Changes to Wisconsin Worker’s Compensation Act
by Jessica Ringgenberg

For the past few years, there has been a lot of discussion in Wisconsin about possible legislative changes after a prior bill failed to pass. On February 29, 2016, Governor Scott Walker approved a bill that originated in the advisory council. 2015 Wisconsin Act 180 became effective March 2, 2016. This legislation makes a number of changes to the Wisconsin Worker’s Compensation Act. The legislative changes affecting substantive benefits and rights are only applicable for claims involving dates of injury on or after March 2, 2016. Those changes include the following:

- The maximum weekly permanent partial disability benefit rate for dates of injury between March 2, 2016, and December 31, 2016 (inclusive), is $342.00. The rate will increase to $362.00 for dates of injury on or after January 1, 2017.
- Most traumatic (“single incident”) injuries will have a six year statute of limitations. ‘Significant’ traumatic injuries (including...
Changes to Wisconsin Worker’s Compensation Act continued

those resulting in loss or total impairment of a hand, foot or any part of the arm or leg proximal to the hand or foot; loss of vision; permanent brain injury; or any traumatic injury resulting in the need for an artificial spinal disc, or a total or partial knee or hip replacement, as outlined in Wis. Stat. 102.17(4)), will not be subject to any statute of limitations, as has been the case since April 2006. Occupational disease injuries will still be subject to a twelve year statute of limitations.

• 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. An employer is still liable for medical expenses and prescription medication expenses.

• If an employee’s employment with the employer has been suspended or terminated due to misconduct or substantial fault (as defined in Wis. Chapter 108 - Unemployment), an employee is not entitled to temporary disability benefits during the healing period.

• If an employee incurred permanent disability, but a percentage of that was caused by accidental injury and a percentage was caused by other factors (before or after the time of accidental injury), the employer is liable only for the percentage of permanent disability caused by the accidental injury. However, if previous permanent disability is attributable to occupational exposure with the same employer, the employer is also liable for the established previous permanent disability.

• Medical providers must now provide a legible, certified duplicate of medical records, in electronic format, upon payment of $26.00 per request.

• 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. This applies to all dates of injury.

• Entitlement to supplemental benefits is now for dates of injury occurring prior to January 1, 2003. These are payable when an employee is receiving continuous permanent total disability or temporary total disability more than 24 months after the injury. As of March 2, 2016, the supplemental benefit rate equals that which, when added to the established rate for the date of injury, totals $669.00.

• 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.

• Judges can now 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. This applies to all dates of injury.

• The Department of Workforce Development may request the Department of Justice to assist in an investigation of suspected fraudulent activity on the part of an employer, employee, insurer, health care provider or other person related to worker’s compensation.

These changes will be discussed in more detail at our upcoming seminars – June 9, 2016 in Minneapolis and June 16, 2016 in Wauwatosa. If you have any questions in the meantime, please feel free to contact any of our Wisconsin worker’s compensation attorneys: Chuck Harris, Susan Larson, or Jessica Ringgenberg.
**Case Law Update**

**Decisions of the Wisconsin Court of Appeals**

**Bad Faith**

*Coe v. Labor and Industry Review Commission*, 868 N.W.2d 198 (Wis. Ct. App. 2015) *(unpublished)*. The independent medical examiner opined that a proposed surgery was not related to the alleged work-related injury. The applicant elected to undergo the surgery on the good faith recommendation of his physician. The Labor and Industry Review Commission held the applicant was not entitled to a bad faith penalty for the employer and insurer’s failure to pay benefits associated with the surgery. The Circuit Court and Court of Appeals affirmed. The *Spencer* rule applies only when there is no dispute the proposed treatment is causally related to a compensable industrial injury (and only the reasonableness and/or necessity of the procedure is in dispute). This was not the situation here, because the independent medical examiner had opined the proposed surgery was not causally related to the injury.

**Evidence**

*Dollas v. Labor and Industry Review Commission*, 871 N.W.2d 692 (Wis. Ct. App. 2015) *(unpublished)*. The applicant sustained a work-related injury when a file cabinet fell on him and hit him on the head. He was paid benefits for a short period of time, and then sought additional wage loss benefits and medical expenses. Conflicting medical expert opinions were submitted. Dr. Xenos’ (independent medical examiner) opinion was determined by the administrative law judge to be more credible than the treating physician. The Labor and Industry Review Commission affirmed the denial of benefits. The Circuit Court and Court of Appeals affirmed the Commission's decision. The Court of Appeal's judgment cannot be substituted for that of the Commission as to the weight or credibility of the evidence on any finding of fact. Conflicts of testimony of medical witnesses are to be resolved by the Commission. A determination made by the Commission that the testimony of one qualified medical witness rather than another is to be believed, is conclusive. The Commission's decision is supported by Dr. Xenos’ medical opinion, which was itself based upon an examination of the applicant and evaluation of medical records.

*Limberg v. Labor and Industry Review Commission*, 871 N.W.2d 866 (Wis. Ct. App. 2015) *(unpublished)*. The applicant was involved in a motor vehicle accident while working as a snow plow driver. He drove himself to the emergency room on the date of injury and then returned to work for the remainder of the day. Two and a half years later he underwent shoulder surgery. Five years later he underwent cervical fusion surgery. The medical experts differed in their opinions regarding whether the work-related injury caused the neck and/or shoulder conditions that necessitated surgery or whether the conditions were related to pre-existing degenerative changes and not otherwise impacted by the effects of the work-related injury. The unnamed administrative law judge credited the independent medical examiner’s opinions regarding the shoulder condition. Additionally, the administrative law judge held that the treating physician’s opinions regarding the cervical condition were based upon inaccurate information, and therefore, the independent medical examiner’s opinions were credited. The applicant’s claims were dismissed. The Labor and Industry Review Commission affirmed. The Circuit Court reversed the Commission’s decision. The Court of Appeals reversed the Circuit Court's decision (reinstating the Commission's decision). The Circuit Court and Court of Appeals shall not substitute their judgement for that of the Commission as to the weight or credibility of the evidence on any finding of fact. There is evidence to support a variety of decisions in this case. However, the question is not whether the Circuit Court's view of the evidence is more reasonable than the Commission’s, but whether there is any credible evidence to sustain the findings the Commission did make. The Commission is the sole judge of the weight and credibility of medical evidence. A treating physician is not accorded special credibility. The Commission's decision was supported by substantial and credible evidence and, therefore, the decision is affirmed.
Procedural Issues

Hoxha v. American Family Mutual Insurance Company, 866 N.W.2d 405 (Wis. Ct. App. 2015) (unpublished). The applicant, while delivering food for his brother’s pizzeria in his personal vehicle, was injured in an automobile accident. The negligent party’s insurer paid its policy limits. The applicant then filed a claim against his personal insurer (Allstate) for underinsured motorist benefits. Allstate requested that the Circuit Court stay its action for underinsured motorist benefits until such time as the applicant had applied for and recovered worker’s compensation benefits. Allstate did this because of a provision within Allstate’s policy which provided that any damages it paid would be reduced by any payments made by the worker’s compensation insurer. The Circuit Court granted Allstate’s request to stay the pending action. The Court of Appeals reversed. Allstate cited Bires v. City of Mauston, 151 Wis.2d 892 (Wis. Ct. App. 1989) for the proposition that whether or not an injury falls within the Worker’s Compensation Act, is an issue for which the Worker’s Compensation Division has primary jurisdiction, as opposed to the Circuit Court. In Bires, the issue involved whether or not an injury to a fireman occurred in the course of his employment (which, if so, he could not sue his employer in tort) or outside of his employment (in which case he could sue the employer in tort). The Bires court held that the Department should decide the issue and the Circuit Court action should be stayed pending the Department’s Decision. However, in the instant case, because the tort claim did not involve the employer, there was no requirement to stay the underlying action.
The employer had hired someone else to take out metal items. The applicant had asked the employer if he could have a refrigerator. The employer advised the applicant that he could have a refrigerator, but asked the applicant to wait to get it until the weekend when the employer could bring his trailer to the job site. The applicant decided not to wait until the weekend to get the refrigerator. Instead, he brought the refrigerator down the stairs with the co-worker. The refrigerator got caught in the carpet. The refrigerator then fell on top of the applicant and the applicant fell down the stairs. Administrative Law Judge Falkner held that the applicant was employed by the employer on his date of injury because the nine-point test for independent contractors was not fully met. Administrative Law Judge Falkner also held that the applicant was in the course of his employment when he was removing the refrigerator. The applicant was on the work site shortly after the fall, the floor was not sticky and her shoes did not stick to the floor. The applicant did not report to the employer representative that there was a sticky substance or provide any explanation for the fall. Another employee testified that she worked in the same area where the fall occurred and the floor was never sticky from humidity. Administrative Law Judge Arnold held the applicant did not establish that the floor was sticky or in any other manner caused her to fall, and her claims were dismissed. The Labor and Industry Review Commission affirmed. Unexplained falls are not compensable and the applicant did not establish that the floor was sticky or the fall was otherwise explained.

Gomez v. Terry Schwietz, Claim No. 2013-007185 (LIRC June 30, 2015). The employer ‘hired’ the applicant as an independent contractor. The applicant was injured while carrying a refrigerator down stairs with a co-worker. The applicant and the co-worker were performing wall demolition work on the employer’s project at the time of the injury. The refrigerator got caught in the carpet. The refrigerator then fell on top of the applicant and the applicant fell down the stairs. The Labor and Industry Review Commission affirmed. Unexplained falls are not compensable and the applicant did not establish that the floor was sticky or the fall was otherwise explained.

Kowalis v. Seek Career Staffing, Inc., Claim No. 2012-030132 (LIRC June 30, 2015). The applicant worked for a temporary staffing company. On his first day of work at a new site, he worked for two and one-half hours. He used a hand held grinder to sand various parts. The applicant testified that after two and one-half hours of sanding, a part became stuck and his arm jerked. He reported this caused pain in his right elbow. He reported the pain to a supervisor, was moved to a different work area, and finished his shift. The applicant subsequently treated for right elbow pain. However, the records do not reflect he reported that his arm being caught and jerked was the cause of his right elbow pain. The applicant’s treating doctor, Dr. DeRoos, opined the applicant did not have a tear in his elbow initially. Dr. DeRoos later opined that the applicant did have a small tear. He proceeded to perform two surgeries on the applicant’s elbow. Dr. DeRoos also opined the applicant’s injury was causally related to his employment. The applicant was assigned a permanent partial disability rating. The applicant underwent an independent medical examination with Dr. Kummer. Dr. Kummer opined that two and one-half hours was not enough time to cause an occupational injury to the applicant’s elbow. Dr. Kummer opined the applicant’s right elbow condition was not work related. Dr. Kummer also opined the applicant did not perform any repetitive labor at his prior job placement locations. Administrative Law Judge Konkol noted the inconsistencies regarding the mechanism of injury between the applicant’s testimony and what was documented in the medical records. He denied the applicant’s claim in its entirety. The Labor and Industry Review Commission
affirmed. Dr. DeRoos’ medical opinions were based upon the applicant’s description of the mechanism of injury. The applicant was not credible. Therefore, because Dr. DeRoos’ opinion was based on what the applicant had reported, Dr. DeRoos’ opinion was unreliable and the independent medical examination doctor’s opinion was more persuasive.

Andreonz v. Petroleum Equipment, Inc., Claim No. 2013-010297 (LIRC July 30, 2015). The applicant worked for the employer for 28 years. She initially worked full time, but later changed her schedule to work only on Thursdays. After her schedule changed, she continued to go in to the office on Tuesdays. This was one of her days off but she went to pick up her check at work, instead of having it mailed to her. On one particular occasion, the applicant came in to get her check, but accidentally left it by the coffee maker. She called the office manager when she got home. The office manager told the applicant that she would put the check in the applicant’s drawer. The office manager asked the applicant to wait to pick the check up until Thursday because they anticipated closing the office early because of heavy snow. The office manager did not have supervisory authority over the applicant. The applicant decided to pick up her check that same day. The applicant’s daughter drove her to the office. The office manager was just locking up when the applicant arrived. The applicant got her check. She subsequently slipped and broke her leg on the employer’s walkway. Administrative Law Judge Michelstetter held that the applicant was providing services that arose out of and incidental to her employment with the employer when she picked up her check. The Labor and Industry Review Commission affirmed. The applicant and employer had an established custom whereby the applicant would pick her check up at the office every Tuesday. Picking up a paycheck is a duty imposed by her employer. Employees have long been held to be covered while picking up their paychecks (see Hackley-Phelps-Bonnell Co. v. Industrial Commission). However, this is not a bright line rule and it does not apply if the reason for picking up the paycheck is for “personal convenience.” In this case, the reason for the applicant’s picking up the paycheck on Tuesday was partly for personal convenience. However, this also saved the employer money for postage. Therefore, this was not done purely for personal convenience and the injury is, therefore, compensable.

Schmidt v. Cardinal Glass Industries, Inc., Claim No. 2012-01382 (LIRC July 30, 2015). The applicant alleged she sustained bilateral carpal tunnel syndrome as a result of her job duties for the employer. All of the medical experts agreed with the diagnosis and that the treatment was reasonable and necessary for the diagnosed conditions. Dr. Siegert performed an independent medical examination. He initially opined the work activities were causally related to the applicant’s bilateral carpal tunnel syndrome. This was based upon written job descriptions. However, he opined it would be helpful to have job duty video. After he reviewed job duty videos, Dr. Siegert changed his opinion. He determined that the job duties reflected on the video were not sufficient to cause bilateral carpal tunnel syndrome. The videos were introduced into evidence at the hearing. The applicant testified that the job duties reflected in one video were not those she had performed in 18 years. She testified that the other video reflected approximately 20% of her daily activities. The applicant testified the remainder of her job duties were not reflected by either video tapes introduced into evidence. There were no other witnesses at the hearing. The unnamed administrative law judge awarded benefits to the applicant. The Labor and Industry Review Commission affirmed the judge’s decision regarding causation. (The Award was slightly modified to reflect assessment of 5% instead of 10% per wrist for permanent partial disability.) The applicant’s testimony established the job duty video was incomplete and somewhat inaccurate with respect to the applicant’s job duties. The video did not show one of the duties the applicant performed regularly, and which required repetitive and forceful wrist use, nor another job that required some force for completion. Additionally, the video showed duties that the applicant did not do at all, or did very infrequently. Watching the job duty videos could have easily led Dr. Siegert to conclude the duties generally were lighter and more varied than they actually were. The written description of the job was more accurate and in line with the applicant’s testimony regarding her job duty. Dr. Siegert initially agreed with causation after consideration of the written information. [Editor’s note: This is a very good reminder of why it is very important to ensure that any job duty video provided to a physician and/or used at a hearing is accurate, and that someone from the employer is available to testify to its accuracy at a hearing.]

Morris v. Family Dollar Stores of Wisconsin, Claim Nos. 2011-014885, 2011-024857 (LIRC September 23, 2015). The store in which the applicant was working was robbed at gunpoint. The applicant testified that he
received phone calls threatening him if he testified against the persons arrested for the robbery. The applicant’s wife had to tell her clients about the threats for safety reasons because she ran an in-home daycare business. The applicant was terminated by the employer over some allegedly missing deposits. The applicant was later arrested as an alleged conspirator in the robbery. He was never prosecuted. He alleged his development of posttraumatic stress syndrome and cardiomyopathy were caused or aggravated by the work injuries. The respondents asserted the applicant could not have been detrimentally affected by the incident because he was involved in the robbery. [The Labor and Industry Review Commission stated the applicant as not a conspirator but provided no explanation or basis for this statement.] The treating physician initially opined there can be an association between stress and cardiomyopathy. He later changed his opinion to indicate it was more reasonable that the stress caused a worsening of the applicant’s hypertension which leads to the development of cardiomyopathy. He indicated that “mental stress from the armed robbery and the posttraumatic stress disorder as was diagnosed by [treating physicians] can come worsening of hypertension which may come cardiomyopathy”[sic]. The unnamed administrative law judge held the applicant sustained posttraumatic stress disorder and cardiomyopathy as a result of the work-related injury. The Commission affirmed in part and reversed in part. The treating physician’s opinion regarding cardiomyopathy was framed as a possibility and not a probability. There is legitimate doubt that the armed robbery caused or accelerated the development of the applicant’s cardiomyopathy by increasing his hypertension. The independent medical examiner’s opinion that a causal relationship between hypertension and cardiomyopathy cannot be built on a single, blood pressure elevating event and instead develops over years of higher than normal blood pressure makes sense. There is no question that the applicant developed posttraumatic stress disorder as a result of the incident, if that incident occurred as alleged.

Jolin v. Wal-Mart Associates, Inc., Claim No. 2014-028885 (LIRC November 30, 2015). The applicant was building tables in the lawn and garden department with a co-worker. He stepped back, caught his left foot between two boards of a skid and experienced pain in his hand, right shoulder and left knee. The applicant testified his hand and shoulder pain resolved shortly thereafter. He continued to report knee symptoms and was ultimately referred for a left knee replacement. A left knee MRI revealed degenerative changes. The applicant’s treating physician opined it was questionable whether the knee condition was the result of the “single event” at Wal-Mart. The treating physician later opined the applicant’s knee condition had been “brewing for some time.” Upon inquiry from the insurer regarding whether the knee condition was precipitated, aggravated, or accelerated beyond its normal progression, the doctor wrote, “Not comp!” The physician later wrote a letter indicating that this comment reflected the fact that worker’s compensation had denied the applicant’s claim and that the applicant had chosen to pursue surgery anyway. Administrative Law Judge Roberts dismissed the applicant’s hearing application. The Labor and Industry Review Commission affirmed. There were inconsistencies raised in the treating doctor’s opinions and medical records. These inconsistencies raised legitimate doubt as to whether the applicant failed to meet his burden of proof.

Average Weekly Wage

Morrick v. Morrick Concrete, Inc., Claim No. 2013-002221 (LIRC May 14, 2015). The applicant had been an officer, director and shareholder of the employer since the employer was founded. In addition to managing the day to day operations of the business, the applicant also provided services to the company as a laborer and supervisor. It was in his capacity as a laborer/supervisor that he was injured (he tripped and fell at a construction site). The payroll records reflected that the applicant’s gross wages in the 52 week period prior to the injury totaled $9,500.00. An average weekly wage of $279.41 was conceded. This was calculated by taking the gross wages divided by the 34 weeks that the applicant actually worked in the year prior to the injury. The applicant alleged his average weekly wage was $500.00. He alleged that, as an officer and shareholder, his wages were dependent on whether there was sufficient capital available in the coffers of the company to allow payment of $500.00 per week. If the revenues at the end of the week exceeded the expenses sufficiently, the applicant paid himself $500.00 for the pay period. If the...
Bad Faith

Graff, Jr. v. E&A Enterprises, Inc., 2006-001645 (LIRC February 5, 2016). In January of 2009, a Compromise Agreement settling the case was approved. The Compromise included a provision for a Medicare Set-Aside account. (The language of this original Compromise was not included in this Decision.) The Medicare Set-Aside account was not funded. In November of 2011, the applicant filed for a bad faith award. A Hearing was held on the matter and the administrative law judge determined there was bad faith. However, thereafter, in 2013, the parties entered into a limited Compromise Agreement resolving the bad faith claim. The Compromise Agreement included language indicating that the insurer was going to obtain funding for an account. The Compromise Agreement also indicated that, while doing so, the insurer was to pay any medical expenses incurred. After the Compromise Agreement was entered into, the parties’ attorneys had a number of discussions regarding exactly how the MSA would be structured. In January 2014, the attorney for the respondents proposed an annuity from Mutual of Omaha. The attorney proposed that the purchase of said annuity would be a complete “release and discharge of the employer and insurer.” The applicant’s attorney objected to the proposed total release of the employer and insurer. In August of 2014, another application for bad faith was filed because the MSA had still not been funded. In October 2014, the applicant’s attorney provided the respondent’s attorney a copy of the division policy on annuities. This policy requires that the annuity carrier is licensed in Wisconsin, is rated A by Best, that the purchasing of the annuity does not constitute an assignment or transfer of liability for payment of the claim, and that the worker’s compensation carrier remains liable for payments in the event of insolvency by the annuity carrier. Thereafter, the respondents’ attorney removed the “total discharge” language. Administrative Law Judge Roberts noted that the Compromise Agreement provided that the insurer would pay the medical expense until the Set-Aside was funded. He determined that, therefore, medical bills were being paid. He noted that there had been extended negotiations over the precise terms and wording of the MSA. Because the respondents immediately dropped the language upon being furnished with a copy of the Department’s policy, it was reasonable to assume that the respondents had simply been unaware of the Department’s policy. This was not bad faith and, therefore, found the insurer had not committed bad faith. The Labor and Industry Review Commission affirmed. The Circuit Court reversed and remanded the decision to the Commission for further action. The Circuit Court held that simply negotiating does not amount to a good faith effort to comply with the requirement that the respondents fund an MSA. The applicant was harmed because her surgery was postponed as a result of unpaid medical expenses. The treating physician opined the delay in surgery was detrimental because the applicant became weaker during the period of the delay. On remand, the Commission awarded the maximum penalty of $30,000 for bad faith.

Burden of Proof

Kowalsky v. Trempealeau Elec Coop, Claim No. 2003-016305 (LIRC June 25, 2015). The applicant alleged he sustained an initial back injury in 1996 as a result of bending over to pick up chains at work. He was released back to perform regular activities after a short period of time. The applicant continued to treat for back pain over a period of several years. The applicant subsequently required a spinal fusion and then another back related surgery. The respondents had initially admitted liability and paid almost $250,000.00. The respondents filed a reverse hearing application asserting that all of the benefits that were paid were done so under a mistake of fact. However, the respondents waived any overpayment through November 11, 2011. The respondents specifically requested that the court issue a determination that the applicant did not sustain an injury that arose of out of his employment. The respondents also requested the applicant’s claims be dismissed on the basis that he did not have sufficient funds, the applicant would forego the paycheck. The payroll records corroborated the applicant’s testimony. Administrative Law Judge Minix held the wages should be determined under Wis. Stat. 102.11(1)(c), which provides for using the usual going earnings paid for similar services on a normal full-time basis in the same or similar employment when an individual is performing services without fixed earnings or where earnings cannot be determined under the methods prescribed elsewhere in the statute. The applicant was not paid on a regular weekly basis and was issued a paycheck only intermittently. He, therefore, qualifies as a person performing services without fixed earnings. The wages claimed by the applicant fit within the low end of the wage data submitted by the parties, and is, therefore, a reasonable and appropriate measure of his average weekly wage. The Labor and Industry Review Commission affirmed the calculation without comment.
not sustain a work-related injury. Finally, the insurer requested a determination that the medical expenses incurred were not generally medically acceptable. The insurer obtained two independent medical examination reports from Dr. David Florence. In his first report, Dr. Florence opined that the applicant had sustained a significant re-aggravation of his low back pain. He opined that a disc excision at L4-5 would have been reasonable. However, in his second report, Dr. Florence opined that the applicant had undergone unreasonable, unnecessary and egregious treatment which resulted in “significant provider exploitation and ultimately iatrogenic disability.” The applicant did not submit a WKC-16b report or any other substantial evidence supporting his claims. Administrative Law Judge O’Connor held that the applicant did not sustain an injury. The Labor and Industry Review Commission affirmed. In addition to the fact that the applicant did not provide a WKC-16B or any other adequate or substantial evidence to make his prima facia case, the conclusions of the opinions of the independent medical examiner are persuasive. The applicant had undergone significant medical treatment in the months leading up to his alleged date of injury. His treatment after his alleged injury was a continuation of his treatment plans before his claimed injury. There were also a number of inconsistencies between his medical records and his recollection, and references by the treating physicians that his subjective symptoms far exceeded the objective findings. The applicant has the burden of proving his claim beyond the legitimate doubt [despite the fact that this proceeded on a Reverse Hearing Application filed by the respondents]. That was not done here and his claims were dismissed.

**Compromise Agreements**

_Zapa v. Albert Tool & Die Company_, 2015 WL 5241288 (LIRC July 22, 2015). The applicant sought to reopen a Compromise Agreement on the basis that, at the time the settlement was reached, he did not believe that his ankle would worsen in the future. The applicant alleged that he believed that he would be able to return to work once his ankle had healed. The settlement had been reached during a settlement conference/mediation with Judge Thurow. Judge Thurow explained the terms of the Compromise Agreement to the applicant at the time of the settlement conference. The medical records reflected that the applicant had been specifically advised of possible complications to the ankle. Administrative Law Judge Lake set aside the Compromise Agreement on the basis that the applicant was very credible and she believed his assertion that he did not believe his ankle would worsen in the future. The Labor and Industry Review Commission reversed. Compromises should not be reopened absent gross inquiry, important newly discovered evidence, fraud, duress or mutual mistake. Even if the applicant’s condition worsened beyond his or her expectations, as long as the applicant was aware of the potential or possibility that the condition would worsen, that was sufficient to deny the request to reopen the Compromise Agreement. Further, the Compromise Agreement speaks for itself in setting out that the applicant read and understood its terms.

**Credibility**

_McCoy III v. Cardinal CG_, Claim No. 2003-048937 (LIRC September 17, 2015). The applicant alleged he sustained various injuries. The medical records reflected that the applicant had a pre-existing condition and sustained prior injuries. The applicant was mostly pro se at numerous hearings held on this case. At one hearing, the applicant was specifically asked whether he had any prior significant injuries before the work-related injury involved in this case. The applicant testified that he had not. Administrative Law Judge O’Connor denied the benefits claimed by the applicant and held that all benefits owed to the applicant had already been paid. The Commission affirmed. The applicant’s denial of any prior significant injuries before the work-related injury involved in this matter destroyed any credibility that the applicant had. The medical records clearly reflect prior injuries which required multiple prior surgeries. No reasonable person could conclude that two spinal surgeries were not significant. The applicant also failed to make reasonable concessions in other areas. Administrative Law Judge O’Connor held the applicant’s presentation at the hearing changed from hearing to hearing, within a given hearing, and from surveillance video to the hearing.

**Duty Disability**

_San Felippo v. City of Wauwatosa_, Claim No. 2013-003032 (LIRC April 20, 2015). The applicant was employed as a firefighter for the City of Wauwatosa. He alleged that he developed asthma as a result of exposure to a fire on November 8, 2012. The fire was in a coal bunker at an energy power plant. In order to extinguish the fire, a chemical had to be added to the water that was sprayed on the fire and the coal. The applicant’s treating doctor opined that the applicant developed asthma as a result of the exposure to this chemical. The independent medical examiner opined the applicant’s symptoms...
developed as a result of exposure to the same bronchial virus that his wife and daughter had around the time of the alleged incident. The independent medical examiner opined the applicant experienced reactivity from the virus, which was the cause of his symptoms. Administrative Law Judge Minix awarded benefits. The Labor and Industry Review Commission reversed. The area of the power plant where the applicant worked during the fire was extensively reviewed. The applicant worked in an area where little of the chemical was used. The applicant did not treat for his symptoms until twenty days after the alleged exposure. He reported the onset of symptoms as four days prior to the date of first treatment. The statute involving a presumption of employment-connected disease for heart or respiratory problems for firefighters (Wis. Stat. §891.45) is applicable in this case. Under the statute, when any evidence rebutting said presumption is introduced, the inference remains, and the opposing party must “affirmatively establish a cause of the respiratory defect other than the presumed occupational cause.” The respondents met their burden in this case.

Delisle v. City of Wauwatosa, Claim No. 2012-031169 (LIRC July 22, 2015). The applicant began working as a firefighter in March 1998. The applicant underwent a pre-employment physical, which showed no respiratory impairment. The first association she made between her respiratory condition and her job duties was exposure to smoke and dust during a live-fire training exercise on September 17, 2010. Administrative Law Judge Martin held that her condition was work related. The Labor and Industry Review Commission affirmed. Wis. Stat. §891.45 provides a presumption of work-related causation when an employee is a state, county or municipal firefighter, has been employed for more than five years in any such capacity, and underwent a qualifying medical examination prior to employment that showed no respiratory impairment or disease, and subsequently experiences disability because of respiratory impairment or disease. Case law has held the presumption is based on probability and not public policy. The presumption applied in this case. When contrary evidence is introduced, the presumption is rebutted but the inference remains. Evidence that attacks the rationale of the presumption (which merely questions the wisdom of the legislature in enacting the presumption) is insufficient to rebut the presumption. Rather, the rebutting evidence must affirmatively establish a cause of the respiratory defect other than the presumed occupational cause. The issue is to be addressed becomes whether, notwithstanding the inference and the applicant’s evidence, the respondent’s evidence creates legitimate doubt that the applicant’s disability was caused by the workplaceexposure. The independent medical examiner testified at the hearing. He testified, in part, that work exposure sufficiently to cause asthma is generally such that multiple individuals are usually affected at the time of an incident that involves exposure to a high dose of a very toxic irritant. That testimony revealed that what drove his opinion that the applicant’s condition was not work related, was an attack on the rationale of the statute. There would be no need to presume a respiratory disease is caused by five or more years as a firefighter if the way one gets such a disease is by a single acute onset event caused by exposure to a high dose of a very toxic irritant. The Commission noted that a consultation with Administrative Law Judge Martin revealed that the applicant readily acknowledged things that might be detrimental to her case without significant hesitancies or inflection and that the independent medical examiner exhibited a degree of combativeness and hostility which was detrimental to his credibility.

Employment Relationship

Hoffmann v. Honda, Inc., Claim No. 2012-015645 (LIRC December 22, 2015). The applicant was simultaneously employed as a general manager of four separate auto dealerships. Two dealerships were in Wisconsin and two were outside of Wisconsin. Each corporation had different ownership groups with some crossover between owners. The corporations had their own federal ID numbers, their own hiring and firing authority, pay structure and worker’s compensation insurance. The applicant was hired to be the sales manager of one company in Wisconsin originally. He received health insurance, participated in the 401K plan and ultimately became the general manager of that location. His pay structure included a commission and guaranteed draw. He was hired by the owner to be the general manager of a new dealer as well, also in Wisconsin. He was later hired to be the general manager of the two non-Wisconsin dealers when the ownership groups opened those locations. His pay structure was similar at each location. He traveled to each location to perform duties. The location to which he was traveling bore the expenses of the applicant’s travel. He was simultaneously employed by all dealers at the same time. He traveled to a non-Wisconsin dealer in order to prepare financial statements for that dealer and meet with the office manager for payroll. That dealer bore the cost of his travel. He slipped and fell while in the parking lot and sustained the injury involved in this litigation. The applicant then sought worker’s
compensation benefits from the dealer in Wisconsin where he was first employed. An unnamed administrative law judge determined that the applicant sustained a compensable injury because his employment was principally localized in Wisconsin (based upon the hours spent in Wisconsin being higher than any of the other two states). He was also considered to be a traveling employee at the time of the alleged injury, employed by the original Wisconsin dealership, and therefore, entitled to worker’s compensation benefits. The Labor and Industry Review Commission reversed. The issue is resolved by determining whether the applicant was actively employed by the respondent employer on the date of injury. He was not so employed. He was not engaged in any activity out of Wisconsin which grew out of and was incidental to his employment for the respondent Wisconsin employer. There was no activity requested or required by the respondent employer that caused him to travel to the non-Wisconsin dealer location. There was no evidence the respondent employer derived any benefit by the applicant being at the non-Wisconsin dealer location. There was no evidence of an overarching enterprise that included all four dealerships such that service for the non-Wisconsin dealerships. The applicant was engaged in active employment duties for the non-Wisconsin dealer when the injury occurred.

Merely being simultaneously employed by a Wisconsin employer does not make that Wisconsin employer liable for the injury that occurred outside of the state.

**Issue Preclusion**

*Simpson v. City of Racine*, Claim No. 2008-034090 (LIRC August 20, 2015). The applicant alleged he sustained a knee injury on July 30, 2008. He alleged that he struck his left knee on a pivot and that this caused him to fall to the ground. He reported the incident and sought medical treatment. The applicant had a pre-existing knee condition, including a prior diagnosis of osteochondritis. At the time he was hired by the employer, he signed a pre-employment medical form which failed to mention his prior history of knee problems. Subsequent to the alleged injury, he underwent surgery, which included removal of the osteochondritis dissecans loose body. The applicant brought a claim against the employer and insurer, which led to a hearing in 2010. The administrative law judge held the applicant had sustained a compensable work-related injury. The Labor and Industry Review Commission affirmed that decision. The applicant later brought another claim against the respondents and causation was questioned. [The case is not very clear about what actually led to the hearing held in 2014 which led to this decision.] The applicant’s physician opined this procedure, and associated condition, was causally related to the work-related injury. The records reflected the treating physician was not aware of the applicant’s prior knee symptoms, condition or diagnosis. Dr. Lemon performed an independent medical examination and testified at a hearing. He was aware of the applicant’s prior knee condition. Dr. Lemon opined this condition occurred during adolescence, as is the case in 99% of individuals with this condition. The unnamed administrative law judge awarded benefits to the applicant. The Labor and Industry Review Commission reversed. The Commission first had to determine whether issue preclusion was applicable on the question of causation because the Commission had previously held that a work-related injury was sustained by the applicant on the same date of injury involved in this matter. Issue preclusion refers to the effect of a judgment in foreclosing re-litigation in a subsequent action of an issue of law or fact that has been actually litigated and decided in the prior action. Generally, when an issue of fact or law is actually litigated and determined by a valid judgment, and the determination is essential to the judgment, the determination is conclusive in a subsequent action... whether on the same or a different claim. However, any application of the issue preclusion doctrine must comport with principles of fundamental fairness. The Supreme Court has adopted a five factor fundamental fairness test. Some or all of these factors may be considered by a court. These factors include (1) could the party against whom preclusion is sought, as a matter of law, have obtained review of the judgment; (2) is the question one of law that involves two distinct claims or an intervening contextual shift in the law; (3) do significant differences in the quality or extensiveness of proceedings between the two courts warrant re-litigation of the issue; (4) have the burdens of persuasion shifted such that the party seeking preclusion had a lower burden of persuasion in the first trial than in the second; or (5) 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 in the initial action. The Commission held that issue preclusion on the question of causation in this case did not apply. The application of issue preclusion in a case where the prevailing party presented false testimony is fundamentally unfair. The Commission reviewed the facts of the case and reversed the administrative law judge’s decision, and denied all benefits sought. The applicant, who testified that he had forgotten about an old knee injury, which resulted in a surgery, was not credible.

**Loss of Earning Capacity**

*Guziec v. Supervalu Holdings, Inc.*, Claim No. 2006-0007172 (LIRC December 10, 2015). The applicant was injured in a work-related motor vehicle accident. She alleged that she sustained cognitive difficulties as a result of the accident. The applicant’s physicians, and at least one of the respondent’s physicians, opined the applicant’s cognitive problems were related to the accident. The applicant worked for the employer for four years after the incident. She was then laid off because of downsizing. The applicant obtained employment with a new employer. Her annual earnings were reduced by approximately $20,000.00. The applicant testified she was terminated from that subsequent employer because of her cognitive issues. The respondents obtained reports from two separate expert physicians, both of whom gave opinions favorable to the applicant. The respondents then obtained an expert opinion from a third physician. This expert opined the applicant sustained no lasting damage as a result of the work-related injury. Based upon this report, the respondents denied payment of loss of earning capacity benefits. Administrative Law Judge Martin held the treating physician opinions were more credible and awarded the benefits sought. The Labor and Industry Review Commission affirmed with respect to the extent of the claim for loss of earning capacity. The applicant did not have a loss of earning capacity claim until her date of injury employer laid her off. The reasons for the layoff did not impact her ability to bring a loss of earning capacity claim. The preclusion of seeking loss of earning capacity benefits if an applicant subsequently earns 85% or more of her average weekly wage only applies to employment with the date of injury employer. This threshold does not apply if an employee subsequently works for a different employer. The award of loss of earning capacity is not solely based upon earnings from the post-injury job. The employee’s capacity to earn income is also considered.

**Medical Issue**

*Zierfus v. Shorty’s Bar & Grill*, Claim No. 2007-018488 (LIRC August 31, 2015). The applicant sustained a work-related shoulder injury which required surgery. The respondents disputed payment of the chiropractic treatment based upon an independent medical examiner’s opinion that the treatment was not reasonable or necessary to cure or relieve the effects of the work injury. The respondents initiated a necessity of treatment dispute for the chiropractic treatment related to the shoulder condition under Wis. Stat. §102.16(2m)(b). The unnamed administrative law judge held that the treatment parameters under Wis. Stat. Chapter 81 were only guidelines and did not apply to this case or any other case brought for a hearing under Wis. Stat. §102.17. The judge awarded payment for the medical expenses. The Labor and Industry Review Commission modified the Order in part. The Commission noted that, in 2013, in *Kroes v. Allied Holdings, Inc.*, the Commission had stated that when a case arises as the result of an application for hearing under Wis. Stat. §102.17, the judge may use the administrative code as a guideline, but is not required to follow it. In this case, the Commission determined it was appropriate to clarify its holding in *Kroes*. The state requires judges and the Commission to apply the treatment guidelines codified in Chapter 81 if the judge or the Commission determines the necessity of treatment regardless of whether an expert is appointed, assuming there are guidelines applicable to the treatment at issue. The Commission has the authority to address whether or not the treatment was necessary. However, the Commission may also notify (or direct the respondents to notify) the health care provider under Wis. Stat. 102.16(2m)(b) that the necessity of treatment is in dispute. The dispute is then resolved under that section, which requires the appointment of and written opinion from an impartial expert required to apply the standards or guidelines in Chapter 81. The Commission chose that route in this case rather than making its own determination.

*Craig v. Marsden Building Maintenance LLC*, Claim No. 2006-021996 (LIRC September 23, 2015). On June 18, 2007, Dr. Orth prepared a medical report. He opined the applicant had reached the end of healing from the effects of the work-related injury. Dr. Orth opined no additional treatment was required because the applicant only temporarily strained his low back. The applicant began treating with Dr. Appel in January 2014. The respondents did not provide a subsequent independent medical examination or other expert medical opinion addressing whether the treatment from Dr. Appel...
(and another physician) were necessitated by the applicant’s work-related injury. There was no doctor who opined that the applicant’s treatment was not reasonable and necessary to treat the work-related injury for any reason much less for the amount of time that passed between the work injury and date of treatment. The unnamed administrative law judge held the treatment was reasonable, necessary and causally related to the work injury. The Labor and Industry Review Commission affirmed. The treatment guidelines in Chapter 81 provide for departures or exceptions from the guidelines in certain situations. There is no medical opinion or evidence that establishes that none of the exceptions were met. There was no request by the respondents that the issue be remanded to address the necessity of treatment under Wis. Stat. 102.16(2m)(b).

**Kadlec v. Don Johnsons Hayward Motors, Inc.,** Claim No. 2013-020253 (LIRC November 24, 2015). The applicant sustained a work-related injury to her SI joint and low back. She underwent an SI joint fusion. This did not involve any levels of her spinal column. Instead, the fusion connected her hip to the trunk. The applicant’s treating physician opined she reached the end of healing 8-12 weeks after the procedure. Her restrictions were removed completely at that point. She did not treat for six months afterward. The applicant subsequently treated with a chiropractor for her entire spinal column. She received ultrasound and other modalities at each office visit. There was no plan established by the applicant and her medical provider. A subsequent MRI was unchanged from a pre-surgical MRI. Her treating physician opined the MRI results did not account for her symptoms. Administrative Law Judge Schaeve awarded the applicant 20% of the chiropractic benefits on the basis that she treated, in small part, for her SI joint and low back symptoms and the other 80% of the treatment was undertaken for higher levels of her spine. He discussed, in great detail, the extent of the treatment undertaken by the applicant, the various findings of medical records pre- and post-injury and specifically with respect to the treatment initiated after recovery from the fusion procedure. The Labor and Industry Review Commission reversed with respect to payment of chiropractic benefits and held the respondents were not responsible for any portion. The applicant did not meet the burden of demonstrating that her chiropractic treatment was reasonable and necessary. Further, the fact that she reached the end of healing so soon after a fusion procedure demonstrates that it was minimally invasive and not significant enough to result in renewed symptoms and treatment more than six months after her release without restrictions. Her gap in treatment post recovery from surgery and failure of the subsequent objective testing to reveal findings correlating to symptoms demonstrates that her subsequent chiropractic treatment was not related to her work-related injury. See also Permanent Partial Disability.

**Mental Injury**

**Gomez v. Dept. of Corrections,** Claim No. 2012-029974 (LIRC April 30, 2015). The applicant was employed as a corrections officer. He was trained to manage inmates and assist inmates with medical issues. On the date of the applicant’s alleged work-related injury, the applicant responded to a claim that an inmate was “down.” When he arrived at the inmate’s cell, there was a stench coming from the cell. The inmate was fully exposed, covered in feces and blood, and unresponsive. The applicant and another officer covered the inmate up and an ambulance took the inmate to a hospital. Because the other inmates were locked in their cells, the applicant and the other officer had to clean the cell. The applicant knew the inmate and had daily interactions with the inmate. The applicant began to have recurring dreams about the incident and sought treatment two years after the incident occurred. He then began reporting low energy, indecisiveness, poor sleep, and a loss of appetite. As he continued to treat, the applicant revealed that he might have been physically and sexually abused as a child. The records reflected he reported that he was also concerned his girlfriend would give birth, prematurely, to their baby. The applicant eventually received in-patient mental health treatment. He was diagnosed with post-traumatic stress disorder. The treating physician opined he sustained 40% permanent partial disability rating. Subsequently, the applicant began looking for a new therapist. The applicant began reporting anger issues and trouble remembering things. Administrative Law Judge McKenzie held the applicant did not sustain a mental injury that arose out of his employment. The Labor and Industry Review Commission affirmed. The incident involving the inmate dying in his cell was stressful. However, this was not unusual because the applicant was trained to deal with sick and dying inmates. Further, they had a protocol for temporarily locking up inmates to deal with the situation and had paid cleaners. While the applicant knew the inmate, he still treated the inmate like an incarcerated individual and did not give him special treatment. The applicant did feel strongly that the inmate should have had more compassionate care,
but those feelings do not rise to the level of a mental injury under the statute. The applicant also was not credible. He had a number of other issues including possible sexual and physical assault as a child and fears of having a premature baby, which were material enough to admit him to a psychological ward for two days. While the applicant’s stress exceeded occupational stress of similarly situated workers, it was not greater than usual for a corrections officer. The applicant’s mental condition was influenced by his work as a prison guard and by stressors outside of his job.

**Occupational Injury**

Garay v. Cooper Power Systems, LLC, Claim No. 2013-009960 (LIRC December 10, 2015). The applicant performed manual labor for 15 years and construction work for 5 years. He then began to work for the employer as an assembly worker. The applicant alleged a traumatic injury to his right shoulder. He testified that a specific injury occurred and that he provided notice of the same. His treating physician opined that the applicant sustained a shoulder injury as a result of a specific incident. The unnamed administrative law judge awarded the benefits sought by the applicant. However, the judge based this decision on his opinion that the applicant sustained an occupational injury rather than a traumatic injury. The Labor and Industry Review Commission reversed. The only medical evidence relating the applicant’s work for the employer to the disability was the treating physician's opinion that a specific injury was sustained. There was no opinion that the applicant sustained an occupational injury. The Commission cannot arrive at a conclusion of occupational injury in the absence of a supporting medical opinion. The evidence fails to demonstrate that the applicant’s shoulder condition is the result of the specific work-related injury as alleged. This is not a situation where the WKC-16b form indicated a traumatic injury theory while establishing an occupational injury theory in a narrative report. In the “wrong boxes” cases, the Commission focuses on the causative theory apparent in the medical record. Here, the applicant’s physician relied solely on a traumatic injury theory and benefits must, therefore, be denied.

**Permanent Partial Disability**

Kadlec v. Don Johnsons Hayward Motors, Inc., Claim No. 2013-020253 (LIRC November 24, 2015). The applicant sustained a work-related injury to her SI joint and low back. She underwent an SI joint fusion. This did not involve any levels of her spinal column. Instead, the fusion connected her hip to the trunk. Administrative Law Judge Schaeve determined that the minimum permanent partial disability benefits did not apply. The Labor and Industry Review Commission affirmed. Removal of bone matter to place a lag bolt for an SI joint fusion is not “displacement” as contemplated by DWD Rule 80.32(11) such that the minimum 5% permanent partial disability is assessed. Further, the spinal fusion ratings under DWD Rule 80.32(11) contemplate a rating per “level,” which suggests it was intended to apply to spinal levels. The SI joint does not involve a “level,” and thus the minimum rating for a fusion under DWD Rule 80.32(11) does not apply.

Sedgwick v. Sunburst Ski Area, Claim No: 2012-010172, (LIRC November 24, 2015). The applicant sustained an admitted injury to her knee. She underwent treatment on two occasions. The first was a left knee arthroscopy with arthroscopic anterior cruciate ligament reconstruction and left knee arthroscopy partial medial meniscectomy. The applicant as rated 10% by the treating physician. This was conceded and paid by the respondents. Wis. Admin. Code DWD 80.32(4) provides a minimum rating of 5% for a total or partial meniscectomy and a minimum of 10% for an anterior cruciate ligament reconstruction. The Department applied this to determine that the proper rating was 15%. The respondents thereafter conceded
and paid 15%. The applicant then underwent a second surgery. This was a left knee arthroscopy, arthroscopic debridement and chondroplasty anterior cruciate ligament fragment, medial tibial plateau, and medial tibia spinc chondroplasty and anterior soft tissue resection, left knee proximal tibial inference screw removal. After this procedure, the treating physician added 2% to his prior permanency rating, for a total of 12% permanent partial disability. The Department notified the respondents than an additional 10% was due based upon the anterior cruciate ligament procedure. The respondents disputed the additional 10% rating from the second surgery after Dr. Yuska reviewed the second surgery record and opined that the second surgery did not include an anterior cruciate ligament repair. Instead, Dr. Yuska opined the procedure was an inspection of the first surgery with removal of hardware. The treating physician opined that, to an orthopedic surgeon, a ‘repair’ means sewing the torn ends of a ligament back together while ‘reconstruction’ means creating a new ligament from another substance thus completely replacing the torn ligament. Administrative Law Judge Endter held that “repair” included any surgical activity affecting the anterior cruciate ligament. She opined that, therefore, the additional 10% permanent partial disability after the second surgery was appropriate. The Labor and Industry Review Commission reversed. The Commission concluded that an anterior cruciate ligament reconstruction is the equivalent of a repair for purposes of Wis. Admin. §80.32(4). This is an invasive surgery that involves drilling holes to secure the new ligament that is created from other material. Cumulative minimum permanency ratings for multiple ligament repair procedures can be awarded even when the resulting award is higher than the highest estimate of permanency in evidence. Therefore, the 10% rating for the anterior cruciate ligament reconstruction and 5% rating for a meniscectomy were appropriate. However, the second procedure was less intrusive than the repair/reconstruction. The term “repair” as used in DWD 80.32 is only for repair or reconstruction and does not apply to other surgeries that may involve the anterior cruciate ligament. Both medical physicians in this case opined the second surgery did not involve a repair or reconstruction. Therefore, this surgery was not a “repair” as defined in Wis. Admin. Code §80.32(4). Therefore, the surgical procedure should be rated for permanency by the medical experts.

Janssen v. Monode Steel Stamp, Inc., Claim No. 2013-007952 (LIRC December 10, 2015). The applicant sustained a work-related injury in the nature of a compression fracture. His treating physician and the independent medical examiner opined the applicant sustained 7% permanent partial disability on the basis that Wis. DWD 80.32(11) requires a minimum rating of 5% permanency. Administrative Law Judge Lake agreed and awarded benefits. The Commission reversed. The rules do not have minimum ratings for compression fractures. The language reflects that “Compression fractures of vertebrae of such degree to cause permanent disability may be rated at 5% and graded upward.” The applicant sustained 2% permanent partial disability because this was the amount awarded by both credible physicians above and beyond the minimum that was mistakenly opined to exist.

**Permanent Total Disability**

Prescott v. Snap on Inc., Claim No. 2009-004468 (LIRC June 30, 2015). The applicant alleged that he was injured when he leaned too far to the left while removing a rack from the production line, and he felt low back pain. He reported his injury to the lead worker. Three days later he treated with his family physician. The applicant was referred to a specialist and underwent conservative treatment. His treating doctor returned him to work without restrictions. He was laid off for a period of time. The applicant then returned to work for a period of time before he was terminated. Subsequently, the applicant began treating with a different physician. He alleged that he was permanently and totally disabled based upon that physician's opinion that his work-related injury had aggravated, accelerated and precipitated his pre-existing low back condition beyond its normal progression. The applicant testified that he was not working. He testified that he could not work because he took Oxycodone for pain. However, surveillance revealed that the applicant was selling hats and sunglasses out of his truck. Further, the medical records revealed that neither of the applicant's treating physicians had prescribed Oxycodone. The independent medical examiner testified at the hearing. He opined the applicant sustained merely a temporary aggravation. He opined the applicant was malingering. Administrative Law Judge Lake held the applicant sustained only a temporary aggravation of his pre-existing low back condition. This was specifically based upon the opinions of the first treating physician and the independent medical examination. Further, Administrative Law Judge Lake specifically held the applicant was not a credible witness. The Labor
and Industry Review Commission affirmed. The applicant’s report of pain did not correlate to the physicians objective findings. The applicant was not permanently and totally disabled.

**Procedural Issues**

*Mallum v. Wisconsin Laborers Health Fund* Claim No. 2011-017470, 2010-004584, 2012-016327 (LIRC September 16, 2015). The applicant had a pending claim against two employers. The Department of Workforce Development had jurisdiction to conduct a hearing or hearings in the future regarding these claims. There was no decision, order, or award from any administrative law judge or department examiner regarding the merits of the applicant’s claim for worker’s compensation benefits or the Fund’s claimed subrogated interest. Regardless, the applicant and his attorney requested that the Labor and Industry Review Commission provide a forum, at which the Wisconsin Laborer’s Health Fund would be a party and compelled to litigate the matter of its claimed subrogated interest, followed by an order from the Commission resolving any disputed issues. The Commission’s staff attorney informed the applicant that the Commission lacks jurisdiction to provide the forum sought. The Commission is an administrative agency and has only those powers which are expressly conferred or, by necessity, are to be implied from the four corners of the statute under which it operates. The statute regarding the Commission’s jurisdiction for workers’ compensation matters provides for a review of decisions, orders and awards of department examiners. There is no statutory basis for the Commission to provide the forum sought by the applicant. If the applicant succeeds in his worker’s compensation claim, case law permits the administrative law judge to determine whether the Fund is entitled to reimbursement of benefits. Any decision regarding the Fund’s claimed subrogated interest would be premature before the Department decides whether the treatment expenses are compensable under Wis. Stat. Chapter 102. The applicant alleged the Fund was actually an industrial insurer providing worker’s compensation coverage. If so, the applicant may be able to have the Fund impede to the worker’s compensation proceedings. This argument needs to be addressed by the Department and not the Commission.

*Mallum v. Wisconsin Laborers Health Fund, Claim No. 2011-017470, 2010-004584, 2012-016327 (LIRC September 16, 2015).* The applicant had a pending claim against two employers. The Department of Workforce Development had jurisdiction to conduct a hearing or hearings in the future regarding these claims. There was no decision, order, or award from any administrative law judge or department examiner regarding the merits of the applicant’s claim for worker’s compensation benefits or the Fund’s claimed subrogated interest. Regardless, the applicant and his attorney requested that the Labor and Industry Review Commission provide a forum, at which the Wisconsin Laborer’s Health Fund would be a party and compelled to litigate the matter of its claimed subrogated interest, followed by an order from the Commission resolving any disputed issues. The Commission’s staff attorney informed the applicant that the Commission lacks jurisdiction to provide the forum sought. The Commission is an administrative agency and has only those powers which are expressly conferred or, by necessity, are to be implied from the four corners of the statute under which it operates. The statute regarding the Commission’s jurisdiction for workers’ compensation matters provides for a review of decisions, orders and awards of department examiners. There is no statutory basis for the Commission to provide the forum sought by the applicant. If the applicant succeeds in his worker’s compensation claim, case law permits the administrative law judge to determine whether the Fund is entitled to reimbursement of benefits. Any decision regarding the Fund’s claimed subrogated interest would be premature before the Department decides whether the treatment expenses are compensable under Wis. Stat. Chapter 102. The applicant alleged the Fund was actually an industrial insurer providing worker’s compensation coverage. If so, the applicant may be able to have the Fund impede to the worker’s compensation proceedings. This argument needs to be addressed by the Department and not the Commission.

**Vandehey v. Milprint Inc., Claim No. 2015-001458 (LIRC December 22, 2015).** The employer, Bemis, filed a Petition for Commission Review to set aside a default order issued by the Department. The employer had previously bought out the company Milprint, Inc. On February 26, 2015, the Department sent a copy of permanent partial disability computation to the insurer for Milprint, Inc. and to the applicant’s attorney. The Department did not send this to the employer. The Department had previously sent letters to Milprint, Inc. at its Denmark, Wisconsin, address. These letters were also sent to the insurer and were reminders to submit an Answer. However, no Answer was filed. Bemis asserted that the Denmark address had not existed in a number of years, that it was self-insured, and that it was not properly served of notice of the hearing application. Under Sec. 102.18(1) (a), all parties shall be afforded opportunity for a full, fair, public hearing after reasonable notice, but disposition of application may be made by a compromise, stipulation, agreement or default - without hearing. The use of the term “may” clearly submits the issue of default orders to the Commission’s discretion. The Labor and Industry Review Commission held the agency is entitled to exercise its discretion based upon its interpretation of its own rules of procedure, the period of time elapsing before the Answer was filed, the extent to which the applicant has been prejudiced by the employer’s tardiness, and the reasons, if any, advanced for the tardiness. Here, it was not established that the employer was aware that an application for hearing was filed. The Commission reversed the default Order and remanded the case to the Department for a hearing on the merits.

**Retraining**

*Miller v. Goex Corp., Claim No. 2008-021517, (LIRC October 29, 2015).* The applicant was approved for retraining services through DVR. The respondents denied the requested program and asserted the applicant withheld or misrepresented material facts about applying for retraining, whether the program beyond 80 weeks was necessary and whether there was an abuse of discretion in approving the program. Portions of the dispute were settled at the hearing. Other portions, including whether there was misrepresentation, were litigated. Additionally, at the hearing, the applicant sought payment for a computer, hardware for the computer and software for the computer. Administrative Law Judge Michelstetter awarded all benefits sought. The respondents conceded the decision regarding the retraining program in general. However, the award of payment for a computer, hardware for the computer and software for the computer was appealed by the respondents. The Labor and Industry Review Commission reversed on that appealed issue regarding the computer related expenses. The Commission held
that Wis. Stat. 102.61(1) does not require the employer and insurer to provide a computer to applicant because a computer is not “actual and necessary costs of tuition, fees, and books...” under the statute. If the applicant had proceeded with a retraining program via a private rehabilitation counselor, the result would likely be different. That statutory language is slightly different and indicates the respondents are responsible for the cost of attendance “including” items such as tuition, fees, books, etc. The statutory language regarding the DVR approved program does not contain the word “including” which demonstrates that only the itemized items are the respondent’s responsibility. A computer is not one of those items and, therefore, is not compensable.

**Safety Violation**

*Merkley (Dec’d) v. Neenah Enterprises, Inc., Claim No. 2012-014917 (LIRC April 28, 2015).* The applicant worked as a journeyman maintenance man/mechanic, and had special training in hydraulics. He was killed while attempting to repair a particular machine, when the cap section of the hydraulic check valve burst out of the valve assembly and struck him in the head. The area where the machine was located had a specific lock in and out procedure because of the nature of the machinery. The employer retained various experts to determine what had happened. The experts determined that a system relief valve had been bypassed inadvertently and the valve failed after the pressure reached a specific PSI limitation. This increased pressure caused the cap to fail. OSHA investigated and cited the employer for three violations. Two violations were irrelevant to the inquiry. The other violation was because the employer failed to conduct a periodic inspection of the energy control procedure at least annually to ensure the procedure and the requirement of the standard were being followed, because the employer did not conduct such inspections of the lockout procedure. Subsequently, the employer modified the machine to prevent an employee from being able to remove a hose that is connected to the relief valve. The employer witness testified that he could not think of anything else that could have been done to prevent the accident. The employer testified that the violation from OSHA on the lockout procedure was a paperwork error. Administrative Law Judge Landowski held the employer had violated the safe place statute (citing the lock out violation noted by OSHA) and awarded the 15% increased compensation penalty. The Commission reversed. An employee has the burden of demonstrating that an employer failed to comply with the safe place statute and that such violation was a substantial factor in causing the employee’s injury. An employer does not breach its duty under the safe place statute merely because the place could be made safer. Similarly, the mere fact that an accident has happened does not demonstrate that the place was unsafe. When both an employee’s failure to follow safety procedures and an employer’s failure to maintain a safe place was a substantial factor in bringing about the injury, an employer is relieved from an increased penalty if the employee’s own negligent act went beyond an intervening factor to a superseding cause. A superseding cause is an act of a third person or other force which by its intervention prevents the actor from being liable for harm to another which his antecedent negligence is a substantial factor in bringing about. An employee’s intervening negligence would not be a superseding cause. OSHA did not cite the employer for failing to wait outside of the lock out room for a specific amount of time. If the employer’s practices regarding the amount of time to wait after the lock out was completed, unreasonably placed the employee in harm’s way, it seems reasonable that OSHA, or another expert retained on the case, would have opined that as a reason for the injury or in formulating a plan to prevent future injuries. However, this was not done. An employer’s duty under the safe place statute is to make the place of employment as safe as the nature of the employment will reasonably permit, not to guarantee safety in all cases.

**Statute of Limitation**

*Schmidt v. Superior Die Set Corp., Claim No. 1979-037984 (LIRC June 25, 2015).* The applicant filed a Hearing Application for the sole purpose of tolling the statute of limitation. The application stated no specific facts as to a claim or any dispute or controversy that was in existence. Administrative Law Judge Schneiders held this was consistent with the Department’s long standing practice. The Commission affirmed. Requiring the applicant to have a claim upon which he or she could proceed at the time of the filing of the application would create uncertainty, whereas its existing rule of allowing an application to be filed for a potential dispute in the future does not create such uncertainty.

**Temporary Total Disability Benefits**

*Smail v. Pentair Sta-Rite, Claim No. 2012-005518 (LIRC October 29, 2015).* The applicant alleged she sustained a work-related injury and sought
The applicant was questioned, in part, about his attachment to the labor market during the period he sought renewed temporary total disability benefits. This issue was not specifically raised by the attorneys at the time of the initial hearing. The applicant’s ability to participate in the labor market or what acts he took to attach to or detach himself from the labor market was not clear from his testimony. Administrative Law Judge Mitchell awarded temporary disability benefits (among other types of benefits not relevant for this issue/purpose of reviewing this case). The Labor and Industry Review Commission remanded for additional testimony to be taken with respect to whether or not the applicant was attached to the labor market at the time he sought renewed temporary disability benefits. The Commission has the duty to find the facts and determine the compensation irrespective of the presentation of the case by the attorneys. The position taken by the parties at the administrative proceedings does not control the ultimate resolution of the case. The Commission, not the administrative law judge, bears the ultimate responsibility for finding facts. The evidentiary record is not sufficient to make a decision regarding the applicant’s entitlement to temporary total disability benefits during the entire period sought. The Commission has the authority to direct the taking of additional evidence even with respect to issues not raised at a hearing. The court cited Keys v. Tower Automotive as a good example of testimony that was sufficient to make findings on attachment to the labor market. The court in that case determined that the applicant’s retirement for reasons unrelated to his injury, subsequent application at only three companies over the course of approximately four to five years, and eligibility for social security disability benefits during that interim period demonstrated that applicant was no longer attached to the labor market. This case involved an employee who separated from his employment after the healing period had ended and was seeking a renewed period of temporary disability benefits years later. This is specifically distinguished from an employee seeking temporary disability benefits after separation from employment during an initial healing period. The purpose of temporary total disability is to replace current lost earnings. There must be actual wage loss to collect temporary disability. Theoretical wage loss does not suffice.

**Unreasonable Refusal to Rehire/Termination**

**De Trinidad v. Ken and Laurie Inc.,** Claim No. 2011-019857 (LIRC April 30, 2015). The applicant was injured at work when he was supposed to be working light-duty restrictions leading up to a scheduled surgery. There was testimony from a co-worker that the employer instructed the co-worker to prevent the applicant from lifting heavier things. The testimony also revealed that things changed once the applicant told his employer he needed surgery. The applicant was terminated approximately four days before his surgery. There was testimony that the work environment included a lot of jokes and horseplay which involved sexual innuendo, inappropriate physical touching, and salacious e-mails/text messages, etc. The employer asserted that the applicant was terminated for sexual harassment after he pulled down the pants of one of the owners’ sons. There was also testimony that the applicant had previously exhibited poor judgment in front of customers. The same witness testified the owner’s son was upset about the incident and eventually told the employer. Administrative Law Judge Martin held that the employer failed to meet the...
burden of demonstrating that the termination was reasonable. The jokes and horseplay were common place. There were no management actions to warn or stop co-workers from acting in such a way. The Labor and Industry Review Commission reversed. The employer made a valid decision to terminate the applicant after he pulled down the pants and underwear of another worker. Even though there was horseplay at work, none of that prior horseplay rose to the level of this specific incident. The applicant was not a credible witness. In this action he claimed he was terminated because of his work injury. However, in a separate complaint filed with the equal rights division under the Wisconsin Fair Employment Act, he claimed he was sexually harassed.

*Bojorquez v. Red Beech Dairy*, Claim No. 2013-001987 (LIRC, June 25, 2015). The applicant sustained a traumatic industrial injury to her right arm after a cow kicked her arm into a steel gate. The applicant returned to work with restrictions. The employer, when aware of them, accommodated the restrictions. The employer hired an individual to hire, manage schedules, and terminate applicants on his farm. After that individual terminated his relationship with the employer, the employer made a verbal work schedule with the applicant. The applicant failed to appear for one of her shifts. The employer attempted to contact her numerous times by phone, text message and even went to her apartment multiple times. The employer told the applicant he was in a crisis situation and he needed workers, especially those trained workers like the applicant. At first the applicant said she would show for her shift. However, the applicant later shook her head “no” when the employer asked her if she wanted to continue to work. The employer returned the next day to ask the applicant if she wanted to continue working for him and she again said no. Administrative Law Judge Doody held that the employer had reasonable cause to determine that the applicant quit her employment and that there was no violation of Wis. Stat. § 102.35(3). The Labor and Industry Review Commission affirmed. The applicant’s assertion that she was medically unable to return to work on the day in question is not credible. The applicant told her employer she could work. She did not tell her employer she was restricted from working by a medical provider. Further, even if she was medically restricted from working, then the employer’s actions were still reasonable because work within the applicant’s physical and mental limitations still would not have been available.

*Gomez-Sandoval v. Amalga Composites, Inc.*, Claim No. 2009-022418 (LIRC October 29, 2015). The applicant sustained a work-related injury on March 20, 2009. She was provided restrictions over a period of time. The employer did not return the applicant to restricted duty because there were no open positions given the nature of the applicant’s restrictions. She was released to full duty on December 12, 2012. The employer’s human resource representative testified that neither the applicant, medical case manager nor anyone else ever told the employer that the applicant was released without restrictions. Evidence was submitted reflecting the employer representative advised the medical case manager that she did not want to receive faxes regarding restrictions. The employer witness testified she may have done this because he wanted the applicant to bring her restrictions to the office in person. The applicant testified that she did inform the employer of her unrestricted release to work during a conversation with the employer’s human resource representative. The applicant did return to work on July 29, 2013. Upon the applicant’s return to work, the employer asked the Social Security Administration to verify the applicant’s social security number. The Administration advised that the number failed because it did not match the applicant’s name. The applicant was told to go to the Social Security office to clear up the problem. She was discharged when she did not do so. Administrative Law Judge Angela McKenzie held the applicant was entitled to benefits during the period claimed because the employer unreasonably refused to rehire the applicant without reasonable cause from December 12, 2012 to July 29, 2013 under Wis. Stat. § 102.35(3). The Commission affirmed. The administrative law judge credited the applicant’s version of events and the Commission adopted that assessment. Documentation supported this credibility determination. An employee may be required to keep his or her employer notified of changes in his or her work limitations, but there is no specific requirement that it be done in person versus some other manner. Once the applicant was able to work without restrictions, there was no reasonable cause for not returning the applicant to work. The employer asserted that payment of compensation under Wis. Stat. 102.35(3) was barred by the Immigration Reform and Control Act of 1986 (IRCA). This was based upon a United States Supreme Court Decision, *Hoffman Plastic Compounds, Inc. v. NLRB*, 535 U.S. 137 (2002) in which the United States Supreme Court determined that allowing the NLRB to award back pay to undocumented workers would unduly trench upon explicit statutory prohibitions critical to federal.
immigration policy. However, Hoffman did not expressly state that the IRCA pre-empted back pay awards under state labor laws. Burlington Graphic Sys. v. Dep’t of Workforce Dev. 859 N.W.2d 446 (Court of Appeals 2014) is the only Wisconsin appellate decision that cites Hoffman. The Burlington court held that federal immigration law is not an absolute defense to an employer’s violation of the Wisconsin Family Medical Leave Act. The Burlington court explained it read Wisconsin and federal laws in a way that allows both statutes to serve their goals. The Burlington court did not expressly hold that back pay could never be awarded to an undocumented worker or that Hoffman categorically barred the payment of back pay to undocumented workers. Claims under Wis. Stat. § 102.35(3) are for back pay. The federal and state statutes involved in Hoffman and Burlington use the term “may” when discussing back pay awards, which implies discretion. However, there is no discretion under Wis. Stat. § 102.35(3). Instead, the award of lost wages is a statutory mandate if the employer violates the statute. Therefore, an undocumented individual can be awarded benefits under Wis. Stat. § 102.35(3).

Bettz v. Link Snack, Inc., Claim No. 2013-005721 (LIRC November 30, 2015). The applicant sustained a work-related ankle sprain when he slipped while pushing a cart. He returned to work without permanent disability or restrictions less than two weeks post injury. Just over one month later, the applicant was terminated a few days after an incident involving plastic wrap being left on a container of meat that was dumped into a hopper to make beef sticks. Several weeks prior to the incident occurring, the employer’s procedure was changed as a result of an incident involving plastic wrap that resulted in a loss of product. The applicant mistakenly assumed that another employee (who was supposed to handle this task under the new procedures) had removed all of the plastic wrap. The applicant dumped the bin of meat. As the bin ascended, the applicant saw the wrap and stopped the production. However, it was too late and the bin dumped into the hopper. The production was stopped for approximately 30 minutes. However, all of the wrap was located and there was no product loss. The applicant was told by a supervisor that he would not be fired as a result of the incident. The applicant was sent home for the remainder of his shift. His next shift was scheduled two days later. He worked for approximately three hours and then was called into a meeting and advised he was being terminated. The applicant’s claim for unreasonable termination is focused on the lack of a termination of the employee who caused the procedure to change several weeks prior to the incident and the alleged fault of the co-worker who failed to remove the plastic wrap before it was sent down the line to the applicant. The applicant testified that his co-worker had told him that the bin was ready to be dumped; however, he did not tell that to the employer during the meeting that preceded his discharge. The evidence reflected it was the applicant who prematurely dumped the bin. Administrative Law Judge Arnold held the applicant was not wrongfully terminated/unreasonably refused rehire. The Labor and Industry Review Commission affirmed the decision. Product purity is of utmost importance to the respondent’s food manufacturing business. There was reasonable cause for terminating the applicant’s employment. There was no bad faith in terminating the applicant’s employment, and therefore, no unreasonable refusal to rehire the applicant.

WAGNER BUTLER DOCTRINE

Midthun v. Solution Staffing, Inc., 2015 WL 4504704 (LIRC June 9, 2015). The applicant, while working for a staffing company, was assigned to work at Clack Corporation. The job involved mixing chemicals which were used to create filters for water softeners. After two weeks on the job, the applicant developed a rash. The applicant’s treating physician opined he had sustained occupational dermatitis. The applicant also obtained an expert opinion from Dr. Rita Lloyd. Dr. Lloyd opined the applicant had longstanding dermatitis and sustained merely a temporary aggravation as a result of the involved exposure. Dr. Lloyd opined the applicant had a sensitization to the involved chemicals. Permanent restrictions of avoiding contact allergens were assigned to the applicant. The applicant’s vocational expert opined the applicant sustained 40-45% loss of earning capacity based upon the permanent restrictions assessed by Dr. Lloyd. The respondents obtained an expert medical opinion from Dr. Hermanson. He opined the workplace exposure contributed to the applicant’s symptoms related to his underlying condition of dermatitis. He opined there was no evidence this exposure was the primary sensitizing event that caused the dermatitis. Finally, he opined there was no evidence this exposure was a permanent sensitization. The respondent’s vocational expert, Mr. Gregory Wisniewski, opined the applicant had no loss of earning capacity if Dr. Hermanson’s opinions were adopted. He opined the applicant sustained 20% to 30% loss of earning capacity if Dr. Lloyd’s opinions were adopted. Administrative Law Judge Lake awarded a 40% permanent disability on a loss of earning capacity basis. The Commission
reversed. A “sensitization” claim is different from a situation where a person has exposure to some sort of chemical (for example, hair dressing chemicals) which cause permanent lesions or where permanent pulmonary respiratory problems are always present. For those types of chemical injuries, disability can be rated on the basis of functional impairment. Sensitization is a situation where a worker, while not previously symptomatic after a long exposure, becomes sensitive to the chemical so that certain problems (such as respiratory problems) which were not present before will clear up when the exposure to the chemical ends, but will reappear if re-exposed. Symptoms in a sensitization case are not “permanent.” Some degree of permanent limitation on a worker’s ability to function is generally a prerequisite to a permanent disability award. In a sensitization case, an employee may be eligible for permanent partial disability based on wage loss. Here, the opinion of the treating physicians that the applicant was experiencing symptoms of allergic contact dermatitis would be sufficient for a temporary disability benefit claim, but is not sufficient to establish that the applicant sustained a permanent sensitization. Sensitization normally occurs over some period of time, whereas the applicant’s symptoms developed virtually immediately upon his commencement of work.

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