Back to School at the Arthur Chapman College of Workers’ Compensation University

AGENDA

7:45 - 8:15 a.m. Registration

8:15 – 8:30 a.m. Freshman Orientation. Welcome and Introductions – “Dean” Christine Tuft

8:30 – 9:00 a.m. The ABCs of Minnesota Workers’ Compensation Law – Ray Benning

“Professor” Benning will review terms, benefits and concepts as they are currently being defined by the legislature and courts. This course will provide you with a better understanding of what constitutes an injury, a causation defense, MMI, job offers and many other ABC’s of Minnesota workers’ compensation claims.

9:00 – 10:00 a.m. MN Case Law Update – “Professor” Rick Nelson

Case Law 101: In this large lecture format, Professor Nelson will present important case law updates from the past year. He will also summarize legislative developments from the 2019 session.

10:00 – 10:15 a.m. Midterm Break

10:15 – 12:00 p.m. Breakout Session Options

Track Option #1 “Foreign Language” Breakout Session – Wisconsin Worker’s Compensation Claims

10:15 – 10:30 a.m. The ABCs of Wisconsin Worker’s Compensation Law – Chuck Harris and Jessica Ringgenberg

Join “Professors” Harris and Ringgenberg for a refresher course on some of the basic components of Wisconsin worker’s compensation claims.

10:30 – 11:00 a.m. Wisconsin: The Socialist Party, The Packers, The Sterling Hall Bombing - A Primer in Vocational Rehabilitation in a Bi- Polar State – Chuck Harris and Jessica Ringgenberg

Join “Professors” Harris and Ringgenberg as they navigate the complex and confusing foreign world of vocational rehabilitation in Wisconsin with useful case studies on how to best prepare for and defend against vocational rehabilitation claims.
11:00 – 12:00 p.m.  Wisconsin Worker’s Compensation Case Law Update – Chuck Harris, Susan Larson and Jack McFarland
In this companion course to the Minnesota update, students will be provided with an overview of Wisconsin case law impacting worker’s compensation claims, along with recommendations for utilizing this information in handling claims. In addition, the “professors” will review Wisconsin legislative changes that are significant to worker’s compensation matters.

Track Option #2  Minnesota

10:15 – 11:00 a.m.  The Impact of the Aging Work Force on Workers’ Compensation Claims – Noelle Schubert
“Professor” Schubert will review how the changing demographics in the work force impact workers’ compensation claims. This course will include a discussion regarding workers’ compensation retirement provisions, utilizing proper job descriptions and ergonomic assessments, factors to consider when analyzing whether a condition is related to work activities versus the natural consequence of an underlying or pre-existing condition.

11:00 – 12:00 p.m.  The Tools in the Rules – Christine Tuft
In this “Dr. Seuss”-inspired course, “Professor” Tuft will look deep in the “Grikle-grass” and provide students with the core proficiencies needed to utilize the Treatment Parameters and make sure that YOU are running the zoo.

12:00 – 1:00 p.m.  HOLIDAY BREAK (Lunch)

1:00 – 3:15 p.m.  Masters Classes

1:00 – 2:00 p.m.  Neuro-Ophthalmology Investigative and Scientific Evaluations – Dr. Alan S. Weingarden
Dr. Weingarden will discuss the impact of TBI/Concussions on vision and what tests are performed in order to differentiate legitimate from fabricated claims. He will also discuss recent testing methods.

2:00 – 2:15 p.m.  Spring Break

2:15 – 3:15 p.m.  Mastering Complex Medical Issues – Jim Pikala, Sue Conley and Emmy LaCourse
This upper level session will feature “Professors” Pikala, Conley and LaCourse who 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.

3:15 – 3:30 p.m.  Questions and Answers

3:30 – 6:00 p.m.  Graduation Party
Ray’s Team
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Elisa L. Blume, Legal Administrative Assistant
612 375-5984   elblume@ArthurChapman.com
Alan S. Weingarden, M.D.
Curriculum Vitae

PRACTICE: St. Paul Eye Clinic, P.A.
Woodbury, Minnesota 1986–Present

EDUCATION: University of Minnesota Medical School
Minneapolis, Minnesota 1975–1979

Macalester College
Saint Paul, Minnesota 1971–1975

POST GRADUATE TRAINING

Fellow, Orbital Diseases

Fellow, Neuro-ophthalmology
University of Minnesota- Minneapolis, Minnesota July 1984-July 1985

Resident,
Tufts University Department of Ophthalmology-Boston, MA 1981-1984

Resident,
Boston University Department of Neurology-Boston, MA 1980-1981

Intern,
Abbott-Northwestern Hospital Department of Medicine-Minneapolis, MN 1979-1980

AWARDS/HONORS

Summa cum laude, Macalester College, 1975
Phi Beta Kappa, Macalester College, 1975
State Finalist Rhodes Scholarship, 1974
American Cyanamid Company, Scholarship for Medical Ed., 1975
COMMITTEES

Student Member, Medical School Admissions Committee
University of Minnesota 1978-1979

Student Member, Ophthalmology, Course Committee
University of Minnesota 1977-1979

PROFESSIONAL SOCIETIES

American Academy of Ophthalmology
Twin Cities Medical Society
Minnesota Medical Association
Minnesota Academy of Ophthalmology
North American Neuro-Ophthalmology Society

FACULTY POSITIONS

Assistant Clinical Professor, Department of Ophthalmology
University of Minnesota

LICENSES

Minnesota Medical License
Diplomat, National Board of Medical Examiners July 1, 1977
Board Certified Ophthalmology June 7, 1986

SPECIAL AREAS OF INTEREST

Neuro-ophthalmology, Oculoplastic Surgery and Orbital Diseases
Medical Legal, Expert Witness 1990-present
Ophthalmic Consultant, BlueCrossBlueShield
2019 WORKERS’ COMPENSATION SEMINAR

JUNE 20, 2019

Arthur Chapman
Kettering, Smetak & Pikala, P.A.

THE ABCS OF MINNESOTA WORKERS’ COMPENSATION LAW

RAYMOND J. BENNING

Arthur Chapman
Kettering, Smetak & Pikala, P.A.

REFRESHER COURSE

Arthur, Chapman, Kettering, Smetak & Pikala, P.A.
**Prior to 1953 Injury**

- Before 1953, compensable personal injuries had to be "caused by accident." Minn. Stat. §176.021 (1949).
- Unusual strain or traumatic force produced a sudden or violent rupture or collapse of some physical structure or bodily function.
- Since then the "caused by accident" requirement has been removed and employees will be compensated for personal injuries.

**Minn. Stat. §176.011 Subd. 16**

- **Personal injury** means any mental impairment as defined in subdivision 15, paragraph (d), or physical injury arising out of and in the course of employment and includes personal injury caused by occupational disease.
- Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable.

**Minn. Stat. §176.011 Subd. 16**

- Mental impairment is not considered a personal injury 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.
- Personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of personal reasons, and not directed against the employee as an employee, or because of the employment.
Minn. Stat. §176.011 Subd. 16

An injury or disease resulting from a vaccine in response to a declaration by the Secretary of the United States Department of Health and Human Services under the Public Health Service Act to address an actual or potential health risk related to the employee’s employment is an injury or disease arising out of and in the course of employment.

Minn. Stat. §176.011 Subd. 15

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

Causation

In Minnesota the work injury does not need to be the sole cause of a disabling condition. The law only requires that the work injury be a substantial contributing cause or factor to the employee’s condition. *Swanson v. Medtronic*, 443 N.W.2d 534 (1989).
Neither statute nor case law precisely defines what constitutes a substantial or significant contributing factor in a workers compensation setting. Because each case must to a great extent stand on its own facts, no one comprehensive definition can be fashioned. See *Flowers v. Consolidated Container Corp.*, 336 N.W.2d 255, 36 W.C.D. 39 (Minn. 1983).

It is because of the many factual variables peculiar to each case that the issue of whether a work injury is a substantial contributing factor in a claimed disability is a factual question for the compensation judge. The term essentially defies precise definition. *Hamm v. Marvin Windows and Doors*, 64 W.C.D. 270 (WCCA 2004)

An injury which is a substantial contributing cause of an employee’s disability is by definition a “legal cause” of that disability. *Salmon v. Wheelabrator Frye*, 409 N.W.2d 495, 498, 40 W.C.D. 117, 122 (Minn. 1989).
AGGRAVATIONS

When determining whether an “injury” or aggravation of a pre-existing condition is temporary or permanent the following factors will be analyzed: (1) the nature and severity of the pre-existing condition and the extent of medical restrictions and disability resulting therefrom; (2) the nature of the symptoms and extent of medical treatment prior to the aggravating event; (3) the nature and severity of the aggravating incident and the extent of restrictions and disability resulting therefrom; (4) the nature of the symptoms and extent of medical treatment following the aggravating incident; (5) the nature and extent of the employee’s work duties and non-work activities during the relevant period; and (6) medical opinions on the issues. McClellan v. Up North Plastics, slip op. (WCCA 10/18/94). Assessment of which of the factors are significant and the weight to be given to any factor is generally left to the compensation judge. Wold v. Olinger Trucking, Inc., slip op. (WCCA 8/29/1994).

INTERVENING/SUPERSEDING

• Whether that intervening injury or condition has broken the causal connection between the employee’s work injury and that disability. See Hughes v. Karps Twin City Supply, slip op. W.C.C.A. Nov. 27, 1996.
• Ultimately, in cases involving superseding, intervening injuries, including Eide, Johnson, and Nelson, the question for the compensation judge is whether there was an “independent intervening cause not attributable to the employee’s customary activity in light of the employee’s condition.” Eide v. Whirlpool Seeger Corp., 266 Minn. 98, 109 N.W.2d 47, 21 W.C.D. 437 (1963) and Nelson v. American Lutheran Church, 420 N.W.2d 588, 40 W.C.D. 849 (Minn. 1988).

CONSEQUENTIAL INJURIES

• Where a compensable injury weakens the employee, who sustains a subsequent injury because of the weakened condition.
• Aggravation of the primary injury by medical treatment (including medical malpractice) is compensable.
**Disability**

- The term disability is referenced in several statutory provisions and forms related to reporting of injury (FROI), commencing payment of benefits for an injury (NOPLD), types of benefits (TTD, TPD, PPD, PTD) and descriptions of acceptable injuries (Occupational Disease).
- State of being disabled from earning full wages at the work at which the employee was last employed. 
  
  *Notch v. Victory Granite Co.*, 238 N.W. 2d 426 (Minn. 1976).
- Date of disablement

**Gillette Injuries**

- The Supreme Court has established factors or ascertainable events for proving when a Gillette injury occurs.
- Ascerturable events cited in the Schnurrer case were:
  - Changing the employee’s work duties because of his physical condition
  - An opinion of the employee's treating physician that he required a total knee replacement
  - A recognition of the employee prior to his last day of work that he could not continue work because of the pain associated with even the lighter work that had been assigned to him
  - His informing the employer three months prior to his last day of work that he had to quit.

**Job Offer**

For injuries from 1984 to 10/1/1995 five major factors come into play when considering the suitability of a job under Minn. Stat. § 176.101, subd. 3e.

1. The timing of the job offer;
2. The physical suitability of the job;
3. The economic suitability of the job;
4. Whether the job offer is in writing; and
5. Whether the job offer was genuine and in good faith.
### JOB OFFER

- For injuries after October 1, 1995, this provision applies.
- Cessation: Temporary total disability compensation shall cease if the employee refuses an offer of work that is consistent with the plan of rehabilitation filed with the commissioner which meets the requirements of Minn. Stat. §176.102, Subd. 4 or, if no plan has been filed, the employee refuses an offer of gainful employment that the employee can do in the employee’s physical condition.

### MMI

- Temporary total disability compensation shall cease 90 days after the employee has reached maximum medical improvement (MMI).
- No significant lasting improvement in the employee’s condition, and significant recovery or lasting improvement is unlikely.

- All diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the employee’s condition have been exhausted, or declined by the employee.
- Any further treatment is primarily for the purpose of maintaining the employee’s current condition or is considered palliative in nature.
MMI

- Any further treatment is primarily for the purpose of temporarily or intermittently relieving symptoms.
- Service and filing on employee and attorney.

REASONABLE AND NECESSARY MEDICAL BENEFITS

- Case by case analysis
- Minn. Stat. §176.135
- Treatment parameters

TREATING HEALTH CARE PROVIDER

If the employee receives medical care after the injury from a provider on two occasions, the provider is considered the primary health care provider if that individual directs and coordinates the course of medical care provided to the employee.
**MINIMAL ASCERTAINABLE PERMANENCY**

MN Stat. §176.021 Subd. 3

- If doubt exists as to the eventual permanent partial disability, payment shall be then made when due for the minimum permanent partial disability ascertainable, and further payment shall be made upon any later ascertainment of greater permanent partial disability.
Minnesota Workers’ Compensation Law Update

Richard C. Nelson

Arthur Chapman
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Questions?

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70 Is the New 50: Aging in the Workforce

Noelle L. Schubert

Arthur Chapman
Kettering, Smetak & Pikala, P.A.
Statistics

- The number of Americans ages 65 and older rose by nearly 35 percent between 2011 and 2016.
- Age group of 65 and older is projected to be the fastest-growing segment in the workforce through 2024.

— SeniorLiving.org (2017)
Statistics

• Among 65 to 74 year-olds, labor force participation predicted to hit 32 percent by 2022, up from 20 percent in 2002.

• At age 75 and up, the rate will jump from 5 percent in 2002 to 11 percent in 2022.

Bureau of Labor Statistics

Statistics

• By 2020, 31 million jobs will become available as Boomers retire, and another 24 million new jobs will be created
• Population of younger workers with education and skills to replace Boomers isn’t large enough or growing fast enough to make up for these departures
• Shortfall of 5 million qualified workers

- Georgetown University report

Factors

• Increased life expectancy
• Rise in education levels
• Fewer children
• Shrinking retirement plans/benefits
• Less physically demanding work
• Psychological benefits/brain health
TRENDS

• Part time
• Retirement
• Medical Issues
  – aggravation of pre-existing conditions
  – slip and falls
• Witness credibility
• Medicare
• Caregivers – expanded leave laws

FACTORS FOR DETERMINING RETIREMENT

• Employee’s intent to retire or continue working
• Application for Social Security retirement benefits
• Evidence of financial need for employment income, adequacy of pension or retirement income
• Who initiates employment discussion
• Whether employee sought rehabilitation assistance
• Whether employee actively sought alternative employment or was working

Dillermuth v. Owatonna Tool Co.

CASE STUDY #1 – MEDICAL ISSUE

• 74 year-old man
• Meat cutter entire career, since 1961
• Chronic bilateral rotator cuff partial tear in 2016, but didn’t report as work-related
• Treated conservatively and continued to work
**Case Study #1 — Medical Issue**

- Advised it would take 6 months to heal following surgery due to age
- August 6, 2017 right shoulder injury from lifting a tub of meat trimmings into a grinder
- Treated with PT, but then required surgery

**Case Study #1 — Medical Issue**

- Returned to work after 3 months
- IME with Dr. Wojcieszki
- Condition was manifestation of personal health condition, degenerative. Pathology noted on radiographs and MRI that pre-dated injury.
- 0% PPD and no restrictions or treatment

**Case Study #1 — Medicare**

- Settled full, final and complete, medical closed, with release and resignation
- Medicare Set Aside zero allocation
- Opted not to get approval of Medicare since allocation was reliable
- Employee agreed to pay for any medical expenses if Medicare declines
CASE STUDY #1 – MEDICARE

“In the event that Medicare declines in the future to pay for medical treatment submitted by the Employee, the Employee agrees that he will pay for such medical expenses pursuant to the medical close-out provisions of this Stipulation for Settlement.”

CASE STUDY #2 – MEDICAL ISSUES

- 67 year old woman
- Dishwasher for school district since 2006
- Prior to that, self employed in the wall papering business for 20+ years
- Alleged left shoulder injury in 2017 from pushing and pulling worn out dishwasher racks
- Symptoms started in 2015, but didn’t report
- No prior left shoulder treatment
- Prior surgeries due to arthritic conditions in knees, hips, back and right shoulder
- IME with Dr. Cederberg: Diagnosed idiopathic, age-related, degenerative arthrosis of the left glenohumeral joint, and did not attribute the condition to any work injury.
Case Study #2 — Medicare

- Had not yet applied for social security
- Medicare made conditional payments
- Settled full, final and complete, with release and resignation
- MSA allocation came back high, closed out future treatment not covered by Medicare
- No MSA, reserved all rights and defenses to future medical claims

Case Study #3 — Part-Time

- Wilton Grieger retired at age 69
- Found a job as a part-time stock person for Menards, worked 20 hours per week
- Still working there at age 81
- Slipped and fell at work, suffered fatal head injury

Surviving spouse argued that the judge erred in adopting vocational expert’s opinion that the number of hours typically worked per week in the industry in which the injury was sustained is 24.

The surviving spouse relied on the industry standard of 33 hours each week based on federal labor statistics for the industry during the month and year when the employee died.
Case Study #3

- Court affirmed compensation judge's ruling
- Vocational expert's opinion was credible, relied on broader segment of the industry, including a wider variety of retail settings.

Case Study #4 — Pension

- Employee was a volunteer firefighter and EMT for a suburb
- Alleged August 1, 2004 thyroid cancer injury and September 20, 2008 injury for the low testosterone due to occupational exposure
- Employer and insurer denied primary liability
- Resigned October 1, 2010
- Claim settled in 2015 for $88,000, full, final and complete

Case Study #4 — Pension

- Stipulation did not mention the employee's anticipated benefits from the Fire Relief Association
- 2016, the Employee applied for disability retirement benefits
- Claimed he was paid only 60% of what he was owed
**Case Study #4 — Pension**

- The City settled a dispute over pensions, with other firefighters, but the employee was not included because he was not employed at the time
- Employee sought to vacate the Stip
- Mistake of fact

- Employee would not have agreed to the settlement of his claim had he known that this pension payout was to be reduced
- WCCA: No mutual mistake of fact
- Recognized that economic detriment to employee, but workers’ comp system does not have jurisdiction over pension benefits

**Case Study #5 — Permanent Total**

- Dept of Labor audited PTD payments
- Underpayment of PTD benefits due to insurer taking an offset from employee’s receipt of public employee retirement benefits
- Insurer disagreed with the amount and hired a forensic accountant to perform an analysis
Case Study #5 — Permanent Total

- Forensic accountant determined that the amount was $10,000 less
- The insurer agreed to pay the underpayment upon receipt of estate information
- The petitioner did not respond to the requests for estate information

Case Study #5 — Permanent Total

- No inexcusable of vexatious delay
- Hired forensic accountant and requested estate information
- Insurer acted in good faith

Case Study #5 — Costs

- Decree of descent needed by heirs
- Claimed as expense
- Court denied because the dispute was over the amount, not to whom it was owed
- The expense was not necessary and not taxable under the Work Comp Act
THANK YOU!

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THE TOOLS IN THE RULES

Christine L. Tuft
The First Book

Objectives

Purpose of the Treatment Parameters - Minn. R. 5221.0620
Definitions – Minn. R. 5221.6040

General Treatment Parameters
Minn. R. 5221.6050

Excessive Treatment and Departures
Minn. R. 5221.6050, subp. 7 and subp. 8
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TREATMENT PARAMETERS FOR LOW BACK, NECK AND THORACIC SPINE – MINN. R. 5221.6200, SUBP. 2, MINN. R. 5221.6205, SUBP. 2, MINN. R. 5221.6210, SUBP. 2

Upper Extremity Disorders
Minn. R. 5221.6300

Reflex Sympathetic Dystrophy
Minn. R. 5221.6305
### Surgical Procedures

**Minn. R. 5221.6500**

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### Chronic Management

**Minn. R. 5221.6600**

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### Conclusion

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Questions?

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Neuro-Ophthalmology
Investigative and Scientific Evaluations

Dr. Alan S. Weingarden

Neuro-ophthalmology
Investigative and Scientific Evaluations

Alan S. Weingarden, MD
N.O.I.S.E.

Traumatic Brain Injuries
Most Common Efferent Dysfunction
1) 3rd Nerve Palsy
2) 4th Nerve Palsy
3) 6th Nerve Palsy
4) Convergence Insufficiency
Post Traumatic Vision Syndrome

Visual Midline Shift Syndrome
Concussion

Visual imbalances between focal and ambient visual processes.

Optometrists use visual evoked potential to diagnose post traumatic vision syndrome.
Imbalance produces a shifting of weight bearing.

Can be observed by wear pattern on soles of shoes

Treatment of visual midline shift
1) Yoked prism
2) Binasal occlusion
Facts About Mild Traumatic Brain Injury

1) Convergence insufficiency is the most common eye injury in blast injuries
2) Unknown if isolated mild TBI can produce permanent injury
3) King Devick test; useful sideline test, requires pre-injury test
4) VEP is not a measure of mild TBI
5) Functional MRI normal 30 days post-concussion

Jama - Ophthalmology 2016

D-1 Football players
More C.I. with
More head trauma
3 weeks rest
Convergence normalized

Jama - Ophthalmology 2019

High school Football players
convergence can be perturbed over the long term,
may start to normalize midseason
Journal Neuro - Ophthalmology 2019

A) Rapid automatized naming tasks- King Devick, requires preseason base line
B) 47-64% C.I. in MTBI
C) Infrared limbal based VOG-eye box approved
D) Positive blood tests for concussion

Updates on Complex Medical Issues in Minnesota Workers’ Compensation

James S. Pikala, Susan K. H. Conley and Emily A. LaCourse

Medical Marijuana Update
Where Marijuana is Legal in the US

Minnesota

On May 29, 2014, Minnesota became the 22nd state to legalize medical marijuana

Medical Cannabis

MINN. STAT. § 152.22, SUBD. 6

“Medical cannabis’ means 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;
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.

MINN. STAT. § 152.22, SUBD. 14
QUALIFYING MEDICAL CONDITIONS

11) Intractable Pain – effective date July 1, 2016
   - Health care practitioners could start certifying intractable pain patients, August 1, 2016.
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

ADDITIONAL QUALIFYING CONDITIONS

11) Intractable Pain – effective date July 1, 2016
   - Health care practitioners could start certifying intractable pain patients, August 1, 2016.
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 typical form is: pill, oil or vaporization (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

Arthur Chapman
Kettering, Smetak & Pikala, P.A.
Attorneys at 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 use, a high potential for abuse and not safe even under direction of medical provider. 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), 2011 and 2013 ("COLE" memos) under President Obama and Attorney General Eric Holder – those complying with state laws are not an enforceable priority. Not law but a guide.

ARGUMENTS

Preemption

STATE COURTS FAVORING PREEMPTION

Courts across the country have concluded that federal law preempts workers' compensation courts from compelling reimbursement for medical marijuana (Maine, Florida and Vermont).
Maaine Bourgain v. Twin Rivers
Paper 187 A.3d10 (ME 2018)

- Declined to authorize medical marijuana in Workers’ Compensation case.


To order an Employer or Insurer to pay for marijuana would violate the CSA.

Michael Hall v. Safelite Group, Inc.
Opinion No. 06-18 WC Vermont Order dated 3/28/18

An order requiring an Employer or Insurer to pay for medical marijuana would require the Employer or carrier to commit a federal crime.
Courts Against Preemption


United States v. Schostag, 895 F. 3d 1025, 1028 (8th Cir. 2018)


The Colorado constitution “require[d] law enforcement officers to return medical marijuana seized from an individual later acquitted of a state drug charge.” this created a “positive conflict” with the CSA and therefore preemption as CSA prohibits distribution and law required law enforcement to distribute.
No Statutory Requirement for Insurers to Reimburse

**No Statutory Requirement to Reimburse**

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.

Reasonableness and Necessity
Reasonableness and Necessity

- Deny that medical marijuana is not reasonable as it’s illegal under the Controlled Substance Act, 21 U.S.C.
- Deny on basis FDA has not approved, medical marijuana except Marinol, Cesamet and CBD Oil.
- Deny reimbursement not required under § 176.135, M.S. 152.22-152.37 or Treatment Parameters.

Take Away – What Do I Do?

- Deny no guidelines under the Treatment Parameters.
- Deny that there are no studies on efficacy or safety of use, or whether addictive, dose, frequency or duration.
- No guidelines or treatment plan for:
  - There are no billing guidelines or cost controls;
  - There are no drug testing guidelines;
  - There are no guidelines where Employee has chemical dependency issues;
  - There is little to no over-sight – Employee’s can self-medicate;
  - There is no over-sight by a medical doctor.

Take Away – What Do I Do?

- Deny that payment must be in cash.
- Look at 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.
# MINNESOTA ANECDOTES

- Judge Tate decision, 1-8-2018, Employee had a right elbow injury and all treatment modalities failed. She suffers from intractable pain and the Judge found that medical marijuana was reasonable and necessary.
- Judge Hartman decision, dated April 2018, Employee had intractable low back pain. Judge Hartman in his decision cited treatment parameters specifying use of medical cannabis is legal and Employee no longer requires opioids. Minn. Rule 5221.6040 subd. 7a.
- Judge Marshall tried a Travelers case week of May 6, 2019 - defenses reasonableness and necessity, preserved 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. Reasonableness and necessity.

# INVESTIGATION

- Medical records
- Chemical dependency records
- Substance abuse treatment
- Leaf line / Medical Solutions records
- Invoices / receipts
- 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.

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.

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

OPIOIDS – ANALYTE

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

**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.

**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.
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 included slowed and slurred speech, slow gait, constricted pupils, droopy eyelids, impaired night vision, vomiting, constipation.

Morphine / Codeine – can also produce drowsiness, cause constipation, and, depending upon the amount taken, depress 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.

**CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN – UNITED STATES, 2016**

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Conversion factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>4</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Hydrocodone (2.0–3.0 mg/day)</td>
<td>6</td>
</tr>
<tr>
<td>Hydrocodone (3.0–4.0 mg/day)</td>
<td>6</td>
</tr>
<tr>
<td>Morphine (10–20 mg/day)</td>
<td>10</td>
</tr>
<tr>
<td>Morphine (20–40 mg/day)</td>
<td>12</td>
</tr>
<tr>
<td>Morphine (≥40 mg/day)</td>
<td>12</td>
</tr>
<tr>
<td>Oxycodone (1.0–2.0 mg/day)</td>
<td>3</td>
</tr>
<tr>
<td>Oxycodone (≥2.0 mg/day)</td>
<td>3</td>
</tr>
<tr>
<td>Hydromorphone (1.0–2.0 mg/day)</td>
<td>4</td>
</tr>
<tr>
<td>Hydromorphone (≥2.0 mg/day)</td>
<td>4</td>
</tr>
</tbody>
</table>

Different medications / Different strengths - How do they compare?

120 Morphine Equivalent Dose (MED)

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Conversion factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone</td>
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</tr>
<tr>
<td>Percocet</td>
<td>1</td>
</tr>
<tr>
<td>Percodan</td>
<td>1</td>
</tr>
<tr>
<td>Vicodin</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1</td>
</tr>
</tbody>
</table>

Arthur, Chapman, Kettering, Smetak & Pikala, P.A.
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 than 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.

• 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.

Timeline of the Opioid Crisis

Drug Scheduling Guide

United States

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Schedule Name</th>
<th>Substance</th>
<th>Schedule Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Schedule I</td>
<td>Heroin</td>
<td>Schedule II</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morphine</td>
<td>Schedule III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fentanyl</td>
<td>Schedule IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oxycodone</td>
<td>Schedule V</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Methadone</td>
<td>Schedule VI</td>
</tr>
</tbody>
</table>

Timeline of the Opioid Crisis
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
**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 Trump 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.

- 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.

- 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.

- 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.

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 ≥90mg per day.
6. For acute pain, use lowest effective dose of immediate-release opioids – three days or fewer.

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.
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.
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

- Burns v. Mid Continent Engineering, Inc., File No. WC08-111 (WCCA April 29, 2008)
  - Terms of narcotic contract enforced

  - 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

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 specific durational limits
**TREATMENT PARAMETERS AND THEIR EFFECTIVENESS (CONTINUED)**

Case Law
  - Rule requires “improvement” in only first six months
  - After first six months, employee need only “maintain”

**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

**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
REFERENCES

- Opioid Overdose Crisis, National Institute on Drug 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
- 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.

MANAGING TRAUMATIC BRAIN INJURY CLAIMS
**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/Brusing 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

### 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).

### Diffuse Axonal Injury (DAI)

[Diagram of brain showing white and gray matter]
Penetrating Head Wound

An object forcefully enters skull and penetrates the brain.

Penetrating Head Wound

Coup/Contrecoup

• Coup - Skull hits first.
• Contrecoup - There is movement away from the opposite.
**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](image)

**Cerebral Contusion**

Bruise of the brain

![Cerebral contusion](image)

**Mass Effect/Midline Shift**

![Figure 4: Mass effect and midline shift](image)
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)**

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)**

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 axonal 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 guanine, a building block for DNA and RNA. Speeding the breakdown of guanine protects neurons 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, Glasgow 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

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**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?

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**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?

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.

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.
**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.

**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

**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.
ACKNOWLEDGEMENTS

- U.S. Department of Veteran’s Affairs study yields potential biomarker for PTSD – Resistant Brains, March 2013.
- 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.
- Politzer, Thomas, O.D., Introduction to Vision & Brain Injury.
- Goodrich, Gregory, M.D., Vision Issues After Brain Injury: Brain Line Talks with Dr. Gregory.
- McDonald, W.S. Ph.D., Brain Injury Research Center, Department of Neurosurgery and Brain Research Center, UCLA, Los Angeles, CA.

PSYCHOLOGICAL CLAIMS

- Mental/Physical Cases
  - Where work-related mental stress or stimulus causes identifiable physical ailments
  - 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
  - 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
- 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)

#### 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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Thank you for attending!
THE ABCs OF MINNESOTA WORKERS’ COMPENSATION LAW

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THE ABCS OF MINNESOTA WORKERS’ COMPENSATION LAW

Introduction

This presentation will provide you with a refresher course on some of the basic components of Minnesota workers’ compensation claims. Terms, benefits and concepts you thought you knew. Many of the terms have been interpreted and defined by the legislature and courts.

It is important to continue your knowledge and understanding of the overt and subtle meaning for even the most basic of terms. The take away is the greater your understanding of the these terms and concepts the stronger your management of the claim.

Injury
Causation/Substantial contributing factor
Intervening/Superseding
Consequential Injuries
Disability
Earning capacity
Job Offer
MMI
Reasonable and Necessary Medical Benefits
Treating Health Care Provider
Case Management Services
Minimal Ascertainable Permanency

RESOURCES: Minnesota Statute Chapter 176
Minnesota Rules Chapter 5220, 5221
Injury

Benefits are payable for compensable injuries, whether specific or *Gillette* injuries, and for occupational diseases. Injuries which occur as a consequence of the work injury are covered.

A work-related injury can be any condition that is caused, aggravated or accelerated by employment activities. This includes traumatic injuries, gradual injuries or occupational diseases, mental impairment.

What denotes an actual injury? Before 1953, compensable personal injuries had to be “caused by accident.” Minn. Stat. §176.021 (1949). Under this law, compensation was awarded only if an unusual strain or traumatic force produced a sudden or violent rupture or collapse of some physical structure or bodily function. *Caddy v. R. Maturi & Co.*, 15 W.C.D. 270, 32 N.W.2d 259 (Minn. 1948). Since then the “caused by accident” requirement has been removed and employees will be compensated for personal injuries.

“Personal injury” means injury arising out of and in the course of employment and includes personal injury caused by occupational disease.

“Personal injury” means any mental impairment as defined in subdivision 15, paragraph (d), or physical injury arising out of and in the course of employment and includes personal injury caused by occupational disease; but does not cover an employee except while engaged in, on, or about the premises where the employee’s services require the employee’s presence as a part of that service at the time of the injury and during the hours of that service. Where the employer regularly furnished transportation to employees to and from the place of employment, those employees are subject to this chapter while being so transported. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable.

Mental impairment is not considered a personal injury 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.

Personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of personal reasons, and not directed against the employee as an employee, or because of the employment.

An injury or disease resulting from a vaccine in response to a declaration by the Secretary of the United States Department of Health and Human Services under the Public Health Service Act to address an actual or potential health risk related to the employee’s employment is an injury or disease arising out of and in the course of employment.
Citation: Minn. Stat. §176.011 Subd. 16 (2018)

“Compensable injury” means an injury or condition for which a payer is liable under Minnesota Statutes, chapter 176.

Citation: Minn. R. 5221.0100 Subp. 6

“Injury” is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a “personal injury.”

Citation: Minn. R. 5221.0100 Subp. 9

Causation/Substantial Contributing Factor

The Employee must prove that the injury was the cause or a substantial contributing factor to the Employee’s condition and disability.

In Minnesota the work injury does not need to be the sole cause of a disabling condition. The law only requires that the work injury be a substantial contributing cause or factor to the employee’s condition. Swanson v. Medtronics, 443 N.W.2d 534 (1989).

Neither statute nor case law precisely defines what constitutes a substantial or significant contributing factor in a workers compensation setting. Because each case must to a great extent stand on its own facts, no one comprehensive definition can be fashioned. See Flowers v. Consolidated Containers Corp., 336 N.W.2d 255, 36 W.C.D. 39 (Minn. 1983). The term essentially contains its own definition that is, a substantial contributing cause is a cause that is both substantial and contributing to the ultimate disability. Stated another way, the cause must be appreciable. Roman v. Minneapolis Street Ry., 268 Minn. 367, 380, 129 N.W.2d 550, 558, 23 W.C.D. 573, 592 (1964). As this court stated in a different context, [w]hen a line is drawn, there are always cases very close to each side of the line. No absolute rule can be derived, since there are too many factual variables that could affect the result. Bohlin v. St. Louis County/Nopeming Nursing Home, 61 W.C.D. 69, 81 (WCCA. 2000). It is because of the many factual variables peculiar to each case that the issue of whether a work injury is a substantial contributing factor in a claimed disability is a factual question for the compensation judge. The term essentially defies precise definition. Hamm v. Marvin Windows and Doors, 64 W.C.D. 270 (WCCA 2004).

An injury which is a substantial contributing cause of an employee’s disability is by definition a “legal cause” of that disability. Salmon v. Wheelabrator Frye, 409 N.W.2d 495, 498, 40 W.C.D. 117, 122 (Minn. 1989).

Causation is a factual determination.

Imposition of liability for a Gillette injury on an employer and insurer requires medical evidence connecting the employee’s disability to the employee’s job duties. Steffen v. Target Stores, 517 N.W.2d 579 (Minn. 1994).
If the employment activity is a substantial contributing factor which aggravates or accelerates a pre-existing condition, the condition is compensable.

When determining whether an “injury” or aggravation of a pre-existing condition is temporary or permanent the following factors will be analyzed: (1) the nature and severity of the pre-existing condition and the extent of medical restrictions and disability resulting therefrom; (2) the nature of the symptoms and extent of medical treatment prior to the aggravating event; (3) the nature and severity of the aggravating incident and the extent of restrictions and disability resulting therefrom; (4) the nature of the symptoms and extent of medical treatment following the aggravating incident; (5) the nature and extent of the employee’s work duties and non-work activities during the relevant period; and (6) medical opinions on the issues. McClellan v. Up North Plastics, slip op. (WCCA 10/18/94). Assessment of which of the factors are significant and the weight to be given to any factor is generally left to the compensation judge. Wold v. Olinger Trucking, Inc., slip op. (WCCA 8/29/1994).

Medical causation is legally supported and found when as stated in McBride v. Anderson Power & Equip., Inc., slip op. (W.C.C.A. Feb. 21, 2002), that a doctor’s causation opinion need not be expressed in any particular words, so long as it appears from the doctor’s words, considered as a whole, and in light of the evidence in the case, that the doctor was of the opinion that it was not merely possible that the employee’s work could have caused the employee’s injury, but that it was probable that it did in fact cause the injury. A failure to identify or explain the specific mechanism of injury does not render a causal relationship opinion legally insufficient. Rather, the presence or absence of such testimony goes to the weight that may be afforded the opinion by the compensation judge. All that is required is, under the facts of the case considered as a whole, that it appears a competent medical witness opined the injury causally contributed to the disabling condition. See, e.g., Goss v. Ford Motor Co., 55 W.C.D. 316 (WCCA 1996).

**Intervening/Superseding**

The defense of a superseding intervening cause is one that can result in a complete bar to all benefits claimed that are attributable to the superseding event. See Nelson v. American Lutheran Church, 40 W.C.D. 845, 420 N.W.2d 588 (1988). If the employee’s compensable injury is found to be a “substantial contributing factor” in the employee’s ongoing disability, however, the defense will fail. See Buford v. Ford Motor Company, 52 W.C.D. 723, 537 N.W.2d 286 (1995).

The legal relationship between a work injury and its reasonable consequences, including medical treatment, is broken where the consequence is also a result of such unreasonable, negligent, dangerous, or abnormal activity on the part of the employee that it can be said that such additional care was not a natural consequence flowing from the primary injury. Eide v. Whirlpool Seeger Corp., 260 Minn. 98, 102, 109 N.W.2d 47, 49-50, 21 W.C.D.
437, 441 (1961); Nelsen, 420 N.W.2d at 590, 40 W.C.D. at 851. If . . . a subsequent aggravation of the initial injury arises from an independent intervening cause not attributable to the employee’s customary activity in light of the employee’s condition, then . . . additional medical care for the aggravation is not compensable. The original work injury in such circumstances is, in effect, no longer a substantial contributing factor in the need for the care at issue.

The issue in intervening cause cases is not merely whether the intervening injury or condition is itself a substantial contributing cause of the employee’s subsequent disability but whether that intervening injury or condition has broken the causal connection between the employee’s work injury and that disability. See Hughes v. Karps Twin City Supply, slip op. (W.C.C.A. Nov. 27, 1996). If the work injury continues to be a substantial contributing cause of the employee’s disability, the intervening injury or condition will not relieve the employer and insurer of liability for benefits, and the burden of proving an intervening cause of the disability at issue is on the employer and insurer.

Ultimately, in cases involving superseding, intervening injuries, including Eide, Johnson, and Nelsen, the question for the compensation judge is whether there was an “independent intervening cause not attributable to the employee’s customary activity in light of the employee’s condition.” Eide v. Whirlpool Seeger Corp., 260 Minn. 98, 109 N.W.2d 47, 21 W.C.D. 437 (1961) and Nelsen v. American Lutheran Church, 420 N.W.2d 588, 40 W.C.D. 849 (Minn. 1988).

**Consequential Injuries**

Subsequent injuries or disabilities that are a direct and natural consequence of a previous compensable injury are likewise compensable. Typically, these cases involve medical causation, such as where a compensable injury weakens the employee, who sustains a subsequent injury because of the weakened condition.

Non-employment aggravations of a work injury, resulting from normal activity reasonable under the circumstances, are compensable. Eide v. Whirlpool Seeger Corp., 109 N.W.2d 47 (Minn. 1961).

Similarly, aggravation of the primary injury by medical treatment (including medical malpractice) is compensable. Radermecher v. FMC Corp., 38 W.C.D. 195, 375 N.W.2d 809 (Minn. 1985).

**Disability**

The term disability is referenced in several statutory provisions and forms related to reporting of injury (FROI), commencing payment of benefits for an injury (NOPLD), types of benefits (TTD, TPD, PPD, PTD) and descriptions of acceptable injuries (Occupational Disease).
The term disablement was previously defined as a “state of being disabled from earning full wages at the work at which the employee was last employed.” MN Stat. §176.066 Subd. 1 (1971) It has been interpreted as occurring when an employee can no longer earn full wages in the position at which he or she was last employed. *Notch v. Victory Granite Co.* 238. N.W. 2d 426 (Minn. 1976).

It come up in the context of *Gillette* injuries. The actual date on which a *Gillette* injury is found to have occurred is an extremely important one. It can mean the difference between liability being placed on one employer or insurer, as opposed to another. Issues regarding when a *Gillette* injury occurs are often mixed with issues of apportionment. The date of disablement, or last day worked, is not necessarily the date of the *Gillette* injury.

The employment immediately preceding the date of disablement must be shown to have been a substantial contributing factor in causing the disability.

The Supreme Court has established factors or ascertainable events for proving when a *Gillette* injury occurs. The Court indicated that the date on which a *Gillette* injury occurs should be determined based upon all of the evidence bearing on the issue. The employee’s “injury” may not necessarily occur on the last day of work. If there are what the Court called “ascertainable events” resulting from the employee’s work that were great enough to “disable the employee from further work,” the injury may occur at an earlier point in time. Ascertainable events cited in the *Schnurrer* case were changing the employee’s work duties because of his physical condition, an opinion of the employee’s treating physician that he required a total knee replacement, a recognition of the employee prior to his last day of work that he could not continue work because of the pain associated with even the lighter work that had been assigned to him, and his informing the employer three months prior to his last day of work that he had to quit. *Schnurrer v. Hoerner-Waldorf*, 345 N.W.2d 230 (Minn. 1984).

**Job Offer**

For injuries from 1984 to 10/1/1995 five major factors come into play when considering the suitability of a job under Minn. Stat. § 176.101, subd. 3e. These factors are as follows: (1) the timing of the job offer; (2) the physical suitability of the job; (3) the economic suitability of the job; (4) whether the job offer is in writing; and (5) whether the job offer was genuine and in good faith. The following sections will describe the requirements for each of these factors in greater detail.

If the job is different from the job at the time of injury, it must be offered and described in writing. The description shall include the specific nature of the job, the rate of pay, the physical requirements, and any other information necessary to fully and completely inform the employee of the duties and responsibilities.

This provision replaces the elaborate system that was created in 1983 and continued for injuries up through September 30, 1995. For injuries after October 1, 1995, this provision applies.
Cessation: Temporary total disability compensation shall cease if the employee refuses an offer of work that is consistent with the plan of rehabilitation filed with the commissioner which meets the requirements of Minn. Stat. §176.102, Subd. 4 or, if no plan has been filed, the employee refuses an offer of gainful employment that the employee can do in the employee’s physical condition.

Citation: Minn. Stat. §176 subd. 1(i)

Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced.

Citation: Minn. Stat. §176 subd. 1(i)

In clarifying what constitutes an offer of “gainful employment” under Minnesota Statutes §176.101, Subd. 1(i), the Workers’ Compensation Court of Appeals, in Detmar v. Kasco Corp., slip op. (WCCA April 28, 2000), stated “an employee may consider an otherwise suitable job to be unsuitable simply because it requires him to relocate.”

Minn. Stat. §176.101, Subd. 1(i) does not apply where the employee was not receiving temporary total disability compensation when the job offer was made. Dell v. Parker Hannifin, slip op. (WCCA, July 12, 2004).

Be familiar with MN Rule 5221.0420 which addresses the Health Care Providers obligations with return to work planning.

MN Rule 5221.0420 Subpart 1 provides cooperation with return to work planning. In addition to completing the required report of work ability under part 5221.0410, subpart 6, a health care provider must participate cooperatively in the planning of an injured employee’s return to work by communicating with the employee, employer, insurer, rehabilitation providers, and the commissioner in accordance with this part. A health care provider must release the employee to return to work, with restrictions if necessary, at the earliest appropriate time.

If no qualified rehabilitation consultant has requested an opinion under subpart 2, item B, subitem (1), the health care provider must respond within ten calendar days of receipt of a request by the employee, employer, or insurer regarding whether the physical requirements of a proposed job are within the employee’s medical restrictions or whether the health care provider requires further information. The health care provider may respond in writing, in person, or by telephone. The health care provider may require that the proposed job be described in writing. The provider may also agree to review a videotape of the job.
MMI

Maximum medical improvement (MMI) is a concept that was introduced by the 1983 Legislature. It applies only to injuries occurring after January 1, 1984. The date on which a person has reached MMI has become a critical one in almost every litigated workers’ compensation case. When MMI is reached and what happens shortly thereafter establishes a substantial amount of the rights and responsibilities of the parties for the remainder of the claim.

Injuries after October 1, 1995

“‘Maximum medical improvement [MMI]’ means the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability, irrespective and regardless of subjective complaints of pain. Except where an employee is medically unable to continue working under section 176.101, subdivision 1, paragraph (e), clause (2), once the date of maximum medical improvement has been determined, no further determinations of other dates of maximum medical improvement for that personal injury is permitted. The determination that an employee has reached maximum medical improvement shall not be rendered ineffective by the worsening of the employee’s medical condition and recovery therefrom”

Citation: Minn. Stat. §176.011 subd. 13a (1995)

Used in context of discontinuing temporary total disability compensation only. Cessation: Temporary total disability compensation shall cease 90 days after the employee has reached maximum medical improvement (MMI), except if the employee is in an approved retraining program, subject to Minnesota Statutes Section 176.102, Subd. 11.

Citation: Minn. Stat. §176.101 subd. 1(j) (1995)

For purposes of this subdivision, the 90-day period after maximum medical improvement commences on the earlier of: (1) The date the employee receives a written medical report indicating that the employee has reached maximum medical improvement; or (2) The date that the employer or insurer serves the report on the employee and the employee’s attorney, if any.

Citation: Minn. Stat. §176.101. Subd. 1(j) (1995)

The Minnesota Rule 5221.0410 provides some guidance in understanding the definition of this concept.

For injuries occurring on or after January 1, 1984, or upon request for earlier injuries, the health care provider must report to the self-insured employer or insurer, maximum medical improvement, when ascertainable, on the health care provider report form or in a narrative report. “Maximum medical improvement” is a medical and legal concept defined by Minnesota Statutes, section 176.011 subdivision 13a.
A. For purposes of sub items (1) and (2), “the employee’s condition” includes the signs symptoms, physical and clinical findings, and functional status that characterize the complaint, illness, or injury. “Functional status” means the ability of an individual to engage in activities of daily life and vocational activities. Except as otherwise provided in item B.

B. In determining maximum medical improvement, the following factors shall be considered by the health care provider as an indication that maximum medical improvement has been reached:

a. there has been no significant lasting improvement in the employee’s condition, and significant recovery or lasting improvement is unlikely, even if there is ongoing treatment;

b. all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the employee’s condition have been exhausted, or declined by the employee;

c. any further treatment is primarily for the purpose of maintaining the employee’s current condition or is considered palliative in nature; and

d. any further treatment is primarily for the purpose of temporarily or intermittently relieving symptoms.

The following factors should be considered by the health care provider as an indication that maximum medical improvement has not been reached:

(a) the employee’s condition is significantly improving or likely to significantly improve, with or without additional treatment;

(b) there are diagnostic evaluations that could be performed that have a reasonable probability of changing or adding to the treatment plan leading to significant improvement; or

(c) there are treatment options that have not been applied that may reasonably be expected to significantly improve the employee’s condition.

Case Law Considerations

Maximum medical improvement is an issue of ultimate fact to be decided by the compensation judge after considering medical opinions, records and other data and circumstances. The opinion of a physician is not necessarily controlling. *Hammer v. Mark Hagen Plumbing & Heating*, 41 W.C.D. 634, 435 N.W.2d 525 (Minn. 1989).
Continuation of medical treatment does not prevent a finding of MMI where the treatment does not demonstrate a reasonable expectation of future improvement. However, treatment which provides such an expectation (e.g., certain surgical procedures) will support a finding that MMI has not been reached.

Like many issues in workers’ compensation, the case law regarding MMI is varied. For every case finding that an employee is at MMI, there is another case with nearly the same facts in which it is determined that the employee is not at MMI. Because of the substantial impact it may have on an employee’s entitlement to benefits, a medical report indicating that MMI has been reached must be in clear and unambiguous terms. *Drake v. Delta-Royal/Stencel Trucking*, 41 W.C.D. 1100 (WCCA 1989).

In order to obtain an opinion as to MMI from a treating physician, an employer/insurer may request that the treating physician provide a Health Care Provider Report. This is a form prescribed by the commissioner that requests that the provider provide certain information. The Rules state that the provider must respond to the request within 10 days, either by filling out the form or providing a narrative report containing the same information requested on the form.

**Minn. R. 5221.0410, subp. 2**

Additionally, the DOLI promulgated a rule which provides that for certain types of injuries (musculoskeletal), and under certain circumstances, an employee may be presumed to be at MMI.

**Minn. R. 5221.0410, subp. 3B**

**Employee Must Reach Maximum Medical Improvement for All Injuries and Conditions**

In order to discontinue an employee’s temporary total disability benefits on the basis of maximum medical improvement, MMI must be reached and served for all compensable conditions and injuries presently contributing to the employee’s disability.

**Service and Filing Requirements**

As noted above, “[t]emporary total disability compensation ceases 90 days after the employee reaches maximum medical improvement, except as provided in section 176.102, subdivision 11, paragraph (b).” The “90-day period after maximum medical improvement commences on the earlier of: (1) the date that the employee receives a written medical report indicating that the employee has reached maximum medical improvement; or (2) the date that the employer or insurer serves the report on the employee and the employee’s attorney, if any.”

The employer and insurer bear the burden of obtaining written medical documentation of MMI and serving the same upon the employee.
a. Who Must be Served

A medical opinion indicating that maximum medical improvement has been reached must be served on the employee; service on the employee’s attorney, in lieu of the employee, is insufficient.

Where an employee is represented by an attorney, service of MMI only on the attorney is insufficient. *Basso v. Transfleet Enterprises*, 40 W.C.D. 19 (WCCA 1987).

b. Contents of Letter Accompanying MMI Report

The DOLI also promulgated the following rule, which requires that certain, specific information be provided to employees when an MMI report is served:

“If the employer or insurer does not serve a notice of intention to discontinue benefits or a petition to discontinue benefits under Minnesota Statutes Section 176.238, at the same time a narrative maximum medical improvement report is served, then the report must be served with a cover letter containing the information in sub-items (1) to (6). Serving the cover letter with the maximum medical improvement report does not replace the notice of intention to discontinue benefits or petition to discontinue benefits required by Minn. Stat. §176.238. The cover letter must include:

i. Information identifying the employee by name, social security number, and date of injury;
ii. Information identifying the employer and insurer;
iii. The date the report was mailed to the employee;
iv. A statement that the attached report indicates that in the opinion of the health care provider, the employee reached maximum medical improvement by the specified date or an explanation that the attached reports indicate the employee has reached maximum medical improvement under the circumstances specified in item B;
v. The definition of maximum medical improvement as defined by Minnesota Statutes Section 176.011, Subd. 25; and
vi. The statement: “There may be an impact on your temporary total disability benefits. If we propose to stop your benefits, a notice of discontinuance of benefits will be sent to you first. If you have any questions concerning your benefits or maximum medical improvement, you may call the claims person…or the workers’ compensation division…”

*Citation: Minn. R. 5221.0410 subp. 3*
Reasonable and Necessary Medical Benefits

The traditional method for determining the reasonableness and necessity of medical treatment has been a case-by-case analysis. If the employee can establish that the particular piece of equipment or prescription is specifically directed to address the needs of a particular injury, the employee may be able to obtain reimbursement or payment for a particular supply or treatment.

The employer is responsible for medical care, which is required because of the employee’s injury. In order for medical benefits to be compensable, the medical care must be reasonable, necessary and causally related to the work injury.

The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medicines, medical, chiropractic, podiatric, and surgical supplies, crutches and apparatus, including artificial members, or, at the option of the employee, if the employer has not filed notice as hereinafter provided, Christian Science treatment in lieu of medical treatment, chiropractic medicine and medical supplies, as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury. This treatment shall include treatments necessary to physical rehabilitation. Moreover, the employer shall furnish replacement or repair for artificial members, glasses or spectacles, artificial eyes, podiatric orthotics, dental bridge work, dentures or artificial teeth, hearing aids, canes, crutches, or wheel chairs damaged by reason of an injury arising out of and in the course of the employment.

Citation: Minn. Stat. §176.135 (1995)

In addition to the cost of the actual treatment, the employer must pay medical mileage to and from the prescribed treatment. Even expenses designed only to test the level of an employee’s physical capabilities, such as a functional capacities evaluation, can be a compensable medical expense, where the evaluation is necessary as a component of the physician’s supervision or management of the employee’s injury.

1. Podiatric treatment

Podiatric treatment is an acceptable and reasonable treatment method for work-related injuries. In addition to actual podiatric treatment, podiatric orthotics are specifically reimbursable under the Act.

2. Christian Science Treatment

Effective April 19, 1953, employees are allowed to elect Christian Science treatment in lieu of medical treatment. A Christian Scientist or other person who endeavors to prevent or cure disease or suffering exclusively by mental or spiritual means or by prayer is specifically exempted from the licensing requirements to practice medicine under Minnesota Statutes Section 147.081.
3. Medical Appliances and Supplies

In addition to providing the specific forms of medical care and treatment, it is required to provide various medical appliances and supplies which are reasonably required to cure or relieve the employee from the effects of the injury.

4. Physical Rehabilitation

Physical rehabilitation under the Minnesota Workers’ Compensation Act includes the following specific items:

a. Physical therapy modalities including but not limited to massage, ultrasound, electrical stimulation, and ice and heat therapy.

b. Supervised exercise instruction in a formal physical therapy setting.

c. Use of health club facilities for an exercise program.

d. Home exercise equipment including but not limited to Nordic tracks, rowing machines and weights.

5. Artificial Members

Since 1951, an employer has been required to provide, replace or repair artificial members. This specifically includes artificial teeth and artificial eyes.

6. Glasses, Spectacles, Hearing Aids, Canes, Crutches, Wheelchairs and Shoes

Glasses, spectacles, hearing aids, canes, crutches, wheelchairs and shoes are included. In the event a person is already using these items prior to a work injury and as a result of the work injury these items are damaged, the employer is liable for the cost of repair or replacement.

7. Medications and Related Supplies and Treatment

The employer is required to furnish all medicines, prescription or otherwise, which are reasonable and necessary to cure or relieve from the effects of the work-related injury. In addition, it has been determined that a prescription for an orthopedic mattress, an air ride seat, and athletic shoes, specifically to address the needs of a work-related injury are reimbursable prescriptions. A related issue is the use of chronic pain programs to aid and assist the employee in the physical rehabilitation
process. Pain clinic treatment is reasonably necessary to effectuate a cure as envisioned by Minnesota Statutes Section 176.135. Body massage and pool therapy were found to be compensable when the treatment provided significant relief to employee.

8. **Home Nursing Services**

The employer shall pay for the reasonable value of nursing services provided by a member of the employee’s family in case of permanent and total disability.

9. **Housekeeping services**

Housekeeping services are not services that qualify as “medical treatment” under Minnesota Statutes Section 176.135(1)(a), since they do not involve customary “nursing” services (such as assistance with bathing, changing dressings, administering medications, or assistance with therapy).

10. **Remodeling of Home**

The employer shall furnish to an employee who is permanently disabled, alteration or remodeling of the employee’s principal residence as is reasonably required to move freely into and throughout the residence.

**Treating Health Care Provider**

The individual health care provider directing and coordinating medical care to the employee following the injury is the primary health care provider. If the employee receives medical care after the injury from a provider on two occasions, the provider is considered the primary health care provider if that individual directs and coordinates the course of medical care provided to the employee. The employee may have only one primary health care provider at a time. The selection of a provider by an employee covered by a certified managed care plan is governed by chapter 5218.

An employee may change primary provider within 60 days of the injury without the need for approval. After the first 60 days, following initiation of medical treatment for the injury, any further changes of primary provider must be approved by the insurer, the department, or a workers’ compensation judge, or as otherwise articulated in Minnesota Rules Part 5221.0430.

If the employee or health care provider fails to obtain approval of a change of provider before commencing treatment where required by this part, the insurer is not liable for the treatment rendered prior to approval unless the insurer has agreed to pay for the treatment. Treatment rendered before a change of provider is approved under this subpart.
is not inappropriate if the treatment was provided in an emergency situation and prior approval could not reasonably have been obtained.

Change of primary provider not approved.

After the first 60 days following initiation of medical treatment for the injury, or after the employee has exercised the employee’s right to change doctors once, the department, a certified managed care organization, or a compensation judge shall not approve a party’s request to change primary providers, where:

A. a significant reason underlying the request is an attempt to block reasonable treatment or to avoid acting on the provider’s opinion concerning the employee’s ability to return to work;

B. the change is to develop litigation strategy rather than to pursue appropriate diagnosis and treatment;

C. the provider lacks the expertise to treat the employee for the injury;

D. the travel distance to obtain treatment is an unnecessary expense and the same care is available at a more reasonable location;

E. at the time of the employee’s request, no further treatment is needed; or

F. for another reason, the request is not in the best interest of the employee and the employer.

Citation: Minn. R. 5221.0430

Case Management Services

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).

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.

**Minimal Ascertainable Permanency**

MN Stat. §176.021 Subd. 3 provides

All employers shall commence payment of compensation at the time and in the manner prescribed by this chapter without the necessity of any agreement or any order of the division.

Except for medical, burial, and other non-periodic benefits, payments shall be made as nearly as possible at the intervals when the wage was payable, provided, however, that payments for permanent partial disability shall be governed by section 176.101.

If doubt exists as to the eventual permanent partial disability, payment shall be then made when due for the minimum permanent partial disability ascertainable, and further payment shall be made upon any later ascertainment of greater permanent partial disability.

Prior to or at the time of commencement of the payment of permanent partial compensation, the employee and employer shall be furnished with a copy of the medical report upon which the payment is based and all other medical reports which the insurer has that indicate a permanent partial disability rating, together with a statement by the insurer as to whether the tendered payment is for minimum
permanent partial disability or final and eventual disability. After receipt of all reports available to the insurer that indicate a permanent partial disability rating, the employee shall make available or permit the insurer to obtain any medical report that the employee has or has knowledge of that contains a permanent partial disability rating which the insurer does not already have.

For injuries after October 1, 1995, permanent partial disability benefits are payable upon cessation of temporary total disability benefits. The compensation is payable in installments at the same intervals and the same amount as the employee’s temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid. If the employee requests payment of permanent partial disability in a lump sum, then the compensation must be paid within 30 days. The lump sum may be discounted to the present value calculated up to a maximum of a 5 percent basis. Minn. Stat. §176.101, Subd. 2 a (b).

The rules pertaining to injury dates prior to October 1, 1995 provided that when permanent partial disability compensation was being paid periodically following the payment of temporary total disability benefits or following or concurrent with the payment of temporary partial disability benefits, the payments must be continued without interruption at the same intervals that the temporary benefits were paid. **When the employee reaches maximum medical improvement, the insurer must request an initial assessment of any permanent partial disability from the employee’s physician.** Minn. R. 5220.2550, subp. 1.

When the extent of permanent partial disability was not disputed, upon receipt of a medical report containing a permanency rating or medical information from which the insurer may determine a rating, the employer must, within 30 days, either (1) make a lump sum payment or begin periodic payments to the employee; or (2) inform the employee in writing of the disability rating and the time when the permanent partial disability payment will be payable under the statute. Minn. R. 5220.2550, subp. 1A.

Minn. R. 5220.2550, subp. 1A.

If the extent of permanent partial disability is disputed, upon receipt of a medical report containing a permanency rating or medical information from which the employer may determine a rating, the employer or insurer must, within 30 days, either make a minimum lump sum payment or begin periodic payments based upon the minimum undisputed permanent partial disability ascertainable and notify the employee in writing that an adverse medical examination has been scheduled and the date, time and place of the examination, or inform the employee in writing of the disability rating and the time when the permanent partial disability payment will be payable by statute.

Failure to comply with the requirements of the rule can subject the insurer to penalties under Minn. Stat. §176.221 and Minn. Stat. §176.225, as set out above. A penalty can also be assessed for failure to file a notice required by the subpart, as indicated under Minn. R. 5220.2830.
MINNESOTA WORKERS’ COMPENSATION
2018-2019 CASE LAW UPDATE

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# Minnesota Workers' Compensation 2018-2019 Case Law Update

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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 prescribed 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 an 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 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.


**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 re-injured 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, Stoffelhahn, 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 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. GGNCS 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.
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.


**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
ARISING OUT OF AND IN THE COURSE OF

By
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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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# Wisconsin
## Arising Out of and In the Course of

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J. Injuries Resulting from Medical Treatment for Related Injuries
This article is intended to introduce the reader to one of the fundamental concepts of the Wisconsin Worker’s Compensation Act “Arising Out Of and In the Course Of.” The question of whether an injury arises out of and in the course of the employment activity is one of the first issues that must be resolved when handling a worker’s compensation claim.

Indeed, the concept of arising out of and in the course of impacts on numerous other areas of worker’s compensation law, including the issues of medical and legal causation, repetitive trauma injuries, occupational diseases, heart attacks, psychological claims, witness credibility, intoxication, and intentionally self-inflicted injuries. The scope of this article does not permit an analysis of all of the corollary topics that interrelate with the concept of “arising out of and in the course of.” The reader is reminded that additional investigation or research may be necessary in individual cases.

The reader is further reminded that the concept of “arising out of and in the course of” is extremely dependent upon the facts in each case. As will be noted below in the analysis of the issues, a particular rule of law or test may have been created by the courts, which on first blush appears to be fairly straightforward and easily interpreted. However, in applying the particular rule or test to a particular case, the specific facts must be explored in detail. It can be a frustrating experience trying to determine why one injury is found to be compensable, when another seemingly identical injury is found to be not compensable. The scope of this article does not permit a detailed analysis of the specific facts of each case. If a specific case is needed for your analysis, please contact us and we will be happy to send it to you. Further, the reader should be reminded that the Labor and Industry Review Commission cases are included in this article for mere purposes of providing illustrative examples of past Labor and Industry Review Commission decisions. The number of published decisions (which are binding on subsequent cases) at the Court of Appeals and Supreme Court are relatively minimal in comparison to the number of cases heard by the Labor and Industry Review Commissions annually. The decisions made by the Labor and Industry Review Commission decisions are demonstrative, but are not binding on future cases.

I. Basic Concepts

A. Two Separate Elements

Wis. Stat. Section 102.03(1)(c)(1) states: liability under this chapter shall exist against an employer only where, at the time of injury, the employee is performing services growing out of and incidental to his or her employment. This statute requires that the injury be sustained in the course of the employee’s employment for the employer.

Wis. Stat. Section 102.03(1)(e) clarifies that the accident or disease causing the injury must also arise out of the employee’s employment.
Generally, both elements (“arising out of” and “in the course of”) must be satisfied in order for an injury to be found compensable.

A condition can arise out of and in the course of employment when there is a specific incident that causes a condition, or a specific incident that precipitates, aggravates, and accelerates a pre-existing condition beyond that condition’s normal progression. Additionally, a condition can arise out of and in the course of employment if the employee’s repetitive job duties for the employer cause a condition or if those job duties materially aggravate a pre-existing condition. Repetitive injuries in Wisconsin are considered occupational diseases, and are treated in similar ways to situations involving asbestos exposure, chemical exposure, etc. See Shelby.

B. As Is Rule

Wisconsin follows the as is rule with respect to pre-existing conditions. The fact that an employee may be susceptible to injury by reason of a pre-existing physical condition does not relieve the last employer from being held liable for worker’s compensation benefits if the employee becomes injured due to his employment, even though the injury may not have been such to have caused disability in a normal individual. See M.&M. Realty Company v. Industrial Commission, 267 Wis. 52, 64 N.W. 2d 413 (1954).

C. Specific Injuries

A work-related injury can be compensable if that injury causes a new condition or disability to occur. Additionally, an aggravation of a pre-existing condition beyond the normal progression is compensable in Wisconsin.

Lewellyn v. Department of Industry, Labor & Human Relations, 38 Wis. 2d 43; 155 N.W.2d 678 (1968) is the most well-known case in Wisconsin with respect to addressing whether a condition arises out of employment, in cases of traumatic injuries, and has become the standard used for every evaluation of these situations. The third of the three-part Lewellyn test has been adopted by the Department in its WKC-16b form, which is the form medical experts need to complete in order for their opinion to be accepted by the Department in lieu of testimony.

1. There are three categories of traumatic injuries under Lewellyn:

   a. Lewellyn 1: Definite breakage, regardless of the existence of a pre-existing condition. These types of injuries are compensable.

   b. Lewellyn 2: No breakage, and a mere manifestation of a pre-existing condition. These types of injuries are not compensable. An opinion that the alleged work-related situation is in the Lewellyn 2
category is what most employers and insurers seek out from an independent medical examiner. Symptoms are not synonymous with causation. (Most recently see Rogers v. Meyers Electric, Inc., Claim Nos. 2015-010853, 2013-025125 (LIRC January 20, 2017).)

c. *Lewellyn* 3: Precipitation, aggravation AND acceleration of a pre-existing condition beyond normal progression, regardless of breakage. These types of situations are compensable.

d. All three factors (precipitation, aggravation and acceleration) must be present. (Most recently see Knight v. ABM Janitorial, Claim No. 2014-016340 (LIRC January 20, 2017).) This category of the three part *Lewellyn* test is included on the Departments WKC-16b form.

2. The *Lewellyn* Evaluation is typically used only for traumatic injuries, and not for repetitive/occupational injuries.

a. However, the courts have used the *Lewellyn* test in some mental/physical occupational disease cases. See United Parcel Service, Inc. v. Lust, 208 Wis. 2d 306, 560 N.W. 2d 301 (Ct. App. 1997).

i. In *United Parcel Service* the court held that elements of proof placed on a claimant alleging a definable physical injury as a result of emotional stress in the workplace are governed by the conventional standard set out in *Lewellyn*, rather than the typical unusual stress test used for mental injuries, when the claim is that the emotional stress in the workplace aggravated or accelerated a condition, rather than producing a condition.

D. Repetitive/Occupational Injuries

The analysis in occupational injury situations is whether the work injury was either the sole cause of the condition OR at least a material factor in the condition’s onset or progression. See Universal Foundry Co. v. Department of Industry, Labor & Human Relations, 82 Wis. 2d 479, 263 N.W. 2d 172 (1978);

The court will also take into consideration facts concerning whether there were outside non-occupational activities to account for the progression of the condition. See Johnson v. Hufcor, Inc.

II. Arising Out Of Employment

In Wisconsin, the arising out of analysis involves evaluating the positional risk of the situation, and looking to whether there is a zone of special danger.

A. Positional Risk Doctrine

Under the positional risk doctrine, accidents arise out of employment if the conditions or obligations of the employment create a zone of special danger out of which the accident causing the injury arose. An accident arises out of employment when, by reason of employment, the employee is present at a place where he is injured through the agency of a third person, an outside force, or the conditions of the location constituting a zone of special danger. See Cutler – Hammer, Inc. v. Industrial Commission, 5 Wis.2d 247; 92 N.W.2d 824 (1958) and Soto v. City of Madison, Claim Nos. 2010-006015; 2010-006018; 2010-006020. (LIRC May 24, 2012).

Cutler-Hammer has been interpreted to hold that an accident arises out of the employment when the connection between the employment and the accident is such that the obligation or circumstances of the employment places the employee in the particular place at the particular time when he is injured by a force which is not solely personal to him. See Allied Manufacturing, Inc. v. Department of Industry, Labor & Human Relations, 45 Wis.2d 563; 173 N.W.2d 690 (1970) and Soto v. City of Madison, Claim Nos. 2010-006015; 2010-006018; 2010-006020. (LIRC May 24, 2012).

1. Determining what constitutes a zone of special danger has been the subject of much litigation, and is typically a very specific fact intensive evaluation.

a. Building layouts, with respect to sidewalk configuration, building fixtures, motor vehicle accidents, ramps, etc. have all been considered to be areas of zones of special danger. See Schampers v. First Choice Auto, Inc., Claim No. 2003-011262 (LIRC April 14, 2006); Applied Plastics, Inc. v. Labor & Industry Review Commission, 121 Wis. 2d 271; 359 N.W.2d 168 (Wis. Ct. App.
2. Falls caused by an outside force are considered to arise out of the course of employment when they occur on the employer’s premises. This includes falls caused by a trip or slip on stairs, and falls caused by one’s foot suddenly catching while stepping from one floor surface onto another, less slippery floor surface. The courts have held that relatively little contribution by the employment or employment environment is necessary to make a fall/near fall compensable. See Schampers.

B. Acts of Third Persons

1. The positional risk doctrine does not apply in those cases where a third party assault causes an employee’s injury, if the origin of the assault is purely personal and the employment conditions in no way contributed to the incident. Weiss v. City of Milwaukee, 208 Wis. 2d 95; 559 N.W.2d 588 (1997).

2. When an attack occurs during the course of employment and arises from personal animus imported from a private relationship, the incident arises out of the claimant’s employment if employment conditions have contributed to or facilitated the attack. See Weiss.

3. The courts also look at whether there is a zone of danger that is inherent in certain types of employment. This can result in a personal assault being considered to be compensable in certain, fact dependent, situations.

   a. There are some employments where the work hazard is equivalent to a zone of danger for purposes of determining whether an injury arises out of employment.

   b. An employee was determined to be in a zone of special danger when she was in an isolated work environment because all other employees had left the building, and she remained in the building to complete her normal and regularly scheduled job duties. This isolation resulted in an increased risk of attack, which brought her into the zone of special danger, and resulted in injuries sustained during an attack being compensable. Allied Manufacturing, Inc. v. Department of Industry, Labor & Human Relations, 45 Wis.2d 563; 173 N.W.2d 690 (1970).

4. In general, fights sustained on the employer’s premises are not compensable for the aggressor; but may be compensable for the non-aggressor/victim. See Vollmer v. Industrial Commission, 254 Wis. 162, 35 N.W. 2d 304 (1948).
C. Self-Inflicted Injuries

Intentionally self-inflicted injuries, including suicide, are not typically compensable. In 1968, the Wisconsin Supreme Court changed the standard used to evaluate suicide/self-inflicted injury situations. See Brenne v. Department of Industry, Labor & Human Relations, 38 Wis.2d 84, 156 N.W.2d 497 (1968). The Brenne court changed the standard from the “voluntary, willful choice” test, to the “chain of causation” test. The Brenne court held the claimant must demonstrate that the industrial injury caused the suicide/self-inflicted injury. The Brenne court looked to 1A Larson, Law of Workmen’s Compensation, p. 510.22, sec. 36.30 Chain of Causation Test, as well as recent case law throughout the country, in order to make this change. The Brenne court cited Larson’s evaluation that:

If the sole motivation controlling the will of the employee when he knowingly decides to kill himself is the pain and despair caused by the injury, and if the will itself is deranged and disordered by these consequences of the injury, then it seems wrong to say that this exercise of will is “independent” or that it breaks the chain of causation. Rather, it seems to be in the direct line of causation.

Following Brenne, the courts now look at whether there is an unbroken chain of events, and whether the claimant can demonstrate the factors included in Larson’s evaluation of the Chain of Causation theory. See Gross v. Roehl Transport, WC Claim No. 2001-001391 (LIRC June 25, 2009).

D. Idiopathic Injuries

Idiopathic injuries, which are due to the disease, physical injury or condition that is personal to the employee, are not compensable. Unless the employee is placed in a position of increased danger because of the effects of employment, a personal condition does not arise out of employment. Stairs, machines, sharp edges, driving, and water have all been considered to be items that place the employee in a position of increased danger, and make otherwise personal conditions, arise out of the employment, and compensable.

In Koziczkowski v. T A Solberg Company, Inc., Claim No. 2003-046741 (LIRC February 23, 2006), the court held that a compensable injury was sustained when an employee turned and twisted to sit at the table in a break room, and his foot in the rubber, non-skid shoe, did not turn with the employee’s body, but instead gripped the floor.

Conversely, in Friedrich v. Labor and Industry Review Commission, 2012 Wisc. App. LEXIS 276 (Wis. Ct. App. April 5, 2012), the Court of Appeals affirmed a denial of benefits on the basis that the condition was idiopathic, where the employee alleged standing all but 40 minutes in a workday was at least a material causative factor in the onset or progression of her right knee osteoarthritis.
In *Dumesic v. Carmax*, Claim No. 2007-030617 (LIRC November 9, 2009), the court outlined the following example: that “…if a person with diabetes falls to the floor at work because of an insulin reaction unrelated to work duties, and is injured in the fall, the fall may be regarded as idiopathic, or due to a solely personal force, and the injury caused by the fall will not be compensable. Such an accident or fall, even though occurring while a worker is performing services for an employer, does not arise out of employment as required under Wis. Stat. 102.03(1)(e)” This was recently reaffirmed by the court in *Soto v. City of Madison*, Claim Nos. 2010-006015; 2010-006018; 2010-006020 (LIRC May 24, 2012).

If an employee sustains an idiopathic injury, and the results of that injury are greater than otherwise, because of circumstances of employment, the employee may be entitled to worker’s compensation benefits. See *Keene v. L & S Trucking*, LIRC 2008-037854 (November 30, 2011).

E. Unexplained Injuries

An unexplained injury, which is not idiopathic and not causally related to work, is *not* compensable in Wisconsin. Wisconsin is in the minority of states in this regard. However, as with the idiopathic injury situations, the courts look very hard to find an explanation to bring an incident into the realm of compensability. See *Koziczkowski*.

For example, in *Johnson v. United Healthcare Services, Inc.*, Claim No. 2008-018633 (LIRC May 26, 2010), the court inferred that the employee’s fall was explained by her foot catching a rough asphalt surface, or by a slip caused by stepping on a foreign object on that surface based upon her initial medical records. The court inferred that her memory of exactly what occurred had faded in the time between the fall and the hearing, and that the incident occurred so fast that the employee was uncertain as to whether her foot caught the surface or slipped on a foreign object on the surface. Her initial reports to the insurer were that she “tripped and fell,” and her initial medical records reported the fall was caused by contact with rough asphalt surface or something on that surface. The court held this was sufficient to determine there was some explanation for the fall, and the injury was determined to be compensable. Similarly, in *Denamur v. Larry’s Markets, Inc.*, Claim No. 2010-028002 (LIRC July 30, 2012), an employee who had to miss a rack of paper bags while turning, and testified her foot stuck to the floor, the lack of proof that there was a floor defect was determined to not be a bar to a compensable injury. See also *Maglio v. Transportation Insurance*, WC Claim No. 2001-053666 (LIRC March 24, 2005), (a fall was determined to be compensable where an employee consistently described the fall as having been caused by her shoe sticking to the carpeting, and her shoes had a low, rubber heel that the court inferred would have grabbed and held the carpet, given the right angle and force); *Schultz v. Dept. of Health &
Family, Claim on. 2010-026442 (LIRC February 28, 2012)(a cart the applicant was pulling was determined to have affected her balance, causing her to fall, and thus she sustained compensable and non-idiopathic or unexplained fall).

In Harris v. ASHA Family Services, WC Claim No. 2002-045614 (LIRC January 26, 2005), a fall was determined to be compensable where it was not idiopathic, and was not unexplained, but where the employee could not identify the specific reason for the floor being slippery, but she testified that she fell because the floor was slippery.

Conversely, when an employee could not identify what caused her foot to stick to the floor, testified that her foot sticking to the floor caused her fall, there was no evidence that the fall was connected to any hazard or zone of danger caused by the employment, and the evidence revealed that the floor was clean, flat, dry and clear of any foreign substances, compensability has been denied. See Walters v. Utecht Bakeries, LLC, Claim No. 2006-16654 (LIRC May 13, 2008).

When there is a clean, dry floor, and no obstacles, cracks or avulsions, no substance on the floor and no sound of “stickiness” between the shoes and floor at the time of a fall, and no definitive explanation of how or why an employee fell, the fall is unexplained. A level floor is not an area of special danger. Merely having a floor that has been waxed in the past is not sufficient to find a hazard or zone of special danger exists. See Korrison v. Aurora Medical Center of Washington, Claim No. 2004-040437 (LIRC June 6, 2013).

An employee who fails to provide a rationale for the cause of a fall during initial medical visits, particularly when those physicians are seeking a reason for the fall, and provides a later “explanation” for the fall, is not always considered to sustain an injury that arises out of employment. See Hoyer v. Milwaukee Board of School Dir., Claim No. 2011-008113 (LIRC August 28, 2014) (finding the applicant’s fall was unexplained and that it was not credible that an applicant would omit the “explanation” when discussing the situation with medical providers, particularly when those providers were clearly seeking a reason for the fall).

Further, when there is no clear explanation for an employee’s death, the Commission will not always “find” an explanation. In Johnson (Dec’d) v. Precise Plumbing, Claim No. 2014-000622 (LIRC June 28, 2016), the Commission noted there is no such law in Wisconsin as the unexplained death proposition. The Commission specifically noted that such a proposition would run counter to the analytically similar situation post by an unexplained fall, which is not compensable.
F. Inguinal Hernias

Special standards and guidelines exist for situations involving inguinal hernias. These are known as the Meade/McCarthy standards, and are as follows:

Inguinal hernias rarely result from accident. They come from inherited or acquired weakness and develop gradually. Because of this, it has been necessary for the Commission to require definite proof that the hernia was produced by accident. The applicant must prove that the accident was such as could produce a hernia; that the hernia appeared immediately after the accident; that it was followed by pain immediately disabling the applicant; and that the applicant gave immediate notice of the injury to the respondent.

More recently, in E.F. Brewer Co., v. DILHR, 82 Wis. 634 (1978), the court explained the rationale for the standards. The court indicated that the basic philosophy of the guidelines is that indirect inguinal hernias are highly unlikely to occur during the course of employment, and when they do occur, the trauma and the subsequent pain are so acute that predictable types of conduct by the injured claimant almost inevitably and immediately ensue. When such conduct does not occur, the existence of work caused inguinal hernia is highly suspect. However, the E.F. Brewer Co. Court also clarified that these guidelines are “standards only for the internal use of the commission...by which the credibility or the probativeness of testimony could be tested.” See Slotowski, Michael, v. Professional Power Products Inc., Claim No. 2011-032758 (LIRC March 26, 2013).

G. Intervening /Superseding Causes

Some work-related injuries cause an employee to be more susceptible to re-injury. Employers and insurers often scour medical records to seek an indication that an employee had a subsequent non-work-related injury. If the employee is determined to have a subsequent non-work-related injury, the employer and insurer then often request an independent medical examination to obtain an opinion as to whether the employee’s subsequent disability is related to the initial work-related injury or the subsequent non-work-related injury, in order to try and find a basis to discontinue ongoing wage loss benefits.

It is important to keep in mind that, if a work-related injury is sustained, and the employee has a subsequent injury, even if that subsequent injury is non-work-related, the disability post subsequent injury may still be compensable under the initial work-related injury. The existence of a non-work-related subsequent injury is not sufficient in and of itself to support a discontinuance of ongoing worker’s compensation benefits.
1. Compensable Situations

a. A work-related injury that plays any part in a second, non-work related injury is properly considered a substantial factor in the re-injury. It will not be a substantial factor, however, where the second injury alone would have caused the damages. *Lange v. Labor and Industry Review Commission*, 215 Wis. 2d 561; 573 N.W. 2d 856 (Ct. App. 1997); *Chase v. QPS Staffing Services*, Claim No. 1995-003590 (LIRC July 27, 2009).

b. The courts have held that, by definition, an aggravation of a pre-existing condition links the two injuries. See *Lange*.

c. The aggravation of a work-related condition due to surgical treatment, medical treatment, or malpractice, is compensable. See *Jenkins v. Sabourin*, 104 Wis. 2d 309; 311 N.W.2d 600 (1981).

d. The courts have held that, although post injury activities may be ill advised, when there is no evidence that (1) any substantial movement of the injured body part was necessary, (2) there was any incident involving substantial physical stress to the injured body part, or (3) the post injury activities actually caused damage, those activities may not be intervening or superseding causes of subsequent disability. See *David Cogdill v. Seater Construction Company, Inc.*, Claim No. 2003-000962 (LIRC Oct 11, 2005).

2. Non-Compensable Situations

a. For the court to conclude that a work-related injury is not a substantial factor in a second, related, injury, it must find that the claimant would have suffered the same injury, to the same extent, despite the existence of the work-related injury. In all other cases where the two injuries are related, the re-injury will be compensable. See *Lange*.

b. An exception applies in limited situations. Compensation for a non-work-related re-injury of which a work-related injury was a substantial cause may be denied where the claimant voluntarily engages in conduct that the claimant should have known would place him or her at a greater risk of re-injury. See *Kill v. Industrial Commission*, 160 Wis. 549; 152 N.W. 148 (1915).

c. Drinking beer and walking on ice is not sufficient to create a foreseeable risk of re-injury such that it is an intervening cause. See *Lange*.
d. In *Vreeland v. Wal-Mart Associates, Inc.*, Claim No. 2002-050183 (LIRC August 30, 2012), the court held that an employee’s obesity was a superseding injury where it was inferred the treating physician’s opinion was that the employee’s underlying obesity made necessary her need for treatment after a specific date.

**III. In The Course Of Employment**

The evaluation of the “in the course of” requirement in worker’s compensation, deals with issues involving time, place, and circumstances. The courts have historically been very liberal in this area, and typically lean toward finding that an employee was in the course of his/her employment. *See Brienen v. Wisconsin Public Service Company*, 166 Wis. 24; 163 N.W. 182 (1917) (statutes are to be liberally construed in favor of including all service that can in any sense be said to reasonably come within them).

The courts have held that there is a presumption that, once an employee is in the course of properly performing his job duties, and there is no evidence to any abandonment of those job duties, the employee continues to be in the course of employment. *Tewes v. Industrial Commission of Wisconsin*, 194 Wis. 489; 215 N.W. 898 (1928).

**A. Coming and Going**

Typically an employee who is coming and going from his or her employment is not considered to be in the course of employment. However, there are a number of exceptions to that general rule.

The Wisconsin legislature has created a statute that governs “coming and going” situations. Wis. Stat. Section 102.03(1)(c)(2) states:

Any employee going to and from his or her employment in the ordinary and usual way, while on the premises of the employer, or while in the immediate vicinity of those premises if the injury results from an occurrence on the premises; any employee going between an employer’s designated parking lot and the employer’s work premises while on a direct route and in the ordinary and usual way; any volunteer firefighter, first responder, emergency medical technician, rescue squad member, or diving team member while responding to a call for assistance, from the time of the call for assistance to the time of his or her return from responding to that call, including traveling to and from any place to respond to and return from that call, but excluding any deviations for private or personal purposes; or any firefighter or municipal utility employee responding to a call for assistance outside the limits of his or her city or village, unless that response is in violation of law, is performing service growing out of and incidental to employment.
1. Parking Lots.

If a parking lot is designated by the employer, (whether the employer owns or otherwise controls the lot) an injury sustained in that parking lot while the employee is on his or her way to, or from, employment, is often considered compensable. This is true even when the parking lot is outside of an enclosed area where employees perform their duties, and the parking lot is separated from that enclosed area by a public street. *American Motors Corporation v. Industrial Commission*, 18 Wis.2d 246; 118 N.W.2d 181 (1962).

2. Travel between an approved parking lot and the employer’s premises.

See Wis. Stat. Section 102.03(1)(c)(2), addressing compensability of an injury occurred while the employee is traveling between an employer owned parking lot and the employer’s premises, in the ordinary and usual course. This is one of the few things considered very narrowly by the courts in worker’s compensation in Wisconsin. Under this statute, travel between the approved parking lots and the employer’s premises is considered compensable when it is performed in the ordinary and usual course, and travel is on a direct route.

In *Oscar Mayer Foods Corporation v. Labor and Industry Review Commission*, 145 Wis. 2d 864, 429 N.W. 2d 89 (Ct. App. 1988), the court held the employee did not sustain a compensable injury when she tripped and fell while attempting to climb over the barrier in the company parking lot on her way to work, even when her travel was a ‘beeline,’ because climbing over barricades that are nearly three feet high are not considered in the direct route under the statute, and are not in the usual and ordinary way, but instead are extraordinary and perilous. The court held that when an employer furnishes a safe means of ingress and egress, and the employee, for his or her own convenience chooses not to use it, but instead, selects a more hazardous means of leaving the premises, not customarily used by the employees, he or she steps outside the scope of his or her employment and it cannot then be said that an injury which he or she sustains while so leaving the premises arises out of his or her employment.

The standard of “usual and customary way” does not require an employee to use crosswalks, even if those are nearby, and even if they are not used for the employee’s own convenience, if most people cut across roads to get from the parking lot to the employer’s premises. In *Giffey v. Randstand*, Claim No. 2001-028890 (LIRC November 29, 2004), the court held the employee sustained a compensable injury when the employee was traveling in a direct, and ordinary and usual way, between the employer’s premises and its designated parking lot. The court held that crossing the road at a non-intersection was not so dangerous that it removed the travel from the ordinary and usual way.
This standard does not apply for those employees who are not traveling between an employer parking lot and the employer’s premises. In Judy A. Lynn v. Stoughton Trailers LLC, Claim No. 2009-015770 (LIRC November 30, 2010), the employee fell on the public sidewalk while approaching her place of employment. The employee was not walking from an employee designated parking lot. The employer’s responsibilities under city ordinances, to clear snow from the sidewalk and mow the area between the street and sidewalk, did not put the sidewalk sufficiently under the employer’s control to make the elbow injury compensable. The injury occurred as a result of the sidewalk and not the portion of her body which extended onto the employer’s premises, such that it would be statutorily compensable.

3. Spilled Over Danger.

The provisions of Wis. Stat. Section 102.03(1)(c) result in “spilled over danger” causing injuries to be compensable. However, this statute does not result in full and complete acceptance of the special hazards doctrine. If an employee is in the immediate vicinity of an employer’s premises, an injury that results from an occurrence on the premises [the spilled over danger] is compensable. Frisbie v. Department of Industry, Labor & Human Relations, 45 Wis.2d 80; 172 N.W.2d 346 (1969).


a. Traditional Reporting to Main Location.

When an employee traditionally reports directly to a main location, and periodically travels to another location before reporting to the main location, an injury sustained during that travel is typically compensable. See Bitker Cloak & Suit Company v. Industrial Commission, 241 Wis. 653; 6 N.W.2d 664 (1942) (injury during employer mandated trip to customer before reporting to work was compensable, despite the fact that the injury occurred in the portion of the trip that was identical to the employee’s normal commute to work).

b. Traditional Reporting to Job Site.

The courts have recently addressed the differences in compensability for injuries sustained when the employee regularly commutes from home directly to the worksite, vs. typically going into the office first.
Where an employee typically reports directly to the job site, and the employee does not typically first travel to the employer’s main location, when there is no pay received for that commute, and the employer did not furnish the transportation, an injury sustained during the travel between the employee’s home and the job site is not compensable. This is based upon the theory that the situation is no different than an injury sustained by a traditional employee commuting to his or her workplace. See McRae v. Porta Painting, Inc. 320 Wis.2d 178, 769 N.W.2d 74 (Ct. App 2009).

c. Employer Provided Transportation.

An injury that is sustained while the employee is commuting with an employer provided vehicle for use in performing job duties, or where the employer paid for expenses related to the employee’s travel, is typically compensable. Doering v. State of Wisconsin Labor and Industry Review Commission, 187 Wis.2d 472; 523 N.W.2d 142, (Ct. App 1994).

The courts look at whether (1) the employer agrees to provide for the transportation and (2) the employer exercises certain control over the means of transportation, such as the vehicle to be used or the destination traveled. See Doering.

d. Employer Paid Wages.

i. If an employer pays an employee wages for his or her travel, the travel is typically considered to be in the course of employment. See Bitker Cloak & Suit Company v. Industrial Commission, 241 Wis. 653; 6 N.W.2d 664 (1942).

e. Special Errands.

The Fay court also discussed Horvath v. Industrial Commission, 26 Wis. 2d 253 (1965). The Horvath Court held that a motor vehicle accident on the employee’s way home to bathe and change for a mandatory banquet was compensable, because the purpose in returning home was directly related to the employee’s employment.

In an unpublished Court of Appeals decision, County of Outagamie v. Labor and Industry Review Commission, 349 Wis. 2d 790 (Wis. Ct. App. 2013), an employee was determined to be on a special errand for his employer when he was paged to go into work on the date of injury while watching television, and slipped and fell while
salting his driveway on his way back into his home after completing the task at work, but before he completed the special errand by resuming watching of television.

5. Bringing Home Work.

Just because a person brings work home with him or her does not mean that the person is in the course of employment during his or her commute home, because it does not turn the home site into a business site or home office. In *Fay v. Trek Diagnostic Systems, Inc.*, Claim No. 2003-049932 (LIRC July 28, 2005), the court discussed an analysis of Larson’s treatise with respect to that issue. Under Larson’s, to determine whether a home is established as a workplace (1) there must be a clear business use of the home at the end of the journey on a particular day or (2) a showing that regularity of work and other factors endow the hours with continuing status of workplace even if there was no evidence the worker meant to perform services on a particular night.

An employee who works at home as an employee/caregiver during specific paid hours and performs the same activities as a daughter during other hours, is not acting in dual capacity such that an injury during “daughter” hours places the employee in the course of employment. See *Key v. Supportive Homecare Options, Inc.*, Claim No. 2011-022487 (LIRC January 9, 2014). See also *Town of Russell Volunteer Fire Dep’t v. LIRC*, 223 Wis. 2d 723, 589 N.W. 2d 445 (Wis. Ct. App. 1998).


Wis. Stat. Section 102.03(1)(c)(2) states, in part,

Any volunteer firefighter, first responder, emergency medical technician, rescue squad member, or diving team member while responding to a call for assistance, from the time of the call for assistance to the time of his or her return from responding to that call, including traveling to and from any place to respond to and return from that call, but excluding any deviations for private or personal purposes; or any firefighter or municipal utility employee responding to a call for assistance outside the limits of his or her city or village, unless that response is in violation of law, is performing service growing out of and incidental to employment.
B. Employer Premises

An injury that is sustained while an employee is on the employer’s premises, even during a lunch or break, regardless if the employee is on the clock, is typically compensable.

Similarly, an employee can sustain an injury after signing in for a shift, even before beginning to be paid for that shift. An employee need not be in pay status in order to be considered in the course of employment under the worker’s compensation act. An employee only needs to be performing services growing out of and incidental to his employment. The courts have long held that employees may still perform services growing out of and incidental to their employment, even though not technically in pay status. See Coates v. Milwaukee Transport Services, Inc., Claim No. 2010-011431 (LIRC July 30, 2012).

1. Breaks.
   a. Paid Breaks.

   If an injury occurs off the premises while the employee is on the clock (i.e. during a paid break) the injury may be compensable. Specifically, if an employee is on a paid break, and the employer furnishes transportation to allow the employee to go off the employer’s premises during that paid break, injuries sustained during that travel are likely compensable. In Krause v. Western Casualty & Surety Company, 3 Wis. 2d 61, 87 N.W. 2d 875 (1958), the employee was paid for the time he traveled to get coffee, and the employer furnished the transportation to and from where the coffee was to be obtained. The Krause court held the injury sustained in route was compensable.

   b. Unpaid Breaks.

   If an injury occurs off the premises of the employer, and while the employee is not on the clock, the injury is typically not compensable. Marmolejo v. Department of Industry, Labor & Human Relations, 92 Wis. 2d 674, 285 N.W. 2d 650 (1979).

2. Home as the workplace.

An employee who works at home may or may not sustain a compensable injury. The courts have not recently addressed this issue, and the significant increase in the number of people working at home may result in a different analysis than previously undertaken by the courts.
The courts most recently addressed this type of issue in 1973 in *Black River Dairy Products, Inc. v. Department of Industry, Labor & Human Relations*, 58 Wis. 2d 537, 207 N.W. 2d 65 (1973). That court provided some precedent for this situation to be a compensable injury, although the court also evaluated this issue under the “coming and going” scenario. In *Black River Dairy Products*, the court held that a compensable injury was sustained when a traveling salesman was injured while leaving his house, when he slipped and fell on his driveway, while he was on the way to the company truck parked in his driveway.

3. Expanded Employer Premises.

If an employee is off premises, and authorized or directed by the employer to be there, the employee may sustain a compensable injury. In *Continental Casualty Company v. Industrial Commission*, 26 Wis. 2d 470, 132 N.W. 2d 584 (1965), a compensable injury occurred when the employee was involved in a motor vehicle accident on the way home from a pheasant hunting trip. Business was discussed during that trip, and the trip also involved other business stops and discussions. The Court held that the hunting trip was in the nature of entertaining customers, and therefore, the injury was compensable.

However, a compensable injury is not automatically sustained just because the invitation for the gathering at the location was provided because of employee’s status in the employer’s organization, when an employee is not directed by the employer to be at the gathering. In *Schwab v. Department of Industry, Labor & Human Relations*, 40 Wis. 2d 686, 162 N.W. 2d 548 (1968), the court held an injury was not compensable when the employee was not performing services incidental to employment while attending social gathering to which he was invited by individuals at the employer’s facility. The *Schwab* court held that, just because an employer experiences some benefit from a social function in the form of increased morale and greater employee efficiency does not, as a matter of law, bring social and recreational pursuits within the course of one’s employment. The employer made it clear an employee would not be discriminated against for failing to attend one of the functions. There was no business formally discussed, and there were no formal speeches by anyone as a representative of the employer.

When there are common areas shared by the employer and another business, an injury sustained in that common area is deemed to have been sustained on the premises of the employer. *See Allikas v. West Beltline Subway, Inc.*, WC Claim No. 2005-043058 (LIRC July 9, 2007).
C. **Injuries Sustained While Participating in Recreational Activities**

Wis. Stat. Section 102.03(1)(c)(3) states, in part:

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.

This statute became effective April 1, 2006.

1. **Injuries Sustained off Employer Premises.**

   In *City of Appleton Police Department. v. Labor and Industry Review Commission*, 2012 WI App 50 (Wis. Ct. App. 2012), this statute was used as a basis to support compensability for a police officer who was injured while at home, performing push-ups, in anticipation of a mandatory physical fitness test. The courts noted that the collective bargaining agreement required all employees to participate in the testing, and if the employees performed well in the testing, they were in fact paid additional bonuses. The court of appeals upheld a determination that performing the same exercise required by the test in order to be able to perform well at the test, made the push-ups the officer was doing at home something that was not voluntary and therefore compensable.

   Also, in *City of Kenosha v. Labor & Industry Review Comm’n*, 2011 WI App 51 (Wis. Ct. App 2011), the court held an on-duty fireman sustained a compensable injury when playing basketball. The court held that it was common for on-duty firefighters to do certain physical activities during their shifts to maintain their physical condition. The fireman did not need to demonstrate that he received any compensation over and above his standard salary in order for this situation to be compensable under Wis. Stat. 102.03(1)(c)(3).

2. **Injuries Sustained on Employer Premises.**

   When participation of a recreational event is part of an employee’s job description, and the employer has control over that recreational event, an injury sustained during that recreational event is compensable. *See Wunsch v. City of Fond du Lac Fire Department*, Claim No. 93-040966 (LIRC December 21, 1994) (employee was subject to employer’s rules of conduct while participating in fund raising donkey baseball event, his participation was part of his job description and was considered in his performance evaluations and promotional opportunities, his participation benefited the department, the employer actively solicited its members to participate in the event, and the department publicized the event).
Additionally, an injury sustained during sports and recreational activities that occur on the employer’s premises, is compensable if performed during a paid break. See *E.C. Styberg Engineering Company, Inc. v. Labor and Industry Review Commission*, 278 Wis. 2d 540, 692 N.W. 2d 322 (Ct. App. 2004) (compensable injury sustained while playing baseball on employer’s premises during paid break, in an area where employer set up basketball hoop and posted a notice the hoop was available for employees to use during break periods. The court held that the participation in the recreational activity could be held to be a momentary and insubstantial deviation from employment.)

3. **Outside Event.**

See also *Weisbrot v. United Healthcare*, Claim No. 2003-020037 (LIRC April 8, 2005) (employee/nurse who was not required to attend a health fair, but did so during regular working hours, and received her regular pay during her attendance at that health fair, was in the course of employment while attending the fair, and the injury sustained during her attendance at the fair was compensable).

When the employee was invited by a supervisor to a baseball game as a reward for job performance, drank some beers, and later went to a bar where the employee was injured while arguing with a co-worker about who was better at playing a videogame, the employee was considered to be in the course of employment. The requirement of performing services growing out of and incidental to his or her employment is to be liberally construed and the activities at the bar were sufficiently related to the applicant’s work activities. See *Deutsch v. Staffing Partners, Inc.*, Claim No. 2010-025435 (LIRC June 25, 2013).

**D. Personal Comfort Doctrine**

Injuries sustained while attending to personal needs are generally determined to be in the course of employment. There are many things that have been determined to be compensable under this doctrine, including some things that are more ‘normal’ and other things that may not be traditionally thought of as personal comfort. Exceptions to the general compensability rule exist when the extent of the departure is so great that an intent to abandon the job temporarily may be inferred. See *Shore v. Dept. of Administration*, Claim No. 1999-033126 (LIRC May 24, 2012).

The courts have generally held that there must be a relation in time or space to employment in order for the personal comfort doctrine to apply. The injuries that have typically been determined to be compensable under the personal comfort doctrine have mainly occurred during specific paid working hours, and while an employee was on the employer’s premises. However, there have been some
exceptions for allowances of some time outside fixed hours of work for time spent
going and coming on premises, as well as an interval before working hours while
waiting to begin or making preparations, and a similar interval after hours, or
during regular unpaid rest periods taken on premises or during unpaid lunch hours
on premises. See American Motors Corp. v. Industrial Comm., 1 Wis.2d 261; 83
N.W. 2d 714 (1957) and Marmolejo v. Department of Industry, Labor & Human
Relations, 92 Wis. 2d 674; 285 N.W. 2d 650 (1979). Marmolego has a good
review of the various types of situations that have been determined compensable
under the personal comfort doctrine. The Marmolejo Court specifically addressed
a situation where the employee was involved in a motor vehicle accident when he
went out for lunch as a passenger in a car driven by a co-worker, and held that the
employee did not sustain a compensable injury.

The Marmolejo Court noted that the personal comfort doctrine has been held to
apply when an employee was involved in the following types of situations: getting
a drink; eating lunch on the premises; sleeping in place provided; visiting toilet;
riding on conveyance provided by master; going from place to place on a city
street; making a toolbox for own tools; acting as a millwright extinguishing fire;
working as a repairman and was eating ice cream in an isolation hospital and
contracted smallpox; sleeping near truck to which he had been assigned; self-
medication in a lumber camp; urinating while standing on running board of
moving truck.

A recent example of the court’s application of the personal comfort doctrine is
In Shore, the employee went to her car to get a can of soda. She stepped onto the
bumper step of the vehicle to see if her roof had been damaged by gravel which
had earlier in the day chipped her windshield. After examining her roof, she
misjudged the distance to the ground, fell, and injured her knee. Obtaining soda
from a vehicle to bring it into work is connected enough to personal comfort to
qualify as within the course of employment. The court held that stepping on the
bumper to check her roof was a momentary, impulsive and insubstantial
deviation. The court held the employee’s decision to check her roof was quite
understandable, the kind of act a perfectly ordinary, reasonable individual might
do, and not an intent to temporarily abandon her job. Her knee injury was
determined to be compensable.

If an employee is on a private errand, but on the premises of the employer or
doing the errand away from the employer’s premises at the employer’s request,
the injury would be compensable. See Rode v. Quality Asphalt, Claim No. 1999-
007149 (LIRC May 5, 2000) (compensable injury when employee was on a paid
lunch excursion made at the employer’s request).
E. Prohibited Acts

Violating an employer directive, if it is only for the employee’s benefit, is not compensable. However, if it is in furtherance of the employer’s interests, even if it violates the employer’s directives, but furthers the employer’s needs and not just the employee’s needs, it is compensable. See Regent Insurance Company, vs. Labor and Industry Review Commission, 320 Wis.2d 482, 769 N.W2d 877 (Court of Appeals 2009) (employee had been instructed specifically by his employer that he was not to operate machinery for which he had not been trained to operate. The employee decided to move a machine that he had not been trained to operate because it was blocking the path he needed to take to complete his job duties. This was determined to be compensable because an employee’s disobedient actions which are undertaken in furtherance of the employer’s interests are still within the scope of employment.). But see Fletcher v. Specialty Automotive, Inc. Claim No. 2009-001519 (LIRC April 28, 2014) (employee moved dirt with his bulldozer after completing his normal workday. The employee was not asked to perform this and the employer was not aware the employee would perform this activity. The activity was not reasonably necessary for the employer’s interests. The employee conceded these activities were not part of his normal job duties.).

F. Deviations

If there is a deviation from employment responsibilities, the injury is not compensable. There is a deviation if there is a willful abandonment of the job duties to perform an act that is in furtherance of employee’s own purpose. See Kosteczko v. Industrial Commission, 265 Wis. 29; 60 N.W. 2d 355 (1953) (ride operator left his post to go on a nearby ride, without the relief operator that was necessary to have permission to leave his post – no compensable injury sustained); Tyrrell v. Industrial Commission, 27 Wis.2d 219; 133 N.W.2d 810 (1965) (salesman/traveling employee went to a nearby city to visit a tavern, a city which did not have any food or lodging available, and had not returned to the normal route used in his work at the time of the injury.). The courts have held that poor judgment is not a deviation. See McFarlin v. Certco Inc., Claim No. 2002-041890 (LIRC March 19, 2007). See also Isaac Bracey v. Milwaukee Transport Services, Inc. Claim No. 2010-018481 (LIRC February 28, 2012)(a bus driver chasing a man who spit on the driver on his way out of the bus, and who slipped and fell on the sidewalk, sustained a compensable injury because the deviation was impulsive, momentary and insubstantial). See also Bernal v. Alpha Homes of Wis., Claim No. 2012-002146 (LIRC March 27, 2014) (a group home counselor slipped and fell while she went to move her car into a garage during a snowstorm sustained a compensable injury. Leaving the residents alone without supervision while moving her vehicle was not a deviation from employment because she regularly unloaded groceries form her vehicle without residents being in her line of sight despite employer policies to the contrary. Further, moving her vehicle was arguably to allow the employer contracted snow removal crews to fully clean the driveway, which furthers the employer’s interests and is therefore not a deviation.)
In order to determine whether the conduct that lead to an injury constituted a substantial deviation from employment, the courts have adopted a four-part test set out in 1A A. Larson, the Law of Workmen’s Compensation, sec. 23.00 at 5-122 (1982). This test includes the following:

i. the extent and seriousness of that deviation;

ii. the completeness of the deviation (i.e. whether it was commingled with the performance of duty or involved an abandonment of duty);

iii. the extent to which the practice of horseplay had become an accepted part of the employment; and

iv. the extent to which the nature of the employment may be expected to include some such horseplay.

See Nigbor v. Department of Industry, Labor & Human Relations, 120 Wis. 2d 375; 355 N.W. 2d 532 (1984); Bruns Volkswagen, Inc. v. Department of Industry, Labor & Human Relations, 110 Wis. 2d 319; 328 N.W. 2d 886 (Ct. App. 1982) (horseplay was fairly common and no formal discipline had ever taken place for horseplay, it occurred during a natural lull in service, was of short duration and impulsive – therefore it was an insubstantial deviation and the injury arose out of the employment). But see Simonz v. Wal-Mart Associates, Inc., Claim No. 2012-010488 (LIRC March 27, 2014) (applicant was mimicking a coworker and attempted to step on the back of his shoes with the goal of having his co-worker’s shoe come off. This was a significant deviation and dangerous for the employee and his co-worker. Horseplay was not tolerated by the employer and the co-worker could have tripped and injured himself. The employee’s injury sustained while engaging in this activity was not in the course of employment).

The court looks at the extent of the departure itself, and not the consequences of the horseplay deviation. See Nigbor (death by cutting a person’s head off is not compensable because it was a substantial deviation).

G. Intoxication

Intoxication via alcohol or drugs does not take an injury out of the course of employment, and intoxication is not synonymous with personal deviation. However, it is considered a safety violation under Wis. Stat. Section 102.58, and compensation is decreased by 15%. See City of Phillips v. Department of Industry, Labor & Human Relations, 56 Wis. 2d 569, 202 N.W. 2d 249 (1972).

Traveling employees who have become intoxicated and then attempted to return to a domicile for the night, but sustained frostbite because of passing out in the winter weather, have been determined to be in the course of employment. See Heritage Mut. Ins. Co. v. Larsen, 234 Wis. 2d 525; 611 N.W.2d 470 (Wis. Ct. App. 2000).
H. Traveling Employees

Under Wis. Stat. Section 102.03(1)(f):

Every employee whose employment requires the employee to travel shall be deemed to be performing service growing out of and incidental to the employee’s employment at all times while on a trip, except when engaged in a deviation for a private or personal purpose. Acts reasonably necessary for living or incidental thereto shall not be regarded as such a deviation. Any accident or disease arising out of a hazard of such service shall be deemed to arise out of the employee’s employment.

Therefore, there is a statutory presumption that traveling employees are covered portal to portal. Under the statute, if there is a personal deviation on the trip, which is not incidental to living or reasonably necessary, an injury sustained during that deviation would not be compensable. Once the employee ended the deviation, the employee would return to being in the course of employment. The burden of proving a personal deviation on the trip by the employee is upon the party asserting the deviation. See CBS Inc. v. Labor and Industry Review Commission, 219 Wis. 2d 564, 579 N.W. 2d 668 (1998) (ski injury of traveling employee assigned to cover winter world games was compensable as an activity incidental to living even when injury occurred during free time).

Eating dinner is not a substantial deviation and is a normal activity for a traveling employee. Hansen v. Industrial Commission, 258 Wis. 623; 46 N.W. 2d 754 (1951).

An employee, who is the aggressor in a physical altercation after purposefully exiting a vehicle (while otherwise in a traveling employee status), and who is not acting in furtherance of the employer’s interests by his actions, does not act within the course of employment for that employer. See Pipkin v. Nick H. Hull, Claim No. 2015-010177 (LIRC October 31, 2016).

1. Dual Purpose Trips.

In order to establish liability of the employer in a traveling employee/dual purpose situation, the service of the employer must be a concurrent cause of the trip, and the trip must have been made although the personal motive had been canceled. If the work had no part in creating the necessity for travel, if the trip would have gone forward though the business errand had been dropped, and if the trip would have been canceled upon failure of the private purpose, despite the potential for a business purpose, the travel is then personal and not in the course of employment. See James v. Industrial Commission, 18 Wis.2d 239; 118 N.W.2d 185 (1962).
I. Assisting or Rescues Others/Rescue Doctrine

An employee who becomes aware of an emergency situation, and rescues an employee from another employer, without any benefit to the rescuer’s regular employer, becomes an employee of the rescued employee’s employer (or the special employer). This is known in Wisconsin as the Conveyors/Cherry doctrine. See Conveyors’ Corp. vs. Industrial Comm’n., 200 Wis. 512, 228 N.W. 118 (1930); Cherry v. Industrial Comm’n, 246 Wis. 279, 16 N.W.2d 800 (1944). This doctrine applies regardless of whether the special employer agents or employees requested the rescuer’s assistance. Michels Pipeline Construction, Inc. v. Labor and Industry Review Commission, 197 Wis. 2d 927, 541 N.W.2d 241 (1995). See also Larsen v. Beloit Corp., 2003 WI Wrk. Comp. LEXIS 73 (LIRC March 31, 2003) (compensable injury when employee rescued a co-worker trapped in a machine).

J. Injuries Resulting from Medical Treatment for Related Injuries

Any medical injury sustained as the consequence of treatment of a work-related injury relates back to the original compensable event. The consequences of medical treatment, whether the result of negligence or not, are the liability of the employer under the act. Jenkins v. Sabourin, 104 Wis. 2d 309; 311 N.W.2d 600 (1981).

The Court addressed a related issue in Hammen v. Kraft Foods Global, Inc., Claim No. 2011-014179 (LIRC January 30, 2013). In this case, an employee alleged medical treatment in the nature of sedentary restrictions, caused him to develop deep vein thrombosis. The Hammen court considered the lack of strict bed rest in holding a compensable injury was not sustained as a result of the sedentary restrictions imposed upon the employee as a result of his compensable back injury. The Hammen Court indicated that, if an employee’s inactivity as a result of a back injury was a material factor in the development or progression of the deep vein thrombosis condition, that condition would be compensable even though the employee was genetically predisposed to the development of that condition because Wisconsin follows an “as is” rule, and in light of Jenkins.
**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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### WISCONSIN WORKER’S COMPENSATION BENEFITS BASICS

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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.” *Kaiser 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 were “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 gastrointestinal 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 not 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 disabled 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

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].

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<th>Employee Name</th>
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<th>Name of Insurance Company or Self-Insured Employer (do not list adjusting company)</th>
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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

- **a. Standard base wage**: $____
- **b. Hours per week**: (fill in "usual scheduled hours," check the box you use to set the wages)
- **c. Base weekly rate**: (Include those hours paid at time-and-a-half: [See Instructions] ______)
- **d. Additional weekly compensation from Section 3 below**: (see 4.c)
- **e. Average weekly earnings**: (hourly)

### 2. Gross Wage Divide

- **a. Gross taxable wages in 52-week period prior to date of injury**: $____
- **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

- **Free meals** (number/week)
- **Room** (number of days/week)
- **Tips** (number/week)
- **House or Apartment Weekly Amt** $____

| Total Weekly Value: $____ |

### 4. Part-Time Employment

- **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. %**: ______

(Choose a, b or c that applies)

- **a. Employee works 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 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.**

**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

- **a. Weekly Wage (Greater of #1 or #2 above)** $____
- **b. 66.67% OR 100% (see 4.c)**
- **c. Weekly TTD Rate**: $____

Insurance Claim Representative Telephone Number ______ (See reverse side for instructions)

WKC-13-A (R. 08/2009)
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, 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 times 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.
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 ____________________

WKC-12698 (R. 03/2009)
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].

<table>
<thead>
<tr>
<th>WC Claim Number</th>
<th>Employee Name</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Employee Social Security Number</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injury Date</th>
<th>Insurance Company Name (not adjusting company)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Week Ending</th>
<th>Hours Emp. Worked</th>
<th>At Hourly Rate</th>
<th>Wages Earned</th>
<th>Weekly Wage at Time of Injury</th>
<th>Wage Loss</th>
<th>% of Wage Loss</th>
<th>TTD Rate</th>
<th>TPD Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

TOTAL

WKC-7359 (R. 02/2009)
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 Equivalent to amputation at next most proximal joint
Prosthesis Grade upward
Stump not functional
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%
1−1/2 inches 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° 30%
dorsiflexion
Mal position Grade upward
Total loss dorsiflexion 12–1/2%  
Total loss palmarflexion 7–1/2%  
Total loss inversion 5%  
Total loss eversion 5%  

**Examples:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01/1992</td>
<td>Fusion</td>
<td>10% PTD</td>
</tr>
<tr>
<td>12/01/1992</td>
<td>Laminectomy &amp; Re–fusion</td>
<td>20% PTD</td>
</tr>
</tbody>
</table>

(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 (dissection) and a 2) fusion procedure, 10% permanent total disability will apply when the 2 surgical procedures are done at the same time or separately.  

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01/1992</td>
<td>Fusion</td>
<td>10% PTD</td>
</tr>
<tr>
<td>12/01/1992</td>
<td>Laminectomy at New Level</td>
<td>20% PTD</td>
</tr>
<tr>
<td>05/01/1993</td>
<td>Fusion at 12/1/92 Level</td>
<td>25% PTD</td>
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<tr>
<td>12/01/1993</td>
<td>Re–fusion at 5/1/93 Level</td>
<td>30% PTD</td>
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(12) Fingers

(a) Complete ankylosis

<table>
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<tr>
<th>Joint</th>
<th>Loss of Motion</th>
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</thead>
<tbody>
<tr>
<td>Distal joint only</td>
<td>100%</td>
</tr>
<tr>
<td>Proximal joint only</td>
<td>90%</td>
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<tr>
<td>Distal and proximal joints</td>
<td>80%</td>
</tr>
<tr>
<td>Carpal metacarpal joint only</td>
<td>70%</td>
</tr>
<tr>
<td>Distal, proximal and carpal metacarpal joints</td>
<td>60%</td>
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</tbody>
</table>

(b) Loss of Motion

<table>
<thead>
<tr>
<th>Joint</th>
<th>Flexion</th>
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<th>Extension</th>
<th>Loss of Use</th>
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</thead>
<tbody>
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<td>1%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
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<td>4%</td>
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<tr>
<td>Distal and proximal joints</td>
<td>30%</td>
<td>3%</td>
<td>30%</td>
<td>6%</td>
</tr>
<tr>
<td>Carpal metacarpal joint only</td>
<td>40%</td>
<td>4%</td>
<td>40%</td>
<td>8%</td>
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<td>Middle joint only</td>
<td>60%</td>
<td>6%</td>
<td>60%</td>
<td>12%</td>
</tr>
<tr>
<td>Proximal joint only</td>
<td>70%</td>
<td>7%</td>
<td>70%</td>
<td>14%</td>
</tr>
<tr>
<td>Distal and middle joints</td>
<td>80%</td>
<td>8%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Distal, middle and proximal joints</td>
<td>90%</td>
<td>9%</td>
<td>90%</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Joint</th>
<th>Flexion</th>
<th>Loss of Use</th>
<th>Extension</th>
<th>Loss of Use</th>
</tr>
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<tbody>
<tr>
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<td>5%</td>
<td>10%</td>
<td>2½%</td>
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<tr>
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<td>10%</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>Middle joint only</td>
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<tr>
<td>Carpal metacarpal joint only</td>
<td>60%</td>
<td>35%</td>
<td>60%</td>
<td>30%</td>
</tr>
<tr>
<td>Distal, proximal and carpal metacarpal joints</td>
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<td>40%</td>
<td>70%</td>
<td>40%</td>
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<tr>
<td>Middle joint only</td>
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<td>45%</td>
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<td>50%</td>
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<tr>
<td>Proximal joint only</td>
<td>90%</td>
<td>50%</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Distal joint only</td>
<td>100%</td>
<td>60%</td>
<td>100%</td>
<td>70%</td>
</tr>
</tbody>
</table>
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.
### Private Rehabilitation Counselor Fee for Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee</th>
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<tbody>
<tr>
<td>1996</td>
<td>$1,028.00</td>
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<tr>
<td>1997</td>
<td>$1,058.00</td>
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<td>1998</td>
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<td>1999</td>
<td>$1,109.00</td>
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<tr>
<td>2000</td>
<td>$1,133.00</td>
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<tr>
<td>2001</td>
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<td>2002</td>
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<td>$1,548.00</td>
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<td>2018</td>
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<td>2019</td>
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### Mileage Expenses

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<th>Rate</th>
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<td>11/15/69</td>
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</tr>
<tr>
<td>07/01/73</td>
<td>$.11 per mile</td>
</tr>
<tr>
<td>07/01/75</td>
<td>$.14 per mile</td>
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<td>07/01/77</td>
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<td>07/01/80</td>
<td>$.19 per mile</td>
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<td>07/01/81</td>
<td>$.20 ½ per mile</td>
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<td>07/01/82</td>
<td>$.21 ¼ per mile</td>
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<td>01/01/91</td>
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<td>01/01/94</td>
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<td>12/01/07</td>
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<td>07/01/08</td>
<td>$.48 ¾ per mile</td>
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<tr>
<td>07/01/12</td>
<td>$.51 per mile</td>
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### Meal Expenses

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<tr>
<th></th>
<th>In-State</th>
<th>Out-of-State</th>
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<tbody>
<tr>
<td>Breakfast</td>
<td>$8.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>Lunch</td>
<td>$10.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>Dinner</td>
<td>$20.00</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

*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.
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Weekly Wage For Temporary, Permanent Total &amp; Death Benefits / Date</th>
<th>Maximum Temporary, Permanent Total &amp; Death Benefits Weekly Rate</th>
<th>Maximum Temporary, Permanent Total &amp; Death Benefits Daily Rate</th>
<th>Maximum Wage for Permanent Partial Only / Rate</th>
<th>Maximum Permanent Partial Monthly Rate</th>
<th>Maximum Permanent Partial Weekly Rate</th>
<th>Maximum Payment from Children’s Fund Monthly Rate</th>
<th>Maximum Payment from Children’s Fund Weekly Rate</th>
<th>Death Benefits to Unestranged Parents</th>
</tr>
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<tbody>
<tr>
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<td>$711.00</td>
<td>$118.50</td>
<td>$363.00</td>
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<td>$676.00</td>
<td>$112.67</td>
<td>$363.00</td>
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<td>$308.10</td>
<td>$71.10</td>
<td>$6,500.00</td>
</tr>
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<td>4/1/2006</td>
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<td>$744.00</td>
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<td>$378.00</td>
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WISCONSIN REHABILITATION AND RETRAINING BENEFITS

By
Susan E. Larson
Charles B. Harris
Jessica L. Ringgenberg
Jack M. McFarland
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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# Wisconsin Rehabilitation and Retraining Benefits

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Appendix A – Basic Questions Regarding Potential Vocational Rehabilitation Claims
Wisconsin Rehabilitation and Retraining Benefits

I. Overview of Rehabilitation Benefits

All employees who sustain injuries which are permanent, irrespective of whether they involve scheduled or unscheduled injuries, may be entitled to vocational rehabilitation benefits.

Wisconsin has created an agency to address vocational rehabilitation issues. 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. An employee is “ranked” in a process called the Order of Selection, to determine if there is eligibility for funding. 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 may proceed with private rehabilitation consultants. The employer and insurer bear the costs of the private rehabilitation consultants.

The employee becomes entitled to vocational rehabilitation benefits if suitable employment is not available by the date of injury employer. Suitable employment is typically considered anything above and beyond 85% to 90% of the employee’s pre-injury average weekly wage. (When an employee is going through private rehabilitation services, 85% of the average weekly wage is considered “suitable.” However, when an employee is going through DVR for rehabilitation services, the threshold is 90% of the average weekly wage.) An employer has sixty days to determine whether suitable employment is available once the employee receives permanent restrictions. If there is no response by an employer, it is assumed there is no suitable employment available. See Wis. Admin. Code DWD §80.61(1g) 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. However, if an employee refuses to accept a suitable employment offer from the date of injury employer, without reasonable cause, the employer and insurer are not responsible for any vocational retraining benefits. Effective March 2, 2016, a judge can direct an employer and insurer to pay for any future course of instruction or other rehabilitation training services under a DVR approved or private rehabilitation developed training program.

II. Retraining Benefits through DVR

If the employee is eligible to begin receiving rehabilitation services through DVR, then DVR will determine whether the employee is entitled to retraining benefits. The employer and insurer are now responsible for the cost of the retraining program. This is a 2012 change to the prior law that allowed for DVR to bear the cost of the tuition. The employer and insurer are also responsible for indemnity benefits for the first eighty weeks of the retraining program, in addition to reimbursement for the actual and necessary travel expenses to and from their vocational retraining, as well as meals and lodging during retraining. Effective March 2, 2016, employees are able to work up to 24 hours per week, while going through an approved retraining program, and still be entitled to temporary total disability benefits.
The amount of weekly indemnity benefits payable to an employee during a retraining program equals the temporary total disability rate. (The rate is escalated pursuant to “renewed period of disability” rate increases when the overall retraining program begins more than two years after the date of injury.) These indemnity benefits can be reduced by social security disability benefits under Wis. Stat. §102.44(5) and Michels Pipeline v. LIRC. Additionally, the indemnity benefits are reduced by any earnings the employee may have during the retraining program. This would result in temporary partial disability benefits being payable to the employee vs. temporary total disability benefits.

The mileage rate for reimbursement is set by the state on an annual basis, and equals the amount that state employees are entitled to receive for mileage reimbursement, under Wis. Stat. §102.61 and Wis. Stat. §20.916. Additionally, the policy is to limit the meal expense to the amount Wisconsin state employees are eligible to receive under Wis. Stat. §20.916(8). The statutes require the employee to be on campus studying in order to qualify for these meal expenses.

Traditionally, if an employee is determined to be eligible for rehabilitation services via DVR, and DVR recommends retraining, there have not been many effective defenses to payment of these retraining benefits. This is true because the DVR retraining programs have traditionally been provided something called “great deference.” Under the “great deference” standard, an ALJ and/or LIRC can only overturn a proposed retraining program on very limited grounds. Under Massachusetts Bonding & Ins. Co v. Industrial Com. (“Mass Bonding”) the Wisconsin Supreme Court held that an ALJ and/or LIRC cannot reverse or second guess the eligibly determination for retraining unless “highly material facts were misrepresented to or withheld from [DVR] or that [DVR] has applied an interpretation of the rehabilitation laws which is entirely outside the reasonable scope of interpretation and hence a clear abuse of administrative power.” The employer and insurer have traditionally been somewhat “stuck” with the determination of retraining being appropriate by DVR unless there is fraud or an abuse of discretion. The cases since Mass Bonding have demonstrated the difficulty of showing the fraud or abuse of discretions. In a situation where the state rehabilitation specialist did not meet with the employee before making a retraining decision, did not attempt to find other retraining alternatives, and did not contact the date of injury employer, the Court of Appeals found there was no abuse of discretion. See Beloit Corp. v. LIRC, and Karpes v. Tradesman Int’l Inc. However, in a case where an employee misrepresented his date of injury average weekly wages by $11,000.00 per year, fraud was determined to be present. See Webster v. LIRC. In Webster, the court also held that retraining was not appropriate because, in light of the correct earnings, the anticipated salary after the retraining would have improved and not restored the employee’s earning capacity. It is important to keep in mind that an employer and insurer need to be careful in defending against claims for retraining benefits when DVR is involved. Under Home Insurance Co. v. Rickie Henderson, the court held there was bad faith when the DVR recommended retraining program was not approved and paid for, despite an opinion by the employer and insurer’s vocational expert that the retraining program was not necessary. This case law was all promulgated prior to the change in the law requiring the employer and insurer to bear the cost of the program. The rationale for the “great deference” standard has been explained by the public funds used to fund these programs when an employee is accepted for services by DVR. Now that there are no public funds used for these retraining programs, the courts may change the standard used to evaluate these cases. There have not been any reported cases, to-date, evaluating this situation under the new statute.
Fortunately, in either case this “great deference” is limited to only an eighty week program. While additional programs may be ultimately determined to be appropriate for an employee’s situation, there are additional defenses to any portion of a retraining plan that exceed eighty weeks. Those defenses are the same defenses that exist with regard to all retraining benefits via a private rehabilitation services, and are discussed in detail below.

One additional point, especially when an employee lives near the border of another state, is that DVR can “sponsor” the employee in a retraining program in a state outside of Wisconsin. If this occurs, the employee would be entitled to the same worker’s compensation benefits during the retraining program that the employee would be entitled to receive if the program was within the state of Wisconsin.

III. Retraining Benefits Via Private Rehabilitation Services

In contrast to when services are provided via DVR, if the employee is receiving rehabilitation benefits through a private organization, the specialist must first 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 Wis. Admin. Code 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 via job search, there is a rebuttable presumption that the employee requires retraining. If an employee were to pursue retraining, the employer and insurer would bear the burden of the entire cost of this program (tuition, books, costs) in addition to the above mentioned indemnity benefits. Effective March 2, 2016, employees are able to work up to 24 hours per week, while going through an approved retraining program, and still be entitled to temporary total disability benefits.

The employer and insurer can rebut the presumption of entitlement to retraining via an independent vocational expert opinion that the employee did not make an appropriate and diligent job search, which job search would restore the employee’s earning capacity, and/or that retraining cannot restore the employee’s pre-injury earning capacity. The only other way to rebut the presumption that retraining is appropriate, when a private rehabilitation specialist is involved, is to demonstrate that the employee or the specialist withheld highly material facts.

The Mass Bonding presumption, as discussed above, does not apply for situations where an employee is receiving benefits via a private rehabilitation specialist. Instead, review of the appropriateness of the retraining program is governed by Wis. Admin. Code DWD §80.49. Under DWD §80.49(1), “the primary purpose of vocational rehabilitation benefits is to provide a method to restore an injured workers as nearly as possible to the worker’s pre-injury earning capacity and potential.” However, the presumption of retraining programs under a private rehabilitation specialist recommendation has the same eighty week provisions that the DVR sponsored programs have. Under §80.49(3), the “extension of vocational rehabilitation benefits beyond 80 weeks may not be authorized pursuant to [Wis. Stat.] §102. (1) or (1m) if the primary purpose of further training is to improve upon pre-injury earning capacity rather than restoring it.”
In addition to those defenses discussed above, one of the main defenses that an employer and insurer has with regard to retraining programs via a private rehabilitation service and/or the programs through DVR that exceed eighty weeks, is the argument that the program is intended to “enhance” versus “restore” the employee’s earning capacity. The defense on this basis must be supported by an independent vocational expert’s opinion. Unfortunately, case law has indicated that the employee’s pre-injury earning “potential” must be considered in these disputes. This has resulted in numerous cases finding that four year, and even five year, retraining programs are appropriate, even when the employee has had a low date of injury average weekly wage. When completion of a G.E.D. program and/or remedial course program is vital to an employee completing a retraining program, some courts have approved worker’s compensation benefits during the ‘entrance’ programs. However, the case law has mainly supported the proposition that the G.E.D. and/or remedial programs must take place in a formal classroom training program.

IV. Strategies for Defense Against Retraining Claims
   
a. Offers of Suitable Employment

   On a threshold basis, an employer and insurer can defend against a retraining claim on the basis that the employee was offered suitable employment, and refused such employment without reasonable cause.

   Wis. Stat. §102.61(1g) in general addresses job offers in the context of benefits during a period of retraining. Once an employee has permanent restrictions imposed, the employer has 60 days to consider whether a job offer can be extended to the employee within such permanent restrictions. If a suitable job offer is made in writing to the employee, and the employee does not have reasonable cause to decline that job offer, the employee does not have a basis to maintain a claim for retraining benefits. This is a threshold defense for employers and insurers against these claims. A job offer that meets the statutory requirements, and there is no reasonable cause for refusal of that job offer, provides a defense against a retraining claim under Wis. Stat. §102.61(1g)(b) (if an employer offers an employee suitable employment as provided in par. (c) the employer or the employer’s insurance carrier is not liable for temporary disability benefits under s. 102.43(5)(b) or for the cost of tuition, fees, books, travel and maintenance under sub. (1)).

   Further, §102.61(a) provides a specific definition of what is considered “suitable employment” within the context of evaluating an employee’s entitlement to retraining benefits. §102.61(a) defines suitable employment as:

   Employment that is within an employee’s permanent work restrictions, that the employee has the necessary physical capacity, knowledge, transferable skills and ability to perform, and that pays not less than 90% of the employee’s pre-injury average weekly wage [excluding limited exceptions as outlined further.]
§102.61(1g)(c) provides the procedural requirements that must be followed in order for an employer and insurer to assert protection against a retraining claim. This section reads, in part:

On receiving notice that he or she is eligible to receive vocational rehabilitation services... an employee shall provide the employer with a written report from a physician... stating the employee’s permanent work restrictions. Within 60 days after receiving that report, the employer shall provide to the employee in writing an offer of suitable employment, a statement that the employer has no suitable employment for the employee, or a report from a physician... showing that the permanent work restrictions provided by the employee’s practitioner are in dispute and documentation showing that the difference in work restrictions would materially affect either the employer’s ability to provide suitable employment or a vocational rehabilitation counselor’s ability to recommend a rehabilitation training program. If the employer and employee cannot resolve the dispute within 30 days after the employee receives the employer’s report and documentation, the employer or employee may request a hearing before the department to determine the employee’s work restrictions. Within 30 days after the department determines the employee’s work restrictions, the employer shall provide to the employee in writing an offer of suitable employment or a statement that the employer has no suitable employment for the employee.  

(Emphasis added).

A job description is helpful to present in order to allow the judge to determine whether the position is within the employee’s permanent restrictions, in a way that meets the statutory requirement and definition of “suitable employment” under Wis. Stat. §102.61(a). If the job duties outlined in the position description will be modified in any way, the modification should similarly be communicated to an employee in writing. The Commission has not addressed the requirements of Wis. Stat. §102.61(1g) in more than a handful of occasions, and the Court of Appeals has not issued any significant cases interpreting this statute.

In Gibbs v. Stoughton Trailers LLC, Claim No. 2005-015799 (LIRC November 15, 2008), the Commission reviewed the position description that was included with the job offer. The position required various physical activities that were recommended against by the functional capacity evaluation. Additionally, the position description required prior experience and skills that the employee lacked. The Commission declined to hold that the employee should have inferred the required skills and functional capacity requirements were being waived by the offer. Instead, to be considered “suitable” the employment must be within the employee’s permanent restrictions, and the employee must have the necessary knowledge, skills and ability to perform the work. The statute puts the burden on the employee to make a suitable offer of work and the employer’s assertion that physical accommodations would have been made, training provided and that no
job offer is perfectly complete was not sufficient to decline to award benefits to the employee. The Commission held there was no way to determine whether the job would have actually been within the employee’s restrictions or skills based upon the documentation provided. Additionally, the Commission concluded the written job offer was made timely under Wis. Stat. §102.61(1g)(c); however, it also held the job offer should have specified the number of weekly hours offered to comply with the statute. [This is required because the employee needed to be aware that the position would exceed 90% of the date of injury average weekly wage, which is the requirement to be considered “suitable” for wage purposes under Wis. Stat. §102.61.]

Lifestyle and transportation must be considered as well. The employee may well have reasonable cause to decline an otherwise suitable job offer that was presented to the employee via the procedure outlined in the statute. If so, the employee is entitled to maintain a claim for retraining benefits.

In John B. Sims v. Time Warner Cable, Claim No. 2011-010016 (LIRC November 29, 2012), the applicant lived on the northwest side of Milwaukee. Prior to the injury, he worked at a location five minutes from his home. He worked Sunday through Wednesday because he had custody of his infant son from Thursday through Saturday. The employer offered the applicant work on the southeast side of Milwaukee. The applicant accepted this position, and used a provided company truck to work at the southeast Milwaukee location. However, the company truck was taken back shortly after this position began, because the applicant was no longer performing installation work. The applicant had no vehicle of his own. The bus ride would have been one and a half hours each way. Additionally, the position offered was Monday through Friday, which would have required the applicant to also get his infant son to daycare. The Labor and Industry Review Commission adopted the decision of the administrative law judge in its entirety, holding that the applicant had reasonable cause to refuse employment offered by the employer. The long bus ride would have required a transfer and over 100 stops. A change of daily commuting time from ten minutes to three hours is unreasonable on its face.

b. Additional Defenses

Even if suitable employment is not offered to an employee within the parameters provided in Wis. Stat. §102.61(1g) and/or an employee has reasonable cause to decline such an offer of employment, there may still be some additional defenses available to an employer and insurer when an employee has brought a retraining benefit claim.

As you likely have seen, retraining claims are becoming more and more common. This is particular true in cases where the injury is a scheduled injury, because there is no potential claim for loss of earning capacity. However, these claims often exist in situations involving unscheduled injury cases as well, because an employee can seek both loss of earnings and retraining benefits.
The cost of these claims is continuing to rise as well. An employee’s attorney will often seek and obtain an opinion that the employee requires a four year retraining program. The value of a four year degree program, including tuition, books, mileage, and meals, in addition to wage loss benefits, can often be between $150,000.00 and $200,000.00. This is typically in addition to other benefits (including wage loss benefits, physical permanency benefits and medical benefits) that have either already been paid out, or are being claimed, on the same case. While an opinion that job search is appropriate and retraining is unnecessary can sometimes be obtained, the situation is often that the defense vocational expert opines that a two year degree program would be sufficient to restore the employee’s earning capacity. A two year degree program is typically about half of the cost of a four year degree program. Therefore, settlement in these latter types of situations of even just a retraining claim (which typically falls somewhere between the cost of a two year program and a four year program), is still an expensive resolution to a matter.

In order to defend against the merits of a retraining claim, it is often helpful to have a lot of information regarding an employee’s background. Initial investigation of this matter can often help to provide an independent vocational expert with vital information that can provide important foundational support for the expert’s opinion. Often times an employee’s expert will not include all of the employee’s prior vocational history in the report. The employee’s expert will often leave out the portion of the vocational history that may indicate a stronger likelihood that the employee would not require retraining and/or would require less retraining than the employee is seeking. Therefore, it is important to get the employee’s employment application from the employer. When a claim is admitted and benefits are not questioned until retraining is proposed, the employee’s personnel file is often overlooked. However, the employment application can provide additional details regarding the employee’s past vocational history. An employee will be more likely to be truthful on an employment application prior to sustaining an alleged work-related injury, and that information can provide an independent vocational expert with vital information to support the defense of a claim.

Given the increased prevalence of retraining claims, it is often useful to anticipate such claims from the very beginning of a work-related incident, even an incident that would otherwise be admitted. Therefore, during a recorded statement, it is often useful to inquire regarding as many details of an employee’s background as possible. Questioning the employee about their educational background, including any degrees, certifications, etc. can often lead to information that an independent vocational expert can use to find the employee a new position without retraining. Additionally, inquiries regarding the employee’s complete vocational background, including all types of positions held in the past, can help provide more information that could lead to employment via job search versus retraining.
In order to defend against these claims, and control the costs as much as possible, this initial investigation is key. Additionally, obtaining a strong independent vocational expert opinion can provide an employer and insurer with increased leverage to seek to reduce the cost of retraining claims via lower settlement values. When retraining claims go to a hearing, it is typically a credibility issue between two vocational experts. The ALJ needs to determine which vocational expert has provided the most credible opinion. In making this determination, the ALJ will consider the foundation of the expert’s opinion. If the defense vocational expert can be provided with additional, relevant, information that the employee’s expert does not discuss, the foundation of the defense expert opinion is often times considered stronger than the employee’s expert opinion. While this is not enough to guarantee a victory at a hearing, with so many liberal ALJs in the Wisconsin Worker’s Compensation system, having a stronger vocational expert foundation is something that can at least help balance out the scales in the eyes of a liberal bench.
APPENDIX A

BASIC QUESTIONS REGARDING POTENTIAL VOCATIONAL REHABILITATION CLAIMS
Basic Questions Regarding Potential Vocational Rehabilitation Claims

Frequently the need for information regarding possible claims for permanent residual disability does not arise until litigation has started and defense counsel can address such issues. Sometimes the need for such information becomes apparent before litigation is commenced. If it does, you may want to consider asking questions of the claimant similar to those listed below.

1. Education
   - If individual did not graduate high school, what year did he/she complete?
   - Did individual obtain GED? If yes, what year? If no, did he/she check into requirements of obtaining GED?
   - Any college courses completed? Degree obtained? Course of study or program pursued?
   - Any Certifications or Licenses obtained throughout work history? Required of job? (ex. Forklift Operator Certification, year obtained, and active/inactive)
   - Computer usage and knowledge? Computer at home with Internet and/or smartphone? Any specific computer usage and knowledge from employment history?

2. Current Employment
   - Length of current employment
   - Job title
   - Perform any other jobs with current employer?
   - Full-time hours, schedule, as well as OT/shift differential, oscillating shifts, etc.

3. Work History
   - Job titles
   - Industries
   - How did the individual typically obtain employment (networking, newspaper, internet, etc.)
   - Supervisory experience, if yes, how many employees and duration of experience

4. Post-Injury
   - Performed any transitional duty tasks or modified pre-injury position? If yes, details regarding type of tasks, duration, etc.

5. Restrictions
   - What is the individual's understanding of his/her restrictions?
   - What are specific aspects of individual's pre-injury position unable to perform due to injury? Why?
   - Dominant hand.

6. Hobbies
   - Ask about pre and post-injury hobbies. Which activities is the individual unable to perform due to injury and why?
   - Volunteer experience
   - Activities of daily living: any changes in ability to perform household chores, driving, children responsibilities, and errands.
# 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 comiled 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 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 effect 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 biomechanical 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 branches 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 temporally 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 all 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 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.
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 satisfactorily 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 implantation. 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 credibility. 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 a right-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 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


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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Association of Football Subconcussive Head Impacts With Ocular Near Point of Convergence

Keisuke Kawata, MS; Leah H. Rubin, PhD, MPH; Jong Hyun Lee; Thomas Sim; Masahiro Takahagi, MEd; Victor Szwanki, MS; Al Bellamy, MS; Kurosh Darvish, PhD; Soroush Assari, BS, MS; Jeffrey D. Henderer, MD; Ryan Tierney, PhD; Dianne Langford, PhD

IMPORTANCE An increased understanding of the relationship between subconcussive head impacts and near point of convergence (NPC) ocular-motor function may be useful in delineating traumatic brain injury.

OBJECTIVE To investigate whether repetitive subconcussive head impacts during preseason football practice cause changes in NPC.

DESIGN, SETTING, AND PARTICIPANTS This prospective, observational study of 29 National Collegiate Athletic Association Division I football players included baseline and preseason practices (1 noncontact and 4 contact), and postseason follow-up and outcome measures were obtained for each time. An accelerometer-embedded mouthguard measured head impact kinematics. Based on the sum of head impacts from all 5 practices, players were categorized into lower (n = 7) or higher (n = 22) impact groups.

EXPOSURES Players participated in regular practices, and all head impacts greater than 10g from the 5 practices were recorded using the i1Biometerics Vector mouthguard (i1 Biometrics Inc).

MAIN OUTCOMES AND MEASURES Near point of convergence measures and symptom scores.

RESULTS A total of 1193 head impacts were recorded from 5 training camp practices in the 29 collegiate football players; 22 were categorized into the higher-impact group and 7 into the lower-impact group. There were significant differences in head impact kinematics between lower- and higher-impact groups (number of impacts, 6 vs 41 [lower impact minus higher impact = 35; 95% CI, 21-51; P < .001]; linear acceleration, 99g vs 1112g [lower impact minus higher impact= 1013; 95% CI, 621 – 1578; P < .001]; angular acceleration, 7589 radian/s² vs 65 016 radian/s² [lower impact minus higher impact= 57 427; 95% CI , 31 123-498; P < .001], respectively). The trajectory and cumulative burden of subconcussive impacts on NPC differed by group (F for group × linear trend1, 238= 12.14, P < .001 and F for group × quadratic trend1, 238 = 12.97, P < .001). In the higher-impact group, there was a linear increase in NPC over time (B for linear trend, unstandardized coefficient [SE]: 0.76 [0.12], P < .001) that plateaued and resolved by postseason follow-up (B for quadratic trend [SE]: −0.06 [0.008], P < .001). In the lower-impact group, there was no change in NPC over time. Group differences were first observed after the first contact practice and remained until the final full-gear practice. No group differences were observed postseason follow-up. There were no differences in symptom scores between groups over time.

CONCLUSIONS AND RELEVANCE Although asymptomatic, these data suggest that repetitive subconcussive head impacts were associated with changes in NPC. The increase in NPC highlights the vulnerability and slow recovery of the ocular-motor system following subconcussive head impacts. Changes in NPC may become a useful clinical tool in deciphering brain injury severity.

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subconcussive can be defined as a low-magnitude head impact that does not elicit clinical signs of concussion but potentially causes significant long-term neurological defects.1-3 Given the concern regarding concussion, understanding the effects of repetitive subconcussive impacts is critical because subconcussive impacts occur more frequently than concussions.4-6 American football, especially at the college level, is the sport associated with the highest incidence of concussion (0.61 per 1000 athlete exposures)7,8; moreover, college football players are reported to endure from 950 to 1353 subconcussive head impacts per season.4,9-11

While sports-related concussion is often attributed to a single impact, prior to the concussive blow, athletes in contact sports are frequently exposed to subconcussive head impacts.12 Establishing a threshold for concussion based on a single impact may be inconclusive given the variation in concussion-associated head acceleration (29g-205g).5,12 Head impact kinematics in contact sports are investigated using the Head Impact Telemetry system13,14 and accelerometer-embedded mouthguards.15,16 However, there are substantial knowledge gaps in the relationships between subconcussive impact kinematics and outcome measures.

The ocular-motor system orchestrates accommodation and vergence, and their concomitant adjustments enable individuals to visualize an object at various distances and directions.17 The near point of convergence (NPC) measures the closest point to which one can maintain convergence while focusing on an object before diplopia occurs.18 Previously, we reported that frontal soccer head headings immediately increased (worsened) NPC compared with baseline, with NPC impairment persisting for 24 hours after heading.19 The near point of convergence immediately after and 24 hours after heading were higher than in control individuals.19 Thus, we hypothesized that repetitive football subconcussive impacts would worsen NPC, particularly among players with higher magnitude and greater frequency of impacts compared with lower-impact players.

Methods
Participants
Thirty-three National Collegiate Athletic Association Division I football players at Temple University volunteered for this study. The study was conducted during a preseason physical examination on June 9, 2015, a series of full contact and no contact training camp practices (August 6-21, 2015), and postseason follow-up. Inclusion criterion was being an active football team member. Exclusion criteria included a history of head, neck, or face injury in the previous 6 months or neurological or ocular disorders. Four players exhibited abnormally high NPC scores (9.75 cm, 10.5 cm, 11 cm, and 12.5 cm) at preseason baseline that were higher than the team mean [SD] baseline (5.5 [2.0] cm). Because NPC scores higher than 9.5 cm to 10 cm are considered defective or convergence insufficiency,9-11 these players were excluded from the analysis. Data from participants diagnosed as having an orthopedic injury (n = 2) and concussion (n = 1) were excluded from further analysis. Participants refrained from substances that could affect their nervous system (eg, stimulants), and alcohol use was prohibited. All participants gave written informed consent, and the Temple University institutional review board approved the study.

Study Procedures
During preseason physical examination, participants were fitted with the Vector mouthguard (i1 Biometrics Inc) that measured the number of hits and magnitude of head acceleration. After being briefly submerged in boiling water, the mouthguard was fitted for each player’s bite for a secure custom fit. Demographic information (eg, age and years of American football experience), Sports Concussion Assessment Tool 3 symptom checklist, and ocular-motor function (NPC) were collected. During training camp practices, head impact data were collected from 5 practices with intervals of 3 to 4 days between measures, starting from first noncontact (pads off), first full contact (pads on), and 3 other full-contact practices (Figure 1). Postseason follow-up measurements were taken 3 weeks after the final game of season in a subset of participants (n = 18), and no practices occurred during this 3-week period.

Based on the sum from 5-practice impact kinematic data collections, players were categorized into lower- and higher-impact groups for analysis. There were at least 6 impacts, 186g, 9614 radian/s², and 15 head injury criterion differences between the highest value of the lower-impact group and the lowest value of the higher-impact group in the number of hits, peak linear acceleration, peak angular acceleration, and head injury criterion, respectively (Table). Symptom checklist and NPC data were collected 1 to 2 hours before and 1 to 2 hours after practices.

Instruments
Head Impact Measurement
The Vector mouthguard (i1 Biometrics Inc) was used for measuring linear and rotational head kinematics during impact. The mouthguard uses a triaxial accelerometer (ADXL377, Analog Devices) with 200g maximum per axis to detect linear acceleration. For rotational kinematics, a triaxial rotational rate gyroscope (L3GD20H, ST Microelectronics) was used. Accelerometer and gyroscope data were low-pass filtered at 180-Hz and 40-Hz cutoffs, respectively. When a preset threshold was triggered (peak linear acceleration magnitude >10g, 16 pretrigger...
Near Point of Convergence
Near point of convergence was assessed based on our established protocol. Participants were seated with their head in neutral anatomical position. No spectacles were permitted; participants wore contact lenses if needed. The accommodative ruler (Bernell Inc) rested on the participant’s upper lip, and an accommodative target (reduced-size Snellen chart) was adjusted horizontally to participant’s eye level. The target was moved down the length of the ruler toward the eyes at a rate of approximately 1 to 2 cm/s. Near point of convergence was taken when the tester observed eye misalignment or when participants verbally signaled experiencing diplopia. On verbal signal, the tester stopped moving the target and recorded the distance between the participant and object. The assessment was repeated twice, and mean NPC was used for analyses. One trained tester assessed all players at all time points, with intrarater reliability resulting in high association between trials of all time points (r = 0.93, P < .001).

Symptom Checklist
Participants were instructed to rate the presence of any symptom at each time point using the symptom checklist, a subset of the Sports Concussion Assessment Tool 3.

Statistical Analysis
Group differences (lower and higher impact) in baseline characteristics were compared using independent-sample t tests for continuous variables and χ² tests for categorical variables. To examine group differences in the effects of subconcussive impacts, we conducted a series of mixed-effects regression models (MRMs) on the primary outcomes (NPC and symptoms). The MRMs were used to accommodate repeated measurements across 12 times that were correlated with different degrees. Relative to other analytic approaches (eg, repeated measures analysis of variance), MRM accounts for missing data, which increases statistical power and preserves the representativeness of the results to the larger population.

Two separate MRMs were conducted on each outcome. The first MRM focused on group differences in the cumulative burden of subconcussive impacts across the study duration to determine whether the trajectory/burden differed between lower- and higher-impact groups. To this end, we conducted random linear and polynomial trend (quadratic) modeling, a subclass of MRM that accounts for both individual differences at baseline and over time (which may not be linear). Variables included in the model were group (lower and higher), time (linear trend), time × time (quadratic trend), and group by trend interactions. Significant group by trend interactions indicate that the pattern of change in an outcome measure over time differs between individuals in the lower- and higher-impact groups. The second MRM identified the initial time where group differences emerged (relative to baseline), remained, and declined across the study duration. The focus was on the rate of change in each outcome from baseline to each time point (eg, pads-off-1). Variables included in the analysis were group (low and high) and dummy variables for each time (eg, pads-off-1 prepractice, pads-off-1 postpractice, pads-on-1 prepractice, pads-on-1 postpractice, etc) and all 2-way interactions (eg, group × pads-off-1 prepractice, etc). The group × time interactions are the primary interest, and significance indicates that the change in an outcome from baseline to each time point differs for individuals in the lower- and higher-impact group. All MRMs were analyzed with SAS, version 9.4 for Windows (SAS Institute Inc) and significance was set at P < .05.

Results
Demographic and Head Impact Kinematics
A total of 1193 head impacts were recorded from 5 training camp practices in the 29 collegiate football players using a Vector...
mouthguard (Figure 2). Demographic and kinematic data for each group are summarized in the Table. There were no significant differences between lower and higher groups in age, body mass index (calculated as weight in kilograms divided by height in meters squared), number of previous concussions, and years of football experience. Conversely, there were significant differences in head impact kinematics between lower- and higher-impact groups (number of impacts, 6 vs 41 [lower impact minus higher impact = 35; 95% CI, 21-51; P < .001]; linear acceleration, 99g vs 1112g [lower impact minus higher impact = 1013; 95% CI, 621-1578; P < .001]; and angular acceleration, 7589 radian/s² vs 65016 radian/s² [lower impact minus higher impact = 57427; 95% CI, 31123–80498; P < .001], respectively) (Table).

Near Point of Convergence
The mean NPC by impact group did not differ at baseline ($F_{1, 238} = 0.15, P = .70$) (Figure 3). Regarding group differences, the trajectory and cumulative burden of subconcussive head impact and ocular-motor function.

### Table. Group Characteristics: Demographics, Position, and Head Impact Kinematics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Players (n = 29)</th>
<th>Group</th>
<th>Group Difference (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demographics, mean (SD)</td>
<td>Low Impact (n = 7)</td>
<td>High Impact (n = 22)</td>
<td></td>
</tr>
<tr>
<td>Age, y</td>
<td>20.6 (1.5)</td>
<td>20.9 (0.9)</td>
<td>20.5 (1.6)</td>
<td>−0.31 (−1.62 to 0.99)</td>
</tr>
<tr>
<td>BMI</td>
<td>30.0 (4.4)</td>
<td>28.3 (4.9)</td>
<td>30.6 (4.1)</td>
<td>2.33 (−1.51 to 6.18)</td>
</tr>
<tr>
<td>No. of previous mTBI</td>
<td>0.61 (0.8)</td>
<td>0.7 (1.1)</td>
<td>0.55 (0.7)</td>
<td>−0.17 (−0.91 to 0.58)</td>
</tr>
<tr>
<td>Years of football experience</td>
<td>9.4 (5.0)</td>
<td>9.14 (5.5)</td>
<td>9.09 (4.9)</td>
<td>−0.05 (−4.56 to 4.46)</td>
</tr>
</tbody>
</table>

### Graphs

- **Figure 2. Head Impact Kinematic Measurements Using Mouthguard and Sideline Monitoring System**
  - **A** Mouthguard
  - **B** Sideline monitoring system

  A, Triaxial accel senses linear acceleration and triaxial gyro senses angular acceleration. B, Sideline antenna receives impact data by radio transmission and store in the network server. Accel indicates accelerometer and gyro indicates gyroscope.

Abbreviations: BMI, body mass index, calculated as weight in kilograms divided by height in meters squared; DB, defensive back; DL, defensive lineman; HIC, head injury criterion; K, kicker; mTBI, mild traumatic brain injury; NA, not applicable; OL, offensive lineman; PAA, peak angular acceleration; PLA, peak linear acceleration; QB, quarterback; RB, running back; WR, wide receiver.

* Based on the sum from 5-practice impact kinematic data collections (see Methods section).
Figure 3. Near Point of Convergence Between Groups Across Time Points

There was a group × time point interaction. Polynomial indicates quadratic trend. Linear × time and quadratic × time interaction (P < .001) were driven by the near point of convergence change after pads-on 1 postpractice in the higher-impact group (P < .001). Pads off indicates a noncontact practice; pads on indicates a full-contact practice.

### Discussion

To our knowledge, this is the first prospective, longitudinal cohort study of collegiate football players examining the effects of repetitive subconcussive head impacts on NPC and self-reported symptoms. The first notable finding was that subconcussive head impacts were not associated with noticeable changes in players’ symptom reports, regardless of frequency and magnitude of impacts. Second, consistent with previous studies, repetitive subconcussive impacts compromised NPC function, but only among players in the higher-impact group. Lastly, after a 3-week rest period, postseason NPC was normalized to the preseason baseline in the higher-impact group, suggesting that ocular-motor function has the potential to reflect subclinical brain damage and its recovery.

While the team mean (SD) baseline NPC (5.5 [2.0] cm) was consistent with our previous study with healthy young adults
Among players in the higher-impact group, exposure to repetitive subconcussive impacts during contact practices increased NPC scores by approximately 29% to 38% relative to baseline levels. This is notable, given that a 3-fold increase in NPC has been demonstrated in both soldiers with blast-induced mild traumatic brain injury compared with non-mild traumatic brain injury control individuals\(^{25}\) and among 64 athletes with concussions compared with control individuals\(^{26,27}\).

When interpreting these findings, it is vital to consider the data collection days in relation to the summer camp schedule. Pads-off practice was the first day of the camp, and players had not sustained any significant impacts for at least the past 3 months. In the helmet-only pads-off 1 practice, most players incurred none or a few subconcussive head impacts (Table). There was no NPC change in prepractice vs postpractice or in preseason baseline in either higher- or lower-impact groups. After pads-off 1, we collected the data on the first full-gear practice of the camp (pads-on 1). While prepractice NPC score from pads-on 1 remained similar to the baseline and pads-off 1 data, postractice NPC scores were significantly increased in the higher-impact group, with no change in the lower impact group. There were 3- to 4-day intervals between each pads-on data collection. We observed consistently increased NPC scores in the higher-impact group, even at prepractice assessments, suggesting incomplete recovery of the ocular-motor system.

When considering the validity of head injury assessment tools, it is imperative to rule out the potential contribution of exercise and/or fatigue in relation to outcomes. The linear increase in NPC scores over time in the high impact group argues against the alternative hypothesis that fatigue and/or exercise influenced NPC. If NPC scores were impacted by fatigue and/or exercise, we would expect to see nonlinear fluctuations in prepractice vs postpractice scores.

Our kinematic data are consistent with several studies using the Head Impact Telemetry system. Mean numbers of hits per player per practice were 7.0, 7.6, and 9.4 hits in our study, Duma et al.,\(^{14}\) and Crisco et al.,\(^{13}\) respectively. Similarly, mean peak linear acceleration per hit was 30.3 g in our study, Duma et al.,\(^{14}\) and Reynolds et al.,\(^{28}\) respectively. Our motivation for using the mouthguard sensor was to avoid factors that may produce considerable measurement errors in a helmet-based approach such as helmet fit and padding type.\(^{29-31}\) Kinematic accuracy of the instrumented mouthguard resulted in an excellent correlation with the matched data from an anthropomorphic testing device (crash test dummy).\(^{15,32}\) Moreover, Wu et al.\(^{33}\) used a human soccer heading model to test the kinematic accuracy among headgear-mounted, mouthguard, and skin patch sensors, compared them with high-speed video, and showed that mouthguard displacements were less than 1 mm, whereas headgear and skin patch displaced as much as 13 mm and 4 mm from the ear canal reference points, respectively.

While larger prospective studies are needed to replicate our findings, this study detected changes in NPC over time as a function of group (higher vs lower impact). The 29 players studied contributed 325 observations for each of the primary analyses. Moreover, our validated NPC measurement\(^{19,22}\) does not require administration by an experienced physician but exhibits an excellent test-retest reliability \((r = 0.93, P < .001)\), suggesting its potential to be used in clinical practice. Future studies should consider additional time points for assessments, particularly during mid and late season. Additional time points might help to determine whether NPC would continue to increase throughout the duration of the season or stabilize before returning back to baseline levels postseason. Although the NPC measurement that we used provides a robust implication to clinical/sideline usage, the effect of subconcussive impact on dynamic convergence parameters, including slower peak velocity, longer latency period, and shorter duration of contractility, remain speculative.\(^{34-35}\) Traumatic brain injury produces heterogeneous signs and symptoms, and although eye movement metrics show vulnerability in response to various forms of traumatic brain injury,\(^{19,25,26,36}\) a single measure of eye movement/alignment does not have the sensitivity and specificity to accurately assess brain damage. Therefore, multiple approaches, including blood biomarkers,\(^{37}\) neuroimaging,\(^{38,39}\) and vestibular function,\(^{40}\) may be key in delineating concussion/subconcussion pathophysiology.

### Conclusions

There is growing concern that even low-level head impacts (subconcussive) can cause significant injury if sustained repetitively. While behavioral changes in response to subconcussive head impacts are difficult to measure, evidence coupled with neuroimaging data suggest that the ocular-motor system is particularly vulnerable and sensitive to head impacts.\(^{19,38,39,41}\) Our data provide evidence of cumulative defect in the ocular NPC, and these changes may be head impact frequency- and magnitude-dependent. After a 3-week rest period, NPC normalized to the baseline. Future prospective cohort studies to investigate the clinical relevance of these NPC changes induced by subconcussive impacts compared with concussion are warranted.

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MEDICAL TREATMENT PURSUANT TO MINNESOTA’S TREATMENT PARAMETERS

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I. INTRODUCTION

The 1992 legislature passed several provisions in an attempt to limit or reduce the cost of medical treatment in workers’ compensation cases. Among the cost containment measures passed by the legislature were the provisions that gave the commissioner authority to adopt emergency and permanent rules establishing standards and procedures for health care provider treatment. Minn. Stat. §176.83, subd. 5. The commissioner was directed to establish rules setting out criteria for diagnosis and treatment of the most common work-related injuries including, but not limited to, low back injuries and upper extremity repetitive trauma injuries; criteria for surgical procedures including, but not limited to, diagnosis, prior conservative treatment, supporting diagnostic imaging and testing, and anticipated outcome criteria; criteria for use of appliances, adaptive equipment and use of health clubs or other exercise facilities; criteria for diagnostic imaging procedures; criteria for inpatient hospitalization; and criteria for treatment of chronic pain.

The establishment of the treatment parameters represented an attempt by the Legislature to provide a more consistent set of guides for treatment. Previously, particular types of treatment were addressed on a case-by-case-by basis, applying the “reasonable and necessary” standard of Minn. Stat. §176.135.

Over the years, a significant body of case law has been established which guides employers, insurers and employees, as well as judges, on the type of medical treatment available to employees and what criteria should be used to determine the reasonableness and necessity of a particular form of treatment or supplies. For example, there has been litigation over whether or not an orthopedic mattress is a reimbursable prescription, whether air ride seats are reimbursable, whether athletic shoes are reimbursable, whether use of health club facilities or exercise programs are reimbursable, and whether home exercise equipment is reimbursable. A case-by-case analysis has been used to determine what is reasonable and necessary. If the employee can establish that the particular piece of equipment or prescription is specifically directed to address the needs of a particular injury, the employee may be able to obtain reimbursement or payment for a particular supply or treatment.

Chiropractic treatment has also been a source of significant litigation over the years. In Horst v. Perkins Restaurant, 45 W.C.D. 9 (WCCA 1991), the WCCA developed the following test to be used in determining whether chiropractic treatment is reasonable and necessary to cure or relieve the effects of a work-related injury:

A. The employee’s testimony as to the relief obtained in terms of extent, frequency and duration of treatment;
B. The possibility of other conditions not discovered by the chiropractor causing the employee’s problem;
C. The setting of a weekly schedule with no reduction to an as-needed status;
D. The period of relief from pain, in particular whether persistent pain returns;
E. The use of alternative medical providers in the event of continuing pain;
F. The employee’s overall activities and the extent of the employee’s ability to continue to work;
G. The recommendation of long term chiropractic care into the future which results in a maintenance rather than injury treatment;
H. The psychological dependency of the employee on chiropractic care.

Previously, the WCCA had established a similar list of factors that a compensation judge should consider when evaluating the compensability of chiropractic treatment. Those factors are as follows:

A. Evidence of a reasonable treatment plan;
B. Documentation of the details of treatment;
C. The degree and duration of the relief resulting from the treatment;
D. Whether the frequency of the treatment was warranted;
E. The relationship of the treatment to the goal of returning the employee to suitable employment;
F. Potential aggravation of underlying conditions by additional chiropractic treatment;
G. Duration of treatment;
H. The cost of treatment in light of relief provided.

Field-Seifert v. Goodhue County, File No. ***-**-0980 (WCCA March 5, 1995). See also Fuller v. Naegele/Shivers Trading, File No. ***-**-5333 (WCCA April 14, 1993); Ostrowski v. Majestic Electric Company, 47 W.C.D. 218 (WCCA 1992) (cost versus results is a factor to be used in determining the compensability of chiropractic services.)

The analysis set out in Horst and Field-Seifert, as well as the analyses that cover the prescription of durable medical equipment or surgery, mandate a case-by-case evaluation of the treatment in question with an emphasis on the individual employee’s response to care.

The Minnesota Department of Labor and Industry, acting pursuant to the assumed authority granted by the Legislature in Minn. Stat. §176.83, adopted emergency treatment parameters [“Emergency Rules”] effective May 18, 1993. The Emergency Rules represented a departure from the case-by-case analysis found in Horst and Field-Seifert. The rules limited treatment costs by specifically excluding certain items from any reimbursement, placing limitations on the length of certain types of treatment, and by requiring preauthorization for certain treatments.

The validity of the Emergency Rules was challenged. Many cases involving the application of the emergency treatment parameters were processed through the Department of Labor and Industry. Many of these cases have been tried to the Office of Administrative Hearings. The Supreme Court passed on some of the major substantive issues concerning the validity of the Emergency Rules. The Court concluded that the rules should be viewed as standards and not binding regulations. Hirsch v. Bartley-Lindsay, 537 N.W.2d 480 (Minn. 1995).
The Supreme Court’s opinion in *Hirsch* contains a historical recitation of the facts and circumstances giving rise to the issuance of the Emergency Rules. The Court specifically cited the enabling legislation which granted to the Commissioner of Labor and Industry authority to “adopt emergency permanent rules establishing standards and procedures for health care provider treatment” for purposes of determining “whether a provider of health care services . . . is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate based upon accepted medical standards for quality health care and accepted rehabilitation standards.” Minn. Stat. §176.83, subd. 5.

In discussing the rules, the Supreme Court focused on Minn. Rule 5221.6050 [Emergency] subp. 8C, which provided an exclusive list of factors that the commissioner or a compensation judge could consider in determining whether treatment given or proposed is excessive under the Emergency Rules. “In resolving a dispute over payment of medical care, a compensation judge is limited to ascertaining whether a treatment rule applies, whether the treatment provided or proposed to be provided is consistent with the rule, and whether departure from the rule is allowed because one of the four reasons specified in the list of departure reasons.” *Hirsch v. Bartley-Lindsay Company*, 537 N.W.2d 480, 483 (Minn. 1995).

When analyzing the rules and comparing them to the enabling legislation found in Minn. Stat. §176.83, as well as the “medical benefit provision” (Minn. Stat. §176.135), the Supreme Court concluded that the Commissioner exceeded his authority when attempting to establish binding regulations with regard to the delivery and compensability of medical care. The Court identified two specific problems with the rules.

The first “problem” identified by the Supreme Court concerned those rules under consideration that provided durational limits on medical care, as well as the timing of the medical care. The Court noted that Minn. Stat. §176.135 had “long been recognized” as placing no limitation on the duration of medical care. It noted that it was significant that the Legislature did not amend the phrase found in Minn. Stat. §176.135, subd. 1, that medical care is provided “at the time of injury and any time thereafter,” “although it could have done so.” *Id.* at 486.

The Supreme Court specifically rejected the argument of the commissioner that durational limits on medical services are essential to accomplishing the legislative goal of cost containment. “While certainly durational limitations on medical care facilitate cost containment, to deny payment for reasonably priced medical care that works, simply because of a time line, subverts the primary purpose of the medical benefits provision.” *Id.* Based upon this conclusion, the Supreme Court ruled that, to the extent durational limits on medical care set out by the rules conflict with Minn. Stat. §176.135, subd. 1, the statute prevails. Therefore, the Supreme Court specifically found as invalid Minn. Rule 5221.6200 [Emergency] subp. 3 (providing a 12-week limitation on passive treatment modalities) and Minn. Rule 5221.6300 [Emergency] subp. 11B (pertaining to the timing of surgery for epicondylitis.)
The Court also found objectionable the “exclusive list of departure reasons” found in Minn. Rule 5221.6050 [Emergency] subp. 8C. The Court analyzed the enabling legislation. Although the legislation authorized the commissioner to establish standards and procedures for health care provider treatment, the provision also provided that “if it determined by the payer level, frequency or cost of procedure of service is excessive, unnecessary, or inappropriate according to standards established by the rules, the provider shall not be paid . . . unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency or cost was not excessive, in which case the insurer, self-insurer, or group of self-insurers shall make a payment deemed reasonable.” *Id.* quoting Minn. Stat. §176.83, subd. 5. The Court concluded that Minn. Stat. §176.135, subd. 1(e) places the issue of necessity for treatment in the discretionary power of the compensation judge. The exclusive list of reasons for departing from the emergency rules infringes on that discretion. The Court indicated that compensation judges do have a certain degree of independence from the agency in which they adjudicate disputes. The compensation judge serves as the fact finder and decision maker in the workers’ compensation adjudication system and must develop all of the evidence, including that contrary to the claimant’s position, through hearings and investigations. The compensation judge must then issue a decision based upon relevant evidence. The Court ruled that, to the extent that the exclusive list of departure reasons (Minn. Rule 5221.6050 [Emergency] subp. 8C) unduly infringes on the discretionary power of a compensation judge, the rule exceeds the authority granted by the Legislature.

The Supreme Court indicated that the rules could be used as “standards” rather than binding regulations. Used in such a manner, all parties would have “guidance” as to what treatment is compensable without dispute. “If the rules could be used as standards, and not as binding regulations, compensation judges would have a model from which to judge the propriety of medical treatment that has been provided, yet retain the flexibility to perform their judicial function based upon the evidence before them in an individual case.” *Id.* at 487.

The Supreme Court in *Hirsch* invalidated what were felt to be the most substantial cost-saving measure in the Emergency Rules. Without strict durational limits and with the rules being relegated to a position of non-binding standards, litigation on medical issues returned to the case-by-case analysis that had been in place prior to the “Rules Era.”


At the time the rules were being proposed, the Department of Labor and Industry was aware of the legal challenges to the Emergency Rules. In response to these challenges, the Department removed the language suggesting an “exclusive” list of factors that a compensation judge must consider when determining the compensability or excessiveness of medical treatment. The operative rule now reads:
A determination of the compensability of medical treatment under Minnesota Statutes, chapter 176, must include consideration of the following factors:

1. whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;
2. if a specific or general parameter applies, whether the treatment is consistent with the treatment parameter and whether the treatment was medically necessary as defined in part 5221.6040, subpart 10; and
3. whether a departure from the applicable parameter is or was necessary because of any of the factors in subpart 8.

Minn. Rule 5221.6050, subp. 7D.

The Department also modified the “departure provision,” which is found in Minn. Rule 5221.6050, subp. 8. That provision provides the following: A departure from a parameter that limits the duration or type of treatment in parts 5221.6050 to 5221.6600 may be appropriate in any one of the circumstances specified in items A to E. The health care provider must provide prior notification of the departure as required by subpart 9.

A. Where there is a documented medical complication.
B. Where previous treatment did not meet the accepted standard of practice and the requirements of parts 5221.6050 to 5221.6600 for the health care provider who ordered the treatment.
C. Where the treatment is necessary to assist the employee in the initial return to work where the employee’s work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee’s response to the treatment, and efforts to promote employee independence in the employee’s own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.
D. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:
   1. the employee’s subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;
   2. the employee’s objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and
   3. the employee’s functional status, especially vocational activity, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.
E. Where there is an incapacitating exacerbation of the employee’s condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts 5221.6050 to 5221.6600.

The Emergency Rules addressed conditions involving low back pain, upper extremity disorders, medical imaging, inpatient hospitalization and surgical procedures. The Treatment Parameters also address those topics. In addition, however, the coverage has been expanded to include the cervical spine, thoracic spine, reflex sympathetic dystrophy, and chronic pain treatment. The rules have been further expanded to regulate prescription medication and long-term opioid use.

On June 11, 1998, the Minnesota Supreme Court issued a decision that addressed the validity of the treatment parameters. In Jacka v. Coca-Cola Bottling Company, 580 N.W.2d 27 (Minn. 1998), the Minnesota Supreme Court addressed questions certified by the Chief Administrative Law Judge of the Office of Administrative Hearings with regard to certain provisions of the Treatment Parameters. The Court held that the Rules in question, Minn. Rule 5221.6200, subp. 3 and Minn. Rule 5221.6050, subp. 8, were valid exercises of authority delegated to the Minnesota Department of Labor and Industry; did not conflict with Minn. Stat. §176.135, subd. 1; were to be used by compensation judges as standards which establish the limits of compensable treatment in all but the most “exceptional” circumstances; and apply to all treatment provided after January 4, 1995, regardless of the date of injury. This decision seemed to validate all of the provisions found in the Permanent Rules. However, decisions rendered by the courts since then have limited the application of the Treatment Parameters in many instances.

The Court specifically determined that the Treatment Parameters remedied the problems that the Court found in the Emergency Rules as discussed in Hirsch v. Bartley-Lindsay Company, 537 N.W.2d 480 (Minn. 1995). The Court, as discussed above, identified two specific problems. The first “problem” was that the enabling legislation did not appear to authorize the Department of Labor and Industry to encroach upon the traditional role of the compensation judge by limiting the grounds for departing from the parameters to an exclusive list. The second “problem” was that the Emergency Rules placed durational limits on medical services, in contravention of Minn. Stat. §176.135.

The Supreme Court cited two “significant” changes that took place since it considered the Emergency Rules. The first was in the Rules themselves, with regard to the durational limits, as well as the departure provisions. With regard to the limits, the Court specifically cited the fact that an additional 12 visits over 12 months would be allowed after the initial 12 calendar weeks of treatment. Additional treatment is allowed, beyond that, if it is approved by the insurer, commissioner or compensation judge, based upon documentation that the treatment is “effective” in maintaining employability or, for a permanently totally disabled employee, in maintaining functional status. Therefore, the Court found that the departure provision was significantly different from its predecessor,
in that it did not provide an exclusive means of departing from the rules. The Court held that the changes in the Treatment Parameters provide a compensation judge with the flexibility to extend medical treatment for as long as it is medically necessary and effective.

In addition, the Court noted that changes subsequently made by the legislature clarified the legislative intent. They specifically cited the 1995 amendment to the enabling legislation, which indicated that the Rules should be used to determine whether a provider is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary or inappropriate “under §176.135, subd. 1.” The legislature also indicated that the Rules were to be used to deny payment, unless the commissioner or compensation judge determines that the level, frequency or cost was not excessive “under the rules.” The Court ruled, therefore, that the Rules in question were valid, given the “inherent flexibility” of the Treatment Parameters and the clarification of the legislative intent.

Thus, the Supreme Court provided significant validity to the Treatment Parameters as a whole. The Court specifically indicated that the Rules should be viewed as standards which establish the limits of compensable treatment “in all but the most exceptional circumstances.” In addition, the decision also appeared to demonstrate the Court’s deference to the Rules. The Court specifically stated that a compensation judge may depart from the Rules only in those “rare” cases in which the departure is necessary to obtain proper treatment. Consequently, while Jacka provided the opportunity for a departure, it appeared that the burden on the employee to substantiate a departure was not to be viewed lightly by a compensation judge. Case law subsequent to Jacka has, through time, watered down the “rare case exception” concept and, generally, made it easier to establish.

In Asti v. Northwest Airlines, 588 N.W.2d 737 (Minn. 1999), the Supreme Court gave an indication as to what qualified as one of the “rare” cases identified in Jacka that would allow a judge to depart from the rules entirely. In that case, the compensation judge awarded a health club membership that began approximately six months after the employee had returned to unrestricted work in his usual occupation as a flight attendant. The WCCA reversed and found that the facts did not support a determination that the health club membership was authorized under Minn. Rule 5221.6050, subp. 8C, as a departure from the Treatment Parameters. The Supreme Court reversed the decision of the WCCA. The Court agreed that the health club membership was not indicated by the parameter covering such treatment, Minn. Rule 5221.6600, subp. 2B(3). It also agreed with the decision of the WCCA that the employee failed to meet the specific departure requirements under Minn. Rule 5221.6050, subp. 8C. However, the Court went on to state that, in spite of these failings, the “inquiry does not end there.” Since the treatment had been found to be “reasonable and necessary” under prior court decisions and, absent participation in the program, the employee would be unable to continue in his employment, the Supreme Court ruled that this was one of those “rare” cases where a departure from Treatment Parameter rules is necessary.
In *Martin v. Xerox Corporation*, File No. ***-**-7357 (WCCA July 15, 1999), the WCCA explicitly stated that the “rare case” departure contemplated by the Supreme Court in *Jacka* is “a departure from the treatment parameters in their entirety, including the departure provision in Minn. Rule 5221.6050, subp. 8.” In that case, the WCCA affirmed the decision of Compensation Judge LeClair-Sommer that allowed a carpal tunnel surgery in spite of a normal EMG. In so doing, she did not follow the requirements of Minn. Rule 5221.6300, subp. 13, which indicated surgery for carpal tunnel syndrome would be indicated “if an EMG confirms the diagnosis.” The WCCA affirmed the finding of the compensation judge that the treatment was reasonable and necessary under prior court decisions in light of the fact that other treatment had not relieved the employee’s symptoms, which were worsening and which symptoms limited her activities of daily living and her ability to perform the job. The WCCA went on to state that the decision “should not be taken as encouragement for compensation judges to resort to the *Jacka* ‘rare case’ exception simply to avoid application of the Permanent Treatment Parameters. Rather, the rare case exception is just that. Furthermore, an award under that exception should not be considered unless the judge first determines that the proposed treatment is otherwise reasonable and necessary under case law criteria and that the treatment is not consistent with any treatment parameters raised by the parties, including the departure parameters.” See also *Pawlitschek v. Dundee Steel, Inc.*, File No. ***-**-3827 (WCCA September 7, 1999).

The “rare case exception” has also been utilized to justify repeat imaging which is beyond the Treatment Parameters. In *Anderson-Olson v. Waters of Park Point*, File No. ***-**-4929 (WCCA April 16, 2003), the employee sustained a work-related injury in 1990. Two MRI scans done during the 1990’s showed mild degenerative changes with no disc protrusion, neural compression or spinal stenosis. Throughout this time she continued to have symptoms of back and leg pain. In 2001 the employee filed a Medical Request for a neurosurgical consultation. This request was granted after an administrative conference. However, the consultation did not proceed because of the neurosurgeon’s request for another MRI prior to the consultation. The insurer denied this request on the basis of the medical treatment parameters. The WCCA affirmed the compensation judge’s approval of the MRI prior to the neurosurgical consultation. It found that the MRI was beyond the medical treatment parameters, but allowed the MRI based upon a “rare case exception.” See *Jacka*. Noting that a determination of a rare case exception is a factual issue, the WCCA found substantial evidence to support the judge’s decision. The evidence supporting this conclusion included the employee’s ongoing complaints, and the fact that the employee would be denied treatment already ordered by another judge if the MRI were denied.

*Comment:* The MRI requested was clearly beyond the treatment parameters, which do not allow for diagnostic studies prior to evaluation of a patient and review of prior records. However, in this case, the neurosurgeon was allowed to avert application of the parameter by requiring the scan prior to the evaluation. Despite the fact that the case law indicates that rare case exceptions should be reserved for exceptional circumstances which cannot be anticipated, the WCCA affirmed the judge’s determination. This case, therefore, demonstrates that the WCCA will give wide discretion to judges in determining what constitutes a “rare case.”
Further, it should be noted that the WCCA has found that the departure provisions of the treatment parameters contemplate situations in which a preexisting condition or other work injuries, in combination with the work injury at issue, cause a more complicated and prolonged course of symptoms, disability, and treatment results. See Jackson v. Minneapolis Public School District No. 1, WC09-5027 (WCCA April 8, 2010).

II. GENERAL TREATMENT PARAMETERS

The Treatment Parameters, like the Emergency Rules, contain general treatment parameters that apply to all treatment provided by health care providers. The rules also provide for very specific treatment parameters for medical imaging, low back pain, neck pain, thoracic back pain, upper extremity disorders, reflex sympathetic dystrophy of the upper and lower extremities, inpatient hospitalization, surgery, chronic pain and certain medications.

A. Purpose and Application - Minn. Rule 5221.6020

The rules establish parameters (criteria) for reasonably required treatment for employees with compensable workers’ compensation injuries to prevent excessive services under Minn. Stat. §176.135. The rules are not intended to affect any determination of liability for an injury under Minn. Stat. Chapter 176. The rules also do not expand the scope of a particular provider’s practice.

All treatment, including that within a specific treatment parameter, must still be “medically necessary” (see Minn. Rule 5221.6040, subp. 10; 5221.6050, subp. 1). “Medically necessary treatment” means those health services for a compensable injury that are:

1. Reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter in parts 5221.6050 to 5221.6600; or

2. Where parts 5221.6050 to 5221.6600 do not govern, the treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider’s license or certification.

Minn. Rule 5221.6040, subp. 10.

In the absence of a specific parameter, any applicable general parameters govern. A departure from a parameter that limits the duration or type of treatment may be appropriate in any one of the circumstances specified in Minn. Rule 5221.6050, subp. 8 (see below).

**B. Effective Date and Application of the Parameters - Minn. Rule 5221.6020**

The treatment parameters apply to all treatment provided after the effective date of the rules (January 4, 1995), regardless of the date of injury. *See Jacka v. Coca-Cola Bottling Co.*, 580 N.W.2d 27 (Minn. 1998).

The parameters do not apply to treatment of an injury after an insurer has denied liability. Minn. Rule 5221.6020, Subp. 2. This rule remains solidly supported in case law through the present time. *See Meyer v. Genmar Transportation, Inc.*, File No. WC15-5845 (WCCA March 1, 2016) (“because the employer and insurer denied medical causation for the employee’s condition at the time of the [treatment], the medical treatment parameters do not apply.”) However, the parameters do apply to treatment given after liability has been established. *See Fulton v. United Defense Systems*, File No. ***-**-1305 (WCCA December 10, 1999). *See also Dawson v. University of Minnesota*, File No. ***-**-6887 (WCCA May 6, 1999.) In a series of decisions, the WCCA has further limited the circumstances under which the Treatment Parameters may be utilized as a defense to the compensability of medical treatment.

In *Oldenburg v. Phillips & Temro Corporation*, File No. ***-**-5328 (WCCA October 29, 1999), the principle was extended to those situations where the employer and insurer has alleged that an injury is merely temporary. The WCCA indicated that, in such circumstances, the employer and insurer may not reasonably rely on the parameters to deny payment for treatment rendered after the alleged resolution of the injury. *See also Johnson v. Metz Baking Co.*, WC08-230 (WCCA May 1, 2009).

In *Mattson v. Northwest Airlines*, the WCCA extended the concept of inapplicability of the Treatment Parameters to also include situations in which primary liability is admitted, but medical causation is disputed. In *Mattson*, the WCCA reversed the compensation judge’s application of the treatment parameters to deny medical expenses claimed by the employee, where the employer and insurer had admitted liability for the work injury, but denied that the employee’s current need for treatment was causally related to the injury. The employer and insurers, while admitting that the employee sustained a personal injury in 1993, denied that the employee’s current condition in 1998 was causally related to that injury and denied primary liability for the employee’s claimed *Gillette* injury in 1997. The employer and insurers contended that Minn. Rule 5221.6020, subp. 2, was not applicable because the insurer initially admitted primary liability for the 1993 injury. The WCCA observed that under that rule, the parameters do not apply to treatment for an injury after an insurer has “denied liability” for the injury. The WCCA held that for the purposes of application of the permanent medical treatment parameters, a denial of liability includes both a denial of primary liability and a denial of medical causation for subsequent
symptoms or conditions. The WCCA held that for all practical purposes, the employer and insurer’s denial of medical causation for the employee’s condition is no different than a denial of primary liability, as in both cases, the employer and insurer effectively have no real interest in information about the course of the employee’s care and no legitimate expectation of influencing or limiting the employee’s treatment options. Thus, the employer and insurer cannot deny that an employee’s “condition” is work related, but assert the protection of the treatment parameters. The WCCA noted that the treatment parameters are a defense to payment of medical expenses incurred after liability is accepted. See Mattson v. Northwest Airlines, File No. ***-**-9040 (WCCA November 29, 1999.)

Along the same lines, the WCCA has found that, where an employer and insurer rely on a medical report in which it is opined that an injury is no longer a substantial contributing factor in the treatment at issue, the treatment parameters cannot be used as a defense to the treatment at issue. See De La Cruz v. Sunrise of Edina, WC12-5530 (WCCA August 9, 2013).

Additionally, the WCCA has ruled that, if an employer and insurer admit primary liability for one injury, but deny primary liability for another injury, the treatment parameters cannot apply to treatment that is later found to be related to the denied injury. Bayliss v. National Steel Pellet Co., WC12-5535 (WCCA June 11, 2013).

On the other hand, the WCCA has suggested that an employer/insurer’s denial of certain diagnoses following from an admitted work injury may not bar use of the Treatment Parameters as a defense. In Wolfe v. Wesi Johnson Screens, File No. ***-**-6801 (WCCA June 6, 2002), the employee sustained an injury to his right upper extremity on March 1, 1994. The injury was admitted and the insurer paid benefits and medical expenses. The employee ultimately was given a diagnosis of reflex sympathetic dystrophy (RSD) and sought approval for spinal cord stimulator implantation surgery. Compensation Judge Hagen approved the request. The insurer argued that the judge erred in finding that the treatment parameters did not apply, and that the case qualified for a “rare case exception” as defined in Jacka. The WCCA affirmed. It concluded that the judge erred in finding that the treatment parameters were inapplicable. The judge had contended that the insurer had denied primary liability with respect to the RSD condition, and alternatively, had argued that RSD, if it had been present, was resolved. The judge ruled that given those arguments, the treatment parameters did not apply. The WCCA concluded that the judge’s findings were incorrect. The WCCA acknowledged that the insurer’s contesting of the RSD diagnosis did not necessarily mean that it contested liability for the work injury, as the insurer had admitted liability for the work injury and had paid benefits since 1994. Nevertheless, the WCCA affirmed that this was a “rare case,” justifying departure from the treatment parameters. It accepted the judge’s rationale that the employee had gone through extensive treatment, was on narcotic medications, and that the surgery had a high probability of providing relief without drug intervention. In 2019 the Minnesota Supreme Court provided a more definitive answer to the question of whether the denial of liability for one condition prevents an
employer/insurer from seeking application of the Treatment Parameters to treatment for admitted injuries. Johnson, William v. Darchuks Fabrication, Inc., Case No. A18-1131 (Minn. Sup. Ct. April 24, 2019). In Johnson, 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.

C. Definitions - Minn. Rule 5221.6040

The Treatment Parameters set forth definitions for the following terms: active treatment; chronic pain syndrome; condition; emergency treatment; etiology; functional status; illegal substance; initial non-surgical management or treatment; medical imaging procedures; medically necessary treatment; morphine-equivalent milligrams; neurologic deficit; passive treatment; and therapeutic injection. Omitted from the definitions which had been contained in the Emergency Rules are the following terms: effective treatment; exacerbation. These definitions should be kept in mind when reading the remainder of the rules, and reference must always be made to the definition section at the beginning of the permanent treatment parameters.

D. Duties of Medical Providers - Minn. Rule 5221.6050

1. General - Minn. Rule 5221.6050, subp. 1

The health care provider must evaluate the medical necessity of all treatment on an ongoing basis. The provider must evaluate at each visit whether initial non-surgical treatment for the low back, cervical, thoracic, and upper extremity conditions is effective. In doing so, the provider must show improvement in at least two of the following three criteria: (1) subjective complaints of pain or disability are progressively improving; (2) the objective clinical findings are progressively improving; and (3) the employee’s functional status, especially vocational activities, is
progressively improving. Unless otherwise provided, if there is not progressive improvement in at least two of the criteria, the treatment modality must be discontinued or modified, or the diagnosis must be reconsidered. It may be necessary to consider surgery or chronic management modalities.

The decision from the compensation judge and the WCCA following the remand of the Jacka case from the Minnesota Supreme Court provides an example of what is determined effective treatment. In that case, Judge Otto found that the chiropractic treatment beyond 12 weeks was awardable as an appropriate departure from the Treatment Parameters pursuant to Minn. Rule 5221.6050, subp. 8D. The WCCA affirmed. It specifically found that the treatment awarded met at least two of the three criteria established for “effective treatment.” Specifically, it affirmed the judge’s determination that the treatment resulted in progressive improvement of subjective complaints and objective improvement of the employee’s functional status. It cited to the records of the chiropractor that indicated that the employee was treating two to four times per month, was showing subjective and objective improvement and the frequency of the treatment was decreasing. Jacka v. Coca Cola Bottling Company, File No. ***-**-3864 (WCCA April 13, 1999).

The provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee’s own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

2. Documentation - Minn. Rule 5221.6050, subp. 2

A health care provider must maintain an appropriate record of any treatment provided to a patient. An appropriate record is a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury (see Minn. Rule 5221.0100, subp. 1a). See Carlson v. ISD No. 709, File No. ***-**-2651 (WCCA October 27, 1994).

3. Nonoperative Treatment - Minn. Rule 5221.6050, subp. 3

A health care provider shall provide a trial of non-operative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, an emergency situation exists, or the accepted standard of initial treatment for the condition is surgery.

4. Chemical Dependency - Minn. Rule 5221.6050, subp. 4

The health care provider shall maintain diligence to detect chemical dependency to any medication prescribed for treatment of the employee’s condition.
E. Referrals - Minn. Rule 5221.6050, subp. 5

1. General

The primary health care provider directing the course of treatment shall make timely and appropriate referrals for consultation for opinion or for the transfer of care if the primary health care provider does not have any reasonable alternative treatment to offer and there is a reasonable likelihood that the consultant may offer or recommend a reasonable alternative treatment plan. A consultation in other circumstances may be appropriate based on accepted medical practice and the patient’s condition, e.g., where a provider would like a confirming opinion in a complicated case.

2. Referrals from Consulting Provider

If the consultant has reasonable belief that another consultation is appropriate, that consultant must coordinate further referral with the original treating health care provider, unless the consultant has been approved as the treating health care provider. The consultant is under no obligation to provide or recommend treatment or further referral, if in the consultant’s opinion, all reasonable and necessary treatment has been rendered. The consultant shall in this situation refer the employee back to the original treating health care provider for further follow-up.

3. Information Sent to Consultant

When a referring health care provider arranges for consultation or transfer of care, except in cases of emergency, the referring health care provider shall, with patient authorization, orally or in writing summarize for the consultant the conditions of injury, the working diagnosis, the treatment to date, the patient’s response to treatment, all relevant laboratory and medical imaging studies, return to work considerations, and any other information relevant to the consultation. In addition, the referring health care provider shall make available to the consultant, with patient authorization, a copy of all medical records relevant to the employee’s injury.

F. Prior Treatment for Condition - Minn. Rule 5221.6050, subp. 6

1. Information Requested by New Health Care Provider

Upon accepting for treatment a patient with a workers’ compensation injury, the health care provider shall ask the patient if treatment has been previously given for the injury by another health care provider. If the patient reports that treatment has been previously given for the injury by another health care provider and if the medical records for the injury have
not been transferred, the new health care provider shall request authorization from the employee for relevant medical records. Upon receipt of the employee authorization, the new health care provider shall request relevant medical records from the previous health care providers. Upon receipt of the request for medical records and employee authorization, the previous health care providers shall provide the records within seven working days.

2. Treatment by Prior Health Care Provider

If the employee has reported that care for an injury has been previously given, where a previous health care provider has performed diagnostic imaging, a health care provider may not repeat the imaging or perform alternate diagnostic imaging for the same condition except as permitted in the rule.

When a therapeutic modality employed by a health care provider was no longer improving the employee’s condition, or has been used for the maximum duration allowed under the parameters, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies under subpart 8, after surgery, or for treatment of reflex sympathetic dystrophy.

It is also inappropriate for two health care providers to use the same treatment modality concurrently.

3. Employee Refusal

An employee’s refusal to provide authorization for release of medical records does not justify repeat treatment or diagnostic testing by a subsequent provider. An insurer is not liable for repeat diagnostic testing or other duplicative treatment.

G. Excessive Treatment - Minn. Rule 5221.6050, subp. 7

1. General

In addition to services deemed excessive under Minn. Rule 5221.0500 and Minn. Stat. §176.136, subd. 2, treatment is excessive if:

(a) The treatment is inconsistent with an applicable parameter; or

(b) The treatment is consistent with the parameters, but is not medically necessary treatment. See Minn. Rule 5221.6040, subp. 10.
2. Notice of Denial to Health Care Providers and Employee

If the insurer denies payment for treatment that departs from a parameter, it must provide the employee and health care provider with written notice of the reason for the denial and that the treatment rules permit departure from the parameters in specified circumstances. If the insurer denies authorization for proposed treatment after prior notification has been given, it must provide the employee and health care provider written notice of the reason why the information given by the health care provider does not support the proposed treatment and notice of the right to review of the denial. (See Minn. Rule 5221.6050, subp. 9.)

The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the health care provider with at least 30 days’ notice of intent to apply any of the chronic management parameters to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

3. Dispute Resolution

If the insurer denies authorization or payment for treatment, the health care provider or the employee may request a determination from the commissioner or compensation judge by filing a Medical Request or petition under Chapter 5220 and the Minnesota Statutes. In cases requiring prior notification of treatment under subpart 9, the Medical Request may be processed on an expedited basis. Certain specific items must be attached to the Medical Request and the Medical Response, if appropriate.

When a legal dispute exists regarding the compensability of medical treatment under the Treatment Parameters, and the dispute is addressed by way of a medical request, administrative conference, claim petition/hearing, or some other type of proceeding, parties are required to identify the specific Parameter at issue or relied upon for their position. Parameters not specifically identified by the parties need not be considered by the compensation judge. See Jordan v. Howard Lumber Company, below.

In Jordan v. Howard Lumber Company, File No. ***-**-6430 (WCCA August 28, 1998), the compensation judge awarded disputed chiropractic treatment and the employer and insurer appealed. The WCCA reversed and remanded the matter to the compensation judge to analyze the case under the Permanent Treatment Parameters. Although the matter was remanded, the WCCA made the following statement: “Because the parameters are so lengthy and convoluted, the parties are directed on remand to identify to the judge which specific parameters are relevant to
the treatment at issue and how those parameters should be interpreted and applied to the facts of this case. The judge need not consider rules not addressed by the parties.”

The WCCA has continued to follow the rationale provided in Jordan. In Lanigan v. Superwood Corporation, File No. ***-**-1732 (WCCA April 25, 2001), the compensation judge denied the employee’s request for physical therapy. The judge ruled that the treatment, which was passive in nature, exceeded the treatment parameters. The WCCA reversed. It found that the employer had failed to identify the specific treatment parameters that apply to the case. Based upon prior case law, the WCCA found that the parties must “inform the judge as to which specific rules are at issue.” The parties did not do so, and the judge did not identify the specific treatment parameter. Therefore, the order denying the treatment was reversed and the matter remanded. See also Olson v. Allina Health System, File No. ***-**-2987 (WCCA February 5, 1999) (WCCA held it would consider appellate challenges based on the Treatment Parameters, “only if the issue is raised in the appellant’s brief, and then, only to the extent of the specific Rule/Parameter cited and addressed in that brief.”)

4. Compensability of Medical Treatment

A determination of the compensability of medical treatment must include consideration of the following factors:

a. Whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;

b. Whether the treatment is consistent with an applicable or general treatment parameter and whether the treatment is “medically necessary”;

c. Whether a departure from the applicable parameter is or was necessary.

H. Departures from Parameters - Minn. Rule 5221.6050, subp. 8

A departure from a parameter that limits the duration or type of treatment may be appropriate in any one of the circumstances specified below. The health care provider must provide prior notification of the departure as required by subpart 9.

1. Where there is a documented medical complication. See Smith v. Country Manor Health Care, File No. ***-**-5291 (WCCA January 31, 2000), in which a low back strain, superimposed upon a pre-existing Scheuermann’s disease, was felt to be a “documented medical complication” warranting a departure from the durational limits of clinical passive treatment modalities for low back pain.
2. Where previous treatment did not meet the accepted standard of practice and the requirements of the parameters for the health care provider who ordered the treatment.

3. Where the treatment is necessary to assist the employee in the initial return to work where the employee’s work activities place stress on the part of the body affected by the work injury. The provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee’s response to the treatment, and efforts to promote employee independence in the employee’s own care to the extent possible so that prolonged or repeated use of providers and medical facilities is minimized.

4. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

   a. The employee’s subjective complaints of pain are progressively improving as evidenced by documentation of decreased distribution, frequency, or intensity of symptoms;

   b. The employee’s objective clinical findings are progressively improving, as evidenced by documentation of resolution or objectively measured improvement and physical signs of injury; and

   c. The employee’s functional status, especially vocational activity, is objectively improving as evidenced by documentation or successive reports of workability of less restrictive limitations on activity.

5. Where there is an incapacitating exacerbation of the employee’s condition. Additional treatment must comply with the parameters, however. See Pawlitschek v. Dundee Steel, Inc., File No. ***-**-3827 (WCCA September 7, 1999).

In Jacka v. Coca Cola Bottling Company, File No. ***-**-3864 (WCCA April 13, 1999), the WCCA affirmed the finding of the compensation judge awarding chiropractic treatment beyond 12 weeks as an appropriate departure from the Treatment Parameters pursuant to Minn. Rule 5221.6050, subp. 8D. The WCCA specifically found that the treatment awarded met at least two of the criteria established for “effective treatment.” Specifically, it affirmed the judge’s determination that the treatment resulted in progressive improvement of subjective complaints and the objective improvement of the employee’s functional status. It cited to the records of the chiropractor that indicated that the employee was treating two to four times per month, was showing subjective and
objective improvement and the frequency of treatment was decreasing.

Likewise, in Boisjoli v. Lyndale Garden Center, File No. ***-**-3649 (WCCA April 20, 1999), the WCCA affirmed a decision of the compensation judge that the employee and the treating chiropractor had satisfied the departure requirements of Minn. Rule 5221.6050, subp. 8. The WCCA cited to subpart 8D which allowed for a departure from the durational limits where the treatment had continued to meet two of three criteria involving the employee’s subjective complaints, objective clinical findings and functional status. The WCCA ruled that the records of the chiropractor, although “not so detailed as we might have wished” were “minimally adequate evidence to support the compensation judge’s finding that a departure from the durational guidelines on passive care was appropriate.”

In Wilmot v. Wal-Mart Stores, Inc., File No. ***-**-0137 (WCCA June 25, 2002), the WCCA set forth “factors” to be considered in determining whether an exacerbation qualifies as an “incapacitating exacerbation” under the Treatment Parameters. In Wilmot, the employee sustained an injury to her low back on December 5, 1990. In September 2000, she returned for treatment because she had developed “suddenly increasing pain”. The physician recommended physical therapy. The employee brought a claim for the physical therapy and, following an Administrative Conference, it was determined that the employee had sustained an incapacitating exacerbation resulting in the need for physical therapy. While the matter was still in litigation, the employee returned for further treatment in November 2001, resulting in another recommendation for physical therapy. The compensation judge determined that the employee had sustained two flare-ups, in September 2000 and in November 2001, that were incapacitating exacerbations of the employee’s work-related low back condition, and she qualified for a departure under the treatment parameters. The WCCA affirmed. It cited “factors” to be considered by a judge in determining whether an exacerbation qualifies as an “incapacitating exacerbation”. See Riendeau. The factors include such things as the exacerbation’s impact on the employee’s ability to work or perform the duties of a job, its impact on the activities of daily living, the severity of the employee’s pain, the documented history of the exacerbation, findings on examination and treatment, and “any other factors that the judge may consider relevant.” In this case, the judge found that the employee’s physician took her off work and school as a result of the exacerbations. The employee also testified that the pain affected her ability to sleep, to perform routine daily tasks, to work, to drive and to go to school. She had told the doctor that her pain was incapacitating.
I. Prior Notification - Minn. Rule 5221.6050, subp. 9

1. When Required

Prior notification is the responsibility of the health care provider who wants to provide the following treatment, and it must be given at least seven working days before the treatment is initiated, except as indicated otherwise (it need not be given in any case where emergency treatment is required):

a. For **chronic management modalities** where prior notification is required under Minn. Rule 5221.6600;

b. For **durable medical equipment** requiring prior notification for low back pain (5221.6200, subp. 8), neck pain (5221.6205, subp. 8), thoracic spine pain (5221.6210, subp. 8), or upper extremity disorders (5221.6300, subp. 8);

c. For any **non-emergency inpatient hospitalization or non-emergency inpatient surgery.** A surgery or hospitalization is considered inpatient if the patient spends at least one night in the facility. (“Emergency treatment” means treatment that is: (a) required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or (b) immediately necessary to alleviate severe pain. Emergency treatment includes treatment that is necessary to determine whether an emergency exists. 5221.6040, subp. 5); or

d. For treatment that **departs** from a parameter limiting the duration or type of treatment. The health care provider must notify the insurer within two business days after initiation of treatment if departure from a parameter is for an incapacitating exacerbation or an emergency.

Failure to provide prior notification can result in denial of treatment. *See Olson v. Allina Health Systems*, File No. ***-***-3987 (WCCA February 5, 1999). In *Olson*, the employee received substantial chiropractic treatment. The employee underwent, and the employer/insurer paid for, 12 calendar weeks of chiropractic care, as provided for under Minn. Rule 5221.6050, Subp. 9. The chiropractor continued chiropractic care beyond the 12 calendar weeks, but did not seek a departure from the Parameters and did not provide prior notification to the employer/insurer, as required by the Treatment Parameters, before undertaking the additional treatment. The WCCA reversed the compensation judge’s award of chiropractic benefits. It held that, since prior notification was not
given by the chiropractor, as required by the Treatment Parameters, before the disputed care was undertaken, the treatment undertaken must be denied.

The WCCA has continued to follow the rationale it outlined in *Olson v. Allina Health Systems*. In *May v. City of Richfield*, 61 W.C.D. 292 (WCCA June 4, 2001), the employee sought chiropractic treatment following a low back injury of January 26, 1996. The employee exhausted the 12 weeks of chiropractic care provided by the Treatment Parameters, as well as the additional 12 visits provided by the Parameters. He then recommenced treatment with the chiropractor and sought payment for same. The compensation judge denied the benefits, finding that the treatment was beyond the durational limits, was reasonable and necessary, and would have qualified for a departure under Minn. Rule 5221.6050, subp. 8. However, the judge denied reimbursement of the treatment because the chiropractor failed to provide prior notification of the departure, as required by Minn. Rule 5221.6050, subps. 8 and 9. The WCCA affirmed. Relying on the prior decision in *Olson v. Allina Health Systems*, 59 W.C.D. 37 (WCCA 1999), the WCCA ruled that the prior notification requirement was more than a mere technicality. It rationalized that the prior notification requirement provides the employer with an opportunity to evaluate the treatment beforehand, as well as its costs, and reduce the likelihood of litigation. The WCCA stated that a good faith effort to comply with the parameters is essential to their effectiveness.

2. Requirements for Prior Notification

The health care provider’s prior notification may be made orally or in writing and shall provide the following information, when relevant:

a. The diagnosis;

b. When giving prior notification for chronic management modalities, durable medical equipment, or inpatient hospitalization or surgery, whether the proposed treatment is consistent with the applicable treatment parameter; and

c. When giving prior notification for treatment that departs from a treatment parameter, or notification of treatment for an incapacitating exacerbation or emergency, the basis for departure from any applicable treatment parameter, the treatment plan (including the nature and anticipated length of the proposed treatment), and the anticipated effect of treatment on the employee’s condition.
3. Insurer’s Responsibilities

a. Fax and Phone Numbers

The insurer must provide a toll-free facsimile and telephone number for health care providers to provide prior notification.

b. Insurer’s Response

The insurer must respond orally or in writing to the requesting provider’s prior notification of proposed treatment indicated above within seven working days of receipt of the request. Within the seven days the insurer must either approve the request, deny authorization, request additional information, request that the employee obtain a second opinion, or request an examination by the employer’s physician. A denial must include notice to the employee and health care provider of the reason for the denial, along with notice of the right to review of the denial. An insurer’s failure to provide that requisite notice will effectively bar the insurer from utilizing the Treatment Parameters as a defense to medical treatment subsequently undertaken pursuant to the request.

In Stillson v. Holiday Company, File No. ***-**-7324 (WCCA August 11, 2000), the employee received chiropractic treatment and exhausted the twelve weeks provided by the Treatment Parameters. The chiropractor then wrote to the insurer requesting authority to provide additional treatment. The insurer responded with a letter denying any further treatment. The chiropractor then requested reconsideration of the decision to terminate treatment benefits. No response was provided by the insurer. The compensation judge, following a hearing on a Medical Request filed by the employee, issued a decision awarding the chiropractic treatment. The judge found that the record did not support a departure from the Treatment Parameters provided for under Minn. Rule 5221.6050, Subp. 8. However, the judge found that the treatment was compensable, citing Jacka and Asti (the “rare case” exception).

The WCCA affirmed, but on other grounds. The WCCA affirmed that the evidence did not support a departure under the Treatment Parameters. The WCCA was also critical of the judge’s reliance on the Jacka and Asti cases. The WCCA ruled that the decision to apply the “rare case” exception was not explained in detail, as required by prior decisions. The WCCA ruled, however, that there were other grounds to support the award of treatment. It pointed to the fact that the insurer, when denying further treatment to the chiropractor, failed to “include notice to the health care provider of the reason why the information given by the health care provider
does not support the treatment proposed, along with notice of the right to review the denial,” as required by Minn. Rule 5221.6050, Subp. 9 C. More importantly, the insurer also failed to respond to the second letter from the chiropractor, asking for reconsideration of the denial. The WCCA specifically cited Minn. Rule 5221.6050, Subp. 9 C (3), which requires the insurer to conduct a review of the denial when requested. The WCCA held that, since the insurer failed to provide a review of its denial as required by the rules, it may not invoke the Treatment Parameters in defense against the employee’s claim for the chiropractic treatment. The WCCA found that the treatment was otherwise reasonable and necessary under case law standards and awarded the chiropractic treatment.

On the other hand, a different result was reached in Fox v. Yellow Freight Systems, File No. ***-***-2359 (WCCA October 1, 2002.) In Fox, the compensation judge awarded chiropractic expenses beyond the 12 week treatment parameter provision, in part, because he found that the insurer failed to respond to the chiropractor’s request for an extension of care beyond the twelve-week parameter within seven days of receipt of the request letter, and the notification ultimately provided by the insurer did not specify the reasons for its denial or the chiropractor’s right to review. See Minn. Rule 5221.6050, subp. 9(C)(3). The WCCA reversed, holding that, while the insurer did not strictly comply with the requirements of the rule, it did send the chiropractor notice of its denial, and the chiropractor did not suggest that he was not aware that the insurer would not pay for additional treatments beyond the initial 12 weeks contemplated under the treatment parameters. The WCCA found “substantial compliance” with the rule and reversed the award of chiropractic benefits.

While the Fox decision appears to suggest that there are circumstances in which an insurer can “substantially” rather than “completely” comply with the denial provisions of the Parameters, self-insured employers and insurers are well served by literal compliance with the Parameters.

If the health care provider seeking approval of treatment does not receive a response from the insurer within the seven working days of its request, authorization is deemed to have been given. (Note: this differs from the emergency treatment parameters.) If the insurer authorizes treatment, the insurer may not later deny payment for the treatment authorized.

If the insurer denies authorization, the health care provider or employee may orally or in writing request that the insurer review its denial. The insurer’s review of its denial must be made by a currently licensed registered nurse, medical doctor, doctor of
osteopathy, doctor of chiropractic, or a person credentialed by a program approved by the department. The insurer may also delegate the review to a certified managed care plan. In lieu of or in addition to the insurer’s review, the insurer may request an examination of the employee under subitems 4, 5, or 6 of Minn. Rule 5221.6050, subp. 9 (discussed below). Unless an examination of the employee is requested, the insurer’s determination following review must be communicated orally or in writing to the requestor within seven working days of receipt of the request for review. Instead of requesting a review, or if the insurer maintains its denial after the review, the health care provider or the employee may file a Medical Request or a Petition for authorization of the treatment, or except as specified in subitems 4, 5, or 6, may proceed with the proposed treatment subject to a later determination of compensability by the commissioner or compensation judge.

Under Minn. Rule 5221.6050, subp. 9C(4), if the insurer requests an examination by the employer’s physician, the provider may elect to provide the treatment subject to a determination of compensability by the commissioner or compensation judge. However, the provider may not provide non-emergency surgery where the insurer has requested an examination for surgery except as provided in subitems 5 and 6, and may not provide continued passive care modalities where prior approval by the insurer, commissioner, or compensation judge is required under Minn. Rule 5221.6200, subp. 3 (low back pain), 5221.6205, subp. 3 (neck pain), 5221.6210, subp. 3 (thoracic back pain), and 5221.6300, subp. 3 (upper extremity disorders).

If prior notification of surgery is required, the insurer may require that the employee obtain a second opinion from a physician of the employee’s choice. If within seven working days of the prior notification the insurer notifies the employee and health care provider that a second opinion is required, the health care provider may not perform the non-emergency surgery until the employee obtains the second opinion. Except as otherwise provided in the specific treatment parameters (e.g., repeat surgeries and dorsal column stimulators require a confirming opinion), if the insurer denies authorization within seven working days of receiving the second opinion, the health care provider may elect to perform the surgery, subject to a determination of compensability by the commissioner or compensation judge. Minn. Rule 5221.6050, subp. 9C(5).
It should be noted that an employee’s failure to submit to a second opinion prior to undergoing surgical treatment will not in and of itself relieve the self-insured employer or insurer from an obligation to pay reasonable and necessary medical expenses related to the surgery. See Hernandez v. Bergerson Caswell, Inc., File No. ***-**-5292 (WCCA December 2, 2002.) In Hernandez, the employee filed a medical request seeking approval for a fusion surgery. The insurer filed a medical response, stating it was exercising its right to “obtain a second opinion” under Minn. Rule 5221.6050, subp. 9(C). The insurer also wrote to the employee and his attorney, advising that it was requesting that the employee undergo a “second opinion” to evaluate the reasonableness and necessity of the proposed fusion surgery under the same rule. By the time the employee presented for the evaluation, he had already undergone the proposed fusion procedure. As a result, the independent medical examiner refused to examine him. The compensation judge found that Minn. Rule 5221.6050, subp. 9(C) did not bar claims for payment of medical expenses for the surgery and the WCCA affirmed. Minn. Rule 5221.6050, subp. 9(C) addresses prior notification by a health care provider to an insurer. If prior notification of surgery is required under the rule, Subpart 9(C)(5) provides “the insurer may require that the employee obtain a second opinion from a physician of the employee’s choice under Minnesota Statutes, section 176.135, subd. 1a.” Minn. Rule 5221.6050, subp. 9(C)(5) provides that the “healthcare provider may not perform the non-emergency surgery until the employee provides the second opinion to the insurer.” The insurer argued that the employee’s failure to submit to a second opinion prior to undergoing the proposed fusion procedure relieved it of the obligation to pay reasonable and necessary medical expenses related to the surgery. The WCCA was not persuaded. It cited Minn. Stat. §176.135, subd. 1a, which provides that “failure to obtain a second surgical opinion shall not be reason for nonpayment of the charges for the surgery.” The WCCA held that the insurer’s interpretation of Minn. Rule 5221.6050, subp. 9(C), was in direct conflict with the statute and, as a result, affirmed.

In any case requiring prior notification of proposed surgery, the insurer may elect to obtain an examination of the employee by the employer’s physician under Minn. Stat. §176.155. If the insurer notifies the employee and health care provider of the examination within seven working days of the notification, the proposed non-emergency surgery may not be provided pending the examination. However, after 45 days following the insurer’s request for an examination, the health care provider may elect to proceed with the surgery, subject to a determination of compensability by the commissioner or compensation judge. (Note: This section is
different from the emergency treatment parameters, which provided that the insurer could obtain an IME for any treatment requiring preauthorization, not just surgery.) Minn. Rule 5221.6050, subp. 9C(6).

The insurer’s request for additional information must be directed to the requesting provider and must specify the additional information required that is necessary to respond to the health care provider’s notification of proposed treatment. The treatment may not be given until the provider provides reasonable additional information. Once the additional information has been received, the insurer must respond within seven working days.

It should be noted that the emergency treatment parameter dealing with advance notice by the insurer to a provider relative to cessation of passive treatment after 12 weeks was omitted from the permanent rules.

In the end, if an employee proceeds with a surgery that was denied by the employer and insurer, and the treatment is ultimately found not to be reasonable or necessary, then the employer and insurer are not liable for the cost of the treatment. See, e.g., Meyer v. Genmar Transportation, Inc., File No. WC15-5845 (WCCA March 1, 2016).

III. MEDICAL IMAGING - MINN. RULE 5221.6100

A. General Principles - Minn. Rule 5221.6100, subp. 1

Certain parameters for medical imaging are general to all treatment situations. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient’s condition, before ordering any imaging study. All medical imaging must comply with the following:

1. Effective Imaging: A health care provider should initially order the single most effective imaging study for diagnosing the suspected etiology (see definition section) of a patient’s condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is indicated, except for repeat and alternative imaging allowed under items 4 and 5 below.
2. Appropriate Imaging: Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient’s condition is not indicated.

3. Routine Imaging: Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

4. Repeat Imaging: Repeat imaging, of the same views of the same body part with the same imaging modality is not indicated except as follows:

   a. To diagnose a suspected fracture or suspected dislocation;

   b. To monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment;

   c. To follow up a surgical procedure;

   d. To diagnose a change in the patient’s condition marked by new or altered physical findings;

   e. To evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study; or

   f. When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is technically inadequate.

In Skogen v. Diversified Builders and Design, File No. 475-98-2800 (WCCA January 12, 1999), the WCCA reversed a decision of Compensation Judge Hagen that ordered the employer and insurer to pay for an MRI scan. The WCCA found the MRI scan, which was a second lumbar MRI scan for the same injury, to be unnecessary and duplicative. The fact that the doctor who ordered the scan may not have had a copy of the original MRI scan when he did so was of no significance.

In Emerson v. Heritage Manor Health Center, File No. ***-**-5729 (WCCA July 12, 1999), multiple MRI imaging was awarded and affirmed by the WCCA. In Emerson, the employer argued that the employee did not need two MRIs. The compensation judge awarded the claimed treatment. The WCCA held that under the facts of the case, it would not be unreasonable to conclude that a repeat MRI might be a useful diagnostic device relative to the work injury, if only to assist in assessing the relatedness of the employee’s current increase in symptoms to her work injury by comparing the two scans and assessing the nature of any changes. Similarly, the EMG, unrequested in the past, was held to not be an unreasonable diagnostic measure for drawing some final conclusions.
on the nature of the employee’s condition. The WCCA employed a reasonableness standard and awarded the medical benefits.

The “rare case exception” has also been utilized to justify repeat imaging which is beyond the Treatment Parameters. In Anderson-Olson v. Waters of Park Point, File No. ***-***-4929 (WCCA April 16, 2003), the employee sustained a work-related injury in 1990. Two MRI scans done during the 1990’s showed mild degenerative changes with no disc protrusion, neural compression or spinal stenosis. Throughout this time, the employee continued to have symptoms of back and leg pain. In 2001 the employee filed a Medical Request for a neurosurgical consultation. This request was granted after an administrative conference. However, the consultation did not proceed because of the neurosurgeon’s request for another MRI prior to the consultation. The insurer denied this request on the basis of the medical treatment parameters. The WCCA (Judges Johnson, Pederson, and Stofferahn) affirmed Compensation Judge Ertl’s approval of the MRI prior to the neurosurgical consultation. The WCCA found that the MRI was beyond the medical treatment parameters, but allowed the MRI based upon a “rare case exception.” See Jacka. Noting that a determination of a rare case exception is a factual issue, the WCCA found substantial evidence to support the judge’s decision. The evidence supporting this conclusion included the employee’s ongoing complaints, and the fact that the employee would be denied treatment already ordered by another judge if the MRI were denied.

Comment: The MRI requested was clearly beyond the treatment parameters, which do not allow for diagnostic studies prior to evaluation of a patient and review of prior records. However, in this case, the neurosurgeon was allowed to avert application of the parameter by requiring the scan prior to the evaluation. Despite the fact that the case law indicates that rare case exceptions should be reserved for exceptional circumstances which cannot be anticipated, the WCCA affirmed the judge’s determination. This case, therefore, stands for the proposition that the WCCA will give wide discretion to judges in determining what constitutes a “rare case.”

5. Alternative Imaging: Persistence of a patient’s subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the patient’s condition is suspected because of the failure of the condition to improve. Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation. Alternative imaging is allowed to follow up abnormal but inconclusive findings in another imaging study, i.e., one that does not provide an adequate basis for an adequate diagnosis.
B. Specific Imaging Procedures for Low Back Pain - Minn. Rule 5221.6100, subp. 2

The rule also details specific imaging procedures for low back pain which are to be used in conjunction with the specific parameter for low back pain, i.e., Minn. Rule 5221.6200. The parameters refer to:

1. Computed tomography (CT) scanning (generally not indicated in the first 8 weeks after an injury);
2. Magnetic resonance imaging (MRI) scanning (generally not indicated in the first 8 weeks after an injury);
3. Myelography (not a preferred technique for routine imaging of the low back according to the SONAR);
4. Computed tomography myelography (not a preferred technique for routine imaging of the low back according to the SONAR);
5. Intravenous enhanced CT scanning (not a preferred technique for routine imaging of the low back according to the SONAR);
6. Gadolinium enhanced MRI scanning (not a preferred technique for routine imaging of the low back according to the SONAR);
7. Discography (not a preferred technique for routine imaging of the low back according to the SONAR);
8. Computed tomography discography (not a preferred technique for routine imaging of the low back according to the SONAR);
9. Nuclear isotope imaging (including technicium, indium, gallium scans)(not a preferred technique for routine imaging of the low back according to the SONAR);
10. Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions found in Minn. Rule 5221.6200, subp. 1A;
11. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine (generally not allowed in the first 8 weeks after an injury except in certain circumstances);
12. Oblique X-rays of the lumbosacral spine; and
13. Electronic x-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions found in Minn. Rule 5221.6200, subp. 1A.

The rule should be consulted for specific limitations on the use of medical imaging.

It should be noted that there were no parameters set forth for specific imaging procedures for cervical or thoracic spine pain.
IV. MEDICATIONS - MINN. RULE 5221.6105

A. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

1. General Principles

Nonsteroidal anti-inflammatory drugs (NSAIDs) are drugs with analgesic, antipyretic, and anti-inflammatory effects. NSAIDs are divided into two groups, nonselective NSAIDs and COX-2 inhibitors. Examples of nonselective NSAIDs include diclofenac, diflunisal, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, mefenamic acid, meloxicam, naproxen, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, and tolmetin. An example of a COX-2 inhibitor is celecoxib.

a. General rules for the prescription of NSAIDs include:

(1) NSAIDs are indicated for the symptomatic relief of acute and chronic musculoskeletal pain. NSAIDs must be prescribed at the lowest clinically effective dose.

(2) When treating musculoskeletal pain, a generic nonselective NSAID is indicated, unless a COX-2 inhibitor is indicated. Treatment with a nonselective NSAID must generally begin with generic ibuprofen or generic naproxyn, unless there is a medical contraindication. Other generic nonselective NSAIDs are not indicated unless one-week trials of both ibuprofen and naproxen are ineffective in reducing pain by at least 50 percent as determined by the prescribing health care provider. Nonselective NSAIDs that are not available as generics are not indicated.

(3) A COX-2 inhibitor may be indicated if the patient is over 60 years of age, the patient has a history of gastrointestinal bleeding or peptic ulcer disease, or the patient has a history of gastrointestinal side effects with nonselective NSAID use.

(4) NSAIDs are indicated only for the shortest duration needed as determined by the prescribing health care provider.
B. Opioid Analgesics

1. General Principles

An opioid is any agent that binds to opioid receptors. There are three broad classes of opioids: opium alkaloids, such as morphine and codeine; semisynthetic opioids such as heroin and oxycodone; and fully synthetic opioids such as meperidine and methadone. Opioid analgesics include codeine, hydrocodone, levorphanol, methadone, morphine, hydromorphone, and oxycodone.

a. General rules for the prescription of opioid analgesics include:

(1) Opioid analgesics are indicated for the symptomatic relief of acute and chronic pain that has been inadequately relieved by nonopioid medications. Opioid analgesics must be prescribed at the lowest clinically effective dose.

(2) When an oral opioid analgesic is used, treatment must begin with generic codeine, generic hydrocodone, generic oxycodone, or generic morphine, unless there is a medical contraindication documented by the prescribing health care provider. If there is a contraindication, any other generic oral opioid analgesic may be prescribed.

(3) Other generic opioid analgesics are not indicated for oral use for the symptomatic relief of acute or chronic pain unless one-week trials of each of hydrocodone, oxycodone, and morphine have been ineffective in reducing the patient’s pain by at least 50 percent as determined by the prescribing health care provider.

(4) A course of oral opioid analgesics or combination of an oral opioid and a nonopioid analgesic is limited. If prescribed within the first four weeks after the date of injury, they are limited to no more than two weeks of medication per prescription. If prescribed more than four weeks after the date of injury, they are limited to no more than one month of medication per prescription. If prescribed for more than 12 weeks, the prescription may be for more than one month of medication, but must comply with all of the requirements of part 5221.6110.

(5) Meperidine is not indicted for treatment of acute or chronic pain.
(6) Transcutaneous opioids are limited to patients with a documented disorder that prevents adequate oral dosing.

(7) Oral transmucosal and buccal preparations are only indicated for breakthrough pain treatment and only in patients with a documented disorder that prevents adequate dosing with swallowed medications.

C. Muscle Relaxants

1. General Principles

A muscle relaxant is a drug that decreases the tone of a muscle. Examples include carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, orphenadrine, and tizanidine. The use of medications that may be used to treat spasticity.

a. General rules for the prescription of muscle relaxants include:

(1) Muscle relaxants are indicated for the symptomatic relief of acute and chronic musculoskeletal pain. Muscle relaxants must be prescribed at the lowest clinically effective dose.

(2) When treating musculoskeletal pain, a generic muscle relaxant is indicated. When a muscle relaxant is used, treatment must begin with one of the following: generic carisoprodol, generic chlorzoxazone, generic cyclobenzaprine, generic metaxalone, or generic tizanide. If there is a medical contraindication, then treatment may begin with any other generic muscle relaxant. Muscle relaxants that are not available as generics are not indicated.

(3) Metaxolone and orphenadrine are not indicated unless one-week trials of each of carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, and tizanide have been ineffective in reducing the patient’s pain by at least 50 percent as determined by the prescribing health care provider.

(4) A course of muscle relaxants or combination of a muscle relaxant and an analgesic is limited. If prescribed within the first four weeks after the date of injury, they are limited to no more than two weeks of medication per prescription or refill. If prescribed more than four weeks after the date of injury, they are limited to no more than one month’s worth of medication per prescription or refill. Treatment with muscle relaxants for more than three consecutive months is not indicated.
V. LONG-TERM TREATMENT WITH OPPIOID ANALGESIC MEDICATION - MINN. RULE 5221.6110

Minn. Rule 5221.6110 was implemented in 2015 in an effort to address the growing, reported epidemic of opiate addiction, and to curb the increasing costs associated with long-term opioid treatment. This new rule provides the employer and insurer with a potentially effective tool to help prevent, limit and diminish excessive prescription and use of opioids in the context of workers’ compensation cases. The effective date of the new rule is July 13, 2015

A. General Principles

“Long-term treatment with opioid analgesic medication” generally means that the medication is taken for at least 90 days. The rule applies to all forms of opioid medications and their uses, except parenteral or intrathecal opioid analgesic medications. Long-term treatment with opioid analgesic medication cannot occur if it does not comply with the requirements of this rule. Before prescription of long-term opioid analgesic medication, the patient’s pain and function must both be assessed with a tool that is validated in peer-reviewed scientific literature for the assessment of pain. The prescribing health care provider must document in the medical record the patient selection criteria, the assessments performed, whether there are any potential contraindications to the long-term prescription of opioid analgesics, the elements of the treatment program, the written treatment contract, an objective assessment of the success of the treatment program, and the results of periodic monitoring and testing, as outlined below.

1. Patient selection criteria – Minn. Rule 5221.6110, Subp. 4

   Before initiating a plan for long-term treatment with opioid analgesic medication, the prescribing health care provider must determine that all the following criteria are met: the patient cannot function at work or in activities of daily living without opiates, the patient does not have a somatic symptom disorder, all other reasonable medical treatment options have been exhausted, the patient does not have a history of failing to comply with treatment or failing to take medication as prescribed, the patient does not have a substance use disorder, and a urine drug test confirms that the patient is not using any illegal substances.

2. Potential contraindications – Minn. Rule 5221.6110, Subp. 5

   Potential contraindications for long-term use of opiate analgesic medications include: history of respiratory depression, potential pregnancy, past substance use disorder, another mental disorder as referenced in the DSM – 5, suicide risk, poor impulse control, and regular activity that renders opioid use unsafe.

3. Opioid risk assessment; program of treatment – Minn. Rule 5221.6110, Subp. 6
Long-term opioid treatment must be part of an integrated program of treatment. The health care provider must completed an opioid risk assessment using a tool validated in peer-reviewed scientific literature. If the patient is at high-risk for abuse, he or she must be referred to a pain or addiction medicine specialist for a second opinion before long-term opioid treatment begins and if opioid treatment is initiated, additional monitoring is required. A formal written opioid contract must be entered into by the health care provider and the patient, which includes a detailed, written plan for the scheduled use of opiate medications, follow-up visits, tapering, and other factors. All such medications must be used in fixed schedules and all prescriptions must be written only by the prescribing health care provider or designated proxy. Other program requirements include: discussion of risks, documenting medications in medical record, establishing a schedule of visits, written reports of work ability, and a tapering schedule upon discontinuance of treatment. All medications and treatment modalities must be prescribed by a single health care provider party to a written contract or designated proxy.

4. Written treatment contract – Minn. Rule 5221.6110, Subp. 7

A written treatment contract must be entered into by the health care provider and the patient. Among others, key agreements that are mandated for inclusion in the contract are: goals of the treatment plan will be followed, the allegation of a “lost or stolen” medication can only be made one time, the prescription will not be renewed earlier than scheduled, illegal substances will not be used, there will be compliance with drug testing, and referrals to other providers will be abided.

5. Monitoring long-term treatment with opioid analgesic medication – Minn. Rule 5221.6110, Subp. 8

The prescribing health care provider must monitor and document the monitoring of the patient’s use of opioid medications in the medical record. The provider must schedule regular visits and must assess at each meeting whether treatment goals are being met. Generally, patients who take more than 120 morphine-equivalent milligrams of an opiate medication per day are considered “high risk.” There is a requirement that these patients be seen more often and are to be monitored more closely. The provider must watch for: side effects, misuse of medications, addiction issues, and contraindications. If there is more than one instance of unreported opiate prescriptions from other providers, the health care provider must discontinue opioid medications by using a tapering schedule. Urine drug testing is within the discretion of the provider. If a urine test is failed, opioid medications must be discontinued, using a tapering schedule.

A prescribing provider’s failure to comply with any requirement of this part is **not a basis to deny payment** for treatment with opioid analgesics unless the insurer has previously sent the provider and the patient a copy of this part and has given the provider at least 30 days to initiate a plan to come into compliance. The insurer is required to send the provider and patient the notice and provide 30 days to initiate a plan for compliance only once.

**PRACTICE TIP:** The practical applications of this new rule have not yet been completely fleshed out. Even though the insurer is required to send the provider and patient the compliance notice only once, it is likely best not to completely cut an employee off immediately from opioid analgesic medication if there is a violation, unless it is specifically indicated to the medical provider and the patient that payment will continue upon compliance with these rules or in conjunction with a medically supervised withdrawal program. The rationale here is that the insurer should promote safe withdrawal from opioid medications to avoid further and/or more serious medical issues. In *Reiners v. Hospice of the Twin Cities*, WC15-5872, (WCCA Apr. 20, 2016), even after the employee was prescribed opiate medications on an ongoing basis at ever-increasing dosages, the WCCA upheld the compensation judge’s decision to qualify the denial of ongoing opioid medication costs to exclude such medications when prescribed as part of a medically supervised withdrawal program.

7. Patients currently receiving treatment – Minn. Rule 5221.6110, Subp. 10.

**These rules regarding long-term treatment with opioid analgesic medications are retroactive and apply to all patients currently receiving long-term opioid analgesic treatment.** Generally, within three months within receipt of written notice of these rules, the health care provider must complete the steps to come into compliance with this rule.

VI. **LOW BACK PAIN - MINN. RULE 5221.6200**

A. **Diagnostic Procedures for Treatment of Low Back Injury - Minn. Rule 5221.6200, subp. 1**

1. **General Principles**

A health care provider shall determine the nature of the condition before initiating treatment. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category. The diagnosis must be documented in the medical record. The rules, according to the SONAR, are specifically
addressed to the mechanical causes of low back pain that predominate in workers’ compensation. In addition, the rules do not apply to fractures, which were deemed too complicated to cover, or to back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

a. Diagnoses included in the rule are:

1. Regional low back pain: including referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and any other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee.

2. Radicular pain, with or without regional low back pain, with static or no neurologic deficit. “Radicular pain” means pain radiating distal to the knee or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This category includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine. In these cases neurologic findings on examination either are absent or do not show progressive deterioration.

3. Radicular pain, with or without regional low back pain, with progressive neurologic deficit. “Radicular pain” means pain radiating distal to the knee or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This category includes the same diagnoses as noted immediately above, however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings (including worsening sensory loss, increasing muscle weakness, or progressive reflex changes).
(4) Cauda equina syndrome is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function.

PRACTICE TIP: Remember to look at the definitions in Minn. Rule 5221.6040 when applying these parameters. Relevant definitions include: active treatment; initial nonsurgical management; neurologic deficit (both static and progressive); passive treatment; and therapeutic injection.

2. Laboratory Tests

Laboratory tests are not indicated in the evaluation of a patient with any of the above diagnoses, except in the following circumstances:

a. When infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders (rheumatoid arthritis or ankylosing spondylitis) are suggested;

b. To evaluate potential adverse side effects of medications; or

c. As part of a pre-operative evaluation.

According to the SONAR, laboratory tests should not be ordered routinely without regard to the facts in a particular case.

3. Medical Imaging

The Rule refers the reader to the specific parameters set out in Minn. Rule 5221.6100, which are described above in detail.

4. EMG and Nerve Conduction Studies

Such studies are always inappropriate for the diagnosis of regional low back pain. They may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome after the first three weeks of radicular symptoms. Repeat studies are not indicated unless a new neurologic symptom or finding has developed, and failure to improve with treatment is not an indication for repeat testing.

5. Prohibited Procedures or Testing

The following procedures or tests are not indicated for the diagnosis of any of the clinical categories above:

a. Surface electromyography or surface paraspinal electromyography;

b. Thermography;
c. Plethysmography;
d. Electronic x-ray analysis of plain radiographs;
e. Diagnostic ultrasound of the lumbar spine; or
f. Somatosensory evoked potential (SSEP) and motor evoked potentials (MEP).

6. Computerized Range of Motion or Strength Measuring Tests

Such tests are not indicated during the period of initial non-surgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. However, during the period of initial non-surgical management, such testing may be performed, but must be done in conjunction with and shall not be reimbursed separately from an office visit with a provider.

7. Personality or Psychological Evaluations

Such evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury.

8. Diagnostic Analgesic Blocks or Injection Studies

These procedures are used to localize the source of pain before surgery and to diagnose conditions which fail to respond to initial non-surgical management. As diagnostic procedures only, they are not indicated unless non-invasive procedures have failed to establish the diagnosis. These procedures can also be used as therapeutic modalities, and would be subject to the parameters under that subpart.

9. Functional Capacity Assessment

Such evaluations are performed to determine a patient’s physical capacities in general or to determine work tolerance for a specific job. Such evaluations are not indicated during the period of initial non-surgical management. Thereafter, such evaluations may be performed if activity restrictions and capabilities must be identified or there is a question about the patient’s ability to do a specific job. Such evaluations are not appropriate to establish baseline performance before treatment or to evaluate change during or after treatment. Only one completed FCE is indicated per injury.
10. **Consultations**

Consultations with other health care providers can be initiated at any time by the treating provider consistent with accepted medical practice.

**B. General Treatment Parameters for Low Back Pain - Minn. Rule 5221.6200, subp. 2**

1. **General Principles - Minn. Rule 5221.6200, subp. 2A**

   All medical care for low back pain is determined by the clinical category to which the employee has been assigned. General parameters for particular treatment modalities are set forth below. Specific treatment parameters also may be applicable for each clinical category as set forth below. The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the employee if warranted. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a simple change of clinical category does not in itself allow the provider to continue with therapy or modality past the maximum duration or to repeat a therapy or treatment previously provided for the same injury.

2. **Course of Treatment - Minn. Rule 5221.6200, subp. 2B**

   In general, a course of treatment is divided into three phases.

   a. All patients with low back problems, except patients with radicular pain with progressive neurological deficit or cauda equina syndrome, must be given initial nonsurgical management which may include both active and passive treatment modalities, and may also include injections, durable medical equipment, and medications. (These modalities are described below.) The period of initial nonsurgical treatment begins with the first modality initiated. It must result in progressive improvement as described in subp. 9 below.

   b. For patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be done in a “timely manner.” (Although this is not defined, the SONAR noted that decisions regarding surgical therapy are best postponed until 8-12 weeks of non-surgical management have been attempted.) But see Barton v. Phoenix Alternatives, Inc., File No. 469-50-0346 (WCCA January 27, 2000), where a four-level fusion surgery was allowed despite the fact that eight weeks of non-surgical care had not occurred. Patients with radicular pain with progressive neurological changes,
or cauda equina syndrome may require immediate surgical therapy. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities for a period of up to eight weeks. This therapy may be in addition to any received during the period of initial nonsurgical care.

c. For those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. (According to the SONAR, at this point the focus of treatment changes from cure to rehabilitation.)

3. Passive Treatment - Minn. Rule 5221.6200, subp. 3

a. Definition

Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments. Minn. Rule 5221.6040, subp. 12.

It should be noted that VAX-D treatment is not included in the definition of “passive treatment.” See Kelly v. Metropolitan Council, File No. ***-***-2681 (WCCA April 3, 2000), the compensation judge found that the employee had sustained a temporary aggravation to her low back as a result of an incident on December 4, 1997. He ruled that the temporary aggravation lasted for a period of one year, a finding which was affirmed by the WCCA. However, he did award treatment from the VAX-D Low Back Clinic. He rejected the argument of the employer and insurer that it should be treatment governed by the treatment parameters and fee schedules governing mechanical chiropractic therapy. Instead, he ruled that Minn. Rule 5221.0500, subp. 2B applied. That rule provides that, as a general rule, payments are limited to 85 percent of the provider’s usual and customary charge. Judge Schultz, therefore, awarded 85 percent of the charge of $3,500.00, or $2,975.00. The WCCA affirmed. Relying on a previous decision in Olson v. Allina Health Systems, 59 W.C.D. 37 (WCCA 1999), the WCCA ruled that it was appropriate to conclude that the VAX-D therapy was not “traction.” It also ruled that, to imply a requirement for providers to provide a procedure code to a service or procedure not listed in the fee schedules, such as VAX-D, would negate the language allowing providers to charge a percentage of their usual and customary charge for unlisted procedures.
b. Duration - Minn. Rule 5221.6200, subp. 3, sub-items A and B

(1) Generally, the use of passive treatment modalities in a clinical setting set forth in the rule is not indicated beyond **12 calendar weeks** after the first passive modality is initiated.

(2) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

   (a) Employee is released to work or is permanently totally disabled and the additional care must result in progressive improvement in, or maintenance of, functional status achieved during the first 12 weeks of care;

   (b) Treatment must not be given on a regularly scheduled basis;

   (c) Provider must document a plan to encourage the employee’s independence on providers;

   (d) Management of employee’s condition must include active treatment modalities;

   (e) The additional 12 visits must not delay the required surgical or chronic pain evaluation; and

   (f) Passive care is inappropriate while the employee has chronic pain syndrome.

(3) Additional passive treatment may be rendered if the requirements of Minn. Rule 5221.6050, subp. 8-9 are met dealing with departures from the parameters. (See discussion above on pages 14 - 16.)

(4) Except as provided in Minn. Rule 5221.6050, subp. 8, treatment may continue beyond the additional 12 visits only after approval by the insurer, commissioner, or compensation judge based on documentation in the record of the effectiveness of the treatment in maintaining employability, or in the case of a permanently totally disabled or retired employee, the effectiveness of the treatment in maintaining functional status. When relying on this provision, the medical record must contain evidence that the treatment was effective to maintain the employee’s

In Stulen v. Halverson Company, Inc., File No. ***-***-8089 (WCCA April 6, 1999), the WCCA affirmed the decision of Compensation Judge Patterson, which awarded chiropractic treatment from July 1996 to July 1998, as well as massage therapy from October 1996 to February 1997. The WCCA indicated that the 12-week rule was not an absolute limit and various provisions allow traditional treatment under certain circumstances. They specifically noted that the compensation judge, based upon the opinions of medical and chiropractic experts, concluded that the employee had shown the treatment rendered was “medically necessary” within the meaning of Minn. Rule 5221.6200, subp. 3B(2). As indicated above, that provision allows for continuance of treatment “based upon documentation in the medical record of the effectiveness of further passive treatment in maintaining employability.” The WCCA felt that there was more than adequate evidence to support the compensation judge’s finding. See also Smith v. Country Manor Health Care, File No. ***-**-5291 (WCCA January 31, 2000).

c. Specific passive treatment modalities - Minn. Rule 5221.6200, subp. 2, subitems C - K

The rule specifies for various passive treatment modalities:

(1) Time for treatment response (i.e., the duration or number of treatments required to determine whether the treatment is going to be “effective” - SONAR and Minn. Rule 5221.6050, subp. 1);

(2) Maximum treatment frequency (i.e., if the intensity of the treatment cannot be reduced then the treatment is not effective - SONAR); and

(3) Maximum treatment duration.

Example: Adjustment or manipulation of joints, includes chiropractic and osteopathic adjustments or manipulations: (1) time for treatment response, three to five treatments; (2) optimum treatment frequency, one to five times per week for the first one to two weeks decreasing in frequency thereafter; and (3) maximum treatment duration, 12 weeks.
Similar provisions are set forth for: Thermal treatment; Electrical muscle stimulation; Mechanical traction; Acupuncture; Manual therapy; Phoresis; Bedrest (not more than 7 days); and Spinal braces. Where appropriate use of passive treatment modalities at home is promoted.

**PRACTICE TIP:** Note that the specified durations for treatment are maximums. The provisions as to necessity of treatment under Minn. Rule 5221.6050 always apply to all treatment, so it may be possible to discontinue treatment even prior to reaching the maximums.

4. **Active Treatment - Minn. Rule 5221.6200, subp. 4**

Active treatment modalities must be used as set forth in items a. to d. Use of these modalities can extend past the 12-week limitation on passive treatment so long as the maximum duration is not exceeded.

- **a. Education** must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

- **b. Posture and work method training** must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

- **c. Worksite analysis and modification** must examine the patient’s work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

- **d. Exercise** is important to the success of an initial nonsurgical treatment program and a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in
part, be specifically aimed at the musculature of the lumbosacral spine. The rule provides further parameters for supervised and unsupervised exercise programs. (Computerized exercise programs and health clubs are governed by Minn. Rule 5221.6600.)

5. Injections - Minn. Rule 5221.6200, subp. 5

The rule provides specific limitations for use of injections. Use of injections can extend past the 12 week limitation on passive treatment so long as the maximum treatment for injections is not exceeded.

a. Therapeutic injections

Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Specific criteria applying to duration and frequency are set forth for: Trigger point injections; Sacroiliac joint injections; Facet joint or nerve injections; Nerve root blocks; and Epidural injections.

b. Permanent lytic or sclerosing injections

Such injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

c. Prolotherapy and botulinum toxin injections

Such injections are not indicated in the treatment of low back problems and are not reimbursable.

6. Surgery - Minn. Rule 5221.6200, subp. 6

Surgery, including decompression procedures and arthrodesis (fusion), may only be performed if it also meets the specific parameters specified in Minn. Rule 5221.6200, subp. 11-13 and 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery pursuant to Minn. Rule 5221.6050, subp.9 (discussed above).

In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities have been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting is 8 weeks from the initiation of the first passive modality utilized after lumbar decompression or implantation of a dorsal column stimulator or morphine pump, and 12 weeks after arthrodesis, except bedrest and bracing.
Repeat surgery must also meet the parameters of the rule and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

Dorsal column stimulators and Morphine pumps have specific additional limitations, including the necessity of a second opinion and a personality evaluation.

On the other hand, the WCCA has held that a “second opinion” or “personality evaluation” is not required prior to “trial screening” employed before implantation. In *Feist v. Packaging of America/Tenneco*, File No. ***-**-1764 (WCCA January 29, 2001), the issue was whether Minn. Rule 5221.6210, Subp. 6C, requires that a personality or psychological evaluation be performed prior to a trial screening period for a morphine pump. The compensation judge awarded the trial screening period for the employee’s thoracic spine injury without a personality evaluation, and the employer/insurer appealed. The WCCA affirmed, holding that although *Minn. R. 5221.6210, Subp. 6C* requires a second opinion and a personality or psychological evaluation before implantation of a morphine pump, the rule does not indicate that these requirements are necessary prior to the “trial screening” employed before implantation.

7. Chronic Management - Minn. Rule 5221.6200, subp. 7

Chronic management of low back pain must be provided according to the parameters of Minn. Rule 5221.6600.

8. Durable Medical Equipment - Minn. Rule 5221.6200, subp. 8

a. Durable medical equipment is indicated only in certain specific situations:

   (1) Lumbar braces, corsets, or supports may be indicated as set forth above in Minn. Rule 5221.6200, subp. 3K.

   (2) Electrical stimulation or mechanical traction devices may be indicated for home use with prior notification if used for more than one month, within the parameters set forth above in Minn. Rule 5221.6200, subp. 3E and 3F.

   (3) Exercise equipment for home use is indicated only within the context of an approved chronic management program and prior notification is required.

b. The following durable medical equipment is not indicated for home use for low back conditions: whirlpools, Jacuzzis, hot tubs, special shower or bath attachments, beds, waterbeds, mattresses, chairs, recliners, or loungers.
9. Evaluation of Treatment by Provider - Minn. Rule 5221.6200, subp. 9

The provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial non-surgical treatment is effective according to the three criteria set forth below. For the specific modalities set forth in subparts 3 (passive treatment modalities), 4 (active treatment modalities), and 5 (therapeutic injections), the provider must evaluate whether the treatment is resulting in progressive improvement within the time period set for treatment response under those subparts, as specified in the three criteria below:

a. Employee’s subjective complaints of pain or disability are progressively improving;

b. The objective clinical findings are progressively improving; and

c. Employee’s functional status, especially vocational activity, is progressively improving.

If there is not progressive improvement in at least two of the three criteria, the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. (*See also* Minn. Rule 5221.6050, subp. 1B (described above)).

10. Medication - Minn. Rule 5221.6200, subp. 10

Treatment with medications may be used during any phase of treatment. The provider must document the rationale for use and must comply with Minn. Rule.

11. Specific Treatment Parameters for Regional Low Back Pain - Minn. Rule 5221.6200, subp. 11

a. Initial nonsurgical treatment:

   (1) Initial nonsurgical treatment must be the first phase of treatment for all patients with regional low back pain.

   (a) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in the subparts described above may be used in sequence or simultaneously during the period of initial non-surgical management.

   (b) The only therapeutic injections indicated for patients with regional back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks.
(2) After the first week of treatment, initial nonsurgical care must at all times contain active treatment modalities.

(3) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(4) Passive treatment: In a clinic setting or requiring attendance by a health care provider is not indicated for a period in excess of 12 weeks. Passive treatment modalities include: bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments (Minn. Rule 5221.6040, subp. 12). Note that additional care may be indicated within the terms of Minn. Rule 5221.6050, subp. 8.

b. Reevaluation: If the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated.

(1) Surgery: The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. Surgical evaluation may begin as soon as 8 weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical care. Surgical evaluation may include the use of appropriate medical imaging techniques, diagnostic blocks and injections, and personality or psychosocial evaluation. Consultation with other health care providers can be an important part of surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient’s ongoing subjective complaints and physical findings.

The only surgical procedures indicated for patients with regional low back pain only are decompression of a nerve root and lumbar arthrodesis, with or without instrumentation. If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical
practice, and consistent with the rule and requirements for prior notification or second opinions. If surgery is not indicated, or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management under Minn. Rule 5221.6600.

(2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.

12. Specific Treatment Parameters for Radicular Pain, With or Without Regional Low Back Pain, With No or Static Neurologic Deficits - Minn. Rule 5221.6200, subp. 12.

a. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits and must be the first phase of treatment. It shall be provided within the specific parameters for regional low back pain (see above) with the following modifications: epidural blocks, and nerve root and peripheral nerve injection blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be indicated.

b. Re-evaluation: If the patient continues with symptoms and physical findings after the course of initial nonsurgical care, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated.

(1) Surgery: It must be provided within the specific parameters set forth above for regional low back pain.

(2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including...
regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.

13. Specific Treatment Parameters for Cauda Equina Syndrome and for Radicular Pain, With or Without Regional Low Back Pain, With Progressive Neurologic Deficits - Minn. Rule 5221.6200, subp. 13

a. Surgery: Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, who have progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. It must be provided within the specific parameters set forth above for regional low back pain, except that surgery may begin at any time.

b. Initial nonsurgical care: If the health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters for radicular pain, with or without regional low back pain, with no or static neurologic deficits.

c. Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.

VII. NECK PAIN - MINN. RULE 5221.6205

Similar to low back conditions, the rules regarding evaluation and treatment of neck pain begin with parameters outlining the appropriate history, physical examination, and diagnostic workup. The rules then set out the initial approach to the patient with subsequent follow-up, surgical treatment as needed, and rehabilitation (chronic management) if necessary. The rules for neck pain follow the same format as the rules for low back pain, and are in many cases identical to the low back parameters.
A. **Diagnostic Procedures for Treatment of Neck Injury - Minn. Rule 5221.6205, subp. 1**

1. **General Principles**

   As with the low back section, the health care provider must assign the patient at each visit to the appropriate clinical category.

   a. Diagnoses included in the rule are:

   (1) Regional neck pain: including referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which effects the cervical region, with or without referral to the upper back or shoulder.

   (2) Radicular pain, with or without regional neck pain, with no or static neurologic deficit. “Radicular pain” means pain radiating distal to the shoulder. This category includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine. In these cases neurologic findings either are absent or do not show progressive deterioration.

   (3) Radicular pain, with or without regional neck pain, with progressive neurologic deficit. “Radicular pain” means pain radiating distal to the shoulder. This category includes the same diagnoses as noted immediately above, however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings (including worsening sensory loss, increasing muscle weakness, and progressive reflex changes).

   (4) Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.
2. Laboratory Tests

Laboratory tests are not indicated in the evaluation of a patient with regional neck pain or radicular pain, except:

a. When a patient’s history, age or examination, infection and other disorders outlined by the rule;

b. To evaluate potential adverse side effects of medications; or

c. As part of a pre-operative evaluation.

3. Medical Imaging

The Rule refers the reader to the specific parameters set out in Minn. Rule 5221.6100, which are described above in detail.

4. EMG and Nerve Conduction Studies

EMG and nerve conduction studies are always inappropriate for regional neck pain, but may be an appropriate diagnostic tool for radicular pain and myelopathy after the first three weeks of radicular and myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated unless a new neurological symptom has developed which would in and of itself warrant EMG testing.

5. Prohibited Procedures or Testing

The following procedures are not indicated for the diagnosis of any of the neck clinical categories:

a. Surface electromyography or surface paraspinal electromyography;

b. Thermography;

c. Plethysmography;

d. Electronic x-ray analysis of plain radiographs;

e. Diagnostic ultrasound of the spine; or

f. Somatosensory evoked potentials and motor evoked potentials.

6. Computerized Range of Motion or Strength Measuring Tests

Computerized range of motion or strength measuring tests are not indicated during the period of initial non-surgical management, but may be indicated during the period of chronic management when used in
conjunction with a computerized exercise program, work hardening or work conditioning program. During the period of initial non-surgical management, computerized range of motion testing may be performed in conjunction with other therapeutic modalities.

7. Personality or Psychological Evaluations

Such evaluations may be appropriate, but the health care provider performing evaluations must consider all of the following:

a. Is symptom magnification occurring?

b. Does the patient exhibit an emotional reaction to the injury such as depression, fear or anger, which is interfering with recovery?

c. Are there other personality factors or disorders which are interfering with recovery?

d. Is the patient chemically dependent?

e. Are there any interpersonal conflicts interfering with recovery?

f. Does the patient have a chronic pain syndrome or psychogenic pain?

g. In cases in which surgery is a possible treatment, are psychological factors such as those indicated above likely to interfere with the potential benefit of the surgery.

8. Diagnostic Analgesic Blocks or Injection Studies

The rules appear to allow these procedures in the following circumstances:

a. To localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial non-surgical management;

b. Are not indicated unless non-invasive procedures have failed to establish the diagnosis;

c. The selection of patients, choice of procedure and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms;

d. These procedures can also be used as therapeutic modalities and, therefore, are subject to the specific rule in Rule 5221.6205, subp. 5.
9. Functional Capacity Assessment

Such assessments are regulated as follows:

a. They are not reimbursable during the period of initial non-operative care;

b. They are reimbursable in either of the following circumstances:

   (1) Permanent activity restrictions and capabilities must be identified; or

   (2) There is a question about the patient’s ability to do a specific job.

Only one completed FCE is indicated per injury.

10. Consultations

Consultations with other health care providers may be initiated at any time by the treating health care provider consistent with accepted medical practice.

B. General Treatment Parameters for Neck Pain - Minn. Rule 5221.6205, subp. 2

1. General Principles - Minn. Rule 5221.6205, subp. 2A

All medical care for neck pain is determined by the diagnosis and clinical category to which the employee has been assigned. As with the low back section set forth above, general parameters for particular treatment modalities are present, and specific treatment parameters also may be applicable for each clinical category.

2. Course of Treatment - Minn. Rule 5221.6205, subp. 2B

As was the case with low back pain, a course of treatment is divided into three phases.

a. All patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy, must be given **initial non-surgical care**.

b. For patients with persistent symptoms, initial non-operative care is followed by a period of **surgical evaluation**. Patients with radicular pain with progressive neurological deficit, or myelopathy may require immediate surgical therapy.
c. For those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of **chronic management** may be indicated.

3. Passive Treatment - Minn. Rule 5221.6205, subp. 3
   
   See the discussion under the low back section.

4. Active treatment - Minn. Rule 5221.6205, subp. 4
   
   See the discussion under the low back section.

5. Injections - Minn. Rule 5221.6205, subp. 5
   
   See the discussion under the low back section, except that sacroiliac injections are omitted.

6. Surgery - Minn. Rule 5221.6205, subp. 6
   
   Surgery may only be performed if it meets the specific parameters specified in Minn. Rule 5221.6205, subparts 11 to 14 and 5221.6500. The health care provider must provide prior notification for nonemergency inpatient surgery pursuant to Minn. Rule 5221.6050, subp. 9 (discussed above). The remaining discussion is the same as under the low back section.

7. Chronic Management - Minn. Rule 5221.6205, subp. 7
   
   See the discussion under the low back section.

8. Durable Medical Equipment - Minn. Rule 5221.6205, subp. 8
   
   See the discussion under the low back section, except that prior notification to the insurer is not required for cervical traction, as it was for low back traction, because cervical traction does not require costly equipment.

9. Evaluation of Treatment by Provider - Minn. Rule 5221.6205, subp. 9
   
   See the discussion under the low back section.

10. Medication - Minn. Rule 5221.6205, subp. 10
    
    See the discussion under the low back section.

11. Specific Treatment Parameters for Regional Neck Pain - Minn. Rule 5221.6205, subp. 11
See the discussion under the low back section. However, as it relates to surgery, the only surgical procedure indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation.

12. Specific Treatment Parameters for Radicular Pain, With or Without Regional Neck Pain, with No or Static Neurologic Deficits - Minn. Rule 5221.6205, subp. 12.

See the discussion under the low back section.


See the discussion under the low back section.


See the discussion under the low back section for cauda equina syndrome.

VIII. THORACIC BACK PAIN - MINN. RULE 5221.6210

As with the section dealing with neck pain, the section of the Treatment Parameters addressing thoracic pain follows the same format as set forth in the low back section of the Treatment Parameters. Comments in this article will be directed to differences between the sections.

A. Diagnostic Procedures for Treatment of Thoracic Back Injury - Minn. Rule 5221.6210, subp. 1

1. General Principles

See the discussion under the low back section.

a. Diagnoses included in the rule are:

   (1) Regional thoracic back pain: includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which affects the thoracic region.

   (2) Radicular pain, with or without regional thoracic back pain. “Radicular pain” means pain radiating in a dermatomal distribution around the chest or abdomen. This category
includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine.

(3) Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response; bowel or bladder dysfunction; sensory ataxia; or bilateral sensory changes.

2. Laboratory Tests

See the discussion under the low back section.

3. Medical Imaging

See the discussion under the low back section.

4. EMG and Nerve Conduction Studies

Such studies are always inappropriate for regional thoracic back pain and radicular pain. In other words, these studies cannot be done for thoracic back pain.

5. Prohibited Procedures or Testing

See the discussion under the low back section.

6. Computerized Range of Motion or Strength Measuring Tests

See the discussion under the low back section.

7. Personality or Psychological Evaluations

See the discussion under the low back section.

8. Diagnostic Analgesic Blocks or Injection Studies

See the discussion under the low back section.
9. Functional Capacity Assessment

See the discussion under the low back section.

10. Consultations

See the discussion under the low back section.

B. General Treatment Parameters for Thoracic Back Pain - Minn. Rule 5221.6210, subp. 2

1. General Principles - Minn. Rule 5221.6210, subp. 2A

See general discussion under the low back section.

2. Course of Treatment - Minn. Rule 5221.6210, subp. 2B

As set forth in the low back and neck sections, there are three phases of treatment: initial non-surgical management; surgical evaluation; and chronic management.

3. Passive Treatment - Minn. Rule 5221.6210, subp. 3

See the discussion under the low back section.

4. Active Treatment - Minn. Rule 5221.6210, subp. 4

See the discussion under the low back section.

5. Injections - Minn. Rule 5221.6210, subp. 5

See the discussion under the low back section, except that sacroiliac injections are omitted.

6. Surgery - Minn. Rule 5221.6210, subp. 6

See the discussion under the low back section.

7. Chronic Management - Minn. Rule 5221.6210, subp. 7

See the discussion under the low back section.

8. Durable Medical Equipment - Minn. Rule 5221.6210, subp. 8

See the discussion under the low back section.
9. **Evaluation of Treatment by Provider - Minn. Rule 5221.6210, subp. 9**

See the discussion under the low back section.

10. **Medication - Minn. Rule 5221.6210, subp. 10**

See the discussion under the low back section.

11. **Specific Treatment Parameters for Regional Thoracic Back Pain - Minn. Rule 5221.6210, subp. 11**

See the discussion under the low back section, except as it applies to surgery. The only surgical procedure indicated for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation.

12. **Specific Treatment Parameters for Radicular Pain - Minn. Rule 5221.6210, subp. 12**

See the discussion under the low back section dealing with radicular pain with no or static neurological deficits. With regard to surgery, the only surgical procedures indicated for patients with thoracic radicular pain are decompression or arthrodesis. Due to the nature of the thoracic spine, there is no section for progressive radicular syndromes.

13. **Specific Treatment Parameters for Myelopathy - Minn. Rule 5221.6210, subp. 13**

See the discussion under the low back section dealing with cauda equina syndrome.

**IX. UPPER EXTREMITY DISORDERS - MINN. RULE 5221.6300**

**A. Diagnostic Procedures for Treatment of Upper Extremity Disorders - Minn. Rule 5221.6300, subp. 1**

1. **General Principles**

A health care provider shall determine the nature of an upper extremity disorder before initiating treatment. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category. Multiple categories may apply. This rule does not apply to upper extremity conditions due to an infectious, vascular, immunologic, metabolic, endocrine, neurologic, visceral, neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.
a. Diagnoses included in the rule are:

1. Epicondylitis. This clinical category includes medial epicondylitis and lateral epicondylitis.

2. Tendonitis of the forearm, wrist, and hand. This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation including, but not limited to, the diagnoses of tendinitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain’s syndrome, intersection syndrome, flexor tendinitis, and trigger digit.

3. Nerve entrapment syndromes. This clinical category encompasses any compression or entrapment of the radial, ulnar, or median nerves, or any of their branches, including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon’s canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg’s syndrome.

4. Muscle pain syndromes. This is a new section under the permanent rules. This category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including, but not limited to, the diagnoses of chronic non-traumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofascitis, non-specific myalgia, fibrositis, fibromyalgia, and fibromyositis.

5. Shoulder impingement syndromes. This is a new section under the permanent rules. This category includes the diagnoses of tendonitis, bursitis, and related conditions. It encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including, but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendonitis.
(6) Traumatic sprains or strains of the upper extremity. This is a new section under the permanent rules. This category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes (see above). Injuries in which the muscle or ligament has been completely torn are excluded from the parameter.

2. Laboratory Tests

Certain laboratory tests may be indicated to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications.

3. Medical Imaging

Routine medical imaging is not appropriate. Medical imaging must comply with the standards set forth in Minn. Rule 5221.6100, subp. 1.

4. EMG and Nerve Conduction Studies

Such studies are only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

5. Prohibited Procedures or Testing

The following diagnostic procedures or tests are not indicated for the diagnosis of upper extremity disorders:

a. Surface electromyography;

b. Thermography; or

c. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

6. Adjunct Diagnostic Procedures or Testing

The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:
a. Vibrometry;
b. Neurometry;
c. Semmes-Weinstein monofilament testing; or
d. Algometry.

7. Computerized Range of Motion or Strength Measuring Tests

Such tests are not indicated during the period of initial non-surgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. However, during the period of initial non-surgical management, such testing may be performed, but must be done in conjunction with and shall not be reimbursed separately from an office visit with a provider.

8. Personality or Psychosocial Evaluations

Such evaluations may be indicated for evaluating patients who continue to have problems despite appropriate initial non-surgical care. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury.

9. Diagnostic Analgesic Blocks or Injection Studies

These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to initial non-surgical management. These procedures can also be used as therapeutic modalities, and would be subject to the parameters under that subpart.

10. Functional Capacity Assessment

Such evaluations are performed to determine a patient’s physical capacities in general or to determine work tolerance for a specific job, task, or work activity. Such evaluations are not indicated during the first 12 weeks of initial non-surgical treatment. Thereafter, such evaluations are indicated if activity restrictions and capabilities must be identified, or there is a question about the patient’s ability to return to do a specific job. Such evaluations are not appropriate to establish base line performance before treatment or to evaluate change during or after treatment. Only one completed FCE is indicated per injury.
11. Consultations

Consultations with other health care providers can be initiated at any time by the treating provider consistent with accepted medical practice.

B. General Treatment Parameters for Upper Extremity Disorders - Minn. Rule 5221.6300, subp. 2

1. General Principles - Minn. Rule 5221.6300, subp. 2A

All medical care for upper extremity disorders is determined by the clinical category to which the employee has been assigned. General parameters for particular treatment modalities are set forth below. Specific treatment parameters also may be applicable for each clinical category as set forth below. The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the employee if warranted. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a simple change of clinical category does not in itself allow the provider to continue with therapy or modality past the maximum duration or to repeat a therapy or treatment previously provided for the same injury. When treating more than one clinical category for which the same treatment modality is appropriate, then the modality should be applied simultaneously, if possible, to all indicated areas.

2. Course of Treatment - Minn. Rule 5221.6300, subp. 2B

In general a course of treatment shall be divided into three phases:

a. All patients with upper extremity disorders must be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities. (These modalities are described below.) The period of initial nonsurgical treatment begins with the first modality initiated. It must result in progressive improvement as described in subp. 9 below.

b. For patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be done in a “timely manner.” (This is not defined.) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.
c. For those patients who are not candidates for or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of **chronic management** may be indicated. (According to the SONAR, at this point the focus of treatment changes from cure to rehabilitation.)

3. Passive Treatment Modalities - Minn. Rule 5221.6300, subp. 3

a. Definition

Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments. Minn. Rule 5221.6040, subp. 12.

b. Duration - Minn. Rule 5221.6300, subp. 3, subitems A and B

(1) Generally, the use of passive treatment modalities in a clinical setting set forth in the rule is not indicated beyond **12 calendar weeks** after the first passive modality is initiated.

(2) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

   (a) Employee is released to work or is permanently totally disabled and the additional care must result in progressive improvement in, or maintenance of, functional status achieved during the first 12 weeks of care;

   (b) Treatment must not be given on a regularly scheduled basis;

   (c) Provider must document a plan to encourage the employee’s independence on providers;

   (d) Management of employee’s condition must include active treatment modalities;

   (e) The additional 12 visits must not delay the required surgical or chronic pain evaluation; and

   (f) Passive care is inappropriate while the employee has chronic pain syndrome.
(3) Except as provided in Minn. Rule 5221.6050, subp. 8, treatment may continue beyond the additional 12 visits only after approval by the insurer, commissioner, or compensation judge based on documentation in the record of the effectiveness of the treatment in maintaining employability, or in the case of a permanently totally disabled or retired employee, the effectiveness of the treatment in maintaining functional status.

c. Specific passive treatment modalities - Minn. Rule 5221.6300, subp. 2, subitems C - J

The rule specifies for various passive treatment modalities:

(1) Time for treatment response (i.e., the duration or number of treatments required to determine whether the treatment is going to be “effective” - SONAR and Minn. Rule 5221.6050, subp. 1);

(2) Maximum treatment frequency (i.e., if the intensity of the treatment cannot be reduced then the treatment is not effective - SONAR); and

(3) Maximum treatment duration.

Example: Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations: (1) time for treatment response, three to five treatments; (2) maximum treatment frequency, one to five times per week the first one to two weeks decreasing in frequency thereafter; and (3) maximum treatment duration, 12 weeks.

Similar provisions are set forth for: Thermal treatment; Electrical muscle stimulation; Acupuncture; Phoresis; Manual therapy; Splints, braces, and other movement-restricting devices; and Rest (not more than 2 weeks, unless rigid immobilization is required). Where appropriate use of passive treatment modalities at home is promoted.

PRACTICE TIP: Note that the specified durations for treatment are maximums. The provisions as to necessity of treatment under Minn. Rule 5221.6050 always apply to all treatment, so treatment may be discontinued prior to reaching the maximums.
4. **Active Treatment Modalities - Minn. Rule 5221.6300, subp. 4**

Active treatment modalities must be used as set forth in items a. to d. Use of these modalities can extend past the 12 week limitation on passive treatment so long as the maximum duration is not exceeded.

a. **Education** must teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

b. **Posture and work method training** must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

c. **Worksite analysis and modification** must examine the patient’s work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

d. **Exercise** is important to the success of an initial nonsurgical treatment program and a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. The rule provides further parameters for supervised and unsupervised exercise programs. (Computerized exercise programs and health clubs are governed by Minn. Rule 5221.6600.)

5. **Therapeutic Injections - Minn. Rule 5221.6300, subp. 5**

Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections can extend past the 12 week limitation on passive treatment so long as the maximum treatment for injections is not exceeded. Specific criteria applying to duration and frequency for each type of injection are set forth for: Trigger point injections; Soft tissue injections; and Injections for median nerve entrapment at the carpal tunnel.
6. Surgery - Minn. Rule 5221.6300, subp. 6

Surgery may only be performed if it meets applicable parameters for specific diagnoses. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with active or passive treatment modalities in a clinical setting is eight weeks from initiation of the first passive or active modality utilized (except bedrest or bracing), except that for rotator cuff repair, acromioclavicular ligament repair, or joint reconstruction, the period is 16 weeks. The health care provider must provide prior notification for surgery. (See 5221.6050, subp. 9.)

Repeat surgery must also meet the parameters of the rule and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

7. Chronic Management - Minn. Rule 5221.6300, subp. 7

Chronic management of upper extremity disorders must be provided according to the parameters of Minn. Rule 5221.6600.

8. Durable Medical Equipment - Minn. Rule 5221.6300, subp. 8

a. Durable medical equipment is indicated only in certain specific situations:

   (1) Splints, braces, straps, or supports may be indicated as set forth above in Minn. Rule 5221.6300, subp. 3I.

   (2) Electrical stimulation or mechanical traction devices may be indicated for home use with prior notification if used for more than one month, within the parameters set forth above in Minn. Rule 5221.6300, subp. 3E.

   (3) Exercise equipment for home use is indicated only within the context of an approved chronic management program and prior notification is required.

b. The following durable medical equipment is not indicated for home use for upper extremity disorders: whirlpools, Jacuzzis, hot tubs, special shower or bath attachments, beds, waterbeds, mattresses, chairs, recliners, or loungers.
9. Evaluation of Treatment by Provider - Minn. Rule 5221.6300, subp. 9

The provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial non-surgical treatment is effective according to the three criteria set forth below. For the specific modalities set forth in subparts 3 (passive treatment modalities), 4 (active treatment modalities), and 5 (therapeutic injections), the provider must evaluate whether the treatment is resulting in progressive improvement as specified in the three criteria below:

a. Employee’s subjective complaints of pain or disability are progressively improving;

b. The objective clinical findings are progressively improving; and

c. Employee’s functional status, especially vocational activity, is progressively improving.

If there is not progressive improvement in at least two of the three criteria, the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. (See also Minn. Rule 5221.6050, subp. 1B (described above)).

10. Medication - Minn. Rule 5221.6300, subp. 10

Treatment with medications may be appropriate during any phase of treatment. The provider must document the rationale for medications and must comply with the requirements of Minn. Rule 5221.6105.

11. Specific Treatment Parameters for Epicondylitis - Minn. Rule 5221.6300, subp. 11

a. Initial nonsurgical treatment:

(1) Initial nonsurgical treatment must be the first phase of treatment for all patients with epicondylitis.

(a) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in the subparts described above may be used in sequence or simultaneously during the period of initial non-surgical management.

(2) After the first week of treatment, initial nonsurgical care must at all times contain active treatment modalities.
(3) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(4) Passive treatment: In a clinic setting or requiring attendance by a health care provider is not indicated for a period in excess of 12 weeks. Passive treatment modalities include: bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments (Minn. Rule 5221.6040, subp. 12). Note that additional care may be indicated within the terms of Minn. Rule 5221.6050, subp. 8.

b. Re-evaluation: If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated.

(1) Surgery: The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. Surgical evaluation must begin no later than 12 months after beginning initial nonsurgical management. Surgical evaluation may include the use of x-rays, laboratory and electrodiagnostic testing, and personality or psychosocial evaluation. Consultation with other health care providers can be an important part of surgical evaluation. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient’s condition. See Minn. Rule 5221.6040, subp. 4.

If surgery is indicated, it may not be performed until 12 months after initial non-surgical management was begun, except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain. In this instance, a second surgical opinion must confirm the need for surgery sooner than 12 months after initial non-surgical management was begun. If surgery is not indicated, or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management under Minn. Rule 5221.6600.
(2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.


a. Initial nonsurgical treatment:

(1) Initial nonsurgical treatment must be the first phase of treatment for all patients with tendonitis of the forearm, wrist, and hand. It must conform to the parameters set forth above for epicondylitis.

b. Re-evaluation: If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated. The parameters from the epicondylitis section apply, except for the following:

(1) Surgery:

(a) De Quervain’s syndrome: Surgical evaluation may begin after only 2 months of initial non-surgical management.

(b) Trigger finger or trigger thumb: Surgical evaluation may begin after only 1 month of initial non-surgical management.

(c) Locked finger or thumb: Surgery may be indicated immediately without any preceding non-surgical management.

(2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the
resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.


a. Initial nonsurgical treatment:

Initial nonsurgical treatment must be the first phase of treatment for all patients with nerve entrapment syndromes. It must conform to the parameters set forth above for epicondylitis, with the following exceptions: Non-surgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, and immediate surgical evaluation may be indicated.

b. Re-evaluation: If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated. The parameters from the epicondylitis section apply, except for the following:

(1) Surgery:

   (a) Immediate surgical evaluation may be appropriate for advanced symptoms of nerve compression.

   (b) Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least 7 days with local injection.

   (c) If there is no confirming EMG or response to local injection, or if surgery has previously been performed, surgery is not indicated unless a second opinion confirms the need for surgery.

In spite of this rule, the WCCA affirmed a decision of a compensation judge allowing surgery where there was not a positive EMG, where there had not been temporary resolution of symptoms lasting at least seven days with local injection and where there was no second opinion confirming the need for surgery. See Martin v. Xerox Corporation, File No. ***-**-7357
(WCCA July 15, 1999). The WCCA indicated that this was one of those “rare” cases where a departure from the rule would be allowed by the Supreme Court’s decision in Jacka v. Coca Cola Bottling Company, 580 N.W.2d 27 (Minn. 1998). It cited the judge’s findings that the employee experienced difficulty with activities of daily living, the symptoms were worsening and the symptoms also affected her ability to perform her job. The WCCA further cited to the fact that the judge had found that the treatment was found to be “reasonable and necessary” under case law principles.

(2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.

14. Specific Treatment Parameters for Muscle Pain Syndromes - Minn. Rule 5221.6300, subp. 14

a. Initial nonsurgical treatment:

(1) Initial nonsurgical treatment must be the first phase of treatment for all patients with muscle pain syndromes. It must conform to the parameters set forth above for epicondylitis.

b. Surgery: Surgery is not indicated for the treatment of muscle pain syndromes.

c. Chronic management: If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.
15. Specific Treatment Parameters for Shoulder Impingement Syndromes - Minn. Rule 5221.6300, subp. 14

a. Initial nonsurgical treatment:

   (1) Initial nonsurgical treatment must be the first phase of treatment for all patients with shoulder impingement syndromes. It must conform to the parameters set forth above for epicondylitis, except continued non-surgical management may be inappropriate and early surgical evaluation may be indicated for patients with:

   (a) Clinical findings of rotator cuff tear; or

   (b) Acute rupture of the proximal biceps tendon.

   (2) Use of home based treatment modalities with monitoring by the provider may continue for up to 6 months.

b. Re-evaluation: If the patient continues with symptoms and objective physical findings after 6 months of initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient’s condition should be reevaluated and surgical therapy or chronic management provided, if indicated. The parameters from the epicondylitis section apply, except for the following:

   (1) Surgery: Surgical evaluation must begin no later than 6 months after beginning initial non-surgical management. Diagnostic injection, arthrography, CT-arthrography, or MRI scanning may be indicated as part of the surgical evaluation. The only surgical procedures indicated for patients with shoulder impingement syndrome and related conditions are: rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion, or repair of proximal biceps tendon.

   (2) Chronic management: If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.
16. **Specific Treatment Parameters for Traumatic Sprains and Strains of the Upper Extremity - Minn. Rule 5221.6300, subp. 16**

   a. **Initial nonsurgical treatment:**

      Initial nonsurgical treatment must be the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. It must conform to the parameters set forth above for epicondylitis.

   b. **Surgery:** Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Such patients may need immediate surgery.

   c. **Chronic management:** If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient’s condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.

X. **REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER AND LOWER EXTREMITIES - MINN. RULE 5221.6305**

This rule sets forth parameters for the entire episode of care for patients with reflex sympathetic dystrophy (RSD), which is a complication of upper and lower extremity injuries.

A. **Scope - Minn. Rule 5221.6305, subp. 1**

1. **Definition:** This clinical category encompasses any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions:

   a. Edema;

   b. Local skin color change of red or purple;

   c. Osteoporosis in underlying bony structures demonstrated by radiograph;

   d. Local dyshidrosis (sweating);

   e. Local abnormality of skin temperature regulation;

   f. Reduced passive range of motion in contiguous joints;

   g. Local alteration of skin texture of smooth or shiny; or
h. Typical findings of RSD on bone scan.

This clinical category includes, but is not limited to, the diagnoses of reflex sympathetic dystrophy, causalgia, Sudek’s atrophy, algoneurodystrophy, and shoulder-hand syndrome.

2. Concurrent Condition: RSD occurs as a complication of another preceding injury. The treatment parameters of this part refer to treatment of the body part affected by the RSD. The treatment for any condition not affected by RSD continues to be subject to other treatment parameters. The treatment under this part for RSD may be in addition to treatment received for the original condition.

3. Thermography: Thermography may be used in the diagnosis of RSD, but is considered an adjunct to physical examination and is not reimbursed separately from the office visit.

B. Initial Nonsurgical Management - Minn. Rule 5221.6305, subp. 2

Initial nonsurgical management is appropriate for all patients with RSD and must be the first phase of treatment. It is limited to the modalities set forth below:

1. Therapeutic Injection Modalities

The only injections allowed for RSD are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block. Sympathetic blocks or intravenous infusion must be used if RSD has continued for 4 weeks and the employee remains disabled. Specific parameters are set forth for the time for treatment response, maximum treatment frequency, and maximum treatment duration. Epidural blocks may only be performed in patients who had incomplete improvement with the former injections.

2. Passive Treatment Modalities

Passive treatment modalities as set forth below in a clinical setting or requiring attendance by a provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the RSD. The only passive treatment modalities which are allowed are as follows: thermal treatment; desensitizing procedures (stroking or friction massage, stress loading, and contrast baths); electrical stimulation; and acupuncture treatments. The rules set forth specific parameters for the time for treatment response, maximum treatment frequency, and maximum treatment duration.
3. **Active Treatment**

   Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise must be specifically aimed at the involved musculature. The provider must objectively measure the treatment response.

4. **Medications**

   Medications may be used during any phase of treatment. The provider must prove the rationale and comply with Minn. Rule 5221.6105.

C. **Surgery - Minn. Rule 5221.6305, subp. 3**

   There are limited surgical options in RSD:

   1. **Surgical sympathectomy**: may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks.

   2. **Dorsal column stimulator or morphine pump**: maybe indicated for a patient with neuropathic pain unresponsive to all other treatment modalities who is not a candidate for any other therapy, and has had a favorable response to a trial screening period. Use of these devices is indicated only if a second opinion confirms that this treatment is indicated, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from the treatment.

D. **Chronic Management**

   If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management pursuant to Minn. Rule 5221.6600.
XI. INPATIENT HOSPITALIZATION PARAMETERS - MINN. RULE 5221.6400

A. General Principles - Minn. Rule 5221.6400, subp. 1

1. Prior Notification

The health care provider must request prior notification for inpatient hospital admission for non-emergency care. Hospitalization is characterized as inpatient if the patient spends at least one night in the hospital.

2. Emergency

Treatment for emergency conditions, including incapacitating pain, should not be delayed to provide prior notification. The admitting health care provider should notify the insurer within 2 business days following an emergency admission, or within 2 business days after the health care provider learns that it is a workers’ compensation injury. The medical necessity for the emergency hospitalization is subject to retrospective review, based on the information available at the time of the emergency hospitalization.

3. Room Limits

Unless the patient’s condition requires special care, only ward or semiprivate accommodations are indicated. The admitting health care provider must document the special care needs.

4. Admission before Surgery

Admissions before the day of surgery are indicated only if they are medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any or all of a preoperative work-up which could have been completed as an outpatient is not indicated.

5. Inpatient Hospitalization

Inpatient hospitalization solely for physical therapy, bedrest, and/or administration of injectable drugs is indicated only if the treatment is otherwise indicated and the patient’s condition makes the patient unable to perform the activities of daily life and participate in the patient’s own treatment and self-care.

6. Discharge

Discharge from the hospital must be at the earliest possible date consistent with proper health care.
7. Transfer

If transfer to a convalescent center or nursing home is indicated, prior notification is required as provided for inpatient hospitalization.

B. Specific Requirements for Hospital Admission of Patients With Low Back Pain - Minn. Rule 5221.6400, subp. 2

Hospitalization for low back pain is indicated in the circumstances in items 1 to 4.

1. When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and in addition, the intensity of service during admission meets the criteria in subitems (a) and (b).

   a. Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion;

   b. Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of three injections in 24 hours. Need for parenteral analgesics is determined by:

      (1) An inability to take oral medications or diet (N.P.O.); or

      (2) An inability to achieve relief with aggressive oral analgesics.

2. For surgery which is otherwise indicated and is appropriately scheduled as an inpatient procedure.

3. For evaluation and treatment of cauda equina syndrome (Minn. Rule 5221.6200, subp. 13).

4. For evaluation and treatment of foot drop or progressive neurologic deficit (Minn. Rule 5221.6200, subp. 13).
XII. SURGICAL PROCEDURES - MINN. RULE 5221.6500

A. General Parameters - Minn. Rule 5221.6500, subp. 1

1. Prior Notification

The health care provider must provide prior notification before proceeding with any elective inpatient surgery.

2. Emergency Surgery

Emergency surgery may proceed without prior notification. The reasonableness and necessity for the emergency surgery shall be subject to retrospective review.

B. Spinal Surgery - Minn. Rule 5221.6500, subp. 2

The spinal surgery rule encompasses:

1. Surgical decompression of a lumbar nerve root(s) which includes, but is not limited to, the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. Detailed parameters are set forth relative to the diagnoses, indications, and clinical findings necessary to support the need for surgery. Repeat surgical decompression of a lumbar nerve root is not indicated at the same nerve root unless a second opinion, if requested by the insurer, confirms that surgery is indicated.

2. Surgical decompression of a cervical nerve root(s) which includes, but is not limited to, the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. Detailed parameters are set forth relative to the diagnoses, indications, and clinical findings necessary to support the need for surgery. Surgical decompression of a cervical nerve root is not indicated for the following conditions, unless a second opinion, if requested by the insurer, confirms that the surgery is indicated: repeat surgery at the same level; or request for surgery at the C3-4 level.

3. Lumbar arthrodesis with or without instrumentation.

   a. Indications: one of the following conditions must be satisfied to indicate that the surgery is reasonably required:

      (1) Unstable lumbar vertebral fracture; or
(2) For a second or third surgery only, documented re-extrusion or re-displacement of lumbar intervertebral disc, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain. Documentation under this item must include an MRI or CT scan or a myelogram; or

(3) Traumatic spinal deformity including a history of compression (wedge) fracture or fractures, and demonstrated acquired kyphosis-scoliosis; or

(4) Incapacitating low back pain, for longer than three months, and one of the following conditions involving lumbar segments L-3 and below is present:

   (a) For the first surgery only, degenerative disc disease with postoperative documentation of instability, or positive discogram at one or two levels; or

   (b) Pseudoarthrosis; or

   (c) For the second or third surgery only, previously operated disc; or

   (d) Spondylolisthesis.

In Kappelhoff v. Tom Thumb/Polka Dot Dairy, File No. ***-**-6566 (WCCA October 22, 1999), the WCCA indicated that the word “incapacitating” did not require that the employee be totally disabled from work. It specifically indicated that the word was “permissive of less than total disability on the part of the employee claiming disability under that rule.”

See also Barton v. Phoenix Alternatives, Inc., File No. ***-**-0346 (WCCA January 27, 2000). In that case, the WCCA allowed a four-level fusion surgery by Dr. Manuel Pinto and rejected the arguments of the employer and insurer that a minimum of eight weeks of non-surgical care was necessary, that Dr. Pinto did not obtain a second opinion and that the employee was not suffering from incapacitating low back pain. The WCCA specifically indicated that the provision regarding a second opinion referred to a “decompression” of the lumbar nerve root and the rule does not require a second opinion confirming the need for surgery.
Conversely, see \textit{Pelowski v. K-Mart Corporation}, 627 N.W.2d 89 (Minn. 2001.) In \textit{Pelowski}, the Supreme Court affirmed the decision of the lower courts that the employee was not entitled to reimbursement for fusion surgery. The relevant treatment parameter, Minn. Rule 5221.6500, subpart 2C(1)(d), provides that fusion surgery is reasonably required if the employee has incapacitating low back pain for more than 3 months and degenerative disc disease with a positive discogram at one or two levels of the spine. In this case, it was shown that the employee had degenerative disc disease with a positive discogram. However, the compensation judge determined that he failed to establish incapacitating low back pain for more than 3 months. The medical experts rendered differing opinions as to whether the proposed surgery was reasonable and necessary. The WCCA affirmed the compensation judge’s decision on the basis that the judge’s choice between expert opinions had the requisite evidentiary support. The Supreme Court acknowledged that the compensation judge’s decision was, in essence, a credibility determination between the medical experts, as well as a credibility assessment of the employee’s testimony, and affirmed the decision. It noted that it is not the function of the reviewing court to evaluate the credibility and probative value of witness testimony and to choose different inferences from the evidence than the compensation judge.

In \textit{Klinefelter v. Quicksilver Express Courier}, File No. ***-**-5358 (WCCA January 6, 2003), the WCCA affirmed the compensation judge’s denial of the employee’s request for fusion surgery. The judge found that the employee had sustained a lumbar sprain at the time of the work injury and had recovered from that sprain within one year. The judge also found that the employee’s low back pain was not incapacitating as required for a lumbar fusion under the treatment parameters. The WCCA agreed that incapacitating does not mean the employee must be totally disabled from work, but is a fact finding within the province of the compensation judge. It held that substantial evidence supported the decision that the employee’s low back pain was not incapacitating for purposes of meeting the requirements for fusion surgery under the treatment parameters.

b. Contraindications: lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.
c. Retrospective review: when lumbar arthrodesis is performed to correct instability created during an authorized decompression, laminectomy, or discectomy, approval for the arthrodesis will be based on a retrospective review of the operative report, because the insurer is not able to give prior authorization for the lumbar arthrodesis.

C. Upper Extremity Surgery - Minn. Rule 5221.6500, subp. 3

The upper extremity surgery rule encompasses:

1. Rotator cuff surgery which may be performed for the following diagnoses: (a) rotator cuff syndrome of the shoulder and allied disorders, unspecified disorders of shoulder bursae and tendons, calcifying tendinitis of shoulder, bicipital tenosynovitis and other specified disorders, or (b) tear of rotator cuff;

2. Acromioplasty may be performed for acromial impingement syndrome;

3. Surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation;

4. Excision of the distal clavicle may be performed for the following conditions: acromioclavicular separation; osteoarthrosis of the acromioclavicular joint; or shoulder impingement syndrome;

5. Surgical repair of a shoulder dislocation may be performed for the following diagnoses: recurrent dislocations, recurrent subluxations, or persistent instability following traumatic dislocation;

6. Surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps;

7. Epicondylitis: specific requirements for surgery for epicondylitis are included in Minn. Rule 5221.6300, subp. 11;

8. Tendonitis: specific requirements for surgery for tendonitis are included in Minn. Rule 5221.6300, subp. 12;

9. Nerve entrapment syndromes: specific requirements for nerve entrapment syndromes are included in Minn. Rule 5221.6300, subp. 13;

10. Muscle pain syndromes: surgery is not indicated for muscle pain syndromes.

11. Traumatic sprains and strains: surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption.
For all of the surgeries set forth above, specific criteria are set forth for the indications and clinical findings necessary to support the need for the surgery.

D. **Lower Extremity Surgery - Minn. Rule 5221.6500, subp. 4**

The lower extremity surgery rule encompasses:

1. Anterior cruciate ligament (ACL) reconstruction may be performed for the following diagnoses: old disruption of anterior cruciate ligament, or sprain of cruciate ligament of knee;

2. Patella tendon realignment or Maquet procedure may be performed for dislocation of patella (open or closed) or chronic residuals of dislocation;

3. Knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee;

4. Fusion may be performed for the following conditions: malunion or nonunion of fracture of ankle, tarsal, or metatarsal; or traumatic arthritis;

5. Lateral ligament ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions: chronic ankle instability or grade III sprain.

For each of the surgeries described above, the rule sets forth various criteria and indications supporting the necessity of the surgical procedures.

XIII. **CHRONIC MANAGEMENT - MINN. RULE 5221.6600**

A. **Scope - Minn. Rule 5221.6600, subp. 1**

This section of the permanent treatment parameters applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by Minn. Rule 5221.6200 to 5221.6500. If a patient continues with symptoms and physical findings after all appropriate initial non-surgical and surgical treatment has been rendered, and if the patient’s condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The WCCA has specifically indicated that this requirement will not be rigidly imposed. See *Jett v. Wal-Mart Stores, Inc.*, File No. ****-4594 (WCCA September 21, 1999). In a situation where the employee’s symptoms had been present for nearly six years and required the employee to change occupations to obtain lighter work, where the employee performs household chores in pain and had to give up leisure activities in order to avoid aggravating her symptoms, the WCCA ruled that a recommendation for a chronic pain management evaluation was appropriately ordered by the compensation judge. *Id.* The purpose of chronic management is twofold: the patient should be made independent of health care
providers in the ongoing care of a chronic condition; and the patient should be returned to the highest functional status reasonably possible.

1. Personality or psychological evaluation: maybe indicated for patients who are candidates for chronic management. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury.

2. Concurrent modalities: Any of the chronic management modalities listed in Minn. Rule 5221.6600, subpart 2 may be used singly or in combination as part of a program of chronic management.

3. Passive treatment modalities: No further passive treatment modalities or therapeutic injections are indicated except as otherwise specified in the specific treatment parameters set forth above.

4. Diagnostic evaluation: No further diagnostic evaluation is indicated unless there is the development of symptoms or physical findings which would in themselves warrant diagnostic evaluation.

5. Medications: A program of chronic management must include appropriate means by which use of scheduled medications can be discontinued or severely limited.

B. Chronic Management Modalities - Minn. Rule 5221.6600, subp. 2

1. Prior Notification

The health care provider must provide prior notification of the chronic management modalities pursuant to Minn. Rule 5221.6050, subp. 9, except for home-based exercises. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized, either in writing or by routine payment for services, without providing the employee and the health care provider with at least 30 days’ notice of intent to apply any of the chronic management parameters in Minn. Rule 5221.6600 to future treatment. This notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

2. Home Based Exercise Program

Such programs consist of aerobic conditioning, stretching and flexibility exercises, and strengthening exercises without the need for supervision. Certain durable medical equipment may be prescribed, but the insurer must be given prior notification. The patient should receive specific instruction and training in the exercise program. This may require one to three visits for instruction and monitoring.
3. Health Clubs
   a. Indications: The employee is deconditioned and requires a structured environment to perform prescribed exercises. The provider must document the reasons why a home-based program of exercise would not suffice.
   b. Requirements: There must be specific prescribed exercises stated in objective terms. There must be a specific timetable of progression in the activities designed so that the goals can be achieved. There must also be a prescribed frequency of attendance with documentation.
   c. Treatment period: 13 weeks. Additional periods of treatment require additional prior notification to the insurer.

4. Computerized Exercise Programs
   a. Indications: The employee is deconditioned and requires a structured environment to accomplish rehabilitation goals. The provider must document why a home-based exercise program would not suffice.
   b. Requirements: The program must have specific goals stated in objective terms and a specific timetable of progression in the activities. There must also be a prescribed frequency and duration of attendance.
   c. Treatment Period: 6 weeks. Additional periods of treatment require additional prior notification of the insurer.

5. Work Conditioning and Work Hardening Programs
   a. Description: Such programs are intensive, highly structured, job oriented, individualized treatment plans based on assessment of the patient’s work setting or job demands. Work conditioning uses physical conditioning and functional activities related to the individual’s work. Work hardening is designed to restore an individual’s physical, behavioral, and vocational functions within an interdisciplinary model. It addresses the issues of productivity, safety, physical tolerances, and work behaviors.
   b. Indications: Employee is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. The provider must document the reasons why work hardening cannot be accomplished through a structured return to work program.
c. Requirements: The program must have specific goals stated in terms of work activities. There must be a specific timetable of progression and there must be a set frequency and hours of attendance, together with documentation of attendance. There must be a set duration.

d. Treatment Period: 6 weeks. Additional periods of treatment require prior notification of the insurer.

6. Chronic Management Programs

a. Description: Such programs consist of multidisciplinary teams who provide coordinated, goal-oriented services to reduce pain disability, improve functional status, promote return to work, and decreased dependence on the health system of persons with “chronic pain syndrome.” See Minn. Rule 5221.6040, subp. 3. They must provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and if indicated, chemical dependency evaluation. The program must be individualized. It may be provided in an in-patient or out-patient setting, as appropriate.

b. Indications: The patient is diagnosed as having chronic pain syndrome.

c. Requirements: An admission evaluation must be performed by a doctor and a licensed mental health professional, each with at least two years’ experience in evaluation of chronic pain treatment, or one year of formal training in a pain fellowship program. There must be a specific set of prescribed activities and treatments, and a specific timetable of progression. There must be a set frequency and hours of attendance with documentation of attendance. There must be a set duration of attendance.

d. Treatment Period: For initial treatment, a maximum of 20 8-hour days and a maximum duration of 4 weeks no matter how many or how long the day is prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is indicated for an injury. But see, Bills v. Northern Castings, File No. ***-***-0294 (WCCA November 12, 1999) (second pain clinic allowed as an “exceptional care” departure).
7. Individual or Group Psychological or Psychiatric Counseling

a. Indications: A personality or psychosocial evaluation has revealed one or more of the problems listed in the rule which interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

b. Requirements: There must be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals. There must be a prescribed frequency of attendance with adequate documentation of attendance. There must be a prescribed duration of treatment.

c. Treatment: A maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is indicated for an injury.

XIV. DISCIPLINARY ACTION AND PENALTIES - MINN. RULE 5221.8900

A health care provider is subject to disciplinary action for failure to comply with the requirements in the Treatment Parameters Rule or the violation of any of the provisions of Minn. Stat., Chapter 176, or other rules or orders issued pursuant thereto.

A. Complaints

Complaints about professional behavior or services of health care providers relating to noncompliance with established workers’ compensation laws, rules, or orders shall be made in writing to the commissioner. The commissioner or a designee shall assist a person in filing a complaint, if necessary. A complaint may be submitted by any person who becomes aware of a violation, including designees of the commissioner, administrative law judges, and presiding officials at judicial proceedings.

B. Review and Investigation

The commissioner shall investigate all complaints to determine whether there has been a violation of established workers’ compensation laws, rules, or orders. The commissioner may refer a matter to another agency that has jurisdiction over the provider’s license or conduct, or to an agency that has prosecuting authority in the event of suspected theft or fraud or to a peer review authority. Absent suspected theft or fraud, providing treatment outside a parameter set forth in the Rule shall not in itself result in a referral to a prosecuting authority.

If an investigation indicates that discipline may be warranted, the commissioner shall determine whether the violation involves inappropriate, unnecessary, or excessive treatment, or whether the violation involves other statutes or rules.
C. **Cooperation with Disciplinary Proceedings**

A provider who is the subject of a complaint shall cooperate fully with the investigation. This includes responding fully and promptly to any questions raised by the commissioner and providing copies of records as requested. The provider may be represented by an attorney.

D. **In-Person Meeting**

When conferring with the parties to a complaint is deemed appropriate, the commissioner shall schedule a meeting for the purpose of clarification of issues, obtaining information, instructing parties to the complaint, or for the purpose of resolving disciplinary issues.

E. **Resolution by Instruction or Written Agreement**

The commissioner may resolve a complaint through instruction of a provider, or may enter into stipulated consent agreements regarding discipline with a provider in lieu of initiating a contested case or medical services review board proceeding.

F. **Inappropriate, Unnecessary, or Excessive Treatment**

If the suspected violation involves a treatment standard the commissioner must refer the health care provider to the medical services review board for review under Minn. Stat. § 176.103, subd. 2, if:

1. The situation requires medical expertise in matters beyond the department’s general scope;

2. Wherever possible under Minn. Stat., Chapter 176, a final determination has been made by a workers’ compensation presiding official, or provider licensing or registration body that the medical treatment in issue was inappropriate, unnecessary, or excessive; and

3. A pattern of consistently providing inappropriate, unnecessary, or excessive services exists for three or more employees.

Where the medical service review board’s report to the commissioner indicates a violation of treatment standards or other inappropriate, unnecessary, or excessive treatment, the commissioner shall order a sanction. **Sanctions may include, but are not limited to, a warning; a fine of up to $200 per violation; a restriction on providing treatment; requiring preauthorization by the board, the payor, or the commissioner for a plan of treatment; and suspension from receiving compensation for the provision of treatment.**
G. Violations of Statutes and Rules Other Than Those Involving Inappropriate, Unnecessary, or Excessive Treatment

If the suspected violation warranting discipline involves a statute or rule other than the treatment standards, the commissioner shall initiate a contested case hearing for disciplinary action.

H. Penalties

In addition to disciplinary action, the commissioner may assess a penalty if a provider fails to release existing written medical data or fails to provide reports required by the rules.

XV. LIST OF TREATMENTS AND PROCEDURES THAT ARE NOT INDICATED

A. Medical Imaging

1. Imaging solely to rule out a diagnosis not seriously being considered as the etiology of patient’s condition is not indicated. Minn. Rule 5221.6100 subp. 1B.

2. Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan. Minn. Rule 5221.6100, subp. 1C.

3. Repeat imaging, of the same views with the same imaging modality is not indicated except as follows:

   a. To diagnose a suspected fracture or suspected dislocation;
   b. To monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy and treatment;
   c. Repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment;
   d. To follow up a surgical procedure;
   e. To work up a change in the patient’s condition marked by new altered objective findings;
   f. To evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study; or
   g. When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study. Minn. Rule 5221.6100, subp. 1D.

   See Skogen v. Diversified Builders and Design, File No. ***-**-2800 (WCCA January 12, 1999) (second lumber MRI scan for same injury denied as being unnecessary and duplicative.)
4. Persistence of a patient’s subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. Minn. Rule 5221.6100, subp. 1E.

5. CT scanning is not indicated for low back pain in the first eight weeks after an injury except when cauda equina syndrome is suspected, for evaluation of progressive neurological deficit, or when bony lesion is suspected on the basis of other tests or imaging procedures. Minn. Rule 5221.6100, subp. 2A.

6. MRI scanning for low back pain is not indicated in the first eight weeks after an injury except when cauda equina syndrome is suspected, for evaluation of neurologic deficit, when previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage, or suspected discitis. Minn. Rule 5221.6100, subp. 2B.

7. Nuclear Isotope scans (including Technicium, Indium, and Gallium scans) are not indicated unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies. Minn. Rule 5221.6100, subp. 2I.

8. Thermography is not indicated for the diagnosis of low back pain, sciatica, or lumbar radiculopathy. Minn. Rule 5221.6100, subp. 2J.

9. Anterior-posterior and lateral x-rays of lumbosacral spine are not indicated in the following circumstances:
   a. To verify progress during initial non-surgical treatment.
   b. To evaluate a successful initial non-surgical treatment program. Minn. Rule 5221.6100, subp. 2K.

10. Oblique x-rays of the lumbosacral spine are not indicated as part of a package of x-rays including anterior-posterior and lateral x-rays of the lumbosacral spine. Minn. Rule 5221.6100, subp. 2L.

11. Electronic x-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions described in the rules. Minn. Rule 5221.6100, subp. 2M.

B. Low Back Pain, Neck Pain and Thoracic Back Pain

1. The following durable medical equipment is **not indicated for home use** for low back conditions:
a. Whirlpools, jacuzzi, hot tubs, or special bath or shower attachments; or
b. Beds, waterbeds, mattresses, chairs, recliners, or loungers.

Minn. Rule 5221.6200, subp. 8D (low back); Minn. Rule 5221.6205, subp. 8D (neck pain); Minn. Rule 5221.6210, subp. 8D (thoracic)

2. Laboratory Tests

a. Low Back Pain

Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain or cauda equina syndrome, except when a patient’s history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic muscular skeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, to evaluate potential adverse side effects of medications, or as part of a pre-operative evaluation.

Minn. Rule 5221.6200, subp. 1B

b. Neck Pain

Laboratory tests are not indicated in the evaluation of a patient with regional neck pain or radicular pain, except when a patient’s history, age or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic muscular skeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, to evaluate potential side effects of medications, or as part of a pre-operative evaluation.

Minn. Rule 5221.6205, subp. 1B

c. Thoracic Back Pain

Laboratory tests are not indicated in the evaluation of a patient with regional thoracic pain or radicular pain, except when a patient’s history, age or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic muscular skeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, to evaluate potential side effects of medications, or as part of a pre-operative evaluation.

Minn. Rule 5221.6210, subp. 1B
3. The use of the following procedures or tests is not indicated for the diagnosis of low back pain, neck pain or thoracic back pain:
   a. Surface electromyography or surface paraspinal electromyography;
   b. Thermography;
   c. Plethysmography;
   d. Electronic X-ray analysis;
   e. Diagnostic ultrasound; or
   f. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

   Minn. Rule 5221.6200, subp. 1E (low back); Minn. Rule 5221.6205, subp. 1E (neck); Minn. Rule 5221.6210, subp. 1E (thoracic).

4. Repeat electrodiagnostic studies are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

   Minn. Rule 5221.6200, subp. 1D (low back); Minn. Rule 5221.6205, subp. 1D (neck).

   EMG and nerve conduction studies are always inappropriate for regional thoracic pain and radicular pain.

   Minn. Rule 5221.6210, subp. 1D

5. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical care, but may be indicated during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical care, computerized range of motion or strength testing may be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

   Minn. Rule 5221.6200, subp. 1F (low back); Minn. Rule 5221.6205, subp. 1F (neck); Minn. Rule 5221.6210, subp. 1F (thoracic).

6. Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical care. A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment. Only one FCE per injury.
7. Except for certain specified exceptions, the use of passive treatment modalities in a clinical setting is not indicated beyond 12 calendar weeks after the first passive modality is initiated.

Minn. Rule 5221.6200, subp. 1I (low back); Minn. Rule 5221.6205, subp. 1I (neck); Minn. Rule 5221.6210, subp. 1I (thoracic).

8. Bedrest should not be prescribed for more than seven days.

Minn. Rule 5221.6200, subp. 3J (low back); Minn. Rule 5221.6205, subp. 3J (neck); Minn. Rule 5221.6210, subp. 3J (thoracic).

9. Prolotherapy and botulinum toxin injections are not indicated in treatment of low back, neck or thoracic back problems.

Minn. Rule 5221.6200, subp. 5C (low back); Minn. Rule 5221.6205, subp. 5C (neck); Minn. Rule 5221.6210, subp. 5C (thoracic).

10. Scheduled and Non-Scheduled Medication

Controlled substance medications scheduled under Minn. Stat. § 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain and is not indicated in the treatment of patients with regional low back pain, regional neck pain or regional thoracic back pain after the first two weeks.

Minn. Rule 5221.6200, subp. 10 (low back); Minn. Rule 5221.6205, subp. 10 (neck); Minn. Rule 5221.6210, subp. 10 (thoracic).

C. Upper Extremity Disorders

1. The following durable medical equipment is not indicated for home use for the upper extremity disorders specified in the rule:

   a. Whirlpools, jacuzzi, hot tubs, or special bath or shower attachments; or
   b. Beds, waterbeds, mattresses, chairs, recliners, or loungers.

Minn. Rule 5221.6300, subp. 8D
2. Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical care. A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment. Only one FCE per injury.

Minn. Rule 5221.6300, subp. 1J

3. The following diagnostic procedures or tests are not indicated for diagnosis of upper extremity disorders:
   a. Surface electromyography;
   b. Thermography; or
   c. Somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

Minn. Rule 5221.6300, subp. 1E

4. The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:
   a. Vibrometry;
   b. Neurometry;
   c. Semmes-Weinstein monofilament testing; or
   d. Algometry.

Minn. Rule 5221.6300, subp. 1F

5. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed, but must be done in conjunction with and not reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

Minn. Rule 5221.6300, subp. 1G
D. Reflex Sympathetic Dystrophy of the Upper and Lower Extremities

Passive treatment modalities are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy. The only passive treatment modalities that are allowed are thermal treatment, desensitizing procedures, electrical stimulation, and acupuncture.
APPENDIX A

TAMING THE BEAST: PROPOSED RULES REGARDING LONG-TERM TREATMENT WITH OPIOID ANALGESIC MEDICATION
TAMING THE BEAST: PROPOSED RULES REGARDING LONG-TERM TREATMENT WITH OPIOID ANALGESIC MEDICATION

By Alicia J. Smith
May 2015

It is an understatement to say that the management of workers’ compensation matters involving chronic pain is often highly complex. This fact is largely due to the widespread prescription of—and often addiction to—opioid medications. The workers’ compensation community can attest to the devastating effects that long-term opioid use and abuse can have, not only on injured workers and their families, but on the system as a whole. Too often, we see cases of employees who sustain relatively minor injuries which, with the continued use of powerful prescriptions, turn into intractable problems. Continual use of opioid medication can negatively affect a worker’s ability to tolerate pain, leading to higher dosages, diminishing returns, and bigger bills. Therefore, it is no surprise that workers’ compensation practitioners in several states, including Minnesota, are formulating more rigorous treatment policies to curb the many negative consequences associated with opioid dependence.

Take, for example, the case of Bowman v. A & M Moving & Storage Co., File No. WC13-5551 (WCCA August 14, 2013). In Bowman, the issue for the WCCA was whether the deceased employee’s death due to oxycodone toxicity was causally related to his work-related low back injury. In the months before the employee’s death, it was discovered that he had a previous history of alcohol abuse. His treating doctor even noted a concern with the employee’s use of narcotics. Nevertheless, his doctor continued to prescribe oxycodone, among other prescriptions. After the employee passed away, the medical examiner’s office evaluated his oxycodone toxicity, and it found that typical levels of oxycodone were only one-tenth of the level found in his blood at the time of death. In the end, the WCCA affirmed the ruling of the compensation judge that the employee’s death due to opioid toxicity was due to the work injury. This decision was summarily affirmed by the Minnesota Supreme Court on January 13, 2014.

In Minnesota, the current workers’ compensation treatment parameters contain Minn. Rule 5221.6105, Subpart 3, which governs opioid analgesics. It lists the most common opioids: codeine, hydrocodone, levorphanol, methadone, morphine, hydromorphone, and oxycodone. The rule provides a relatively rudimentary outline of how opioids can be initially prescribed, with just a few instructions by which they can be re-prescribed. Basically, treatment with opioid medications can begin on a trial basis with the lowest clinically effective dose of a generic brand, and then be re-prescribed upon clinical evaluation at different points of time following the date of injury. For several years, we have seen pain management bills run rampant, and the need for increased oversight of opioid treatment has become increasingly clear.

The Minnesota Department of Labor and Industry (DOLI) is in the process of adopting revisions to the workers’ compensation treatment parameters that govern long-term treatment of chronic pain with opioid medications. The most notable proposed addition is of a new section, Minn. Rule 5221.6110, which is very aptly titled “Long-Term Treatment with Opioid Analgesic Medication.” This rule sets forth more stringent requirements for health care providers in administering these prescriptions among injured workers. The definitions in Minn. Rule 5221.6040 would be consequently updated, and the current Minn. Rule 5221.6105, Subpart 3 would be revised to add that “continued prescription of” opioid analgesics must comply with the new long-term opioid treatment rule.
Unlike the current rule, the new rule contains mandatory criteria for initiating a prolonged opioid treatment plan. Criteria include: the worker is unable to maintain function without long-term use of opioid medications; all other reasonable medical treatment options have been exhausted; the patient does not have a history of failing to comply with treatment or failing to take medication as prescribed; the patient does not have a current substance use disorder; and, a drug test confirms that the worker is not using any illegal substances. The new rule also offers guidance for determining whether long-term opioid treatment would be contraindicated, such as when there is a relevant mental disorder or suicide risk, the patient has poor impulse control, and the patient regularly engages in activity that would be unsafe in combination with use of opioid medications. A risk assessment must be completed before a long-term opioid treatment plan can be initiated, so as to determine whether such treatment will, in fact, be contraindicated.

Once the long-term opioid plan is actually initiated, there are additional parameters for the administration of the plan. The new rule requires that long-term treatment with opioid medication must be part of an integrated treatment program, ensuring that recovery from injury is an active process. Fixed schedules of dosing must be followed, and only the prescribing health care provider or a designated proxy may write opioid prescriptions. Along the way, there are several hoops through which a provider must jump in order to continue prescribing these medications. Namely, the health care provider must assess the patient for possible negative side-effects or addiction at each follow-up visit, adherence to the treatment program must be monitored at each visit, and in the event that there is more than one instance of unreported opiate prescriptions from other providers, a schedule to taper dosages must be implemented. These critical features of the new rule will force health care providers to scrutinize their work when it comes to people most at risk for dependence, and will dramatically reduce the ad nauseam re-prescription of opioids that we too often see in our cases today.

As is the case with every rulemaking initiative, DOLI published a Statement of Need and Reasonableness (SONAR) with regard to these proposed rule changes. The SONAR mentions that the rule changes will affect workers’ compensation stakeholders across the state, from workers and their health care providers who administer opioid medications, to the employers and insurers who pay for them. While employers and insurers have applauded these proposed changes to the treatment parameters, the SONAR addresses that some providers may be less-than-enthused about the additional layers of assessment that will be required in the administration of opioid medications. Providers may cite the mandate for continuous evaluation of opioid use as a cause for additional expense. However, the SONAR makes clear that the rules do not require any provider to spend money to comply with the rules—compliance will merely require knowledge and attention.

Overall, the proposed new workers’ compensation treatment parameters on long-term opioid treatment will be beneficial not only for employees, but also for employers and insurers, which is a welcome bridge over our often-existent divide. The comment period for this rulemaking initiative ended on April 15, 2015. DOLI is currently submitting information relative to the new rules to the Office of Administrative Hearings (OAH). The OAH will have 14 days to review the information. Assuming it approves, it will then submit the rules to the Secretary of State, and the Revisor will prepare a Notice of Adoption. The rule becomes effective five working days after the Notice of Adoption is published.

A comprehensive list of information related to the proposed rules and the adoption process can be found at: http://www.dli.mn.gov/PDF/docket/5221_6020_8900TrtmPar_2.pdf.
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<thead>
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<th>STATE</th>
<th>MEDICAL MARIJUANA CASE LAW</th>
<th>SUMMARY</th>
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<tr>
<td>Alaska</td>
<td><em>Sonntag v. Gabe’s Trucking &amp; Auto Repair</em>, 2013 WL 4508817 (Alaska Work. Comp. Bd. 2013)</td>
<td>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.</td>
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<tr>
<td>Arizona</td>
<td>no relevant cases found.</td>
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<td>California</td>
<td><em>Cockrell v. Farmers Insurance &amp; Liberty Mutual Insurance Company</em></td>
<td>no relevant cases found.</td>
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<td>Colorado</td>
<td><em>In the Matter of Armendariz v. Chief Masonry</em>, 2014 WL 3886663 (Colo. Ind. Cl. App. Off. 2014)</td>
<td>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.</td>
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<td>Connecticut</td>
<td>no relevant cases found.</td>
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<td>Illinois</td>
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<td>Maine</td>
<td><em>Schoendorf v. RTH Mechanical Contractors Inc.</em>, 2014 WL 4491370 (ME. Work. Comp. Bd. 2014)</td>
<td>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.</td>
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<td></td>
<td><em>Wade v. Martindale Country Club</em>, 2012 WL 6827338 (ME. Work. Comp. Bd. 2012)</td>
<td>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.</td>
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<td>New Jersey</td>
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<td>New Mexico</td>
<td><em>Vialpando v. Ben's Automotive Services</em>, 331 P.3d 975 <em>Mac3 v. Riley Industrial</em></td>
<td>Held Workers' Compensation Act authorizes reimbursement for medical marijuana and did not require employer to commit a federal crime.</td>
</tr>
<tr>
<td>New Mexico</td>
<td><em>Maez v. Riley Industrial</em>, 2013 WL 4238545 (N.M. Workers’ Comp. Admin. 2013)</td>
<td>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.</td>
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<td>New Mexico</td>
<td><em>Lewis v. American General Media</em>, 2013 WL 6517276 (N.M. Workers’ Comp. Admin. 2013)</td>
<td>Court held employer/insurer must reimburse employee for medical marijuana prescribed. Court found this was consistent with New Mexico state law.</td>
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<td>New York</td>
<td><em>Employer: Navarre Prescription Ctr., Inc.</em>, 2008 WL 3180396 (N.Y. Work. Comp. Bd. 2008)</td>
<td>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.</td>
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<td>Oregon</td>
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<td>Rhode Island</td>
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<td>Vermont</td>
<td>No relevant cases found.</td>
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<tr>
<td>Washington</td>
<td><em>Roe v. Teletech Customer Care Management LLC</em>, 171 Wash. 2d 736 (Wash. 2011)</td>
<td>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.</td>
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TRAUMATIC BRAIN INJURY

By
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Jessica L. Ringgenberg
Emily A. LaCourse
Jack M. McFarland
# Traumatic Brain Injury

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TRAUMATIC BRAIN INJURY

I. CONDITIONS

A. Amnesia

1. Retrograde: loss of memory prior to 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 mental 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)**

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 fractures: 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 Glasgow Coma Score of ≤ 8.

<table>
<thead>
<tr>
<th>Best Eye Response</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No eye opening</td>
<td>1. No verbal response</td>
<td>1. No motor response</td>
</tr>
<tr>
<td>2. Eye opening to pain</td>
<td>2. Incomprehensible sounds</td>
<td>2. Extension to pain</td>
</tr>
<tr>
<td>3. Eye opening to verbal command</td>
<td>3. Inappropriate words</td>
<td>3. Flexion to pain</td>
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<td></td>
<td>5. Appropriate verbal responses</td>
<td>5. Localizing to pain</td>
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<td></td>
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<td>6. Obeys commands</td>
</tr>
</tbody>
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*Brian Ledlow, University of Pennsylvania, School of Medicine.*
IV. MANAGEMENT OF TRAUMATIC BRAIN INJURY BASED ON SEVERITY OF INJURY.

A. Severity


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 neuroophthalmologist to address vision issues and a neuropsychologist to assess cognitive function.

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

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. 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.

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*. 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.

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*.

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. This amendment provided an exception to the general rule that mental-mental injuries are not compensable.

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7 *Miels* at 715.
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.”

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.”

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.” 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.”

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.”

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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.  

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 stress disorder were compensable.

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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.