while being prescribed a variety of other drugs (including opioids)
- The physician decided to **certify** marijuana use
- The physician was deposed and said the patient "had failed traditional pain management and was a candidate for the cannabis program"
- The Court held since the physician confirmed its use, it should be deemed **"reasonable and necessary"**

http://www.nmcompcomm.us/nmcases/slips/CA33,154.pdf
Prium



## Payment Denied for Medical Marijuana

In *Cockrell v. Farmers Insurance & Liberty Mutual Insurance Company*, a 2012 California, Workers' Compensation Appeals Board issued a decision reversing the WCJ's finding that an injured worker was entitled to reimbursement for medical marijuana. The basis was the statute **did not require the health care provider to be** liable for any claim for reimbursement for the use of medical marijuana.

## *Maaine Bourgain v. Twin Rivers Paper* ___ A.3d___(ME 2018)

- Declined to authorize medical marijuana in Workers' Compensation case.
- Basics: Federal law pre-empts. Maryland from compelling Employer v. Insurers to reimburse Plaintiff's for medical marijuana.



## Minnesota Anecdotes

- Judge Tate decision reasonable and necessary.
- Judge Hartman decision reasonable and necessary.
- Judge Marshall tried a Travelers case week of May 6, 2019 – raised preemption.
- Judge Marshall tried our case May 14, 2019 raised preemption; no requirement under the law for Employers/Insurers to reimburse employees for medial marijuana. Reserved preemption.



## Take Away – What Do I Do?

- Deny on basis that medical marijuana is not reasonable and necessary.
- Deny on basis FDA has not approved, "medication," except Marinol and Cesamet and CBD Oil.
- Deny reimbursement no required under § 176.135, M.S. 152.22-152.37 Treatment Parameters.
- Deny that distribution of marijuana is illegal under the Controlled Substance Act, 21 U.S.C. §811 – Pre-Emption.

## Take Away – What Do I Do?

- Deny no guidelines under the Treatment Parameters.
- Deny that there are no studies on efficacy of use, the dose, or frequency allowed or side effects.
- Deny that payment must be in cash.
- Use these factors: symptoms not on and of themselves insufficient to support treatment; extent, frequency and duration of treatment; period of relief; psychological dependence; addition potential; evidence of a treatment plan; degree of relief; frequency warranted; duration of treatment; cost in light of relief.



## Investigation

- Chemical dependency records
- Substance abuse treatment
- Leaf line / medical solutions records
- Invoices
- Mental health records



## Authorization

Reimburse Employee, DO NOT pay Vendor directly with cash.

# Opioids

## The Problem

- November 29, 2017: CDC reports 91 Americans will die today from opioid overdose.
- Recent study indicates the number is now 130 per day.
- We are facing the worst drug crisis in the history of our country.
- Recent estimates of the total cost of the opioid crisis $78.5 billion
- Health care costs
- Substance abuse treatment
- Lost productivity
- Criminal justice expenses
- One month of use – withdrawal
- Opioids daily – withdrawal starts within a day



## The Problem

- The Midwestern region saw opioid overdoses increase 70 percent from July 2016 through September 2017.
- Opioid overdoses in large cities increase by 54 percent in 16 states.

**Quarterly rate of suspected opioid overdose, by US region**

Source: Centers for Disease Control and Prevention

## The Problem

- Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.
- Between 8 and 12 percent develop an opioid use disorder.
- An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.
- About 80 percent of people who use heroin first misused prescription opioids.
- Opioid overdoses increased 30 percent from July 2016 through September 2017 in 52 areas in 45 states.

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## Work Comp Costs

- Work Comp costs increasing by $1.4 billion annually.
- Delay in RTW.
- Opioids account for 25% of the WC drug costs according to NCCI and 35% or more for claims over 3 years old.
- Liberty Mutual study found Employees given opioids have increased lost time by as much as 69 days.
  - 6 times likelier to use opioids later on
  - 3 times the likelihood of needing surgery

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## Opioids – Analyte

6-MAM (Heroin), Codeine, Morphine, Oxycodone (OxyContin), Hydrocodone (Vicodin), Hydromorphone (Dilaudid)

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## Street Names / Slang Terms

- **Heroin** – Black Tar, Poppy, Al Capone, Brown Crystal
- **Codeine** – Empirin compound with codeine, Tylenol with codeine, Codeine in cough medicine
- **Morphine** – Morph, Monkey, Pectoral Syrup, Duramorph
- **OxyContin** – Hillbilly Heroin, 80, Oxy, OCs, Ox, Pills, 40, 40-Bar, Kicker, Cotton
- **Trade Names for Oxycodone** – Tylox, Percodan, OxyContin
- **Vicodin** – Vikings , Vikes, Hydros, Watson387
- **Trade Names for Hydrocodone / Vicodin** – Lortab, Lorcet, Hycodan, Vicoprofen
- **Dilaudid** – Hospital Heroin, Dillies, Hydro, M2, Dust, Juice, Smack, Footballs, D

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## Description

- Heroin is a highly addictive drug derived from morphine, which is obtained from the opium poppy. It is a “downer” or depressant that affects the brain’s pleasure systems and interferes with the brain’s ability to perceive pain.
- Morphine and Codeine are opiates, derived from the poppy plant and are commonly prescribed to manage pain.
- Oxycodone / Hydrocodone / Hydromorphone are prescription pain relievers.

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## What Does It Look Like?

- Heroin is a white to dark brown powder or tar-like substance.
- Morphine / Codeine is commonly available in the form of a tablet, syrup, injection, or as a suppository.
- Oxycodone / Hydrocodone / Hydromorphone are tablets and capsules.

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## How Is It Used?

- Heroin can be injected into a vein ("mainlining"), injected into a muscle, smoked in a water pipe or standard pipe, mixed in a marijuana joint or regular cigarette, inhaled as smoke through a straw, known as "chasing the dragon," or snorted as powder via the nose.
- Morphine / Codeine - Depending on its form, it may be injected, swallowed, or even smoked.
- Oxycodone / Hydrocodone / Hydromorphone are prescribed medically as analgesics, to treat pain. When abused, they are swallowed or injected.



## Short Term Effects

Heroin – The short-term effects of heroin abuse appear soon after a single dose and disappear in a few hours. After an injection of heroin, the user reports feeling a surge of euphoria ("rush") accompanied by a warm flushing of the skin, a dry mouth, and heavy extremities. Following this initial euphoria, the user goes "on the nod," an alternately wakeful and drowsy state. Mental functioning becomes clouded due to the depression of the central nervous system. Other effects include slowed and slurred speech, slow gait, constricted pupils, droopy eyelids, impaired night vision, vomiting and constipation.



## Short Term Effects

Morphine / Codeine – can also produce drowsiness, cause constipation, and, depending upon the amount taken, depressed breathing. Taking a large single dose could cause severe respiratory depression, coma, or death.

## Short Term Effects

Oxycodone / Hydrocodone / Hydromorphone – Relief from pain. In some people, prescription pain relievers also cause euphoria or feelings of well being by affecting the brain regions that mediate pleasure. This is why they are abused. Other effects include drowsiness, constipation, and slowed breathing. Taking a large single dose of prescription pain relievers can cause severe respiratory depression that can lead to death. Use of prescription pain relievers with other substances that depress the central nervous system, such as alcohol, antihistamines, barbiturates, benzodiazepines, or general anesthetics, increases the risk of life-threatening respiratory depression.



## Long Term Effects

Heroin – Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, cellulites, and liver disease. Pulmonary complications, including various types of pneumonia, may result from the poor health condition of the abuser, as well as from heroin's depressing effects on respiration. Withdrawal, which in regular abusers may occur as early as a few hours after the last administration, produces drug craving, restlessness, muscle and bone pain, insomnia, diarrhea and vomiting, cold flashes with goose bumps ("cold turkey"), kicking movements ("kicking the habit"), and other symptoms.



## Long Term Effects

Morphine / Codeine – Long-term use of morphine also can lead to physical dependence. This can also include tolerance and addiction.

## Long Term Effects

Oxycodone / Hydrocodone / Hydromorphone – Taken exactly as prescribed, pain relievers can manage pain effectively. But chronic use or abuse of opioids can result in physical dependence and addiction. Dependence means that the body adapts to the presence of the drug, and withdrawal symptoms occur if use is reduced or stopped. Symptoms of withdrawal include: restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, and cold flashes with goose bumps ("cold turkey"). Tolerance to the drugs' effects also occurs with long-term use, so users must take higher doses to achieve the same or similar effects as experienced initially. Addiction is a chronic, relapsing disorder characterized by compulsive drug seeking and use.

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## CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016

Morphine milligram equivalent (MME) doses for commonly prescribed

| Opioid | Conversion factor |
|---|---|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| 1–20 mg/day | 4 |
| 21–40 mg/day | 8 |
| 41–60 mg/day | 10 |
| ≥61–80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |
| Tapentadol[†] | 0.4 |

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# How Did We Get Here? The Evolution of the Crisis

## Timeline of the Opioid Crisis

1861-1865 – During the Civil War, morphine was often utilized as a battlefield anesthetic. Many soldiers developed morphine dependency as a result.

## Timeline of the Opioid Crisis

- 1898 – Heroin is first produced for commercial distribution by the Bayer Company (the same company that produces Aspirin). At the time, heroin is perceived as less habit forming then morphine, and as such is given to those individuals who were addicted to morphine, thus exacerbating their addiction.
- 1914 – Congress passes the Harrison Narcotics Act, which requires a written prescription for any narcotic. Importers, manufacturers and distributors of narcotics must register with the Treasury Department and pay applicable taxes.
- 1924 – The Anti-Heroin Act bans the production and sale of heroin in the United States.

## Timeline of the Opioid Crisis

1970 – The Controlled Substances Act is written into law. It creates groupings of drugs based on their potential for abuse. Heroin is classified as a schedule I drug while other opiates including morphine, fentanyl, oxycodone and methadone are schedule II.



## Timeline of the Opioid Crisis

**Drug Scheduling Guide**
**United States**

| Schedule | Description | Examples |
|---|---|---|
| Schedule I | Most potential for abuse and dependence<br>No medicinal qualities | Heroin, LSD, Marijuana Ecstasy, Peyote |
| Schedule II | High potential for abuse and dependence<br>Some medicinal qualities | Vicodin, Cocaine, Meth, OxyContin, Adderall |
| Schedule III | Moderate potential for abuse/dependence<br>Acceptable medicinal qualities<br>Doctor's prescription required | Tylenol with Codeine, Ketamine, Steroids, Testosterone |
| Schedule IV | Low potential for abuse and dependence<br>Acceptable medicinal qualities<br>Prescription required - fewer refill regulations | Xanax, Darvon, Valium, Ativan, Ambien, Tramadol |
| Schedule V | Lowest potential for abuse/dependence<br>Acceptable medicinal qualities<br>Prescription required - fewest refill regulations | Robitussin AC, Lomotil, Motofen, Lyrica |

Source: United States Drug Enforcement Agency



## Timeline of the Opioid Crisis

- 1980 – A letter entitled "Addiction Rare in Patients treated with Narcotics" is published in the New England Journal of Medicine. This was not a study, but rather an exploratory article that looked at incidences of addiction in a very specific set of hospitalized patients. This article would become widely cited as proof that narcotics were a safe treatment for chronic pain.
- 1995 – OxyContin, a longer acting iteration of oxycodone, is introduced and is aggressively marketed as a safe pain pill by Purdue Pharma.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

*To the Editor:* Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.



## Timeline of the Opioid Crisis

- 2007 – The federal government files criminal charges against Purdue Pharma for advertising OxyContin as a safer and less addictive alternative than other opioids. Purdue Pharma and a handful of executives plead guilty, and agree to pay 634.5 million in criminal and civil fines.
- 2010 – FDA approves a new formulation of OxyContin that is said to contain abuse deterring qualities. It is still abused.



## Timeline of the Opioid Crisis

2015 – DEA announces that it has arrested 280 people, including 22 doctors and pharmacists, after a comprehensive 15-month sting operation that focused on health care providers who dispensed large amounts of opioids.

## Timeline of the Opioid Crisis

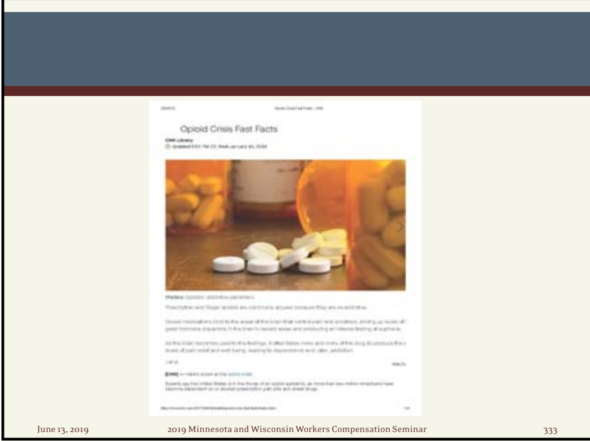
- 2016 – The CDC publishes specific guidelines for prescribing opioids for patients with chronic pain. Recommendations include prescribing over the counter pain relievers like acetaminophen. Individuals who had previously managed their pain through an opioid prescription were now forced to find alternative methods of treatment, as many doctors would no longer prescribe them.
- 2017 – President Trump declares a national public health emergency to combat the opioid crisis. President Trump has yet to outline how he specifically plans to combat this crisis.



## What is Being Done?

- Greater publicity and awareness
- Minnesota: Treatment parameters
- CDC: Guidelines for prescribing opioids for chronic pain
- Legal action
- Potential Legislative Action




Opioid Crisis Fast Facts

## Recent Developments

- March 29, 2017 – President Donald Trump signs an executive order calling for the establishment of the President's Commission on Combating Drug Addiction and the Opioid Crisis. New Jersey Governor Chris Christie is selected as the chairman of the group, with Trump's son-in-law, Jared Kushner, as an adviser.
- July 31, 2017 – After a delay, the White House panel examining the nation's opioid epidemic releases its interim report, asking rump to declare a national public health emergency to combat the ongoing crisis.
- September 22, 2017 – The pharmacy chain CVS announces that it will implement new restrictions on filling prescriptions for opioids, dispensing a limited seven-day supply to patients who are new to pain therapy.



## Recent Developments

- November 1, 2017 – The opioid commission releases its final report. Its 56 recommendations include a proposal to establish nationwide drug courts that would place opioid addicts in treatment facilities rather than prison.
- February 9, 2018 – A budget agreement signed by Trump authorizes $6 billion for opioid programs, with $3 billion allocated for 2018 and $3 billion allocated for 2019.
- February 27, 2018 – Attorney General Jeff Sessions announces a new opioid initiative: the Prescription Interdiction & Litigation (PIL) Task Force. The mission of the task force is to support local jurisdictions that have filed lawsuits against prescription drug makers and distributors.



## Recent Developments

- March 19, 2018 – The Trump administration outlines an initiative to stop opioid abuse. The three areas of concentration are law enforcement and interdiction; prevention and education via an ad campaign; and job-seeking assistance for individuals fighting addiction.
- April 9, 2018 – The US surgeon general issues an advisory recommending that Americans carry the opioid overdose-reversing drug, naloxone. A surgeon general advisory is a rarely used tool to convey an urgent message. The last advisory issued by the surgeon general, more than a decade ago, focused on drinking during pregnancy.

## Recent Developments

- May 1, 2018 – The Journal of the American Medical Association publishes a study that finds synthetic opioids like fentanyl caused about 46% of opioid deaths in 2016. That's a three-fold increase compared with 2010, when synthetic opioids were involved in about 14% of opioid overdose deaths. It's the first time that synthetic opioids surpassed prescription opioids and heroin as the primary cause of overdose fatalities.
- June 7, 2018 – White House announces a new multimillion dollar public awareness advertising campaign to combat opioid addiction. The first four ads of the campaign are all based on true stories illustrating the extreme lengths young adults have gone to get a hold of the powerful drugs.



## Recent Developments

- October 24, 2018 – Trump signs sweeping legislation into law that includes provisions aimed at promoting research to find new drugs for pain management that will not be addictive. It also expands access to treatment for substance use disorders for Medicaid patients.
- December 12, 2018 – According to the latest numbers from the CDC's National Center for Health Statistics, fentanyl is now the most commonly used drug involved in drug overdoses. The rate of drug overdoses involving the synthetic opioid skyrocketed by about 113% each year from 2013 through 2016.



## Recent Developments

January 14, 2019 – The National Safety Council finds that, for the first time on record, the odds of dying from an opioid overdose in the United States are now greater than those of dying in a vehicle crash.

## Treatment Parameters

Medications – 5221.6105

- Effective date
- Rules for NSAIDs, Opioids and Muscle Relaxants
  - Need to start with generic unless unavailable
  - Opioids
    - First 4 weeks after injury no more than 2 weeks per prescription
    - More than 4 weeks may not be for more than one month per prescription
    - More than 12 weeks may be for more than a month but most comply with rules for long-term use.



## Treatment Parameters

Long-term treatment with Opioid Analgesic Medications – 5221.6110

- Effective date 7/1/15
- Multiple requirements:
  - Pain and function assessment tools
  - Patient selection criteria
  - Must be part of an integrated program of treatment
  - Written treatment contract
  - Required monitoring
- Providers failure to comply can result in denial of treatment
- Must provide notice and allow 30 days to comply



## Treatment Parameters

Long-term treatment with Opioid Analgesic Medications – 5221.6110

- Patients already on long-term opioids prior to 7/1/15
  - Must provide written notice and allow three months to comply

## CDC Guidelines

1. Non-opioids are preferred for chronic pain.
2. Must establish treatment goals before starting opioids.
3. Must continually discuss risks and realistic benefits of opioid therapy.
4. Immediate-release opioids preferred over extended-release or long-acting opioids.
5. Lowest effective dosage possible – avoid 90mme per day.
6. For acute pain, use lowest effective dose of immediate-release opioids – three days or fewer.



## CDC Guidelines

7. Evaluate benefits and harms within one to four weeks of starting opioid therapy. Then, every three months.
8. Evaluate risk factors for opioid-related harms.
9. Review history of controlled substance prescriptions – Physician Drug Monitoring Program (PDMP).
10. Urine drug testing – before and during use.
11. Avoid opioids and Benzodiazepine concurrently.
12. Evidence based treatment for patients with opioid use disorder.



## Legal Action

- 2007 suit against Sackler
- January 31, 2019

  Commonwealth of Massachusetts

  v. Purdue Pharma, et. al.

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. No. 1884-cv-01808 (BLS2)

COMMONWEALTH OF MASSACHUSETTS,

v.

PURDUE PHARMA L.P., PURDUE PHARMA INC., RICHARD SACKLER, THERESA SACKLER, KATHE SACKLER, JONATHAN SACKLER, MORTIMER D.A. SACKLER, BEVERLY SACKLER, DAVID SACKLER, ILENE SACKLER LEFCOURT, PETER BOER, PAULO COSTA, CECIL PICKETT, RALPH SNYDERMAN, JUDITH LEWENT, CRAIG LANDAU, JOHN STEWART, MARK TIMNEY, and RUSSELL J. GASDIA

FIRST AMENDED COMPLAINT AND JURY DEMAND

RECEIVED

*Complete Unredacted Corrected Version*
*For The Public File*
*Submitted According To Court Order*
*January 31, 2019*

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**I. INTRODUCTION**

1. Dangerous opioid drugs are killing people across Massachusetts. Prescription medicines, which are supposed to protect our health, are instead ruining people's lives. Every community in our Commonwealth suffers from the epidemic of addiction and death.

2. Purdue Pharma created the epidemic and profited from it through a web of illegal deceit. First, Purdue deceived Massachusetts doctors and patients to get more and more people on its dangerous drugs. Second, Purdue misled them to use higher and more dangerous doses. Third, Purdue deceived them to stay on its drugs for longer and more harmful periods of time. All the while, Purdue peddled falsehoods to keep patients away from safer alternatives. Even when Purdue knew people in Massachusetts were addicted and dying, Purdue treated doctors and their patients as targets to sell more drugs. At the top of Purdue, a small group of executives led the deception and pocketed millions of dollars.

3. On behalf of the Commonwealth, the Attorney General asks the Court to end Purdue's illegal conduct and make Purdue and its culpable executives pay for the harm they inflicted in our state.

**II. PARTIES**

4. The plaintiff is Attorney General Maura Healey, who brings this action in the public interest in the name of the Commonwealth of Massachusetts.

5. The defendants are two companies and seventeen individuals who engaged in a deadly, deceptive scheme to sell opioids in Massachusetts. This Amended Complaint addresses the bases for jurisdiction and liability as to each of the nineteen defendants, arising from their decade-long course of misconduct in Massachusetts that involved hundreds of deaths, hundreds of thousands of unlawful acts, and hundreds of millions of dollars.

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6. Defendant Purdue Pharma Inc. is a drug company incorporated in New York with its principal place of business in Connecticut. It is the general partner of Defendant Purdue Pharma L.P., a limited partnership established in Delaware with its principal place of business in Connecticut. This Complaint refers to Purdue Pharma Inc. and Purdue Pharma L.P. collectively as "Purdue."

7. The seventeen individual defendants are current and former directors and officers of Purdue Pharma Inc. In Massachusetts, directors, officers, and employees of corporations are not immune from jurisdiction or liability when they break the law. Instead, every individual is accountable for his or her actions.[1]

8. Defendants Richard Sackler, Beverly Sackler, David Sackler, Ilene Sackler Lefcourt, Jonathan Sackler, Kathe Sackler, Mortimer Sackler, and Theresa Sackler controlled Purdue's misconduct. Each of them took a seat on the Board of Directors of Purdue Pharma Inc. Together, they always held the controlling majority of the Board, which gave them full power over both Purdue Pharma Inc. and Purdue Pharma L.P. They directed deceptive sales and marketing practices deep within Purdue, sending hundreds of orders to executives and line employees. From the money that Purdue collected selling opioids, they paid themselves and their family billions of dollars.

9. Defendants Peter Boer, Judith Lewent, Cecil Pickett, Paulo Costa, and Ralph Snyderman took seats on the Board and knowingly advanced the Sacklers' scheme.

[1] *E.g., Kleinerman v. Morse*, 26 Mass. App. Ct. 819 (1989); *Hongyu Luo v. Tao Ceramica*, 32 Mass. L. Rptr. 134 (Mass. Sup. Ct. 2014); *Rissman, Hendricks & Oliverio v. MIV Therapeutics*, 901 F. Supp. 2d 255 (D. Mass. 2012); *Trans National Travel v. Sun Pacific Intern.*, 10 F. Supp. 2d 79 (D. Mass. 1998); *Yankee Group v. Yamashita*, 678 F. Supp. 20 (D. Mass. 1988); *Johnson Creative Arts v. Wool Masters*, 573 F. Supp. 1106 (D. Mass. 1983). "The question of personal jurisdiction over an individual, therefore, rests on whether there is an independent basis for jurisdiction based on an individual's actions, regardless of the capacity in which those actions were taken." *Rissman*, 901 F. Supp. 2d at 263. A defendant's "status as a corporate officer and director does not insulate him from personal jurisdiction." *Id.* at 264.

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10. Defendants John Stewart, Mark Timney, and Craig Landau each directed Purdue's deception as CEO of Purdue Pharma Inc. and Purdue Pharma L.P. Defendant Russell Gasdia carried out the misconduct as Vice President of Sales and Marketing.

11. Beverly Sackler, Jonathan Sackler, Kathe Sackler, Paulo Costa, Mark Timney, and Craig Landau reside in Connecticut. David Sackler, Ilene Sackler Lefcourt, and Mortimer Sackler reside in New York. Richard Sackler, Peter Boer, and John Stewart reside in Florida. Judith Lewent and Cecil Pickett reside in New Jersey. Ralph Snyderman resides in North Carolina. Theresa Sackler resides in the United Kingdom. Russell Gasdia resides in Massachusetts.

12. The Court has jurisdiction over all the defendants for the reasons set forth on pages 51-269 below.

**III. OUTLINE OF THE COMPLAINT**

13. On May 15, 2007, this Court entered Judgment ("2007 Judgment") to prohibit Purdue's deceptive conduct in the sale of opioids. This suit addresses Purdue's misconduct since that 2007 Judgment.

14. The Complaint begins with the story of Purdue's misconduct in Massachusetts (pages 1-51). The Complaint then explains how each individual defendant broke the law (pages 52-256). Sections addressing jurisdiction, the counts, prayers for relief, and the jury demand then follow, as outlined in the following Table of Contents.

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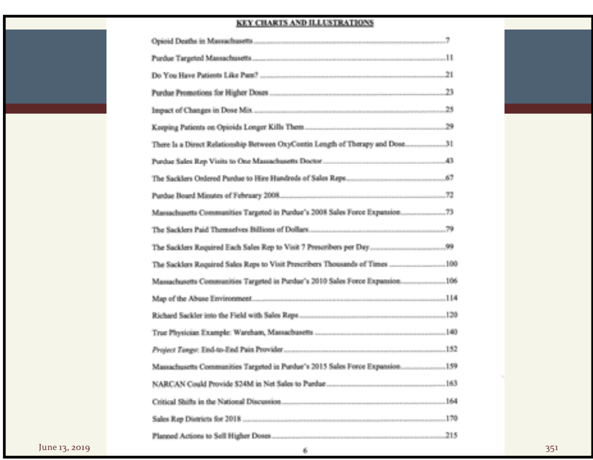

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## Case Evolution of Opioid Management

- *Port v. Potlach Corp.*, File No. WC05-286 (WCCA April 11, 2006)
  - Medications allowed
    - 22mg/day – Morphine
    - 160 mg – 3x/day - OxyContin
  - Specifically applied
    - "Cure or Relieve" standard
  - Medical science is less a 'science' and more an "art"
- *Rushmeyer v. Lyngblomsten Care Center*, File No. WC06-177 (WCCA December 20, 2006)
  - Allowed medications
  - Applied "rare case" exception

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## Case Evolution of Opioid Management *(continued)*

- *Burns v. Mid Continent Engineering, Inc.*, File No. WC08-111 (WCCA April 29, 2008)
  - Terms of narcotic contract enforced
- *Bowman v. A & M Moving & Storage Company*, File No. WC13-5551 (WCCA August 14, 2013)
  - Accidental overdose on Oxycodone found to be causally related to injury
- *Winter v. Blackwoods Bar & Grill*, File No. WC15-5859 (WCCA April 5, 2016)
  - Medications allowed:
    - Condition stable
    - Maintained functional status
    - Executed regular pain contracts
    - Random drug tests
    - Compliant with care

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## Treatment Parameters and Their Effectiveness

- Minn. Rule 5221.6105
  - Adopted August 2, 2010
  - Provide no specific limitations, other than to require a clinical evaluation every six months
- Minn. Rule 5221.6110
  - Adopted July 6, 2015
  - Apply to all dates of injury
  - Must provide notice
  - Requires ongoing monitoring
  - Requires contract
  - No specified durational limits

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## Treatment Parameters and Their Effectiveness *(continued)*

Case Law

- *Castro v. Super America*, File No. WC16-5958 (WCCA, January 9, 2017)
- Rule requires "improvement" in only first six months
- After first six months, employee need only "maintain"

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## Recommendations for Using the Workers' Compensation System to Manage or Eliminate Opioid Use

- Intervene early
  - Three months
- Look for obvious red flags
  - As outlined in rules
- Consider peer-to-peer intervention
- Obtain an evaluation with a well-recognized pain specialist
- Offer weaning / tapering schedule
- Be prepared to consider chemical dependency treatment

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## Recommendations for Using the Workers' Compensation System to Manage or Eliminate Opioid Use

- Need to reduce or eliminate medications before settlement
- If no settlement possible, take case to trial
  - Nothing to lose in most cases
  - CDC report
  - State and national publicity
  - Greater awareness of abuse and potential harm

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## References


- Opioid Overdose Crisis, National Institute on Drub Abuse (NIDA), www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
- What are Opiates? Psychemedics Corporation
- CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016, March 18, 2016
- Different medications / Different strengths – How do they compare? Express Scripts Holding Company, 2014
- Timeline of the Opioid Crisis, By Ryan Carbone, MSW, LCSW, Column Health
- Addiction Rare in Patients Treated with Narcotics, Jane Porter, Hershel Jick, M.D., Boston Collaborative Drug Surveillance Program, Boston, University Medical Center, The New England Journal of Medicine, October 4, 2017
- Opioid Crisis Fast Facts, CNN Library, January 16, 2019




## Suggested Reading

- Complaint: Commonwealth of Massachusetts v. Purdue Pharma, Et. Al.
- "The Family That Built An Empire," Patrick Radden Keefe, The New Yorker, October 30, 2017
- "Dream Land: The True Tale of America's Opiate Epidemic," Sam Quinanes, 2015



## Managing Traumatic Brain Injury Claims

sensorimotor area
frontal eye field
parietal lobe
frontal lobe
prefrontal area
visual
Broca's area (in left hemisphere)
visual association
temporal lobe
auditory
auditory association (including Vernicke's area, in left hemisphere)

Arthur Chapman
Kettering Smetak & Pikala, P.A.
Paradigm
MES Solutions
Since 1978

## Definition of TBI

Traumatic insult to the brain.



## Types of Classifications of TBI

- Closed – Occurs when head forcefully collides with another object (windshield).
- Open – Occurs when an object fractures the skull/debris enters the brain damaging brain tissue (bullet).



## Types of Classifications of TBI

**Open- Head Injury (penetrating)**

- Skull fracture that penetrates the brain
- Nail
- Gunshot wound
- Largely focal damage

**Closed-Head Injury**

- Coup-Contre Coup
- Diffuse Axonal Injury
- From falls, MVA's
- No penetration to skull

## Classifications of TBI

**Primary Lesions**

- Injury occurs at time of trauma or impact

1. Contusion/Bruising of Brain
2. Skull Fracture
3. Diffuse Axonal Injury
4. Hematoma (Blood Clot)

**Secondary Lesions**

- Injury occurs subsequent to the primary lesion, evolving over a period of hours/days after initial trauma

1. Brain Swelling/Edema
2. Increased Cranial Pressure
3. Lack of Oxygen to Brain/Hypoxia/Ischemia

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## Diffuse Axonal Injury (DAI)

- Devastating TBI.
- Damage over widespread area than in focal brain injury.
- Extensive lesions/shearing of axons in white matter.
- Major cause of LOC/Persistent vegetative state after head trauma (hit head, acceleration/deceleration).

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## Diffuse Axonal Injury

FINR Atlas of Brain Injury & Anatomy

White matter

Grey matter

Damaged axon

Myelin sheath

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## Penetrating Head Wound

An object forcefully enters skull and penetrates the brain.



## Penetrating Head Wound

FINR Atlas of Brain Injury & Anatomy

Dura layer

Skull

Penetrating object

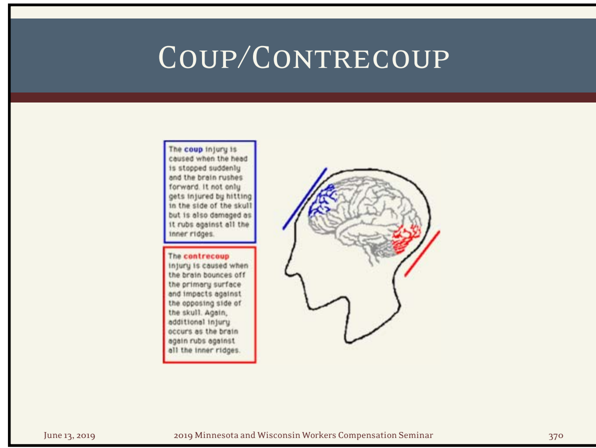
Bone fragments

Damage to brain tissue



## Coup/Contrecoup

- Coup – Skull hits first.
- Contrecoup – There is movement away from the opposite.


Coup/Contrecoup
The coup injury is caused when the head is stopped suddenly and the brain rushes forward. It not only gets injured by hitting in the side of the skull but is also damaged as it rubs against all the inner ridges.
The contrecoup injury is caused when the brain bounces off the primary surface and impacts against the opposing side of the skull. Again, additional injury occurs as the brain again rubs against all the inner ridges.
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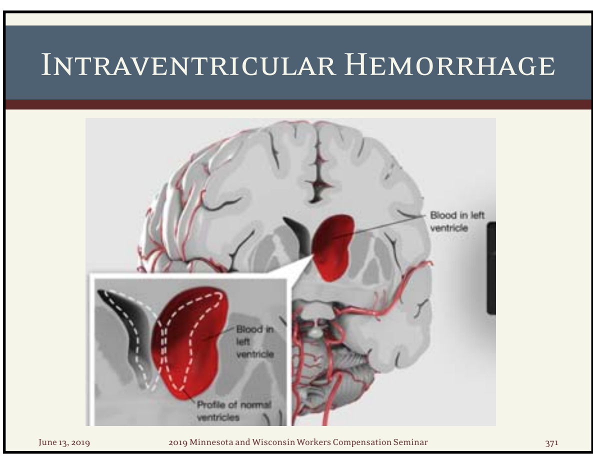
Intraventricular Hemorrhage
Blood in left ventricle
Blood in left ventricle
Profile of normal ventricles
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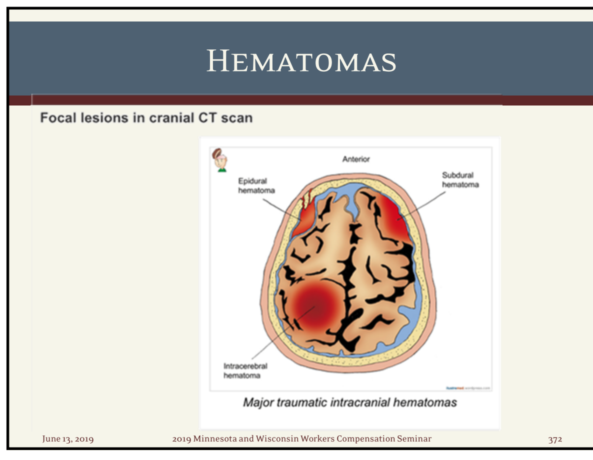
Hematomas
Focal lesions in cranial CT scan
Anterior
Epidural hematoma
Subdural hematoma
Intracerebral hematoma
Major traumatic intracranial hematomas
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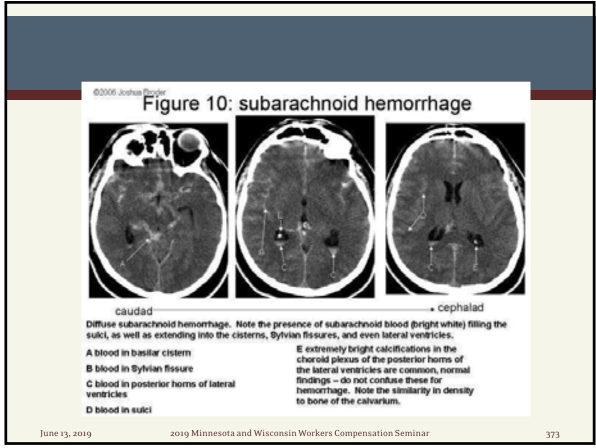




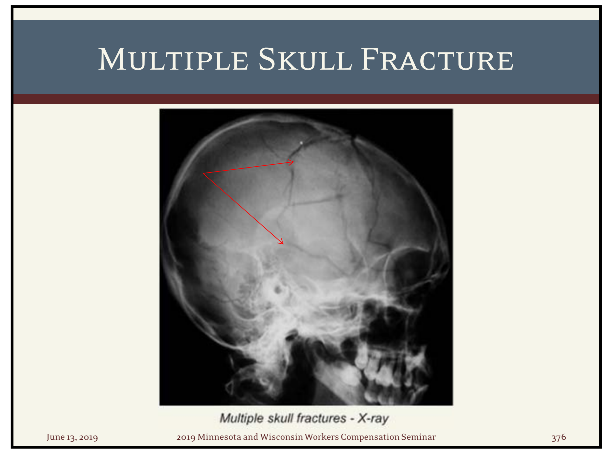

## Skull Fractures Types

- Linear – breaks in bone transversing full thickness of skull, usually straight.
- Depressed- comminuted fractures where broken bones are displaced inward (e.g., struck with hammer, rock, kicked in head). Carry risk of pressure on brain.



## Fractured Skull

*Skull X-ray showing fracture line*


Multiple Skull Fracture
Multiple skull fractures - X-ray
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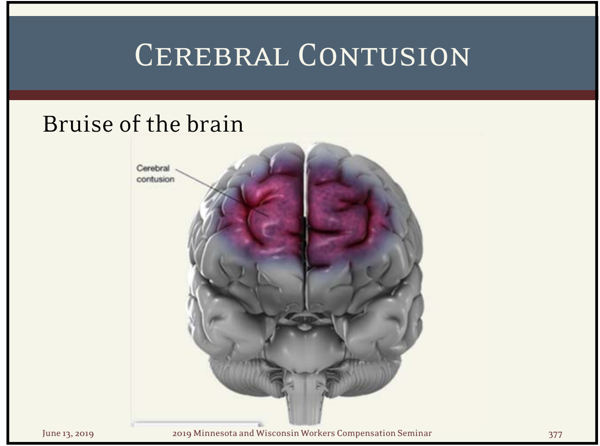
Cerebral Contusion
Bruise of the brain
Cerebral contusion
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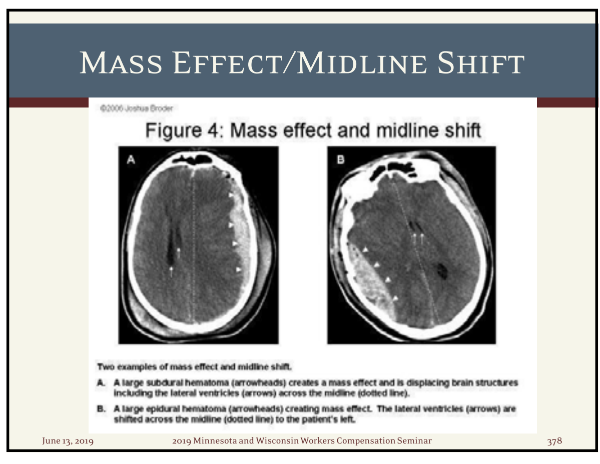
Mass Effect/Midline Shift
©2006 Joshua Broder
Figure 4: Mass effect and midline shift
A
B
Two examples of mass effect and midline shift.
A. A large subdural hematoma (arrowheads) creates a mass effect and is displacing brain structures including the lateral ventricles (arrows) across the midline (dotted line).
B. A large epidural hematoma (arrowheads) creating mass effect. The lateral ventricles (arrows) are shifted across the midline (dotted line) to the patient's left.
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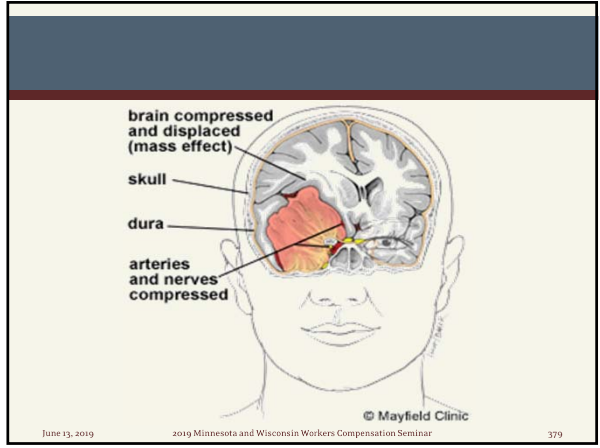


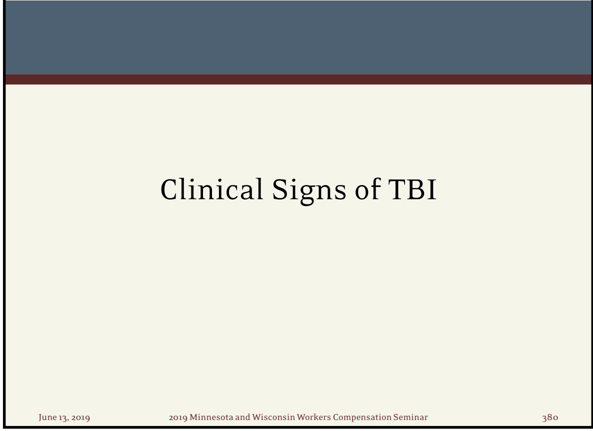


## Clinical Signs of TBI

- Loss of consciousness / amnesia
- Alteration in mental state at time of injury (confusion, disorientation, slowed thinking, etc.).
- Headache
- Vomiting
- Seizure

## Clinical Signs of TBI

- Neurological Deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia etc.) that may or may not be transient reflects focal neurologic dysfunction
- Intracranial Lesion
- DoD Definition (2007)



## Clinical Presentation

- Glasgow Coma Scale (motor/verbal response/eye opening)
- 15 point test helps doctors assess the initial severity of injury
- GCS less than 8 = Severe Injury
- GCS 9 – 12 = Moderate Injury
- GCS 13 – 15 = Minor Injury



## Severity of TBI

- *Mild Injury*
- 0-20 minute LOC – GCS = 13-15
- Post Traumatic Amnesia <24 hours
- *Moderate Injury*
- *20 minutes – 6 hours LOC –GCS =9-12*
- Severe *Injury*
- *> 6 hours LOC – GCS = 3-8*

Diagnostic Measures



## Diagnostic Measures Computerized Tomography

CT – uses a series of x-rays to create a detailed view of the brain. A CT can quickly visualize fractures, uncover evidence of bleeding in the brain (hemorrhage), blood clots (hematomas), bruised brain tissue (contusions) and brain tissue swelling.



## Spectrum Imaging

SPECT Scan – measures blood flow and activity levels of the brain. SPECT Scans examine functional activity of the brain.

The SPECT Scan indicates when there is excessive or insufficient activity in one area of the brain or various areas of activity.

## Magnetic Resonance Imaging

MRI – uses powerful radio waves and magnets to create a detailed view of the brain. MRI's are typically not done in the emergency room as they take too long. They are typically used once the person has stabilized.



## Diffusion Tensor Imaging (DTI)

DTI – is being used to track mild TBI. Proponents of this test contend DTI is useful to visualize the brain's white matter and study nerve fiber connections between different areas of the brain. It measures movement of water and nerve fibers in the brain; an abnormal flow may indicate an injury.



## Positron Emission Tomography

PET Scan – offers greater clarity than a SPECT Scan, but expensive. PET Scans color code areas of the brain based on the absorption of radioactivity as a reflection of relative metabolic activity of the lobes of the brain. Healthy parts of the brain absorb lots of glucose showing as bright orange/red. Blue/purple indicates damaged, dying or dead parts of the brain; therefore, using less glucose.

Current Science Landscape / Testing



## Blood Test

February 2018 the FDA approved a blood test to determine if people who had a blow to the head suffered a TBI / concussion.



## Banyan Brain Trauma Indicator

- Biomarker test detects two proteins present in blood soon after hit to the head.
- If negative, highly unlikely no injury.

## Banyan Brain Trauma Indicator

Blood test is effective up to 12 hours following injury and picks up brain proteins UCH-L1 and GFAP.



## Molecules

UCLA found a brain lipid molecule elevated. Lysophosphatidic acid (LPA) was significantly increased after a TBI in an animal model. Elevated in areas with cell death and axoral injury, hallmarks of moderate / severe TBI.



## Molecules

- A Rutgers team identified two molecules that protect nerve cells after a TBI and could lead to new treatments. The protein CYPIN, an enzyme that breaks down guagnine, a building block for DNA and RNA. Speeding the breakdown of guagnine protects neuron from injury and retains brain function.
- Goal – develop drugs from molecules for further study.

## Vision

- Many employees complain of visual problems following minor concussion.
- Eye tracking technology to test for TBI.
- Being used by US military to test soldiers suffering from various degrees of brain injury.
- Oculogica received FDA approval for EyeBox Device Test for Concussion (December 28, 2018).



## Vision

- EyeBox device uses eye-tracking to aid in assessment of patients with concussion via an easy, one minute test.
- Sync.Think. device also FDA approved to track visual impairments to aid in assessment of concussion.



## Handling Investigation of a TBI Case

What Should I Do?



## Investigation of TBI

- Obtain all medical records, scans, eye testing, blood work, Glascow scores, psychological exams (testing)
- Obtain EMT / ambulance records
- Prior medical records – birth to present; prior head injuries
- Complete vision history
- School records and all testing (grade school – college) (grades, discipline history)
- Mental health records – substance abuse / treatment records



## Investigation of TBI

- Military records
- Witness interviews
- Claims history
- ISO report
- Prior workers compensation records at DOLI
- Baseline testing for athletes for concussion protocols
- Employment records – performance reviews
- Pre-natal / birth records

## Records for Baseline of Function

- School transcripts
- Work performance reviews
- Awards
- IQ
- Neuropsych / psychological testing pre-injury and after injury
- SAT / ACT testing



## Evaluate Changes Against Baseline

- Friends
- Family
- Co-workers
- Supervisor

Baseline analysis pre-injury, is important for headaches, cognitive, vision.



## Experts

Understand the experts you may need in a traumatic brain injury case, crucial to adequate defense, and having a foundation for opinions.

Expensive but necessary.

## Neurologist

- The neurologist can explain the mechanism of a TBI, the results of the clinical exam, the significance of diagnostic testing, treatment recommendations, prognosis, and permanency.
- Key Question: What area of Brain impacted by injury?



## Location of Brain Injury

Injuries of the left side of the brain can cause:

- Difficulties in understanding language
- Difficulties in speaking
- Depression / anxiety
- Verbal memory deficits
- Impaired logic
- Sequencing difficulties
- Decreased control over right-sided body movements



## Location of Brain Injury

Injuries of the right side of the brain can cause:

- Visual-spatial impairment
- Visual memory deficits
- Altered creativity and music perception
- Loss of “big picture” type thinking
- Decreased control over left-sided body movements

## Location of Brain Injury

Diffuse Brain Injury – injuries scattered throughout both sides of brain can cause:

- Reduced thinking speed
- Confusion
- Reduced attention and concentration
- Fatigue
- Impaired cognitive thinking in all areas



## Neuropsychologist

Cognitive issues involve problems with attention and concentration, memory and learning issues, processing speed, and problem-solving abilities.

Key Questions:

- What instruments used to test?
- Variance from baseline?



## Key Questions

- What instruments used in neuropsych testing?
  - WAIS III from 1990's
  - WAIS IV out 4-5 years now
  - WAIS V 10/2014
- Make sure state of art updated instruments used.
- Make sure you provide pre-injury records of baseline through school records and test scores as well as mental health records.

## Cognitive Deficits
## Some Things to Look For

- Attention and concentration
- Self-monitoring
- Organization
- Speaking
- Motor planning and initiation
- Awareness of abilities and limitations
- Personality
- Mental flexibility
- Emotions
- Problem solving
- Information processing speed

Richard Perrillo, Ph.d.



## Neuro-Ophthalmologist

- TBI can be associated with vision problems.
- A neuro-ophthalmologist can assist you in sorting through what may be pre-existing problems, age-related disorders, or from the TBI.

Key Questions:

- Vision issues (prior – post injury)?
- Cause?
- Premature birth?
- What testing performed?
  - OCT and Visual field – is message getting into brain – optic nerve.
  - Convergence testing from brain out – extra ocular muscle movement.



## Fact Scenario #1

- Employee had a TBI with vision problems.
- Adjuster filed a NOID after her neurologist found Employee at MMI.
- At the conference, Employee's counsel brought a new report outlining ongoing vision therapy. The report outlined vision problems were due to problems with brain functioning.
- Counsel for Employer and Insurer reviewed the report and saw the doctor was a doctor of optometry, not a neuro-ophthalmologist and objected to the report on foundation.
- The judge allowed discontinuance and found the OD had not provided documentation of qualifications to opine on brain function.

## Take Away

Have the right expert!



## Fact Scenario #2

- Employee bumped her head on a railing sustaining a small laceration. She complained of vision problems and was diagnosed with convergence and divergence insufficiency.
- Counsel for Employer and Insurer, in strategy with adjuster, obtained a neuro-ophthalmology IME. During his exam, IME determined Employee was premature at birth and that premature babies have a high risk of vision problems.
- He determined the type of vision problems Employee had were lifelong and related to her premature birth.



## Take Away

- Appropriate investigation and litigation strategy.
- Get the right expert.
- Resulted in great settlement!

## Fact Scenario #3

- Employee slipped and fell striking his head with loss of consciousness for at least five minutes. He had severe vision problems and received ongoing therapy at HCMC.
- What can be done to stop or limit ongoing vision therapy treatment?

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## Fact Scenario #3

- IME with neuro-ophthalmologist.
- Employee had multiple diagnoses of vision disorders.
- The IME was able to delineate pre-existing eye problems unrelated to TBI, the conditions related to TBI that had resolved, and the conditions related but needed minimal treatment or no treatment.
- This IME added in the ability to close much of the vision therapy in the stipulation.

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## Fact Scenario #4 Red Flag Indicators

- After one year, symptoms worsening.
- Employee now complains of memory issues.
- What should you do?
  - Deny treatment
  - Look at MRI and other scans for unrelated conditions.
  - Get an IME – first neurologist and second if problems persist, neuro-psychologist.
  - Update scans, such as an MRI.

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## Fact Scenario #4 Red Flag Indicators

- MRI report – plaques-lesions in brain.
- Employee may have demyelinating disease.
- Neuropsych report reflects memory problems due to neurodegeneration disorder.
- Employee could have Alzheimer's.
- Neither condition due to injury.

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## Fact Scenario #5

What should you do if Employee contends Multiple Sclerosis aggravated by TBI?

- Deny causation
- Obtain all medical and scans
- IME with neurologist

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## Conclusion

- TBI can be complex and expensive to defend and manage.
- With the correct team and focus, you can hopefully mitigate loss and exposure.
- If symptoms are continuing after six weeks, schedule IME first neurologist.

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## Acknowledgements


- U.S. Department of Veteran's Affairs study yields potential biomarker for PTSD - Resistant Brains, March 2013.
- Report to Congress - Report on Research and Treatment of Post Traumatic Stress Disorder, October 2012.
- Neural Network Modulation by Trauma as a Marketing of Resilience, James, Engdahl, Leuthold, Lewis, Van Kampen, Georgopoulos, JAMA Psychiatry, February, 2013.
- The Trail of Trauma, University of Minnesota, August 27, 2013.
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- The Laucet Neurology (2018)
- McDonald, W.S. Ph.D., Brain Injury Research Center, Department of Neurosurgery and Brain Research Center, UCLA, Los Angeles, CA.




## Post-Traumatic Stress Disorder

Arthur Chapman
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## Psychological Claims

- Mental/Physical Cases
  - Where work-related mental stress or stimulus causes identifiable physical aliments
  - Compensable where the employee shows stress was extreme or at least "beyond the ordinary day to day stress to which all employee's are exposed
- Physical/Mental Cases
  - Where work-related physical injury or trauma causes, aggravates, accelerates, or precipitates mental injury
  - Compensable
- Mental/Mental Cases

## Mental/Mental Cases

- General rule: not compensable
- *Lockwood v. Independent School District No. 877*, 34 W.C.D. 305, 312 N.W.2d 924 (Minn. 1981)
  - Employee, a high school principal, claimed a disabling mental injury caused by work-related mental stress
  - Minnesota Supreme Court found non-compensable because the legislature did not expressly allow this type of injury in the Workers' Compensation Act
  - Legislature subsequently amended the Workers' Compensation Act



## Post-Traumatic Stress Disorder Minn. Stat. § 176.011, subd. 15(d)

- 2013 Amendment
  - Creates "PTSD exception" to mental/mental cases
  - States that "occupational disease" means a "mental impairment" which is defined as "a diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist"
  - Defines post-traumatic stress disorder as "the condition described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association"
  - Confirms that physical/mental cases are compensable, excluding certain situations
- 2019 Amendment
  - Creates PTSD presumption for certain employees



## Post-Traumatic Stress Disorder Minn. Stat. § 176.011, subd. 15(d)

DSM-5 Criteria

1. Exposure to threatened or serious injury;
2. Presence of intrusive symptoms following an event;
3. Persistent avoidance of stimuli associated with the event;
4. Two or more negative alterations in cognition or mood associated with the event;
5. Two or more marked alterations in arousal or reactivity associated with the event;
6. Duration of the disturbance over one month;
7. Distress or impairment in social or occupational functioning; and
8. The symptoms are not due to a medical condition or some form of substance abuse

## Post-Traumatic Stress Disorder Case Law

- *Nelson v. State of Minnesota/Department of Human Services*, No. WC17-6033 (WCCA 2017)
- *Flicek v. Lincoln Electric Co.*, WC18-6139 (WCCA 2018)
- *Kopischke v. Food Services of America*, No. WC18-6155 (WCCA 2018)
- *Petrie v. Todd County*, No. WC18-6176 (WCCA 2018)
- *Smith, Chadd v. Carver County*, No. WC18-6180 (WCCA 2019)

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## Post-Traumatic Stress Disorder Takeaways

- WCCA is interpreting the statute strictly
- Make sure your IME:
  - Knows the requirements of the law
  - Knows the DSM-5
  - Analyzes the statutory criteria

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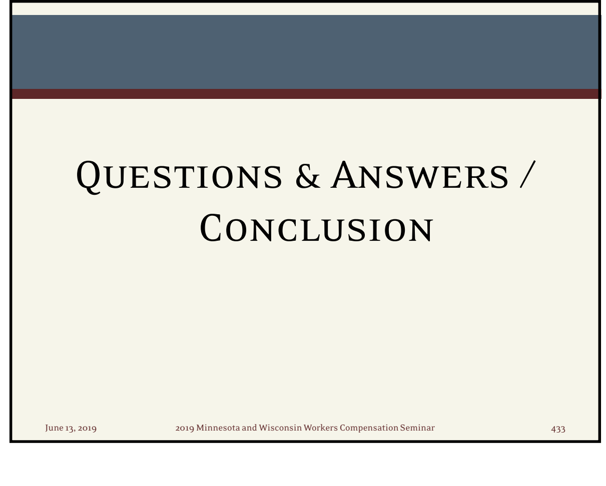
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# MINNESOTA WORKERS' COMPENSATION 2018-2019 CASE LAW UPDATE

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## Minnesota Workers' Compensation 2018-2019 Case Law Update
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# MINNESOTA WORKERS' COMPENSATION 2018-2019 CASE LAW UPDATE

## APPEALS

*Lowe v. NW. Airlines Corp.*, File No. WC17-6111, Served and Filed May 31, 2018. The employee injured her left ankle, and separately suffered an inhalation injury due to exposure to chemicals from a fire extinguisher, while employed as a flight attendant. She subsequently claimed consequential injuries in the nature of anxiety and depression, which were determined to be causally related to her inhalation injury. The WCCA affirmed that determination in 2010. Four months after the employee's employment with the employer ended, the insurer informed the employee's treating psychologist, Dr. Fresh, that it would no longer authorize or pay for ongoing psychological or psychiatric counseling, citing the treatment parameters. Approximately a year and a half later, the employee filed a medical request seeking approval for ongoing mental health treatment with Dr. Fresh, who herself had earlier filed a medical request seeking payment for an outstanding bill. An arbitrator at DOLI concluded that the treatment sought by the employee and the payment sought by Dr. Fresh were beyond what is allowed under the treatment parameters, that a departure from the treatment parameters was not appropriate, and that further treatment was not reasonable or necessary. The employee, acting pro se, filed a timely request for a formal hearing. Later, the employee retained a new attorney, who requested a continuance of an upcoming hearing on the employee's request for formal hearing. The request was granted and the hearing was continued. The parties then engaged in settlement discussions which delayed the matter further. After that, the employee's attorney withdrew and no settlement agreement was filed. Compensation Judge Arnold wrote the employee, again pro se, requesting a response within two weeks as to whether she had retained counsel. The judge further stated that failure to respond would result in the matter being stricken from the active trial calendar. The employee did not respond within the proscribed two weeks, and the Judge Arnold struck the matter from the active trial calendar. The employee retained new counsel. After the matter had been stricken for more than one year, Judge Arnold issued a notice of pending dismissal to the parties, serving a copy on both the employee and her retained counsel. The notice indicated that a written request for reinstatement was required within 60 days to avoid dismissal. The employee responded via letter to the judge, within the 60-day window, asking that her case not be dismissed and stating that she needed an extension to determine whether she would continue with her current lawyer or retain a new one. The employer and insurer objected to the written request for reinstatement on the basis that no new evidence had been provided and her representation status was not clear. Judge Arnold issued a notice for a special term conference on his motion to dismiss, which was held approximately three months later. The employee appeared pro se by telephone, as did counsel for the employer and insurer. No evidence was received and no record was made of the conference. Two days later Judge Arnold issued an order dismissing the employee's request for formal hearing and underlying medical request on the basis that the employee failed to prosecute her claim for more than two years. The judge dismissed the claim without prejudice and pursuant to his statutory authority under Minn. Stat. §176.305, subd. 4. The WCCA (Judges Hall, Milun, and Stofferahn) dismissed the employee's appeal for lack of jurisdiction. Minn. Stat. §176.421, subd. 1 limits and mandates the jurisdiction of the WCCA to hearing appeals from "an award of disallowance of compensation or other order affecting the merits of the case."

An order affecting the merits of the case is one that "finally determines the rights of the parties or concludes the action," "preventing a later determination on the merits." The WCCA found that, because the employee's request for formal hearing was dismissed without prejudice, the compensation judge's order does not affect the merits of the case. Accordingly, the WCCA lacks jurisdiction to consider an appeal from that order.

**APPORTIONMENT**

*Sather v. NewMech Companies, Inc.*, File No. WC18-6188, Served and Filed November 9, 2018. The employee was injured while working for NewMech in 1998. He was working on a ladder and experienced low back pain. NewMech accepted the injury. He began physical therapy, but was discharged with no change in his pain level, range of motion, or functional status, and with an indication that he had been unable to tolerate strength exercises. A CT scan in May 1998 showed a small L5-S1 disc herniation. An orthopedist in February 1999 placed permanent work restrictions of no lifting greater than 50 pounds. In March 1999 the orthopedist placed the employee at maximum medical improvement and rated him as having 10 percent permanent partial disability pursuant to Minn. R. 5223.0390, subp. 3C(2). NewMech paid the PPD benefits. Over the next 14 years the employee suffered a number of exacerbations. A 2002 CT scan showed mild-to-moderate degenerative changes throughout the lumbar spine with mild disc bulging at L3-4 and L5-S1. A 2012 CT scan showed mild degenerative disc disease at L1-2 and L3-4 and moderate bulging of the L3-4 disc. He received lumbar epidural steroid injections in July 2012. He was seen in the emergency room in October 2013 with another exacerbation. Less than a week later, on October 30, 2013, the employee sustained another low back injury while working for Harris Companies. He was diagnosed with an acute lumbar sprain. At an October 31, 2013, appointment scheduled prior to the new work injury, the employee underwent a CT scan that the orthopedist thought was indicative of congenital canal stenosis. The employee received an epidural injection at L3-4 and underwent a decompression at L2-3 and L3-4. The employee reported no relief and subsequently underwent fusion surgery at L3-4. The employee appeared for an IME on Harris' request on January 8, 2016. The IME physician concluded that the employee's medical care was reasonable and necessary as well as related to the October 30, 2013, injury. The IME physician opined that the 2013 injury was a permanent aggravation of the employee's underlying condition. Harris and the employee subsequently entered into a settlement resolving all claims, except medical expenses, on a full, final, and complete basis. Contribution and reimbursement claims by Harris against NewMech were explicitly left open. After a record review on October 19, 2016, the IME physician opined that the 1998 injury was a substantial contributing factor in the employee's spine condition and need for treatment. He concluded that he would not apportion anything to the Harris injury. Harris then filed a Petition for Contribution and Reimbursement against NewMech. Compensation Judge Marshall determined that the NewMech injury was a substantial contributing factor in the employee's symptoms and need for treatment from and after October 30, 2013. Judge Marshall further found that both injuries were equally responsible for the employee's symptoms and treatment from and after October 30, 2013. Judge Marshall ordered NewMech to reimburse Harris 50 percent of the benefits and expenses paid related to the employee's low back injuries since October 30, 2013. NewMech obtained a separate IME and appealed. The WCCA (Judges Stofferahn, Hall, and Quinn) affirmed. In doing so, the WCCA cited *Goetz* for the proposition that apportionment determinations are a question of fact for the compensation judge.

Per *Hengemuhle*, the WCCA's job is to determine whether the compensation judge's decision is supported by substantial evidence. The WCCA determined that a compensation judge has the discretion to choose between competing and conflicting medical experts' reports and opinions. The compensation judge did not abuse his discretion in weighing the opinions of both doctors in light of the employee's testimony and medical records.

**ARISING OUT OF**

*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 decided by the Minnesota Supreme Court on August 8, 2018, and that decision is reported below.

*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. This case was summarily affirmed by the Minnesota Supreme Court October 2, 2018.

***Roller-Dick v. CentraCare Health System*, 916 N.W.2d 373 (Minn. August 8, 2018).** [Please reference the WCCA decision above for historical background of the case.] The employee was leaving work. In order to do so, she accessed a stairway from the second floor where she worked, walking down to the first floor. The stairs are not usually accessible to the general public. The stairway had railings on both sides, as well as non-slip treads on the steps. There was nothing unusually dangerous about the stairs themselves – they were a reasonable and consistent height, well-lit, free of debris, moisture, and defects. As she was walking down the stairs, she was holding a plant with both hands, which had been given to her by a co-worker, as well as her purse in the crook of her elbow. As she was descending, she was unable to hold on to the handrails. She fell down the stairs, fracturing her left ankle. As she was falling, she dropped the plant and caught herself on the handrail, but that did not prevent the injury. The employee testified that the rubber sole on her shoe "stuck" to the treads of the stairs, but the compensation judge had determined that the non-skid surface of the stairs did not contribute to or increase the risk of her fall, and that specific issue was not appealed. The judge had determined that the injury did not arise out of the employment on the basis that the employee failed to establish that the stairs were "more hazardous than stairs she might encounter in everyday life or that her work duties in some way increased her risk of falling as she descended them." She did not identify a "work-related reason" why she was not using the handrails. The WCCA had reversed, determining that stairs, in and of themselves in the workplace, are inherently hazardous, and as such, are not a "neutral condition" like the floor at issue in *Dykhoff*.

The Supreme Court (Justice McKeig writing for the majority) affirmed the result reached by the WCCA, but on different grounds. The Court reiterated that an employee must show that an injury arose out of the employment and occurred in the course of the employment in order to establish liability. In this case, it is undisputed that the injury occurred in the course of her employment. For an injury to arise out of employment there must be some "causal connection"

between the injury and the employment. "This causal connection 'is supplied if the employment exposes the employee to a hazard which originates on the premises as a part of the working environment, or…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.'" *See Nelson; Dykhoff*. This case turns on whether the employee faced a hazard that originated on the premises as a part of the working environment.

Pursuant to *Dykhoff*, there are two categories of hazards. The first category involves "special hazards" created by employment. These include obvious or easily understood risks such as "unsafe conditions" caused by the employment. The second category involves hazards created by "neutral conditions" which are not "inherently dangerous or risky," but "something about [them]…increases the employee's exposure to injury." An example of this second category of hazards was set forth in the previous *Kirchner* case, where an employee was descending stairs which were not obviously hazardous, but turned out to be hazardous because of the absence of a second handrail, which increased the employee's risk of injury. A third type of condition was encountered in the *Dykhoff* case itself – a "neutral condition." In that case, the employee inexplicably fell while walking on the employer's floor, which was clean, dry, and flat. There was no explanation for the employee's fall, and thus, no causal connection existed between the work environment and her injury. That injury was determined to have not arisen out of the employment.

The Court described this inquiry as the "increased risk test." Most recently, the Court had considered the increased risk test in the *Hohlt* case, involving an employee who slipped and fell on an icy sidewalk owned and maintained by her employer. The Court had concluded in *Hohlt* that the employee had been exposed to a hazard – the icy sidewalk – which hazard originated on the premises as part of the working environment. *See Nelson*. Contrary to the situation in *Dykhoff*, the injury in *Hohlt* was not inexplicable.

In the instant case, the circumstances of the employee carrying a plant from her desk, as well as her handbag, while descending the stairs at work created an increased risk that the employee would fall and injure herself on the stairs, thus satisfying the requisite causal connection between the workplace and her injury. This case is similar to *Kirchner*, where the employee was faced with a hazard – stairs. Due to the circumstances in that case (other persons using the stairs), the employee had not been able to hold onto the only handrail available at the time of his fall. Similarly, in this case, because the employee's hands were full, she was also not able to use the handrail. In workers' compensation cases, the Court does not inquire into whether the circumstances that led to an employee's injury were attributable to either the employee or the employer. Negligence is not part of the inquiry. The Court simply asks whether there is a causal connection between the injury and the workplace. Again, when an employee faces a hazard originating on the premises as part of the working environment, the requisite causal connection is satisfied. Based on the facts of this case, the causal connection between the injury and the workplace was established. In a footnote, the Court specifically indicated that it was not holding, as did the WCCA, that stairs in and of themselves are workplace hazards exposing employees to an increased risk of injury. It noted that "[w]hether stairs generally are hazardous is a matter for another case and another record."

Chief Justice Gildea wrote a dissenting opinion, in which Justice Anderson joined. She would have determined that the employee did not establish a causal connection between her injury and the employment, and therefore, the injury did not arise out of the employment. She felt that the rule as applied by the majority opinion adopts what amounts to the "positional risk test," which had been specifically rejected in *Dykhoff*. She noted that the fact that the employee fell on stairs at work establishes the "in the course of" element of the statute, but that something more needs to be shown to prove the "arising out of" element. The stairway is not a hazard. There was nothing about the stairs that contributed to her fall. By contrast, in *Hohlt*, the icy sidewalk was hazardous. That is not the case with the stairway in this situation. The Court has held in *Kirchner* and *Dykhoff* that "[m]any workplaces have stairways and there is nothing inherently dangerous or risky about requiring employees to use them." The employee's decision not to take advantage of the safety of the handrails provided by the employer was not attributable to her employment. In contrast to the majority opinion, this is not implying that the employee was negligent. She simply was not holding onto the handrails because of circumstances separate from her employment. The fact that she did not use the handrail was not attributable to the employer.

*Comment*: This decision [and the summary affirmance of the *Lein* case above] can be viewed as moving the Minnesota Workers' Compensation system one step closer to the "positional risk doctrine," which indicates that if the employer puts the employee in a position wherein he or she is injured, then the injury is compensable. In *Roller-Dick*, the Supreme Court did not adopt the WCCA's determination that stairs are inherently hazardous in and of themselves. [However, in *Lein*, the WCCA also held that way and the Supreme Court summarily affirmed.] Nonetheless, the Court makes it easier for employees to show that stairs can be made hazardous, not only by conditions which are presented by the employment (as was the case in *Kirchner*), but also by conditions which are created by the employee separate and apart from the employment activities (such as the carrying of a personal plant in this case.) Based on current application of the "increased risk" test, employers and insurers are now left with a very thin opportunity to deny that an injury "arose out of" the employment. Essentially, employers and insurers need to prove that the injury was the result of a completely "neutral condition" as exhibited in the *Dykhoff* case.

*Forrest v. Children's Health Care*, File No. WC18-6140, Served and Filed August 16, 2018. The employee worked as a respiratory therapist who would see patients on three adjacent floors. She testified that she could take the elevator between floors, but typically used the stairs if she was going up or down one or two floors. On the date of injury, she was using the stairs to go down two floors to obtain a medical device. She testified that she was likely holding the handrail. She could not recall if she had anything in her hands. As she reached a landing, she pivoted to descend the next flight of stairs. Her foot did not pivot with her, and she felt a sharp pain in her knee. Primary liability was denied on the basis that the injury did not arise out of her employment. The employer and insurer had the employee undergo an independent medical examination with Dr. Simonet, who determined that the employee's knee condition was caused by her pre-existing arthritic condition and not related to any work injury. Compensation Judge Marshall determined that "the preponderance of the evidence shows the employee sustained an injury to her left knee arising out of and in the course and scope of her work activities." Benefits were awarded. The employer and insurer appealed. The WCCA (Judges Stofferahn, Milun, Hall, Sundquist, and Quinn) stated that the phrase "arising out of" refers to a causal connection between the injury and the employment, but not necessarily in the sense of proximate cause. The Supreme Court held in the *Hohlt* case that the causal connection is established if the employee, while on the employer's premises and in the course of employment, is subjected to an increased

risk of injury. The WCCA noted that, in this case, the compensation judge determined that "the employee was required to ascend and descend the stairs on a regular basis to access the various floors as required by her job. That alone increases her risk of injury." The employer and insurer argued that the employee could have used the elevator but, citing *Roller-Dick*, the WCCA rejected this argument, as it "smacks of a return to the negligence standard the Workers' Compensation Act expressly rejects." The WCCA addressed, head-on, the question of whether, absent other circumstances, the use of stairs in the course of employment represents an increased risk of injury. It determined that, unlike the neutral risk of traversing a clean flat floor considered in *Dykhoff*, use of stairs is not a neutral risk, but instead inherently presents an increased risk of injury. The WCCA stated that it acknowledged the concern that a conscientious employer cannot avoid a workers' compensation claim in this situation, but that this is a function of the "grand bargain" between workers and employers under the workers' compensation system. The employer does not need to worry about any negligence standard and, in return, an employee's claim is not foreclosed because of an employer's attempt to minimize risk. In conclusion, "the stairs on an employer's premises constitute an increased risk of injury, and for an employee . . . who is in the course of her employment and is injured on stairs located on her employer's premises, the claim is compensable under Minnesota law." This case was summarily affirmed by the Supreme Court on January 8, 2019.

*James v. Duluth Clinic*, File No. WC18-6128, Served and Filed August 21, 2018. The employee worked as a nurse anesthetist, performing moderated anesthesia care or "MAC" on patients. One day, he was performing MAC on a patient undergoing a colonoscopy. This required him to observe the patient, the amount of medication being used and when the medication was discontinued, and charting. The procedure room was a tight space and the employee sat with the patient while the patient was on a table with a pump on the other side of the patient. While doing this work, the employee was 100 percent focused on the patient. At the end of the procedure, he turned off the pump and observed the patient before rolling his chair backwards to the computer to chart. He stood and pivoted to the right to use the computer and felt his right knee pop. His right foot did not move. He was eventually diagnosed with an anterior cruciate ligament rupture. The claim was denied on the basis that it did not arise out of his employment, and the employee filed a Claim Petition. At hearing, the employee testified that when he pivoted, there might have been a substance on the floor or the traction of his shoes could have caused his injury. Compensation Judge Baumgarth held that the employee's testimony that he "planted and twisted" his knee was credible, but that there was no proof something was stuck to the floor, and, thus, there was no increased risk. The compensation judge denied the claim and the employee appealed. The WCCA (*en banc* with Judge Quinn writing the opinion) affirmed the compensation judge's finding that there was no clear evidence of a substance on the floor at the time of the alleged injury, but reversed the compensation judge's decision for failure to apply the correct legal standard. While there was no evidence of a substance on the floor, the employee encountered a "set of circumstances" as part of the working environment, which, when combined, created a hazard. He was working in a confined space with his focus entirely on the patient. He rolled his chair back, stood up, planted his foot, and twisted towards his computer, which resulted in a twist of his body and a rupture of his anterior cruciate ligament. This set of circumstances presented an increased risk and provided a causal connection between his injury and employment. Thus, his injury did arise out of his employment. This case was summarily affirmed by the Minnesota Supreme Court on January 9, 2019.

*Rosar v. Southview Acres Health Care Center*, File No. WC18-6143, Served and Filed September 21, 2018. The employee worked as a nursing assistant and "always" walked fast at work. When she was not at work, she apparently walked at a "more relaxed pace." One day, she finished her shift, completed her charting task and washed her hands. Then, she turned to go down the hall, grab her purse and punch out of work for the day. The floor was carpeted, dry and there was nothing on it. It was also flat and non-slippery. She walked a few steps before falling and was injured. She sought workers' compensation benefits, and, at the hearing, testified that at the time of her fall, she was walking at a fast pace, but did not know why she fell. Compensation Judge Grove held that the employee's injury did not arise out of her employment and denied her claim. The employee appealed. The WCCA (*en banc* with Judge Quinn writing the opinion) affirmed, finding that there was substantial evidence to support the compensation judge's decision that there was insufficient evidence to show a causal connection between the employee's "hurrying" and her fall. Thus, the employee's fall was unexplained and non-compensable.

*Krull v. Divine House, Inc.*, File No. WC18-6166, Served and Filed September 27, 2018. The employee worked at a group home and in the day in question, she was helping to carry groceries into the home for the residents of the group home. She was carrying three gallons of milk from the car to the home, when she heard a pop in her knee. She experienced severe pain and was unable to bear weight on that leg. She suffered from pre-existing left knee osteoarthritis. She filed a claim seeking workers' compensation benefits. At the hearing, she acknowledged that there was nothing wrong with the surface she was walking on, she was walking normally, and the milk she was carrying did not impact her stability while walking. Based on her testimony, Compensation Judge Daly found that her injury did not arise out of her employment because there was no increased risk. The WCCA (Judges Hall, Sundquist, and Quinn) affirmed, holding that there was no evidence of any twisting motion or other action that would constitute an increased risk. She was striding normally at the time of the incident. There was no showing that carrying the milk affected her walking normally. Because there was no increased risk, she did not meet her burden of proof.

**ATTORNEY FEES**

*Caswell v. North Country Sheet Metal, LLC*, File No. WC18-6148, Served and Filed June 18, 2018. The employee retained an attorney, Aaron Ferguson, to represent him with respect to a work-related injury. Attorney Ferguson submitted a letter to the employee's treating physician, asking for a rating of permanent partial disability. The treating physician issued a report that outlined the PPD rating, and Attorney Ferguson sent this letter to the insurer. Fewer than three weeks later, the insurer issued payment of PPD benefits in accordance with the treating physician's report. Attorney fees were withheld from the benefits paid. The employee discharged Attorney Ferguson and retained a new attorney. Attorney Ferguson subsequently filed a Statement of Attorney Fees, seeking to obtain the fees relative to the PPD benefits paid by the insurer. The employee objected to Attorney Ferguson's request for fees. Compensation Judge Tate determined that there was no genuine dispute relative to the payment of PPD benefits and denied the fee claim. The WCCA (Judges Stofferahn, Milun, and Sundquist) affirmed. Attorney Ferguson argued to the WCCA that, despite the insurer paying the PPD within three weeks of receiving the treating physician's report, that timeframe nonetheless constituted a "delay" and the insurer should have known based on the records that PPD would be owed. However, the WCCA pointed out that the treating physician's report in which the PPD ratings were provided

also indicated that the employee was at maximum medical improvement (MMI). The WCCA found that PPD is not ordinarily ascertained until after MMI is established. There was no indication that MMI had been reached in this case until the physician's report was issued, so the insurer's payment for PPD benefits was timely. The WCCA noted that, while Attorney Ferguson did assist the employee with obtaining payment of PPD benefits, "the statute is clear that unless there is a genuine dispute over the receipt of those benefits, the attorney will not be entitled to a fee from the employee's benefits."

***Hufnagel v. Deer River Health Care Center*, 915 N.W.2d 747 (Minn. July 18, 2018).** 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. 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.

On appeal, the WCCA found that 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 and remanded the finding relative to the *Roraff* fee. The defense argued that the employee's attorney had spent time trying to establish the 2009 injury, and there was no award of benefits specifically for the 2009 injury, so the attorney fees for that issue were unreasonable. However, 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.

The Supreme Court (Justice Hudson writing for the majority) affirmed the decision of the WCCA. It began its analysis with a reference to Minn. Stat. §176.191, subd. 1:

> Where compensation benefits are payable under this chapter, and a dispute exists between two or more employers or two or more insurers . . . [w]hen liability has been determined, . . . [t]he claimant *shall* also be awarded a reasonable attorney fee, to be paid by the party held liable for the benefits.

The Court noted that the plain language of the statute uses the word "shall," making the award to a claimant mandatory when there is a dispute between two or more employers or two or more insurers, which is the case here. The efforts by each employer to shift responsibility to the other employer "greatly increased the burden on [the employee's] counsel to provide effective representation." Therefore, the employee was entitled to receive reasonable attorney fees under .191.

Regarding the *Roraff* issue, the Supreme Court noted that, "Attorneys should be compensated for the preparation required to thoroughly represent their clients and not just for time spent developing the argument that is ultimately successful." The WCCA's vacation and remand of the *Roraff* fee issue was upheld.

*Dilley v. Carver County Sheriff*, File No. WC18-6205, Served and Filed February 22, 2019. The employee sustained two work injuries on July 14, 2015, and September 27, 2015, and underwent three surgeries. He was released to return to work with permanent restrictions. In a Findings and Order of January 27, 2017, the employer was ordered to provide the employee with vocational rehabilitation services. A QRC initiated rehabilitation services for which she billed the employer. A dispute arose over payment of the services. The QRC filed four rehabilitation requests seeking payment in full. The employer filed rehabilitation responses objecting to payment. A September 27, 2017, administrative conference addressed the rehabilitation requests. The employee and his attorney were served notice of the conference. A Department of Labor and Industry mediator adopted the employer's position and denied full payment of the QRC's bills. The employee appealed by filing a request for formal hearing. The employer objected to the employee's request, claiming that he had no standing to raise the issue. The compensation judge agreed and dismissed the employee's request for formal hearing. However, the QRC also filed a request for formal hearing, and the matter went to hearing on January 9, 2018. The QRC represented herself. The employee's attorney attended the hearing and asserted that the employee had "no direct claim." Compensation Judge Behounek awarded full payment of the QRC's bills. The employee's attorney filed a statement of attorney fees claiming 16.3 hours of time billed at $500.00 an hour for a total of $7,162.00 for *Heaton* fees. At the attorney fee hearing the employee's attorney argued that his client's rights were affected by the QRC's rehabilitation requests. Because the dispute may have placed caps on job placement and job development, he argued that the outcome could have adversely affected the employee's ability to return to work and entitlement to future rehabilitation services. The employer argued that the employee's attorney had already been paid for prior disputes and that no issue was presented which affected the employer's future vocational rehabilitation benefits. Claiming that the QRC is a neutral party working for both the employee and the employer, the employer maintained that there was no dispute with the employee and therefore no attorney fees were warranted. The judge found that the employee's attorney was not entitled to attorney fees. She explained that the QRC represented herself in a dispute involving past bills for rehabilitation services and that the dispute was limited to the statutory interpretation and application of rules relating to categorization of services as job development versus job placement. The employee's entitlement to ongoing rehabilitation benefits was not at issue, there was no dispute as to a change in the rehabilitation plan, and there was no issue as to whether the employee was qualified for rehabilitation services. The WCCA (Judges Sundquist, Stofferahn, and Hall) reversed and remanded. The WCCA noted that Minn. Stat. §176.081 makes no distinction based on whether a rehabilitation dispute is between the QRC and the employer or between the employer and employee. The statute requires

only that there be a dispute related to the payment of rehabilitation benefits. The WCCA also reversed the judge's determination that the employee's rights were not implicated where the issue involved payment for past rehabilitation bills. The statute makes no distinction between disputes regarding the past, present, or future entitlement to rehabilitation benefits. The statute provides only that if there is a dispute related to the payment of rehabilitation benefits, and contingent fees do not adequately compensate the employee's attorney, the attorney is entitled to a reasonable attorney fee under the statute. The employee need not be a direct party to the dispute for attorney fees to be awarded.

*Beager v. North Valley, Inc.*, File No. WC19-6262, Served and Filed May 15, 2019. The employee represented himself in the first round of litigation and settled his workers' compensation claim on a full, final, and complete basis. The award on stipulation was filed and approved by the OAH. The employee then hired an attorney to represent him in vacating the previous award on stipulation. The employee's attorney contacted the employer and insurer and attempted to negotiate an agreement to vacate the prior award on stipulation, but was not successful. The employee's attorney then collected additional medical evidence, including a narrative report, and drafted a petition to vacate, which was filed with the WCCA. Shortly thereafter, the employer and insurer notified the WCCA that they were waiving their right to object to the petition to vacate. The WCCA vacated the award on stipulation, and the employee's attorney filed a petition for attorney's fees. In his petition, he sought $5,395 in fees based on his hourly rate of $350 per hour for 14.5 hours of work, and 3.2 hours of paralegal work, reimbursement of attorney's fees under Minn. Stat. §176.081, subd. 7, and costs and disbursements. The employer and insurer objected to the hourly attorney's fees on the basis that they were excessive, there was no actual litigation as they did not object to the petition to vacate, the fees were not supported by adequate information, and the fees were not in compliance with Minn. Rule 1415.3200. The employer and insurer did not object to the fee reimbursement under Minn. Stat. §176.081, subd. 7, nor costs and disbursements. The employee's attorney argued that he had unsuccessfully tried to negotiate an agreement to vacate the award on stipulation, and thus, there was litigation. The WCCA (Judges Quinn, Milun and Hall) held that the employee's attorney was justified in seeking an award of attorney's fees, but only awarded him $3,300 in fees, as that is what the WCCA has generally awarded to employee's attorneys for successful representation on appeals and on petitions to vacate in non-oral argument settings, and there was no reason to deviate from this practice in this particular case. The WCCA also declined to award fee reimbursement under Minn. Stat. §176.081, subd. 7, as that statutory provision applies to contingency fees payable from the employee's compensation benefits, not to appeal fees under Minn. Stat. §176.511.

### COORDINATION OF BENEFITS

*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.

***Bruton v. Smithfield Foods, Inc.*, Case No. A18-0914 (Minn. Sup. Ct. February 27, 2019).** The employee sustained a work injury on August 25, 2016. At the time of the injury, the employer maintained workers' compensation insurance that included a $2,000,000 deductible per claim (essentially making the employer self-insured.) The employer also maintained a short-term disability (STD) policy for its employees. That plan was administered by the employer's human resources department. The parties stipulated that the employer owned the funds held in that plan and administered the plan on behalf of its employees. It was not an ERISA plan. The employer initially denied liability for the employee's work injury, though it did not dispute that the employee was disabled as a result of his injuries. Accordingly, the employer paid STD wage-loss benefits under its private plan. The employee subsequently filed a petition for workers' compensation benefits. The employer conducted an investigation and filed an amended notice of primary liability determination that accepted liability for the injury under the Workers' Compensation Act. The insurer began paying temporary total disability benefits and also paid benefits retroactively for the period during which liability was denied. For that period of time, the insurer paid the employee benefits representing the difference between the STD benefits that the employer had already paid and the TTD benefits that the employee would have received had the employer accepted liability at the outset. The employer argued to the compensation judge that it did not owe the employee additional TTD benefits for the period when the employee had already received wage-loss benefits under its STD plan. Relying on public policy that disfavors double recovery, the compensation judge concluded that an offset in the employee's TTD benefits was required based on the amount that the employer had paid as STD benefits. The WCCA reversed, concluding that the STD benefits were not workers' compensation benefits and, thus, the employer could not invoke either of two statutory routes to reduce benefit payments to an injured worker. The WCCA additionally noted that the employer had no contractual right to reimbursement under the facts of this case.

The Supreme Court (Justice McKeig writing for the majority) affirmed. The Court acknowledged its prior jurisprudence decrying "the injustice of double recovery" which was to be avoided in awarding workers' compensation benefits. However, the Court distinguished this case in that the employee sought the TTD benefits to which he was entitled by statute, in addition to the STD benefits conferred, separately, by his employer. The Court noted that the issue presented was whether the employer had a "statutory right" to reduce workers' compensation benefits otherwise payable by the employer simply because STD benefits have been paid through

a self-funded, self-administered plan. [In a footnote, the Court noted that an insurer may have a claim for reimbursement when benefits are paid in the absence of a contractual obligation to do so. However, in the instant case, the employer expressly chose not to rely on the contractual language of its STD policy as a basis for a claim to offset payments previously made to the employee. Ed. Note: At least suggesting that different contractual language in the STD policy may have given the employer an argument for the offset.] The Court then cited several provisions enacted by the Legislature that provide employers with certain offset remedies. None of those provisions was applicable here. The Court declined to extend those provisions beyond their plain and unambiguous terms. Although there was strong public policy against double recovery of benefits, there was nothing in Minn. Stat. §176.101, subd. 1(a) to prevent the employee from receiving both STD and TTD benefits. [In a footnote, the Court noted that the employer did not invoke Minn. Stat. §176.191, subd. 3 as a possible means of asserting an offset.] The Court declined to insert words or meanings that were intentionally or inadvertently omitted by the Legislature. *See Rohmiller*. The Court indicated that, if a different result is necessary or intended, the Legislature – not the Judiciary – must act.

Justice Thissen concurred, but wrote separately to emphasize his opinion that the majority decision did not foreclose an employer from seeking reimbursement for STD benefits paid to an employee under a contract or STD policy that requires such reimbursement if the employee later recovers wage replacement workers' compensation benefits for the injury that caused the disability. Under such terms, Justice Thissen indicated the employer could intervene in the case for recovery under Minn. Stat. §176.361, subd. 2(b)(1), (5). Justice Thissen specifically noted that the employer's STD policy in this case did not contain a claw back provision if workers' compensation benefits were subsequently paid for the same disability. Justice Anderson joined in the concurrence.

## COSTS

*Oseland v. Crow Wing County*, File No. WC17-6120, Served and Filed August 30, 2018. For a summary of this case, please refer to the Interest category.

***Oseland v. Crow Wing County*, Case No. A18-1550 (Minn. Sup. Ct. May 29, 2019).** For a summary of this case, please refer to the Interest category.

## 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.

*Grieger v. Menards*, File No. WC18-6237, Served and Filed April 29, 2019. The employee retired at age 69 and subsequently started working as a part-time stock person for Menards. He worked 20 to 21 hours per week, on average. While working at Menards, the employee sustained a fatal injury at age 81. He was survived by his wife, who was paid dependency benefits by the employer and insurer based on an average weekly wage of $205.18. The dependent spouse filed a claim for underpayment of benefits arguing that she was entitled to dependency benefits based on "the number of hours normally worked in the employment or industry in which the injury was sustained," pursuant to Minn. Stat. §176.011, subd. 18, not based on the employee's actual average weekly wage. At the hearing, multiple witnesses testified about the number of hours worked in the industry. Compensation Judge Marshall found that the employer and insurer had properly paid dependency benefits. That finding was previously appealed to the WCCA, which reversed and remanded for a determination of benefits consistent with Minn. Stat. §176.011, subd. 18. On remand, Judge Marshall relied on the employer and insurer's vocational expert's opinion and concluded that the number of hours normally worked in the industry was 24 hours, which raised the wage to $260.40. In doing so, the compensation judge rejected the dependent spouse's position that the number of hours should have been based on federal labor statistics which indicated that the industry average was 33 hours per week. On appeal the dependent spouse argued that the federal labor statistics for the industry was the best evidence, an argument rejected by the compensation judge on the basis that it was unreasonable to pay a dependent at a rate significantly higher than the employee's actual earnings.

The WCCA (Judges Sundquist, Stofferahn, and Hall) affirmed. The WCCA concluded that substantial evidence supported the compensation judge's reliance on the employer and insurer's expert over the dependent spouse's argument and expert, finding that the use of a broad or narrow approach to the assessment of the deceased employee's industry is a question of fact for the compensation judge.

**EVIDENCE**

*Krumwiede v. GGNSC Slayton*, File No. WC18-6134, Served and Filed July 10, 2018. For a summary of this case, please refer to the Medical Issues category.

*Thaemert v. Honeywell International Inc.*, File No. WC18-6164, Served and Filed December 20, 2018. For a summary of this case, please refer to the Medical Issues category.

**EXCLUSIVE REMEDY**

***Daniel v. City of Minneapolis*, Case No. A17-0141 (Minn. Sup. Ct. February 27, 2019).** The employee worked as a firefighter for the City for 14 years. During this time he sustained multiple injuries, including injuries to his right ankle and shoulders. The focus of this case involved the employee's request for a footwear accommodation. Following his 2014 right ankle injury, the employee's doctor prescribed supportive "tennis shoes with arch support + high rescue boot high ankle" to reduce pain and improve stability. An IME agreed that the employee's ankle issues were aggravated by his need to work on uneven surfaces wearing heeled shoes at work, and the City accepted liability for the workers' compensation claim. A captain told the employee that he could wear black tennis shoes in the station house, and the employee purchased black tennis shoes and fitted them with special inserts. The City paid for these along with supportive rescue boots. The employee wore the tennis shoes in the station house for 6-8 weeks until the Deputy Chief told him that he could no longer wear them because they did not comply with the Department's policy for station shoes. The employee claims that after he reverted to wearing station shoes his ankle started to swell and his pain increased. Ultimately, he reinjured his ankle and seriously injured his shoulder when he lost his footing climbing down from a fire truck. The Department placed the employee on light-duty for his shoulder, but would not allow him to wear his prescribed tennis shoes. Therefore, the employee claimed that the light-duty position was outside of his restrictions and he was placed on leave. While he was on leave there were "numerous" meetings regarding the footwear issue, but no agreement was reached. Based upon a functional capacities evaluation, the City offered the employee early retirement, which he accepted. In addition, the employee settled his workers' compensation claims for $125,000. The employee filed a district court complaint asserting that the City violated the MN Human Rights Act (MHRA) by not allowing him to wear doctor-prescribed tennis shoes inside the station house. He asserted that allowing him to wear the shoes would be a reasonable accommodation. Further, he asserted that the City retaliated against him for seeking a reasonable accommodation. The City moved for summary judgment, arguing that the exclusivity provision in the Workers' Compensation Act (WCA) prevented the Employee's MHRA law suit. Minn. Stat. §176.031 (2018) states, in-part: "[t]he liability of an employer prescribed by this chapter is exclusive and in the place of any other liability to such employee . . . on account of such injury . . ." A district court judge denied the request for summary judgment, and the City filed an interlocutory appeal to the Minnesota Court of Appeals (MNCOA), arguing that the district court lacked subject-matter jurisdiction because of the exclusive remedy provision in the WCA. The MNCOA agreed

with the City, and Daniels appealed to the MN Supreme Court (SC). The SC reversed the MNCOA and remanded the matter to the district court to proceed on the merits of the MHRA claim. Justice Chutich, writing for the majority, reasoned:

> Because Daniel's alleged injury under the human rights act arose not from his original ankle injury but from his employer's alleged discriminatory response to that injury, his injury is not a covered injury under the workers' compensation act. The two statutory schemes address distinct injuries. As a result, we conclude that no conflict exists between the exclusivity provisions of the workers' compensation act and the human rights act.

The SC focused on the fact that the WCA provides remedies for "physical" injuries, whereas the MHRA is a *civil rights* law that protects employees from unlawful employment discrimination, including this employee's claims that his civil rights were violated by harming his dignity and self-respect as a disabled employee. The SC concluded that the alleged damage to the employee's "individual dignity, as well as the loss of a fair employment opportunity because of the alleged failure to accommodate his physical disability, are alleged injuries distinct from the ankle injury suffered by Daniel many months before the dispute over accommodation arose." This determination specifically overrules the long-standing precedent established in the 1989 case of *Karst v. F.C. Hayer Co.*, 447 N.W.2d 180 (Minn. 1989), however, the majority believes that its conclusion "harmonizes" the legislative intent behind each act.

Justice Anderson wrote a lengthy dissent to this decision (joined by Chief Justice Gildea). Justice Anderson indicated that "[b]ecause Daniel's failure-to-accommodate claim is 'on account of' the same physical injuries that gave rise to the City's workers' compensation liability, I would hold that the City's workers' compensation liability is exclusive. In concluding otherwise, the Court undermines the foundational exclusivity principle on which our workers' compensation system rests, ignores the plain statutory language of the exclusivity provision, and overrules our decision in *Karst v. F.C. Hayer Co.*, 447 N.W.2d 180 (Minn. 1989), without addressing the principles upon which it stands." Further, Justice Anderson warned that "the Court fails to appreciate the troubling consequences of its decision. The Court's reasoning undermines workers' compensation exclusivity, implicates double-recovery by employees, and likely will result in a proliferation of failure-to-accommodate litigation over workplace injuries."

*Comment*: It is important to note that this case does NOT conclude that the City violated the MHRA. That issue has been remanded to the district court for a determination on the merits. As is indicated by the dissent, we do anticipate that there may be an increase in failure-to-accommodate cases. These are not covered by workers' compensation policies, but may be covered by employment practices liability insurance (ELPI). It will be important for employers to document accommodation requests, efforts to comply with these requests, and reasons for not complying if it is determined that this cannot be done. Employers which are inclined to reject an accommodation requested by an injured employee, and which cannot reach a compromise acceptable to the employee, would be well-advised to seek legal advice. There are a number of reasons that an employer may have to not accommodate, at least in the way an employee requests. But refusals to accommodate can lead to protracted litigation and, sometimes, to expensive liability.

## *GILLETTE* INJURIES

*Noga v. Minnesota Vikings Football Club*, File No. WC18-6133, Served and Filed September 19, 2018. (For additional information on this case, please refer to the Notice and Statute of Limitations categories.) The employee played football during junior high, high school, and college. He was drafted by the Minnesota Vikings and played for them from 1988 through the 1992 season. He then played for the Washington Redskins, Indianapolis Colts, and in the Arena Football League, eventually retiring from professional football in 1999. During his tenure with the Vikings, and due to the nature of his tackling, he complained of headaches and dizziness and occasionally reported these symptoms to the team trainer or team doctor. He typically was provided with Advil or Tylenol and occasionally was told to rest in the training room. He continued to experience these symptoms and receive hits to the head during the rest of his career. In 2001 he filed a claim petition in Minnesota for benefits associated with a number of specific orthopedic injuries. These injuries were the subject of a stipulated settlement. Attached to the settlement was a "very brief" February 17, 2004, report by Dr. Fruean, which listed twelve complaints that the employee attributed to injuries sustained while playing for the Vikings. These included blackout episodes from concussions and headaches from football injuries. Dr. Fruean recommended that the employee be evaluated by a neurologist. Over the years the employee treated with neurologists and developed dementia. In 2014 he was rated with 86.5 percent permanent partial disability and not currently employable. He underwent a vocational/psychological evaluation and was deemed permanently and totally disabled due to his dementia and ADHD in combination with orthopedic injuries. The employee filed a claim petition on January 15, 2015, seeking benefits against the Vikings for a *Gillette* injury to the head. The employer and insurer obtained a neuropsychological IME, who attributed the employee's condition to other factors, including drug addiction, sleep deprivation, chronic pain, ADHD, and vision problems. At an April 8, 2016, hearing Compensation Judge Marshall concluded that the employee's testimony credibly showed that he had sustained multiple concussions while playing for the employer, resulting in a *Gillette* injury culminating on the last day of his employment. The employer appealed and the WCCA vacated, ruling that Judge Marshall did not provide an analysis of how the evidence supported a *Gillette* injury against the employer. It remanded for further proceedings. Judge Marshall relied on the record as well as new depositions of the employee's and the employer's neuropsychological evaluators. Judge Marshall again concluded that the employee suffered a *Gillette* injury as a result of his employment with the employer. The WCCA (Judges Hall, Milun, Stofferahn, Sundquist, and Quinn) affirmed, finding that substantial evidence existed to support Judge Marshall's decision. It was the compensation judge's role to evaluate the probative value of witness testimony and resolve conflicts in expert medical testimony. The WCCA additionally found that an argument that primary liability rested with the last team for which the employee played during his professional career is an apportionment argument, not a *Gillette* argument, and thus is irrelevant. "[L]iability for a *Gillette* injury generally is held to rest with the employer and insurer on the risk on the date of disablement, so long as the duties of that employment were also substantial contributing factors to the *Gillette* process." This case has been appealed to the Minnesota Supreme Court, and was orally argued on February 6, 2019.

## INTEREST

*Oseland v. Crow Wing County*, File No. WC17-6120, Served and Filed August 30, 2018. Following the employee's injury in 1980, he was found to be permanently and totally disabled. The PTD benefits paid by the employer and insurer were offset under Minn. Stat. §176.101, subd. 4, for the employee's PERA benefits. The employee subsequently died, and his PTD benefits ceased in February 2013. In August 2014, the Minnesota Supreme Court issued the decisions in *Ekdahl v. Independent School District No. 213*, 851 N.W.2d 874 (Minn. 2014) and *Hartwig v. Traverse Care Center*, 852 N.W.2d 251 (Minn. 2014), which held that the Minn. Stat. §176.101, subd. 4 offset for an employee's receipt of "any old age and survivor's insurance benefits" applied only to social security benefits. In September 2015, the Department of Labor and Industry took the position that *Ekdahl* and *Hartwig* applied prospectively and retroactively and directed insurers to identify all employees who were underpaid past PTD benefits within 45 days. The insurer notified DLI within the 45 days that it would need additional time to review its files. In November 2015, the insurer determined that the employee's estate in this case was owed an underpayment. The total underpayment was ultimately determined and communicated to the employee's heirs in September 2016. The employee's heirs then filed a claim petition seeking an underpayment of PTD benefits and interest on that amount, as well as penalties and taxable costs. Compensation Judge Tate determined that the employer and insurer accurately calculated the underpayment, that interest was allowed on the underpayment from the date the original benefits were owed at the rate in effect at the time, and denied the claim for penalties and taxable costs. The WCCA (Judges Stofferahn, Milun, Hall, Sundquist, and Quinn) reversed the compensation judge's award of interest, finding that the insurer made payment within the time frame set forth in Minn. Stat. §176.1292, subd. 2(d)(3), so no interest was due. It held that interest does not accrue until: (1) the employer and/or insurer are aware of the claim for benefits; (2) there is an obligation to pay benefits; and (3) the amount of benefits owed is "fixed and ascertainable." Regarding taxable costs, the WCCA affirmed the compensation judge's finding that the costs for obtaining the decree of descent (where the workers' compensation attorney for the employee's heirs retained probate counsel to obtain the decree of descent to prove who was entitled to receive the underpayment of benefits), were not taxable costs under Minn. Stat. §176.511, subd. 2. Finally, the WCCA affirmed the compensation judge's denial of penalties finding that substantial evidence supported the determination that the employer and insurer did not inexcusably delay reimbursement to the employee's heirs for the underpayment due to the heirs.

Judge Milun dissented on that part of the decision relative to interest – she would have awarded interest from the dates of the underpayment of benefits, regardless of the time frame set forth in Minn. Stat. §176.1292. Judge Quinn also dissented on that part of the decision relative to interest – he would have awarded interest as of the date of the *Ekdahl* and *Hartwig* decisions. This case was heard by the Minnesota Supreme Court and its decision is reported below.

***Oseland v. Crow Wing County*, Case No. A18-1550 (Minn. Sup. Ct. May 29, 2019).** The employee sustained an admitted injury in January 1980. Benefits were paid. Approximately nine years after the injury, the employee became permanently and totally disabled and PTD benefits were paid. In June 1996 the employee began receiving retirement benefits from the Public Employees Retirement Association (PERA), and the insurer began offsetting those benefits from the PTD benefits (which was in accord with WCCA precedent at the time). These benefits were paid until the employee died in 2013, at which time all benefits ceased. In 2014, the Supreme

Court decided *Ekdahl* and *Hartwig*, holding that insurers cannot reduce PTD benefits by amounts being paid as PERA benefits. In September 2015, the insurer performed an audit of its files and notified the Department of Labor and Industry that it had taken a PERA offset, that the employee had passed away, and requesting guidance as to what to do. DOLI did not respond to that letter and the insurer did not follow up. In June 2016, DOLI advised the insurer that it had audited the claim and determined that the insurer had underpaid $169,177 in benefits as the result of the PERA offsets. DOLI instructed the insurer to pay the estate these underpaid benefits. The insurer hired a forensic accountant to verify the amount of underpaid benefits, and that audit took two months, revealing that the underpaid benefits were approximately $10,000 less than what DOLI had calculated. The insurer sent the results of its audit to DOLI in September 2016, and DOLI agreed with that assessment. The insurer sent emails to one of the employee's heirs about the underpaid benefits, requesting the name of the estate and the personal representative. The heir did not respond. In November 2016, the heirs filed a claim petition seeking underpaid benefits and interest. The insurer acknowledged that it owed underpaid benefits to the heirs and was ready to issue payment upon provision of the personal representative and address. The insurer denied that it was liable for interest on the underpaid benefits. The heirs obtained a decree of descent to establish that they were legal heirs, and that was sent to the insurer in February 2017. In May 2017, the parties executed a stipulation for settlement providing for payment of the forensic accountant's overpayment calculation, but leaving claims open for additional underpayment of benefits, interest, and penalties. A compensation judge held that the heirs were not entitled to additional underpaid benefits, penalties, or expenses, but determined that they were entitled to interest on the underpaid benefits. The judge further determined that the applicable rate of interest on the underpayments was based on the date of each underpayment. In other words, the applicable interest rate was "the rate set by statute at the time the benefits became due and owing." Both parties appealed.

The WCCA affirmed the denial of the claim for penalties and expenses, agreeing that the obtaining of a decree of descent was not a taxable expense. The WCCA reversed on the issue of interest, holding that the due date for the underpaid benefits was the statutory deadline set forth in Minn. Stat. §176.1292, subd. 2(d)(3) (2018), and that no interest was owed because the insurer paid the heirs before that statutory deadline had passed. One of the WCCA judges dissented, noting that interest would have been payable in accordance with the compensation judge's determination, and another judge dissented, ruling that the interest would have accrued from the date the *Ekdahl* and *Hartwig* decisions were issued. The employee's heirs appealed to the Supreme Court.

The Supreme Court (Chief Justice Gildea writing for the unanimous court) affirmed in part and reversed in part. With regard to the interest issue, the Court determined that Minn. Stat. §176.221, subd. 7 was controlling. That statute indicates that payment of compensation "not made when due shall bear interest from the due date to the date the payment is made." Over the years, there have been a number of interest rate revisions. The interest rate on the date of injury was 8%, and the heirs claimed that interest should be based on that percentage. The Court agreed with the compensation judge that the benefits which were reduced by application of the PERA offset were "due" when each reduced benefit payment was made. For each payment of PTD benefits, a PERA offset was applied, and that mistaken offset amount was due at the time that each payment was made. The Court determined that *Ekdahl* and *Hartwig* applied retroactively, making the reductions of PERA benefits improper. Each offset amount would have been due on each date of payment of PTD benefits, and interest would be payable from each of those

individual dates. With regard to the rate that would apply, the Court determined that the interest rate to be applied is the rate in effect when each of the payments was due. Again, this interest rate has fluctuated over the years. The Court concluded that each offset that the insurer took bears interest at the rate in effect during the calendar year in which it was taken, making the applicable interest rate variable over the course of 17 years of underpayments. The Court remanded the case to the compensation judge to calculate the interest owed.

With regard to the issue of penalties, the employee's heirs argued that the insurer did everything in its power to hold onto the underpayment for as long as it could, thereby creating an unreasonable and vexatious delay of payment. The heirs pointed out a number of instances which they felt constituted unreasonable delay of payment on the part of the insurer. The compensation judge had ruled that the insurer cooperated with DOLI and took reasonable steps to have an audit performed, and then took appropriate steps to see that payment was made. As such, penalties were not owing. The WCCA had affirmed, and the Supreme Court also affirmed, noting that the decision was supported by substantial evidence.

Finally, with regard to the issue on costs, the employee's heirs argued that the cost of obtaining a decree of descent was a taxable expense under the Workers' Compensation Act. That cost was $2,000. The Court agreed with the WCCA that the expense incurred was not "necessary" to the litigation, which was about *how much* the insurer owed, and not *to whom* the money was owed. The expense incurred simply verified a right to inherit, which was a condition precedent to the receipt of benefits. It was not part of the litigation of a disputed issue.

*Comment*: The Supreme Court has clarified the law on interest. It is now clear that once it is determined that a benefit is "due," interest will be payable from that date. The Court has also clarified that the rate of the interest will be the rate in effect at the time the payment should have been made. Obviously, in this case, it will be an extremely laborious task to calculate the interest for 17 years of weekly or biweekly PTD benefits, with varying rates throughout that time. The interest calculations over that period of time on an underpayment of $160,000 will be large, and one would imagine that additional expense will need to be undertaken with a forensic accountant before this case comes to a conclusion.

**INTERVENERS**

*Zaragoza v. Golden Employment Group, Inc.*, File No. WC18-6198, Served and Filed January 31, 2019. The employee sustained an admitted injury at work. She sought treatment at HCMC, including physical therapy. HCMC intervened and sought payment for treatment through and after August 1, 2014. HCMC was ordered to attend the hearing, but did not appear at the hearing. HCMC also did not submit any medical records for treatment provided after August 1, 2014. Compensation Judge Dallner found that the treatment up through August 1, 2014, was reasonable, necessary and causally related to the work injury and ordered the employer and insurer to pay for that treatment. She denied payment for treatment after August 1, 2014, because medical records were not provided for those dates of service with HCMC's motion to intervene, or in response to multiple requests from counsel for the employer and insurer. The employer and insurer appealed arguing that HCMC's failure to attend the hearing, after they were ordered to do so, required that its entire intervention claim be forfeited, pursuant to Minn. Stat. §175.361, subd. 4.

The WCCA (Judges Quinn, Stofferahn, and Hall) held that HCMC's attendance at the hearing was necessary to preserve its claims for treatment provided after August 1, 2014, but not before August 1, 2014, as all of the earlier records had been provided. Thus, the WCCA affirmed the compensation judge's decision that HCMC was entitled to reimbursement of treatment provided before August 1, 2014, despite its failure to attend the hearing.

*Miskowiec v. CM Information Specialists, Inc.*, File No. WC18-6227, Served and Filed May 16, 2019. (For additional information on this case, please refer to the Medical Issue category.) The employee sustained an admitted injury on November 12, 2012. She treated for several years with many providers; she began seeing Dr. Morales at Central Medical Clinic (CMC) in May 2016. On January 15, 2018, the employee's attorney sent a letter to CMC notifying it of its right to intervene in the employee's workers' compensation claim. The intervention notice stated in bold print that CMC had 60 days to file its intervention notice. On January 18, 2018, the employee filed a medical request seeking payment for the medical care she received from CMC and for the narcotic pain medications prescribed by Dr. Morales. CMC was notified of the administrative conference on January 24, 2018. The administrative conference took place on February 23, 2018. CMC filed its motion to intervene on February 26, 2018, greater than 30 days after receipt of the notice to intervene and of notice of the administrative conference, but less than 60 days after receiving the notices. The administrative decision was issued on March 9, 2018, and was timely appealed to OAH. The hearing took place more than six months after CMC filed its intervention claim. One of the issues before Compensation Judge Tate was whether or not CMC had timely intervened. Judge Tate rejected the employer and insurer's argument that CMC violated Minn. §176.361, subd. 2(a), which requires that a motion to intervene must be served and filed within 60 days after a potential intervenor has been served with a notice of right to intervene or within 30 days of notice of an administrative conference. The WCCA (Judges Quinn, Stofferahn, and Sundquist) affirmed, noting that Minn. Rule 1415.1100, Subp. 2(d) provides that parties providing notice to potential intervenors must inform them of the 60 or 30 day time limits. In this case, the record showed no indication that CMC was directly notified of the 30-day time limit to file its motion to intervene after notice of the administrative conference. The notice of right to intervene included a reference to the 60-day time limit and was served before the administrative conference was even requested. Once the conference was requested, neither party clearly notified CMC of the separate 30-day time limit. Additionally, the WCCA found that neither party suffered any prejudice given the long time that elapsed between CMC's intervention and the subsequent hearing at OAH.

**JURISDICTION**

*May v. Independent School District 115,* File No. WC18-6126, Served and Filed May 30, 2018. The employee was employed by Leech Lake Behavioral Health Services Program, Leech Lake Band of Objibwe ("Band"). The Band entered into a Memorandum of Understanding with Cass Lake/Bena Schools, Independent School District 115 ("District"), in which the Behavioral Health Services Program was to provide therapy and mental health services for the school year. The employee alleged that she sustained a work-related injury in the nature of PTSD during her employment. The Band was self-insured. Its claims administrator notified the employee that her claim was denied because "injury arising from an emotional and/or mental condition, component, or dysfunction" was not covered by the Band's insurance policy. The employee later filed a claim petition, naming the District as the employer and claiming various workers' compensation benefits. The District filed a motion to dismiss the claim petition on the grounds

that the employee was an employee of the Band and not the District, and thus, was covered by the Band's workers' compensation policy on the date of injury. The employee objected and argued that the agreement between the Band and the District required that the Band provide workers' compensation insurance coverage. The fact that the Band's insurance policy did not cover PTSD claims, when such claims were covered by carriers subject to Minnesota Workers' Compensation Act under Minn. Stat. Ch. 176, meant that the Band was uninsured. The employee further argued that the Band was a subcontractor of the District, and that because the Band was uninsured, the District, as a general contractor, was liable for benefits under Minn. Stat. §176.215. The employee conceded that the Band was a sovereign entity not subject to the laws of Minnesota, including the workers' compensation statutes. The employee contended, however, that the Band waived its sovereignty by entering into the Memorandum of Understanding with the District. Finally, the employee argued that these questions were factual questions and not suitable for consideration on a motion to dismiss. Compensation Judge Kelly granted the District's motion to dismiss. The WCCA (Judges Stofferahn, Milun, and Sundquist) affirmed. The WCCA wrote that Minn. Stat. §176.215 provides that a general or intermediate contractor is responsible for paying workers' compensation benefits to the injured employee of an uninsured subcontractor. The WCCA identified at least four preliminary questions that must be answered for Minn. Stat. §176.215 to apply to this case: whether the District was a contractor within the contemplation of the statute; whether the Band was required to cover injuries such as PTSD in its workers' compensation plan; whether the Band was uninsured because it did not do so; and whether the Band is liable to the school district in a subrogation claim. The WCCA found that answering those questions required application of Minnesota statutes and case law, and such an application of law would impinge on the sovereignty of the Band. As a sovereign entity, the Band is not subject to Minnesota jurisdiction. The WCCA found that the employee cited no basis for the argument that the Band waived its immunity by entering into an agreement with the District. Finally, the sovereign status of the Band and its immunity from workers' compensation claims asserted under Minnesota workers' compensation law, whether brought directly by the employee or by a party under Minn. Stat. §176.215, is a question of law and thus properly considered on a motion to dismiss. This case was summarily affirmed by the Minnesota Supreme Court on January 29, 2019 – see below.

*Lowe v. NW. Airlines Corp.*, File No. WC17-6111, Served and Filed May 31, 2018. For a summary of this case, please refer to the Appeals category.

***May v. Independent School District 115*, Case No. A18-0695 (Minn. Sup. Ct. January 29, 2019).** The case involved an alleged injury to an employee of the Leech Lake Band, not ISD 115. However, the employee argued that ISD 115 was responsible for paying her workers' compensation benefits because ISD 115 is a statutory employer under Minn. Stat. §176.215, which states that a general contractor is liable for benefits when its subcontractor fails to provide coverage or pay benefits. The employee argued that ISD 115 was the general contractor and the Leech Lake Band was the subcontractor in this situation and because the Leech Lake Band denied her benefits, ISD 115 must pay. The WCCA affirmed the compensation judge's dismissal of the employee's claim petition on the basis that the employee was not employed by ISD 115. The Minnesota Supreme Court (Justice Hudson writing for the majority) affirmed the decision without opinion.

Justice Lillehaug issued a separate concurring opinion indicating that based on the plain language of Minn. Stat. §176.215, ISD 115 was not liable because by entering into a contract with the Leech Lake Band, ISD 115 procured services for itself, not as a general contractor. In addition the Leech Lake Band was not a subcontractor because it did not provide services to a general contractor or provide services under an existing contract between others.

**MEDICAL ISSUES**

*Johnson, William v. Darchuks Fabrication, Inc.*, File No. WC17-6114, Served and Filed June 13, 2018. The employee injured his right ankle on September 4, 2002. The injury included an avulsion fracture of the talus. By June 2003, he was also diagnosed with CRPS. The injury and the CRPS diagnosis were admitted by the employer and insurer. In 2005, the employee began treating with Dr. Sperle, his current treating physician, who continued the employee on a medication regimen that included Endocet, an opioid medication, to treat the employee's pain arising from the CRPS. The employee has continued on this same exact medication regimen to-date. He underwent an IME with Dr. Wojciehoski at the request of the employer and insurer on May 2, 2016. Dr. Wojciehoski opined in his initial and supplemental IME reports that he did not support a CRPS diagnosis for the employee's condition, noting that the employee did continue to suffer from subjective complaints of pain that were out of proportion to any physical findings. Dr. Wojciehoski also recommended that the employee be weaned off the opioid medications, indicating that they were not prescribed properly under the treatment parameters. The employer and insurer sent a letter to Dr. Sperle requesting he come into compliance with Minn. R. 5221.6110, related to long-term use of opioid medications. The employee subsequently filed a medical request requesting payment of medications including Endocet. The employer and insurer responded with a medical response claiming that the treatment was not reasonable and necessary and that the treatment parameters were not followed. The case proceeded to a hearing where the issues included whether the employee's CRPS had resolved, whether Endocet and two other medications were reasonable and necessary, and whether the treatment parameters applied to the Endocet prescription. Compensation Judge Hartman determined that the employee's CRPS condition had not resolved, that the medications were reasonable and necessary, and that the treatment parameters did not apply. The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed. Minn. R. 5221.6020, subp. 2, states that where liability is denied, the treatment parameters do not apply until after liability is established. Citing *Schulenburg*, *Oldenburg*, and *Mattson*, the WCCA found that in denying liability for the prescriptions by challenging causation of the condition at issue, the treatment parameters were rendered inapplicable under the rule. The WCCA found that when the employer and insurer argued that the employee recovered from the CRPS condition they contested liability. The WCCA affirmed on the basis that "there is no special status in the rules that allows an insurer that accepts the occurrence of a work injury the ability to contest liability for the particular treatment sought while simultaneously asserting that the treatment parameters apply to limit payment for that treatment," therefore Minn. R. 5221.6020, subp. 2 precludes application of the treatment parameters. This case was heard by the Minnesota Supreme Court and its decision is reported below.

*Krumwiede v. GGNSC Slayton*, File No. WC18-6134, Served and Filed July 10, 2018. The employee sustained two work injuries to her low back occurring on July 3, 2012, and March 7, 2013. Immediately following the second date of injury, she underwent an independent medical examination with Dr. Cederberg, who opined that the employee sustained a temporary aggravation of underlying degenerative disc disease at L4-S1 and required no further medical

care. Dr. Cederberg subsequently conducted a second IME on July 8, 2013, at which time his opinions remained unchanged. In August 2014, the employee's treating physician, Dr. Asfora, recommended fusion surgery. The employee agreed to surgery in February 2015, but a different treating physician, Dr. Janssen, first recommended additional physical therapy, and if not successful, injections and an MRI. Dr. Cederberg conducted a third IME on October 8, 2015, specifically addressing the proposed fusion surgery. He opined that the employee was a poor candidate because of her smoking history and suggested a microdiscectomy would be reasonable instead, opining that any surgery would be unrelated to her work injuries. The employee then requested approval for the proposed fusion surgery, which went to hearing on November 24, 2015, before Compensation Judge LeClair-Sommer. The compensation judge found that the employee's work injuries caused her low back condition, but that the proposed surgery was not reasonable or necessary due to her smoking history and because she had not exhausted conservative care set forth in the treatment parameters. After the date of the hearing, but prior to the issuance of the Findings and Order, the employee underwent additional physical therapy, seven transforaminal steroid injections, and ultimately the fusion at L4-5 and L5-S1 on April 25, 2016. The employee did not appeal the Findings and Order from the hearing. Instead, she filed a new Claim Petition seeking payment for the fusion, as well as TTD, TPD and 20 percent PPD benefits related to the fusion. A hearing on this second Claim Petition was held before Compensation Judge LeClair-Sommer. The employer and insurer relied on the same IME reports from Dr. Cederberg that they did at the first hearing, and the employee relied on the opinions of her treating physicians. The compensation judge again found that the employee did not meet her burden to show that the fusion surgery was reasonable and necessary, noting that the employee's neurologic pain resolved, but her low back pain did not, denied the TTD and TPD claims, and awarded only 10 percent PPD for her low back condition, denying the 10 percent PPD for the fusion surgery itself. The WCCA (Judges Hall, Milun, and Stofferahn) vacated in part, reversed in part, and remanded. The WCCA found that substantial evidence did not support the compensation judge's determination finding that although Dr. Cederberg's opinions adequately addressed the issue of whether the proposed surgery was reasonable and necessary at the first hearing, they inadequately addressed whether the surgery performed was reasonable and necessary, because Dr. Cederberg's opinions were rendered before the employee underwent and failed additional conservative treatment and before the employee underwent the fusion. Therefore, the WCCA found that Dr. Cederberg's opinions were based on speculation or conjecture, which rendered his opinions unreliable for deciding the issue at the second hearing. The WCCA indicated that the employer and insurer pointed to no other medical evidence to support their position regarding the fusion and remanded for specific findings on the reasonableness and necessity of the surgery performed and for a determination of whether the medical expenses provided were compensable. Regarding the PPD, TTD, and TPD claims, the WCCA reversed the compensation judge and awarded the additional 10 percent PPD for the fusion and the TTD and TPD claims, finding that the employee's decision to proceed with the surgery was reasonable under the circumstances regardless of whether the surgery was ultimately found to be reasonable and necessary due to the lengthy delay in the issuance of the Findings and Order after the first hearing, the employee's failure of additional conservative treatment, approval of the procedure by her health insurer, the recommendations of her treating doctor, and Dr. Cederberg's opinion that some type of surgery was reasonable to address her ongoing symptoms. This case was summarily affirmed by the Minnesota Supreme Court on January 15, 2019.

*Roux v. R.J. Reynolds Tobacco*, File No. WC18-6174, Served and Filed November 28, 2018. The employee was involved in a work-related motor vehicle accident in 2011. Primary liability was admitted. The parties settled on a full, final and complete basis in 2013, and the stipulation closed out all medical expenses relative to the left eye, neck, back, head/brain, traumatic brain injury, and mental health treatment. Only medical expenses related to the right ankle remained open. Subsequently, the employee continued to treat, which resulted in complicated and piecemeal litigation. In the latest hearing before Compensation Judge Daly, there was an award of treatment for ongoing acupuncture and physical therapy. The compensation judge found the employer's request for medical treatment to be undertaken not in the Twin Cities, but in Rice Lake, WI, closer to the employee's home, was reasonable. He also awarded medical mileage and approved a prescription for opioids. However, the judge denied treatment with Dr. Hess along with related mileage, pool therapy, some acupuncture treatment with a particular doctor, and occupational therapy, on the basis that these various treatments were not reasonable, necessary, or causally related to the work injury. Finally, he denied various prescriptions on the basis that they were for conditions that were foreclosed by the prior stipulation for settlement. The employee appealed from the denial of medical treatment, and the employer and insurer cross-appealed relative to the award of medical treatment. The WCCA (Judges Sundquist, Stofferahn, and Quinn) completely upheld the judge's findings and order, finding that the judge relied on substantial evidence in rendering all of his various decisions. Particularly interesting was the WCCA's decision that the compensation judge did not err in compelling the employee to seek future treatment in Rice Lake, WI, near his home. It was pointed out that Minn. Stat. §176.135 requires that medical treatment be not only necessary, but also reasonable, so "if similar treatment can be obtained in a location closer to the employee's home, it was within the judge's discretion to determine that it was the more reasonable choice."

*Thaemert v. Honeywell International Inc.*, File No. WC18-6164, Served and Filed December 20, 2018. The employee suffered an admitted work injury on January 29, 1993, as a result of assembly work. She began experiencing headaches and pain in her neck, bilateral shoulders, and bilateral arms. She was eventually diagnosed with degenerative disc and joint disease in the cervical spine at C3 through C6, tendinitis of the right shoulder, and lateral epicondylitis in the right arm. In 1995 her treating physician placed her at maximum medical improvement, opined 10.5 percent permanent partial disability for the cervical spine and 3 percent for the right shoulder, and recommended continuing conservative care. He also began prescribing opioids in December 1995. The employee suffered a second, denied, work injury on June 17, 1998, in the nature of bilateral carpal tunnel, while working for the same employer. The employee underwent carpal tunnel surgery on the right side in December 1998 and the left side in February 1999. She continued to take opioids during this period. A December 1998 IME opined that the employee did not suffer a *Gillette* injury and the narcotics were unnecessary to treat any claimed work injury. The treating physician opined in December 1999 that the carpal tunnel surgery was unsuccessful, attributed the employee's ongoing pain syndrome to 22 years of work, and opined that the employee was permanently totally disabled. He further opined that the ongoing opioid prescriptions were needed to give the employee enough pain relief to sleep and perform ordinary activities of daily living. During a second IME in May 2000, the IME physician opined that the ongoing symptoms were unrelated to the work injury. A July 2001 settlement closed out claims, including chiropractic care and treatment, formal chronic pain clinic programs, and psychological treatment. Future non-chiropractic medical expenses not explicitly closed out were left open. All benefits described in the stipulation were attributed to the 1993 injury. The alleged 1998 injury was left open to all defenses, including a denial of primary liability. The employee

continued a narcotics-based pain management program for the next 16 years. In a July 2017 IME, Dr. Friedland (not the prior IME physician) explicitly discounted any impairment in the employee's ability to perform the activities of daily living and maintained that no such impairment was document in the employee's medical records (which was inaccurate). Dr. Friedland opined that the amounts of opioids prescribed were excessive and the last 10 years of prescriptions were not medically reasonable and necessary or causally related. Dr. Friedland opined that the employee's symptomology was highly exaggerated and nonanatomic. The employee filed a Claim Petition seeking payment for treatment. The Injured Workers' Pharmacy filed a motion to intervene seeking payment for a year's worth of opioids and morphine sulfate. Judge Cannon credited the employee's complaints and pain, found that the employee suffered permanent work-related *Gillette* injuries on both dates of injury, and found that the chronic pain was causally related to the work injuries. Nonetheless, Judge Cannon found that the employee's benefit from medication was "extremely temporary" and that the intervention interest was excessive for one year's supply of opioid medication. Judge Cannon denied the claims of the employee and IWP, in part because there was never a referral to another medical provider to explore alternative modes of treatment. The WCCA (Judges Milun, Stofferahn, Hall, Sundquist, and Quinn) vacated Judge Cannon's decision in part and remanded for further consideration. The WCCA found that Judge Cannon cannot unambiguously credit the employee's complaints of pain and then simultaneously credit IME opinions that materially rely on facts contrary to those found by the compensation judge. The WCCA additionally found that the treatment parameters, even where primary liability is denied, can "provide useful guidance for analyzing whether the treatment claimed is reasonable and necessary." *See Armstrong*. The WCCA remanded for reconsideration.

***Johnson, William v. Darchuks Fabrication, Inc.*, Case No. A18-1131 (Minn. Sup. Ct. April 24, 2019).** The employee injured his right ankle in September 2002. The injury was admitted and benefits were paid to and on behalf of the employee. After a short period of time, the employee developed complex regional pain syndrome ("CRPS"). This diagnosis was also initially admitted and a significant amount of medical treatment was paid. As of 2005, after receiving various forms of alternative treatment, the employee's treatment primarily consisted of a medication regimen that included opioid medications. In 2016, due to concerns about the ongoing use of opioid medications, the employer and insurer pursued an independent medical examination to review the employee's condition and the appropriateness of the medication regimen. The IME opined that the employee no longer had CRPS, that the use of ongoing narcotics was not in compliance with the Treatment Parameters, and recommended that the employee be weaned off narcotics. Based on that report, a letter was sent to the employee's physician indicating that treatment for the employee's CRPS diagnosis was denied. Further, the letter requested that the treating physician begin weaning the employee from the opioid medications and comply with the Treatment Parameters governing long-term use of opioid medications, Minn. R. 5221.6110. When the treating physician did not respond, the employer and insurer ceased paying for medication reimbursement. The employee subsequently filed a Medical Request seeking payment of his medications. The employer and insurer denied payment, contending that the employee's CRPS has resolved, that the treatment was not reasonable and necessary to cure and relieve the effects of the injury, and that his continued treatment with opioid medications was not compliant with the Treatment Parameters. The case went to a Hearing before Compensation Judge Hartman, who found that the employee's CRPS had not resolved, and that in denying that the employee had CRPS, the employer and insurer had in effect "denied liability" for the employee's injury. Consequently, he denied application of the Treatment Parameters. The

Workers' Compensation Court of Appeals affirmed. Citing *Schulenburg, Oldenburg,* and *Mattson*, the WCCA found that challenging even one component of an otherwise admitted injury is akin to a denial of liability, and, in doing so, the employer and insurer lost the ability to apply the Treatment Parameters.

The Supreme Court (Justice Chutich writing for the majority) reversed the decision of the WCCA. The Court analyzed the meaning of Minn. R. 5221.6020, Subp. 2, which governs the application of the Treatment Parameters. That rule states that the Treatment Parameters "do not apply to treatment of an injury after an employer has denied liability for the injury." The Court examined the specific language of this rule and concluded that under the Workers' Compensation Act, the phrase "liability for the injury" refers to the "employer's obligation to pay statutory benefits for personal injuries that are covered by the workers' compensation act." The Court found that when an employer and insurer claim that they have no obligation to pay for an injury, the Treatment Parameters do not apply. However, in situations such as this case, where the employer admits that the employee sustained a work injury and continues to admit that the employee has not fully recovered from an injury, the employer has not "denied liability" for the injury so as to prevent defenses based upon the Treatment Parameters. In other words, the Court found that employers and insurers can contest a diagnosis and alternatively assert defenses under the Treatment Parameters, as long as they do not deny all obligations to pay compensation for the underlying injury.

*Comment*: The Treatment Parameters set forth the appropriate types of and course of treatment for various work-related injuries. If a request for medical treatment is not in compliance with the Parameters, an employer and insurer can deny approval of or payment for the requested treatment based upon the parameters. The rules, as interpreted in prior case law from the WCCA, have been interpreted as establishing that the Treatment Parameters do not apply when primary liability for an injury has been denied or when the employer and insurer have argued that the employee has fully recovered from a work injury, meaning they have no ongoing obligation to pay benefits for an injury. The facts of this case were unique in that a specific diagnosis only was challenged, while liability for the injury itself continued to be admitted. We now know that under these circumstances, the Treatment Parameters can be used as a defense to medical treatment for the underlying injury. In other words, as long as the employer and insurer are not denying all obligations to pay compensation for the work injury, the Treatment Parameters do apply and should be looked to for an additional or alternative defense to requested medical treatment.

*Miskowiec v. CM Information Specialists, Inc.*, File No. WC18-6227, Served and Filed May 16, 2019. (For additional information on this case, please refer to the Interveners category.) The employee sustained an admitted injury on November 12, 2012. She had preexisting injuries and had started taking narcotic pain medication on a regular basis as early as 2008. After the work injury, the employee treated at Minnesota Advanced Pain Specialists (MAPS). This treatment included opioid pain medication. In July 2015 the employee was discharged from treatment at MAPS due to a violation of the controlled substance agreement. About one month prior to that, in June 2015, she had begun treating at HealthPartners Clinic, receiving narcotic pain medication from that clinic through August 2016. In December 2015 she began treatment with Dr. Hess at United Pain Clinic. She was prescribed with narcotic pain medication. By April 2016 the employee was discharged from Dr. Hess' care due to three separate violations of her pain contract. On May 26, 2016, the employee began treating with Dr. Morales at Central Medical Clinic (CMC). She did not inform Dr. Morales that she had previously treated with Dr. Hess or

that she had been discharged from Dr. Hess' care. Dr. Morales began prescribing narcotic pain medication. On July 13, 2016, after treating with Dr. Morales on two occasions, the employee contacted Dr. Hess' office by phone requesting a referral to Dr. Morales. The employee explained that Dr. Morales performed injections into the pain site. Dr. Hess' records for the same date indicate "per patient's request – is transferring care to Dr. Morales." There is no evidence that Dr. Morales was ever provided with this note. The CMC records from both before and after July 13, 2016, described the employee as a "self-referral" to Dr. Morales. Compensation Judge Tate determined that this constituted a valid referral and authorized change of physician. The employer and insurer appealed, and the WCCA (Judges Quinn, Stofferahn, and Sundquist) reversed. The WCCA cited Minn. Rule 5221.0430, Subp. 2, which states in relevant part that any changes of primary care provider after the first 60 days following initiation of medical treatment *must* be approved by the insurer, the department, or a workers' compensation judge. Exceptions to this requirement include conditions beyond the employee's control such as, in relevant part, a referral from the primary care provider to another provider. The rule additionally states that the insurer is not liable for treatment rendered prior to obtaining approval of a change in provider unless the insurer has agreed to pay for treatment and except in emergency situations where prior approval could not have reasonably been obtained. The WCCA found that the employee did not have approval from the employer and insurer or DOLI to change providers from Dr. Hess to Dr. Morales, and there were no emergency or exigent circumstances for her treatment with Dr. Morales. The WCCA reversed Judge Tate's finding that there was a retroactive referral. In *Gibbs*, the WCCA affirmed an award of medical care after a retroactive referral where the referring physician reviewed the care provided by the later physician and endorsed the care provided by that physician. Here, there was no evidence that Dr. Hess was aware of the nature or efficacy of the care provided by Dr. Morales, or that Dr. Hess endorsed the care provided at CMC. Additionally, the WCCA found that the employee provided an inaccurate description (that Dr. Morales performed injections into the injury site) of what care was actually being provided by Dr. Morales. Moreover, Dr. Morales' records consistently referred to the employee as a self-referred patient and there was no evidence that Dr. Morales obtained the records of Dr. Hess or was aware of Dr. Hess' earlier participation in the employee's care. The WCCA thus found that the change in physicians was unauthorized under Minn. Rule 5221.0430, and the employer and insurer were not liable for payment for the care provided by Dr. Morales or CMC.

## NOTICE

*Noga v. Minnesota Vikings Football Club*, File No. WC18-6133, Served and Filed September 19, 2018. (For additional information on this case, please refer to the *Gillette* Injuries and Statute of Limitations categories.) The employee played football during junior high, high school, and college. He was drafted by the Minnesota Vikings and played for them from 1988 through the 1992 season. He then played for the Washington Redskins, Indianapolis Colts, and in the Arena Football League, eventually retiring from professional football in 1999. During his tenure with the Vikings, and due to the nature of his tackling, he complained of headaches and dizziness and occasionally reported these symptoms to the team trainer or team doctor. He typically was provided with Advil or Tylenol and occasionally was told to rest in the training room. He continued to experience these symptoms and receive hits to the head during the rest of his career. In 2001 he filed a claim petition in Minnesota for benefits associated with a number of specific orthopedic injuries. These injuries were the subject of a stipulated settlement. Attached to the settlement was a "very brief" February 17, 2004, report by Dr. Fruean, which listed twelve complaints that the employee attributed to injuries sustained while playing for the Vikings. These

included blackout episodes from concussions and headaches from football injuries. Dr. Fruean recommended that the employee be evaluated by a neurologist. Over the years the employee treated with neurologists and developed dementia. In 2014 he was rated with 86.5 percent permanent partial disability and not currently employable. He underwent a vocational/psychological evaluation and was deemed permanently and totally disabled due to his dementia and ADHD in combination with orthopedic injuries. The employee filed a claim petition on January 15, 2015, seeking benefits against the Vikings for a *Gillette* injury to the head. The employer argued that it lacked sufficient notice because it became reasonably apparent to the employee that he was suffering a cognitive disability at least as of Dr. Fruean's report of February 17, 2004. Compensation Judge Marshall determined that this report was attached to the stipulation for settlement, at which time the employer and insurer had actual knowledge of the employee's condition, and his position of the relationship to his work activities, regardless of whether he brought a claim at that time or not. The WCCA (Judges Hall, Milun, and Stofferahn) affirmed, finding that the employee became reasonably aware of the possibility of compensable, work-related injury as of the issuance of Dr. Fruean's report. Thus, the statute of limitations began to run as of February 17, 2004. The WCCA held that, as a general rule, an employee need only give notice of the injury itself and not of the specific details of the mechanism of injury or specific body parts affected. The WCCA held that, upon receipt of the Stipulation for Settlement, signed on behalf of the employer in March 2004, the employer had actual knowledge of an alleged work-related condition. The WCCA rejected the argument that, because notice must be given to an employer and not the employer's attorney or agent, the Stipulation was inadequate and Judge Marshall's finding was legally erroneous. The WCCA found that the issue was one of imputed notice by actual knowledge and the employer had sufficient knowledge of the content of Dr. Fruean's report.

Judge Sundquist dissented on this point, arguing that the report did not provide sufficient notice and there was no evidence the employer itself received the report. Judge Quinn joined. This case has been appealed to the Minnesota Supreme Court, and was orally argued on February 6, 2019.

## PENALTIES

*Oseland v. Crow Wing County*, File No. WC17-6120, Served and Filed August 30, 2018. For a summary of this case, please refer to the Interest category.

***Oseland v. Crow Wing County*, Case No. A18-1550 (Minn. Sup. Ct. May 29, 2019).** For a summary of this case, please refer to the Interest category.

## PSYCHOLOGICAL INJURY

*Petrie v. Todd County*, WC18-6176, Served and Filed November 9, 2018. The employee, employed by Todd County as a correctional officer, claimed post-traumatic stress disorder due to three inmate-involved altercations at work. The employee ultimately underwent an independent psychiatric examination with Dr. Yarosh, a licensed psychologist. Dr. Yarosh diagnosed the employee with a pre-existing post-traumatic stress disorder, but concluded that the work incidents did not cause or aggravate her pre-existing mental health condition. Compensation Judge Rykken found that Dr. Yarosh's opinion did not meet the statutory criteria for diagnosis of post-traumatic stress disorder under Minn. Stat. §176.011, subd. 15(d), and denied the employee's claims, noting that although Dr. Yarosh diagnosed the employee with post-traumatic

stress disorder, he concluded it was not causally related to her employment. Judge Rykken did not address the issue of whether the employee's post-traumatic stress disorder was causally related to her work injury or whether her injury could be considered a physical-mental injury. The WCCA (Judges Hall, Milun, and Sundquist) reversed in part, vacated in part, and remanded for a determination whether the work injury caused, aggravated, or precipitated the employee's post-traumatic stress disorder diagnosis, finding that Minn. Stat. §176.011, subd. 15(d) does not require that the diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist include a causation opinion. Instead, the post-traumatic stress disorder diagnosis by a licensed psychiatrist or psychologist without a causation opinion was sufficient to meet the statutory requirement of establishing the condition itself. The compensation judge then needs to examine the remainder of the evidence to determine whether the appropriately-diagnosed post-traumatic stress disorder is causally related to the work activities. The WCCA also found that the compensation judge erred by not addressing the employee's physical-mental injury claim that was raised at the hearing.

*Smith, Chadd v. Carver County*, File No. WC18-6180, Served and Filed January 4, 2019. The employee applied to be a deputy sheriff and underwent a pre-employment psychological evaluation. He was hired and worked for ten years. He did patrol duties, such as responding to car accidents, suicides, etc. Some of which were people he knew and others paralleled his personal life (e.g., responded to a motor vehicle accident with a pregnant woman at a time when his wife and sister were both pregnant.) He sought help with a counselor and psychologist. Initially he was diagnosed with anxiety and depression. Eventually, he was also diagnosed with post-traumatic stress disorder (PTSD). Dr. Keller, a licensed psychologist, diagnosed him with PTSD. He brought a claim for PTSD and the employer/insurer denied it. They obtained an IME from Dr. Aribisi who looked at DSM-5 criteria and other criteria and opined the employee did not have PTSD. Compensation Judge Kelly accepted Dr. Aribisi's opinions and denied the claim. The WCCA (Judges Stofferahn, Hall, and Quinn) reversed and remanded. The WCCA held that for diagnostic purposes a doctor can use criteria other than the DSM-5 to diagnose a patient's condition, but for workers' compensation cases, the doctor's opinions and the judge's decision should follow the requirements of Minn. Stat. §176.011, subd. 15(d) and the DSM-5 criteria. Because Dr. Aribisi's opinion did not follow that statutory requirement, the WCCA reversed and remanded the case to the compensation judge to assess whether Dr. Keller's opinion satisfied the statutory requirements. This case was appealed to the Minnesota Supreme Court and oral arguments are scheduled on June 4, 2019.

**REHABILITATION/RETRAINING**

*Washek v. New Dimensions Home Healthcare*, File No. WC18-6142, Served and Filed August 24, 2018. In 2002, the employee sustained an admitted work injury when her car was struck by a semi-truck and she sustained several injuries and was considered to be paraplegic. She underwent extensive medical treatment, and the employer and insurer paid medical, wage loss, permanent partial disability benefits of 94.6496 percent, rehabilitation expenses, and costs to remodel her residence. The parties had pursued litigation regarding several issues over the years, including the compensability of the base cost of various vehicles. In 2016, her rehabilitation plan was amended to include working with an employment specialist for job leads. A job placement plan was prepared and the employee began working at Shopko. Her drive from home to work and vice versa was about 28 miles and there was no public handicap accessible transportation available to her. She filed a Claim Petition seeking the base cost for a 2014 Toyota Sienna,

which the employer and insurer denied. Compensation Judge Hartman awarded reimbursement of the base cost of the vehicle to the employee, and the employer and insurer appealed. The WCCA (Judges Milun, Stofferahn, and Sundquist) affirmed. It refused to overrule *Wong v. Won Ton Foods*, and, instead, held that the base cost of an accessible vehicle can be compensable as a rehabilitation expense, when, as was the case here, the employee was searching for work when she became medically able to do so. The employee was motivated to return to work, and the vehicle helped her seek and engage in work on a sustained basis. As such, the base cost of the vehicle was reimbursable. This case was summarily affirmed by the Minnesota Supreme Court on February 13, 2019.

*Ewing v. Print Craft, Inc.*, File No. WC18-6197, Served and Filed March 12, 2019. The employee sustained an injury at work on December 1, 2015, injuring his left ankle. He was subsequently diagnosed with several other conditions, including CRPS, alleged to have been consequential injuries from the work injury. Medical treatment was provided. In April 2016 he was taken off of work due to the effects that chronic pain had on his work performance. Also in April 2016 he underwent a rehabilitation consultation by a QRC, who opined that the employee was qualified for rehabilitation services. The QRC filed an R-2 in July 2016 to initiate the provision of rehabilitation services, and the employer made no objection. The plan was amended via an R-3 in October 2016 to indicate that medical management would continue pending the employee being released to return to work. On November 7, 2016, the employee underwent an IME conducted by Dr. Gedan, who opined that the employee's injury was limited to his left ankle and none of the claimed consequential injuries were the result of the work injury. The employee subsequently filed a claim petition, seeking medical benefits. The claim petition made no mention of rehabilitation benefits, nor did the employer's answer. On December 5, 2016, the employer filed a NOID seeking to terminate TTD benefits. By order served and filed on January 4, 2017, TTD benefits were discontinued following a .239 administrative conference, with the judge holding that the employee was no longer restricted from work activities from his work-related ankle injury and he did not have CRPS. On December 9, 2016, the employer informed the QRC by email that the only admitted injury was to the left ankle and that medical management services regarding any other body part or condition would not be reimbursed. The employee filed an amended claim petition seeking other specific medical expenses and claiming TTD. On February 3, 2017, the employer filed a letter answer, indicating that a rehabilitation program for the employee's ankle was approved but that any other condition or body part was denied. On January 9, 2017, Dr. Friedland issued an IME report on behalf of the employer. He opined that the employee sustained only a mild left ankle strain that was temporary and would have resolved by April 20, 2016. On February 6, 2017, the QRC filed an R-3 amending the rehabilitation plan to extend medical management. The employer did not file an objection to the proposed R-3 amendment. On April 6, 2017, the employer filed a Rehabilitation Request seeking termination of the rehabilitation plan. The QRC continued to provide rehabilitation management services after receiving that notice. The employee's counsel filed a Rehabilitation Response and the parties agreed to consolidate the issue with the existing issues brought by the employee in his claim petition. Compensation Judge Marshall found that the employee's work injury resolved on April 20, 2016, and he ordered that all claims through April 20, 2016, be paid and all other claims were dismissed. The QRC appealed. The WCCA (Judges Hall, Stofferahn, and Sundquist) reversed. The WCCA found that the compensation judge erred as a matter of law in assigning the cutoff date for rehabilitation services. Citing Minn. Stat. §176.102, subd. 8, the WCCA noted that a rehabilitation plan in place could be terminated on a showing of good cause "[u]pon request to the commissioner . . . by the employer . . . " Thus, the WCCA determined that the

language in subdivision 8 required notice to close the rehabilitation plan. Minn. R. 5220.0510, Subp. 7 indicates that the notice must take the form of a rehabilitation plan amendment seeking to terminate services. [Ed. Note: Subp. 5 indicates the employer or insurer must file a Rehabilitation Request to seek closure of a rehabilitation plan based on good cause.] Because the employer did not make such a filing until April 6, 2017, the employer did not make a potential showing of good cause until that date, and it was necessary to pay for rehabilitation services until that date. However, the WCCA agreed with the compensation judge that the injury had resolved as of April 20, 2016, and it held that the good cause standard had been met *as a matter of law* on April 6, 2017, the date on which notice was given to the QRC. Rehabilitation services were not payable after that date. *See Parker*.

*Comment:* This case sets forth a new basis for a showing of "good cause" to terminate a rehabilitation plan – recovery from an injury, as a matter of law, constitutes "good cause." Full recovery from an injury has always been thought of as an automatic defense to all workers' compensation benefits, including rehabilitation services. However, it was not one of the four "good cause" bases listed in Minn. Rule 5220.0510, Subp. 5 for purposes of terminating a rehabilitation plan. The WCCA has now added it.

**STATUTE OF LIMITATIONS**

*Noga v. Minnesota Vikings Football Club*, File No. WC18-6133, Served and Filed September 19, 2018. (For additional information on this case, please refer to the *Gillette* Injuries and Notice categories.) The employee played football during junior high, high school, and college. He was drafted by the Minnesota Vikings and played for them from 1988 through the 1992 season. He then played for the Washington Redskins, Indianapolis Colts, and in the Arena Football League, eventually retiring from professional football in 1999. During his tenure with the Vikings, and due to the nature of his tackling, he complained of headaches and dizziness and occasionally reported these symptoms to the team trainer or team doctor. He typically was provided with Advil or Tylenol and occasionally was told to rest in the training room. He continued to experience these symptoms and receive hits to the head during the rest of his career. In 2001 he filed a claim petition in Minnesota for benefits associated with a number of specific orthopedic injuries. These injuries were the subject of a stipulated settlement. Attached to the settlement was a "very brief" February 17, 2004, report by Dr. Fruean, which listed twelve complaints that the employee attributed to injuries sustained while playing for the Vikings. These included blackout episodes from concussions and headaches from football injuries. Dr. Fruean recommended that the employee be evaluated by a neurologist. Over the years the employee treated with neurologists and developed dementia. In 2014 he was rated with 86.5 percent permanent partial disability and not currently employable. He underwent a vocational/psychological evaluation and was deemed permanently and totally disabled due to his dementia and ADHD in combination with orthopedic injuries. The employee filed a claim petition on January 15, 2015, seeking benefits against the Vikings for a *Gillette* injury to the head. The employer argued that the claim was barred by the statute of limitations under Minn. Stat. §176.151, subd. 1. Compensation Judge Marshall found that provision of treatment by the employer's training room staff for head traumas and concussions sustained by the employee while playing for the team was a "proceeding" initiated prior to the running of the statute of limitations. The WCCA (Judges Hall, Milun, and Stofferahn) affirmed, noting that it was "well settled that when the employer assumes responsibility for the medical treatment of a workers' compensation injury, that act may constitute a 'proceeding' for the purposes of Minn. Stat. §176.151." The WCCA rejected the

employer's argument that the training room treatment was too minor and was to assist players with their daily afflictions; as a result, there was no showing that the provision of treatment was the knowing treatment of a work-related injury. Judge Marshall found that the treatment was rendered for concussions sustained while playing football, and there was expert medical evidence that the treatment provided was consistent with the protocol for such injuries at that time. The WCCA cited *Meyers*, where training room splinting and taping of a wrist sprain was a "proceeding" which met the statute of limitations because the treatment was "clearly specific to an injury very reasonably proceeding directly from the employee's specific profession, and the injury's treatment in that manner quite reasonably implies an admission of responsibility." Thus, the statute of limitations was met sometime between 1988 and 1992 when the employee received treatment. The WCCA also rejected an argument that, because the treatment occurred prior to the date of disablement, it cannot satisfy the statute of limitations. The date set for a *Gillette* injury will inevitably be later than some or all of the contributing traumatic events and any subsequent treatment.

Judge Sundquist dissented (and Judge Quinn joined) on this point, arguing that the majority opinion might require that any provision of first aid or medication for the relief of minor ailments might constitute "payment by the employer" of a workers' compensation benefit, even when there is no known injury. Moreover, the employee received treatment prior to the date of the disablement and, without a disabling injury, it was not possible for him to be aware that one existed and for the statute of limitations to begin to run. This case has been appealed to the Minnesota Supreme Court, and was orally argued on February 6, 2019.

**VACATING AWARDS**

*Strand v. R&L Carriers Shared Services, LLC*, File No. WC18-6202, Served and Filed February 14, 2019. The employee was injured while working as a delivery driver for the employer on September 16, 2016. Primary liability was admitted and various benefits were paid. His treating doctor found him to be at maximum medical improvement and released him to return to work without restrictions. He began treating with various other medical providers, who diagnosed him with ankylosing spondylitis of the thoracic and lumbar spines, for which the employer and insurer denied primary liability. The employee filed a Claim Petition for alleged injuries to his low and mid back, rib cage, and radicular pain in both legs. An MRI and a CT scan were done, both of which showed a T11 fracture. Dr. Chang recommended various surgical options, including a T11 corpectomy, posterior thoracic laminectomy at T11, correction of kyphosis and thoracic pedicle screws from T4 to L2. Dr. Raih performed an IME and recommended a TLSO brace for the T11 fracture before considering surgery. The parties settled for a lump sum of $80,000 to the employee and $20,000 to his attorney, which included closing out future medical treatment. Soon after the settlement, the employee was evaluated by Dr. Polly, who recommended surgery, which included a posterior spinal fusion from T4 to S1, segmental spinal instrumentation from T4 to S1, pelvic fixation, and osteotomies from T12 to L3, with complications of presumed positional femoral nerve neurapraxia. He underwent surgery, but was hospitalized afterwards, diagnosed with paraplegia, bilateral leg weakness, impaired mobility, generalized weakness, impaired activities of daily living, and impaired cognition. He was unable to return to work until at least early 2019, and continued to have gait and balance problems that required him to use a walker or cane. He was also given a 26 percent permanent partial disability rating. The employee filed a petition to vacate the earlier stipulation for settlement based on a substantial change in his medical condition that had not been anticipated and could not have been

anticipated at the time of the parties' settlement. The WCCA (Judges Hall, Sundquist, and Quinn) agreed and vacated the earlier stipulation for settlement. The WCCA held that the facts of this case were distinguishable from the facts in *Swanson v. Kath Fuel Oil Service* because in *Swanson* the employee's surgery had been scheduled prior to the parties' settlement, whereas here, at the time of the parties' settlement, the employee had not yet decided whether to have surgery, or attempt to wear a brace. The surgery recommended prior to settlement was also significantly different than the surgery suggested after settlement.

*Block v. Exterior Remodelers, Inc.*, File No. WC18-6214, Served and Filed March 19, 2019. In 2016, the employee petitioned to vacate a stipulation for settlement from 1992, which was granted by the WCCA at that time. The employee then filed a Claim Petition seeking additional benefits. While the employer and insurer did not dispute the claim for benefits, they argued they were entitled to a credit of $40,000 from the 1992 stipulation for settlement. Compensation Judge Behounek granted the employer and insurer a full credit of $40,000 and the employee appealed. The employee argued that Minn. Stat. §176.179 applied, which would cap the credit at 20 percent. The WCCA (Judges Milun, Stofferahn, and Quinn) affirmed. The vacation of the award on stipulation does not determine or imply whether the employee's claims are compensable. Instead, the vacation merely establishes the employee had statutory grounds to vacate the award on stipulation and the vacation puts the parties in the same position as they had been in prior to the settlement. Thus, the WCCA held that, consistent with *Flanagan v. Southern Minnesota Construction Company*, 62 W.C.D. 221 (WCCA 2002), the employer and insurer were entitled to a credit of the full $40,000 from the 1992 stipulation for settlement.

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# WISCONSIN WORKER'S COMPENSATION 2019 CASE LAW UPDATE

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# Wisconsin Worker's Compensation 2019
# Case Law Update

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## WISCONSIN WORKER'S COMPENSATION 2019 CASE LAW UPDATE

### ARISING OUT OF

***Michael Bukovic v. Labor and Industry Review Commission,* 2018 WL 6523326 (Wis. Ct. App. 2018 (final publication decision pending).** The applicant had purchased a private welder for his personal use. That welder used argon gas. The applicant did not have argon gas or an argon tank. He had decided to take an acetylene gas tank from his employer and transfer argon gas (from his employer) into it so that he could take the argon gas home for his private use. In order to transfer the argon gas into the acetylene tank, the applicant brought a hose from home. When his manager saw him arrive at work with the hose in hand, he asked the applicant why he had brought the hose to work. The applicant indicated he needed to put some fittings on the hose in order to do some work at home. However, the applicant, while unsupervised, attempted to use his personal hose to transfer the argon into the acetylene tank. Argon is stored at a higher pressure than an acetylene tank is designed to handle. The tank exploded, injuring the applicant. The applicant asserted that he intended to pay for the gas later. He acknowledged that he had no work-related reason to be near the gas tanks when the explosion occurred. The employer did allow employees to buy items out of its stock of items. However, the applicant had not asked to purchase the argon gas and had also not asked to use the acetylene tank to transport the argon gas. The administrative law judge denied the applicant's claim on the basis that his activities did not arise out of or incidental to his employment. The evidence established that the applicant intended to pilfer the argon gas and to purloin the acetylene tank which he had unilaterally decided was abandoned. The Circuit Court of Forest County and the Court of Appeals affirmed. The applicant was not involved in a mere insubstantial deviation from work as asserted. Instead, he had undertaken a complete abandonment and departure from his work responsibilities and duties. The applicant was in a substantial deviation from his employment when the incident occurred, and was, thus, no longer in the course of his employment.

*Bach v. Hospice Advantage Inc*., Claim No. 2016-014617 (LIRC May 31, 2018). The applicant alleged she sustained a knee injury after she slipped and fell on ice on March 1, 2016. She alleged that she was walking to work and slipped and fell on an icy parking lot. Her treating physicians opined the fall caused disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression. Dr. Bartlett performed an independent medical examination. He noted the records reflected the applicant had been diagnosed with a loss of medial meniscal function five years prior to the injury. Surgery was recommended at that time, but never completed. He opined the applicant's ongoing symptoms were the result of degenerative arthritis and not a meniscal tear. Administrative Law Judge O'Connor denied the applicant's claims. He adopted Dr. Bartlett's opinions as more credible. The applicant repeatedly failed to make reasonable concessions regarding her condition prior to the work-related injury. The applicant failed to treat for almost one month post alleged injury. Further, the original medical records failed to indicate any work-related injury was sustained. The Labor and Industry Review Commission affirmed. There are repeated, clear, references in the medical records to the applicant's knee locking. This, together with her prior history of left knee injury and falls, makes it not credible that she never felt a locking sensation but nevertheless described the same to her physicians. The applicant's testimony was not credible and was inconsistent with the medical records. Therefore, there is legitimate doubt that the applicant's fall on the claimed date of injury was caused by a slip and

fall as opposed to an idiopathic fall related to her prior medical condition of proclivity to left knee locking. Further, the applicant initially sought treatment for her left knee condition under her private health insurance. She did not bring the worker's compensation claim until she learned the private insurer would not cover her proposed meniscal surgery. The applicant has a law degree and has dealt with medical insurance issues related to prior injuries. It is not credible that, if she knew her fall had been caused by a slip and fall in the course of employment, she would not have immediately claimed the medical and disability coverage under worker's compensation.

*Cities and Villages Mutual Inc. Co. v. Kedrowski, City of Stevens Point*, Claim Nos. 2013-028657, 2016-001124 (LIRC June 19, 2018). The applicant was a firefighter and paramedic. He sustained work-related injuries to his low back on October 7, 2013 and November 12, 2013. The October 7, 2013 injury resulted from lifting several heavy patients. The treating physicians did not opine a permanent injury was sustained. The November 12, 2013 injury also occurred from lifting an obese patient. Dr. Hendricks diagnosed the applicant with sacroiliac joint dysfunction and right piriformis syndrome. He assigned a two percent permanent partial disability to the body as a whole. EMC conceded the injuries and paid medical expenses for both injuries and indemnity benefits for the second. The applicant sustained a third work-related injury to his low back on January 11, 2016. The applicant sustained the injury after climbing three flights of stairs while carrying a 250 pound stretcher of equipment, and returning down the stairs carrying a patient. The applicant reported an instantaneous onset of pain with that effort. He described the pain as much worse than the pain he experienced in 2013 and 2014. The City was self-insured and its claims were administered by Cities and Villages Mutual Insurance Co. (CVMIC) at the time of the 2016 work-related injury. The City and CVMIC paid temporary total disability compensation and medical expenses. CVMIC filed a reverse hearing application seeking reimbursement from EMC for the benefits paid. CVMIC asserted that the January 11, 2016 injury was not a new injury but simply a manifestation of the applicant's October 7, 2013 injury. Administrative Law Judge Landowski denied CVMIC's application without hearing, based upon stipulated facts and exhibits. The Labor and Industry Review Commission affirmed. CVMIC misstated Dr. Hendricks' opinions regarding the January 11, 2016 injury. CVMIC asserted that Dr. Hendricks opined that the 2013 injuries caused a permanent injury to the applicant's back, and that the 2016 injury was a manifestation of that injury, not a new injury. However, Dr. Hendricks described the 2016 injury as an aggravation of the pre-existing injury, which the Commission considered more than a manifestation of the pre-existing injury. Further, Dr. Monacci performed an independent medical review and opined that the event of January 11, 2016 was not a mere manifestation of the applicant's pre-existing low back pain syndrome. He opined the incident was an aggravation of his condition beyond normal progression. The Commission held the applicant recovered from his 2013 injuries as evidenced by his performance of unrestricted duty with no medical treatment for nearly two years before sustaining a new work-related injury in 2016. Further, the mechanism of injury in January 2016 involved an extraordinary effort by the applicant. This effort could reasonably cause more than a manifestation of his prior condition.

*Bayer v. Marinette Marine Corp.*, Claim Nos. 2015-009885, 2016-007204 (LIRC June 29, 2018). The applicant had a substantial history of shoulder complaints prior to the alleged injuries. The applicant's treating physicians did not accurately describe the alleged mechanism of injury. The mechanisms outlined by the treating physicians were confusing. Other records were inaccurate. Some of the treating physicians comingled the claim for traumatic versus occupational injuries. Other treating physicians did not have an accurate understanding of the alleged mechanism of injury. The independent medical examiner opined the applicant did not sustain a work-related injury. The administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The applicant acknowledged errors in history, but asserted that errors do occur in histories. This may be true; however, the errors that occurred reflected a significant misunderstanding of the incident that allegedly caused the injury and makes the physician's opinions suspect. The physician further only opined that it was "conceivable" that an injury occurred as the result of a specific incident. Instead, the independent medical examiner had an accurate understanding of the claimed injury. The records reflect he performed a very thorough examination and review of the medical records. There is legitimate doubt the applicant sustained a work-related injury.

*Jurkiewicz v. County of Milwaukee, County BHD*, Claim No. 2016-018194 (LIRC June 29, 2018). The applicant worked for the Milwaukee County highway maintenance department. On June 23, 2015, the applicant experienced right leg soreness after spraying for weeds along a three-mile stretch of highway. He was carrying a 40 to 50 pound backpack. He reported intensifying soreness the next two days. He did not report the injury until he experienced leg collapse at work on June 29, 2015. Dr. Schwab, an orthopedic surgeon, opined that x-rays showed osteonecrosis (avascular necrosis) with likely subchondral fracture. Dr. Schwab indicated that the osteonecrosis was a chronic condition and the work incident was likely an acute exacerbation of a previously asymptomatic condition. He indicated that the most likely etiology for the osteonecrosis was excessive alcohol use. Dr. Schwab opined both a specific and repetitive injury had been sustained. In a letter dated April 22, 2016, which responded to questions posed by the applicant's attorney, Dr. Schwab opined it was possible that the work duties described by the applicant could create an acute exacerbation of a previously asymptomatic hip that had pre-existing osteonecrosis. Dr. Schwab opined there was no evidence that the work duties described by the applicant would have been a cause of or risk factor for osteonecrosis. Dr. Schwab opined that, because the applicant denied any hip pain prior to June 23, 2015, it was reasonable to assume that the activities which caused the pain were a substantial factor in necessitating the treatment provided. Dr. Xenos performed an independent medical examination on January 14, 2017. He opined that the applicant's symptoms were likely secondary to a manifestation of his underlying, preexisting osteonecrosis and that those symptoms were consistent with the natural history of the underlying condition including collapse of the osteonecrotic lesion. Dr. Xenos opined that, in general, routine activities were not considered a cause of osteonecrotic femoral head collapse. He opined such collapse is considered to be a natural progression of the underlying process related to the location of the lesion in the femoral head. The administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. Dr. Schwab's opinions were, on balance, more unsupportive than supportive of the applicant's claim of a work-related hip injury. Dr. Schwab unambiguously described the work incident as an acute exacerbation of a previously existing, previously asymptomatic chronic condition. He identified the applicant's past alcohol abuse as the most likely etiology. Dr. Schwab later opined that it was reasonable to conclude that the symptoms

were brought on by the applicant's work. He did not indicate that this symptom onset could be related to more than an acute exacerbation of the applicant's underlying idiopathic condition. Further, Dr. Schwab's did not provide support for checking both causation boxes. Dr. Schwab's April 22, 2016 letter contained ambiguities and was inconsistent in its causation opinion. Dr. Xenos provided a credible, straightforward explanation for the symptomatic manifestation of the applicant's preexisting, degenerative right hip osteonecrosis. That opinion was consistent with the accompanying evidence of a bilateral hip condition and consistent with the longstanding nature of the applicant's idiopathic condition. Dr. Xenos credibly opined that the regular work activities were not a causative factor in the onset or progression of the osteonecrosis. Dr. Schwab's April 22, 2016 opinion also stated that there was no evidence that the applicant's work duties would have been a cause of or risk factor for osteonecrosis. As a result, the Commission determined that there was no causative relation between the condition and the work activities.

*Acker v. Speedway Super America, LLC*, Claim No. 2013-006284 (LIRC July 18, 2018). The applicant worked part-time at a gas station. She alleged that, on February 23, 2013, she was injured while cleaning a drip pan under a roller grill. She pulled the large, wide drip pan out from under the roller grill to clean underneath, and the pan was at her chest level. She used a circular motion to clean up the drippings. She heard her shoulder make a pop and felt a sharp pain in her shoulder with one of the motions. Her arm was fully extended. She had been cleaning for about a minute or two when this happened. She underwent an MRI that showed a small nondisplaced tear involving the posterior superior labrum. Dr. Boyle diagnosed post-traumatic right shoulder pain and a possible symptomatic superior labrum anterior-posterior tear. He recommended physical therapy and a follow-up visit in three weeks. The applicant did not go to physical therapy and cancelled her follow-up appointment. She did not seek medical treatment because she did not have insurance. Dr. Boyle provided a written response to the applicant's attorney indicating that the applicant's MRI demonstrated minor findings not to be significant, that the February 23, 2013 reported exposure likely caused the applicant's symptoms, and that she reached end of healing as of April 3, 2013, the date of her canceled appointment. He did not authorize any other time off or restrictions. He opined that additional evaluation/treatment was not indicated and no impairment/disability was applicable. Dr. Grossman performed an independent medical examination. He opined that circular motion above shoulder height was not the type of activity that would cause significant tissue yielding or structural breakage and it was not a medically plausible cause for a SLAP tear. He thought it was conceivable that the applicant had a minimal overuse event that resulted in symptoms at that time. More than a year after treatment with Dr. Boyle, the applicant was referred to Dr. Gershtenson. Dr. Gershtenson diagnosed the applicant with a posterior superior labral tear. He opined that her reported activity at work was likely to have caused the labral tear. Dr. Gershtenson indicated she would almost certainly need surgery. She preferred to observe her symptoms. She subsequently obtained full-time employment with Hertz Car Rental. She cleaned from one to ten cars per day. She worked there approximately six or seven months. She then underwent right shoulder surgery. Dr. Gershtenson opined that the work incident directly caused the applicant's disability. The unnamed administrative law judge granted the applicant's request for benefits. The Labor and Industry Review Commission reversed. The circular motion performed by the applicant at or above shoulder height is not the type of activity that would cause significant tissue yielding or structural breakage. This was not a medically plausible cause for her SLAP tear. The applicant was not credible because she denied pre-existing complaints with her shoulder when treating

with Dr. Gershtenson, but provided a history to Dr. Boyle after the injury indicating that she had some minor shoulder discomfort before the work incident. The Commission, therefore, discredited Dr. Gershtenson's opinions because they were based on an inaccurate medical history.

***Vallier v. Labor and Industry Review Commission,* 2019 WI App 15 (Wis. Ct. App. 2019)**(***unpublished***). The applicant was a nurse at Aurora Health. While exiting a room, she hit her right elbow and right shoulder against the corner of the wall. She immediately experienced a tingling sensation, which she thereafter reported consistently. Two neurosurgeons diagnosed her with a C6-7 disk extrusion. Dr. Thomas Lyons performed an independent medical examination. Dr. Lyons opined that the involved nature of the event made it impossible for the incident to have caused or contributed to the problem by aggravation and acceleration of the underlying degeneration. The unnamed administrative law judge held Dr. Lyons opinion was not credible. He opined that there was nothing to indicate the applicant had experienced symptoms prior to the incident. The Labor and Industry Review Commission held Dr. Lyons' opinion was more credible and dismissed the claim. The Circuit Court and Court of Appeals affirmed the decision of the Commission. The law required the courts to affirm the Commission's decision if there was any credible evidence in the record to support the decision. Dr. Lyons' opinion was such evidence.

*Redlinger v. Meda Care Ambulance*, Claim No. 2014-020996 (LIRC February 21, 2019). The applicant filed a hearing application alleging bilateral hip injuries (labral tears) on August 13, 2014. She testified that, while moving from a squatting to a standing position, she felt a grinding pain in her right hip. When she began to walk, she experienced pain but no longer had a grinding sensation. The applicant provided several other explanations for the mechanism of injury according to the records. These included: (1) lifting a patient, (2) squatting down, (3) getting up from a chair and feeling a pop in the right hip, (4) stooping and experiencing pain, and (5) experiencing a grinding sensation in the hip when getting out of a car. The treating physician opined a specific injury occurred. The treating physician opined the mechanism of injury involved the applicant squatting, pivoting, and standing. He opined the condition was caused by precipitation, aggravation, and acceleration of a preexisting progressively deteriorating or degenerative condition beyond its normal progression. Dr. Krug performed an independent medical examination of the applicant. Dr. Krug opined that there was no significant trauma sustained on August 13, 2014. He opined that labral fraying was a degenerative phenomenon and not associated with trauma. He opined that her symptoms were medically probably a manifestation of an underlying personal condition. He opined that the high hip forces associated with her morbid obesity and gastric bypass surgery were more likely the source of her hip fraying than her work exposure. Dr. Krug also opined that the applicant experienced femoral acetabular impingement caused by bones that did not form normally during her childhood growing years. Dr. Krug provided a very detailed discussion of her femoral acetabular impingement, including numerous references to expert medical literature on which he relied. Dr. Krug noted that fraying, rather than an acute labrum tear, typically develops over time rather than with a single motion such as standing. Administrative Law Judge O'Connor held the applicant did not sustain a work-related injury. He opined the applicant's symptoms were a manifestation of her preexisting femoral acetabular impingement. Administrative Law Judge O'Connor noted that the applicant did not fall, did not experience pain while moving a patient, and was not lifting anything at the time of her injury. The Labor and Industry Review

Commission affirmed. The applicant provided new literature at the time of the *pro se* appeal, which supported the denial of her claim. This literature noted labral tears could be caused by (1) trauma, (2) structural abnormalities of the hip such as femoral acetabular impingement, or (3) repetitive motion. The applicant sustained no trauma. The evidence did not demonstrate any repetitive motion was performed. The applicant did have structural abnormalities that the applicant's supportive literature indicated could lead to a manifestation of the condition claimed. Dr. Krug provided a thoughtful analysis of medical literature on the causation issue and explained how the condition could lead to the applicant's abnormal bone growth and labral fraying over time. The treating physician did not explain how abnormal bone growth and labral fraying would have developed or occurred with even just rising from a squatting position.

*Sibilski v. Cleveland Marble,* Claim No. 2017-010879 (LIRC March 11, 2019). The applicant was hired by the employer as a marble setter/finisher. The applicant subsequently admitted that he lied on his job application for the employer. Specifically, he lied when he denied that he had any prior back injuries or chronic ailments. He lied when he indicated that he had not treated with a physician in the past three years. He also lied when he indicated that he had not received worker's compensation benefits in the past. The applicant testified that he lied to get the job. The applicant provided a job description to give to his physician, which was attached to the WKC-16B. The employer representative testified that the job description was not accurate and that the applicant did not perform the physical and heavy job duties that he asserted in the job description he prepared. The applicant was laid off by the employer. Prior to that date, he did not report to anyone at the employer that he had hurt his back or that he had back pain. He was taking narcotic pain medication the entire time he worked for the employer. Three days after he stopped working for the employer, he treated for low back pain. He reported the symptoms started over the past few days. He completed a form and indicated that his injuries were not work related. He was referred to a surgeon. The applicant initially did not report that he had sustained a work-related injury. He later requested the surgeon change the document to reflect the condition was due to a work-related injury. The applicant testified that he was a narcotic addict and that he abused the narcotics prior to the work-related injury. He indicated he was not honest with his medical providers about the narcotic usage and that he violated agreements. Dr. Timothy O'Brien performed an independent medical examination. He opined the applicant had a multilevel degenerative disc disease and that his back condition would have progressed to the same extent at the same rate and to the same degree regardless of his work for the employer. He opined the applicant's diminished pain threshold was a side effective from the chronic narcotic/opioid abuse. Dr. O'Brien opined the applicant did not sustain a work-related injury because his job duties were varied and none involved biomechanical forces or non-anatomical or non-physiologic positioning of the lumbar spine that would have contributed to or caused his degenerative disc disease. The unnamed administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The Application for benefits was dismissed. The applicant's description of his job duties as attached to the surgeon's WKC-16B was not credited. The applicant's testimony contradicted the description of the applicant's actual job duties. The treating surgeon's opinion is not credited because it is based on a misunderstanding of the applicant's job duties. Instead, Dr. O'Brien's opinions are credited. The applicant's job duties did not involve bio mechanical forces or non-anatomical or non-physiological positioning of the lumbar spine that would have contributed to or caused the applicant's degenerative disc disease. The applicant failed to provide beyond a legitimate doubt that he sustained an occupational injury.

## Bad Faith

*Andres v. County of Juneau c/o Minute Men HR Management of Wisconsin, Inc.*, Claim No. 2006-033350 (LIRC April 9, 2019). The applicant alleged that he sustained a work-related injury to his knee. The applicant required surgery as a result of the work-related injury. He subsequently developed an infection. A dispute arose regarding whether the infection was causally connected to a work-related injury. A hearing was held and benefits awarded. The applicant subsequently alleged bad faith on the part of the employer because the employer had appealed the original decision to the Circuit Court and the Court of Appeals. The applicant asserted that the underlying case turned upon factual determination made by the Commission which had no substantial chance of being overturned on appeal. The administrative law judge dismissed the bad faith claim. The Commission affirmed. The court has routinely held that there are basically three types of delays in payment: (1) delays caused by excusable neglect; (2) delays caused by inexcusable neglect; and (3) delays caused by bad faith conduct. In order for there to be a bad faith claim, there must be proof that the insurer did not have a reasonable basis to conclude that the claim was fairly debatable and the insurer recklessly disregarded that fact. Where there were a number of conflicting medical records and conflicting doctors' opinions, the insurer had a reasonable basis for continuing its appeal.

## Burden of Proof

*Rangle v. Tailwaggers Doggy Day Care LLC*, Claim No. 2017-013498 (LIRC November 8, 2018). The administrative law judge issued a default Order for the employer's failure to appear on a refusal to rehire claim. The exhibits were limited to descriptions of the work injury and resulting medical treatment. There was no testimony from the applicant or any competent evidence to establish any unreasonable refusal to rehire, the applicant's average weekly wage, whether the applicant was employed in a regular full-time or part-time position, or whether the applicant had sustained 52 weeks of lost wages. The administrative law judge, nevertheless, ordered compensation for 52 weeks of lost wages based upon full-time employment, at an average weekly wage of $340.00. The Commission reversed for a determination regarding excusable neglect. (*See Default Judgement* category, below.) Under proper circumstances, it might be appropriate to issue a default order for failure to appear. However, even if such a judgment is appropriate, the applicant still has the evidentiary burden to establish essential facts in support of his or her claim. In a default judgment, the fact finder accepts as true all competent evidence offered. However, the competent evidence must still be submitted and entered into the record. Therefore, even if there was no excusable neglect and a default order again issued, both parties should be allowed to submit evidence regarding the applicant's part or full-time status and the amount of lost wages.

*Davis v. Jenkins*, Claim No. 2014-024439, (LIRC November 20, 2018). The applicant worked as a bouncer at a nightclub called the Ivy Lounge in Milwaukee. He alleged that he sustained a head injury in a bar fight. The applicant could not determine the worker's compensation carrier. He filed an application for benefits with the Uninsured Employers Fund (UEF). The applicant listed Jenkins as his employer because he believed Jenkins owned the Ivy Lounge. When Jenkins failed to respond to a letter and voicemail regarding the applicant's claimed employment, the UEF determined that Jenkins employed the applicant. The UEF sought reimbursement for payment of medical expenses related to the work injury. Jenkins filed a reverse hearing application to seek a determination that he was not the applicant's employer. The administrative law judge held

Jenkins was not the employer. The Labor and Industry Review Commission remanded the case. The UEF asserted Jenkins was the "applicant" because he filed the reverse hearing application that Jenkins had to prove that he was not the employer, and that he failed to do so. This is not correct. The applicant (and the UEF who stands in his shoes) has the burden of proof because the applicant seeks to receive benefits under the Worker's Compensation Act, even if the alleged employer filed the reverse hearing application for a determination as to the correct employment relationship. The applicant /UEF must prove, beyond a legitimate doubt, all of the facts essential to recovery of compensation. The applicant must prove that he was an employee and that an employer/employee relationship existed.

*Tomasini v. Classic Concrete*, Claim No. 2016-014312 (LIRC November 20, 2018). The applicant allegedly sustained a left ankle injury on June 3, 2016. He alleged that he was walking with a wheelbarrow when it tipped over, he fell down and twisted his ankle, and the wheelbarrow hit his ankle. There were no witnesses. Two coworkers' testimonies contradicted the applicant. There was nothing apparent that would indicate to his coworkers that he had injured his left foot or ankle. The applicant testified he had planned to drive up north with his wife on the date of the alleged injury but instead had to go to the emergency room because the pain was unbearable. The record indicated that he stated he was pushing a wheelbarrow and it tipped, causing bricks to fall out onto his left ankle, and that he rolled his ankle at the same time. His treating physician referenced bricks falling onto the applicant's medial lower leg and foot as the mechanism of injury. The applicant filed a hearing application in March of 2017, alleging that he injured his left foot/ankle by "fall + bricks from wheelbarrow fell on leg + foot." The employer does not use bricks in its concrete work. The applicant admitted at the hearing that there were no bricks involved in the work incident. The applicant acknowledged that the reference to bricks was a mistake. Dr. Barron performed an independent medical record review. Dr. Barron identified a number of records that he reviewed, including statements taken from the applicant, the applicant's supervisor, and the applicant's coworkers, but did not attach the referenced documents to his report. The unnamed administrative law judge granted the applicant's application. The Labor and Industry Review Commission reversed. The applicant's testimony was not credible due to inconstancies and contradictions in his testimony and that of the other witnesses, as well as the applicant's mischaracterization of the work incident. The Commission did not credit the treating physician's medical opinion because it was based on an erroneous mechanism of injury. However, the Commission also did not credit Dr. Barron's medical opinion because he relied on information that was not medical (the claims file notes), and which was not in the record. The applicant had the burden of proof and failed to prove beyond a legitimate doubt that he sustained a work-related injury.

### CAUSAL CONNECTION

*Kothlow v. Menard, Inc.* Claim No. 2014-029554 (LIRC May 31, 2018). The applicant sustained a work-related injury on January 14, 2014. A potted plant tipped over and the upper braches and foliage of the plant struck her on the shoulder and neck while she was sitting in a chair. She stated she was more frightened than hurt when the incident originally occurred. She finished her work shift. She treated with Dr. Bodeau the following day. She was diagnosed with a contusion of the left shoulder. She treated a few weeks later and reported her symptoms had entirely resolved. Her examination revealed no pain or swelling and her range of motion was back to her baseline. Dr. Bodeau opined she reached end of healing. A WKC-16 was completed indicating

that she had no permanent disability as a result of this incident. She reported ongoing symptoms which Dr. Bodeau related to a prior work-related injury with another employer. During treatment a few months later, he noted that the applicant had just completed a settlement for the prior injury and that the applicant now reported the symptoms began after the January 2014 incident. Dr. Bodeau subsequently completed a WKC-16B. He opined the 2014 incident precipitated, aggravated and accelerated a pre-existing progressively deteriorating cervical spine condition beyond normal progression. He opined the cervical symptoms never fully resolved after the 2014 incident and were masked by her shoulder symptoms. Dr. Barron performed an independent medical examination and adopted Dr. Bodeau's first opinion (that there was a temporary contusion that resolved within a few weeks, with no permanent disability). Administrative Law Judge Minix determined that the applicant sustained a work-related injury which was temporary in nature and nothing more than a minor contusion, from which she fully recovered within a few weeks. The Labor and Industry Review Commission affirmed. The applicant alleges the administrative law judge rendered his own diagnosis by finding the work incident only temporarily aggravated the applicant's neck condition, in the absence of any such medical diagnosis. While there was no such medical diagnosis, the administrative law judge did not make up that diagnosis. He did not make a finding that the work incident temporarily aggravated the applicant's neck condition. Instead, the judge determined that she sustained an injury and rejected the idea that she sustained a disabling neck injury. The applicant and her physician initially reported the plant impacted the applicant's shoulder and not her neck. She reported she was pain free within two weeks after the incident occurred. Dr. Bodeau opined she had fully recovered at that point. The applicant did not report that she had continued neck pain until five months after the incident. This pain was not dissimilar to what she reported prior to the incident. Further, Dr. Bodeau originally opined there was no connection between the incident and disability cervical condition. While an expert's change of mind does not necessarily detract from the new opinion, the evidence suggests Dr. Bodeau arrived at the new opinion through an inaccurate recollection of the applicant's clinical history. Finally, the photographic evidence of the plant and location of the plant reflects only the leafy and pliable part of the plant struck the applicant. It is a reasonable inference that Dr. Barron's opinion regarding causation was based upon a belief that the force involved in the toppling of the plant was insufficient to be causally related to the progression of the applicant's cervical disc protrusion.

### CLAIM AND ISSUE PRECLUSION

*Russell v. Trek Bicycle Corp.,* Claim No. 2016-008163 (LIRC August 31, 2018). The applicant sustained a significant injury while riding his bicycle on the employer's premises over his lunch hour. *See* Voluntary Recreation category for additional factual background. The applicant filed a claim in civil court initially, alleging negligence against the employer and other parties. This claim was dismissed on summary judgment after a determination that the defendants were cloaked with immunity under Wis. Stat. 895.52(6)(e) (the Wisconsin Recreational Immunity Statute). The applicant did not dispute the statement, in the civil claim, that he was not acting within the scope of his employment at the time of his injury. This does not result in Claim Preclusion in the worker's compensation court. The circuit court proceeding has no preclusive effect on the worker's compensation claim. There is no claim preclusion. In order for this to apply, there must be (1) an identity between the parties or their privies in the prior and present suits, (2) an identity between the causes of action in the two suits, and (3) a final judgement on the merits in a court of competent jurisdiction. Claim preclusion may not apply where issues of

subject matter jurisdiction arise. The Worker's Compensation Act is the exclusive remedy available to employees who sustain work-related injuries. The applicant could not have raised his worker's compensation claim in circuit court. The civil court lacked subject matter jurisdiction over the worker's compensation claim. The applicant is, therefore, not precluded from bringing his claim under the Act in an action before the Division. Similarly, there is no issue preclusion bar. In determining whether issue preclusion applies, one must first decide whether an issue of fact or law was actually litigated and determined by a valid judgement, the determination of which was essential to the judgement. Under the applicable case law, where such a showing is made, the determination is conclusive in a subsequent action whether on the same or different claim unless the application of issue preclusion precepts offend principles of fundamental fairness. In the civil claim, the employer argued it was immune from liability under the civil Recreational Immunity Statute. The employer's motion proposed various findings of fact, including a statement that the applicant's use of the trails on the date of injury was for non-business activities beyond the scope of his employment for the employer. The release signed by the applicant supported this position. The applicant did not dispute the proposed findings of fact. The civil court did not evaluate whether the applicant's activities on the date of injury went beyond the scope of his employment for the employer. The specific issue before the Division is whether the applicant was performing services growing out of and incidental to his employment in accordance with the statute and case law. The circuit court's decision is silent on this question. The court could not and did not litigate the matters currently in dispute and, therefore, there is no issue preclusion. A finding by the Division that the applicant was in the course of employment would not be inconsistent with the circuit court's action against the employer. Whether the employee is acting within the scope of his duties is a different analysis than under the present case. The Worker's Compensation Act does not require an injury be within the "scope of employment;" instead, the evaluation is whether the employee is performing services growing out of and incidental to his employment per the case law.

**COMPROMISE AGREEMENT**

*Swenson v. Just One More Ministry*, Claim No. 2017-012963 (LIRC October 5, 2018). An administrative law judge approved the terms of a compromise agreement. The applicant subsequently filed 15 separate petitions for Commission review of the order approving the compromise. The applicant also submitted an application to reopen the compromise agreement. An administrative law judge issued an order dismissing the application to reopen the compromise. This was dismissed without prejudice at the request of the applicant. The applicant's subsequent petition was considered a request for review of the dismissal order and/or another request to reopen the compromise. Pursuant to Wis. Stat. 102.16(1)(b), requests to reopen compromise agreements must first be submitted to the Department and not the Commission. This must be done within one year from the date an award was entered based on the compromise. If the Department denies the request to reopen the compromise, the party can submit a timely petition for Commission review. The Commission has no jurisdiction to review a request to reopen a compromise prior to final adjudication by the Department. Only one of the petitions for Commission review was filed after the Department's adjudication of the applicant's request to reopen the compromise. The Commission has no jurisdiction to accept the previously filed petitions for review. Further, the Department's order dismissing the application at the applicant's request, without prejudice, was not a final adjudication. This order did not award or deny compensation. Therefore, under Wis. Stat. 102.18(3) (providing a party in interest can

petition the Commission for review for a decision awarding or denying compensation), the Commission also did not have jurisdiction to accept the petition submitted after that order was issued. The applicant can file a new application with the Department to reopen the compromise, no later than one year after the order approving the compromise agreement. The applicant's assertion that medical expenses were not being paid in accordance with the terms of the compromise was a separate enforcement issue. The applicant could file a subsequent hearing application to address this issue after discussing the matter with the insurer's attorney.

**DEFAULT JUDGMENT**

*Rangle v. Tailwaggers Doggy Day Care LLC*, Claim No. 2017-013498 (LIRC November 8, 2018). The applicant sustained a conceded injury from a dog bite. The administrative law judge issued a default Order based upon the employer's failure to appear at the scheduled hearing on November 22, 2017. The judge held there was an unreasonable refusal to rehire. The administrative law judge awarded ordered compensation for 52 weeks of lost wages based upon full-time employment at a weekly wage of $340.00. The employer submitted an affidavit with its Petition for Review by the Labor and Industry Review Commission. The employer's president asserted that no one from the employer ever received a notice of hearing. She indicated that the mailbox opened at both the front and back sides and that, on occasion, delivered mail had fallen out of the back side into a ditch. The employer also indicated that mail service was disrupted in front of the workplace due to construction. She also submitted wage records, indicating that the applicant worked as a part-time employee for a total of 53 hours and earned $403.59 in her employment. The Labor and Industry Review Commission set aside the administrative law judge's decision and remanded for further proceedings. An established procedure exists when reviewing a default order issued for a party's failure to appear. The Commission initially assumes that the non-appearing party's explanation for failure to appear is true, unless there is something in the record making that explanation inherently incredible. Assuming that it is not inherently incredible, the next step is to determine whether the explanation, if assumed to be true, would constitute "excusable neglect." If the explanation meets that standard, a remand is necessary. The excusable neglect standard was articulated in *Hedtcke*: "that neglect which might have been the act of a reasonably prudent person under the same circumstances. It is not synonymous with neglect, carelessness, or inattentiveness." The employer's mailbox explanation could constitute excusable neglect. The Commission remanded the case to the Division for a hearing to determine whether or not the employer's failure to appear was due to excusable neglect.

**DISFIGUREMENT**

*Vang v. Pro Metal Works,* Claim No. 2014-00776 (LIRC October 31, 2018). The applicant's right hand middle and ring fingers were accidentally crushed in the brake press at work. He required surgery and amputation of portions of the fingertips. His restrictions were accommodated. The applicant testified that he found performing the job duties difficult. However, he did not report that to the employer. The employer testified that alternative accommodations would have been made if the applicant had notified the employer he was having difficulty performing his duties. The applicant walked off during a shift and quit his employment. The applicant applied for a position with a different company prior to quitting this employment. The applicant was terminated from that employment seven months later for attendance reasons. He subsequently worked for several different companies. The unnamed

administrative law judge awarded disfigurement benefits. Under *Landowski vs. Harnischfeger Corporation*, the applicant's employment status (to determine whether Wis. Stat. 102.56(2) applies) on the date of the hearing applies. The applicant was not employed by the date of injury employer on the date of the hearing. The administrative law judge, therefore, held the potential wage loss standard under Wis. Stat. 102.56(1) versus the actual wage loss standard under Wis. Stat. 102.56(2) is applicable. The Labor and Industry Review Commission reversed and denied all disfigurement claims. The applicant's employment status on the date of the hearing is not applicable in this case, as compared to *Landowski,* because the applicant in this case quit his employment with the employer voluntarily, whereas the applicant in *Landowski* was laid off. Further, subsequent to *Landowski*, in *Gajewski v. B&E General Contractors*, the Commission held that the applicability of the proper subsection depends on whether the applicant was laid off or fired versus voluntarily quit. The Commission held that, if the applicant voluntarily quit, then Wis. Stat. 102.56(2) is applicable. Wis. Stat. 102.56(2) states, "If an employee who claims compensation under subd. (1) returns to work at the employer who employed the employee at the time of the injury, or is offered employment with that employer, at the same or higher wage, the department or the division may not allow that compensation unless the employee suffers an actual wage loss due to the disfigurement." Wis. Stat. 102.56(1) contains similar provisions for employment at a different company, but with a potential wage loss standard. Here, the employer returned the applicant to an ongoing position at the same wage he had been earning on the date of injury. The applicant failed to demonstrate actual wage loss due to the disfigurement. The only actual wage loss sustained was temporary and due to the applicant's attendance violations, subjective functional concerns and personal choice.

### EMPLOYMENT RELATIONSHIP

***Glowacki v. Lakeview Neurorehab Center Midwest,* 383 Wis. 2d 602 (Wis. Ct. App. 2018) (unpublished).** The applicant was a clinical psychotherapist. She was hired originally by Lakeview Neurorehab Center Midwest (hereinafter "Midwest"). In order to expand its services, Midwest created a related entity Lakeview Care (hereinafter "Care"). Four employees from Midwest were "allocated" to "Care." This change allowed Midwest to provide expanded services under a new license and under new billing parameters. Both Midwest and Care were owned by Lakeview Care Partners Management, which was owned by two people. The applicant and her supervisor were both directed and supervised by an employee of Midwest. The clinic facility, office, staff, and general supplies used by the applicant for her practice were all provided by Midwest. The applicant was injured at work when attacked by a patient. The applicant sued Midwest for its alleged negligence. Midwest raised as a defense the argument that it was the employer and that the applicant's sole remedy was worker's compensation. The applicant asserted that her employer was Care. The Circuit Court granted summary judgment to Midwest. The Court of Appeals affirmed. The sole remedy clause of the worker's compensation statute applies to Midwest as the employer and to its worker's compensation insurer. The primary test for determining whether or not a person is in the service of another and, thus, in an employee-employer relationship, is whether or not the alleged employer has a right to control the details of the work. While the paycheck for the applicant was drawn on Care, this was solely for revenue enhancing purposes and it had nothing to do with what entity had the right to control the details of the work. The evidence reflected Midwest controlled supervision and provided all of the supplies, materials, etc., and the applicant was clearly an employee of Midwest for purposes of the worker's compensation statute. There is no evidence Midwest possessed a second persona so

completely independent from, and unrelated to, its status as employer that the law would recognize it as a separate legal person. [Dual persona doctrine (wherein an employer normally shielded from tort liability by the exclusive remedy principle may become liable in tort to his own employee if he occupies, in addition to his capacity as employer, a second capacity that confers on him obligations independent of those imposed on him as employer) would otherwise be an exception to the exclusive remedy provision of the Worker's Compensation Act.]

*Davis v. Jenkins*, Claim No. 2014-024439, (LIRC November 20, 2018). The applicant worked as a bouncer at a nightclub called the Ivy Lounge in Milwaukee. He alleged that he sustained a head injury in a bar fight. The applicant could not determine the worker's compensation carrier. He filed an application for benefits with the Uninsured Employers Fund (UEF). The applicant listed Jenkins as his employer because he believed Jenkins owned the Ivy Lounge. When Jenkins failed to respond to a letter and voicemail regarding the applicant's claimed employment, the UEF determined that Jenkins employed the applicant. The UEF sought reimbursement for payment of medical expenses related to the work injury. Jenkins filed a reverse hearing application to seek a determination that he was not the applicant's employer. In the meantime, Jenkins began to make payments to UEF. Jenkins provided evidence that Centercourt Pub & Grill used the Ivy Lounge as overflow, the Ivy Lounge evolved into a nightclub restaurant, and that Ivy Lounge was used to boost sales for Centercourt. Jenkins indicated that the Ivy Lounge was nothing more than a brand name. Jenkins additionally provided a printout from the Wisconsin Compensation Rating Bureau which indicated that Travelers Indemnity Company of Connecticut held a worker's compensation policy for Connections Ticket Services, Inc., which was located at the building location of the Ivy Lounge. Jenkins indicated that the same individuals owned Centercourt and Connections. Jenkins had provided some of this information to UEF prior to filing the reverse hearing application; however, the UEF did no further investigation and instead demanded that Jenkins make payment. The unnamed administrative law judge held that Jenkins did not employ the applicant. The UEF determined that that Jenkins was the employer due only to lack of contradictory evidence. The Labor and Industry Review Commission set aside the decision and remanded. The Commission held that all putative employers/potential owners have an interest in seeing that the liabilities of potential co-owners are properly determined. This cannot be accomplished with individualized hearings. The Commission remanded the case for one hearing with all of the potential employers. It is possible that the other potential employers would provide proof that Jenkins was the proper employer.

*Vasquez-Maldonado v. Carlos Aragonez Twin Exteriors & Construction,* Claim No. 2016-001712 (LIRC March 11, 2019). The employer filed a reverse Hearing Application to seek a decision that he was not the employer, and not liable for medical expenses or indemnity benefits paid for by the Uninsured Employers Fund. [Although this was the initiation of litigation, for purposes of this summary, the alleged employee is listed as the applicant for ease of reading and consistency.] The applicant moved from Honduras to the United States to live with his brother in Texas. His brother was already working for the alleged employer. The applicant's brother told the applicant that the alleged employer was looking for people. The applicant met the alleged employer on a job site. The employer told the applicant that he needed to do the roofing work right or keep an eye on the material. The applicant had never done roofing work before. He worked in Texas from May to September. He was paid weekly in cash, based upon the number of squares worked. He worked with a crew of about eight people. In September, the employer told the applicant and his coworkers that the employer had a job in Wisconsin and that they

should move to Wisconsin. The workers drove to Wisconsin in two vehicles owned by the alleged employer. The alleged employer paid for the applicant and the other workers to share two apartments. The applicant installed at least ten roofs. He brought his own nail gun, air house, scissors, hammers, etc. He was required to purchase a nail gun to work for the alleged employer. The applicant did not personally secure roofing jobs (Texas or Wisconsin). He was never paid by the homeowners directly. The alleged employer drove the workers to the job sites. The alleged employer did not actually perform the roofing work. The alleged employer told the workers what to do and saw that the work was done well. The applicant fell off the roof of a house. He did not recall the incident. The alleged employer took the applicant to the hospital. The alleged employer paid the applicant after the injury. The alleged employer owns a company registered in Texas. The alleged employer is an employee of the business. The business was primarily in Texas, and only had jobs in Wisconsin two or three months each year. The employer located the jobs in Wisconsin by finding roofing companies in areas where storm damage had occurred and asking those companies for the work. The alleged employer did not locate the jobs or obtain payment from the homeowners. The company which secured the employment checked on the work and monitored the progress. The alleged employer asserted that he located one person to lead a crew, and that leader then secured the other people in the crew. The alleged employer asserted the applicant was working for a crew led by the applicant's brother. He also testified that he only paid the leader of the crew. The alleged employer testified that each worker paid his own portion of the hotel room in Wisconsin. He provided conflicting testimony about transportation to Wisconsin. The alleged employer indicated he only told the leaders where the job sites were located and the leader was in charge of getting the crews to the job sites and ensuring the work was done accurately. He indicated that he did not check on the job performance on each site. The alleged employer indicated that the crew could start and finish the days when they wanted and take lunches when they wanted. He testified he did not have any control over whether the crew showed up for work. He indicated that he was not able to fire the crews if they did not show up. He testified that he did not train the leaders or the crew. He indicated the crews could refuse work. The alleged employer indicated the vendor would check up on the work to ensure it was done. The alleged employer testified that he issued 1099s to the crew leaders. He indicated that he did not pay or withhold taxes for anyone in the crew. The alleged employer indicated he hired the applicant's brother as an independent contractor. He was not sure if the brother had his own business. He did not know if the brother could lose money doing the work. An unnamed administrative law judge determined that the applicant was an employee but that there was not an employment relationship between the alleged employer and the applicant. The Labor and Industry Review Commission affirmed in part and reversed in part. The Commission held the applicant and his brother were employees and not independent contractors. The applicant was the helper of his brother, and employed with actual knowledge of the alleged employer, and thus, under Wis. Stat. 102.07(4)(a), the applicant was an employee. The applicant was paid cash weekly by the alleged employer. The alleged employer told the workers what to do and supervised the work. He told the workers if jobs needed to be redone. The alleged employer provided housing and transportation in Wisconsin. The alleged employer provided for the applicant's labor. He exercised sufficient control over the work to establish an employer-employee relationship between the applicant and the alleged employer. The alleged employer did not demonstrate that any of the workers (including the applicant) met the nine independent contractor elements in Wis. Stat. 102.07(8). Alternatively, at least the crew leaders were employees. Therefore, the applicant would be still be considered an employee under Wis. Stat.

102.07(4)(a), which defines an employee as "every person in the service of another under any contract of hire, experts or implied, all helpers and assistants of employees, whether paid by the employer or the employee, if employed with the knowledge, actual or constructive, of the employer, including minors, who shall have the same power of contracting as adult employees, but not including the following: (1) domestic servants and (2) any person whose employment is not in the course of a trade, business, profession or occupation of the employer, unless as to any of said classes, the employer has elected to include them. There is a rebuttable presumption that a person is an employee and that a relationship of employer and employee exists when the person was rendering services for the alleged employer. The law in this case requires that the applicant be considered an employee unless the nine part test under 102.07(8) for independent contractors was met. These detailed requirements were not met under the facts of this case for the lead of the applicant's crew. Therefore, under the statute, the applicant is also an employee. Additionally, there was an employment relationship between the alleged employer and the applicant under the *Kress* test. This is the primary test for determining whether an employee and employer relationship exists. This test evaluates whether the alleged employer has a right to control the details of the work. In making that determination, four factors are considered: (1) direct evidence of the exercise of right of control, (2) method of payment of compensation, (3) furnishing of equipment or tools for the performance of the work, and (4) the right to fire or terminate the employment relationship. Just because a benefit is conferred upon the employer, does not necessarily mean there is an employee/employer relationship. Here, the applicant's testimony that the alleged employer hired the applicant, paid the applicant in cash, drove the applicant to the work sites in Wisconsin, handled the transportation and housing for the workers, told the workers what to do and checked to see that the work was done well was credited. The alleged employer also made a substantial profit off the workers that he hired. There is substantial evidence the alleged employer directed the crews as to where to go and what to do, and exercised direction and control regarding the details of the work in a sufficient hands on manner to meet the *Kress* test.

*Stelloh v. Waste Management of Wisconsin,* Claim No. 2015-018764 (LIRC April 9, 2019). The applicant started working part time for Waste Management as a handyman. He subsequently lost his concurrent job as a truck driver. His hours working for Waste Management expanded. He was working 60 hours per week for Waste Management by the time the involved injury occurred. He worked for Waste Management at a number of different locations. He billed each job separately. He was injured while working at Waste Management. The applicant alleged he was an employee. Waste Management asserted he was an independent contractor or an employer/sub-contractor. The applicant's submitted bills had shown that he had billed for times his sons worked on a smattering of jobs. The actual testimony demonstrated, however, that his sons were never paid. Therefore, the sons could not be employees and the applicant could not be an employer of the sons. By statute, an individual is presumed to be an employee unless the individuals work meets <u>all</u> of nine statutory requirements so as to constitute an independent contractor. Administrative Law Judge Schneiders held the applicant was an employee. The Labor and Industry Review Commission affirmed. The applicant did not maintain a separate business with his own equipment and facility. He never had specific contracts with Waste Management. The applicant did not incur the main expenses incurred for the performance of the work under a contract because there was no contract and also because all purchases were billed to Waste Management. Further, it was impossible for the applicant to experience a financial loss because he was always paid an hourly rate and reimbursed for disbursements.

## EVIDENCE

*Groesnick v. Professional Detailing Network, Inc. Publicis Touchpoint Solutions*, Claim No. 2013-012166 (LIRC November 20, 2018). The applicant filed a hearing application seeking additional compensation for a conceded injury. The employer and insurer submitted an unsigned WKC-16B in support of the defenses. (The applicant did not raise an objection to this lack of proper certification at the hearing, but did raise it before the Labor and Industry Review Commission.) The applicant failed to submit some or all of her proposed medical evidence to the respondents 15 days prior to the hearing date, in violation of Wis. Stat. § 102.17(1)(d)(3). The applicant offered no cause for her failure to comply with this statutory directive. The unnamed administrative law judge attempted to remedy the applicant's failure to timely submit evidence by allowing a representative of the respondents to temporarily remove the applicant's proposed exhibits and make copies of the documents, before returning the documents to the proceeding. The unnamed administrative law judge thereafter accepted the exhibits into evidence. The applicant also, on her own, attached a medical record to a WKC-16B. The Labor and Industry Review Commission remanded the matter for a new hearing. The applicant properly objected to the lack of certification by the employer and insurer's experts. The failure to raise the objection at the hearing did not forfeit the argument. Even though a reviewing court will normally not consider issues not properly raised before an administrative agency, the court does retain the power to consider such issues. Under *Bunker vs. Labor and Industry Review Commission,* where all the necessary facts are of record and the issue is a legal one of great importance, reviewing courts may choose to decide the issue. However, the administrative law judge's findings were compromised by the unorthodox procedure used to admit the applicant's exhibits. Remand is appropriate because the evidence submitted by both the applicant and the respondents was either inadmissible or indeterminate with regard to the disputed issues. The Commission did warn all the parties that they need to follow the procedures for securing competent medical evidence and timely file such evidence. The applicant was also advised to refrain from attempting to supplement the record in the future at the Commission (should the case proceed to the Commission again). Finally, the administrative law judge was warned to not accept into evidence any medical document that was altered by a party or compromised by entry of personal commentary on the document.

*Rowe v. Milwaukee Transport Service, Inc.,* Claim No. 2015-029225 (LIRC April 26, 2019). The Commission determined that additional information was needed to evaluate the claims and assertions by the parties. The Commission determined that one particular individual could provide relevant information. The Commission remanded the case for additional evidence. The Office of Worker's Compensation Hearings was ordered to schedule a hearing for the purposes of obtaining testimony from the particular individual. The respondent was ordered to provide the identity of the individual (listed as a specific driver number in the documents) with a last known address, and employment status, within 30 days. The Commission ordered the employer to compel the attendance of the individual if the driver was still an employee. If not, the Division of Hearings and Appeals was ordered to issue a subpoena to attend the hearing. The Commission provided eight specific questions it wanted answered. The Commission ordered the line of questioning to be limited to those eight questions. However, the parties were allowed to cross examine the witness, as necessary, on the questions and present evidence to challenge the witness' testimony on those questions if necessary.

## EXCLUSIVE REMEDY

***Payton-Myrick v. Labor and Industry Review Commission*, 384 Wis. 3d 270 (Wis. Ct. App. 2018)(unpublished).** The applicant had a long established history of back, neck and low back problems. In July 2009, while bending over to pick up a piece of paper under her desk, the applicant fell forward out of her office chair. The applicant asserted that the incident precipitated, aggravated and accelerated her degenerative condition. The treating physician, Dr. Kurpad, concluded that as a result of the work-related injury, the applicant needed to undergo a lumbar fusion. Dr. Orth, who performed an independent medical examination, opined that the applicant did not need a fusion. He further opined that any such procedure was unrelated to the work incident. Dr. Burton also provided a causation opinion on behalf of the employer and insurer. Dr. Burton opined the applicant sustained merely a temporary work-related injury and that the surgery was not causally related to that temporary injury. The applicant elected to undergo the fusion (which failed). Another subsequent surgery intended to correct the failure, similarly failed. The administrative law judge held that the involved incident did aggravate, precipitate and accelerate the previous degenerative condition. The administrative law judge held the medical expenses for the surgery were necessary and reasonable. The Labor and Industry Review Commission agreed with Dr. Kurpad in part, and with Dr. Orth in part. The Commission held the applicant did sustain a work-related injury. However, the Commission held that the work-related injury was temporary in nature and did not necessitate surgery or any permanent disability. On appeal to the Circuit Court, the applicant asserted a right to disability benefits under Wis. Stat. §102.42(1m). [Wis. Stat. §102.42(1m) provides that if an employee who has sustained a compensable injury undertakes in good faith invasive treatment that is generally medically acceptable, but that is unnecessary, the employer shall pay disability benefits.] The Commission objected to the applicant raising that argument at the Circuit Court, because the argument had not been advanced in the appeal to the Commission. The Circuit Court refused to find the argument was waived. The case was remanded to the Commission for the Commission to determine whether or not the applicant had undertaken the surgeries in good faith. The Court of Appeals agreed with the Circuit Court that the argument should not be deemed waived. However, the Court of Appeals reversed the Circuit Court based on *Flug v. Labor and Industry Review Commission,* 376 Wis. 2d 571 (Wis. 2017), which it held was the decisive precedent in this case. The *Flug* decision made it clear that, if the treatment received was necessitated by a pre-existing condition not caused or worsened by the work-related injury, the issue of whether or not the treatment was undertaken in good faith was not relevant because such treatment would not be for a compensable work injury. Here, because the Commission concluded that there had not been a permanent aggravation, acceleration, and precipitation of the underlying condition that caused the need for surgery, there was not an underlying work injury which necessitated surgery. Credible and substantial evidence supports the Commission's decision. Therefore, the issue of whether or not the applicant had undertaken the surgery in good faith was not relevant.

## HEARING LOSS

*Maybee v. City of Janesville Fire Dept.*, Claim No. 2001-010925 (LIRC November 20, 2018). The applicant sought payment for hearing aid expenses more than 12 years after the last payment of compensation made by the employer and insurer. Because the applicant's hearing application was filed more than 12 years after the last payment of compensation, the Work Injury Supplemental Benefit Fund (WISBF) was originally impleaded as a party. Prior to the hearing

date, WISBF asserted that WISBF had no potential liability in the matter because Wis. Stat. §102.555(11) provides compensation for permanent partial disability, due to occupational deafness, may be paid only if there is over 20 percent binaural hearing loss. The applicant's hearing loss did not exceed 20 percent binaural. The Division mistakenly accepted the WISBF's pre-hearing assertion that it could, therefore, not be liable for the applicant's hearing aid expense. The Division removed WISBF as a party to the proceeding. WISBF did not participate in the hearing or in the appeal before the Labor and Industry Review Commission. The Commission set aside the Division's order and remanded for further consideration. Wis. Stat. § 102.55(11) precludes liability only for permanent partial disability and not liability for medical treatment expenses. Accordingly, the WISBF may have potential liability for medical expenses and the proceeding should not have gone forward without WISBF as a party.

**ISSUE PRECLUSION**

*Joosten v. Miller Masonry & Concrete, Inc.*, Claim Nos. 2001-019919, 2004-041400 (LIRC November 8, 2018). The applicant sustained several work-related injuries. On November 28, 2007, an unnamed administrative law judge issued an interlocutory order which included an award for 75 percent loss of earning capacity. The applicant's claim for permanent and total disability was dismissed. At the end of his decision, the administrative law judge used the following language to reserve jurisdiction: "The Department reserves jurisdiction for further claims. The above findings are not to be relitigated as far as they go." This decision was not appealed. On December 19, 2014, the applicant submitted a new application for hearing. He asserted that he had become permanently and totally disabled due to alleged deterioration in his cervical condition, attributable to either, or both, of the work injuries. The employer and insurer asserted that the first administrative law judge's decision fully and finally decided the permanent total disability issue and it was now foreclosed by the doctrine of issue preclusion. The applicant petitioned *pro se* and did not address this legal issue. Instead, he simply argued that he was now permanently and totally disabled. On June 6, 2017, a second administrative law judge held that the applicant's claim for permanent total disability was barred by the doctrine of issue preclusion. Jurisdiction was reserved in accordance with the findings of the first administrative law judge's decision. The Labor and Industry Review Commission reversed. Nowhere in his 2007 decision did the first administrative law judge dismiss the claim for permanent total disability "with prejudice." The administrative law judge's language was ambiguous. It was unfortunate that such language was used without further explanation. The Commission inferred that the first administrative law judge did not intend to foreclose the issue of the applicant's future disability, both medical and vocational, given the possibility that his circumstances could change. Two of the five fundamental fairness tests used for determining whether or not issue preclusion should be invoked are applicable. These two tests include: "Is the question one of law that involves two distinct claims or intervening contextual shifts in the law; and, are matters of public policy and individual circumstances involved that would render the application of collateral estoppel to be fundamentally unfair, including inadequate opportunity or incentive to obtain a full and fair adjudication of the initial action?" The issue of permanent total disability is a factual/legal question. It would be fundamentally unfair and a denial of due process not to allow the applicant the opportunity to prove his new claim before the fact finder.

## JURISDICTION

*Gonzalez v. ISPC Castallow Inc. Co.,* Claim No. 2014-012666 (LIRC August 31, 2018). The applicant sustained a compensable medial meniscus injury to the left knee. The applicant also alleged a lateral meniscus injury to the same knee. He amended his claim to assert a claim under Wis. Stat. 102.35(3) for unreasonable refusal to rehire. A hearing was held and the administrative law judge determined the applicant sustained injuries to both menisci and awarded benefits. The claim for unreasonable refusal to rehire benefits was reserved. The order was interlocutory. The Labor and Industry Review Commission reversed and determined the applicant had not sustained compensable lateral injury. The decision was not interlocutory. That decision was not appealed. The applicant filed a new hearing application alleging bad faith, on the basis of a claimed unreasonable delay in payment of compensation due for the medial meniscus injury. Administrative Law Judge Enemuoh-Trammel dismissed the application on the basis of lack of jurisdiction. The Labor and Industry Review Commission affirmed. The issue of bad faith was ripe for adjudication prior to the original hearing held. This was true until the Commission issued its original decision. However, the applicant did not amend the original hearing application to assert a bad faith claim, nor did he bring any such claim until after receipt of the Commissions original decision. The original decision from the administrative law judge was interlocutory for unresolved issues, including unreasonable refusal to rehire. However, no bad faith issue was raised and, thus, no such issue was unresolved. The Commission's original order was considered final with respect to all issue not reserved pursuant to Wis. Stat. 102.18(4)(a). This statute provides: "unless the liability under s. 102.35(3), 102.43(5), 102.49, 102.57, 102.58, 102.59, 102.60 or 102.61 is specifically mentioned, the order, finding or award are deemed not to affect such liability." Apart from those claims listed in 102.18(4)(a), and the issue of medical expenses pursuant to case law, the Commission's original order resolved all other issues stemming from the applicant's claim. This decision was final. There was specifically no jurisdiction reserved over additional issues, including the alleged prior act of bad faith under Wis. Stat. 102.18(1)(bp). The applicant was still within the twelve year statute of limitations applicable for the original injury claim. However, the claim is not available when issues are resolved with a final unappealed decision.

## LOSS OF EARNING CAPACITY

***William Hyde v. LIRC, Daimler Chrysler Motors Company*, 382 Wis. 2d 832 (Wis. Ct. App. 2018)(unpublished).** The applicant sustained an admitted work-related lumbar injury. His treating physician and surgeon opined the applicant could work eight hours per day within specific restrictions. Later, the treating physician opined the applicant could only work four hours per day. A pain management specialist agreed with permanent four hour restrictions (recommended by a therapist following a Functional Capacity Evaluation). Dr. Aschliman performed an independent medical examination and opined the applicant could work eight hours per day. Subsequent to some additional surgeries, the applicant's vocational expert's opined the applicant sustained 70-75% loss of earning capacity. The employer and insurer's vocational expert opined he sustained 45-55% loss of earning capacity. An unnamed administrative law judge adopted Dr. Aschliman's opinions regarding restrictions and workability. The administrative law judge awarded the applicant 55% loss of earning capacity. The Labor and Industry Review Commission affirmed. The Circuit Court and the Court of Appeals affirmed. The determination of the extent of an applicant's disability is a question of fact. The

Commission's findings are reviewed and not those of the administrative law judge. The court shall not substitute its judgement for that of the Commission as to the weight or credibility of the evidence on any finding of fact. Wis. Stat. 102.23(56). Instead, the court seeks to locate in the record, the credible and substantial evidence to support the determination, rather than weighing any opposing evidence. *Vande Zande*. The evidence in support of the finding need not comprise preponderance or the great weight of the evidence, it need only be sufficient to exclude speculation or conjecture. *Bumpas*. Here, the record amply supports the Commission's conclusions. The Commission's findings were based on Dr. Aschliman's professional opinion. There is credible and substantial evidence in the record to support the Commission's decision. The treating physician's opinion changed, and the subsequent opinion was less credible than the earlier opinion because he did not adequately explain his changed opinion. Further, the physical therapy evaluator did not satisfactory connect the results of the Functional Capacity Evaluation to his conclusion that the applicant could work only four hours per day. Finally, the applicant testified that he had not looked for work for the past year, but that he might be able to work eight hour days if he took his medication.

*Liegakos v. Old Carco, LLC*, Claim No. 1999-062505 (LIRC July 31, 2018). The applicant sustained a conceded back injury on November 3, 1999. Administrative Law Judge Mitchell found that the applicant sustained a 55 percent loss of earning capacity in 2002. In November 2014, the applicant filed a hearing application alleging that he had become permanently and totally disabled due to more restrictive functional limitations. He testified that he began experiencing increased back pain around 2011. In 2012 or 2013, his prescription for Norco, five times a day, was changed to Percocet, six times a day. He received eleven sets of epidural steroid injections between December 2011 and April 2014. He began excessively using a heating pad for pain relief, to the point that it was causing scarring on his back. He underwent a trial use of an external spinal cord stimulator and a trial use of an external morphine pain pump. In July 2015, an internal morphine pain pump was surgically implanted. The applicant testified that he had to cease performing chores around the house, such as raking, mowing the grass, or weeding. (The applicant had testified to an inability to perform some of these same activities at the 2002 hearing.) His treating physician, Dr. Stauss, (who had treated the applicant since 1999) refused to revise his permanent work restrictions. Dr. Johnson performed a functional capacity type evaluation, once, in July 2016. Dr. Johnson opined that, as a result of the work injury, the applicant required new permanent restrictions. Based on these restrictions, the applicant's vocational expert opined that the applicant was totally and permanently disabled. Dr. Brown performed an independent medical examination. He opined that the applicant's prior permanent restrictions were appropriate. Video surveillance showed the applicant engaging in activity in his yard and outside on his stoop. The activities included pulling and removing branches from a nearby tree, bending and squatting, and using a hose to water his stoop. Administrative Law Judge McKenzie denied the applicant's claims. The Labor and Industry Review Commission affirmed. Dr. Johnson's opinion was not credible. His opinion conflicted with the opinion of the applicant's treating doctor. Dr. Johnson misstated the cause of the applicant's condition as the result of return-to-work activities when in fact the applicant engaged in practically no return-to-work activities after his November 1999 injury. No imaging indicated a significant change in the applicant's condition.

The video surveillance contradicted the applicant's testimony. The activities depicted in the video were more consistent with Dr. Stauss' restrictions than they were with Dr. Johnson's restrictions. To change a prior finding of loss of earning capacity, there must be a substantial change in the applicant's ability to perform work due to progression of the work-related injury. There was not a substantial change in the applicant's abilities in this case.

**MEDICAL ISSUE (NARCOTICS)**

*Liegakos v. Old Carco, LLC*, Claim No. 1999-062505 (LIRC July 31, 2018). The applicant was prescribed various narcotic pain medications after the work-related injury. In the six to seven years prior to the hearing involved in this case, the medication was increased and treatment changed. This was based upon his treating physician's recommendations. He also underwent an invasive pain pump implementation. Dr. Brown performed an independent medical examination and opined the ongoing pain treatment was not medically necessary or reasonable, including the implantation of the pump. The employer and insurer stopped paying some of the medical expenses. Administrative Law Judge McKenzie ordered the claims paid. The applicant reasonably and in good faith relied upon the medical opinions of his treating physician for the treatment of a conceded injury, and, therefore, the employer and insurer are still responsible for payment of all medical treatment related to the work-related incident. The Labor and Industry Review Commission affirmed on this issue. The administrative law judge relied upon *Spencer*, which held that, as long as the applicant engages in medical treatment undertaken in good faith, even if that treatment is later determined to be unnecessary and unreasonable, the employer and insurer are responsible for payment. The recent decision in *Flug* does clarify that the treatment must be for a compensable injury. Treatment which is for a personal/not work-related compensable injury does not need to be paid for by the employer and insurer. However, based upon the independent medical examiner's opinion, the necessity of ongoing/future narcotic treatment is in reasonable dispute. This case is appropriate for the dispute resolution process under Wisconsin Administrative Code § DWD 80.73 (which provides a process by which the insurer and health care provider can respond 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).

**MEDICAL TREATMENT**

*Forster v. AIF Leasing, LLC*, Claim No. 2010-019559 (LIRC January 31, 2019). The applicant sustained an admitted work-related injury on June 15, 2010. Among the numerous injuries sustained, the applicant underwent a left arm amputation above the elbow joint. He underwent a surgical revision of his left arm amputation on November 10, 2010. The applicant subsequently received a mechanical arm prosthesis. The applicant testified that he attempted to use his prosthetic left arm for approximately one year. He testified that he eventually gave up because he could not twist and turn his body as was required in order to effectively operate the mechanical arm. He stopped wearing the prosthesis altogether sometime in 2013. Toward the end of that year, someone suggested to him the possibility of a robotic (myoelectric) arm and he began to pursue that option. A myoelectric arm (with a cost of approximately $250,000.00) was recommended. He chose to undergo additional surgery on his left arm stump in order to facilitate proper nerve alignment for attachment of the myoelectric arm. He then brought a claim for payment of the robotic arm. He asserted that he would not be able to operate a conventional prosthetic arm primarily due to his chronic back and shoulder pain. He supported this assertion with opinions from his treating physician that the myoelectric arm was medically necessary.

Video surveillance showing the applicant performing various tasks on an extended basis, including repeated and significant bending and twisting of his back and bending and stretching in various positions with no apparent difficulty. Dr. O'Brien performed an independent medical examination. He opined that the applicant required merely a mechanical left upper extremity prosthesis and appropriate fit for that prosthesis. Dr. O'Brien opined that the type of prosthesis most beneficial to the applicant would be a conventional body-powered upper extremity prosthesis. He also opined that the applicant's projected cost and replacement was not realistic. He opined a myoelectric prosthesis would be available for $50,000.00-$75,000.00 and, with appropriate maintenance, would never need to be replaced. The unnamed administrative law judge awarded the applicant's claim for the robotic arm. The Labor and Industry Review Commission reversed. The applicant's testimony that he could not sufficiently bend and twist to use a mechanical arm was not credible in light of the video surveillance evidence. Further, the applicant did not follow through with medical recommendations to have his mechanical arm refitted or readjusted. Instead, he simply gave up wearing it. He subsequently concluded on his own that he would be better off with a myoelectric arm. His supporting medical opinions were based primarily upon his subjective complaints and not the objective evidence demonstrated on surveillance.

*Mathis v. Mayo Clinic*, Claim No. 2014-012027 (LIRC April 9, 2019). The applicant alleged she sustained a right shoulder injury when she helped position a patient. She underwent various types of medical treatment including arthroscopic surgery on May 8, 2014. The applicant required additional injections and physical therapy after surgery. She subsequently underwent two additional surgeries. The applicant continued to report ongoing shoulder pain. Dr. Kulwicki performed an independent medical examination. He opined the applicant sustained merely a temporary work-related injury, which fully resolved. Dr. Kulwicki assigned a 20% permanent partial disability rating, on a regardless of causation basis. The Administrative Law Judge Roberts awarded benefits, including permanent partial disability and prospective trial of a spinal cord stimulator. The Labor and Industry Review Commission affirmed. The injury was permanent and that the permanent partial disability rating assigned by the treating physician was appropriate in light of limited movement and ongoing pain. Further, all treating physicians (including a pain management specialist and orthopedic specialist) opined the spinal cord stimulator treatment would be beneficial in relieving the applicant's shoulder pain. [Editor's note: Our office handled this claim. The decision does not outline the opinions from the medical physicians which were in contrast to that of the two treating physicians. Specifically, the judge and Commission failed to note that multiple additional physicians, who performed consultations at the request of the applicant, as well as Dr. Kulwicki, opined the applicant's symptoms were not likely to improve with a spinal cord stimulator.]

**MENTAL INJURY**

*Mattson v. Aurora Healthcare, Inc.*, Claim No. 2015-011429 (LIRC June 29, 2018). The applicant worked as a registered nurse at a medical facility from December 2010 until October 2014. She asserted that she developed post-traumatic stress disorder (PTSD) due to extraordinary stress she experienced while working there. Prior to this employment, the applicant treated for a number of mental conditions/issues including: depression, adult attention deficit disorder, suicidal ideation, memory-based learning disorder, anxiety, and lack of concentration. She was prescribed medication, pre-injury, to treat a number of those conditions. She also worked in three

medical settings before working for the employer. During her prior medical related employment, she reported difficulties with making decisions and prioritizing. She also stated that management was not supportive, she had conflicts with coworkers, and she felt that she was the recipient of criticism or blame. Based on her mental health, the applicant had restrictions placed on the amount of patient contact she could have and the length and number of shifts she could work. While working for the employer, the applicant encountered the same problems. At the applicant's request, the employer placed her on a work improvement plan in an attempt to address her performance issues. Her performance did not improve. Her mental health declined, at times resulting in paranoia and delusions, requiring leaves from work and various work restrictions. She ultimately resigned her position in lieu of receiving a corrective action. The applicant's psychiatrist opined that the employer's failure to fairly develop a program of support for the applicant was the stressor leading to the development of applicant's PTSD. Dr. Meyer referred to the employer's failure to adhere to restrictions imposed, staff harassment, and lack of supervisory support. Dr. Lynch performed an independent medical examination. He diagnosed the applicant with psychosis in remission, memory-based learning disorder, and a history of anxiety, depression, attention difficulties, and bipolar disorder. Dr. Lynch opined that the psychotic break the applicant experienced did not occur because of her employment with the employer. He noted that her symptoms had predated employment for the employer. Dr. Lynch further disagreed with Dr. Meyer's PTSD diagnosis based on a lack of exposure to actual or threatened death or serious injury. Dr. Lynch opined that, using the DSM-V definition of PTSD, a failure to provide avenues of support was not a stressor that could lead to PTSD. Administrative Law Judge Konkol dismissed the application. The Labor and Industry Review Commission affirmed. Dr. Meyer's opinions contradicted his own prior findings that the employer had been supportive and helpful. Dr. Meyer's opinion was predicated exclusively on what the applicant told him during a time when she was experiencing delusions. Moreover, even if the applicant had established a causal relationship between her work and her condition, she did not establish that she sustained a compensable mental injury. Under the *School District No. 1* standard, a non-traumatically caused mental injury must have resulted from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience. The stresses and strains the applicant experienced must be measured against the stresses and strains that similarly situated employees face. The applicant was not bullied or harassed by management or other coworkers. The employer followed its normal protocol in handling the applicant's work performance issues. Numerous other nurses encountered the same matters of which the applicant complained. None of those matters could be said, singly or collectively, to be out of the ordinary from the countless emotional strains and differences encountered by nurses on a daily basis.

*Anderson, Sarah v. City of Madison*, Claim No. 2015-026938 (LIRC July 18, 2018). The applicant was employed as a police officer. In October 2011, her sister died unexpectedly. Around the same time, she also had marital difficulties. She sought counseling and took time off work through June 2012. In October 2012, her divorce became final and her dog died. The alleged work incident occurred on October 7, 2012. On this date, she had left her duty rifle in her squad car instead of taking it to the armory. The next officer to use the car returned the rifle to the armory. Another police officer took the rifle and disassembled/field stripped the rifle, placed it in a soft case, and put the case on a top shelf in the armory where it was not easily seen. He placed a Post-It note in the applicant's mailbox indicating where the rifle could be found. He then joked about this with another officer. At the beginning of her next shift, the applicant could

not locate her rifle. She did not see a Post-It note. During the course of her shift, she thought about where the rifle could be and what she would do tactically if there was a call and she needed her rifle. By the end of the shift, she thought it was possible that her ex-husband (also a police officer) had taken the rifle and she was concerned for the safety of her children. She called her children and told them to go to a family member's house. Within minutes of calling her children, a sergeant found the rifle. The applicant had been unable to locate the rifle for about eight hours. A similar incident previously occurred with another officer's handgun. At the time the rifle was found, she was in shock and disbelief that a fellow officer had taken her rifle. She emailed the officer and thanked him for securing the rifle but stated that she considered his actions to be harassment. Her lieutenant indicated that the incident would be investigated. The applicant did not receive information about when the investigation was going to be conducted. The officer continued to work. The department sent squads to her house to check on her, which she felt was bullying. She believed the department did not take care of her, she was being bullied and shoved out by her supervisors. She felt betrayed and scared. She indicated the rifle incident "shattered" her view of the relationship between officers. She sought counseling. The officer was charged with untruthfulness, firearm safety violations, immoral or offensive conduct, and harassment by the department for the rifle incident. The applicant then underwent a fitness for duty evaluation. Dr. Spierer determined that she met the criteria for axis I diagnosis of dissociative amnesia, a form of dissociative disorder, and that she manifested characteristics of dissociative fugue. He opined that she was unable to perform the duties of a police officer. The applicant filed two additional supportive expert medical opinions. One physician opined the external stressors made her vulnerable to the development of a psychiatric disorder after the rifle incident. Administrative Law Judge O'Connor dismissed the application. The Labor and Industry Review Commission affirmed. The applicant failed to meet her burden of proof under the *School District Number 1* standard. The court must consider whether a person of ordinary sensibility performing the duties of the job would be subjected to greater stress than those who are similarly situated. Here, the applicant was dealing with a number of external stressors (divorce, anniversary of a sibling's death, etc.) that contributed to her psychological condition. The applicant failed to meet her burden to prove that the rifle incident was so egregious and out of the ordinary from the strains of a similarly situated police officer that a police officer of ordinary sensibility would suffer a nontraumatic mental injury as a result of the rifle incident and the department's response. Instead, most of the applicant's anxiety about the incident appeared to have been a result of her erroneous thoughts about what happened and the way she chose to interpret the events. This was a duty disability case and the court also held the applicant did not suffer a duty disability under Wis. Stat. § 40.65.

**MISCONDUCT**

***Wisconsin Department of Workforce Development v. Wisconsin Labor and Industry Review Commission,* 914 NW2d 625 (Wis. 2018).** The Employer's Benefits Manual specifically provided in its attendance policy that an employee who was in the probationary period could be terminated if he or she, on one occasion, missed work without having called in two hours before their shift. The applicant did not call in when she missed a shift for flu-like symptoms. She was terminated. The Labor and Industry Review Commission held she was entitled to unemployment benefits. Wis. Stat. §108.04(5)(e) provides that a violation of an employer's policy regarding attendance, if the policy is in a written manual signed by the employee, constitutes misconduct. However, another provision within the same statute specifically states that more than two

absences in 120 days constitutes misconduct. The Commission interpreted the two statutory provisions together to mean that, for any absences to qualify as "misconduct," there would have to be at least the statutory minimum of two absences in 120 days. The Commission basically held the two absence requirement was a "floor" despite the handbook provision allowing for termination for violation of only one absence. The Court of Appeals agreed with the Commission. The Supreme Court reversed. The statutory language was clear. The plain language of Wis. Stat. 108.04(5)(e) allows an employer to adopt its own absenteeism policy that differs from the policy set forth in 108.04(5)(e). Termination for the violation of the employer's absenteeism policy will result in disqualification from receiving unemployment compensation benefits even if the employer's policy is more restrictive than the absenteeism policy set forth in the statute. Further, the Supreme Court noted that, under its recent decision in *Tetra Tech EC, Inc. v. Department of Revenue*, 914 N.W.2d 21 (Wis. 2018), the interpretation of the law by an administrative agency was no longer automatically deferred to, and under the due weight analysis, it found no basis to justify the Commission's interpretation of the statute which appeared contrary to the statute's plain language.

*Rank v. DBA Tapped Sports Bar & Grill*, Hearing No. 18401727AP (LIRC November 29, 2018). The applicant sent a text to fellow former co-workers which expressed the view that other fellow employees were "a dead man walking at this point." He indicated that a "blood sacrifice must be paid" by that fellow worker. He also texted that "one or more of these tan, blackmailing f*** will be eliminated." The applicant sent a number of additional, similar, text messages. He was terminated by the employer and sought unemployment benefits. The issue in dispute was whether he was terminated for either misconduct or substantial fault. The Labor and Industry Review Commission held that the actions of the applicant evinced such a willful and substantial disregard of the employer's interest as to constitute misconduct. The Commission follows a three step approach in analyzing discharges. First, the Commission determines if any of the specific actions set forth in Wis. Stat. §108.04(5)(a)-(g) apply (such as harassment, assault, or other violence). If such a specific provision was not violated, the Commission will look as to whether or not the original case law definition of misconduct (under *Boynton Cab Company v. Neubeck*, 237 Wis. 249 (1941)) is applicable. If there is no misconduct, the Commission will then determine whether the discharge was justified on the basis of substantial fault under Wis. Stat. 108.04(5g). Here, none of the specific enumerated provisions apply. The statutory definition of misconduct specifically includes 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. However, the evidence did not establish the applicant was at the workplace when he sent the text messages. Misconduct under the original case law definition means conduct showing an intentional and substantial disregard of the employer's interests or the employee's job duties and obligations, or negligence so gross or repeated as to demonstrate equal culpability. The text messages were overtly threatening. The applicant clearly disliked the co-worker. The applicant asserted he was just intending to convey to the co-worker that he would be discharged. However, the text messages were threatening and connected with employment because the threat was made against a co-worker. These actions evinced such a willful and substantial disregard of the employer's interests as to amount to misconduct connected with his employment.

***Faude v. Wisconsin Employment Relations Commission*, 386 Wis. 2d 350 (Wis. Ct. App. 2019)(*unpublished*).** The applicant, who was a union steward, alleged she had been terminated in whole or in part due to her union-related activity. The county asserted the applicant's termination was the result of workplace misconduct. The examiner in the initial administrative hearing held the employer had terminated the applicant because of her protected union activity and awarded benefits. The Wisconsin Employment Relations Commission set aside the examiner's decision. The Commission held the termination occurred solely because of her misconduct. While the applicant had been an aggressive union steward for years, the evidence showed that the only reasons for which the applicant was terminated arose out of her disruptive and disrespectful conduct at times of shift changes when she was functioning as an employee and not as a union steward. The applicant had been disrespectful not only of supervisory staff, but had openly and disrespectfully questioned a physician's orders for patients. Such activity did constitute misconduct on the part of the applicant and the termination was justified. The Circuit Court and Court of Appeals affirmed the Commission's decision.

*Miller v. FedEx Ground Package System, Inc*., Hearing No 18005890MD (LIRC March 29, 2019). The employer's attendance policy (receipt of which the employee acknowledged with his signature) indicated an employee could be discharged for having three unscheduled absences in a 30 day period. Unscheduled absences included absences due to illness of the employee or his or her dependent when paid time off was not available or used, or was voluntarily not used. The employee was in an automobile accident. He was absent, with notice, to attend physical therapy as a result of injuries sustained in the absence. This occurred on October 2, 2018. The employer considered the absence unscheduled. He missed work again, with notice, on October 12, 2018 and October 15, 2018, because of residual pain from that accident. These were considered one unscheduled absence because of the policy regarding absences on consecutive work days. The applicant was absent with notice on October 17, 2018 because of food poisoning. This was considered unscheduled. The applicant was terminated for accumulating three unscheduled absences in a 30 day period. The hearing officer determined that these three absences from work were considered "misconduct" under Wis. Stat. §108.04(5)(e). The appeal tribunal applied the Commission's rationale in an earlier case, *Stangel v. Spancrete, Inc*., UI Dec. Hearing No. 17402720MW (LIRC July 30, 2018). In *Stangel*, the Commission had ruled that common law notions regarding notice given to the employer of missing work and the need, therefore, and the existence of a "valid reason" for missing work, were not relevant on the issue of whether or not the absences were misconduct. The *Stangel* Commission determined notice and valid reason limitations were as defined under the employer's policy, and that, so long as the termination comported with the terms of the policy, the applicant's violation of the policy would constitute misconduct under Wis. Stat. §108.04(5)(e). The Labor and Industry Review Commission reversed. The Commission determined that its reasoning in *Stangel* was incorrect because the reasoning does not comport with the plain language or the structure of the statute. [Please note that, while this decision was issued in March 2019, this was one of the first decisions made by Commissioners Falstad and Gillick.] The Commission also determined that the reasoning does not comport with the other categories of misconduct (the enumerated categories or the general standard).

All of the standards incorporate intent, recklessness or other willful behavior on the applicant's part. The Commission, therefore, determined that a (5)(e) analysis of the attendance failures, whether pursuant to statutory standard or the employer standard, must use traditional, common law notions of notice and valid reason. Therefore, here, there is no conclusion of misconduct. The applicant's three unscheduled absences were with notice and for valid reasons. Illness and injury are valid reasons for absences, and all three unscheduled absences fall within these categories. Further, the absences were not within the definition of substantial fault.

**OCCUPATIONAL INJURY**

*Eddington v. Adrich Chemical Co Inc.*, Claim No. 2015-027399 (LIRC May 15, 2018). The applicant worked for approximately nine years as a packaging operator for a chemical manufacturing company. He performed his job duties under an exhaust system. He did not use a respirator. On the date of claimed injury, a chemical leaked out of a container the applicant was handling, and onto his glove. The applicant inhaled the fumes, felt dizzy and had tingling in his chest and throat. He treated with a physician's assistant the same day and reported mild discomfort to his upper airway and a minor headache. He was released to work but was advised to avoid exposure to chemicals. Two months prior to this incident, the applicant experienced shortness of breath when climbing stairs at home. He received treatment for shortness of breath with exertion. The medical records confirm a pre-existing pulmonary impairment consistent with development of asthma. The applicant underwent additional medical treatment over the next few weeks. He reported pleuritic chest pain, persistent cough and shortness of breath with activity. The following month, the applicant reported he had increased dyspnea with exertion over the past several years. His physician reported reactions to chemicals he was exposed to at work, including shortness of breath with any and all activity. His physician opined the work injury precipitated, aggravated and accelerated the asthma; and that the asthma was caused by an appreciable period of workplace exposure that was either the sole cause or at least a material contributory causative factor in the asthma onset or progression. Dr. Habel performed an independent medical examination. He opined that the applicant had undiagnosed asthma prior to the work-related injury. He opined the applicant had a temporary aggravation of his asthma that resolved in one day. There was no testimony regarding specific details about the nature and extent of the job duties. Administrative Law Judge Konkol adopted Dr. Habel's opinion and denied the claim for benefits. Based upon the applicant's testimony, it is unclear what factors of the job, including tasks, exposure or movement were a material contributory or causative factor of the condition. The applicant, therefore, did not sustain an occupational lung injury arising out of or incidental to the employment on or about November 12, 2015. The Labor and Industry Review Commission affirmed. The applicant discussed his chronic problems with breathing difficulties associated with exertion, with his treating physician prior to the alleged injury. His symptoms at the time of the hearing included shortness of breath. The treating physician's opinion regarding causation rested on the applicant's report that he had a reaction to chemicals that he was exposed to at work and had symptoms for a year. The record does not support the treating physician was aware of the chemicals the applicant was exposed to, or the extent of such exposure. There is nothing in the record demonstrating what the treating physician relied upon or based his ultimate causative opinion on. The applicant's testimony lacks sufficient details to support the opinion of the treating physician.

The treating physician provided no opinion regarding a traumatic work incident. He instead opined an occupational injury occurred. The opinions are confusing, inconsistent (internally and with the applicant's claims), and thus, not credible. The fact that the applicant worked around and handled chemicals does not inexorably lead to the conclusion that his asthma was caused by work exposure.

*Suprise v. Pierce Mfg., Inc.*, Claim No. 2016-030358 (LIRC July 31, 2018). The applicant started working for the employer in 2006. His job duties included assembling fire panels and welding fire truck bodies. According to the applicant, the work environment was dirty, dusty, and smoky. He had a history of sinus issues dating back to at least 1993. In 2012, an ENT specialist, Dr. Vandenberg, found a mass in the applicant's right nostril. This was determined to be an extranodal NK/T-cell lymphoma of the nasal type. The applicant was successfully treated with chemotherapy and radiation. He continued to have sinus problems. He eventually resigned on June 2, 2017. Dr. Vandenberg opined that the applicant's ongoing exposure to welding fumes directly caused his disability. Dr. Vandenberg opined that the applicant sustained a 50 percent permanent partial disability to his body as a whole. Dr. Blake performed an independent medical examination. He opined that the applicant's lymphoma was unrelated to his workplace exposure. Dr. Blake noted that the applicant had preexisting documented history of recurrent sinusitis which preceded his employment with the respondent. Dr. Blake opined that, after a careful review of the medical literature, he could not find a single case that associated extranodal NK/T-cell lymphoma of the nasal type with welding activity, or a case that implicated welding as a cause of the applicant's type of lymphoma. Dr. Blake further stated that any exposure to hexavalent chromium in the course of his welding activity would have been below the permissible exposure limit. Administrative Law Judge Falkner dismissed the hearing application. The Labor and Industry Review Commission affirmed. Dr. Vandenberg did not provide a credible mechanism of causation. Dr. Vandenberg also contradicted himself without explanation when he signed various forms entitled "Attending Physician's Return to Work Recommendations" where he selected "Not Work Related" for the applicant's chronic sinus issues and headaches. Dr. Blake conducted a review of the medical literature and could not find a single case that associated the applicant's condition with his type of work. Dr. Blake's opinion was well-reasoned and based on a review of the applicant's medical records, a physical examination of the applicant, and the current medical literature about the specific nasal lymphoma suffered by the applicant.

*Bretl v. Marinette Marine Corp.*, Claim No. 2016-004518 (LIRC November 20, 2018). On August 16, 2006, the applicant was welding inside a ship's fuel tank when an equipment fire started in a tank chamber adjacent to him. His respirator mask dislodged and the applicant inhaled some black smoke. When filling out the injury report, however, the applicant only indicated that he sustained a wrist sprain. The applicant testified that, after the incident, he began to experience a throat symptom that persisted for the rest of his career. The applicant continued to work. He first received medical treatment after a 2008 pulmonary function test when he experienced choking difficulty. A chest x-ray then demonstrated minimal left basilar atelectasis. A pulmonary function test showed reduced lung capacity. The applicant returned to work. Two years later, Dr. Khayat diagnosed symptoms suggestive of reactive airway disease, possibly related to the work-related incident. The applicant continued to work until he was terminated in 2015. His respiratory difficulties increased after his termination. On January 13, 2016, Dr. Khayat completed a questionnaire drafted by the applicant's attorney. He diagnosed the

applicant with moderate restrictive lung disease, reactive airway disease, dyspnea, and cough. He opined that the applicant's condition was occupationally caused and that it was possible that there was also a direct causation component. At the applicant's attorney's request, Dr. Brown also examined and evaluated the applicant. Dr. Brown diagnosed the applicant with "(1) Dysphonia, dyspnea, cough, and limited endurance secondary to moderate reactive airway disease and moderate restrictive disease (intrinsic lung disease); (2) Obesity." Dr. Brown attributed the condition to direct work causation rather than occupational disease. Dr. Habel performed an independent medical examination. Dr. Habel diagnosed the applicant with chronic cough due to a lengthy history of poorly treated gastroesophageal reflux disease (GERD), in addition to reduced total lung capacity and dyspnea consistent with restrictive physiology due to the applicant's elevated body mass. The applicant testified not being aware that he was previously diagnosed with GERD. He did acknowledge that he took Protonix (which the records indicated was for the GERD diagnosis). However, Dr. Habel indicated the applicant acknowledged to him that he had experienced problems in the past with GERD and treated for the same. Medical records indicated noncompliance with medication for his GERD. Air emissions of contaminants at the workplace were within OSHA guidelines. The applicant regularly wore a respirator for the vast majority of his time employed there. The applicant heated his house with a wood-fired boiler and that he supplied the wood for the fire prior to 2012. Maintenance included almost weekly cleaning of creosote build-up in a pipe extending from the boiler to the chimney flute. The unnamed administrative law judge granted the applicant's application for benefits. The Labor and Industry Review Commission reversed. The applicant had a chronic cough and restrictive lung physiology due to poorly-treated GERD along with an elevated body mass. This was not a work-related lung condition. Dr. Khayat did not provide a credible medical explanation for his relation of multiple diagnoses to the applicant's work exposure with the employer. Neither Dr. Khayat nor Dr. Brown adequately addressed Dr. Habel's causation opinion relating the applicant's symptoms to GERD and obesity. The applicant was not a credible witness. He testified that, immediately after the work incident, he experienced throat symptoms that continued for the rest of his work career. However, he did not mention any throat, lung, or breathing symptoms when completing the injury report. He did not receive any treatment that could possibly be related to the effects of the work incident until he experienced choking difficulty two years post injury. The choking difficulty was at least as likely to be related to GERD as to a residual effect from the work incident.

*Fredricks v. Spa At Riverfront Ltd.,* Claim No. 2016-029977 (LIRC January 31, 2019). The applicant alleged that she sustained an occupational injury. Her attorney asserted they were not claiming a traumatic injury. The WKC-16B completed by the treating physician contained a typed indication as to the description of the injury, outlining the claim as repetitive in nature. One treating physician hand wrote a notation (on the WKC-16B, next to the pre-typed information) about a conceded traumatic incident that occurred the day prior to the date of claimed occupational injury. The physician did not address the applicant's job duties and outline any information about the same until subsequent to an independent medical examination and an opinion that the applicant did not sustain a traumatic injury. Those job duties were not detailed, and the record merely indicated the applicant was required to perform repetitive activities and frequently reach, push, and pull. The employer and insurer provided surveillance video of that incident. Dr. Bartlett performed an independent medical examination. He opined that the applicant did not sustain a work-related injury as a result of that incident. He further opined that the applicant's job duties for the employer were not of sufficient magnitude and duration to

result in a compensable occupational injury. An unnamed administrative law judge awarded benefits. The Labor and Industry Review Commission reversed. The applicant's claim for benefits was dismissed. The Commission must deny compensation if it has legitimate doubt regarding the facts necessary to establish a claim for compensation. Not every doubt is automatically legitimate. Legitimate doubt must arise from contradictions and inconsistencies in the evidence. Dr. Bartlett's opinions regarding the potential alleged traumatic injury and the claimed occupational injury were credited. His description of the work activities was minimal. However, it was still significantly greater than the description documented by the treating physician. Further, even if Dr. Bartlett underestimated the vigorousness of one aspect of the job (as per the applicant's claim and her co-worker's testimony), the job duties still did not involve the frequent or vigorous overhead work, which were the activities Dr. Bartlett opined was harmful to shoulders. The treating physician's opinions were not credited on the basis of an occupational injury. The medical records did not include any discussion of the applicant's work activities. Additionally, they provided no analysis or rationale regarding how the work activities would have caused a claimed occupational injury. Further, the treating physician's opinions were contradictory regarding the type of injury the doctor believed the applicant sustained (in that he discussed the traumatic incident but the applicant did not allege the same at the hearing).

*Posey v. Reindl Bindery, Co, Inc.*, Claim No. 2017-017096 (LIRC March 11, 2019). The applicant alleged she sustained an occupational back injury occurring on June 21, 2016. She testified that, on June 21, 2017, she was performing a repetitive task. This task included grabbing product and lifting approximately five pounds each time. She testified that, while performing this activity, she began experiencing extreme pain in the right hip and buttocks and right leg pain. The treating surgeon, Dr. White, opined that the applicant sustained a work-related injury based upon the applicant's description of her job demands. He opined this resulted in the acute low back pain with radiation to right lower extremities, resulting in the need for surgery. He further opined that the applicant's periodic work exposure was also a causative factor or at least a material contributory causative factor in a preexisting degenerative disease's onset of progression. A co-worker testified the physical demands that the applicant self-reported to Dr. White were accurate. Dr. Lyons performed an independent medical examination. Dr. Lyons opined that the applicant's condition was consistent with a specific work-related injury occurring on June 21, 2016 if she performed heavy lifting. He opined no specific injury would have occurred without heavy lifting. Dr. Lyons did not provide a specific opinion regarding an occupational injury. He was asked to provide an opinion regarding whether an injury was sustained and whether it was traumatic or occupational. The applicant denied in a June 21, 2016 medical record that she performed any significant heavy lifting or movement. However, the testimony demonstrated she performed medium and heavy lifting. Administrative Law Judge Mitchell held that the applicant sustain an injury that was occupational in nature. The Labor and Industry Review Commission affirmed. Dr. Lyons failed to address the causative theory of an occupational injury. Therefore, there was no countervailing medical opinion to Dr. White's occupational causation opinion. Dr. White's opinion was supported by reasonable evidence. [Editors' note: To fully defend a claim at a hearing, make sure to obtain an opinion regarding each theory of causation alleged by the applicant or supported by the treating physicians. Requesting a supplemental or clarification report from the doctor is sometimes necessary if the doctor does not otherwise provide an opinion on each relevant type of injury.]

*Sullivan v. Colony Brands, Inc.,* Claim No. 2017-017998 (LIRC April 9, 2019). The applicant alleged she sustained an occupational injury to her right hand and wrist occurring on September 7, 2015. She had no wage loss. Her initial onset of pain occurred while on a personal camping trip from September 5, 2015 to September 7, 2015. She treated with APNP Kieler on September 9, 2015. She reported bilateral hand/wrist pain began a few months prior to this visit, and had worsened in her right hand/wrist in the two to three days prior to the visit. Dr. Kummer performed an independent medical examination. Dr. Kummer opined that the applicant was experiencing right hand/wrist pain entirely as a result of preexisting arthritis. Dr. Kummer did not find any causal connection between the applicant's wrist condition and her work activities. APNP Kieler and Dr. Sathoff completed WKC-16-Bs. Dr. Sathoff diagnosed the applicant with right wrist pain and radial styloid tenosynovitis. He opined that the work duties directly caused the injuries. Dr. Sathoff's records did not reflect that he knew the applicant reported her symptoms began when she was on a personal camping trip. The unnamed administrative law judge adopted Dr. Sathoff's opinion and held that an occupational injury occurred. The Labor and Industry Review Commission affirmed. The Commission determined that Dr. Sathoff knew the applicant had been experiencing right wrist symptoms for several months prior to the date of injury and that those symptoms worsened with the applicant's work exposure. Whether Dr. Sathoff knew or did not know that the applicant's acute onset of symptoms occurred while she was on a personal camping trip does not impact his credibly. Because the applicant did not miss any work or wages as a result of her work injury, she did not have a statutorily-defined date of occupational injury pursuant to Wis. Stat. § 102.01(2)(g). However, where medical expenses have been legitimately incurred as a result of the occupational injury, but before a statutorily-defined date of injury, those medical expenses are still compensable and payable, pursuant to *United Wisconsin Ins. Co.* and Wis. Stat. § 102.42(1).

**PENALTY**

*Rouse III v. Milwaukee Transport Services Inc.,* Claim No. 2013-013536 (LIRC August 31, 2018). The parties settled the applicant's worker's compensation claim. An Order approving the compromise agreement was issued February 8, 2017. The employer issued checks to the applicant and his attorney on February 16, 2017. The funds were transferred to cover those checks on February 24, 2017. The third party administrator mailed the checks on February 28, 2017. There was a one day delay in receipt of payment. The applicant subsequently asserted a claim for inexcusable delay of payment following a Department order for payment. The payments were ordered to be made within 21 days from the date of the order and were received by the applicant on the 22nd day after the order. Administrative Law Judge McKenzie dismissed the claim. Payment was issued via mailing within the 21 day time frame accounted for in the Order. The statutory provisions were satisfied by the employer and its administrator issuing payment one day before the 21st day mandated. Therefore, there was no inexcusable delay under Wis. Stat. 102.22(1). The Labor and Industry Review Commission affirmed with modification. The Commission does not condone any delay in receipt of a payment due pursuant to an order from which no appeal is made. All orders are issued on the basis that payment will be ***received*** by the due date. While the one day delay in receipt of payment is not condoned, it is inferred from the facts that there was no intent to delay, nor any actual negligence by the employer in providing for timely payment.

The negligence of the third-party administrator is imputed to the employer because the administrator was its agent. However, because the delay was only one day, the minimal negligence was on the part of the employer's agent rather than the employer itself, and the inappropriateness of such a large monetary penalty for such a short delay, discretion under Wis. Stat. 102.22(1) was be exercised to forego assessment of the ten percent penalty for inexcusable delay.

*Pages v. Dedicated Fleet Services LLC,* Claim No. 2018-004779 (LIRC February 21, 2019). The Department sent a letter to the employer on March 27, 2018. This letter indicated that it appeared payment had been delayed to the applicant because of the employer's failure to promptly report the work-related injury to the insurer. The employer was asked to respond in 30 days with an explanation for the delay. The employer was advised that failure to respond could result in a default order assessing a penalty for the alleged delay. The Department did not receive a response. A default order was issued on December 11, 2018 (just under nine months later). An unnamed administrative law judge issued a default order assessing a penalty against the employer in the amount of $693.34 for inexcusable delay pursuant to Wis. Stat. 102.22(1). The employer appealed the default Order. The employer asserted that the applicant did not provide notice of the alleged injury until February 13, 2018. The employer asserted paperwork was completed two days later and faxed to the insurer the following day. The Labor and Industry Review Commission set aside and remanded the claim to the Department for a hearing to address whether or not the employer inexcusably delayed providing notice to the insurer of the applicant's claim that a work-related injury was sustained and whether a penalty should be assessed. The employer should have timely responded to the Department's March 2018 correspondence. Yet, the Department did not provide any evidence that a reasonable investigation was conducted to determine the reason the first payment of compensation was made on the date paid. The letter did not even indicate what date the Department concluded the payment was or should have been made. However, no hearing was held on the issue. There are no competent facts relevant to notice to the employer, to the insurer or the department's actions, apart from the default order, in evidence. The Commission prefers to avoid default orders whenever reasonably possible. Because of the lack of evidence establishing a reasonable basis for issuing the default order, as well as the employer's assertions in the Petition for Review, the Commission will set aside the default Order and remand the case for further proceedings.

### PERMANENT PARTIAL DISABILITY

*Lehman v. Fincantieri Marine Group, LLC*, Claim No. 2015-025125 (LIRC May 31, 2018). The applicant sustained bilateral upper extremity injuries as a result of use of vibrating tools. His treating surgeon referred him to Dr. Sherrill for evaluation of permanent partial disability. Dr. Sherrill opined the applicant had 35% permanent partial disability at the right wrist for median nerve dysfunction. Dr. Sherrill rated the applicant with an additional 10% permanent partial disability to the right wrist for painful range of motion and scar. He assigned the applicant with 5% of the left upper extremity for carpal tunnel syndrome status post satisfactory surgical repair. He assigned another 5% at the left upper extremity for painful surgical scar with persistent swelling and limited function. The applicant reported numbness in his thumb and the first two fingers of his right hand. He reported that he had difficulty maintaining a grip on some things and had some incidents with burning himself and having a crush injury to his thumb because of the numbness. The applicant continued to work in his date of injury position. Dr. Bax

performed an independent medical examination. He noted the applicant's left hand symptoms had resolved and were fine. Dr. Bax noted the applicant still had numbness in his right thumb and two fingers. He also noted the applicant dropped things and had nocturnal paresthesia. Dr. Bax opined the applicant had 0% permanent partial disability of the left hand. He noted the applicant had normal sensation, full range of motion and full strength. Dr. Bax opined the applicant sustained 5% permanent partial disability to the right wrist because of residual symptoms. Administrative Law Judge Falkner held the applicant sustained 45% permanent partial disability to the right upper extremity. The sensory and physical deficits made it more difficult for the applicant to work. He held the applicant sustained 5% permanent partial disability to the left hand. There was some loss of ability that was probably affecting the applicant's work. There was no award appropriate solely for the surgery because there are no regularly minimums for carpal tunnel surgery and because this procedure with good to excellent results usually results in no disability. The Labor and Industry Review Commission modified the decision. The applicant sustained 0% permanent partial disability to the left wrist. The applicant had an excellent result and does not require pain medication for his wrist despite reports of a persistent painful scar. Dr. Bax's opinion is more credible for an excellent result from carpal tunnel surgery when there is normal sensation, full range of motion and full strength. The applicant sustained 20% permanent partial disability to the right wrist. Dr. Sherrill assigned 10% for residual scar and range of motion. However, the applicant does not need to take pain medication. Therefore, a 2% rating is more appropriate for residual pain and loss of range of motion. Dr. Sherrill rated another 35% for loss of sensory perception. This was based upon his opinion that the applicant had one half of the impairment provided for in DWD 80.32(10) for total medial sensory loss. However, the dorsal side of the applicant's right hand had less sensory loss and light touch testing was essentially intact. Therefore, the applicant did not sustain half of a complete sensory loss. Instead, the applicant sustained 18% permanent partial disability for the sensory loss (approximately 25% of the middle ground of the rating for total sensory loss). For scheduled injuries, the schedule in Wis. Stat. 102.52 is presumed to include its own award for loss of earning capacity. The loss of earning capacity evaluation is inherent in the schedule. The applicant is permitted to recover physical permanent partial disability despite the fact that the applicant returned to his prior job and essentially has no wage loss. The reasonable relationship between a permanent partial disability benefit award and impairment of earning capacity is already built into the schedule for scheduled injuries.

*Schwab v. County of Jefferson*, Claim No. 2015-001493 (LIRC August 31, 2018). The applicant sustained a specific work-related left knee injury. She underwent multiple surgeries for ongoing knee symptoms. She was provided a two percent rating following one procedure and an eight percent rating following another. She then underwent a unicompartmental medial knee replacement. The applicant was assigned 45 percent permanent partial disability to the knee. Dr. Lemon performed a records review and opined the surgeries were unrelated to the work-related injury. The parties entered into a full and final compromise which was approved. The parties noted the applicant was claiming 45 percent permanent partial disability to the knee. The applicant returned to work for the employer. Approximately five years later, in 2015, the applicant sustained another specific work-related left knee injury. She underwent another several surgeries, including a total left knee replacement. The applicant was assigned 60 percent permanent partial disability to the knee. Dr. Summerville performed an independent medical examination. He opined the applicant sustained only a left knee contusion as a result of the 2015 incident. The decision did not outline the nature of the administrative law judge's decision. The

Labor and Industry Review Commission indicated it affirmed that decision in part and reversed in part. The treating physician's opinion regarding causation and the 60 percent permanent partial disability rating to the left knee, as a result of the 2015 work-related injury, is credible. However, the applicant sustained 45 percent partial disability to the left knee as a result of the 2008 unicompartmental medial knee replacement. That 45 percent rating must be deducted from the current rating. Therefore, only 15 percent additional compensation is due for the 2015 work-related injury. When there is an identifiable disability attributed to a prior injury, that disability is deducted from the disability assessed for a subsequent injury to the same body part. Only when there are multiple surgeries, each attributable to and taking place after the ***same*** work-related injury, are the disabilities stacked (added together for a cumulative award). Here, the applicant had previously undergone a unicompartmental medial left knee replacement in 2008, for which the minimum permanent partial disability assessment is 45 percent. The contemplation of a total knee replacement as an alternative at the time of the 2010 compromise does not result in the applicant giving up the right to claim that a new, subsequent injury, accelerated the need for a total knee replacement.

Further, the prior eight percent and two percent ratings for other prior surgeries were provided prior to the 45 percent rating, and were logically subsumed in the 45 percent assessment. Overpayment of temporary total disability must be subtracted from the permanency award.

*Overman v. Marinette Marine Corp.*, Claim No. 2016-008107 (LIRC January 31, 2019). The applicant had a history of back problems dating back to a motorcycle accident in the early 1980s. He also had sustained a prior work-related injury for a different employer. He underwent a microdiscectomy at L4-5 in 2000 as a result of that injury. In November 2014, the applicant slipped on ice and had a twinge in his back while working for the date of injury employer. The applicant alleged that he sustained a specific work-related injury on March 21, 2016. On June 3, 2016, the applicant underwent a right-sided L3-4 hemilaminectomy, foraminotomy, and discectomy, and aright-sided L4-5 hemilaminectomy, foraminotomy, and microscope micro technique discectomy. Dr. Lyons performed an independent medical examination. He opined the applicant's condition was preexisting degenerative lumbar disc disease and spondylosis. He opined that no injury or breakage occurred. Dr. Lyons opined the applicant had an appearance of symptoms consistent with his severe degenerative lumbar disc disease and the work incident did not cause or aggravate the applicant's preexisting condition. The applicant's surgeon opined the applicant sustained 8% permanent partial disability. His pain physician opined he sustained 3% permanent partial disability. The unnamed administrative law judge held that an injury was sustained. He awarded 10% permanent partial disability based upon the two surgical procedures performed. The Labor and Industry Review Commission affirmed on causation and reversed and remanded on the permanent partial disability determination. Wis. Admin. Code § DWD 80.32 minimums assume a body part was previously without disability. Wis. Admin. Code § DWD 80.32(11) provides that an appropriate reduction must be made for any preexisting disability. Historically, the Commission has calculated permanent partial disability due, when there was a preexisting disability, by subtracting the percentage of the pre-injury assessed disability from the assessed percentage of disability attributable to the work injury, before computing the weeks of benefits due. Where (as here) no prior medical assessment had specifically been made (as with the 2000 microdiscectomy), the Commission has assessed a disability percentage for a preexisting surgery based on the code minimum. The administrative law judge attempted to do so in this case. He held that the applicant had a preexisting 5% disability in his spine. This was

based on a combination of the applicant's testimony, a description of the 2000 surgery, and the minimum disability ratings. However, the statute now requires that this type of apportionment be made with reference to specific medical evidence in the WKC-16-Bs. Specifically, Wis. Stat. § 102.175(3)(b) requires that WKC-16-Bs assessing disability include an opinion as to the percentage of permanent disability caused by the accidental injury and the percentage of permanent disability caused by other factors. Although the applicant's doctors checked a box indicating that the applicant had no prior disability, this was too vague to decide the apportionment issue in light of the applicant's prior back surgery and the current /new statutory requirement. The Commission remanded the issue for the taking of additional evidence, additional briefing, and for the administrative law judge to make a new decision on the issue of the assessment of permanent partial disability attributable to the work injury.

*Henderson v. Lowell C. Hagen Trucking*, Claim No. 2010-014360 (LIRC March 11, 2019). The applicant sustained an admitted work injury on May 28, 2010 when he fell off the top of a trailer and landed on concrete on his right side. The injuries included a conceded right knee injury and conceded right elbow injury. The administrative law judge held the applicant sustained a right ankle injury. The Labor and Industry Review Commission affirmed. The Commission also held the applicant sustained a cervical injury. [Editor's note: The Commission's decision is very detailed and instructive in how multiple permanency ratings are combined in cases involving numerous permanently injured body parts.] Permanent partial disability was assessed as follows: 5% to the right knee, 5% to the right elbow, 4% to the right ankle and 5% to the cervical spine. The right elbow injury results in 22.5 weeks of disability (450 weeks times 5%). The right ankle injury results in 10 weeks of disability (250 weeks times 4%). Pursuant to Wis. Admin. Code §DWD 80.50(1), the more distal disability (the right ankle) must be deducted from the scheduled weeks for the more proximal disability (the right knee) before applying the 5% disability to the right knee. Therefore, the 425 weeks for the right knee is reduced by 10 weeks. The resulting 415 weeks is then multiplied by 5% to result in 20.75 weeks owed for the right knee. Further, under Wis. Stat. §DWD 80.50(2) the number of weeks attributable to scheduled disabilities are deducted from 1,000 weeks before calculating the number of weeks due for nonscheduled injuries resulting from the same injury (not including multiple injury factors). The 1,000 weeks for the cervical spine is reduced by 22.5 weeks for the right elbow, 10 weeks for the right ankle, 20.75 weeks for the right knee. The remaining 946.75 weeks is multiplied by 5% to result in 47.34 weeks owed for the cervical spine. Further, the multiple injury factor under Wis. Stat. 102.53(4) requires a 20% increase of the permanency payable for each additional or lesser disability. Therefore, an additional 2 weeks is owed for the right ankle, 4.15 weeks for the right knee and 4.5 weeks for the right elbow. The total owed is 111.24 weeks of permanent partial disability.

**PERMANENT TOTAL DISABILITY**

*Barnes v. Bremner Food Grp, Inc.*, Claim No. 2015-010274 (LIRC June 19, 2018). The applicant sustained an admitted head injury. Testimony regarding the mechanism of injury was inconsistent. The applicant treated for headaches, including migraines, for several years prior to this injury. Her symptoms continued post injury. A CT scan and MRI were performed. The MRI showed findings consistent with chronic migraine headaches. Neither revealed signs of traumatic brain injury. The applicant treated with Dr. Lancaster at the Mild Traumatic Brain Injury Clinic. He noted that significant residual physical and cognitive sequelae would not be expected at that

time. He opined significant emotional factors were contributing to her current presentation. Three treating doctors supported her claim for full disability. Dr. Novom performed an independent medical examination. He noted few findings consistent with severe disability during his first examination. Dr. Novom opined the applicant was being overtreated. Dr. Novom opined that the applicant showed signs of symptom exaggeration. He opined that the applicant was capable of histrionic behavior. The applicant appeared at the hearing using a walker. She appeared very debilitated, hunched over and deliberate of movement. She reported ongoing pain and dizziness, even with sitting. She reported that she could not pick anything up because it hurt her head. She could bend and squat some. The applicant testified that, if she did as much as ten minutes of sweeping, she was in bed for the two days. She testified that any motion at all made her light-headed and dizzy. The respondents presented video surveillance from a little over five weeks prior to the hearing. The surveillance showed the applicant driving a motor vehicle as if movement did not make her dizzy. The applicant moved about and exhibited no signs of alleged dizziness or similar dysfunction. The applicant lifted in a manner that did not indicate she had concerns of a headache. The applicant did not use a walker. She had no signs of possible gait instability or uncertainty. She bent and straightened up with fluidity and ease. She engaged in much more than ten minutes of activity without apparent difficulty. Administrative Law Judge Falkner dismissed the applicant's claim for permanent total disability. The Labor and Industry Review Commission affirmed. The applicant asserted that it was uncontradicted that her post-concussion syndrome medically led to post-traumatic stress disorder, with an associated set of extreme physical and psychological limitations that rendered her permanently and totally disabled. However, the surveillance and Dr. Novom's opinions contradicted these assertions. Further, the supportive medical opinions were based upon the applicant's version of events, which were not credible. Therefore, the foundation of the applicant's supportive medical opinions was flawed and there is legitimate doubt that the applicant is entitled to any additional disability indemnity.

*Crass v. Tradesman International Inc.,* Claim No. 2014-003413 (LIRC October 25, 2018). The applicant was employed as a maintenance electrician. He was on a lift approximately 25 feet in the air when the lift was hit and tipped over. He sustained significant pelvic, spinal and rib fractures as a result of the incident, in addition to shoulder and wrist injuries. The applicant reported ongoing low back and left lower extremity pain after he reached the end of healing. He testified that he could, however, perform some chores on his 80 acre farm. Dr. Friedel performed an independent medical examination at the request of the employer and insurer. Dr. Friedel opined the applicant required light-duty restrictions, six hours per day, and additional functional restrictions, due to the unscheduled injuries. The treating physician opined the applicant could only work up to four hours per day. The employer provided the applicant transitional thrift store employment for a period of time; however, this ended when the applicant's condition did not improve. The applicant did not look for work after the injury occurred. He did not accept offered rehabilitation services by DVR. He testified that he did not intend to seek employment, and he was delaying applying for social security benefits until age 70 so that he would receive a higher monthly amount. When considering the treating physician's restrictions, both vocational experts opined the applicant was odd lot permanently and totally disabled. The employer and insurer conceded the applicant sustained 65% loss of earning capacity based upon their vocational expert's opinion when considering Dr. Friedel's assigned restrictions. The unnamed administrative law judge held the applicant was permanently and totally disabled. The treating physician's opinions regarding restrictions were adopted. The Labor and Industry Review

Commission reversed. Dr. Friedel's opinion regarding restrictions was clearly explained and more well founded than the treating physician's opinions. The employer and insurer's independent vocational expert's opinion that the applicant sustained only 65% loss of earning capacity was credible and consistent with Dr. Friedel's medical opinions. The applicant has transferable skills and could secure employment. His failure to seek work, ignoring a contact from DVR and testimony regarding a lack of intention to seek work, reflects he withdrew from the labor market. This undercuts a permanent and total disability benefit claim.

*Crossen v. Harley-Davidson Motor Co. Group LLC,* Claim No 2013-031064 (LIRC October 25, 2018). The applicant alleged she sustained a work-related back injury as a result of a specific incident. She removed a three to four pound item from a turntable and started to transfer the item to a different table. The item hit a bar but the impact did not knock the item out of her hands. She subsequently placed the item on the table, took a step, and felt pain in her groin and back. The applicant saw a nurse and was provided ice. The applicant did complete her shift. She continued to self-treat with ice. She then treated with a chiropractor and pain management physician. The applicant was released to full duty work. An MRI revealed the applicant had significant scoliosis. The applicant reported occasional flare ups over the next two and a half years until she retired. At the time of the hearing, she had ongoing pain inside her left leg, back and groin. Her physicians agreed her ongoing symptoms were likely caused by an osteophyte formation at L2-3. This did not appear until two years after the alleged injury occurred. Two independent medical experts (Dr. Cederberg and Dr. Wojciehoski) opined the applicant sustained merely a manifestation of a pre-existing condition. Administrative Law Judge Minix held the applicant sustained a temporary work-related injury and was not permanently and totally disabled. The Labor and Industry Review Commission affirmed. The incident was minor. Dr. Cederberg's opinion that the minor nature of the mechanism of injury could not have caused a significant injury and the ongoing symptoms are a manifestation of the pre-existing condition was credible. The applicant's release without restrictions shortly after the incident occurred was a significant factor. Further, the doctors agreed that the primary source of the applicant's ongoing symptoms (the osteophyte formation at L2-3) did not become symptomatic until approximately two years after the work-related incident.

*Joosten v. Miller Masonry & Concrete, Inc.*, Claim Nos. 2001-019919, 2004-041400 (LIRC November 8, 2018). The applicant sustained several work-related cervical injuries. On November 28, 2007, an administrative law judge issued an interlocutory order which included an award for 75 percent loss of earning capacity. The judge dismissed the applicant's claim for permanent and total disability benefits. The applicant, after an unspecified date in the year 2008, did not continue to look for work. Since 2008, the applicant had not had any genuine attachment to the labor market. Dr. Graunke began treating the applicant in May 2010 and continued to see him on an almost monthly basis. On August 31, 2015, Dr. Graunke opined that "[the applicant] has seen a gradual decline in his condition since I have been following him and it seems quite unlikely that he will have any improvement in the future unless some new treatment is developed . . . Based on his condition and prognosis, I do not think that [the applicant] would qualify for any type of gainful employment either now or in the future." The applicant's vocational expert opined that, based on Dr. Graunke's opinion, the applicant would not qualify for any type of employment now or in the future. He specifically opined that the applicant was permanently and totally disabled. On December 19, 2014, the applicant filed another application for hearing. He asserted that he was permanently and totally disabled due to alleged deterioration in his cervical

condition, attributable to either, or both, of the work injuries. On June 6, 2017, a second administrative law judge held a hearing. He issued an order finding that the applicant's claim for permanent total disability was barred by the doctrine of issue preclusion. [See Issue Preclusion category, above, for additional information regarding this issue.] The Labor and Industry Review Commission held issue preclusion did not apply but that the applicant was not permanently and totally disabled. The applicant did not look for work after 2008, and had no genuine attachment to the labor market after that period of time. The medical and vocational evidence submitted by the applicant did not credibly support the claim that his circumstances changed after the decision of November 28, 2007. Dr. Graunke's statement constituted a vocational opinion unaccompanied by any discussion of physical restrictions. Dr. Graunke's clinic records revealed assessments of the applicant's overall condition that were inconsistent with his statement that the applicant would not qualify for any type of gainful employment. Dr. Graunke provided no credible medical explanation for this vocational opinion. The applicant's vocational consultant, meanwhile, based his opinion on Dr. Graunke's vocational opinion. He did not address the extent of the applicant's loss of earning capacity based upon the independent medical examiner or earlier treating physician's assessment of permanent restrictions. The independent medical examiner's opinions regarding permanent restrictions were credible. Those restrictions did not render the applicant permanently and totally disabled.

**RETRAINING**

*Karpes v. Tradesman Int'l, Inc.*, Claim Nos. 2013-027630, 2015-000831 (LIRC June 19, 2018). On August 29, 2013, the applicant sustained a work-related left ACL tear which required a repair. The applicant sustained an aggravation on October 24, 2014. He eventually underwent a second surgery in September of 2015. The applicant continued to work for the employer in light-duty positions until he was terminated in July of 2016. Dr. Kulwicki performed an independent medical examination. He opined the applicant required no work restrictions. The applicant underwent a functional capacity evaluation on July 21, 2016. The therapist indicated that the applicant could rarely kneel and crawl, and occasionally crouch. On August 1, 2016, Dr. Angeline opined that the applicant required the permanent restrictions as outlined in the Functional Capacity Evaluation. The applicant applied for services through the Department of Vocational Rehabilitation (DVR). The counselor at DVR prepared an Individualized Plan for Employment (IPE) on November 4, 2016. The counselor recommended the applicant obtain a two-year Associate degree in a CNC program. Ms. Veith prepared an independent medical examination report for the employer and insurer. She opined that retraining was not necessary under Dr. Kulwicki or Dr. Graf's opinions that the applicant had no permanent work restrictions. Ms. Veith opined that, under Dr. Angeline's restrictions, the applicant could not return to his carpentry job with the employer. She opined that the applicant could obtain a job under Dr. Angeline's restrictions without retraining and that such a job would be in line with the applicant's pre-injury earnings when considering his annual salary. If the applicant's hourly wage was considered for full-time, year-round work, retraining would be necessary because the jobs would not pay within 15% of his hourly wage. She also opined that the applicant could work as a welder, which would require a two-semester training program and would return him to his pre-injury hourly earnings. The administrative law judge's decision is not specifically outlined in the decision. The Commission held that the applicant had permanent work restrictions and, thus, was eligible for vocational retraining benefits. Under the *Massachusetts Bonding* presumption, a DVR counselor's IPE program is presumed valid unless there was fraud (via highly material

facts misrepresented) or an abuse of discretion (abuse of administrative power). The potential for a vast improvement of the applicant's preinjury wage earning capacity is not applicable. Alternative, less expensive, programs are not relevant. Further, the fact that the training may improve the applicant's pre-injury wage is not dispositive. Vocational retraining generally is to restore earning capacity and potential, not simply to replace lost wages.

A finding that vocational retraining may increase an applicant's earning capacity above the preinjury level does not alone make the program unreasonable. The record did not establish that the applicant misrepresented highly material facts to the DVR, or that the DVR abused its administrative power in approving the retraining plan. Therefore, the IPE prepared by DVR was appropriate.

**STANDARD OF REVIEW**

***Tetra Tech EC, Inc. v. Wisconsin Department of Revenue,* 382 Wis. 2nd 496 (Wis. 2018).** This case, while technically not a worker's compensation case, will impact future Wisconsin cases when appeals are taken from any Commission order. The Supreme Court held that courts will no longer defer to conclusions of law reached by an administrative agency. The courts will only give such conclusions "due weight" while considering the experience, technical competence, and specialized knowledge of the administrative agency. The Supreme Court has indicated for some time that it was contemplating reconsidering the practice that it had developed over the years, of deferring to an administrative agency's conclusions of law. The Supreme Court has now made this change. The opinion is a very interesting one if you enjoy the concept of divisions of powers between the three branches of government. From a worker's compensation point of view, however, the important thing to remember about the decision is that an agency's conclusion of law is no longer "the law." A reviewing court now does have authority to review whether or not the conclusion is correct. However the agency's conclusion will be given "due weight" when the interpretation of the law involves technical competence or specialized knowledge which the agency might have.

***Wisconsin Bell, Inc. v. LIRC and Charles E. Carlson,* 283 Wis. 2d 624 (Wis. 2018).** This case is not a worker's compensation case. It is applicable to worker's compensation law only in that it involved the issue of what degree of respect or authority a court should assign to an administrative agency's conclusion of law in light of the *Tetra Tech* decision. This case involved an action brought under the Wisconsin Fair Employment Act. A disabled person, Mr. Carlson, sought benefits under the Act. The Labor and Industry Review Commission interpreted the Fair Employment Act. The Commission held that Wisconsin Bell had intentionally discriminated against Mr. Carlson. The Supreme Court reversed. The facts are not of importance to our evaluation. The Supreme Court noted that it is now reviewing the administrative agency's interpretation and application of statutes de novo. This was based upon the *Tetra Tech EC, Inc.* case. Based upon the new standard of review, "the court shall set aside or modify the agency action if it finds that the agency has erroneously interpreted a provision of law and a correct interpretation compels a particular action, or it shall remand the case to the agency for further action under a correct interpretation of the provision of law." Wis. Stat. 227.57(5). The review of the Commission's findings of fact remains more limited. "If the agency's action depends on any fact found by the agency in a contested case proceeding, the court shall not substitute its judgement for that of the agency as to the weight of the evidence on any disputed finding of fact." Wis. Stat. 227.57(6). The court will set aside or remand a matter to the agency based on a

factual deficiency only if "the agency's action depends on any finding of fact that is not supported by substantial evidence in the record." Wis. Stat. 227.57(6). "Substantial evidence does not mean a preponderance of evidence. It means whether, after considering all of the evidence of record, reasonable minds could arrive at the conclusion reached by the trier of fact." *Milwaukee Symphony Orchestra, Inc.*

***Wise v. Labor and Industry Review Commission*, 2018 WL6787950 (Wis. Ct. App. 2018)(final publication decision pending).** The applicant was hired as a caregiver at Grand Horizons. She slipped and fell in an icy parking lot while leaving the facility on the date of injury. The applicant eventually required a replacement of the left hip and, subsequently, a replacement of the right hip. She also reported related low back symptoms. The MRIs reflected the applicant had pre-existing avascular necrosis in both femoral heads in her hips. The applicant, however, had never sought treatment nor reported any hip related symptoms to any medical care provider prior to the time of the accident. The medical records were extensive and conflicted somewhat regarding the extent of pain, when the pain started, and a number of related issues. The administrative law judge held that the applicant's left hip condition was aggravated, precipitated and accelerated by the fall, and that the applicant had sustained a consequential soft tissue back injury. The Labor and Industry Review Commission reversed. The Circuit Court of Winnebago County affirmed. The Court of Appeals reversed and remanded. The decision of the Commission is reviewed by the Court of Appeals, not the decision of the Circuit Court. Whether or not the work-related injury precipitated and aggravated a pre-existing condition is a question of fact. A court should not substitute its judgment as to a fact, for that of the Commission, when the weight or credibility of the evidence on any finding of fact is at issue. Credible and substantial evidence is relevant, credible, and probative evidence upon which reasonable persons could rely to reach a conclusion. The Commission's decision was dependent upon the Commission holding that the applicant had fully recovered from any aggravation to the left hip caused by the fall, no later than March 4, 2013. (The independent medical examiners had opined that the effects of any temporary aggravation would have ended by that date.) The basis for the independent medical examiner's opinion is a clear misinterpretation of the medical records relied upon, and the record evidence as a whole. Based upon the evidence, it defies logic and common sense that the applicant had fully recovered from the aggravation of the work-related injury on March 4, 2013. The Commission's holding was, therefore, unsupported by credible and substantial evidence. There is no reading of the record which could reasonably lead the Commission to its finding.

**SUPPLEMENTAL BENEFITS**

*Haydysch v. Holmes Carpentry, Inc.,* Claim No. 2015-014373 (LIRC May 31, 2018). The applicant sustained a significant work-related injury resulting in a permanent quadriplegia. He was deemed permanently and totally disabled as a result of the injury. Benefits were conceded and paid to the Applicant accordingly. The employer and insurer also conceded and paid a $20,000.00 liability to the Work Injury Supplemental Benefit Fund. This payment was to fulfil the obligation under Wis. Stat. 102.59(2). A reverse hearing application was filed to seek to relieve the employer and insurer of the obligation to pay more than $20,000.00. An unnamed administrative law judge ordered the employer and insurer to pay a total of $80,000.00 to the Work Injury Supplemental Benefit Fund because they were obligated to indemnity the applicant for a June 8, 2015 injury that caused quadriplegia. The Labor and Industry Review Commission reversed. The employer and insurer have no obligation under Wis. Stat. 102.59(2) to pay an

additional $60,000.00 to the Work Injury Supplemental Fund based on an injury to the applicant on June 8, 2015. Wis. Stat. 102.59(2) states: "in the case of the loss or of the total impairment of a hand, arm, foot, leg, or eye, the employer shall pay $20,000 into the state treasury. The payment shall be made in all such cases regardless of whether the employee or the employee's dependent or personal representative commences action against a 3rd party as provided in 102.29." The plain meaning of Wis. Stat. 102.59(2) is to assess a single contribution to the Work Injury Supplemental Benefit Fund of $20,000.00 in the event of any of the conditions of the statute is satisfied in a compensable injury. Even if the statute is ambiguous, the most reasonable interpretation, in light of the legislative history, is to require an employer to make only one payment of $20,000.00 to the fund so long as there is a loss or total impairment of any of the listed body parts in a compensable injury.

### TEMPORARY TOTAL DISABILITY

*Karpes v. Tradesman Int'l, Inc.*, Claim Nos. 2013-027630, 2015-000831 (LIRC June 19, 2018). On August 29, 2013, the applicant sustained a work-related left ACL tear which required a repair. The applicant sustained an aggravation on October 24, 2014. He eventually underwent a second surgery in September of 2015. Dr. Kulwicki performed an independent medical examination. He determined the applicant reached the end of healing as of June 3, 2016 (the date of his evaluation). On August 1, 2016, Dr. Angeline determined that the applicant reached the end of healing. The administrative law judge's decision was not outlined in the decision. The Labor and Industry Review Commission noted the applicant was only entitled to temporary disability compensation while the applicant remained in a healing period. The healing period ends where there has occurred all of the improvement that is likely to occur as a result of treatment and convalescence. The Commission credited Dr. Kulwicki's opinion that the applicant reached a healing plateau as of June 3, 2016. Although the applicant continued to have physical therapy and treated with Dr. Angeline after June 3, 2016, the applicant testified that he did not really know if he improved at all during this time, but possibly got more strength in his leg. The Commission expressed legitimate doubt that the applicant needed any additional time for medical healing.

### UNREASONABLE REFUSAL TO REHIRE

*Inman v. Morgan Tire & Auto LLC,* Claim No. 2014-007042 (LIRC October 31, 2018). The applicant worked as a shop foreman and lead technician. He sustained a conceded surgical, left shoulder injury. Temporary restrictions post-surgery were accommodated. He then underwent another surgery. The surgeon assigned the applicant permanent restrictions. The employer subsequently wrote to the applicant, and outlined their recent telephone conversation. The employer noted that assigning essential job functions to other teammates was not a workable accommodation. The applicant was advised his employment was separated because he was unable to perform essential job functions. The applicant was advised he could reapply if his ability to perform the essential job functions improved. The applicant denied discussing the accommodation of permanent restrictions and essential job functions with the employer. He later conceded having a discussion with the employer but not recalling the content of the discussion. The applicant acknowledged his physical restrictions prevented him from performing a number of job duties at the employer's facility. However, the applicant asserted his date of injury positions did not require performance of those job duties. The employer's manager testified regarding the job duties the applicant would need to perform in his date of injury positions. The

unnamed administrative law judge held the employer had unreasonably refused to rehire the applicant. The applicant was awarded 52 weeks of lost wages. The employer was able to accommodate the applicant's temporary restrictions, and therefore, it should not have been a hardship to offer continued employment after the assignment of the permanent restrictions. The Labor and Industry Review Commission reversed and dismissed the claim under Wis. Stat. 102.35(3). The employer's manager testified credibly that the applicant's date of injury position duties included tasks that were incompatible with the applicant's permanent restrictions. The employer demonstrated it had reasonable cause to terminate the applicant's employment because of his physical inability to perform all duties required in several different positions at the facility. The court in *DeBoer Transportation v. Swenson* held that Wis. Stat. 102.35(3) does not contain accommodation requirements. The *DeBoer* holding is clear that an employer is not required to rehire an injured worker if to do so requires that the employer to fashion an accommodation, to change its valid business protocol or alter substantial, long standing employment policies. Here, to rehire the applicant within his assigned permanent restrictions would have required the employer to substantially modify the job duties regularly required of any individual employed in any applicable job position. There was reasonable cause for termination and no pretextual motive.

*Riech v. SM & P Utility Resources, Inc.*, Claim No. 2016-029538 (LIRC November 30, 2018). The applicant alleged he sustained a work-related knee injury one week after he began employment, while in training. This injury was not conceded. He reported pain and swelling in his knee. The employer permitted him to perform classroom training for the two days after the alleged incident occurred. The applicant then took the following two days off work at the employer's suggestions, because of his reports of ongoing knee symptoms. When he returned, his restrictions were accommodated. The applicant did not miss any in-class training. His supervisor opined his performance the second week of training was poor. He could not perform as expected given his experience and training. This was not based upon any physical capabilities. The applicant did not retain information that was being taught. He was apathetic toward his job. He crossed a road without looking both ways, not at a crosswalk, and a minivan had to stop and wait for him to pass. This was reported to a supervisor by a peer coach immediately. The supervisor did not believe that the applicant would be able to pass certification given his performance during training. The supervisor terminated the applicant two business days later. Administrative Law Judge Eneuoh-Trammell held the applicant sustained a work-related injury, but that there was reasonable cause for discharge. The claim for unreasonable refusal to rehire was dismissed. The Labor and Industry Review Commission affirmed. The applicant's medical expert was more credible and causation for a work-related injury was established. The applicant demonstrated he was an employee, who sustained a work-related injury, and was discharged. The employer, therefore, had the burden to demonstrate reasonable cause for the discharge. This burden was met. The applicant was terminated for reasons not related to the work-related injury. The applicant did not get the job or understand the nature of the business. He consistently demonstrated that he lacked the competence to perform the job. The employer terminated the applicant for performance issues and violating a safety rule, and not because of the knee injury.

*Torres v. RP's Pasta Co.*, Claim No. 2015-027890 (LIRC November 30, 2018). The applicant sustained a conceded right shoulder injury. He was terminated during the healing period. The employer asserted that the applicant was terminated for lack of motivation, "unmotivating" behavior towards his coworkers, and an alleged incident of harassment. Administrative Law Judge Lake held that the employer violated Wis. Stat. § 102.35(3) for unreasonable termination. The Labor and Industry Review Commission affirmed. Wis. Stat. § 102.35(3) places upon the injured employee the prima facie burden of demonstrating that (1) he was an employee of the employer, (2) he was injured in employment with that employer, and (3) he was not rehired or was discharged. Upon establishment of those evidentiary facts, the burden shifts to the employer to show a reasonable cause for the failure to rehire or discharge. Here, the employer's explanations for its decision to discharge the applicant were not credible. The employer referenced a crude, but offhanded and rather innocuous comment as "just so opposite of the culture of what I try to represent at RP's as an owner." However, the employer had not overtly disciplined the applicant for alleged prior behavior that a reasonable person would have considered significantly more serious. Other evidence, which was proffered to support allegations of "unmotivating" behavior, was alternately nonexistent, hearsay and/or incredible. Because the employer's testimony was discredited, the employer did not meet its burden of proving that reasonable cause existed to discharge the applicant.

*Oldenburg v. Big Lots Stores, Inc.,* Claim No. 2015-011721 (LIRC January 31, 2019). The applicant was employed as a Furniture Sales Lead. He sustained a specific, admitted, left shoulder injury. He was assigned permanent restrictions. The applicant was terminated two days after those permanent restrictions were assigned. He asserted that he was unreasonably terminated. The applicant met his initial burden under the statute. The employer, therefore, needed to establish that suitable work was not available within the applicant's permanent restrictions and/or it had reasonable cause to not rehire the applicant. The applicant's date of injury position, and all sales positions, required lifting over 50 pounds. The applicant's restrictions limited him to lifting only up to 20 pounds with certain motions and up to 40 pounds otherwise. The applicant acknowledged the job duties were not within his restrictions in a letter he wrote to the employer on the date he was assigned permanent restrictions. He noted that he wanted to return to work but had major concerns regarding his ability to perform the job duties. The employer discussed other potential available positions with the applicant. He declined to consider those because he believed they were outside his permanent restrictions or the positions were part time. The unnamed administrative law judge dismissed the applicant's claim in its entirety on the basis that the employer established there was no suitable work available for the applicant within his permanent restrictions, and therefore, the employer acted reasonably in terminating the applicant. The Labor and Industry Review Commission affirmed. The applicant's assertion that he could have modified his job duties to successfully perform a sales position, within his restrictions, was not credible. The applicant initially declined consideration of performing two other positions at the employer's store, which he may have been able to perform within his restrictions with only minor modifications because the applicant believed the job duties involved tasks in excess of his physical restrictions. Further, he indicated that he was considering retirement if he could not return to a sales position.

Therefore, the credible evidence demonstrates the employer acted reasonably and without pretext in discharging the applicant because he was physically unable to return to the job he was performing when injured. Further, the employer credibly demonstrated the applicant precluded consideration of being hired in alternative lower paying positions because he knew those would involve duties that exceeded his physical restrictions and he was only interested in sales positions.

### VOCATIONAL RETRAINING

*Love v. SSM Health Care of Wisconsin*, Claim No. 2014-025255 (LIRC April 26, 2019). The applicant alleged she sustained an occupational back injury. An administrative law judge agreed and ordered benefits paid in 2014. The parties subsequently entered into a limited compromise. The applicant then sought vocational retraining benefits. The employer applied for and accepted a different position with the employer post injury, within her permanent restrictions. The employer determined the restrictions could not be accommodated after a period of time because of the applicant's reports that the job duties were outside of her restrictions. The applicant was offered a different position (more part time) which would have paid her same hourly wage. This was a part-time position, but it did not include fringe benefits. The applicant subsequently obtained employment elsewhere. The DVR counselor opined that the applicant was a good candidate for a one year retraining program after review of her wage pre and post injury. Administrative Law Judge Mallon awarded benefits. The Labor and Industry Review Commission affirmed. The applicant did not unreasonably refuse valid work offers. The applicant did not create her own loss of employment and forfeit her right to vocational retraining benefits as asserted by the employer. The applicant acted reasonably in rejecting a part-time position with the employer with drastically reduced hours and no benefits, after the employer determined that her restrictions could no longer be accommodated. The declined position with the employer would not have exceeded the applicant's gross weekly wage. Further, just because the applicant secured subsequent employment at another company does not mean she does not require vocational retraining. The DVR counselor credibly testified the applicant was seeking employment at a higher number of hours per week than the part-time employment she had subsequently secured, and a position with paid benefits. DVR's approval of a one year vocational program was made with full knowledge of all of the material facts and was reasonable. Therefore, the Commission cannot overturn the decision because of the deference required to the DVR's determination regarding the appropriateness of retraining.

### WELLNESS PROGRAMS

*Russell v. Trek Bicycle Corp.,* Claim No. 2016-008163 (LIRC August 31, 2018). The employer encouraged its employees to be fit. The facility was equipped with a gym, locker rooms and showers. Fitness classes and bike riding classes were available. Facilities were available to store personal bikes. Since at least the 1990s, the employer knew the employees were using private trails just north of the employer's headquarters for running, hiking and cross country skiing. The employer had a lease agreement with the owner of the trails for formal use of the property by the employer's employees for business and personal purposes. Employees had to sign a release and carry a trail pass while on the trails for personal purposes. The applicant executed the release for personal use of the trail which indicated that each employee deciding to participate in the non-business activities on the property outside the scope of his or her employment was doing so voluntarily. The applicant was salaried. His lunch hour was flexible. He did not have to punch

out and was free to do as he pleased. On the date of injury, he decided to ride his personal bike over the lunch break to engage in physical fitness of a personal benefit to him. He sustained a significant injury while he was on the private trails on this date, which rendered him a T9 complete paraplegic. Administrative Law Judge Enemuoh-Trammel dismissed the application for worker's compensation benefits. The Labor and Industry Review Commission agreed with the dismissal of the application. The applicant was voluntarily participating in a personal, recreational bicycle riding activity designed to improve his well-being when he was injured. The applicant's salary did not include remuneration for non-work activities such as his recreational bicycle riding on the date of injury. His claim is subject to the statutory coverage exclusion in Wis. Stat. 102.03(1)(c)(3). This statute provides that "an employee is not performing service growing out of and incidental to employment while engaging in a program, event, or activity designed to improve the physical well-being of the employee, whether or not the program, event or activity is located on the employer's premises, if participation in the program, event, or activity is voluntary and the employee receives no compensation for participation." The three pre-requisites to coverage under the statute include (1) the employee is engaged in an activity designed to improve his well-being; (2) the activity is voluntary; and (3) the employee receives no compensation for participating in the activity. The statute does not require that a formal wellness program has been established. It only requires an activity designed to improve the physical well-being of the employee. This clearly applies to recreational bicycle riding. The employer encouraged the activity and took steps to promote it on a personal basis. Wisconsin case law does not establish a clear distinction between the personal comfort doctrine and coverage during recreational activities. Personal comfort analyses have historically addressed momentary divisions, which may be seen as distinct from the deliberate and usually extended abandonment of work that characterizes recreational activities. The significant analysis considers the degree of deviation from the work-related purpose, the degree of time and space deviation from employment and whether or not the applicant was being compensated at the time he or she was pursuing the activity. Here, the applicant's activity involved a substantial physical and temporary deviation from any work-related activity. The applicant was on the employer's premises at the time of the work-related injury. The applicant was salaried. However, no part of his salary was paid for regular lunch breaks. He was, therefore, on an unpaid break. During those breaks (including the one he was taking when he was injured), the applicant was not performing any work duties for the employer. His outing was voluntary and personally motivated. There was no identified work-related purpose for his personal activity which constituted a voluntary, deliberate and substantial deviation that occurred during an unpaid break.

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# REHABILITATION: REQUIREMENTS OF STATUTE AND RULE

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# 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**

A-1 Disability Status Report

A-2 Rehabilitation Consultation Report

A-3 R-2 Rehabilitation Plan

A-4 R-3 Rehabilitation Plan Amendment

A-5 Plan Progress Report

A-6 On the Job Training Plan

A-7 Insurer’s Notice to Employee: Request for Retraining

A-8 Retraining Plan

A-9 R-8 Notice of Rehabilitation Plan Closure

A-10 Rehabilitation Job Placement Plan and Agreement (JPPA) (Decertified)

A-11 Rehabilitation Request

A-12 Rehabilitation Response

A-13 Rehabilitation Rights and Responsibilities of the Injured Worker

A-14 Report of Work Ability

# 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.

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.

R C 0 1

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.

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

11. INSURER/SELF-INSURER/TPA

12. INSURER ADDRESS

CITY STATE ZIP CODE

13. CLAIM REPRESENTATIVE

14. PHONE NUMBER

15. QRC NAME

16. QRC FIRM

17. ADDRESS

CITY STATE ZIP CODE

18. QRC #

19. QRC FIRM #

20. QRC PHONE NUMBER

21. Occupation at time of injury

22. Pre-injury AWW

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:



cc: Employee, Insurer, Attorney(s) or other parties

## 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.

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 | | | + | | = | |

| | Duration to date | | Expected additional duration to plan completion | | Estimated total duration |
|---|---|---|---|---|---|
| 18. Plan duration from plan filing date (in weeks) | | + | | = | |

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** | **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.

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.

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 | | |



cc: Employee, Insurer, OJT Employer

**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.

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)<br>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.

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 engage 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

# Rehabilitation Request

CHECK BOX IF THIS REQUEST ADDS REHABILITATION ISSUES TO A PENDING 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 | | 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:**

- 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.** ☐ **YES** ☐ **NO**
**For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354.**

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 | | TO | |
|---|---|---|---|
| | NAME | | NAME |
| | FIRM NAME | | FIRM NAME |
| | ADDRESS | | ADDRESS |
| | PHONE # (include area code) | | 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)

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.** ☐ YES ☐ NO
**For more information, call the Benefit Management and Resolution Unit at (651) 284-5032 or 1-800-342-5354.**

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.

IW05

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.

| WID or SSN | DATE OF INJURY | EMPLOYEE NAME |
|---|---|---|
| | | |

IW05

## 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**

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.**

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# MEDICAL MARIJUANA RESEARCH

| STATE | MEDICAL MARIJUANA CASE LAW | SUMMARY |
|---|---|---|
| **Alaska** | *Sonntag v. Gabe's Trucking & Auto Repair*, 2013 WL 4508817 (Alaska Work. Comp. Bd. 2013) | Dicta regarding medical marijuana. The judge looked to which specialist should perform a second IME. One discussed treatment was the prescription of medical marijuana as the employee was afraid of the long term effects of prescription narcotics. The court mentioned a dispute over what treatment is necessary, and a specialist could aid the court in finding if medical marijuana was appropriate. |
| **Arizona** | No relevant cases found. | |
| **California** | *Cockrell v. Farmers Insurance & Liberty Mutual Insurance Company*<br>*US of America v. Marin Alliance*<br>2015 WL 6123062 (N.D. Cal 10/19/15) | |
| **Colorado** | ***In the Matter of Armendariz v. Chief Masonry*, 2014 WL 3886663 (Colo. Ind. Cl. App. Off. 2014)** | **Employer appealed ALJ ruling. One issue was that "Marinol," a brand name for "dronabinol," was prescribed by the employee's doctor. Dronabinol, while not distinctly marijuana, is a "pharmaceutical cannabinoid product." The ALJ decision was affirmed on this issue despite the Colorado statute stating insurers do not have to pay for marijuana by distinguishing this as an FDA approved product that is specifically addressed in the Guidelines.** |
| **Connecticut** | No relevant cases found. | |
| **Delaware** | No relevant cases found. | |
| **D.C.** | No relevant cases found. | |
| **Hawaii** | No relevant cases found. | |
| **Illinois** | No relevant cases found. | |
| **Maine** | *Schoendorf v. RTH Mechanical Contractors Inc.*, 2014 WL 4491370 (ME. Work. Comp. Bd. 2014)<br><br>*Wade v. Martindale Country Club*, 2012 WL 6827338 (ME. Work. Comp. Bd. 2012) | Employee's provider prescribed medical marijuana. A second medical provider advised medical marijuana was a depressant and not appropriate for low back pain. The court found the second medical provider persuasive and denied the medical marijuana request.<br><br>Court ultimately dismissed request for medical marijuana for lack of express opinion from the section 312 examiner and no bills were presented for payment. The court refused to determine reasonableness without bills for payment. Additionally, the court acknowledged there are federal preemption issues, but did not address. |

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| STATE | MEDICAL MARIJUANA CASE LAW | SUMMARY |
|---|---|---|
| | *Maaine Bourgain v. Twin Rivers Paper Co.*, A.3d (ME 2018) | Conflict between Federal and State law, Federal law takes precedence. |
| | | |
| **Maryland** | No relevant cases found. | |
| | | |
| **Massachusetts** | No relevant cases found. | |
| | | |
| **Michigan** | *Todor v. Northland Farms, LLC*, 2011 WL 4674784 (Mich. Comp. App. Com. 2011) | Court affirmed Magistrate's decision that state law forbid insurer reimbursement for medical marijuana. |
| | | |
| **Minnesota** | No relevant cases found. | |
| | | |
| **Montana** | *Johnson v. Columbia Falls Aluminum Co., LLC*, 350 Mont. 562 (Montana Supreme Court 2009) (Unpublished) | The court stated an Employer does not have to accommodate an Employee's use of medical marijuana per the Medical Marijuana Act. Company policy stated they could terminate employee for use of marijuana. The court found no wrongful discharge. |
| | | |
| **Nevada** | No relevant cases found. | |
| | | |
| **New Hampshire** | No relevant cases found. | |
| | | |
| **New Jersey** | No relevant cases found. | |
| | | |
| **New Mexico** | ***Vialpando v. Ben's Automotive Services*, 331 P.3d 975**<br>*Mac3 v. Riley Industrial* | **Held Workers' Compensation Act authorizes reimbursement for medical marijuana and did not require employer to commit a federal crime.** |
| | | |
| **New Mexico** | *Maez v. Riley Industrial*, 2013 WL 4238545 (N.M. Workers' Comp. Admin. 2013) | Employer was not liable for purchase of medical marijuana based on the fact that the medical marijuana was not prescribed by the authorized health care provider. |
| | | |
| **New Mexico** | ***Lewis v. American General Media*, 2013 WL 6517276 (N.M. Workers' Comp. Admin. 2013)** | **Court held employer/insurer must reimburse employee for medical marijuana prescribed. Court found this was consistent with New Mexico state law.** |
| | | |
| **New York** | *Employer: Navarre Prescription Ctr., Inc.*, 2008 WL 3180396 (N.Y. Work. Comp. Bd. 2008) | Court denied request for Marinol, a legal form of marijuana. Denial was based on the fact that the provider did not give a rationale as to why Marinol was necessary. If the doctor gave an appropriate rationale, the court may reconsider. |
| **Oregon** | No relevant cases found. | |
| | | |
| **Rhode Island** | No relevant cases found. | |
| | | |
| **Vermont** | No relevant cases found. | |
| | | |
| **Washington** | *Roe v. Teletech Customer Care Management LLC*, 171 Wash. 2d 736 (Wash. 2011) | The Medical Use of Marijuana Act does not prohibit an employer from discharging an employee for medical marijuana use, nor does it provide a civil remedy against the employer. |

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# TRAUMATIC BRAIN INJURY

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# TRAUMATIC BRAIN INJURY

## I. CONDITIONS

### A. Amnesia

1. Retrograde: loss of memory prior to impact.
2. Anterograde: Loss of memory after impact.

### B. Basilar skull fracture

Located at the base of the skull and can involve the temporal, occipital, sphenoid and/or ethmoid bones. This type of fracture can result in leakage of central spinal fluid from the nose or ear. Blood can be seen behind the tympanic membrane or in the external ear. There can be ecchymosis behind the ear called Battle's sign or around the eye, known as raccoon eyes. With a CT, this is usually visible.

### C. Concussion

Transient metal status that is loss of consciousness or memory lasting less than six hours. This is based on clinical findings and a CT or MRI. Concussion is defined as a transient and reversible post-traumatic alteration in mental status, (e.g. loss of consciousness or memory) last from seconds to minutes and by arbitrary definition, less than six hours. Chronic subdural hematoma. Usually evidences a gradual headache, somnolence, confusion sometimes with focal deficits or seizures. A CT scan usually will diagnose.

### D. Contusion

Is a bruise of the brain tissue and can occur with open or closed injuries and can impair a wide range of brain functions, depending on contusion, size, and location. Large contusions may cause brain edema and increased cranial pressure (ICP). Usually diagnosed with a CT scan.

### E. Coup/Coutrecoup Injuries

1. An example of a coup injury is when the forehead strikes the dash or windshield of a car.
2. An example of contrecoup is when the brain hits the primary surface then impacts against the opposite side of the skull.

## F. Diffuse Axonal Injury (DAI)

Is a devastating injury with damage over a more widespread area rather than a focal area. The loss of consciousness can last over six hours but may not have focal deficits or motor posturing. The CT scan at first may be normal but the MRI is often abnormal.

1. Diffuse CNS Dysfunction: scattered/widespread.
2. Focal Dysfunction: one area.

## G. Hematomas

Collections of blood in and/or around the brain and can occur with open or closed injuries and may be epidural, subdural or intracerebral. An acute subdural hematoma can be focal or non-focal or both. They are slower to evolve with progressive decline. With small hematomas, normal function is possible. In order to diagnose, a CT will show a classic crescent shaped hematoma; the degree of mid-line shift is important. Subarachnoid hemorrhage (SAH) is bleeding into the subarachnoid space). Epidural hematomas are collections of blood between the skull and dura matter. An epidural hematoma is an emergency, as it is an arterial rupture. An individual with this is initially fine, then goes home and could be dead an hour later. Intracerebral hematomas are collections of blood within the brain itself and result from hypertension.

## H. Herniation of the Brain

Deadly side-effect of very high intracranial pressure, this occurs when part of the brain is squeezed across structures within the brain and is seen with TBI, intracranial hemorrhage or brain tumor.

## I. Mass Effect

A growing mass resulting in secondary pathological effects.

## J. Mid-Line Shift

A shift of the brain past the center line.

## K. Primary and Secondary Lesions

1. Primary Lesions occur at time of trauma, e.g., contusions, lacerations, fractures, diffuse axonal injury.
2. Secondary Lesions occur subsequent to the primary lesion, e.g., edema, hypoxia and ischemia.

### L. Skull Fractures

Skull fractures are breaks in one or more of the eight bones forming the cranial portion of the skull. Skull fractures usually occur from blunt force trauma. Closed head injuries and penetrating type injuries may cause skull fractures. The eight cranial bones are: one frontal, two parietal, two temporal, one occipital, one sphenoid and one ethmoid.

### M. Types of Fractures

1. Linear: are fairly straight and involve no displacement of the bone.
2. Depressed: usually from blunt force trauma, such as getting struck with a rock, hammer or kicked in the head. These are comminuted fractures where broken bones are displaced inward and can cause increased pressure on the brain.
3. Other types of factures: diastasis, basilar, growing skull, cranial burst, compound, and compound elevated.

## II. DIAGNOSTIC TESTS

### A. Computerized Tomography (CT)

A CT scan uses a series of x-rays to recreate a detailed view of the brain. A CT scan can quickly visualize fractures and uncover evidence of bleeding in the brain (hemorrhage), blood clots (hematomas), bruised brain tissue (contusions) and brain tissue swelling.

### B. Diffusor Tensor Imaging (DTI)

DTI is used by certain providers as they contend it can track mild TBI. Proponents of this test contend DTI is useful to visualize the brain's white matter. It is said to measure movement of water and nerve fibers in the brain; an abnormal flow may indicate an injury.

### C. Electroencephalogram (EEG)

Seizures can be detected by using an EEG monitor which changes the normal pattern of brain activity. An EEG is a test that detects abnormal electrical activity in the brain. Persons who have sustained head injuries are, by some studies, 12 times more likely to suffer seizures than the general population. An EEG is also a useful test for diagnosing epilepsy.

### D. Functional MRI (FMRI Scan)

An FMRI scan identifies with greater precision, activity within certain brain regions and how long those regions remain active. An FMRI scan also identifies the exact areas of the brain being activated. An FMRI creates images of the brain nearly every second.

## E. High Definition Fiber Tracking (HDFT)

This test will show images of the brain fiber network. It was developed by a team at the University of Pittsburgh to help identify which brain's neuro pathways have been disrupted. It can dissect forty major fiber tracks in the brain and find damaged areas quantifying the proportion of fibers lost relative to the uninjured side of the brain. They will run algorithms on data collected from MRI scans to view the brains fiber tracks, each of which contain millions of connections.

## F. Intracranial Pressure Monitor

Tissue swelling from a traumatic brain injury can increase pressure inside the skull and cause additional damage to the brain. Doctors may insert a probe through the skull to monitor this pressure.

## G. Magnetic Resonance Imaging (MRI)

An MRI uses powerful radio waves and magnets to create a detailed view of the brain. Doctors don't often use MRIs during emergency assessments of traumatic brain injuries because the procedure takes too long. This test may be used after the person's condition has been stabilized.

## H. Neuropsychological Testing

These tests are recognized as being specifically sensitive to the presence of brain function or dysfunction. Neuropsychological testing consists of a battery of psychological tests conducted over a period of several hours and possibly even two to three days. Neuropsychological testing can identify brain impairments and provide useful information for the development of cognitive remediation and rehabilitative strategies to improve cognitive function. Frequently, neuropsychological testing is conducted as part of a comprehensive neuropsychological evaluation of the patient both before and after injury, utilizing transcripts from schools, standardized test scores (e.g., ACT, SAT), records from employers and medical providers, as well as consideration of information provided by friends, family members and co-workers, and emergency personnel at the scene of the accident, regarding cognitive, emotional, behavioral, and physical changes, apparent following the brain injury.

## I. Positron Emission Tomography (PET Scan).

A PET scan offers greater clarity than a SPECT scan but is a more expensive diagnostic test. PET scans color code parts of the brain based on the absorption of radio activity tagged glucose and reflection of relative metabolic activity of lobes of brain. Parts of the brain that are healthy absorb a lot of glucose and appear bright orange or red. Blue or purple indicates parts of the brain that absorb little glucose because they are damaged, dying, or dead; therefore, using less glucose.

### J. Single-Photon Emission Computed Tomography (SPECT Scan)

A SPECT scan measures blood flow and activity levels in the brain. A SPECT scan examines functional activity of the brain. A SPECT scan indicates where there is excessive or insufficient activity in one area of the brain or various areas of activity.

### K. Voxel-Based Morphometry (VBM)

VBM is a neuroimaging analysis technique allowing investigation of focal differences in brain anatomy, using the statistical approach of statistical parametric mapping.

### L. Blood Test

The FDA has approved a blood test to determine if a brain injury occurred. The Traumatic Brain Injury test must be done within 12 hours of injury and will identify two proteins that will be elevated in a serious TBI. The DOD and US Army funded research to develop the Banyan biomarkers.

### M. Eye Box Test

The FDA has approved this test to assess and aid in diagnosis of concussions. It uses eye-tracking to assess patients suspected of a concussion in a four minute test.

## III. SIGNS AND SYMPTOMS OF BRAIN INJURIES

Most patients with moderate or severe TBI lose consciousness, usually for seconds or minutes, although some patients with minor injuries have only confusion or amnesia. Amnesia is usually retrograde, loss of memory prior to the impact but can also be anterograde, loss of memory after the impact. The Glasgow Coma Score (GCS) is a quick reproducible scoring system to be used during the initial examination to estimate the severity of the TBI. It is based on eye opening, verbal response, and the best motor response. The lowest total score of 3 indicates likely fatal damage, especially if both pupils fail to respond to light and oculovestibular responses are absent. Higher initial scores tend to predict better recovery, but not always. The convention used for the severity of head injury is initially defined by the GCS:

**A. Areas Assessed:**

1. Eye Opening

| | |
|---|---|
| Opens Spontaneously | 4 |
| Open to verbal command | 3 |
| Open in response to pain applied to the limbs or sternum | 2 |
| No response | 1 |

2. Verbal Orientation

| | |
|---|---|
| Verbal Orientated | 5 |
| Disoriented but able to answer questions | 4 |
| Inappropriate answers to questions/words discernible | 3 |
| Incomprehensible speech | 2 |
| None | 1 |

3. Motor Response

| | |
|---|---|
| Motor or base commands | 6 |
| Response to purposeful movement | 5 |
| Withdraws from pain stimuli | 4 |
| Response to pain with abnormal flexion | 3 |
| Response to pain with abnormal rigid extension | 2 |
| None | 1 |

Combined scores of less than 8 are typically regarded as coma, 14-15 is mild TBI, 9-13 is moderate TBI and 3-8 is severe TBI. However the severity and prognosis are predicted more accurately by also considering CT finding and other factors. Some patients with initially moderate TBI and a few patients with an initially mild TBI can deteriorate.

4. Severe Traumatic Brain Injury (TBI). Definition: Head trauma associated with a Glasglow Coma Score of $\leq$ 8.

| Best Eye Response | Best Verbal Response | Best Motor Response |
|---|---|---|
| 1. No eye opening<br>2. Eye opening to pain<br>3. Eye opening to verbal command<br>4. Eye opening spontaneously | 1. No verbal response<br>2. Incomprehensible sounds<br>3. Inappropriate words<br>4. Confused words<br>5. Appropriate verbal responses | 1. No motor response<br>2. Extension to pain<br>3. Flexion to pain<br>4. Withdrawal from pain<br>5. Localizing to pain<br>6. Obeys commands |

*Brian Ledlow, University of Pennsylvania, School of Medicine.*

## IV. MANAGEMENT OF TRAUMATIC BRAIN INJURY BASED ON SEVERITY OF INJURY.

### A. Severity

1. Mild 14-15 Management: Observation at home.

2. Moderate 9-13 Management: Observation in hospital.

3. Severe 3-8 Management: Rapid sequence intubation, intensive supportive care, monitoring and treatment of increased cranial pressure, as indicated.

### B. Treatment Recommendations

1. Seizures can worsen brain damage and increase ICP; therefore, should be treated promptly. In patients with significant structural injury, example large contusions or hematomas, brain laceration, depressed skull fracture or GCS less than 10, prophylactic anti-convulsants, medications to decrease brain swelling and induced comas should be considered.

2. Skull fractures, aligned closed fractures, no specific treatment. Depressed fractures may require surgery to elevate fragments, manage to lacerate cortical vessels, repair dura mater and debride injured brain. Open fractures require debridement.

3. Surgery. Intracranial hematomas may require urgent surgical evacuation to prevent brain shift, compression, and herniation; hence, early neurosurgical consultation is mandatory. However, not all hematomas require surgical removal. Small intracerebral hematomas rarely require surgery. Patients with small subdural hematomas can often be treated without surgery. Epidural hematomas are extremely serious and will require surgery. Factors that suggest the need for surgery include a mid-line brain shift of over 5 millimeters, compression of the basal cisterns, and worsening neurologic examination findings.

4. When neurological deficits persist, rehabilitation is needed with a combined interdisciplinary approach of:

    a. Physical;
    b. Occupational;
    c. Speech therapy skill building activities and counseling to meet the person's social and emotional needs.

For patients whose coma exceeds 24 hours, 50% of who have major persistent neurologic sequelae will require a prolonged period of rehabilitation, particularly in cognitive and emotional areas.

## V. INVESTIGATION

Investigation of a TBI is key to an adequate defense. There are two key aspects:

1. Obtain appropriate records – accident, medical, school, vision and mental health are the minimum needed;
2. Retain the appropriate experts, which may include a neurologist, a neuro-ophthalmologist to address vision issues and a neuropsychologist to assess cognitive function.

The appropriate experts will help to mitigate exposure and ongoing issues.

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# TBI At A Glance

## I. Definition of how an injury occurs.

- Head struck by object.
- Head strikes object.
- Acceleration/deceleration movements without direct external trauma to head.
- Foreign body penetrating the brain.
- Forces generated from blast or explosion.

## II. Severity of Injury

Range from "mild" (brief change in mental status or consciousness) to "severe" (extended period of unconsciousness or amnesia after injury).

### A. Mild

- Loss of consciousness lasting < 30 minutes
- Alteration of consciousness or mental state lasting up to 24 hours
- Post-traumatic amnesia up to 24 hours
- Glasgow Coma Scale (best available score during first 24 hours) of 13-15; not a predictor of function or rehabilitative outcome.

### B. Moderate

- LOC > 30 Minutes and < 24 hours*
- AOC > 24 hours
- PTA > 1 and< 7 days
- GCS = 9-12

### C. Severe

- LOC > 24 hours
- AOC > 24 hours
- PTA > 7 days
- GCS = 3-8

## III. TBI Symptoms

Symptoms typically fall into one of three categories:

### A. Physical

Headache, nausea, vomiting, dizziness, blurred vision, convergence insufficiency (eyes don't track), sleep disturbances, weakness, paresis/plegia, sensory loss, spasticity, aphasia, dysphagia, dysarthria, apraxia, balance disorder, disorders of coordination or seizure disorder.

### B. Cognitive

Problems with attention, concentration, memory, speed of processing, new learning, planning, reasoning, judgment, executive control, self-awareness, language or abstract thinking.

### C. Behavioral/Emotional

Depression, anxiety, agitation, irritability, impulsivity or aggression.

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## IV. Investigation

The following should be obtained:

- Mechanism/Force of Injury
- Medical Records, Scans, Blood Work, Eye Exams/Tests, Psychological Exams/Testing
- Prior Medical and Vision Records/Testing
- Prior mental Health/Psychological/Chemical Dependency Records
- Educational Records – including all testing ACT, SAT, 504 Plans, etc.
- Military Records
- Employment Records
- Social Media Records
- Witness Interviews for observations of behavior changes pre/post injury
- EMT/Ambulance/Police Records/interview/observations/Glasgow Scale
- Emergency Room Records
- Birth Records – Premature Birth
- Ophthalmology Records
- Chemical Dependency/Drug Dependency Records
- Neuro psychological testing/RAW data
- Consults

## V. IME Consideration

- Neurologist
- Neuropsychologist
- Neuro Ophthalmologist
- Vocational/Speech/Occupational
- Speech Pathologist
- Audiologist

## VI. Vision Symptoms

Vision issues fall into:

**A. Visual acuity loss.**
Loss of clarity.

**B. Visual field loss.**
Think of visual field as a pie that's cut off a slice.

**C. Visual-Perceptual Dysfunction.**
Binocular function difficulties in the form of strabismus, phoria, oculomotor dysfunction, convergence and divergence. This involves visual motor integration, that is, eye-hand, eye-foot, and eye-body coordination.

**D. Visual Motor.**
Eye posture – eyes are straight and aligned.

**VII.** Current Landscape for TBI / Concussion (May 2019)

- FDA continues to research diagnostic tools for TBI
- Biomarkers proteins in blood
- Banyan Biomarkers (March 2019 DOD & US ARMY)
- Eye tracking (Eye Box Test; Sync-Think's Eye Sync Platform)
- Diffuse Correlation Spectroscopy (monitors blood flow in brain from scalp)

*Legend:
LOC - Loss of Consciousness
AOC - Alternation of Consciousness
PTA - Post Traumatic Amnesia
GCS - Glasgow Coma Scale
DOD/VA 2007

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# POST-TRAUMATIC STRESS DISORDER

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# POST-TRAUMATIC STRESS DISORDER
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# POST-TRAUMATIC STRESS DISORDER

## A. Psychological Claims

Claims involving psychological or mental problems are divided into three categories: (1) cases in which mental stimulus produces physical injury; (2) cases in which physical stimulus produces mental injury; and (3) cases in which mental stimulus produces mental injury. Workers' compensation claims based upon the first two categories are recognized under certain circumstances, but the general rule is that compensation for claims where a mental stimulus results in mental injury are denied. [1] The one exception to this rule is for claims involving post-traumatic stress disorder as outlined further below.

### 1. Mental/Physical Cases

Cases in which work-related mental stress or stimulus produces identifiable physical ailments are generally compensable. The work-related stress need not be the only cause of the physical injury; it is sufficient for the stress to be a substantial contributing factor. [2] In order to prove legal causation, the employee must produce evidence that the stress was extreme or at least "beyond the ordinary day-to-day stress to which all employees are exposed." [3] The test of *extreme* stress applies to cases in which a single precipitating cause is at issue. The test of "beyond day-to-day" stress applies where stress that has been accumulated over a long period of time is at issue.

Compensability of a claim in which mental stress produces physical ailments depends upon the nature of the physical ailments. In order to be compensable, the physical ailments must be susceptible to discrete medical treatment, separate from and independent of treatment of the employee's emotional condition. If, however, the physical ailments are "characterized not as independently treatable physical injuries but as physical symptoms or manifestations of employee's anxiety or personality disorder and amenable to treatment only as an inseparable aspect of the employee's psychiatric condition," the claim is not compensable. [4]

### 2. Physical/Mental Cases

Cases in which work-related physical injury or trauma causes, aggravates, accelerates, or precipitates mental injury are compensable.[5] Once again, it is not necessary that the physical injury be the sole cause of the mental injury; it is sufficient that the work-related

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[1] *Johnson v. Paul's Auto & Truck Sales*, 40 W.C.D. 137, 409 N.W.2d 506 (Minn. 1987); *Lockwood v. Independent School District No. 877*, 34 W.C.D. 305, 312 N.W.2d 924 (Minn. 1981).
[2] *Aker v. Minnesota*, 32 W.C.D. 50, 282 N.W.2d 533 (Minn. 1979); *Wever v. Farmhand Inc*. 243 N.W.2d 37 (Minn. 1976).
[3] *Egeland v. City of Minneapolis*, 36 W.C.D. 465, 344 N.W.2d 597, 603 (Minn. 1984).
[4] *Johnson* at 508-509.
[5] In *Hartman v. Cold Spring Granite Company*, 18 W.C.D. 206, 67 N.W.2d 656 (Minn. 1954), a condition of "traumatic neurosis" resulting from the cumulative effect of work-related back injuries was held compensable. In *Dotolo v. FMC Corp.*, 28 W.C.D. 205, 275 N.W.2d 25 (Minn. 1985), major depression from work-related tinnitus was found compensable.

physical injury be a substantial contributing factor to producing the mental injury. [6] Even death by suicide may be compensable "if a work-related injury and its consequences, such as extreme pain and despair, directly cause a mental derangement of such severity that it overrides normal or rational judgment.[7]

### 3. Mental/Mental Cases

The general rule is that claims involving a mental stimulus that results in a mental injury are not compensable. Minnesota was among the minority of jurisdictions which did not allow compensation for cases in which mental stress or stimulus produces only mental injury. This issue was presented for the first time in Minnesota in the case of *Lockwood v. Independent School District No. 877*.[8] In that case, the employee was a senior high school principal who suffered a disabling mental injury caused by work-related mental stress. In holding that the claim was not compensable, the Minnesota Supreme Court concluded that the legislature had "probably not" intended such claims to be included under the Workers' Compensation Act. The Court held:

> …the issue raised in this case involves a policy determination which we believe should be presented to the legislature as the appropriate policy-making body. If it wishes to extend workers' compensation coverage to mental disability caused by work-related mental stress without physical trauma, it is free to articulate that intent clearly. In the absence of a clearly expressed legislative intent on the issue, however, we will not hold such a disability to be compensable.[9]

The Supreme Court has declined to overrule *Lockwood* in subsequent cases and the Workers' Compensation Court of Appeals has declined to distinguish subsequent cases from the facts in *Lockwood*. [10]

However, in response to the *Lockwood* decision, the legislature did amend the Workers' Compensation Act in 2013, to include an exception to the general rule that mental-mental injuries are not compensable. This exception is for post-traumatic stress disorder.

## B. Post-Traumatic Stress Disorder

In 2013, the legislature amended the Workers' Compensation Act to include a claim for post-traumatic stress disorder. [11] This amendment provided an exception to the general rule that mental-mental injuries are not compensable.

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[6] *Miels v. Northwestern Bell Telephone Company*, 37 W.C.D. 164, 355 N.W.2d 710 (Minn. 1984).
[7] *Miels* at 715.
[8] *Lockwood v. Independent School District No. 877*, 34 W.C.D. 305, 312 N.W.2d 924 (Minn. 1981).
[9] *Lockwood* at 927.
[10] *Schuette v. City of Hutchinson*, 843 N.W.2d 233 (Minn. 2014) (Finding that the *Lockwood* case expressly left it to the Legislature to make the policy determination as to whether to expand the Workers' Compensation Act to include a mental-mental injury. The Court noted that only in 2013, did the Legislature act on this issue, and when it did, it only acted prospectively).
[11] Minn. Stat. § 176.011, subd. 15(d).

### 1. Minn. Stat. § 176.011, subd. 15(d)

The Statute states that an "occupational disease" means a "mental impairment" which the legislature has defined as meaning "a diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist." [12] Post-traumatic stress disorder is further defined as "the condition described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association." [13]

The amendment also codified prior case law by stating that "physical stimulus resulting in mental injury stimulus resulting in physical injury shall remain compensable," and provides some exclusionary language to make clear that "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." [14] This legislation applies to all dates of injury after October 1, 2013.

Minn. Stat. § 176.011, was further amended effective January 1, 2019, to create a presumption for certain employees. Specifically, the statute now states that if prior to the date of death or disablement, an employee who was employed on active duty as a licensed police officer, firefighter, paramedic, emergency medical technician, licensed nurse employed to provide emergency medical services outside of a medical facility, public safety dispatcher, officer employed by the state or a political subdivision at a corrections, detention, or secure treatment facility, sheriff or full-time deputy sheriff of any county, or member of the Minnesota State Patrol and was diagnosed with post-traumatic stress disorder as defined in the statute, "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 the employment. This presumption may be rebutted by substantial factors brought by the employer or insurer." [15]

It is worth noting that with this the creation of this "PTSD exception," for the first time, a claim under the Minnesota Workers' Compensation Act, is directly tied to an outside source. The legislature identified that a post-traumatic stress disorder diagnosis qualifies as a mental impairment, compensable under the Minnesota Workers' Compensation Act. However, as noted above, the legislation specifically states that what constitutes "post-traumatic stress disorder" is the condition "as described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association."

[12] Minn. Stat. § 176.011, subd. 15 (a) and (d).
[13] Minn. Stat. § 176.011, subd. 15 (a).
[14] Minn. Stat. § 176.011, subd. 15(e).
[15] *Id.*

The current edition of the DSM is the DSM-5. Pursuant to the DSM-5, a diagnosis of post-traumatic stress disorder requires that all of the following factors are met:

1. Exposure to threatened or serious injury;
2. Presence of intrusive symptoms following an event;
3. Persistent avoidance of stimuli associated with the event;
4. Two or more negative alterations in cognition or mood associated with the event;
5. Two or more marked alterations in arousal or reactivity associated with the event;
6. Duration of the disturbance over one month;
7. Distress or impairment in social or occupational functioning; and
8. The symptoms are not due to a medical condition or some form of substance abuse. [16]

### 2. Case Law

Since the 2013, amendment adding a claim for post-traumatic stress disorder, the Minnesota Workers' Compensation Court of Appeals and the Minnesota Supreme Court have addressed a number of post-traumatic stress disorder cases.

In *Nelson v. State of Minnesota/Department of Human Services*, No. WC17-6033 (WCCA 2017), the employee, a nurse, was assaulted while assisting a patient. The employee had been seeking treatment from a certified nurse practitioner for depression and anxiety prior to the assault. The employee subsequently underwent an independent psychiatric examination performed by Dr. Thomas Gratzer at the request of the employer and insurer, who found that the employee showed no evidence of post-traumatic stress disorder. She was also evaluated by Dr. Keller at the request of her attorney, who found she met all of the DSM-5 criteria for post-traumatic stress disorder. The compensation judge chose between the two conflicting medical opinions and sided with the employer and insurer's medical expert, finding that the employee did not have post-traumatic stress disorder. The employee appealed to the WCCA arguing that Dr. Grazer did not adequately address the post-traumatic stress disorder criteria under DSM-5 as required by Minn. Stat. § 176.011. The WCCA upheld the compensation judge, determining that his findings were supported by substantial evidence.

Similarly, in *Flicek v. Lincoln Electric Co.*, No. WC18-6139 (WCCA 2018), the employee claimed a post-traumatic stress disorder injury after he was electrocuted on the job. Multiple medical professionals evaluated the employee who was diagnosed with post-traumatic stress disorder by an Advanced Practice Registered Nurse, a burn surgeon, and a licensed psychologist at Courage Kenny. The employer and insurer obtained opinions from two medical experts as well, Dr. Burgarino, a neurologist, and Dr. Arbisi, a licensed psychologist, who both concluded that the employee failed to meet the criteria for a post-traumatic stress disorder diagnosis. The compensation judge found in favor of the employee. The WCCA affirmed, finding that substantial evidence, including medical records, expert medical opinion, and lay testimony supported the compensation judge's determination that certain medical expenses related to the employee's post-traumatic

[16] *Diagnostic and Statistical Manual of Mental Disorders*, 271-72 (American Psychiatric Association, 5th ed. 2013).

stress disorder were reasonable, necessary, and causally related to the employee's work injury.

The WCCA took a closer look at post-traumatic stress disorder cases in *Kopischke v. Food Services of America*, No. WC18-6155 (WCCA 2018). This case is notable as it is one of the first cases decided by the WCCA that shows that the court is going to apply a "strict constructionist" view to post-traumatic stress disorder cases under Minn. Stat. § 176.011, subd. 15(d). In *Kopischke,* the employee worked as a truck driver for the employer beginning March 2014. On January 2, 2017, he was driving a company truck with an empty trailer on Interstate 94. He was traveling at approximately 65 miles per hour when a car next to his truck began to fish-tail while passing. This car struck the employee's truck while on a bridge overpass. The employee lost control of his vehicle, which jack-knifed, left the highway, and came to a stop in a ditch just beyond the overpass. Due to the stress of the crash, the employee sat in the damaged tractor for 15-20 minutes. He considered himself to have narrowly avoided death. Eventually, he checked on the occupants of the car and then contacted the Minnesota State Highway Patrol. His truck was towed for repairs. When the employee returned to driving trucks, he felt that his driving behavior changed. He felt unsafe in operating the truck, both for himself and for others. On January 10, 2017, he was diagnosed by a CNP with neck strain and post-traumatic stress disorder (PTSD). He was medically restricted against truck driving or riding along as a passenger pending a psychological examination. The employer and insurer denied primary liability for any mental health injury arising out of the work injury. He was examined by a licensed psychologist who diagnosed the employee with acute stress disorder and anticipated that the diagnosis would change to PTSD if the symptoms persisted longer than one month from the date of injury. The employee then began working as a wholesale manager for a winery. This position did not include driving a large truck or performing as much lifting. In May 2017, he began treating with Ms. Rusk, an L.M.F.T., M.A., who documented a number of psychological symptoms related to the motor vehicle accident. These symptoms included fear around large trucks, unusual dreams, disrupted sleep patterns, and hypervigilance. Ms. Rusk diagnosed the employee with PTSD under the criteria of the DSM-5 for that condition. Ms. Rusk recommended a psychiatric evaluation and psychotherapy. In ongoing visits with Ms. Rusk, the employee described improving functioning primarily through positive ideation and self-coaching. On July 27, 2017, the employee was interviewed by Dr. Voigt, Psy.D., L.P. Dr. Voigt agreed with Ms. Rusk's assessment of the employee's psychological condition and the diagnosis of PTSD. The employee's last therapy session with Ms. Rusk occurred on September 1, 2017. At that time the employee indicated that his symptoms were decreasing and described himself as "overall functioning okay." No specific symptoms were identified beyond "distressing events on the road when has to pass or encounter a big rig."

The employee underwent an independent psychological examination with Dr. Arbisi on behalf of the insurer. Dr. Arbisi administered the MMPI-2-RF test and the Life Event Checklist 5. Dr. Arbisi concluded that the employee did not meet the criteria for PTSD because he did not experience exposure to threatened death. He based this conclusion on the absence of serious injury to the employee or the other persons involved in the accident. As a result, Dr. Arbisi opined that this incident lacked significant magnitude to

support a diagnosis of PTSD under the DSM-5. The employee's responses were assessed as not "particularly upset nor demonstrated any physiological reactivity when describing the accident." Dr. Arbisi noted that the employee was not receiving any PTSD treatment beyond a general discussion of his feelings. He denied mood changes, sleeplessness, or increased activity for any period of at least three consecutive days. He did not have any difficulty driving his personal vehicle and did not significantly react to seeing tractor-trailers while driving. The employee denied being irritable, having problems with memory, or being in any form of negative emotional state. Dr. Arbisi assessed the employee's MMPI-2-RF results as inconsistent with the development of PTSD or any consequential psychological condition. Dr. Arbisi concluded that the employee did not meet the criteria for a PTSD diagnosis or any psychological injury as a direct or consequential result of the work injury, outside of a temporary adjustment disorder that would have resolved within 30 days of the accident.

The employee filed a claim petition seeking medical and economic benefits. He testified regarding the circumstances of the work injury, including that he believed he was going to die in the crash. He described his continuing psychological symptoms and how those symptoms have reduced in intensity over time. The compensation judge determined that the employee did not suffer from PTSD as a result of the work injury. The WCCA affirmed. Under Minn. Stat. §176.011, subd. 15(d), mental impairment includes the condition of PTSD as defined in the most recent version of the American Psychiatric Association's manual regarding such disorders. The WCCA determined that the employee bore the burden to demonstrate that his condition met all eight criteria for a diagnosis of PTSD pursuant to the DSM-5: (1) exposure to threatened death or serious injury; (2) presence of intrusive symptoms following the events; (3) persistent avoidance of stimuli associated with the events; (4) two or more negative alterations in cognition or mood associated with the events; (5) two or more marked alterations in arousal or reactivity associated with the event; (6) duration of the disturbance over one month; (7) distress of impairment in social or occupational functioning; and (8) absence of other cause for the disturbance. The WCCA noted that Dr. Arbisi's report, upon which the employer and insurer relied, misstated some facts. In particular, Dr. Arbisi's criticism of Dr. Voigt's evaluation was based, in part, on the incorrect assumption that Dr. Voigt did not perform a face-to-face evaluation. Additionally, the WCCA found that a highway speed crash in the vicinity of a highway overpass was certainly capable of inducing a fear of death, particularly at the moment when control is lost and the outcome remains uncertain. Dr. Arbisi appeared to rely on the employee not being seriously injured in the crash, when the applicable criterion plainly stated actual *or threatened* death or serious injury.

Nonetheless, the WCCA determined that the record supported Dr. Arbisi's conclusion that some of the PTSD criteria were lacking in the employee's symptomology. The employee's medical record lacked the multiple negative alterations in cognition or mood and marked alterations in arousal or reactivity, as required by the DSM-5. The WCCA noted that *all* of the criteria are required to support a diagnosis of PTSD; the absence of any single criterion precluded such a diagnosis. The employee's testimony at the hearing was consistent with the compensation judge's conclusion that the employee's ongoing symptoms were minor and becoming less frequent. As a result, the compensation judge's

decision was supported by substantial evidence. The WCCA found that Dr. Arbisi's opinion did not lack adequate foundation because he reviewed the employee's medical record, conducted an in-person interview, administered several psychological tests, and evaluated the results of those tests. Dr. Arbisi also accurately described the mechanism of injury. The WCCA determined that this was adequate foundation for an opinion on the employee's psychological condition.

The WCCA took another look at a post-traumatic stress disorder case in the case of *Petrie v. Todd County*, No. WC18-6176 (WCCA 2018). The employee, employed by Todd County as a correctional officer, claimed post-traumatic stress disorder due to three inmate-involved altercations at work. The employee ultimately underwent an independent psychological examination with Dr. Yarosh, a licensed psychologist. Dr. Yarosh diagnosed the employee with a pre-existing post-traumatic stress disorder, but concluded that the work incidents did not cause or aggravate her pre-existing mental health condition. The compensation judge found that Dr. Yarosh's opinion did not meet the statutory criteria for diagnosis of post-traumatic stress disorder under Minn. Stat. §176.011, subd. 15(d), and denied the employee's claims, noting that although Dr. Yarosh diagnosed the employee with post-traumatic stress disorder, he concluded it was not causally related to her employment. The compensation judge did not address the issue of whether the employee's post-traumatic stress disorder was causally related to her work injury or whether her injury could be considered a physical-mental injury. On appeal, the WCCA reversed in part, vacated in part, and remanded for a determination of whether the work injury caused, aggravated, or precipitated the employee's post-traumatic stress disorder diagnosis. The WCCA specifically found that Minn. Stat. §176.011, subd. 15(d) does not require that the diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist include a causation opinion. Instead, the WCCA held that the post-traumatic stress disorder diagnosis by a licensed psychiatrist or psychologist without a causation opinion was sufficient to meet the statutory requirement of establishing that the employee had the condition. Once the post-traumatic stress disorder diagnosis is appropriately established, the compensation judge then needs to examine the remainder of the evidence to determine whether the appropriately diagnosed post-traumatic stress disorder is causally related to the work activities. The WCCA also found that the compensation judge erred by not addressing the employee's physical-mental injury claim that was raised at the hearing.

Finally, in *Smith, Chadd v. Carver County*, No. WC18-6180 (WCCA 2019), the case involves an employee who applied to be a deputy sheriff and underwent a pre-employment psychological evaluation. He was hired and worked for ten years. He did patrol duties, such as responding to car accidents, suicides, etc. Some of which were people he knew and others paralleled his personal life (e.g., responded to a motor vehicle accident with a pregnant woman at a time when his wife and sister were both pregnant.) He sought help with a counselor and psychologist. Initially, he was diagnosed with anxiety and depression. Eventually, he was also diagnosed with post-traumatic stress disorder (PTSD). Dr. Keller, a licensed psychologist, diagnosed him with PTSD. He brought a claim for PTSD and the employer/insurer denied it. They obtained an IME from Dr. Aribisi who looked at DSM-5 criteria and other criteria and opined the employee did not have PTSD. The compensation judge accepted Dr. Aribisi's opinions

and denied the claim. The WCCA reversed and remanded. The WCCA held that for diagnostic purposes a doctor can use criteria other than the DSM-5 to diagnose a patient's condition, but for workers' compensation cases, the doctor's opinions and the judge's decision should follow the requirements of Minn. Stat. §176.011, subd. 15(d) and the DSM-5 criteria. Because Dr. Aribisi's opinion did not follow that statutory requirement, the WCCA reversed and remanded the case to the compensation judge to assess whether Dr. Keller's opinion satisfied the statutory requirements. This case was appealed to the Minnesota Supreme Court and oral arguments were heard June 4, 2019.

The takeaway from these post-traumatic stress disorder cases is that the WCCA is interpreting the statute strictly and requiring strict compliance with the statute when it comes to PTSD injuries. Therefore, a practice tip is to make sure that your IME choice is well-versed in the requirements of the law and the DSM-5, and analyzes all of the statutory criteria in their report.

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# WISCONSIN WORKER'S COMPENSATION BENEFITS BASICS

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# FOREWORD

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# WISCONSIN WORKER'S COMPENSATION BENEFITS BASICS

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# WISCONSIN WORKER'S COMPENSATION BENEFITS BASICS

## I. The Wisconsin Worker's Compensation Act

### A. Nature of the Wisconsin Worker's Compensation Act

Like other worker's compensation acts, the Wisconsin Worker's Compensation Act is a no-fault system designed to provide indemnity and medical benefits to employees injured at work. Under Wis. Stat. §102.03, in order to prevail, the employee must demonstrate:

- A sustained injury;
- Both the employer and employee are subject to the Wisconsin Worker's Compensation Act at the time of the injury;
- The claimed injury was not intentionally self-inflicted; and
- The accident or disease causing the injury arises out of the employee's employment with the employer, and in the course of the employee's employment.

Like all worker's compensation acts, the Wisconsin Worker's Compensation Act serves as an exclusive remedy for workplace injuries. It is also given a liberal construction.

### B. Who is an Employer and Employee

#### 1. Definition of an Employer

Under Wis. Stat. §102.04, an employer typically includes state or local municipalities, any person, except a farmer, who employs three or more individuals in a given trade; any person who employs another and pays wages of $500 or more in a calendar quarter; or farmers who employ six or more individuals for 20 or more days in a calendar year. Any person who has purchased a worker's compensation insurance policy is also considered an employer pursuant to Wis. Stat. §102.05(2). Wis. Stat. §102.04(2m) specifically indicates that a temporary help agency is the employer of an employee whom the temporary help agency has placed with or leased to another employer, which compensates the temporary help agency for the employee's services. Additionally, joint ventures can elect to be an employer.

#### 2. Definition of an Employee

Under the Wisconsin Worker's Compensation Act, only individuals who are defined as employees are covered. Wis. Stat. §102.07 defines employee and contains the primary test for determining whether or not an individual is an employee, by focusing on the right of control on the employee's work activities. There is also an examination as to whether the employer has the right to fire or terminate the relationship. *Kress Packing Company v. Kottwitz*, 61 Wis.2d 175, 212 N.W.2d 97 (1993).

In *Kress Packing Company*, the injured worker was driving a truck from a picnic site following its use at the employer's annual Memorial Day outing. While operating the truck, the employee sustained an injury, which was denied. At hearing, it was determined that there was an implied employee/employer relationship and benefits were awarded to the injured employee. On appeal, the Court overruled the initial liability determination. The employee subsequently appealed to the Wisconsin Supreme Court.

In examining this matter, the Wisconsin Supreme Court determined that the finding of an employer/employee relationship is a question of ultimate fact, which cannot be upset on appeal. As a result, the Supreme Court determined that the Appellate Court exceeded its authority in reversing the finding of the hearing examiner.

The Court in *Kress Packing Company* also noted that for many years, the employer had provided meat for the Memorial Day picnic in question and that for a period of about 10 years, arrangements to procure meat had usually been handled by the employee. The Court went on to note that the injured worker received instructions from his supervisor as to when he needed to pick-up the truck and return it to the employer's premise. Ultimately, it was determined that there was "benefit" to the employer and, thus, an employer/employee relationship.

The Wisconsin Worker's Compensation Act does provide for exceptions to who constitutes an employee for purposes of recovery. Generally, this includes independent contractors, volunteers, corporate owner-officers, or partners/sole proprietors who do not elect coverage. [For example, under Wis. Stat. §102.07(8)(b), an independent contractor is not an employee of an employer if the independent contractor meets all 9 enumerated statutory conditions.] Qualified religious sects can also be exempt from coverage under the Act, provided they provide alternative benefits.

### C. Compensable Injuries

The Wisconsin Worker's Compensation Act has a broad statutory definition of what constitutes an "injury." Under the Act, any injury means

> mental or physical harm to an employee caused by accident or disease, and also means damage to or destruction of artificial members, dental appliances, teeth, hearing aids and eyeglasses, but, in the case of hearing aids or eyeglasses, only if such damage or destruction resulted from accident which also caused personal injury entitling the employee to compensation therefore either for disability or treatment. Wis Stat. §102.01 (2) (c).

As a result, there are a number of factors to examine when analyzing a claim in the Wisconsin Worker's Compensation system.

### 1. Traumatic or Single Incident Injuries

These injuries are typically the easiest to identify as they occur at a specific instance. In order for these injuries to be compensable, the Wisconsin Supreme Court has adopted a broad standard to include those instances in that the incident giving rise to the injury is a "fortuitous event, unexpected and unforeseen by the injuries person." *Kasier Lumber Company v. ILRC*, 181 Wis. 513, 513, 195 N.W. 329 (1923). As a result, worker's compensation benefits will be awarded for the injury if "the cause was accidental character or if the effect was the unexpected result of routine performance of the claimant's duties." *School District No. 1 v. DILHR*, 62 Wis. 2d 370, 375, 215 N.W.2d 373 (1974).

The causation standard was enumerated most historically in *Llewellyn v. DILHR*, 38 Wis. 2d 43 (1968), 155 NW 2d 678 (1968). In *Llewellyn*, the Supreme Court held that, if an employee was engaged in normal exertive activity and there was no definite breakage or demonstrable physical change which occurred at the time, but only a manifestation of a definitely pre-existing condition of a progressively deteriorating nature, recovery should be denied. The courts have outlined this standard in the WKC-16B form, which is completed by physicians in lieu of testimony at a hearing. Specific injuries which (1) directly cause a disability, or which (2) cause the disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression, are compensable. However, if there is a mere manifestation of a definitely pre-existing condition of a progressively deteriorating nature, the condition is not compensable under worker's compensation.

### 2. Occupational Exposure/Repetitive Minute Trauma Injuries

Injuries of this nature do not occur at one specific moment or event. Instead, occupational injuries occur over a period of time due to the work environment. This can include the loss of hearing which is defined under the Act at Wis. Stat. §102.555.

In *Shelby Mutual Insurance Company v. DILHR*, 109 Wis. 2d 655, 327 N.W.2d 178 (Wis. Ct. App. 1982), the definition of occupational exposure injuries was expanded. In *Shelby*, the employee did not have a history of back problems prior to his work with the employer. The employee worked as a laborer for a municipality and did a variety of work, which included road repair work and garbage collection. The employee then suffered a series of back injuries, which culminated in him being taken off work. While off work, he sneezed and had a new acute onset of low back pain, which resulted in surgery on his back. He tried to return to work, but the employer refused to re-hire him.

Following this refusal to re-hire, the employee applied for worker's compensation benefits, which were awarded after a hearing. The employer and insurer appealed. On appeal, they argued that the sneezing incident, while off work, was not compensable. The Court of Appeals noted that the employee did not have a low back problem prior to his employment with the employer, and he did have a series of back injuries during his employment. However, they also recognized that (an employee can . . . with repeated events . . . an employee can sustain compensable injuries) with repeated events over a period of time.

The Wisconsin Courts have also determined that employers take their employees as they find them, which is typically referred to as the "egg shell" or "as is" rule. Under this theory, an employer is liable for the worsening of a pre-existing condition due to workplace exposure/activities when it exceeds the point of "breakage," resulting in a compensable injury.

In *Sermons Department Store v. ILHR*, 50 Wis. 2d 518, 184, N.W.2d 871 (1971), the employee sought worker's compensation benefits for a left shoulder injury. This employee had suffered two prior injuries to his left shoulder. The employer and insurer denied benefits based on this fact. On appeal, the employer and insurer argued that the events leading up to the injury where "not fortuitous or unexpected." However, the Wisconsin Supreme Court noted that at hearing, there was ample evidence to support the medical evidence to "justify men of ordinary reason and fairness in making that finding" that a work injury occurred.

Repetitive/occupational injuries are compensable under worker's compensation if the work activities were the sole cause of the condition, or at least a material contributory causative factor in the condition's onset or progression. Recently, in *Payne v. Sentry Insurance,* 372 N.W.2d 834 (Wis. Ct. App. 2016) *(unpublished),* the court of appeals affirmed a Labor and Industry Review Commission's application of a *Llewelyn* evaluation to a repetitive /occupational injury claim. This has traditionally not been the appropriate evaluation for repetitive cases, and we will need to monitor the cases going forward on this issue.

### 3. Non-Traumatic Mental Stress Injuries

As noted above, mental injuries are covered under the Wisconsin Worker's Compensation Act. Wis. Stat. §102.01 (2) (c). In the traditional sense, compensability of mental injuries involving physical injuries is widely accepted under the Act. However, the Act also covers those injuries where no physical impact is present, but merely the mental injury resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions which all employees must experience. *School District No. 1. v. ILRC*, 62 Wis 2d 370, 375, 215 N.W.2d 373, 376 (1974).

In *School District No. 1*, the employee worked as a guidance counselor at a high school and became deeply distributed about recommendations from the student council that she be removed from her position. After questioning several students about this "recommendation," she developed severe neurosis tension state with gastro intestinal signs and symptoms, and also had problems sleeping and eating, and developed anxiety with nausea. While the Wisconsin Supreme Court did overturn the award of benefits, the Court noted that they did not intend to limit an employer's liability for mental injuries, but would award benefits for "mental injuries non-traumatically caused" that were the result of "a situation of greater dimensions that the day-to-day emotional strain and tension which all employees must experience." 62 Wis.2d 370, 377-378, 215 N.W.2d 373, 378. This has become known as the "unusual" or "extraordinary" stress test.

In reversing the award of benefits, the Court noted that the critical remarks directed at the employee was an occurrence experienced by other employees in their day-to-day activities. While the Court did not specifically dwell on the complete facts of the case in their opinion, they also noted that the employee in question recovered from her mental disability just in time to serve as a chaperone on a school trip to Europe.

While the courts in Wisconsin have limited some claims for non-traumatically caused mental injuries, their approval of other claims has been quite liberal. In other instances, the courts have upheld claims where the employee allegedly sustained mental injuries after observing a friend being hurt at work (*International Harvester v. LIRC*, 116 Wis.2d 298, 341 N.W.2d 721 (Wis. Ct. App. 1983)), or where the employee suffered mental injuries from continual berating from a supervisor. (*Swiss Colony, Inc. v. ILHR*, 72 Wis.2d, 240 N.W2d 721 (Wis. Ct. App. 1976)). These are most often cases that include severe trauma, and the courts have limited the ability of police officers to recover in many instances, opining that the individual is not experiencing extraordinary stress as compared to other similarly situated co-workers. In all cases, one of the courts focuses is on what is expected in the type of position held by the employee, and what is expected in that type of position. *See Bretl v. Labor and Industry Review Commission*, 204 Wis.2d 93 (1996) (non-compensable mental injury where SWAT team member can anticipate shooting of an armed suspect); *County of Washington v. Labor and Industry Review Commission,* 2012 AP1858FT (Wis. Ct. App. 2013)(compensable injury where police officer returned wallet to suspect and suspect used item in the wallet to commit suicide in officer's presence).

## II. Compensation Benefits

If an employee sustains a compensable injury, the employee is entitled to benefits under the Wisconsin Worker's Compensation Act. These benefits vary depending on the nature of the injury and the employee's ability to return to work.

### A. Average Weekly Wage and its Computation

The employee's average weekly wage serves as the basis for payment of temporary total disability, temporary partial disability, permanent total disability and permanent partial disability benefits. Wis. Stat. §102.11 outlines the method of calculating an employee's average weekly wage. In order to calculate an employee's average weekly wage, the following two different formulas must be followed in every case:

a. Multiply the employee's hourly rate of pay by the normal full time workweek established by the employer for an average week. Overtime is not included unless it is a part of the "normal full-time working day as established by the employer" (*See* Wis. Stat. §102.11(1)(a).)

b. Divide the employee's actual gross wages in the 52-week period prior to the injury by the number of weeks actually worked in that 52-week period.

Wages received for vacation pay, sick pay, and disability should not be included. Overtime is included in this calculation.

The average weekly wage to be used is the higher of these two calculations.

It is important to keep in mind that there is a rebuttable presumption that all employees (except flight attendants and firefighters) have an average weekly wage of not less than 40 hours. The presumption can be rebutted with a self-restrict statement or by demonstrating an employee is a member of a regularly scheduled class of part time employees. (*See* Wis. Stat. §102.11(1)(am) for part time class requirements. *See Appendix A*.) If an employee works a multi-week schedule (i.e., 34 hours the first week and 46 hours the second week) the hours are averaged.

If an employee is under the age of 27, there is a presumption that the employee is entitled to the maximum compensation rate for permanent disability benefits. This takes into account the potential for an employee to continue with education to obtain a higher-paying position in the future. This does not apply to temporary disability benefits.

If there is a renewed period of disability (including entitlement to indemnity benefits for a retraining program-see below) which begins more than two years after the date of injury, the employee's average weekly wage and corresponding compensation rate is escalated. Wis. Stat. §102.43(7) regulates the increases in the maximum compensation rate. In order for a period of disability to be considered renewed, the employee must have had a minimum of 10 days of employment before the second (or next) period of disability. This statute states that, if an employee was entitled to the maximum weekly benefits at the time of injury, payment for the "renewed" temporary disability benefits shall be at the maximum rate in effect at the commencement of the new period. However, if the employee was entitled to receive less than the maximum rate, the employee shall receive the same proportion of the maximum which is in effect at the time of the commencement of the "renewed" period as the employee's actual rate at the time of injury bore to the maximum rate in effect at that time. For example, if the employee's compensation rate on the date of injury was 75% of the maximum rate in effect on the date of injury, the employee is entitled to receive 75% of the maximum compensation rate in effect at the time of the "renewed" period of disability.

## B. Temporary Disability Benefits

### 1. Temporary Total Disability

Pursuant to Wis. Stat. §102.43, an employee who sustains an injury and is not able to work at all is entitled to temporary total disability (TTD) benefits. These benefits are typically payable at a rate of two-thirds of the injured worker's average weekly wage. However, these benefits are subject to statutorily-defined maximum compensation rates based upon the employee's date of injury. *See Appendix A*. There is also a minimum average weekly wage under *Wis. Stat.* §102.11(1). However, that minimum has been very low since at least January 1, 1982. Therefore, very few situations result in application of the minimum rate. The average weekly wage minimum rate is $30.00, which results in a compensation rate of $20.00 per week.

There is a three-day waiting period before the employee is entitled to receive temporary total disability benefits. If the employee is "disabled" after seven calendar days postdate of injury (temporary disability or permanent disability and including losing wages for medical appointments), then he or she is entitled to payment for the first three days of wage loss.

While there are no statutory limitations on the number of weeks these benefits can be paid to an injured worker, temporary benefits are payable only during the healing period. Additionally, the employee must have restrictions to be entitled to temporary total disability benefits.

The healing period is based upon medical evidence. Under the case law, the employee is found to have reached the end of the healing period when that employee reaches a plateau in their healing from the work injury, has become stable, or there is no substantial improvement expected in his or her condition. The term "healing period" is not defined under the Act itself.

One of the earliest cases involving the end of healing period is *Knobbe v. Industrial Commission*, 208 Wis. 185, 242 N.W. 501 (1932). In *Knobbe*, the issue of the employee's healing period was in dispute. In reviewing the evidence, the Wisconsin Supreme Court found that the healing period is:

> "The period prior to the time when the condition becomes stationary. This requires the postponement of the fixing of the permanent partial disability to the time that it becomes apparent that the leg will get no better or no worse because of the injury. The healing period is expected to be temporary; during it the employee is submitting to treatment, is convalescing, still suffering from his injury, and unable to work because of the accident. The interval may continue until the employee is restored so far as the permanent character of his injuries will permit."

**2. Temporary Partial Disability Benefits**

An injured worker who is able to return to work following an injury, but is working in a reduced capacity, may be entitled to payment of temporary partial disability benefits. Under Wis. Stat. §102.43 (2), "during the partial disability, such proportion of the weekly indemnity rate for total disability as the actual wage loss of the injured employee bears to the injured employee's average weekly wage at the time of the injury." (i.e. if the employee earns 75% of the date of injury average weekly wage at subsequent employment, the employee is entitled to 75% of the compensation rate.) *See Appendix B* for Temporary Partial Disability worksheet. Circumstances for payment of these benefits arise in situations where a worker is still recovering from their injury, has not reached the healing plateau, and is given a restriction from their medical provider, which allows them to return to work.

When paying temporary partial disability benefits, the employer and insurer are required to pay the employee the difference of the wage loss. As is the case with temporary total disability benefits, there is no limit on the number of weeks of benefits the employee may receive temporary partial disability benefits, provided the employee has not reached the end of the healing period. Temporary partial disability benefits are not payable to the employee once the employee has reached the healing plateau. Similarly, the employee must have restrictions in order to be entitled to temporary partial disability benefits.

### 3. Defenses to Temporary Total and Temporary Partial Disability Benefits

There are a number of defenses an employer and insurer have to paying ongoing temporary total or temporary partial disability benefits even if an employee has sustained an admitted injury, is assigned restrictions and remains in the healing period.

#### a. Suitable Employment

Under Wis. Stat.§102.43(9)(a), and effective April 1, 2006, temporary disability is not payable when suitable employment that is within the physical and mental limitations of the employee is furnished to the employee by the employer or some other employer. Under the statute, if the employer or some other employer makes a good faith offer of suitable employment that is within the physical and mental limitations of the employee, and if the employee, refuses without reasonable cause to accept that offer, the employee is considered to have returned to work as of the date of the offer at the earnings that the employee would have received but for the refusal.

The courts have held that the days and shifts offered to the employee, as well as the location of employment, can factor into whether a position is suitable. *See Sims v. Time Warner Cable,* Claim No. 2011-010016 (LIRC November 29, 2012).

If the job offer would have resulted in payment of temporary partial disability benefits, then those benefits must still be paid to the employee even if the employee does not accept the employment. This is the situation that gives many employers and insurer much frustration because temporary partial disability benefits need to be paid to an employee who is not actually working.

#### b. Commission of a Crime

If an employee's employment with the employer has been suspended or terminated due to the employee's alleged commission of a crime, the circumstances of which are substantially related to that employment, and the employee has been charged with the commission of that crime, temporary total disability benefits are not payable to an employee under Wis. Stat. §102.43(9)(b).

This provision also became effective on April 1, 2006. However, it is important to keep in mind that the statute specifically holds than an employee is owed the compensation in full if the employee is found not guilty of the crime.

Additionally, under Wis. Stat. §102.43(9)(d), effective May 1, 2010, temporary disability benefits are not owed to an employee when the employee has been convicted of a crime, is incarcerated and is not available to return to a restricted type of work during the healing period.

### c. Employee Termination for Misconduct or Substantial Fault

For dates of injury prior to March 2, 2016, an employee's termination for misconduct is not a defense to payment of temporary total disability benefits. *See Brakebush Brothers, Inc. v. Labor and Industry Review Commission,* 210 Wis. 2d 623 (1997).

For dates of injury on or after March 2, 2016, if an employee has been suspended or terminated due to misconduct or substantial fault, as those terms are defined in Wisconsin's Unemployment law (Wis. Ch. 108), an employee is not owed temporary disability benefits even while still within the healing period and under the effect of restrictions, under Wis. Stat. §102.43(9)(e).

There is currently an argument over whether this new statutory provision should apply to terminations on or after March 2, 2016 even with a date of injury prior to that time. The courts have not yet issued a decision on this issue, and there are no current appellate cases pending to address this. We anticipate this will take several years for an applicable situation to make it to an appellate court to provide guidance.

Wisconsin's Unemployment law recently enacted the provisions referenced by the Wisconsin Compensation Act (in 2013) and there are not many judicial decisions currently in existence to provide guidance as to how the statute will be interpreted. The statutory provisions did codify some prior case law regarding the misconduct situation. This case law stems from the infamous *Boynton Cab Co*. case. Additionally Wis. Stat. §108.04(5)(a)-(g) also outlines a number of additional situations which are considered to be misconduct. If an employee is terminated for one of these enumerated reasons, the employee is not owed temporary total disability benefits under workers' compensation, provided the date of injury is on or after March 2, 2016.

> "Wis. Stat. §108.04(5) Discharge for Misconduct….For purposes of this subsection, "misconduct" means 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. In addition, "misconduct" includes:

(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 2 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."

In addition to the misconduct statute, temporary total and partial disability benefits can also be terminated if an employee has been terminated for substantial fault. That term is also defined in Wisconsin's Unemployment Law, under Wis. Stat. §108.04(5g)(a). This statutory provision was also enacted in 2013. 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 <u>not</u> constitute "substantial fault"

"Wis. Stat. §108.04(5g)(a)

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."

*In Operton v. Labor and Industry Review Commission*, 375 Wis. 2d. 1 (Wis. 2017), the Wisconsin Supreme Court considered whether an employee had been terminated for substantial fault. This case was an issue of first impression. The court held that an employee's multiple inadvertent errors, even if the employee had been warned about the errors, did not necessarily constitute substantial fault disqualifying the employee from receiving unemployment compensation benefits. Specifically, the court held the employee's eight accidental or careless cash-handling errors over the course of 80,000 cash handling transactions during a 21 month period were inadvertent and exempted from statutory definition of substantial fault, which would disqualify the employee from receiving unemployment benefits.

The Supreme Court is currently considering the appeal on a case of first impression regarding the misconduct statute. In *Wisconsin Department of Workforce Development v. Wisconsin Labor and Industry Review Commission,* No. 2016AP1365 (Wis. Ct. App. 2017), the court of appeals affirmed the Labor and Industry Review Commission's determination that two absences in 120 days was a statutory minimum. The court held that an employee's policy that termination was appropriate for one instance of no call no show, therefore did not meet the definition of misconduct.

### d. Employee Termination for Drug Use

Effective April 1, 2006, an employee is not owed temporary disability benefits when the employee's employment with the employer has been suspended or terminated due to the employee's violation of the employer's policy concerning employee drug use during the period when the employee could return to a restricted type of work during the healing period, under Wis. Stat. §102.43(9)(c). This is only applicable if the employer's policy concerning employee drug use was established in writing and regularly enforced by the employer.

This statutory exception does not apply to situations where an employee undergoes a drug test immediately after the injury occurs, and is terminated as a result of that drug test. Instead, this only applies if the employee is required to submit to a pre return to work type of drug test, after the injury has occurred and the employee has been released to return to work with restrictions. This is a very frustrating situation for many employers with mandatory drug testing policies post injury.

Prior to March 2, 2016, under Wis. Stat.§102.58, an employee's benefits may be decreased by 15% (up to the cap of $15,000.00) if the injury was due to the employee's intoxication or illegal drug/controlled substance use. However, that is a very difficult standard to meet and technically requires judicial approval for the reduction of benefits.

In response to the frustration of many employers and insurers to only having a complete defense to payment of temporary disability benefits if an employee fails a return to work drug test versus failing a post injury drug test, effective March 2, 2016, there are additional defenses to payment of temporary total disability benefits in this situation.

For dates of injury on or after March 2, 2016, if an employee violates the employer's policy regarding drug or alcohol use and is injured, and if the violation is causal to the employee's injury, no compensation or death benefits are payable to the employee or a dependent, under Wis. Stat. §102.58. This statutory provision only relates to indemnity benefits. The employer is still liable for medical expenses and prescription medication expenses.

### e. Refusal of Medical Treatment

Temporary total disability benefits may be denied or suspended if an employee refuses to follow a treating physician's orders. However, this refusal must be unreasonable. The standard is not met just because the employee refuses reasonable medical treatment Instead, the refusal itself must be unreasonable.

## C. Permanent Disability Benefits

### 1. Permanent Partial Disability Benefits

Permanent partial disability for physical permanent injuries is governed by Wis. Stat. §102.44, and §102.52 through §102.56. An employee is only entitled to permanent disability benefits after the healing plateau has been reached and the healing period has ended. Therefore, an employee will never be entitled to both temporary disability benefits and permanent disability benefits at the same time.

An employee can be entitled to permanent partial disability benefits based on a less than 100% permanent injury. As discussed below, a physician or vocational evaluator may opine that an employee sustained a percentage of permanent injury. The Wisconsin legislature has determined that this percentage must then be multiplied by a statutorily determined number of weeks, applicable to the type of injury the employee sustained, to determine the amount of permanent benefits the employee is entitled to receive.

Permanency ratings can be stacked, such that if an employee requires a meniscectomy as a result of the work related injury, and receives payment for that procedure, and then later requires a total replacement of a joint, the employee is entitled to an additional payment of the full amount of permanency due under the joint replacement procedure, without an offset for the prior meniscectomy. This is applicable for all situations where there are minimum permanency ratings for an employee who undergoes a specific medical procedure. This has been applied to back injuries, knee injuries, hip injuries, etc. *See DaimlerChrysler v. Labor and Industry Review* Commission, 727 N.W.2d 311(2007); Madison *Gas & Elec. v. Labor and Industry Review Commission, 2011 WI App 110 (Wis. Ct. App. 2011)*; *Blasius v. Central Contractors Corp.* Claim No. 1998-036577 (LIRC February 28, 2013). There is a maximum of 100% permanent partial disability that can be awarded to an employee when the employee has sustained a scheduled injury. *Wis. Stat.* §102.44(4).

Effective March 2, 2016, under Wis. Stat. §102.175(3)(a), "if it is established by the certified report of a physician… or other competent evidence that an injured employee has incurred permanent disability, but that a percentage of that disability was caused by an accidental injury sustained in the course of employment with the employer against whom compensation is claimed and a percentage of that disability was caused by other factors, whether occurring before or after the time of the accidental injury, the employer shall be liable only for the percentage of permanent disability that was caused by the accidental injury. If, however, previous permanent disability is attributable to occupational exposure with the same employer, the employer is also liable for that previous permanent disability so established." This provision does not apply to repetitive/occupational injuries. It is only applicable to specific/accidental injuries which occur on or after March 2, 2016. This new apportionment statute permits additional discovery to take place and requires medical physicians to address apportionment in applicable cases.

## 2. Types of Permanent Partial Disability Benefits

Under the Wisconsin Worker's Compensation Act, there are "scheduled" and "unscheduled" disabilities. It is necessary to first determine whether the employee has sustained a scheduled or unscheduled injury because the employee's entitlement to permanent benefits is dependent upon the type of disability they have sustained.

In determining whether an injury is a scheduled or non-scheduled injury, the courts in Wisconsin have cautioned practitioners and administrative law judges in how these determinations are made. If an employee has sustained both a scheduled and unscheduled injury, symptoms and disability from the separate injuries cannot be combined and benefits determined under only one type of injury. In *Vande Zande v. ILHR Department*, 70 Wis. 2d 1086, 236 N.W.2d 255 (1975), the employee sustained a head injury, which resulted in a skull fracture. The injured worker also suffered from a malaise of symptoms, which included headaches, dizziness, vertigo, hearing loss in one ear, and other ongoing sensory problems. The Wisconsin Supreme Court determined that the non-scheduled head injury and the scheduled hearing loss injury should be separated and not included, together in the claim for a non-scheduled injury. The site of disability should control whether the injury is scheduled or non-scheduled. Complex regional pain syndrome, and similar types of conditions, can result in disputes over the site of the disability. The benefits available for non-scheduled injuries are significantly higher than benefits for scheduled injuries, and thus it is important to contain injuries to scheduled locations when possible. *See Leisz v. Twin Town Cheese Factory¸* Claim No. 92-006883 (LIRC August 28, 1997); *Murawski v. Contract Transport Services*, Claim No. 20000-041229 (LIRC November 26, 2003).

This article contains examples of the main types of permanency benefits. If an employee sustains multiple injuries as a result of the same incident to the same body part, or to different body parts, or injures a dominant hand, there are specific permanency rating requirements under the statute. *Wis. Stat. §102.53 and §102.54* should be reviewed in these situations to determine the potential for additional compensation that an employee might be entitled to receive.

### a. Scheduled Injuries

Scheduled disabilities involve injuries sustained to anything besides the employee's trunk. As you might imagine from the name, if an injury is scheduled, payment of permanent disability benefits are more regulated by the legislature. The schedule is found at Wis. Stat. §102.52. Under this schedule, the employee shall receive additional benefits at the rate of two-thirds of the average weekly wage, as computed pursuant to Wis. Stat. §102.11. There are minimum and maximum rates applicable to permanent disability benefits as well. These rates differ from, and are less than, the minimum and maximum rates applicable to temporary benefits.

Under the current Wisconsin worker's compensation disability schedule, the number of weeks used in for scheduled injuries in calculating the permanent benefits due is maximized includes the following:

- Loss of an arm at the shoulder: 500 weeks;
- Loss of an arm at the elbow: 450 weeks;
- Loss of a hand: 400 weeks;
- Loss of a leg at the hip joint: 500 weeks;
- Loss of a leg at the knee: 425 weeks;
- Loss of a foot at the ankle: 250 weeks;
- Loss of an eye by enucleation or evisceration: 275 weeks;
- Total impairment of one eye for industrial use: 250 weeks;
- Total deafness from accident or sudden trauma: 330 weeks;
- Total deafness in one ear from accident or sudden trauma: 55 weeks.

This list is not exclusive. There are additional scheduled injuries for loss of fingers and toes at various joints. *See* Wis. Stat. §102.52 for a complete listing.

Please keep in mind that these schedules do not require, as an example, an employee to physically lose their arm at the shoulder in order to be regulated under the appropriate scheduled injury. If an employee has an injury to his rotator cuff, the employee is considered to have sustained a loss of the arm at the shoulder. This is the same with all scheduled injuries. The schedule merely points to the physical location of the injury.

For example, if an employee sustained any type of injury to their shoulder (e.g., a rotator cuff injury), they would be rated as having sustained a scheduled injury with a loss of their arm at the shoulder. If a physician were to opine that the employee sustained a 20% permanent physical injury, the calculation of permanent partial disability benefits payable would be calculated as follows:

- 500 weeks x 20% = 100 weeks of PPD benefits

The employee would then be entitled to the applicable rate (two-thirds of the average weekly wage subject to minimum and maximum limitations) for the 85 weeks. For example, if the employee was subject to the maximum rate in 2017, the calculation to determine the amount of permanent partial disability benefits for his physical injury would be as follows:

- 100 weeks x $362.00 = $36,200

If an employee has sustained a scheduled injury, the employee or she is entitled to permanent disability benefits based only on the physical injury. The employee cannot make a claim for a loss of earning capacity. The employee or she cannot seek permanent disability benefits based on any type of vocational loss subsequent to reaching the end of the healing period. (Prior to the end of the healing period, the employee is entitled to temporary partial disability benefits if physical injuries restricted the employee from earning their date of injury wage as discussed above.)

**b. Unscheduled Injuries**

All injuries not covered under Wis. Stat. §102.52 (or hearing loss claims pursuant to Wis. Stat. §102.555) are defined under the Wisconsin Worker's Compensation Act as unscheduled injuries. These are typically injuries to an employee's trunk area of the body. All unscheduled injuries are subject to the statutory maximum of 1,000 weeks of permanent disability. The potential for permanent partial disability benefits are substantially greater for an unscheduled injury compared to a scheduled injury. The potential maximum number of weeks for a scheduled injury is, at most, less than 50% of that permitted for an unscheduled injury. Additionally, unscheduled injuries also allow for "loss of earning capacity" claims, which can increase the overall value dramatically of a worker's compensation claim.

(1) Physical Permanent Partial Disability Benefits

The formula for calculating the permanent partial disability benefits payable for a physical unscheduled injury is the same as for a scheduled injury. First, determine the permanency rating provided by a physician and the qualifying permanent partial disability rate. That percentage rating is taken against 1,000 weeks to determine the time period for which the employee is entitled for benefits. Those weeks are then taken against the permanent partial disability payment rate to determine total benefits due.

For example, assume that an employee sustained a back injury in 2017 and qualifies for the maximum rate with a rating of 20%. The injured worker would receive benefits as follows:

- 20% x 1,000 weeks = 200 weeks of PPD benefits
- 200 weeks x $362 per week = $72,400 in physical PPD benefits

(2) Vocational Permanent Partial Disability Benefits (Loss of Earning Capacity)

As noted above, an injured employee can only make a loss of earning capacity claim if the employee has sustained a non-scheduled injury. An employee is able to claim loss of earning capacity benefits if the employee sustained vocational permanent partial disability. A rehabilitation specialist opinion is necessary for an employee to pursue this claim. If a rehabilitation specialist opines that the employee is only able to earn 50% of his date of injury average weekly wage as a result of the physical injuries the employee has sustained, the employee has a claim for 50% vocational permanent partial disability benefits.

Calculating potential exposure for loss of earning capacity is similar to calculating potential benefits due for a physical permanent partial disability benefit. The percentage of vocational loss the employee has sustained is taken against the 1,000 week maximum and then multiplied by the individual's permanent partial disability rate.

The factors considered in a loss of earning capacity claim are enumerated in DWD 80.34. These include the following: age, education, training, previous work experience, previous earnings, present occupation and earnings, likelihood of future suitable occupational change, efforts to obtain suitable employment, willingness to make reasonable change in a residence, and success of and willingness to participate in reasonable physical and vocational rehabilitation program.

a. 85% Rule

Pursuant to Wis. Stat. §102.44 (6) (a)

> Where an injured employee claiming compensation for disability [under the provision for an unscheduled injury or physical permanent total disability], has returned to work for the employer for whom he or she worked at the time of the injury, the permanent disability award shall be based upon the physical limitations resulting from the injury without regard to loss of earning capacity unless the actual wage loss in comparison with earnings at the time of injury equals or exceeds 15%.

In other words, a claim for loss of earning capacity can only be made if the employee has returned to work below 85% of their pre-injury wage. As a result, an employee cannot bring a loss of earning capacity claim while working at the date of injury employer, as long as the employee continued to earn over 85% of his date of injury wage.

In order to bring a loss of earning capacity claim, if an employee stops working after he or she has returned to work at a wage above 85%, the employee must provide medical documentation that the work to which they have returned exceeds their physical limitations. A voluntary termination of employment for personal reasons after a return to work precludes such a loss of earning capacity claim. Keep in mind that the employee's termination paperwork should indicate this was an involuntary termination.

Provisions for re-opening a claim for loss of earning capacity are found under Wis. Stat. §102.44(6) (b). The Wisconsin Supreme Court has held that the statute applies in cases when the employer terminates a worker for reasons other than the limitations from the work injury. *See Mireles v. LIRC*, 237 Wis.2d 69, 84, 86 and 91 (noting that under Wis. Stat. §102.44(6)(b) an employee may revisit an award if terminated by the employer. No reason for the termination is required. The limitations that require an employee to end the work relationship under Wis. Stat. §102.44(6)(b) need not arise from an unscheduled injury).

Loss of earning capacity claims may also be brought following an injury in instances where an employee returns to work, but later is unable to continue working with an employer. However, the Wisconsin Industrial Commission has recognized an exception to reopening a loss of earning capacity award when an employer in good faith makes an offer of suitable employment at over 85% of the average weekly wage which is refused by the employee without reasonable cause (Wis. Stat. §102.44(6) (g)) or due to misconduct that justifies the commission in not exercising its discretion to "reopen" a loss of earning capacity award under Wis. Stat. §102.44(6) (b). *See Wellsandt v. Chippewa County*, WC Case No. 93050745 (LIRC, November 28, 1997). The twelve year statute of limitations applies to these situations. Therefore, there is exposure for up to twelve years after the last indemnity benefit payment is made to the employee, for the employee to seek to re-open the loss of earning capacity award.

Recently, the Commission held that an employee could be instructed to seek, in good faith, services from the Division of Vocational Rehabilitation before the employee would be awarded compensation for loss of earning capacity, especially if the employee was relatively young, had strong grades in high school and successfully completed some prior vocational training. *See Meitzen v. McLane Foodservice, Inc.*, Claim No. 2012-024273 (LIRC March 31, 2014).

Additionally, the Commission recently again addressed the issue of loss of earning capacity claims brought by undocumented employees. The Commission held that residency and employment status were factors that deserved substantial weight, especially if the employee could not demonstrate that she or he would obtain legal residency status in the United States shortly after the hearing. The Commission held that the loss of earning capacity benefit award to an employee in that situation could be substantially reduced because of his inability to legally obtain employment in the United States. *See Zaldivar v. Hallmark Drywall, Inc.,* Claim No. 2010-010154 (LIRC March 6, 2014).

#### c. Scheduled and Unscheduled Injuries

If an employee has sustained both a scheduled and unscheduled injury in the same incident, he or she can still bring a loss of earning capacity claim. However, the loss of earning capacity is determined only based upon the loss caused by the unscheduled injury. For example, if the employee sustains both a shoulder (scheduled) and back (unscheduled) injury, the employee could only bring a loss of earning capacity based on limitations due to the back injury. Therefore, if the only reason the employee has reduced earnings is due to restrictions related to the shoulder, the employee cannot prevail in a loss of earning capacity claim. However, if the vocational expert opines the employee is unable to obtain employment at the date of injury rate because of ongoing back conditions, the employee would have a loss of earning capacity claim. *See Langhus v. LIRC,* 557 N.W.2d 450 (Ct. App. 1996).

### 3. Minimum Permanent Partial Disability Benefit Ratings

Sometimes an employee must be paid a minimum amount of permanent partial disability benefits. Failure to do so at the time an employee reaches the end of healing or returns to work at full wage is bad faith.

Most of these minimum ratings are outlined in DWD 80.32 and have been in effect, without modification, for over 20 years. (There are separate rules for vision and hearing loss cases.)

Effective March 2, 2016, the Department of Workforce Development must review and revise the minimum permanent partial disability ratings at least once every eight years as necessary to reflect advances in the science of medicine. Before the ratings are revised, the Department must appoint a medical advisory committee to review and recommend such revisions.

The rules are too voluminous to list in an article such as this, however, examples of the common minimum ratings include a 10% per level rating for each spinal level fused, 50% for a total knee prosthesis, 50% for a total shoulder prosthesis, 45% for a total hip prosthesis, 5% for a meniscectomy, and 10% for an anterior cruciate ligament repair. These ratings assume there was no disability prior to the injury, and are minimum ratings. An employee may have an excellent result and

be released without restrictions and still entitled to the minimum permanency ratings. Additionally, an employee may have a poor result and be assessed with additional permanent partial disability.

## D. Permanent Total Disability Benefits

Permanent total disability benefits under the Wisconsin Worker's Compensation Act do not have a statutorily defined benefit period and are subject to the provisions of Wis. Stat. §102.44 (2). An employee can be considered permanently totally disabled as a result of a scheduled or unscheduled injury. With regard to scheduled injuries, under §102.44(2), an injured worker is permanently and totally disability if they lose the use of "both eyes, or the loss of both arms at or near the shoulder, or of both legs at or near the hip, or of one arm at the shoulder and one leg at the hip." The statute goes on to state that this is not an exclusive list of what defines some as being permanently and totally disabled. A treating physician could opine that an employee sustained 100% physical permanency as the result of an unscheduled injury as well.

Additionally, with regard to unscheduled injuries, there is a concept titled the "odd lot" doctrine. This is what most people think of when they consider an employee to be permanently totally disabled. Basically, an employee is considered permanently totally disabled for unscheduled injuries if the employee has a total (100%) loss of earning capacity. Under *Balczewski v. ILHR*, 251 N.W.2d 794 (1977), a number of different factors are considered, including the employee's age, work history and job skills, and their inability to find suitable gainful in their labor market. The *Balczewski* court adopted the definition of permanent total disability as the following: "an employee who is so injured that he can perform no services other than those which are so limited in quality, dependability or quantity that a reasonable stable market for them does not exist, may well be classified as totally disabled."

Once an employee has shown that he cannot secure continuing and gainful employment, the employer and insurer have the burden of proof to show that the employee is, in fact, employable and jobs do exist. *See Balczewski.* This will require an independent vocational evaluation to be conducted. This evaluation would examine the employee's work history and skills, the jobs available at the employer, their job search efforts, and jobs available in the employee's community. Additionally, a complete labor market survey is typically necessary to demonstrate actual jobs available and not just the potential for jobs that the employee could perform. Vocational evaluations at the request of both parties involved (the employee and the employer/insurer) are necessary to any claim and/or defense of permanent total disability.

More recently, in *Beecher v. LIRC*, 682 N.W.2d 29 (2004), the court noted that all factors of DWD 80.34 must not be met in order to prevail in a claim for permanent total disability benefits. Instead, the combination of the factors are looked at in making this determination. Additionally, *Beecher* clarified that the employer and insurers have the burden to rebut an employee's *prima facie* case by demonstrating that the claimant is employable and that jobs exist.

While odd lot for permanent total disability benefits and loss of earning capacity for permanent partial disability benefits seem similar, there are some important differences. The most important difference is the rate at which an employee is compensated for disability. With permanent partial disability benefits, there is a lower maximum rate for compensation. Therefore, for any loss of earning capacity claim up to 99%, the employee will be compensated at either 2/3 of the average weekly wage or the maximum permanent partial disability rate. However, for permanent total disability claims, the employee is compensated at the higher maximum rate for temporary disability benefits. Additionally, an employee is entitled to permanent total disability benefits for life. There is no presumption of retirement.

For example, if the employee has sustained an injury on April 1, 2017 with 90% loss of earning capacity, and he or she is entitled to the maximum compensation rate, he or she would be entitled to 900 weeks of benefits at $362. Total exposure would, therefore, be $325,800. Compare that to if the same injury had resulted in permanent total disability benefits. The employee would then be entitled to **lifetime** weekly benefits of $961. If the employee happened to be 30-years-old, he would have a life expectancy of approximately 48 years. Potential exposure in this situation would be approximately $2,400,000.

Therefore, it is extremely important to have a vocational evaluation performed to seek to obtain an opinion that the employee has at least some earning capacity and is not 100% vocationally disabled.

Recently, the Commission held that, just because an employee has significant permanent work restrictions prior to beginning to work for the employer and fails to advise the employer of such restrictions when beginning employment, that employee is not precluded from being considered *odd lot* permanently and totally disabled from the effects of a subsequent work-related injury. Wisconsin's worker's compensation system is a no-fault system. An employee's employment outside of his or her previously imposed restrictions, and subsequent injury as a result of said employment outside of such restrictions, does not constitute an intervening injury such as to bar her claim for benefits. *See Eilers v. Wal-Mart Associates, Inc.*, Claim No. 2010-029451 (LIRC February 18, 2014).

Additionally, the defenses outlined above related to non-payment of compensation benefits when an employee sustains an injury that is causally related to intoxication or drug use, for dates of injury on or after March 2, 2016, would arguably apply to claims for permanent total disability benefits.

### E. Medical Benefits

Under the Wisconsin Worker's Compensation Act, employers and insurers are liable for all "reasonable and necessary" medical care and treatment for an admitted work injury. Unlike the limits on liability for wage loss benefits, liability for medical care and treatment is not limited by the end of healing period. As a result, liability for ongoing treatment can extend long past the date of injury.

Liability for medical benefits is governed by Wis. Stat. §102.42. Under this statute an injured worker can receive various medical benefits, which include treatment that is "medical, surgical, chiropractic, psychological, podiatric, dental and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances, and training in the use of artificial members and appliances," and other options. In addition to being required to pay for medical benefits, which directly treat the effects of the work injury, liability for future medical benefits can also be extended to treatment to prevent deconditioning, further deterioration of the injury, or for maintenance of the employee's existing status. *Id.* Injured workers are also entitled to Christian Science treatment in lieu of medical treatment. Wis. Stat. §102.42 (4).

Injured workers are also entitled to his or her choice of medical providers to cure and relieve the effects of a work injury. This choice is limited to medical providers licensed to practice in the state of Wisconsin. By agreement with the employer, the employee may also receive treatment with a provider not licensed to practice medicine in Wisconsin.

Under the Act, the employer is only liable for medical expenses incurred that are "reasonable." This has been determined to only be those expenses charged for services rendered. "Necessary" medical expenses refer to the treatment required to cure and relieve the effects of the work injury. These expenses can be disputed only by medical evidence supporting the contention that the treatment is not necessary, and typically arise from an independent medical examination

However, if an employee undergoes medical treatment in good faith, even if that medical treatment is subsequently determined to be unreasonable and unnecessary, an employer and insurer can be liable for payment of those medical expense, and related disability benefits *See Spencer v. Department of Industry, Labor and Human Relations*¸200 N.W.2d 611 (1972); and *Wis. Stat.* §102.42(1m). This rationale applies only when the employee has already undertaken the medical treatment after having sustained a compensable injury, and there is no causation dispute. If there is a causation dispute, this rationale specifically does not apply. *See City of Wauwatosa, v. Labor and Industry Review Commission,* 328 N.W.2d 882 (Ct. App. 1982). Further, under *Wis. Stat.* §102.42(1m), this rationale applies to medically acceptable, invasive, treatment only. The defenses against already undertaken medical treatment therefore need to focus on whether the medical treatment was causally related to the work related injury, as well as whether the medical treatment was medically acceptable. These defenses must be based upon expert medical opinions, typically in the form of an independent medical examination.

Employer and insurers have a right to an independent medical examination under Wis. Stat. §102.13 (1) (a). Under this statute, "the employee shall, upon the written request of the employee's employer or worker's compensation insurer, submit to reasonable examinations by physicians, chiropractors, psychologists, dentists, physician assistants, advanced practice nurse prescribers, or podiatrists provided and paid for by the employer or insurer." Prior to this examination, the employer and insurer may be required to pay the employee "all necessary

expenses including transportation expenses." Additionally, the request for an examination should include the date, time, and place of the examination and the identity and area of specialization of the examining doctor. In injuries resulting in death, the employer and insurer are also allowed to have an autopsy conducted, subject to limitations under the Wisconsin Worker's Compensation Act.

### F. Vocational Rehabilitation

All employees who sustain **permanent** injuries which are, irrespective of whether they involve scheduled or unscheduled injuries, may be entitled to vocational rehabilitation benefits. The Department requires the insurer to advise the employee of the potential entitlement to receive vocational rehabilitation benefits when the end of healing is reached. *See DWD 80.49(7)(a)*. The Department has a form for this specific requirement that must be used.

Wisconsin has created an agency to address vocational rehabilitation issues. The State of Wisconsin's Division of Vocational Rehabilitation (DVR) determines whether an employee is eligible for assistance and then whether funding is available to assist the employee. There are rankings provided. If it is determined there is funding available, the employee must proceed with rehabilitation through DVR. However, if it is determined there is no funding available for the employee, he or she must proceed with private rehabilitation consultants.

The employee becomes entitled to these vocational rehabilitation benefits if suitable employment is not available by the date of injury employer. Suitable employment is typically considered anything above and beyond 90% of the employee's pre-injury average weekly wage. An employer has 60 days to determine whether suitable employment is available once the employee receives permanent restrictions.

If suitable employment is not available at the date of injury employer, the vocational benefits for which the employee is eligible include assistance in obtaining suitable employment and/or vocational retraining.

If the employee is receiving service through DVR, the agency will determine whether the employee is entitled to retraining benefits. However, even if an employee proceeds with retraining through DVR, then the cost of tuition is currently borne by the employer and insurer. This is a recent change to the prior law that allowed for DVR to bear the cost of the retraining. Additionally, the employer and insurer would be responsible for indemnity benefits for the first 80 weeks of the retraining program in addition to reimbursement for the actual and necessary travel expenses to and from their vocational retraining, meals, and lodging during retraining. The level of deference afforded to the agency's determination as to whether an employee is entitled to retraining benefits has traditionally been very high. Defending against claims where an employee was opined to be able to pursue benefits via DVR has traditionally been focused on whether there were material facts that were misrepresented or whether the agency abused its discretion. However, now that the employer and insurer bear the entire cost of the program, even when the employee has been accepted by DVR for services, there may be some additional case law on the level of deference afforded, and an increased ability to defend against these cases.

However, if the employee is receiving rehabilitation benefits through a private organization, the specialist must determine if suitable employment is reasonably likely to be available without retraining. If so, the employee must attempt to obtain suitable employment for at least 90 days. *See DWD 80.49(9)*. However, if that job search is unsuccessful, or the private rehabilitation specialist determines the employee is not likely to obtain suitable employment, there is a rebuttable presumption that the employee requires retraining. The employer and insurer would bear the burden of the entire cost of this program in addition to the above mentioned indemnity benefits. However, the employer and insurer can rebut the presumption of entitlement to retraining through an independent vocational evaluation finding that the employee did not make an appropriate and diligent job search or that retraining cannot restore the employee's pre injury earning capacity.

## G. Disfigurement

Under the Wisconsin Worker's Compensation Act, if an employee sustains an injury that is a disfiguring permanent injury, which is visible in the ordinary course of his or her employment, that individual can also receive additional compensation of up to one year's wage. In order to be entitled to these benefits, the injured worker must demonstrate that they are likely to sustain a future wage loss due to the appearance of this disfigurement if he has not returned to work for the employer. If he has returned to work for the date of injury employer, the employee must demonstrate *actual* wage loss. The standard for disfigurement recovery when the employee has returned to work for the date of injury employer was changed in the legislation effective April 2012, to require that actual wage loss be demonstrated in these cases. Consideration for disfigurement benefits is also confined to the areas of the body that are exposed in the normal course of the injured worker's employment, and the award is also limited to the location of the disfigurement.

There have been a number of cases in recent years addressing this issue. A limp now qualifies as a disfigurement in certain situations. Under *County of Dane v. Labor and Industry Review Commission,* 315 Wis.2d 293 (2009) a limp, in combination with a fast drag and an imperfect and asymmetrical looking leg, did qualify as a disfigurement.

## H. Death Benefits

These benefits are payable under three circumstances: (1) the employee dies from a work injury; (2) the employee is permanently and totally disabled from a work injury and dies from any cause, and (3) the employee has permanent disabilities, dies from an unrelated cause, and dies before all permanency benefits are paid.

A. The Employee Dies from a Work Injury.

1. When death is caused by the work injury, and the employee leaves a person wholly dependent upon him for support, the dependent is entitled to benefits equal to four times the employee's annual earnings (subject to the maximum wage caps).

a. The annual earnings are calculated by taking the weekly wage times 50. However, this amount cannot be lower than the actual earnings.

b. If an employee is under age 27, the maximum benefit is presumed

c. The benefits are paid out at 2/3 the average weekly wage (the temporary total disability rate), and are paid monthly.

d. The benefits are paid to the spouse, under the presumption the benefits will be used for the benefit of the children as well (when appropriate).

2. If an employee leaves a spouse and children dependent upon him, any children under the age of 18 when the above benefits are paid in full, is entitled to payments of 10% of the weekly indemnity benefit, until that child's 18th birthday. (The benefits continue longer for a disabled child, but not more than 15 years in total.)

3. Burial expenses are payable as well, up to a maximum

B. The employee is permanent total disability from a work injury and dies from **any** cause.

1. When the employee dies within approximately one decade after permanent total disability benefits began, the regular death benefits are payable (see above).

2. There is a limitation on the amount that can be paid. The death benefit, plus permanent total disability benefits paid during the lifetime, cannot exceed 1,000 weeks times the temporary total disability rate.

3. Burial expenses would still be payable.

4. If there are no surviving dependents, the death benefit is payable to the Supplemental Benefit Fund.

Example

The employee has an average weekly wage of $800.00. The death benefit is $160,000.00. The maximum limitation is $533,330.00.

1. If the employee was paid $100,000 in permanent total disability benefits during his lifetime, he would be entitled to the maximum death benefit amount.

2. However, if the employee was paid $400,000 in permanent total disability benefits during his lifetime, he would be entitled to only $133,330.00 in death benefits.

C. The employee has permanent disabilities, dies from an unrelated cause, and dies before all permanency benefits are paid.

1. In this situation, all un-accrued permanency benefits are payable to dependents as a death benefit.

2. The accrued and unpaid benefits for permanent partial disability are payable to the employee's estate.

3. The first $10,000.00 of un-accrued benefits is paid as a burial expense.

4. The balance is paid monthly to dependents. If there are no dependents, the un-accrued benefits are paid to the Supplemental Benefit Fund.

D. Dependents

1. Spouse
2. Child
3. Parent
4. Close relatives in some situations
5. Full benefits are payable to those who were totally dependent. If there is no such person, a reduced amount can be claimed by parents or others as "the department determines is fair and just."
    a. The following are determined automatically as the total dependent: a surviving spouse who resided with the employee, if none, a surviving child under the age of 18 (older if disabled) and who lived with the employee.
    b. If none, then divorced or separated spouses (not remarried), siblings, lineal descendants or ancestor or "other members of the family" may receive full benefits if they can prove total dependency.

6. Determination of dependency is made on the date of death

7. Please note there are specific requirements under Wis. Stat. Section 102.51 for dependents, or potential dependents, residing outside of the United States. The Department has taken the position that, despite statutory language that appears to be contrary, if an out of country child can demonstrate a familial relationship via a birth certificate to a deceased parent, the Department will not require that child to provide proof of dependency in order to be entitled to death/dependency benefits.

E. Payment to the Supplemental Benefit Fund

1. The Employer/Insurer must also pay $20,000 to the Supplemental Benefit Fund when compensability for a death caused by a work injury is conceded. When contested, the Fund may settle on a proportional amount.

2. If there are no dependents, the Employer/Insurer must pay to the Fund, the full amount of death benefit – less any payment made to un-estranged parents. Payments to the Fund are made in five equal installments, the first due as of the date of death.

3. If there are partial dependents, these dependents are paid, and the remaining balance goes to the Supplemental benefit Fund.

# APPENDIX A

# WKC-13A - WAGE INFORMATION SUPPLEMENT AND STATEMENT OF SELF-RESTRICTION TO PART-TIME

# WAGE INFORMATION SUPPLEMENT

**Department of Workforce Development**
**Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

**Read instructions on reverse carefully before completing.**

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

| Employee Name | Employee Social Security Number | Date of Injury |
|---|---|---|
| Employer Name | | |
| Name of Insurance Company or Self-Insured Employer (do not list adjusting company) | | |
| Claims Handling Address (number, city, state, zip code) | | |

**Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)**

**1. Hourly Wage** Multiply — Equals — Add — Equals

| a. Hourly rate at time of injury: | x | b. Hours per week: ( fill in "usual scheduled hours," check the box you use to set the wages) | = | c. Base weekly rate: (See reverse for computing rates for time and a half employees) | + | d. Additional weekly compensation from Section 3 below: (exclude tips) | = | e. Average weekly earnings: (hourly) |
|---|---|---|---|---|---|---|---|---|
| ☐ Standard Base $_____<br>☐ Piece Rate (if higher than the standard rate)<br>☐ Standard base rate plus tips<br>Tip Rate only: $_____<br>Base + Tip $_____ | | ☐ **Normal scheduled hours:** _____<br>Includes those hours paid at time-and-a-half: **(See Instructions)** _____<br>☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____<br>☐ Expand to: (See Section 4) 24<br>☐ Expand to Normal Full-time: _____<br>☐ Seasonal: (See instructions) 44 | | $_____ | | $_____ | | $_____ |

**2. Gross Wage** Divide — Equals — Add — Equals

| a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips) | ÷ | b. Number of weeks worked in 52-week period prior to injury: | = | c. Base Gross Wage: | d. Additional weekly compensation from Section 3 below: | = | e. Actual average weekly earnings: |
|---|---|---|---|---|---|---|---|
| $_____ | | _____ | | $_____ | $_____ | | $_____ |

**3. Additions to Cash Wage Received by Employee Per Week** ( Mark any that apply)

☐ Free meals (Number/week) _____ Weekly Amount $_____
☐ Room (Number of days/wk _____ Weekly Amount $_____
☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)
☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability

☐ Fuel Weekly Amount $_____
☐ Lights Weekly Amount $_____
☐ Other Weekly Amount $_____
**Total Weekly Value: $_____**

**4. Part-Time Employment** (Worked less than 35 hrs/wk ) Divide — Equals

| **Part of Class Determination** | 1. Normal number of hours scheduled per week: | 2. Number of other part-time employees doing same work on same schedule: | ÷ | 3. Number of full-time employees doing the same type of work: | = | 4. |
|---|---|---|---|---|---|---|
| | _____ | _____ | | _____ | | _____**%** ☐ Yes, part of class (2 divided by 3 is greater than 10%)<br>☐ No, not part of class (2 divided by 3 is less than 10%) |

**(Choose a, b or c that applies)**

**a** ☐ Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

**b** ☐ Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

**c** ☐ Employee works less than 27 hrs/wk., and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

**Important:** These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

**5. Weekly Wage and TTD Rate Computation** Multiply — Equals

| a. Weekly Wage (Greater of #1 or #2 above) | X | **b.** | = | c. Weekly TTD Rate: |
|---|---|---|---|---|
| $_____ | | ☐ 66.67% **OR**<br>☐ 100%(see 4.c) | | $_____ |

| Insurance Claim Representative | Telephone Number |
|---|---|
| | (     ) |



(See reverse side for instructions)

# Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-3264 or 261-6532, or send an e-mail to **wcwage@dwd.state.wi.us.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **http://www.dwd.state.wi.us/wc_train**

**Section 1a- Hourly Rate at Time of Injury:** Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

**Section 1b- Hours Per Week:** Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

**Section 1c- Base Weekly Rate:** Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

**Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings:** Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

**Section 2a-e Gross Wages and Average Weekly Earnings** Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

**Section 3- Additions to Cash Wages:** Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

**Section 4- Part-Time Employment:** Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

**Part of Class Determination:** Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.
**Self Restriction:** An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found in the training website at **http://www.dwd.state.wi.us/wc_train**.

**Section 5-- Wage and Rate Computation:** Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).
*Exception to using 100% in Sections 4c and 5b:* If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
*Exception Note:* If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

**Department of Workforce Development**
**Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Imaging Fax Server: (608) 260-2503
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

## STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

EMPLOYEE NAME:

EMPLOYEE S.S. #:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits. Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured ?
   ☐ Yes ☐ No

   If yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
   ☐ Yes ☐ No

   If Yes, please provide us with the name and address of your other employer below:

   Employer Name:

   Employer Address:

Signed________________________________ Phone Number: (______) _____ _______
Area Code

Dated_________________

# APPENDIX B

# WORKSHEET FOR TEMPORARY PARTIAL DISABILITY

## WORKSHEET FOR TEMPORARY PARTIAL DISABILITY

The provision of the claimant's social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

| WC Claim Number | Employee Name |
|---|---|
| Employee Social Security Number | Employer Name |
| Injury Date | Insurance Company Name (not adjusting company) |

Each period of Temporary Partial Disability (TPD) is to be entered as a line of compensation on the WKC-13-E. Use this form only to verify the TPD rate.

Figure TPD on a weekly basis, Sunday to Saturday.

**This worksheet is provided for informational use only by Insurance Companies, Self-Insurers and Third Party Administrators.**
**Data must be submitted through the Worker's Compensation Pending Reports Internet Application**

**Are the wages reported in column 4 below from the job the employee had at the time of injury?** ☐ Yes ☐ No
If Yes, compute and pay TPD using the "actual" wages in column 5 below that were used to set the TTD rate.
**If No, are the earnings from a second job that was held at the time of injury?** ☐ Yes ☐ No
*(Use "expanded wages in column 5 below if earnings were from a 2nd job held at the time of injury and expanded wages were used to set the TTD rate)
Note: If earnings were not from the same job held at the time of injury or were from another full-time or part-time job held at the time of injury and "expanded" wages were not used to set the TTD rate, pay TTD, not TPD.

| 1<br>Week Ending | 2<br>Hours Emp. Worked | 3<br>At Hourly Rate | 4<br>Wages Earned | 5<br>Weekly Wage at Time of Injury | 6<br>Wage Loss | 7<br>% of Wage Loss | 8<br>TTD Rate | 9<br>TPD Rate |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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| TOTAL | | | | | | | | |

# APPENDIX C

# MINIMUM PPD RATINGS - DWD 80.32

**DWD 80.32 Permanent disabilities.** Minimum percentages of loss of use for amputation levels, losses of motion, sensory losses and surgical procedures.

**(1)** The disabilities set forth in this section are the minimums for the described conditions. However, findings of additional disabling elements shall result in an estimate higher than the minimum. The minimum also assumes that the member, the back, etc., was previously without disability. Appropriate reduction shall be made for any preexisting disability.

**Note:** An example would be where in addition to a described loss of motion, pain and circulatory disturbance further limits the use of an arm or a leg. A meniscectomy in a knee with less than a good result would call for an estimate higher than 5% loss of use of the leg at the knee. The same principle would apply to surgical procedures on the back. The schedule of minimum disabilities contained in this section was adopted upon the advice of a worker's compensation advisory council subcommittee after a survey of doctors experienced in treating industrial injuries.

**(2)** Amputations, upper or lower extremities

| | |
|---|---|
| At functional level | Equivalent to amputation at midpoint |
| Stump unsuitable to accommodate Prosthesis | Equivalent to amputation at next most proximal joint |
| Stump not functional | Grade upward |

All ranges of joint motion or degrees of ankylosis not listed below are to be interpolated from existing percent of disability listed.

**(3)** Hip

| | |
|---|---|
| Ankylosis, optimum position, generally | |
| 15° to 30° flexion | 50% |
| Mal position | Grade upward |
| To compute disabilities for loss of motion relate % of motion lost to average range | |
| Shortening of leg (no posterior or lateral angulation) | |
| No disability for shortening less than 3/4 inch | |
| 3/4 inch | 5% |
| 1 inch | 7% |
| 1−1/2inches | 14% |
| 2 inches | 22% |
| Greater than 2 inches of shortening results in greater proportionate rating than above | |
| Prosthesis Total | Minimum of 40% |
| Partial | 35% |

**(4)** Knee

| | |
|---|---|
| Ankylosis, optimum position, 170° | 40% |
| Remaining range, 180° − 135° | 25% |
| Remaining range, 180° − 90° | 10% |
| Prosthesis Total | 50% |
| Partial | 45% |
| Removal of patella | To be based on functional impairment |
| Total or partial meniscectomy (open or closed procedure) | |
| Excellent to good result | 5% |
| Anterior cruciate ligament repair | Minimum of 10% |

**(5)** Ankle

| | |
|---|---|
| Total ankylosis, optimum position, total loss of motion | 40% |
| Ankylosis ankle joint | |
| Loss of dorsi and plantar flexion | 30% |
| Subtalar ankylosis | |
| Loss of inversion and eversion | 15% |

**(6)** Toes

| | |
|---|---|
| Ankylosis great toe at proximal joint | 50% |
| All other toes at proximal | 40% |
| Ankylosis great toe at distal joint | 15% |
| All other toes at any interphalangeal joint | If no deformity, no disability |
| Mal position | On merits |
| Loss of motion | No disability |

**(7)** Shoulder

| | |
|---|---|
| Ankylosis, optimum position, scapula free | 55% |
| In mal position | Grade upward |
| Limitation of active elevation in flexion and abduction to 45 but otherwise normal | 30% |
| Limitation of active elevation in flexion and abduction to 90 but otherwise normal | 20% |
| Limitation of active elevation in flexion and abduction to 135° but otherwise normal | 5% |
| Prosthesis | 50% |

**(8)** Elbow

| | |
|---|---|
| Ankylosis, optimum position, 45° angle | |
| With radio−ulnar motion destroyed | 60% |
| With radio−ulnar motion in tact | 45% |
| Rotational ankylosis in neutral position | 20% |
| Any mal position | Grade upward |
| Limitation of motion elbow joint, radio−ulnar motion unaffected | |
| Remaining range—180° − 135° | 35% |
| Remaining range—135° − 90° | 20% |
| Remaining range—180° − 90° | 10% |
| Rotation at elbow joint | |
| Neutral to full pronation | 10% |
| Neutral to full supination | 15% |

**(9)** Wrist

| | |
|---|---|
| Ankylosis, optimum position 30° dorsiflexion | 30% |
| Mal position | Grade upward |

| | |
|---|---|
| Total loss dorsiflexion | 12−1/2% |
| Total loss palmarflexion | 7−1/2% |
| Total loss inversion | 5% |
| Total loss eversion | 5% |

**(10)** Complete Sensory Loss

| | |
|---|---|
| Any digit | 50% Lesser involvement to be graded appropriately— 35% for palmar, 15% for dorsal surface |
| Total median sensory loss to hand | 65−75% |
| Total ulnar sensory loss to hand | 25% |
| Ulnar nerve paralysis | |
| Above elbow, sensory involvement | 50% at wrist |
| Below elbow, motor and sensory involvement | 45−50% at wrist |
| Below elbow, motor involvement only | 35−45% at wrist |
| Below elbow, sensory involvement only | 5−10% at wrist |
| Median nerve paralysis | |
| Above elbow, motor and sensory involvement | 55−65% at wrist |
| Thenar paralysis with sensory loss | 40−50% at wrist |
| Radial nerve paralysis | |
| Complete loss of extension, wrist and fingers | 45−55% at wrist |
| Paroneal nerve paralysis At level below knee | 25−30% at knee |

**(11)** Back

| | |
|---|---|
| Removal of disc material, no undue symptomatic complaints or any objective findings | 5% |
| Chymopapain injection | To be rated by doctor |
| Spinal fusion, good results | 5% minimum per level |
| Implantation of an artificial spinal disc | 7.5% per level |
| Removal of disc material and fusion | 10% per level |
| Cervical fusion, successful | 5% |
| Compression fractures of vertebrae of such degree to cause permanent disability may be rated 5% and graded upward | |

**Note:** It is the subcommittee's intention that a separate minimum 5% allowance be given for every surgical procedure (open or closed, radical or partial) that is done to relieve from the effects of a disc lesion or spinal cord pressure. Each disc treated or surgical procedure performed will qualify for a 5% rating. Due to the fact a fusion involves 2 procedures a 1) laminectomy (dissectomy) and a 2) fusion procedure, 10% permanent total disability will apply when the 2 surgical procedures are done at the same time or separately.

Examples:

| | | | |
|---|---|---|---|
| Patient A | 12/01/1990 | Laminectomy | 5% PTD |
| | 05/01/1992 | Fusion | increases to 10% PTD |
| Patient B | 12/01/1990 | Laminectomy & Fusion | 10% PTD |
| | 05/01/1992 | Re−fusion | increases to 15% PTD |
| | 12/01/1992 | Laminectomy at New Level | increases to 20% PTD |
| | 05/01/1993 | Fusion at 12/1/92 Level | increases to 25% PTD |
| | 12/01/1993 | Re−fusion at 5/1/93 Level | increases to 30% PTD |

**(12)** Fingers

(a) Complete ankylosis

| Thumb | Mid−position | Complete Extension |
|---|---|---|
| Distal joint only . . . . . . . . . | 25% | 35% |
| Proximal joint only . . . . . . | 15% | 20% |
| Distal and proximal joints . | 35% | 65% |
| Carpometacarpal joint only | 20% | 20% |
| Distal, proximal and carpometacarpal joints . . . . | 85% | 100% |
| **Fingers** | | |
| Distal joint only . . . . . . . . . | 25% | 35% |
| Middle joint only . . . . . . . . | 75% | 85% |
| Proximal joint only . . . . . . | 40% | 50% |
| Distal and middle joints . . . | 85% | 100% |
| Distal, middle and proximal joints . . . . . . . . . . . . . . . . . | 100% | 100% |

(b) Loss of Motion

| Fingers | Loss of Flexion | Loss of Use | Loss of Extension | Loss of Use |
|---|---|---|---|---|
| Distal joint only . . . | 10% − | 1% | 10% − | 2% |
| | 20% − | 2% | 20% − | 4% |
| | 40% − | 3% | 30% − | 6% |
| | 40% − | 5% | 40% − | 8% |
| | 50% − | 10% | 50% − | 15% |
| | 60% − | 15% | 60% − | 20% |
| | 70% − | 20% | 70% − | 30% |
| | 80% − | 25% | 80% − | 40% |
| | | | 100% − | 60% |
| Middle joint only . . | 10% − | 5% | 10% − | 2½% |
| | 20% − | 10% | 20% − | 5% |
| | 30% − | 15% | 30% − | 10% |
| | 40% − | 25% | 40% − | 15% |
| | 50% − | 40% | 50% − | 30% |
| | 60% − | 50% | 60% − | 50% |
| | 70% − | 60% | 70% − | 70% |
| | 80% − | 70% | 80% − | 90% |
| | | | 100% − | 100% |
| Proximal joint only | 10% − | 5% | 10% − | 2½% |
| | 20% − | 10% | 20% − | 5% |
| | 30% − | 15% | 30% − | 15% |
| | 40% − | 20% | 40% − | 20% |
| | 50% − | 25% | 50% − | 25% |
| | 60% − | 30% | 60% − | 40% |
| | 70% − | 35% | 70% − | 75% |
| | 80% − | 40% | 80% − | 85% |
| | | | 90% − | 100% |

Thumb

Distal joint same as fingers

Proximal joint 40% of the loss of use indicated for fingers

**(13)** Kidney

Loss of one kidney 5% permanent total disability.

**(14)** Loss of Smell

Total loss of sense of smell 2−1/2% permanent total disability.

**History:** Cr. Register, October, 1965, No. 118, eff. 11−1−65; r. and recr. Register, April, 1975, No. 232, eff. 5−1−75; r. and recr. (1), Register, September, 1982, No. 321, eff. 10−1−82; cr. (13) and (14), Register, September, 1986, eff. 369, eff. 10−1−86; am. (intro.), (3) to (5), (7), (9), (11) and (12) (a) and (b), Register, June, 1994, No. 462, eff. 7−1−94; reprinted to restore dropped copy in (1), Register, March, 1995, No. 471; CR 07−019: am. (11), Register October 2007 No. 622, eff. 11−1−07.

# APPENDIX D

# WISCONSIN TABLE OF RATES & BENEFITS

811 1st Street, Suite 201
Hudson, WI 54016

Phone 715 386-9000
Fax 612 339-7655

**www.ArthurChapman.com**

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

WI WC Practice Group

Susan E. Larson
Charles B. Harris
Jessica L. Ringgenberg
Jack M. McFarland

**WISCONSIN TABLE OF RATES AND BENEFITS**

| PRIVATE REHABILITATION COUNSELOR FEE FOR SERVICES | |
|---|---|
| 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 |
| 2018 | $1,664.00 |
| 2019 | $1,704.00 |

| 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.


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| 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 |
|---|---|---|---|---|---|---|---|---|---|
| **1/1/2005** | $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 |
| **1/1/2019** | $1,524.00 | $1,016.00 | $169.33 | $543.00 | $1,568.67 | $362.00 | $440.27 | $101.60 | $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 |
|---|---|---|---|---|---|---|---|---|---|
| **1/1/2005** | $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 | $298,200.00 | $4,307.33 | $994.00 | $20,000.00 | $59,640.00 | $58,340.00 |
| **1/1/2019** | $10,000.00 | $20,000.00 | $76,200.00 | $304,800.00 | 4402.66 | 1016.00 | $20,000.00 | $60,960.00 | $59,660.00 |


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# TOP TIPS AND TRICKS TO ASSIST IN HANDLING WISCONSIN WORKER'S COMPENSATION CLAIMS

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# FOREWORD

If you have questions or would like more information regarding the topics in this publication, we encourage you to contact any of the attorneys listed below. We hope you find this publication both educational and valuable in your day-to-day handling of Wisconsin claims.


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# TOP TIPS AND TRICKS TO ASSIST IN HANDLING WISCONSIN WORKER'S COMPENSATION CLAIMS

This article is intended to review some of the more unique aspects of Wisconsin Worker's Compensation Claims, and includes things to keep in mind while evaluating claims and fact situations. This article is not intended to be an in-depth review of any of these areas, but instead will introduce an overview of the topic in order to allow for these items to be on the "radar screen." For more detailed information on any of these areas, please contact one of our Wisconsin worker's compensation attorneys.

1. Prescription Drugs

Wis. Stat. Section 102.425 became effective April 1, 2006. There have not been any Labor and Industry Review Commission decisions addressing this statute. The footnote to the statute states the purpose was to create a pharmacy fee schedule that limited the charges to the average wholesale price, plus a $3.00 dispensing fee and applicable taxes. The purpose of this statute also further encouraged the use of generic drugs and prohibited billing the employee for charges over the fee scheduled amount. Wis. Stat. Section 102.425(2)(a) requires the pharmacist or other dispenser of the drug to substitute a drug product equivalent in place of the prescribed drug if:

(1) in the professional judgment of the dispensing pharmacist or practitioner, the drug product equivalent is therapeutically equivalent to the prescribed drug; AND

(2) the charge for the drug product equivalent is less than the charge for the prescribed drug.

However, there are exceptions to this general rule. There cannot be a substitute equivalent provided if:

(1) the prescribed drug is a single source patented drug for which there is no drug product equivalent; OR

(2) the prescriber determines the prescribed drug is medically necessary and indicates that no substitution may be made for that prescribed drug by writing on the face of the prescription order, or if transmitted electronically by designating in the electronic format, "no substitutions" or "dispense as written" or words of similar meaning.

Unless one of these two exceptions applies, if an employee requests that a specific brand name drug be used, the pharmacist or practitioner dispensing the prescription is required to dispense the specific brand name drug as requested. If this occurs, the employer, insurer and employee are required to share in the cost of the prescription. The employer and insurer are responsible for the amount equal to the average wholesale price of the lowest priced drug product equivalent the pharmacist has in stock on the day the brand name drug is dispensed (determined pursuant to the Drug Topics Red Book or its successor), plus a $3.00 per prescription dispensing fee and any taxes that would be payable for the drug product equivalent. The employee is liable for the amount equal to the difference between the amount the employer and insurer are responsible for and the amount of the average wholesale price of the brand name drug on the day it is dispensed,

plus any remaining applicable taxes. The pharmacy cannot collect any remaining amount from the employee unless the employer and insurer dispute or deny liability for the prescription.

If causation is accepted, but the fee amount is disputed, the employer and insurer must notify the pharmacy of the dispute within 30 days of getting the bill. The pharmacy then has six months to file a dispute within the Department. The pharmacy cannot request payment of the disputed charges from the employee. The Department has jurisdiction to determine whether the requested fee is reasonable. This is similar to the dispute process in place for reasonableness of fee disputes.

The employer and insurer are responsible for the cost of non-prescription drugs at the usual and customary charge to the general public when used to treat an injured employee. Payment for mileage also must be made for travel incurred to obtain prescription medication.

TIP: This provision can be used to reduce medical expenses related to prescription and non-prescription medication.

2. Rescue Rule

If an employee of employer B attempts to save or rescue an employee of employer A from injury or a dangerous situation, and employee of employer B sustains an injury while attempting such rescue, employee of employer B may be treated as the employee of employer A for worker's compensation benefit purposes. This is known as the *Conveyors/Cherry* doctrine. This transfer of employment relationship under *Conveyors/Cherry,* from the general employer to a "special" employer, for purposes of worker's compensation benefits, was held to occur whether or not the employees of employer A specifically requested the assistance of an employee of employer B, under *Michels Pipeline Construction, Inc. v. Labor and Industry Review Commission.*

The purpose of the rule is to promote reasonable attempts to rescue people as well as put the responsibility for worker's compensation benefits on the employer who justly should be bearing that cost. Whether or not the rescuer is engaged in job activities as an employee for a company at the time the rescue is attempted can have a significant impact on the benefits paid or payable. This can also affect whether there would be liability of a party on a worker's compensation basis or on a tort/negligence basis.

TIP: Full investigation of all aspects of a situation is very important. The courts generally look at whether the injured individual becomes aware of an emergency situation from contacts with employees or agents of the "special" employer, whether the injured employee feels obligated to assist, and whether the rescue benefited the injured employee's general employer. Additionally, the injury must occur during the rescue. An insurer of employer B in this situation would want to determine whether the alleged employee was injured as part of a rescue of another person, and if so, whether that other person was employed by another employer. In those situations, investigation should focus on whether the elements generally considered by the court provide the general employer and insurer with a basis to assert that the injured individual was an employee of a "special" employer during the injury and thus the "special" employer and its insurer are solely liable for worker's compensation benefits.

3. Horseplay

An injury must arise out of and in the course of employment in order to be compensable. An issue which often frustrates employers is whether or not an employee should be considered injured in the course of employment, or injured as a result of a non-compensable deviation, when he or she has been injured as a result of involvement in horseplay or has otherwise "been goofing around." The Wisconsin Supreme Court has held the factors significant in determining whether an act of horseplay is a deviation from employment include: (1) the extent and seriousness of the deviation (i.e. the extent of the deviation from the employment); (2) the completeness of the deviation (i.e. had the employee entirely abandoned his or her work duties); (3) the extent to which the practice of horseplay has become an accepted part of the employment; and (4) the extent to which the nature of the employment may be expected to include such horseplay. The knowing assumption of the risk, not simply the consequences, support findings of substantial deviations. Additionally, the need to completely stop work duties to engage in conduct leading to the injury is a factor supporting a complete deviation. When individuals engage in horseplay like activities (i.e. wrestling, pushing, bantering) throughout a work day, and that conduct is not disciplined, an injury resulting from the activities is not likely to be considered a deviation, and would remain potentially compensable.

TIP: Obtaining information from supervisors and co-workers is just as important as obtaining information from a main employer contact in this type of situation. Whether or not an activity is in violation of an employer's policy or handbook is not dispositive of this issue. Oftentimes there are activities that are in technical violation of a policy or handbook but are accepted within the nature of the employment, occur on a regular basis, and are not disciplined when observed by supervisors. This information should be determined ahead of a hearing, in order to allow for appropriate witnesses to be present at a hearing if in fact activity is disciplined, not commonplace, and not accepted within the employer's facility.

4. Termination and Refusal to Rehire Claims

Wisconsin Statute §102.35(3) provides: "Any employer who without reasonable cause refuses to rehire an employee who is injured in the course of employment, where suitable employment is available within the employee's physical and mental limitations, upon order of the department and in addition to other benefits, has exclusive liability to pay to the employee the wages lost during the period of such refusal, not exceeding one year's wages." This provision has been applied to situations both where an employer has refused to rehire an injured employee and where an employer has initially rehired an injured employee with intentions of terminating the employee at a later date. Under *Universal Foods Corporation v. Labor and Industry Review Commission, 467 N.W.2d 793 (Wis. Ct. App. 1991),* an employee has the burden of demonstrating that he or she (1) was an employee; (2) sustained a compensable injury; (3) applied for rehire; and (4) had the application for rehire refused due to the injury. The employee does not need to demonstrate there was a refusal to rehire (or termination) due to his or her work injury. The employee does not need to have any restrictions on his or her activities to be wrongfully refused rehire or wrongfully terminated. The employer then has the burden of demonstrating that there was reasonable cause to refuse to rehire (or terminate) an employee.

An employer can meet this burden by demonstrating it acted, without pretext, in compliance with its uniformly enforced safety practices and procedures. There must be an absence of motivation related to the fact that the employee sustained a work injury. An employer is not required to make work for the applicant.

a. For example, consider an employee that has incurred 11 of the 12 absences allowed by company policy in a 6 month period. The employee then injures his back. After one week, the applicant is returned to work without restriction. Two weeks later he takes off work to see the doctor for his back which is bothering him. The employer then terminates the employee.

b. Next, consider a hard-headed employee who sustains a finger injury. He is released by his physician one day later to return to work. He is advised to keep his hand clean. The employer makes arrangements so that the employee can do one-handed work. The employee is advised of these accommodations. However, the employee does not appear for work. He is mailed a notice of termination. The employee is also advised of his termination by a phone message. The basis of the termination is that he has exceeded the number of absences allowed by company policy. The following day, the employee again treats with his physician. He is provided a retroactive release from work for the previous day because he had pain in his hand.

c. Finally, consider a situation where the employee sustains a compensable injury. He is paid worker's compensation benefits. The employer tells the insurer that the employer has told the employee he is "done." Two years later, the employee files a claim for permanent partial disability and wrongful refusal to hire.

TIP: Employers need to be cognizant of this potential claim for penalties and the standard that must be met to meet the employer's burden of proof. All situations involving an employee who has sustained an injury, and who is then refused rehire or terminated, should be documented in as much detail as possible. The rationale for the refusal to rehire or termination should be documented in writing. Internal policies and procedures should be followed in making a determination regarding refusal to rehire or termination. This potential claim for penalties does not end when an employee returns to work immediately following a work-related injury. Case law has held this burden is not indefinite; however, there is no specific time frame during which the employee has the "safety" of this claim. The employer must balance the potential exposure of a claim for an unreasonable refusal to rehire/termination (up to one year's worth of wages) with general employment decisions.

5. Suitable Job Offers

Wis. Stat. §102.43(9)(a) provides that temporary disability, during which compensation shall be payable for loss of earnings, shall include the period during which an employee could return to a restricted type of work during the healing period, unless suitable employment that is within the physical and mental limitations of the employee is furnished to the employee by the date of injury employer or some other employer. The statute further provides that, for purposes of this paragraph, if the employer or some other employer makes a good faith offer of suitable

employment that is within the physical and mental limitations of the employee, and if the employee refuses without reasonable cause to accept that offer, the employee is considered to have returned to work as of the date of the offer at the earnings that the employee would have received but for the refusal. The paragraph further explains the employee's right to file a hearing application if there is a dispute over the extent of the employee's physical and mental limitations.

Many of the disputes and litigation regarding the job offers occur because the parties disagree about the appropriate physical restrictions (and thus whether the job offer is suitable), whether the job offer is made in good faith, and whether the employee had reasonable cause to decline a job offer. Courts have considered commute times and locations in evaluating whether there was reasonable cause to decline a job offer, and typically compare the job offer commute requirements to the date of injury commute requirements to determine whether it is reasonable for the employee to decline the offer.

Additionally, it is important to keep in mind that an employee is entitled to temporary partial disability benefits if a job offer is made that would result in earnings below the employee's average weekly wage. The earnings of the job offer are imputed for purposes of payment of temporary partial disability benefits.

When an independent medical examiner opines that certain restrictions are appropriate, an employer can consider those restrictions in determining whether a job offer can be made. This is true even when the treating physician's opinions regarding restrictions differ. If the Employee disagrees with the restrictions opined by the independent medical examiner to be appropriate, he or she can file a Hearing Application. If the employee declines a job offer that is based upon an independent medical examiner's opinions regarding restrictions, the initial issue at the hearing will be whether the restrictions imposed by the treating physician or those imposed by the independent medical examiner are appropriate. If the restrictions imposed by the treating physician are determined to be appropriate, and the job offer is not within those restrictions, the discontinuance of temporary disability benefits because of refusal of a suitable job offer will not stand. In contrast, if the restrictions imposed by the independent medical examiner are determined to be appropriate, the evaluation will next turn to whether the suitable offer was made in good faith, and if so, whether the employee had reasonable cause to refuse the offer.

TIP: When obtaining restrictions from an independent medical examiner, the employer should consider whether such restrictions can be accommodated. If so, and a job offer within the restrictions would be otherwise suitable (considering hours, shifts, commute, pay, etc.), and could be made in good faith, the value of the employee's claim for benefits may decrease if such an offer is made. This is an often overlooked potential method to reduce or eliminate exposure for ongoing wage loss benefits, and potentially stop such benefits from being paid to the employee on an ongoing basis.

6. Safety Violation

An employee can be awarded 15% increased compensation if the injury is caused by the failure of the employer to comply with any statute, rule or order of the department, under Wis. Stat. Section 102.57. The total increase may not exceed $15,000.00. Failure of an employer to reasonably enforce compliance by employees with statutes, rules or orders of the department is

failure by the employer to comply with that statute, rule or order. In contrast, if an injury is caused by the failure of an employee to use safety devices that are provided in accordance with a statute, rule or order of the department, and that are adequately maintained, and the use of which is reasonably enforced by the employer, OR if the injury results from the employee's failure to obey any reasonable rule adopted and reasonably enforced by the employer for safety of the employee and of which the employee has notice, the compensation benefits are reduced by 15%. This reduction cannot exceed $15,000.00. If an employer and employee safety violation exists in the same situation, the employer effectively pays the insurer 15% of the benefits payable to the employee.

The actual employer has primary liability for these benefits. Many of these safety violations are determined to occur when the Wisconsin safe place statute is violated, but it can occur with the violation of any rule. Wisconsin employers must provide safe employment, and not just a safe place of employment. Violation of any federal OSHA regulations can be used as a basis to demonstrate a violation of the Wisconsin safety statute. The employer is responsible for enforcing safety rules. Evidence of remedial measures taken after the injury are permitted to be introduced as evidence that the injury arose from an unsafe workplace. An employer must have actual or constructive notice of unsafe equipment, a condition or practice that caused the injury. Ordinary care and foreseeability are aspects of constructive notice. If the employer, by use of ordinary care, could have become aware of the existence of the unsafe condition and remedied the situation prior to the employee sustaining an injury, then the employer is determined to have proper notice. If a supervisor observes conditions, the employer is deemed to have notice. Further, the employer has duty to anticipate what the job premises will be used for, and to inspect the premises to make sure they are safe. This duty extends to situations where an unsafe condition occurs at another worksite, one not owned by the employer, or where an unsafe condition occurs because of employees from other employers. The direct employer has the safe place duty even for situations it did not control. Therefore, if the employer is a temporary agency, the temporary agency is responsible for payment of the benefits, and not the company where the employee was assigned to work. Similarly, a construction employer is responsible for payment of these benefits to its employees. However, a general contractor cannot be held responsible for violation of safe place statutes for employees of its subcontractors. This was recently addressed in the February 2014 Court of Appeals case of *Taylor v. Cedar Falls Bldg. Systems, Inc., et al.* We do not know whether this has been appealed to the Supreme Court.

TIP: Employers who have employees working on other job sites cannot always be aware of every situation and scenario that might occur on that job site. Individuals in supervisory capacities can impute notice to the employer. Therefore, if a supervisor or foreman on a job site observes activities or situations that are clearly in violation of safety regulations, OSHA, etc., that individual needs to correct the violation or not allow its employees to continue being exposed to the unsafe area or activity. Otherwise, the employer may be held responsible for a 15% increase of compensation, up to a maximum of $15,000.00. This may not be feasible in all situations; however, employers should be cognizant of this potential exposure when foremen and supervisors are trained and given responsibility for employees on the job site.

Additionally, an employer should regularly enforce safety rules and regulations, and appropriately maintain all provided safety equipment. Documentation of this regular enforcement and maintenance should be kept by an employer in order to have that information available for any argument that might be required in support of a 15% reduction in compensation. Additionally, if there are safety rules that are in effect, an employer should make sure all employees are on proper notice of the rules and regulations. Documentation should be kept demonstrating that notice was properly provided. Further, documentation should be kept to demonstrate that such a rule was regularly enforced. An employee often testifies (or has a co-worker testify) that while the rule existed, the employer never or rarely enforced the same, and it became common practice to violate such rule during the course of employment.

7. Primary and Secondary Liability

Wis. Stat. Section 102.62 provides that an employer has primary liability for safety violations, illegal employment of minors and unreasonable refusal to rehire/termination penalty claims. An insurer has secondary liability for penalties for safety violations and illegal employment of minors. If an employer cannot satisfy a judgment, the insurer is responsible for payment of the benefits. An insurer cannot try to guarantee primary liability or avoid secondary liability. If the employer is bankrupt or has made an assignment for the benefit of the creditors, if the employer has gone out of business or been dissolved, or if the business charter has been revoked, the insurer is liable for payment without judgment or execution against the employer, but without altering the primary liability of the employer.

If an employee claims a safety violation, the employer is responsible for payment of any increase of benefits awarded by the judge. However, the insurer would be best served by maintaining contact with the claim and being involved in any potential settlement discussions or defense strategy because the secondary liability exists. While most companies will not go out of business prior to payment of an award, it is possible and therefore something to keep in mind. A $15,000.00 penalty payment could be sufficient to push an employer over the edge into bankruptcy, dissolution, etc.

TIP: When a claim has the potential for a safety violation to be assessed, and settlement discussions take place, including a close out of these potential claims is often discussed. While a settlement is typically paid only by the insurer, depending on the situation it might be worthwhile to consider increased payment in a lump sum settlement in order to avoid any penalties from being brought at a later date. This increased payment could be issued by the employer directly under the terms of the settlement agreement, but is more likely paid by the insurer. When there is a higher likelihood that the insurer would be responsible for payment under its secondary liability obligations, including an increased amount often makes even more fiscal sense. When there is a documented violation of an OSHA regulation, it is quite difficult to defend against claims for safety violations.