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ARTHUR CHAPMAN
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ATTORNEYS AT LAW

Minnesota Workers' Compensation Update

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Workers' Compensation Practice Group

James S. Pikala, Partner
Richard C. Nelson, Partner
Raymond J. Benning, Partner
Christine L. Tuft, Partner
Susan K. H. Conley, Partner
Susan E. Larson, Partner
Noelle L. Schubert, Partner
Charles B. Harris, Sr. Attorney
Jessica L. Ringgenberg, Associate
Emily A. LaCourse, Associate
Jack M. McFarland, Associate

Renae J. Eckberg, Paralegal
Kristen A. Nelson, Paralegal
Amanda Q. Mechelke, Paralegal
Lynne M. Holm, Paralegal
Brenda M. Stacken, Paralegal
Laura M. Stewart, Paralegal
Bao Vang, Paralegal
Krista L. Carpenter, Paralegal

Decisions of the Minnesota Supreme Court

Coordination of Benefits

Bruton v. Smithfield Foods, Inc., Case No. A18-0914 (Minn. Sup. Ct. February 27, 2019.) The employee sustained a work injury on August 25, 2016. At the time of the injury, the employer maintained workers' compensation insurance that included a $2,000,000 deductible per claim (essentially making the employer self-insured.) The employer also maintained a short-term disability (STD) policy for its employees. That plan was administered by the employer's human resources department. The parties stipulated that the employer owned the funds held in that plan and administered the plan on behalf of its employees. It was not an ERISA plan. The employer initially denied liability for the employee's work injury, though it did not dispute that the employee was disabled as a result of his injuries. Accordingly, the employer paid STD wage-loss benefits under its private plan. The employee subsequently filed a petition for workers' compensation benefits. The employer conducted an investigation and filed an amended notice of primary liability determination that accepted liability for the injury under the Workers' Compensation Act. The insurer began paying temporary total disability benefits and also paid benefits retroactively for the period during which liability was denied. For that period of time, the insurer paid the employee benefits representing the

continued on next page . . .

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

811 1st Street
Suite 201
Hudson, WI 54016
Phone 715 386-9000 Fax 715 808-0513

www.ArthurChapman.com

difference between the STD benefits that the employer had already paid and the TTD benefits that the employee would have received had the employer accepted liability at the outset. The employer argued to the compensation judge that it did not owe the employee additional TTD benefits for the period when the employee had already received wage-loss benefits under its STD plan. Relying on public policy that disfavors double recovery, the compensation judge concluded that an offset in the employee's TTD benefits was required based on the amount that the employer had paid as STD benefits. The WCCA reversed, concluding that the STD benefits were not workers' compensation benefits and, thus, the employer could not invoke either of two statutory routes to reduce benefit payments to an injured worker. The WCCA additionally noted that the employer had no contractual right to reimbursement under the facts of this case.

The Supreme Court (Justice McKeig writing for the majority) affirmed. The Court acknowledged its prior jurisprudence decrying "the injustice of double recovery" which was to be avoided in awarding workers' compensation benefits. However, the Court distinguished this case in that the employee sought the TTD benefits to which he was entitled by statute, in addition to the STD benefits conferred, separately, by his employer. The Court noted that the issue presented was whether the employer had a "statutory right" to reduce workers' compensation benefits otherwise payable by the employer simply because STD benefits have been paid through a self-funded, self-administered plan. [In a footnote, the Court noted that an insurer may have a claim for reimbursement when benefits are paid in the absence of a contractual obligation to do so. However, in the instant case, the employer expressly chose not to rely on the contractual language of its STD policy as a basis for a claim to offset payments previously made to the employee. Ed. Note: At least suggesting that different contractual language in the STD policy may have given the employer an argument for the offset.] The Court then cited several provisions enacted by the Legislature that provide employers with certain offset remedies. None of those provisions were applicable here. The Court declined to extend those provisions beyond their plain and unambiguous terms. Although there was strong public policy against double recovery of benefits, there was nothing in Minn. Stat. §176.101, subd. 1(a) to prevent the employee from receiving both STD and TTD benefits. [In a footnote, the Court noted that the employer did not invoke Minn. Stat. §176.191, subd. 3 as a possible means of asserting an offset.] The Court declined to insert words or meanings that were intentionally or inadvertently omitted by the Legislature. *See Rohmiller*. The Court indicated that, if a different result is necessary or intended, the Legislature – not the Judiciary – must act.

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

Costs

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

Exclusive Remedy

Daniel v. City of Minneapolis, Case No. A17-0141 (Minn. Sup. Ct. February 27, 2019.) The employee worked as a firefighter for the City for 14 years. During this time he sustained multiple injuries, including injuries to his right ankle and shoulders. The focus of this case involved the employee's request for a footwear accommodation. Following his 2014 right ankle injury, the employee's doctor prescribed supportive "tennis shoes with arch support + high rescue boot high ankle" to reduce pain and improve stability. An IME agreed that the employee's ankle issues were aggravated by his need to work on uneven surfaces wearing heeled shoes at work, and the City accepted liability for the workers' compensation claim. A captain told the employee that he could wear black tennis shoes in the station house, and the employee purchased black tennis shoes and fitted them with special inserts. The City paid for these along with supportive rescue boots. The employee wore the tennis shoes in the station house for 6-8 weeks until the Deputy Chief told him that he could no

longer wear them because they did not comply with the Department's policy for station shoes. The employee claims that after he reverted to wearing station shoes his ankle started to swell and his pain increased. Ultimately, he reinjured his ankle and seriously injured his shoulder when he lost his footing climbing down from a fire truck. The Department placed the employee on light-duty for his shoulder, but would not allow him to wear his prescribed tennis shoes. Therefore, the employee claimed that the light-duty position was outside of his restrictions and he was placed on leave. While he was on leave there were "numerous" meetings regarding the footwear issue, but no agreement was reached. Based upon a functional capacities evaluation, the City offered the employee early retirement, which he accepted. In addition, the employee settled his workers' compensation claims for $125,000. The employee filed a district court complaint asserting that the City violated the MN Human Rights Act (MHRA) by not allowing him to wear doctor-prescribed tennis shoes inside the station house. He asserted that allowing him to wear the shoes would be a reasonable accommodation. Further, he asserted that the City retaliated against him for seeking a reasonable accommodation. The City moved for summary judgment, arguing that the exclusivity provision in the Workers' Compensation Act (WCA) prevented the Employee's MHRA law suit. Minn. Stat. §176.031 (2018) states, in-part: "[t]he liability of an employer prescribed by this chapter is exclusive and in the place of any other liability to such employee . . . on account of such injury . . ." A district court judge denied the request for summary judgment, and the City filed an interlocutory appeal to the Minnesota Court of Appeals (MNCOA), arguing that the district court lacked subject-matter jurisdiction because of the exclusive remedy provision in the WCA. The MNCOA agreed with the City, and Daniels appealed to the MN Supreme Court (SC). The SC reversed the MNCOA and remanded the matter to the district court to proceed on the merits of the MHRA claim. Justice Chutich, writing for the majority, reasoned:

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

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

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

Comment: It is important to note that this case does NOT conclude that the City violated the MHRA. That issue has been remanded to the district court for a determination on the merits. As is indicated by the dissent, we do anticipate that there may be an increase in failure-to-accommodate cases. These are not covered by workers' compensation policies, but may be covered by employment practices liability insurance (ELPI). It will be important for employers to document

accommodation requests, efforts to comply with these requests, and reasons for not complying if it is determined that this cannot be done. Employers which are inclined to reject an accommodation requested by an injured employee, and which cannot reach a compromise acceptable to the employee, would be well-advised to seek legal advice. There are a number of reasons that an employer may have to not accommodate, at least in the way an employee requests. But refusals to accommodate can lead to protracted litigation and, sometimes, to expensive liability.

Interest

Oseland v. Crow Wing County, Case No. A18-1550 (Minn. Sup. Ct. May 29, 2019.) The employee sustained an admitted injury in January 1980. Benefits were paid. Approximately nine years after the injury, the employee became permanently and totally disabled, and PTD benefits were paid. In June 1996 the employee began receiving retirement benefits from the Public Employees Retirement Association (PERA), and the insurer began offsetting those benefits from the PTD benefits (which was in accord with WCCA precedent at the time). These benefits were paid until the employee died in 2013, at which time all benefits ceased. In 2014, the Supreme Court decided *Ekdahl* and *Hartwig*, holding that insurers cannot reduce PTD benefits by amounts being paid as PERA benefits. In September 2015, the insurer performed an audit of its files and notified the Department of Labor and Industry that it had taken a PERA offset, that the employee had passed away, and requesting guidance as to what to do. DOLI did not respond to that letter and the insurer did not follow up. In June 2016, DOLI advised the insurer that it had audited the claim and determined that the insurer had underpaid $169,177 in benefits as the result of the PERA offsets. DOLI instructed the insurer to pay the estate these underpaid benefits. The insurer hired a forensic accountant to verify the amount of underpaid benefits, and that audit took two months, revealing that the underpaid benefits were approximately $10,000 less than what DOLI had calculated. The insurer sent the results of its audit to DOLI in September 2016, and DOLI agreed with that assessment. The insurer sent emails to one of the employee's heirs about the underpaid benefits, requesting the name of the estate and the personal representative. The heir did not respond. In November 2016, the heirs filed a claim petition seeking underpaid benefits and interest. The insurer acknowledged that it owed underpaid benefits to the heirs and was ready to issue payment upon provision of the personal representative and address. The insurer denied that it was liable for interest on the underpaid benefits. The heirs obtained a decree of descent to establish that they were legal heirs, and that was sent to the insurer in February 2017. In May 2017, the parties executed a stipulation for settlement providing for payment of the forensic accountant's overpayment calculation, but leaving claims open for additional underpayment of benefits, interest, and penalties. A compensation judge held that the heirs were not entitled to additional underpaid benefits, penalties, or expenses, but determined that they were entitled to interest on the underpaid benefits. The judge further determined that the applicable rate of interest on the underpayments was based on the date of each underpayment. In other words, the applicable interest rate was "the rate set by statute at the time the benefits became due and owing." Both parties appealed.

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

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

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

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

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

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

Jurisdiction

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

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

Medical Issue

Johnson, William v. Darchuks Fabrication, Inc., Case No. A18-1131 (Minn. Sup. Ct. April 24, 2019.) The employee injured his right ankle in September 2002. The injury was admitted and benefits were paid to and on behalf of the employee. After a short period of time, the employee developed complex regional pain syndrome ("CRPS"). This diagnosis was also initially admitted and a significant amount of medical treatment was paid. As of 2005, after receiving various forms of alternative treatment, the employee's treatment primarily consisted of a medication regimen that included opioid medications. In 2016, due to concerns about the ongoing use of opioid medications, the employer and insurer pursued an independent medical examination to review the employee's condition and the appropriateness of the medication regimen. The IME opined that the employee no longer had CRPS, that the use of ongoing narcotics was not in compliance with the Treatment Parameters, and recommended that the employee be weaned off narcotics. Based on that report, a letter was sent to the employee's physician indicating that treatment for the employee's CRPS diagnosis was denied. Further, the letter requested that the treating physician

begin weaning the employee from the opioid medications and comply with the Treatment Parameters governing long-term use of opioid medications, Minn. R. 5221.6110. When the treating physician did not respond, the employer and insurer ceased paying for medication reimbursement. The employee subsequently filed a Medical Request seeking payment of his medications. The employer and insurer denied payment, contending that the employee's CRPS has resolved, that the treatment was not reasonable and necessary to cure and relieve the effects of the injury, and that his continued treatment with opioid medications was not compliant with the Treatment Parameters. The case went to a Hearing before Compensation Judge Hartman, who found that the employee's CRPS had not resolved, and that in denying that the employee had CRPS, the employer and insurer had in effect "denied liability" for the employee's injury. Consequently, he denied application of the Treatment Parameters. The Workers' Compensation Court of Appeals affirmed. Citing *Schulenburg, Oldenburg*, and *Mattson*, the WCCA found that challenging even one component of an otherwise admitted injury is akin to a denial of liability, and, in doing so, the employer and insurer lost the ability to apply the Treatment Parameters.

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

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

Penalties

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

Decisions of the Minnesota Court of Appeals

There were no decisions for this reporting period.

Decisions of the Minnesota Workers' Compensation Court of Appeals

Attorney Fees

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

Beager v. North Valley, Inc., File No. WC19-6262, Served and Filed May 15, 2019. The employee represented himself in the first round of litigation and settled his workers' compensation claim on a full, final, and complete basis. The award on stipulation was filed and approved by the OAH. The employee then hired an attorney to

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

Death

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

Interveners

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

failure to attend the hearing, after they were ordered to do so, required that its entire intervention claim be forfeited, pursuant to Minn. Stat. §175.361, subd. 4. The WCCA (Judges Quinn, Stofferahn, and Hall) held that HCMC's attendance at the hearing was necessary to preserve its claims for treatment provided after August 1, 2014, but not before August 1, 2014, as all of the earlier records had been provided. Thus, the WCCA affirmed the compensation judge's decision that HCMC was entitled to reimbursement of treatment provided before August 1, 2014, despite its failure to attend the hearing.

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

Medical Issues

Miskowiec v. CM Information Specialists, Inc., File No. WC18-6227, Served and Filed May 16, 2019. (For additional information on this case, please refer to the Interveners category.) The employee sustained an admitted injury on November 12, 2012. She had preexisting injuries and had started taking narcotic pain medication on a regular basis as early as 2008. After the work injury, the employee treated at Minnesota Advanced Pain Specialists (MAPS). This treatment included opioid pain medication. In July 2015 the employee was discharged from treatment at MAPS due to a violation of the controlled substance agreement. About one month prior to that, in June 2015, she had begun treating at HealthPartners Clinic, receiving narcotic pain medication from that clinic through August 2016. In December 2015 she began treatment with Dr. Hess at United Pain Clinic. She was prescribed with narcotic pain medication. By April 2016 the employee was discharged from Dr. Hess' care due to three separate violations of her pain contract. On May 26, 2016, the employee began treating with Dr. Morales at Central Medical Clinic (CMC). She did not inform Dr. Morales that she had previously treated with Dr. Hess or that she had been discharged from Dr. Hess' care. Dr. Morales began prescribing narcotic pain medication. On July 13, 2016, after treating with Dr. Morales on two occasions, the employee contacted Dr. Hess' office by phone requesting a referral to Dr. Morales. The employee explained that Dr. Morales performed injections into the pain site. Dr. Hess' records for the same date indicate "per patient's request – is transferring care to Dr. Morales." There is no evidence that Dr. Morales was ever provided with this note. The CMC records from both before and after July 13, 2016, described the employee as a "self-referral" to Dr. Morales. Compensation Judge Tate determined that this constituted a valid referral and authorized change of physician. The employer and insurer appealed, and the WCCA (Judges Quinn, Stofferahn, and Sundquist) reversed. The WCCA cited Minn. Rule 5221.0430, Subp. 2, which states in relevant part that any changes of primary care provider after the first 60 days following initiation of medical treatment must be approved by the insurer, the department, or a workers' compensation judge. Exceptions to this requirement include conditions beyond the employee's control such as, in relevant

part, a referral from the primary care provider to another provider. The rule additionally states that the insurer is not liable for treatment rendered prior to obtaining approval of a change in provider unless the insurer has agreed to pay for treatment and except in emergency situations where prior approval could not have reasonably been obtained. The WCCA found that the employee did not have approval from the employer and insurer or DOLI to change providers from Dr. Hess to Dr. Morales, and there were no emergency or exigent circumstances for her treatment with Dr. Morales. The WCCA reversed Judge Tate's finding that there was a retroactive referral. In Gibbs, the WCCA affirmed an award of medical care after a retroactive referral where the referring physician reviewed the care provided by the later physician and endorsed the care provided by that physician. Here, there was no evidence that Dr. Hess was aware of the nature or efficacy of the care provided by Dr. Morales, or that Dr. Hess endorsed the care provided at CMC. Additionally, the WCCA found that the employee provided an inaccurate description (that Dr. Morales performed injections into the injury site) of what care was actually being provided by Dr. Morales. Moreover, Dr. Morales' records consistently referred to the employee as a self-referred patient and there was no evidence that Dr. Morales obtained the records of Dr. Hess or was aware of Dr. Hess' earlier participation in the employee's care. The WCCA thus found that the change in physicians was unauthorized under Minn. Rule 5221.0430, and the employer and insurer were not liable for payment for the care provided by Dr. Morales or CMC.

Psychological Injury

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

Rehabilitation / Retraining

Ewing v. Print Craft, Inc., File No. WC18-6197, Served and Filed March 12, 2019. The employee sustained an injury at work on December 1, 2015, injuring his left ankle. He was subsequently diagnosed with several other conditions, including CRPS, alleged to have been consequential

injuries from the work injury. Medical treatment was provided. In April 2016 he was taken off of work due to the effects that chronic pain had on his work performance. Also in April 2016 he underwent a rehabilitation consultation by a QRC, who opined that the employee was qualified for rehabilitation services. The QRC filed an R-2 in July 2016 to initiate the provision of rehabilitation services, and the employer made no objection. The plan was amended via an R-3 in October 2016 to indicate that medical management would continue pending the employee being released to return to work. On November 7, 2016, the employee underwent an IME conducted by Dr. Gedan, who opined that the employee's injury was limited to his left ankle and none of the claimed consequential injuries were the result of the work injury. The employee subsequently filed a claim petition, seeking medical benefits. The claim petition made no mention of rehabilitation benefits, nor did the employer's answer. On December 5, 2016, the employer filed a NOID seeking to terminate TTD benefits. By order served and filed on January 4, 2017, TTD benefits were discontinued following a .239 administrative conference, with the judge holding that the employee was no longer restricted from work activities from his work-related ankle injury and he did not have CRPS. On December 9, 2016, the employer informed the QRC by email that the only admitted injury was to the left ankle and that medical management services regarding any other body part or condition would not be reimbursed. The employee filed an amended claim petition seeking other specific medical expenses and claiming TTD. On February 3, 2017, the employer filed a letter answer, indicating that a rehabilitation program for the employee's ankle was approved but that any other condition or body part was denied. On January 9, 2017, Dr. Friedland issued an IME report on behalf of the employer. He opined that the employee sustained only a mild left ankle strain that was temporary and would have resolved by April 20, 2016. On February 6, 2017, the QRC filed an R-3 amending the rehabilitation plan to extend medical management. The employer did not file an objection to the proposed R-3 amendment. On April 6, 2017, the employer filed a Rehabilitation Request seeking termination of the rehabilitation plan. The QRC continued to provide rehabilitation management services after receiving that notice. The employee's counsel filed a Rehabilitation Response and the parties agreed to consolidate the issue with the existing issues brought by the employee in his claim petition. Compensation Judge Marshall found that the employee's work injury resolved on April 20, 2016, and he ordered that all claims through April 20, 2016, be paid and all other claims were dismissed. The QRC appealed. The WCCA (Judges Hall, Stofferahn, and Sundquist) reversed. The WCCA found that the compensation judge erred as a matter of law in assigning the cutoff date for rehabilitation services. Citing Minn. Stat. §176.102, subd. 8, the WCCA noted that a rehabilitation plan in place could be terminated on a showing of good cause "[u]pon request to the commissioner . . . by the employer . . . " Thus, the WCCA determined that the language in subdivision 8 required notice to close the rehabilitation plan. Minn. R. 5220.0510, Subp. 7 indicates that the notice must take the form of a rehabilitation plan amendment seeking to terminate services. [Ed. Note: Subp. 5 indicates the employer or insurer must file a Rehabilitation Request to seek closure of a rehabilitation plan based on good cause.] Because the employer did not make such a filing until April 6, 2017, the employer did not make a potential showing of good cause until that date, and it was necessary to pay for rehabilitation services until that date. However, the WCCA agreed with the compensation judge that the injury had resolved as of April 20, 2016, and it held that the good cause standard had been met as a matter of law on April 6, 2017, the date on which notice was given to the QRC. Rehabilitation services were not payable after that date. *See Parker*.

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

Vacating Awards

Strand v. R&L Carriers Shared Services, LLC, File No. WC18-6202, Served and Filed February 14, 2019. The employee was injured while working as a delivery driver for the employer on September 16, 2016. Primary liability was admitted and various benefits were paid. His treating doctor found him to be at maximum medical improvement and released him to return to work without restrictions. He began treating with various other medical providers, who diagnosed him with ankylosing spondylitis of the thoracic and lumbar spines, for which the employer and insurer denied primary liability. The employee filed a Claim Petition for alleged injuries to his low and mid back, rib cage, and radicular pain in both legs. An MRI and a CT scan were done, both of which showed a T11 fracture. Dr. Chang recommended various surgical options, including a T11 corpectomy, posterior

thoracic laminectomy at T11, correction of kyphosis and thoracic pedicle screws from T4 to L2. Dr. Raih performed an IME and recommended a TLSO brace for the T11 fracture before considering surgery. The parties settled for a lump sum of $80,000 to the employee and $20,000 to his attorney, which included closing out future medical treatment. Soon after the settlement, the employee was evaluated by Dr. Polly, who recommended surgery, which included a posterior spinal fusion from T4 to S1, segmental spinal instrumentation from T4 to S1, pelvic fixation, and osteotomies from T12 to L3, with complications of presumed positional femoral nerve neurapraxia. He underwent surgery, but was hospitalized afterwards, diagnosed with paraplegia, bilateral leg weakness, impaired mobility, generalized weakness, impaired activities of daily living, and impaired cognition. He was unable to return to work until at least early 2019, and continued to have gait and balance problems that required him to use a walker or cane. He was also given a 26 percent permanent partial disability rating. The employee filed a petition to vacate the earlier stipulation for settlement based on a substantial change in his medical condition that had not been anticipated and could not have been anticipated at the time of the parties' settlement. The WCCA (Judges Hall, Sundquist, and Quinn) agreed and vacated the earlier stipulation for settlement. The WCCA held that the facts of this case were distinguishable from the facts in *Swanson v. Kath Fuel Oil Service* because in *Swanson* the employee's surgery had been scheduled prior to the parties' settlement, whereas here, at the time of the parties' settlement, the employee had not yet decided whether to have surgery, or attempt to wear a brace. The surgery recommended prior to settlement was also significantly different than the surgery suggested after settlement.

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

500 Young Quinlan Building
81 South Ninth Street
Minneapolis, MN 55402

Phone 612 339-3500
Fax 612 339-7655

www.ArthurChapman.com