The Sixth Annual

Louisiana

Workers' Compensation Educational Conference

January 21-22, 2016
Renaissance Baton Rouge
Baton Rouge, Louisiana

Presented by:
The Louisiana Office of Workers' Compensation in association with the International Workers' Compensation Foundation, a nonprofit corporation dedicated to workers' compensation research and education.

SIXTH ANNUAL
LOUISIANA WORKERS' COMPENSATION EDUCATIONAL CONFERENCE
Renaissance Baton Rouge • Baton Rouge, Louisiana • January 21-22, 2016

DAY ONE - THURSDAY, JANUARY 21st

7:30 a.m. - 8:30 a.m.
Registration

8:30 a.m. - 9:00 a.m.
OWC Update
OWC Director Patrick Robinson

9:00 a.m. - 10:00 a.m.
Formularies and other solutions to opioid issues in workers' compensation
Joseph Paduda, Health Strategy Associates

10:00 a.m. - 10:10 a.m.
Success Story #1

10:10 a.m. - 10:30 a.m.
Break

10:30 a.m. - 11:30 a.m.
BREAK-OUT 1
Workplace safety and keeping the "injured" out of "injured worker"
Terry Secrest, Roy O'Martin

BREAK-OUT 2
Judicial independence and Administrative Law Judges (ethics)
William Raftery, National Center for State Courts

11:30 a.m. - 12:30 p.m.
Lunch

12:30 p.m. - 1:30 p.m.
Constitutional challenges to workers' compensation
Hon. David Langham, Florida Office of Judges of Compensation

1:30 p.m. - 2:30 p.m.
Accommodating Medicare's interest in workers' compensation
Rafael Gonzales, Helios Workers' Comp Solutions

2:30 p.m. - 2:40 p.m.
Success Story #2

2:40 p.m. - 3:00 p.m.
Break

3:00 p.m. - 4:00 p.m.
Successfully navigating the OWCA 1009 process
Jan Clary, R.N., Louisiana Office of Workers' Compensation

4:00 p.m. - 5:00 p.m.
Issues concerning medical fee schedules in workers' compensation
Francine Johnson, Coventry Workers' Comp. Services

5:00 p.m. - 6:30 p.m.
Reception

DAY TWO - FRIDAY, JANUARY 22nd

7:00 a.m. - 8:00 a.m.
Continental Breakfast

8:00 a.m. - 9:00 a.m.
A panel discussion on vocational rehabilitation and solutions to Louisiana's disability problem
Patrick Robinson, OWCA (moderator); Hon. Diane Lundeen, OWC District 8; Larry S. Stokes, Ph.D., LRC, LPC, Stokes & Associates; Gregory J. Hubachek, Esq., Workers' Compensation, LLC; Michael E. Parker, Esq., Allen & Gooch

9:00 a.m. - 10:00 a.m.
A primer on Jones Act and the LHWCA
Henry LeBas, Lebas Law Offices

10:00 a.m. - 10:20 a.m.
Break

10:20 a.m. - 10:30 a.m.
Success Story #3

10:30 a.m. - 11:30 a.m.
Is the preliminary determination process working?
Hon. Sheral Kellar, OWCA (moderator); Hon. Elizabeth Lanier, OWC District 9; Joseph H. Jolissaint, Esq., Attorney at Law; B. Scott Cowart, Esq., Taylor, Wellons, Politz & Duhe

11:30 a.m. - 12:30 p.m.
Recent jurisprudence
Eric E. Pope, Esq., Blue Williams, LLP; Steve Wanko, Esq., The Wanko Law Firm, LLC

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THURSDAY, JANUARY 21 ST

9:00 AM – 10:00 AM

Formularies and other solutions to opioid issues in workers' compensation

Workers' Compensation Pharmacy Management: The Landscape in 2016

Joseph Paduda
President, CompPharma, LLC

Health Strategy Associates

Learning Objectives

- Stuff you need to know about drugs and workers' comp
- What is a formulary and how does it work?
- What other states are doing
- Beyond formularies…

A Formulary is:

- A list of medicines
- Intended to insure the right medications are available to patients that need them
- Most basic - Specific drugs that are pre-approved to be prescribed under a specific insurance or benefit plan
- Most common – disease or condition-specific

The Key Data Points

15 – 17% of work comp medical expense is Rx

35% of that is for opioids

85% of spend is for pain

Workers' comp accounts for **17%** of total US spend for opioids

Formularies

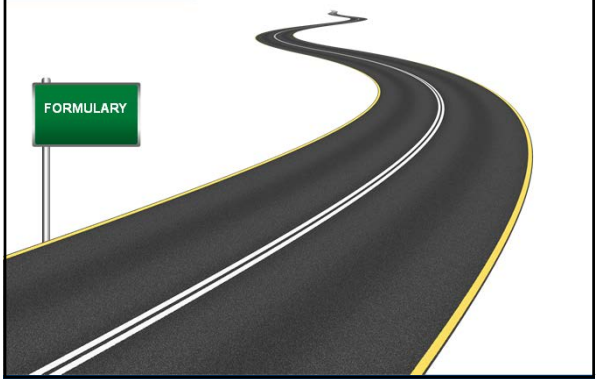
Non-workers comp

- Formularies are ubiquitous
- Almost all formularies are medically-appropriate but financially-driven
  - Financial incentives to use lower-cost, "preferred" drugs
    - Generics
    - Preferred brands
    - Non-preferred brands
    - Specialty drugs
  - Rebates are a major consideration

Closed, Open, and Condition-specific Formularies

- Closed formulary– list of drugs that are acceptable for use, regardless of disease state or medical condition
- Open formulary – access to any FDA-approved drug is allowed
- Condition-specific or Selective/ Partially-closed formulary– drugs are approved for condition/diagnosis and/or disease state (acute v chronic)

A Formulary is:



A Formulary is:

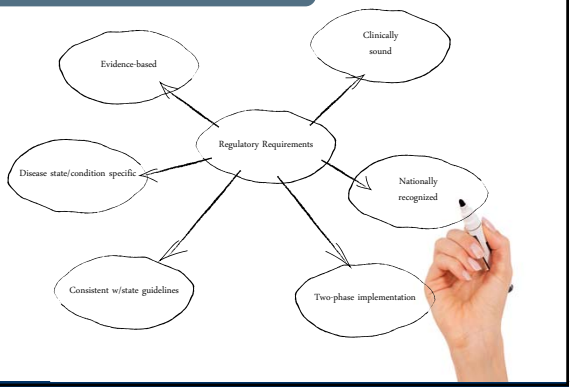
A Formulary is:

- Only half of a pharmacy management program
  - The other half is the utilization review process
  - Non-formulary drugs must be approved via a standardized drug utilization review process prior to dispensing
- Properly done, formularies ***DO NOT*** restrict access to appropriate medicine

Drug Utilization Review

- Prior Authorization
- Review of Medical Necessity
- Emergency Medical Interlocutory Orders

Designing a Formulary – Regulatory Requirements

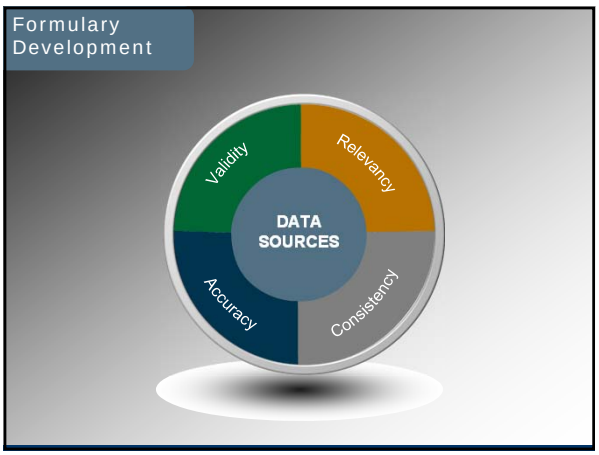


Formulary-type Guidelines

Chronic pain or diagnosis-specific guidelines usually incorporate drug recommendations

Formulary Development

Formulary Development

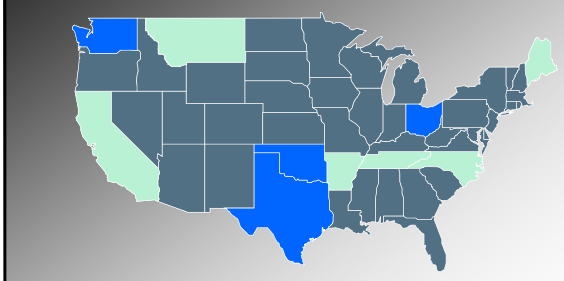


Closed Formularies Explained

- Simple, straightforward
- Examples include WLDI's ODG formulary
  - Currently in use in Texas and Oklahoma
  - Includes all FDA-approved drugs except experimental/investigational
- Same formulary applies to any diagnosis, disease state or medical condition.
- "Y" or approved drugs may not be compensable or related to the claimant's diagnosis
  - E.g. antibiotics are "Y" regardless of the claimant's diagnosis

The Problem With "Yes/No"

Current Landscape



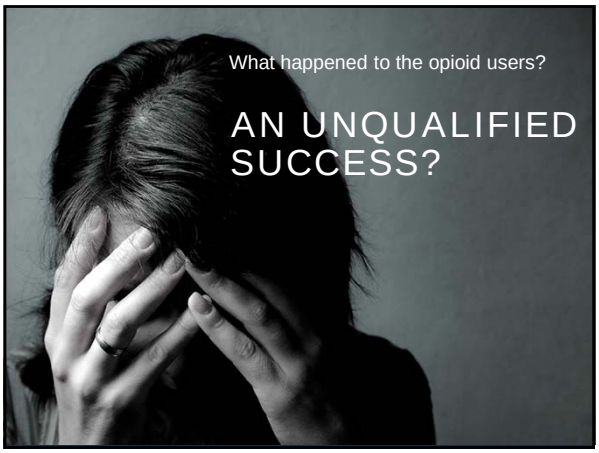
What About Ohio and Washington

What Happened in Texas?

THUMBS UP TEXAS

Sustained Results

Date	Reduction in # of Claims with "N" drug Rx	Reduction in Cost of "N" Drugs	Reduction in total # of Prescriptions
Oct. 2012	60%	81%	12%
June 2013	59%	80%	9%
Mar. 2014	65%	82%	9%



Other Tools…

- Opioid Agreements
- …rs to manage opioids
- Prescription Drug Monitoring Pro…

Takeaways

- Medical care is not binary
- Patient access to the right medications for their condition is critical
- Formularies must have UR to be effective – or even relevant
- Formularies and UR are critical – but they aren't enough
- It is far better to do it right the first time

THURSDAY, JANUARY 21 ST

10:30 AM – 11:30 AM

Break-Out 1

Workplace safety and keeping the “injured” out of “injured worker”

"Did you hear the one about the guy who *didn't* have a workplace accident?"

Terry Secrest
Vice President of OSB & Corporate Safety Director
RoyOMartin

RoyOMartin Overview

- 1923: Founded by Roy O. Martin, Sr. in Alexandria, LA
- Today:
  - Family owned (3rd and 4th generation leadership)
  - Professionally managed
  - 1,200 employees in LA and TX
  - 570,000 acres of timberland
  - Businesses: OSB, plywood, & timber manufacturing; logging; forest management; medical clinic

RoyOMartin Values (RICHES)

R **Respect** for each other as human beings uniquely created by God.

I **Integrity** in what we do and say we will do, regardless of the cost, legally and ethically.

C **Commitment** to our business, to our employees, to our customers, and to each other.

H **Honesty** in our interaction with our fellow employees, our supervisors, our customers, our vendors, and our families.

E **Excellence** in safety, product quality, employee training and development, and process improvements.

S **Stewardship** of our land, timber, and plant assets.

What is Safety?

RoyOMartin

What is a Workplace Accident?

- An accident is an **undesirable incidental** and **unplanned** event that **could have been prevented** had circumstances leading up to the accident been recognized, and acted upon, prior to its occurrence.
- Most scientists who study unintentional injury avoid using the term "accident" and focus on factors that increase risk of severe injury and that reduce injury incidence and severity.

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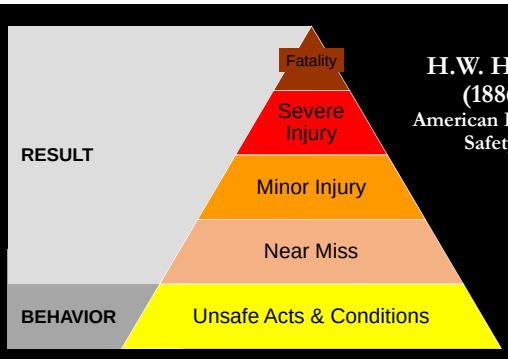

H.W. Heinrich (1886-1962),
American Industrial Safety Pioneer

Unsafe Behaviors (Acts)

- Complacency
- Fatigue
- Taking eyes off task at hand
- Taking mind off task at hand
- Disregard of safety procedures

Unsafe Conditions

- Improper guarding
- Poor lighting
- Poor housekeeping
- Lack of safety procedures

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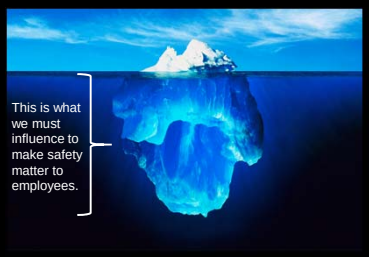

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Can Accidents Really be Prevented?

IBiZ
I believe in zero

RoyOMartin

A Winning Safety Culture

- Safety leadership starts at the top.
- At RoyOMartin, we actively engage employees and encourage safety ownership:
  - Set expectations
  - Model safety best practices
  - Train employees and provide refreshers
  - Seek employee involvement through:
    - Audits
    - Near-miss & incident reports
    - Root-cause analyses (RCA)
    - Continuous-improvement ideas

RoyOMartin

CORPORATE SAFETY POLICY

At RoyOMartin, we believe that our employees, shareholders, suppliers, and other stakeholders benefit from our commitment to health, safety, and the environment (HSE), both at work and at home.

- Each employee is expected to accept responsibility for his/her personal safety, as well as the safety of fellow team members.
- All injuries are preventable; all work activities at RoyOMartin can be done safely. Our goal is "injury free" at home, at work, and while traveling.
- Every employee is empowered to stop any process, procedure, or action in which they recognize an HSE-related concern and engage the appropriate people and resources to resolve the concern.
- HSE is a core value at RoyOMartin, and operations will be organized, resources will be provided, and people will be trained to drive HSE excellence. All team members will participate in that drive to excellence by focusing on safety, every day, all the time.

Simply put,

1. We are all accountable for safety.
2. All injuries are preventable (I Believe in Zero).
3. We are empowered to stop!
4. **Keep** the safety switch on all the time.

IBiZ

Jonathan E. Martin
Chairman & CEO

Roy O. Martin III
President & COO

E. Shaw Bagwell
Executive Vice President & COO

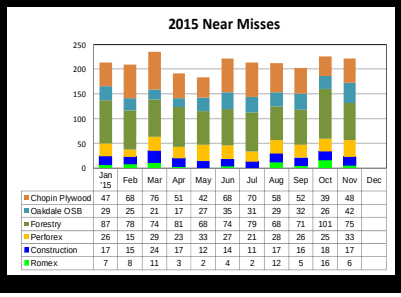
June 2015

PO Box 1110 Alexandria, LA 71309-1110 (800) 299-5174 royomartin.com

Safety Audits

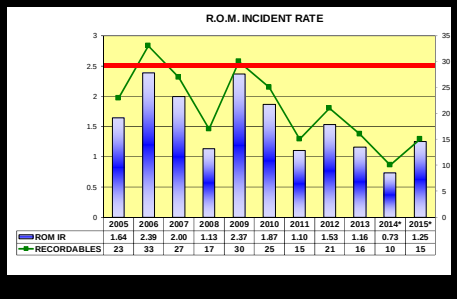
Observed Behaviors	Safe/Unsafe	Describe how behavior was reinforced/corrected
observed millwright working on stenciler	P/Safe	checked there jsa and also wearing all there ppe. thanked them for working safely and asked them if the had any other concerns
observed employee not wearing ear plugs	PPE/Uns	gave him a set of ear plugs. and also talked him about the effects of hearing lose
observed lift driver 1	PPE/Saf	asked to see his checklist he showed it to us. thanked him for having it and also thanked him for wearing his ppe
observed lift driver 2	P/Unsafi	asked to she his checklist did not have one made him stop and fill one out also gave him a set of ear plugs to wear since he did not have any. talked to him about the reasons why we use checklists and also wear ppe.
observed sawline area	H/Safe	thanked sawline rover working in the area for having the area clean and orderly.

Near-Miss Reporting



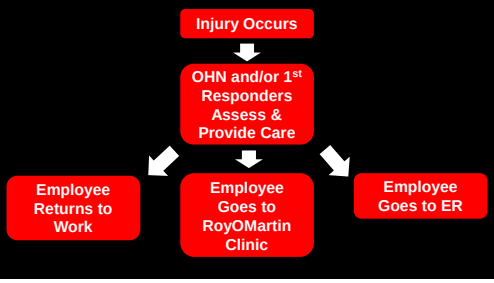
	Jan '15	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Chopin Plywood	47	68	76	51	42	68	70	58	52	39	48	
Oakdale OSB	29	25	21	17	27	35	31	29	32	26	42	
Forestry	87	78	74	81	68	74	79	68	71	101	75	
Perforex	26	15	29	23	33	27	21	28	26	25	33	
Construction	17	15	24	17	12	14	11	17	16	18	17	
Romex	7	8	11	3	2	4	2	12	5	16	6	

Incident-Rate Tracking

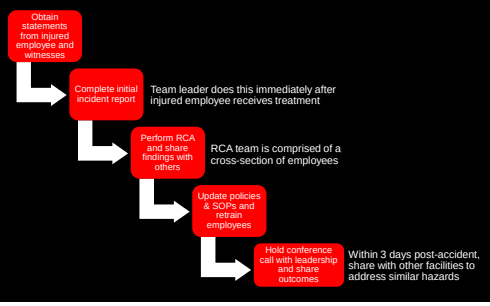


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014*	2015*
ROM IR	1.64	2.39	2.00	1.13	2.37	1.87	1.10	1.53	1.16	0.73	1.25
RECORDABLES	23	33	27	17	30	25	15	21	16	10	15

Incident Flow Chart



RCA




IBiZ
I believe in zero
RoyOMartin

THURSDAY, JANUARY 21 ST

10:30 AM – 11:30 AM

Break-Out 2

Judicial independence and Administrative Law Judges (ethics)

The Challenge of Judicial Independence

William E. Raftery, PhD
KIS Analyst
Williamsburg, VA

Overview

- Earliest iterations
- Defining Judicial Independence
- Limitations
- Fairness and Impartiality

Earliest iterations

- VA Supreme Court of Appeals (1776)
- Entitled to 300 pounds, by 1781 paid in tobacco
- 1788 District Court Act

Remonstrance of the Judges (4 Call 135 (1788))

"That the propriety and necessity of the independence of the judges is evident in reason, and the nature of their office, since they are to decide between government and the people, as well as between contending citizens; and if they be dependent on either, corrupt influence may be apprehended."

NCSC

Defining Judicial Independence

- Kornhauser (2002): cannot be defined or has too many definitions
- Geyh (2014): Unqualified vs. Qualified

NCSC

Defining Judicial Independence

- Unqualified: "not subject to control by others"
- Effectively indefensible: "we want no part of a government [utterly] independent of the people"

NCSC

Defining Judicial Independence

- Qualified: focus on the desired ends & sources
- Structural
  - Decisional/Individual
  - Institutional/Collective
- Behavioral
  - External
  - Internal

NCSC

Defining Judicial Independence

- Structural: Decisional
  - Physical harm
  - Election/Appointment
  - Impeachment
  - Disciplinary
- 2011: record number of impeachment efforts
- 2015: uptick

NCSC

Defining Judicial Independence

- Structural: Institutional
  - Separation as a branch
  - Administrative control
  - Budgetary control
  - Elimination of court(s)
- Kansas: Strike down law, entire judicial budget eliminated

NCSC

Defining Judicial Independence

- Structural: Institutional
  - Move out of executive, into judiciary
  - WCC: MT, NE, OK, RI
  - Tax: AZ, IN, OK, OR

NCSC

Defining Judicial Independence

- Behavioral: External
  - Temper decisions strategically to win acceptance
  - Elections/Appointment
- Harsher sentences in election year
- "Will this be the case"

NCSC

Defining Judicial Independence

- Behavioral: Internal
  - Selection of options as determined by judge
  - Attitudinal/ideology vs. neo-institutionalist
- Values and ethics vs. this is what "the law" requires

NCSC

Limitations of Judicial Independence

- Justice at Stake (2005)
  - Courts should be free from political interference
  - Courts should uphold the constitution/law
  - "Judicial Independence": does not resonate and/or alienates
  - "Fair and impartial courts"

Limitations of Judicial Independence

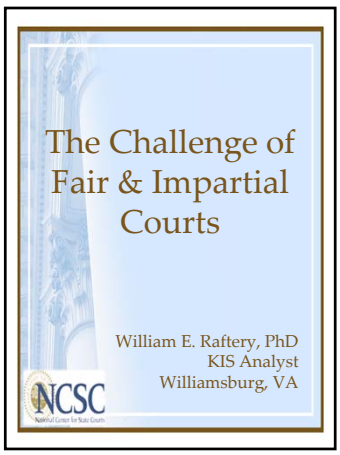
- NCSC/JAS (2012): Funding Justice
  - "Fair and impartial"
  - Emphasis on separation backfires
  - Attorneys should not be the messengers to the public

Fairness and Impartiality

- Embrace accountability in the proper context
  - "friction between independence
  - and accountability" (Moliterno, 2006)
  - Acknowledge shortcomings
  - Performance measures
  - Mission is to deliver justice, not particular outcomes


Fairness and Impartiality
• Public distrust of government taints the courts
– Fewer than 1 in 5 report "great deal" of confidence in courts
• Focus on harm to the public, not the courts
NCSC


Fairness and Impartiality
• Procedural Fairness
• CourTools Measure 1:
– I was treated with courtesy and respect
– The way my case was handled was fair
– I was treated the same as everyone else
NCSC


The Challenge of Fair & Impartial Courts
William E. Raftery, PhD
KIS Analyst
Williamsburg, VA
NCSC

THURSDAY, JANUARY 21 ST

12:30 PM – 1:30 PM

Constitutional challenges to workers' compensation

Challenges to Workers' Compensation

David Langham
Florida Office of Judges of Compensation Claims

Challenges to Workers' Compensation

Federal
State

Challenges to Workers' Compensation

Judicial
Legislative

Challenges to Workers' Compensation

Statutory

Constitutional

Constitutional Challenges

Pre-Emption Doctrine

Separation of Powers

Due Process - Equal Protection

Access to Court

Compensation for Labor

Federalism

Other Judicial Challenges

Stare Decisis

Consistency

Challenges to Workers' Compensation

Judicial

Judicial

- Equal Protection
- Preemption
- Access to Courts
- Due Process
- Delegation
- Log Rolling

Equal Protection

Rodriguez v. Brand West Dairy, 356 P.3d 546 (N.M. Ct. App. 2015); Aguirre v. M.A. and Sons Chili Products, (cons).33,675

Workers' Compensation exemption for agricultural workers.

Equal protection,

Distinguishing, Cueto v. Stahman Farms Inc, 608 P.3d 535 (NM Ct. App. 1980)

Rodriguez v. Brand West Dairy, 356 P.3d 546 (N.M. Ct. App. 2015); Aguirre v. M.A. and Sons Chili Products, (cons).33,675

"Excluding farm and ranch laborers from workers' compensation denies them the benefits, including but not limited to the monetary benefits, that the act was intended to provide. It also circumvents the policy of the Act – to balance the interests and rights of the worker and the employer."

http://law.justia.com/cases/new-mexico/court-of-appeals/2015/33-104.html

Preemption

Martinez v. Lawhon (TN)

Statutory workers' compensation distinction in benefits for undocumented workers. Trial Court decision, has been appealed to the Tennessee Supreme court. Oral Argument is pending.

Arizona v. United States, 567 U.S. ___, 132 S. Ct. 2492 (2012)

Preemption

Brock v. State of Florida

Brock v. State of Florida, 138 So.3d 1060 (Fla. 4th DCA 1060)(SC14-1208)
Review Denied, 151 So.3d 1223 (Fla. 2014)

Hector v. State of Florida
Companion case, State of Florida v. Hector, 138 So.3d 1063)
Review Denied, 160 So.3d 895 (Fla. 2015)

Access to Courts

Castellanos v. Next Door Company, 124 So. 3d 392 (Fla. 1st DCA 2013).
Jurisdiction accepted by the Florida Supreme Court March 14, 2014, ___ So.3d _____ (2014).
December 9, 2013, 143 So.3d 924 (2013).

Due Process

Florida Workers' Advocates v. State of Florida, (Fla. 3rd DCA 2015)(June 24, 2015).

Judge Cueto concluded that the diminution in benefits over time has rendered the quid pro quo insufficient.

http://www.3dca.flcourts.org/Opinions/3D14-2062.pdf

Due Process

Stahl v. Hialeah Hospital, Case No. 1D14-3077 (March 25, 2015).

Adequacy of remedy, in the context of the "exclusive remedy."

Focus on statutory amendments decreasing benefits, imposing costs, or mandatory participation.

Due Process

Barber v. Louisiana Workforce Commission, ___ So3d____ (LA 2015)(2015)(Case 15-CA-1700)

"The constitutional issue was not properly raised in the district court."

Barber v. Louisiana Workforce Commission, ___ So3d____ (LA 2015)(2015)(Case 15-CA-1700)

"(1) the automatic 'tacit denial' of a request for authorization of medical treatment (on Form 1010s), if not approved by the employer within 5 business days, is unconstitutional as well as (2) the requirement of an employee to request variances from the MTG if the requested medical treatment is not covered by the MTG. The Judge also ruled that the Louisiana Workforce Commission is enjoined from applying the aforementioned provisions. The Judge also made a broad ruling regarding the unconstitutionality of Louisiana's Workers' Compensation system as a whole without any specifics of the impact of this finding."

Log Rolling

Coates v. Falin, 316 P.3d 924 (OK 2013)(December 16, 2013)

Amendments to the Oklahoma statute challenged in expedited fashion. Narrow Constitutional holding

Oklahoma

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Delegation

Protz v. Workers' Compensation Appeal Board (Derry Area School District)(September 18, 2015)

Statute 306(a.2)(2) of the Act, 77 P.S. §511.2(2). The impairment rating is determined pursuant to Section 306(a.2) of the Act, providing that it shall be determined under "the most recent edition of the American Medical Association 'Guides to the Evaluation of Permanent Impairment.'"

Article II, Section 1 of the Pennsylvania Constitution

Livingood v. Transfreight and Consol of Kentucky v. Goodgame

Stare Decisis

Stare Decisis

Livingood v. Transfreight reverses Chrysalis House Inc. v. Tackett, 283 S.W.3d 671 (KY 2009)

In *Livingood*, the recovering worker had committed no such criminal offense. The Court reversed *Chrysalis* (in which the injured worker would have received double benefits but for the created judicial exception) reasoning that the *Chrysalis* analysis did not "promote the statute's obvious purpose of encouraging continued employment," and cited the Kentucky theme that "all statutes of this state shall be liberally construed with a view to promote their objectives and carry out the intent of the legislature."

Stare Decisis

Consol of Kentucky v. Goodgame reverses Manalapan Mining v. Lunsford, 204 S.W.3d 601 (KY 2006)

The Court created a statute of repose in *Manalapan* (disease). In *Goodgame*, it created a new definition of the repose it created in *Manalapan*, holding that the repose for repetitive trauma likewise begins in Kentucky when "the date a claimant is informed of a work-related cumulative trauma injury." Thus, the new accident repose, is inferred from the Kentucky occupational disease statute.

Stare Decisis

Westphal v. City of St. Petersburg, (Panel, 38 Fla. L. Weekly D504a (Fla. 1st DCA February 28, 2013) ("natural justice").

Reverses Matrix Employee Leasing, Inc. v. Hadley, 78 So.3d 621 (Fla. lst DCA 2011) and City of Pensacola v. Oswald, 710 So.2d 95 (Fla. 1st DCA 1998)

Stare Decisis

Westphal v. City of St. Petersburg Jurisdiction accepted by the Florida Supreme Court December 9, 2013, 143 So.3d 924 (2013).

Challenges to Workers' Compensation

Legislative

Legislative

Opt-Out

Opt-Out

- Texas
  - Non subscribers
  - Subscribers
- Oklahoma
  - Opt out of liability through system
  - Retain protections of "exclusive remedy"

Opt-Out

- Tennessee (SB721)
  - "free-market alternative to traditional workers' compensation insurance offerings in the state"
  - "opt-out of private insurance plans and implement their own either fully insured or self-insured occupational injury benefit plans for their employees"

Opt-Out

- South Carolina (HB4197)
  - "instead obtain certification from the South Carolina Department of Insurance to provide coverage through a qualified employer injury plan."
  - "The Option will also require high benefit levels, which is a win for hardworking South Carolina workers."

Legislative

Presumptions

Presumptions

- Firefighters
- Paramedics
- Police Officers
- Correctional Officers

Legislative

Benefit Contraction

Benefit Contraction

- Caps and Restrictions
  - Indemnity
  - Medical
- Copayments
- Statutes of Repose/Limitation
- Statutory Definition

Federalism

National Standards or Laws

Interstate Commerce Clause

- Hammer v. Dagenhart, 247 U.S. 251 (1918).
- Schecter Poultry v. United States, 295 U.S. 495 (1935).
- NLRB v. Jones and Laughlin Steel, 301 U.S. 1 (1937).

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Challenges to Workers' Compensation

I. Trends include

A. Constitutional Challenges

1. Preemption

2. Access to Courts

3. Due Process

4. Log Rolling

5. Delegation

B. Statutory Interpretation Challenges

1. Expansions

2. Contractions

C. Federalism Challenges

D. Stare Decisis Challenges

E. Opt Out.

II. Constitutional Challenges

A. Equal protection

1. Rodriguez v. Brand West Dairy, 356 P.3d 546 (N.M. Ct. App. 2015)(33,104); Aguirre v. M.A. and Sons Chili Products, (cons).33,675

B. Preemption

1. Martinez v. Lawhon; Statutory workers' compensation distinction in benefits for undocumented workers. Trial Court decision, has been appealed to the Tennessee Supreme court. Oral Argument is pending.

2. Arizona v. United States, 567 U.S. ___, 132 S. Ct. 2492 (2012). U.S. Supreme Court held that state law regarding police monitoring of immigration status was preempted by federal law.

3. Florida Cases

a. Brock v. State of Florida, 138 So.3d 1060 (Fla. 4th DCA 1060)(SC14-1208) Review Denied, 151 So.3d 1223 (Fla. 2014).

b. Hector v. State of Florida; State of Florida v. Hector, 138 So.3d 1063) Review Denied, 160 So.3d 895 (Fla. 2015). Employees terminated for use of false social security number, under workers' compensation law. Sought review on claim of constitutional impairment under Arizona. Court denied review.

C. Access to Courts

1. Castellanos v. Next Door Company, 124 So. 3d 392 (Fla. 1st DCA 2013). Jurisdiction accepted by the Florida Supreme Court March 14, 2014, ___ So.3d ____ (2014). December 9, 2013, 143 So.3d 924 (2013).

D. Due Process

1. Florida Workers' Advocates v. State of Florida, (Fla. 3rd DCA 2015)(June 24, 2015). Judge Cueto concluded that the diminution in benefits over time has rendered the quid pro quo insufficient.

http://www.3dca.flcourts.org/Opinions/3D14-2062.pdf

2. Stahl v. Hialeah Hospital, Case No. 1D14-3077 (March 25, 2015). Adequacy of remedy, in the context of the "exclusive remedy." Focus on statutory amendments decreasing benefits, imposing costs, or mandatory participation.

3. Barber v. Louisiana Workforce Commission, ___ So3d____ (LA 2015)(2015)(Case 15-CA-1700). "(1) the automatic 'tacit denial' of a request for authorization of medical treatment (on Form 1010s), if not approved by the employer within 5 business days, is unconstitutional as well as (2) the requirement of an employee to request variances from the MTG if the requested medical treatment is not covered by the MTG. The Judge also ruled that the Louisiana Workforce Commission is enjoined from applying the aforementioned provisions. The Judge also made a broad ruling regarding the unconstitutionality of Louisiana's Workers' Compensation system as a whole without any specifics of the impact of this finding."

E. Log Rolling

1. Coates v. Falin, 316 P.3d 924 (OK 2013)(December 16, 2013). Amendments to the Oklahoma statute challenged in expedited fashion. Narrow Constitutional holding.

F. Delegation

1. Protz v. Workers' Compensation Appeal Board (Derry Area School District)(September 18, 2015). Statute 306(a.2)(2) of the Act, 77 P.S. §511.2(2). The impairment rating is determined pursuant to Section 306(a.2) of the Act, providing that it shall be determined under "the most recent edition of the American Medical Association 'Guides to the Evaluation of Permanent Impairment.'" Article II, Section 1 of the Pennsylvania Constitution

III. Statutory Changes

1. Expansions

a. New presumptions

2. Contractions

a. More stringent burdens of proof

b. Decreasing benefit volumes

c. Decreasing entitlement periods

d. Employee contribution requirements

IV. Federalism

A. Federal oversight

1. Lawmakers Seek Federal 'Oversight' Of Workers' Comp As States Limit Benefits, The Two-Way, Breaking News from NPR, October 21, 2105.

2. Hammer v. Dagenhart, 247 U.S. 251 (1918). Court denied interstate commerce implication of state laws.

3. Tenth Amendment.

4. Schecter Poultry v. United States, 295 U.S. 495 (1935)

5. NLRB v. Jones and Laughlin Steel, 301 U.S. 1 (1937) "the beginning of the Court's modern trend to expand the reach of the Commerce Clause.

V. Stare Decisis

A. Livingood v. Transfreight reverses Chrysalis House Inc. v. Tackett, 283 S.W.3d 671 (KY 2009). In *Livingood*, the recovering worker had committed no such criminal offense. The Court reversed *Chrysalis* (in which the injured worker would have received double benefits but for the created judicial exception) reasoning that the *Chrysalis* analysis did not "promote the statute's obvious purpose of encouraging continued employment," and cited the Kentucky theme that "all statutes of this state shall be liberally construed with a view to promote their objectives and carry out the intent of the legislature."

B. Consol of Kentucky v. Goodgame reverses Manalapan Mining v. Lunsford, 204 S.W.3d 601 (KY 2006). The Court created a statute of repose in *Manalapan* (disease). In *Goodgame*, it created a new definition of the repose it created in *Manalapan*, holding that the repose for repetitive trauma likewise begins in Kentucky when "the date a claimant is informed of a work-

related cumulative trauma injury." Thus, the new accident repose, is inferred from the Kentucky occupational disease statute.

C. Westphal v. City of St. Petersburg, (Panel, 38 Fla. L. Weekly D504a (Fla. 1st DCA February 28, 2013)("natural justice"). Reverses Matrix Employee Leasing, Inc. v. Hadley, 78 So.3d 621 (Fla. lst DCA 2011) and City of Pensacola v. Oswald, 710 So.2d 95 (Fla. 1st DCA 1998)

1. Westphal v. City of St. Petersburg Jurisdiction accepted by the Florida Supreme Court December 9, 2013, 143 So.3d 924 (2013). ("Westphal II").

VI. Opt-Out

A. Texas, classic non-subscriber

B. Oklahoma, non-subscriber with alternate plan.

1. No need for collective bargaining.

2. Eleven states already allow alternate plan, with exclusive remedy, if collective bargaining. Called "carve-outs." Florida is one.

C. Tennessee and South Carolina in process of debate.

THURSDAY, JANUARY 21 ST

1:30 PM – 2:30 PM

Accommodating Medicare's interest in workers' compensation

Current Issues in MSP Compliance

An Update on MIR, CPR, and MSAs

Louisiana Workers Compensation Educational Conference

Baton Rouge, LA

January 21, 2016

About Rafael Gonzalez and Helios

- Over 30 years of liability, work comp, social security litigation experience.
- Involved with Medicare/Medicaid issues since 1983. Actively engaged in all aspects of Medicare Secondary Payer Act legislation since 1990.
- Adjunct professor at FSU College of Law, Stetson University College of Law, UT College of Arts and Sciences, and USF College of Public Health teaching liability, workers compensation, social security, Medicare, Medicaid, and ACA law.
- Previously served as CEO of the Center for Medicare Lien Resolution, the Center for Medicare Set Aside Administration, and the Center for Special Needs Administration.
- Currently serve as VP of Strategic Solutions at Helios, largest pharmacy, medical, durable equipment, and Medicare/Medicaid compliance vendor in US.
- Publish on MedicareInsights.com, blog on LinkedIn (Medicare and Medicaid Compliance), Twitter, and Facebook.
- Speak throughout the country at seminars, conferences, symposiums, and forums on interplay between liability, workers compensation, social security, Medicare, Medicaid, and ACA.

www.medicareinsights.com

- CMS Announces Conditional Payment Portal Process Functionality Details – 12/28
- MSP Compliance Webinar Series: An Update on Medicare Set Asides – 12/22
- MSP Compliance Webinar Series: An Update on Conditional Payments Resolution – 12/8
- MSP Compliance Webinar Series: An Update on Mandatory Insurer Reporting – 12/2
- CMS Keeps $1,000 Mandatory Reporting and Conditional Payment Threshold – 11/20
- As Promised, Conditional Payments Resolution via Web Portal to Start 1/1/16 – 11/13
- Arizona Federal Court Dismisses Case Asking Whether Liability MSA is Necessary – 11/6
- 2nd Circuit Dismisses Pro Se's PCA Claim for Lack of Allegation of Injury-in-Fact – 11/3

Agenda

- Mandatory Insurer Reporting
  - ICD-9 vs ICD-10
  - ICD-10 Conversion and MIR
  - ICD-9 and ICD-10 Effect on MSP
- Conditional Payment Resolution
  - Effective Dates
  - The New Conditional Payment Recovery Process
  - The New Conditional Payment Portal Resolution Process
  - The New Conditional Payment Formal Appeals Process
- Medicare Set Asides
  - Claimant's Agreement Not to Seek Treatment
  - Annual Medical Costs vs. Future Allocation
  - Denied Claims and Denied Body Parts
  - Zero Allocation – No Future Treatment
  - WCMSA Submission to CMS
  - Request for Re-Review

Mandatory Insurer Reporting

ICD-9 vs ICD-10

ICD-9	ICD-10
3-4 digits	7 digits and alphanumeric
3,824 Procedure codes 14,025 Diagnosis codes	71,924 Procedure codes 69,823 Diagnosis codes
Outdated technology	Updated technology and EHR
Inflexible in adding new codes	Flexible to add new codes
Diagnosis/injury detail is lacking	Specific diagnosis/injury information provided
Generic terms for body parts	Precise terms for body parts
Methodology and approach for treatment lacks detail	Precise detail on methodology and approach to treatment
Lack of detail to describe specific procedures	Specifically details methodology, body part, and diagnosis for procedures

ICD-10 Conversion and MIR

- For submissions prior to October 1, 2015, use of ICD-9-CM diagnosis codes is mandatory.
- For submissions beginning October 1, 2015, ICD-10-CM diagnosis codes will be required on all production Claim Input Files (CIP) and Direct Data Entry (DDE) add and update records with a CMS DOI on or after October 1, 2015.
- For submissions beginning October 1, 2015, either ICD-9-CM or ICD-10-CM diagnosis codes will be accepted on all add and update records with a CMS DOI prior to October 1, 2015. However, each record can only contain either all ICD-9-CM or all ICD-10-CM codes. RREs may not submit a combination of ICD-9-CM and ICD-10-CM diagnosis codes on one single record.
- RREs will not be required to convert or crosswalk ICD-9-CM codes submitted on previously accepted records to ICD-10-CM codes when submitting subsequent updates to those records.

ICD-9 and ICD-10 Effect on MSP

- Effective January 1, 2016, CMS will add an additional limitation to Medicare claims payments where insurers or workers' compensation entities have reported to CMS that they have Ongoing Responsibility for Medicals (ORM).
- In situations where an insurer or workers' compensation entity has reported to CMS that it has ongoing responsibility for medicals (ORM) for specific care, CMS' claims processing contractors will use the information provided by the insurer or workers' compensation entity to determine whether Medicare is able to make payment for those claims.
- Insurers and workers' compensation entities that notify Medicare that they have ORM are strongly encouraged to report accurate ICD-9 or ICD-10 codes as Medicare's claims processing contractors will use this information to pay accordingly.
- Therefore, conditional payments and set aside allocations will be affected by ICD-10. There should be less confusion as to whether a payment made by CMS is or is not related to a claim, as the detail of ICD-10 codes should help to answer same. And there should be less disagreement as to whether specific treatment should or should not be included in MSA for same reasons.

Conditional Payment Resolution

Effective Dates

- Effective **October 5, 2015**, the Commercial Recovery Center has assumed responsibility for the recovery of conditional payments where CMS is pursuing recovery directly from a liability insurer (including a self-insured entity), no-fault insurer or workers' compensation entity as the identified debtor through the new conditional payment recovery process.
- Starting **January 1, 2016**, authorized MSP portal users will be able to notify CMS that a recovery case is 120 days (or less) from an anticipated settlement, challenge unrelated conditional payments, and if able to settle the claim within a specified time period, inform CMS of procurement costs and request final demand through the new conditional payment portal resolution process.
- After **April 28, 2015**, any applicable plan that is a party to an initial determination issued where CMS is pursuing recovery directly from an applicable plan may request formal appeal through the new conditional payment formal appeals process.

The New Conditional Payment Recovery Process

The New Conditional Payment Recovery Process

- **Reporting**
  - An applicable plan reports that it has primary payment responsibility to the BCRC, including reporting ORM through MMSEA Section 111 reporting, or a beneficiary/beneficiary's representative reports that an applicable plan may have primary payment responsibility.
- **Conditional Payment Notice**
  - If ORM has been reported and no previous BCRC involvement, the CRC will identify conditional payments related to the claim made by Medicare. A Conditional Payment Notice will then be issued to the applicable plan. If the applicable plan's primary payment responsibility does not terminate and the CRC identifies additional conditional payments, further CPNs (and demand letters) may be issued for these additional conditional payments.
- **Dispute**
  - Applicable plans will have the opportunity to dispute medical claims identified on the CPN before a formal request for repayment, or demand, is issued. APs will have 30 days from the date of the CPN to dispute whether the payments included in the CPN are related to the claim. If the AP does not respond within 30 days, CRC will assume such charges are related to the claim and forward a demand letter.

The New Conditional Payment Recovery Process

- **Demand**
  - If one or more conditional payments remain following the dispute response period, a demand letter, or initial determination, is issued. This is the CRC's first request for payment. The AP will have 60 days within which to make payment without being charged any interest. Payments made after such 60 days will be charged interest from the date of the demand letter.
- **Appeal**
  - Applicable plans may appeal the amount or existence of the debt, in part or in full. Applicable plans have an opportunity to initiate the formal appeal process by requesting redetermination. Formal appeals process available thereafter also includes a request for reconsideration, request for a hearing, request for review, and federal court action.
- **Failure to Respond**
  - Interest accrues from the date of the demand letter and is assessed if the debt is not resolved within 60 days. If the debt continues to be unresolved, the CRC will issue an Notice of Intent to Refer (NITR) letter informing the applicable plan of next steps should the debt remain unpaid, including referral to the Department of Treasury (DOT) for collections.

HELIOS 13

The New Conditional Payment Recovery Process

- **Referral to Treasury**
  - If any portion of the debt remains delinquent more than 180 days from the date of the demand letter, the CRC will initiate the process to refer the debt to the Department of the Treasury for additional collection activities.
- **Communicating with the CRC**
  - All recovery correspondence will be mailed to the address provided for the applicable plan. As a result, it is the responsibility of the applicable plan to provide accurate recovery address information through MMSEA Section 111 reporting.
  - If the applicable plan wishes to have another individual or entity involved with post-demand correspondence (including filing an appeal) to resolve the matter on the plan's behalf, the CRC must have a written authorization on file.
  - Once the demand is issued, recovery agents will need to submit written authorization to continue working with the CRC. An applicable plan must submit a separate authorization for each CRC Recovery ID # to ensure recovery agents are included on correspondence post-demand.

HELIOS 14

The New Conditional Payment Portal Resolution Process

HELIOS 15

The Conditional Payment Portal Resolution Process

- **Registering and Proper Authorization**
  - A beneficiary's attorney or other representative or an applicable plan must properly register to access the web portal, and obtain proper authorization from the beneficiary and submit it to the appropriate Medicare contractor in the form of either consent to release (in order to access the beneficiary's case specific information) or proof or representation (in order to dispute claims, upload settlement information, and receive a final CP demand).
- **Provide Initial Notice of Claim**
  - A beneficiary's attorney or other representative or an applicable plan must provide initial notice of a pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlement, judgment, award, or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement, judgment, award, or other payment.
- **Medicare Posts Claims**
  - The Medicare contractor compiles and posts claims for which Medicare has paid conditionally that are related to the pending settlement, judgment, award, or other payment within 65 days of receiving the initial notice of the pending settlement, judgment, award, or other payment.

The Conditional Payment Portal Resolution Process

- **Notification to CMS Settlement is Expected**
  - Beginning any time after CMS posts its initial claims compilation, and up to 120 days before the anticipated date of a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney, or other representative or applicable plan may notify CMS, once and only once, via the web portal, that a settlement, judgment, award or other payment is expected to occur within 120 days or less from the date of notification.
- **Disputing the Claim**
  - The beneficiary, or his or her attorney, or other representative or applicable plan may address discrepancies by disputing a claim, once and only once, if he or she believes that the claim included in the most up-to-date conditional payment summary form is unrelated to the pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment.
- **Resolution of Disputes**
  - Disputes submitted through the web portal are to be resolved within 11 business days of receipt of the dispute and any required supporting documentation.

The Conditional Payment Portal Resolution Process

- **Time and Date Stamped Summary**
  - When any disputes have been fully resolved and the beneficiary, or his or her attorney, or other representative or applicable plan has executed and obtained confirmation of the completion of a final claims refresh, then the beneficiary, or his or her attorney or other representative, or applicable plan may download or otherwise request a time and date stamped conditional payment summary form through the web portal. If the download or request is within 3 days of the date of settlement, judgment, award or other payment, that conditional payment summary form will constitute Medicare's final conditional payment amount.
- **Submission of Settlement Documentation**
  - Within 30 days of securing a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney or other representative or applicable plan, must submit through the web portal settlement documentation which indicates the date of settlement, judgment, award, or other payment, including the total settlement amount, the attorney fee amount or percentage, as well as any additional costs borne by the beneficiary to obtain his or her settlement, judgment, award, or other payment.

The Conditional Payment Portal Resolution Process

- **Final Demand Void**
  - If settlement information is not provided within 90 days of securing the settlement, the final conditional payment amount obtained through the web portal is void.
- **Final Recovery Demand**
  - Once settlement, judgment, award, or other payment information is received, CMS applies a pro rata procurement reduction to the final conditional payment amount in accordance with 42 CFR Section 411.37 and issues a final MSP recovery demand letter.

The New Conditional Payment Formal Appeals Process

The Conditional Payment Formal Appeals Process

- **First Level of Appeal: Redetermination**
  - A redetermination is an examination of a claim by BCRC or CRC personnel who are different from the personnel who made the initial determination. The appellant (the applicable plan filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination. The contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request.
- **Second Level of Appeal: Reconsideration**
  - A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of the appealed issue(s). A minimum monetary threshold is not required to request a reconsideration. A written reconsideration request must be filed within 180 days of receipt of the redetermination. Any evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless good cause is shown for submitting the evidence late. QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration.

The Conditional Payment Formal Appeals Process

- **Third Level of Appeal: Administrative Law Judge Hearing**
  - If the applicable plan disagrees with the QIC decision, the applicable plan may request an ALJ hearing within 60 days of receipt of the reconsideration. ALJ hearings are generally held by video-teleconference (VTC) or by telephone. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons.
- **Fourth Level of Appeal: Appeals Council Review**
  - If an applicable plan is dissatisfied with the ALJ's decision, the applicable plan may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons.
- **Fifth Level of Appeal: Judicial Review in U.S. District Court**
  - The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. There is a certain or specific threshold sum that must be in controversy in order to file an appeal with the USDC.

HELIOS 22

Medicare Set Asides

HELIOS 23

Claimant's Agreement Not to Seek Treatment

- CMS Memorandum dated April 22, 2003:
  - Settlements cannot be approved when there is a promise not to bill Medicare for services in lieu of including those services in a MSA.
  - This applies even if the claimant offers to execute an affidavit or other legal document agreeing to this fact.
  - Irrespective of such an agreement or indication, if the medical evidence indicates a need and recommendation for such medical care, CMS will include such care in MSA.
- Example:
  - The treating physician recommends a Spinal Cord Stimulator (SCS).
  - The claimant (or counsel) affirms and stipulates in writing he/she will not seek this treatment in the future or use Medicare card to pay for such treatment.
  - Language to this effect is agreed upon and placed in the settlement documents.
  - Irrespective of such an agreement or indication, if treating physician recommends SCS, CMS will still require the Spinal Cord Stimulator in the MSA.

HELIOS 24

Annual Medical Costs vs. Future Allocation

- CMS will review the last two years of medical records, payouts and prescription invoices to determine the future Medicare covered treatment needs and costs.
- Cases with low annual medical spend for the last year or last two years could still generate a significant future allocation. Examples:
  - The claimant is at maximum medical improvement with no current ongoing treatment but requires a revision of their total knee replacement in the future.
    - Although payout shows no payments, CMS will include knee replacement.
  - Treating physician prescribed Vicodin. The employer/carrier has never been billed for or has ever paid for Vicodin.
    - CMS will likely include Vicodin in the allocation even though the carrier has not paid for this medication.
    - Medicare/Advantage Plan or Medicaid could be paying for the medication.
    - The claimant may have health insurance (through a spouse or ACA) paying for the medication.

Denied Claims and Denied Body Parts

- CMS will accept a zero allocation on totally denied claims/body parts if certain criteria are met:
  - No medical or indemnity payments made (medical-legal expenses or payments made within a statutory pay and investigate period are acceptable).
  - WCRC has advised that they will not approve a zero allocation if the settlement has been finalized and settlement funds have been dispersed (including advance payments) prior to CMS approval.
  - CMS will require the carrier/TPA/defense counsel to provide a notice of denial, controvert, or confirmation on letterhead that no medical or indemnity payments have been made for the denied conditions/claim.
  - Judicial determination after merits hearing that claim denied or specific body part denied is still best evidence.
- Despite denial, no payments, and documentary evidence, high settlement amount may undo zero allocation.

Zero Allocation – No Future Treatment

- Even though condition compensable, and benefits paid, CMS will accept zero allocation if no future medical treatment recommended related to the injury.
- Requirements:
  - Medical documentation from the treating physician (not an IME/QME) confirming to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the workers' compensation injury.
  - The settlement documents should demonstrate that the injured individual is only being compensated for past medical expenses and that no other aspects of the settlement (i.e. lost wages/disability) are being maximized to Medicare's detriment (4/22/03 Memo Q20).
- Exceptions:
  - The claimant sustained a low back injury which required surgical procedures, the most recent being a three level fusion w/instrumentation. Claimant had good result from surgery and the treating physician states no future medical care is required.
  - Medicare may not approve a zero allocation in this case due to the fact that the claimant has retained hardware from the fusion which will likely require periodic evaluation (at a minimum periodic x-rays to evaluate the fusion and hardware).

WCMSA Submission to CMS

- While there are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review, submission of a WCMSA proposal is a recommended process.
- If parties choose to submit a WCMSA for review, CMS requests that parties comply with its established policies and procedures. CMS will only review WCMSA proposals that meet the following criteria:
  - The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
  - The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00

Request for Re-Review

- Although there is no formal appeals process regarding the WCMSA determination, submitters may file re-review request on following limited items:
  - (1) CMS' determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred); or
  - (2) There exist additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal and which warrants a change in CMS' determination.
- On February 11, 2014, CMS announced (but has not yet adopted) proposed expansion of the WCMSA Re-Review process for the following reasons:
  - Submitter disagrees with how the medical records were interpreted.
  - Items or services priced in the approved set-aside amount are no longer needed or there is a change in the beneficiary's treatment plan.
  - A recommended drug should not be used because it may be harmful to the beneficiary.
  - Dispute of items priced for an unrelated body part.

Thank You!

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THURSDAY, JANUARY 21 ST

3:00 PM – 4:00 PM

Successfully navigating the OWCA 1009 process

Successfully Navigating the OWC 1009 Process

LOUISIANA WORKFORCE COMMISSION
We put people back to work.

Jan Clary, R.N. – Medical Services Director
Patrick Robinson, OWC Director

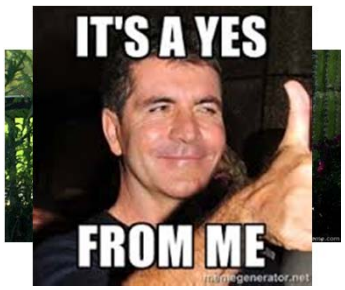
Jan wanted to be here, but…

Let's talk about…

1. How to avoid rejection of your 1009
2. Recent court decisions on MTG appeals
3. Panel discussion – How's the MTG process working (or not)?

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

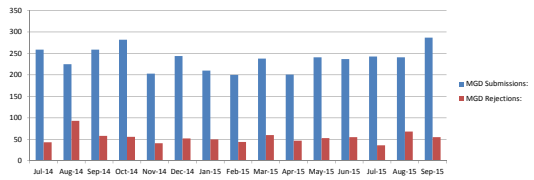
How to avoid 1009 Rejections. . .



SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

What is a 1009 Rejection?

OWCA Medical Services
3rd Quarter 2014 to 3rd Quarter 2015
Medical Guideline Dispute Rejections



OWCA – MEDICAL SERVICES
3rd Quarter 2015
Top 4 Reasons for MGD Rejections (157 Distinct Cases):

- Not filed within 15 days: 51
- No 1010 Form submitted: 38
- No required medical documentation: 33
- Medical Guidelines do not address issues of compensability: 32

NOTE: Each case may have multiple rejection reasons.

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

TOP 5 REASONS FOR REJECTIONS:

1. 1009 not filed within 15 days of 1010 denial

Per LAC 40:I:2715(B)(3)(e), "Disputes shall be filed by any aggrieved party on a LWC-WC-1009 within 15 calendar days of receipt of the denial or approval with modification of a request for authorization."

Arrant v. Wayne Acree PLS, Inc., 49,698 (La. App. 2 Cir. 4/15/15) [Attorneys – Daniel Street (C), Jeff Warrens (D); WCJ – Jones; Panel – Pitman, Caraway, Garrett]

Affirmed WCJ's decision finding (1) medical bill was paid timely, (2) authorization for a neurosurgical exam was timely, and **(3) appeal of medical director's denial of treatment filed more than fifteen days after the decision was untimely.**

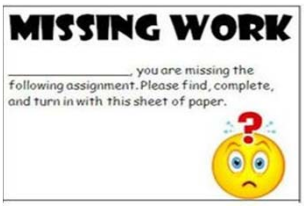
Claimant injured his back in a compensable vehicle accident. He initially consulted a PI attorney, who scheduled an appointment with an orthopedist. The PI attorney eventually referred claimant to a WC attorney, who filed disputed claims seeking penalties and attorney fees and contending that the insurer, LWCC, failed to properly pay for and/or authorize medical treatment. Following trial on the merits, the WCJ rendered a decision in favor of the employer/insurer. The court found that (1) Defendants received a disputed medical bill on October 17, 2013, and paid it November 30, 2013, within the 60–day requirement of La. R.S. 23:1201(E)(1); **(2) claimant failed to appeal the medical director's denial of treatment within fifteen days as required under LAC40:2715(K), and thus, the appeal was untimely;** and (3) LWCC approved a request for examination by a neurosurgeon within thirty days after receiving the request, i.e. within the statutory delay.

The court of appeal found no manifest error, specifically noting that the **OWC has authority to promulgate rules to implement the MTG, and that the delays provided in LAC 40:2715 "comport with the legislature's intent" to provide treatment in an "efficient and timely manner."** Further, regarding timely payment, the court stated: "*A demand by a claimant for reimbursement for out-of-pocket expenses is insufficient to trigger a reimbursement obligation. Once the LWCC received the proper form on October 17, 2013, it timely reimbursed the funds on November 30, 2013, which was within the 60–day requirement of La. R.S. 23:1201(E)(1).*"

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

TOP 5 REASONS FOR REJECTIONS:

2. Missing 1010 form



Per LAC 40:I:2715, the 1009 "shall include":

b. a copy of LWC-WC-1010 which shows the history of communications between the health care provider and the carrier/self-insured employer that finally resulted in the request being denied or approved with modification; and

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

TOP 5 REASONS FOR REJECTIONS:

3. Missing medical documentation

Per LAC 40:I:2715(J), the 1009 "shall include":

"all of the information previously submitted to the carrier/self-insured employer;"

LAC 40:I:2715(C) lists the following "minimum information" that must be submitted to the carrier/self-insured employer with a 1010 form:

1. Initial Request for Authorization. The following criteria are the minimum submission by a health care provider requesting care beyond the statutory non-emergency medical care monetary limit of $750 and will accompany the LWC-WC-1010:

a. history provided to the level of the condition and as provided in the medical treatment schedule;

b. physical findings/clinical tests;

c. documented functional improvements from prior treatment, if applicable;

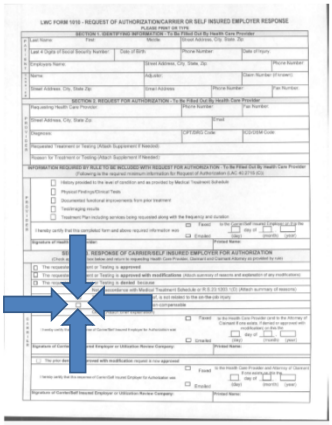
d. test/imaging results; and

e. treatment plan including services being requested along with the frequency and duration.

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

TOP 5 REASONS FOR REJECTIONS:

4. Medical Treatment Guidelines do not address compensability



SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

TOP 5 REASONS FOR REJECTIONS:

5. Medical Treatment Guidelines do not address physician referral.

SUCCESSFULLY NAVIGATING THE OWCA 1009 PROCESS

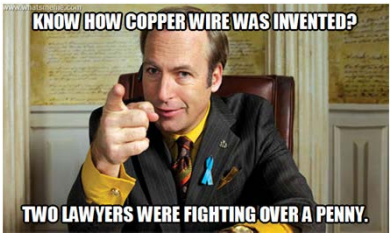
Resources:

1.) Questions about the Medical Treatment Guidelines
http://www.laworks.net/Downloads/OWC/MedicalGuidelines_MedicalTreatmentGuidelineFAQs.pdf

2.) Title 40 of the Louisiana Administrative Code
http://www.doa.la.gov/Pages/osr/lac/books.aspx
(Once you arrive on this website, scroll down to & click on Title 40. It will take a few min. to download as it is a large document. Then, you may use the search option to find Medical Treatment Guidelines, CPT Codes, Reimbursement, etc. If you do not have a search option, use "Control" & "F" for find.)

RECENT CASELAW ON MEDICAL TREATMENT GUIDELINE DISPUTES

PANEL DISCUSSION -



RECENT MTG DECISIONS

Church Mut. Ins. Co. v. Dardar, 2012-0659 (La. App. 4 Cir. 6/26/13) [Attorneys – C. Ray Murry (C), Azelie Shelby (D); WCJ – Warrens; Panel – Love, Bagneris, Landrieu]

> **Reversed** WCJ's decision and held that Medical Treatment Schedule enacted under La. R.S. 23:1203.1 does not apply retroactively to accidents occurring before the MTS effective date of July 13, 2011. In addition, the court reversed the trial court's assessment of sanctions against claimant's attorney for failure to attend a SMO and/or filing a motion for sanctions against defense counsel, stating: "*When there is the slightest justification for the assertion of a legal right, sanctions are not appropriate*." The court concluded that claimant's attorney was legitimately attempting to assert a legal right, such that 863 sanctions were inappropriate.

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Courville vs. Turner Industries, 2013 CW 0711 (La. App. 1 Cir. 7/15/13) [Attorneys – Ted Williams (C), Ryan Zumo (D); WCJ – Ourso; Panel – McDonald, Welch, Crain]

> Granted claimant's writ application and **reversed** WCJ's dismissal of claim, finding that La. R.S. 23:1203.1 and the Medical Treatment Guidelines established under it are substantive changes in the law and cannot be applied retroactively.

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Cook vs. Family Care Services, Inc., WCW 13-108 (La. App. 3 Cir. 8/28/13) [Attorneys – Dorwan Bizzier (C), Douglas Hunter (D); WCJ – Braddock; Panel – Keaty, Pickett, Conery]

> **Denied claimant's application for supervisory writs** and found that La. R. S. 23:1203.1 and the Medical Treatment Guidelines apply retroactively to claims arising prior to its effective date. Erroneously stating that "no courts have interpreted the retroactive or prospective application of La.R.S. 23:1203.1," [see *Church Mutual vs. Dardar* (4th Cir. 6/26/13) and *Courville vs. Turner Industries* (1 Cir. 7/15/13)], the court concluded that La. R.S. 23:1203.1 does not remove any substantive right to medical care and is procedural in nature. Further, the court found that the language of the statute evidenced a legislative intent to apply the law retroactively. Accordingly, the court affirmed the WCJ's decision applying the MTG to the claimant's request for treatment. (Overruled by *Romero vs. Garan's, infra*).

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Usie v. Lafayette Parish Sch. Sys., 2013-294 (La. App. 3 Cir. 10/9/13) [Attorneys: Jan Barber (C), Dawn Morris (D); WCJ – Johnson; Panel: Ezell, Painter, Genovese]

> **Affirmed** WCJ's judgment upholding the OWC Medical Director's denial of a fourth round of physical therapy as unnecessary under the Medical Treatment Guidelines, in favor of a home exercise program. The court approved the WCJ's consideration of evidence beyond the documentation submitted to the Medical Director, rejecting claimant's contention that such altered the applicable burden of proof. Note that while claimant's accident occurred prior to the effective date of the MTG, retroactivity was not raised as an issue.

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Bridges v. New Orleans Trucking & Rental Depot, Inc., 2013-0769 (La. App. 1 Cir. 12/27/13) [Attorneys – Joseph Albe (C), Richard Voelker (D); WCJ – Thompson; Panel – Crain, Whipple, Welch]

> **Affirmed** WCJ's decision reversing the Medical Director's denial of a lumbar MRI requested by claimant's treating orthopedist. Initially, the court of appeal noted that treatment recommended by a treating physician pursuant to an initial evaluation under R.S. 23:1121 is not exempt from the MTG process. Nevertheless, the court affirmed the trial court's decision, stating: "*The given rationale for the Medical Director's decision was that only one clinical record from the physician requesting the MRJ was provided, and that record did "not include a thorough neuromuscular history and physical exam to warrant testing approval." However, the appellate record reflects that the Medical Director was presented with records of treatment prior to Bridges' examination by Dr. Johnston, the requesting physician. When viewed* in globo, *the treatment records reflect that Bridges was referred to Dr. Johnston after more than six months of treatment had not resolved his back symptoms. Radiographic imaging was requested early in the course of Bridges' treatment, therefore the Medical Treatment Guidelines support follow-up imaging study. Additionally, the Medical Treatment Guidelines do not expressly require a neuromuscular history and physical exam by the requesting physician. Thus, the medical records show by clear and convincing evidence that the decision of the Medical Director was not in accordance with the applicable provisions. The Medical Director's decision was correctly reversed."*

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Romero v. Garan's, Inc., 2013-482 (La. App. 3 Cir. 12/26/13) [Attorneys – Michael Miller (C), Douglas Hunter (D); WCJ – Johnson; Panel – Peters, Thibodeaux, Cooks, Saunders, Amy, Pickett, Ezell, Painter, Genovese, Gremillion, Keaty, Conery]

> **Reversed** the WCJ and specifically overruled the court's prior opinion in *Cook v. Family Care Services, Inc.,* 13–108 (La.App. 3 Cir. 8/28/13), 121 So.3d 1274, *supra*, concluding La.R.S. 23:1203.1 and the Medical Treatment Guidelines are substantive changes in the law and can have prospective application only.

Church Mut. Ins. Co. v. Dardar, 2013-2351 (La. 5/7/14)

Reversed appellate court decision, holding that La. R.S. 23:1203.1 and the Medical Treatment Schedule are procedural laws that apply to treatment recommendations for injuries occurring prior to the effective date of the MTS.

For the reasons assigned, we conclude that application of La. R.S. 23:1203.1 in the instant case does not constitute a retroactive application. The statute does not go back to the past to either evaluate the conditions of the legality of an act, or to modify or suppress the effects of a right already acquired, or vested. Effectively, La. R.S. 23:1203.1 is a procedural vehicle that concerns the procedure for enforcing a substantive right. As such, it does not impinge on or lessen the substantive right to necessary medical treatment conferred by La. R.S. 23:1203. Rather, it applies prospectively to all requests for medical treatment and/or disputes arising out of requests for medical treatment arising after the effective date of La. R.S. 23:1203.1 and the medical treatment schedule, regardless of the date of accident. Since Ms. Dardar's request for injections was submitted after the effective date of La. R.S. 23:1203.1 and the medical treatment schedule, Trinity and Church Mutual's exception of prematurity should have been sustained. The contrary conclusion of the court of appeal is reversed, and the judgment of the OWC, maintaining the exception of prematurity and ordering Ms. Dardar to "re-submit the request for injections to the payor on Form 1010 and to the Medical Director on Form 1009 within thirty days" of the finality of this decision, is reinstated. The matter is remanded to the OWC for further proceedings. [See also ***Cook v. Family Care Servs., Inc.,*** 2013-2326 (La. 5/7/14), a companion case to *Dardar*, *supra*, where the court **affirmed** the appellate court's decision applying La. R.S. 23:1203.1 and the MTS to claims arising from accidents that occurred prior to the effective date of the MTS.]

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Daniels v. State, Dep't of Transp. & Dev., 48,578 (La. App. 2 Cir. 6/25/14) [Attorneys – Daniel Street (C), David Gilmer (D); WCJ – Jones; Panel – Brown, Pitman, Garrett]

Reversed WCJ's judgment finding that proposed surgery was reasonable and necessary. Initially, noting the Louisiana Supreme Court's decision in *Church Mutual v. Dardar*, the

court acknowledged that the MTG adopted under 1203.1 governed the issue and remanded the case accordingly. Albeit apparently in dicta, the court also referenced decisions from other circuits in which the parties were allowed to present and the WCJ was allowed to consider evidence beyond the record submitted to the Medical Director. The court concluded that on remand, "*either party may present evidence before the WCJ to show, by clear and convincing evidence, whether the medical director's conclusion was appropriate. La. R.S. 23:1203.1(K).*"

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Gilliam v. Brooks Heating & Air Conditioning, 49,161 (La. App. 2 Cir. 7/16/14) [Attorneys – Robert L. Beck, III (C), Walter S. Salley (D); WCJ – Robinson; Panel – Caraway, Lolley (Brown dissenting)]

Affirmed WCJ's judgment upholding the Medical Director's denial of back surgery.

Claimant injured his back in a compensable fall. His treating neurosurgeon (Ramos) repeatedly recommended a four level laminectomy and microdiscectomy. Each time, the surgery was denied by UR and the Medical Director, who found it was not in accord with the MTG. Claimant ultimately appealed the denial via a 1008. At trial, the parties offered various records not submitted to the Medical Director, including a deposition of the claimant's treating neuro and the SMO report of defendant's neuro. The WCJ concluded that while the surgery may have been appropriate before the MTG, claimant had failed to prove by clear and convincing evidence that the Medical Director's decision was wrong.

On appeal, despite the absence of a contemporaneous objection at trial, claimant argued that the WCJ erred by considering the defendant's SMO. The Second Circuit rejected that contention, holding that on an appeal of the Medical Director's decision, the parties may offer and the WCJ may consider evidence not submitted to the Medical Director. Based on the evidence and with one dissent, the court then affirmed the trial court's decision that claimant failed to meet the clear and convincing burden imposed by La. R.S. 23:1203.1.

***

Moran v. Cajun Well Servs., Inc., 2013-821 (La. App. 3 Cir. 2/12/14) [Attorneys – Thomas DeJean (C), Skylar Comeaux (D); WCJ – Morrow; Panel – Painter, Cooks, Gremillion]

Affirmed WCJ's reversal of Medical Director's denial of lumbar epidural steroid injections, and awarded $2500 attorney fee.

Claimant's accident and injury were not disputed. He underwent an LESI that provided only temporary relief. A second LESI was denied several months later. The treatment was submitted to the Medical Director who concluded that additional injections were not indicated per the MTG because the records failed to demonstrate improvement after the first injection. The WCJ found that the records showed three weeks of improvement. Thus, the Director's denial of treatment was "clearly wrong." The court of appeal agreed that because the WCJ's decision did not involve a finding of fact, the decision was subject to a de novo review. However, the court found that the WCJ was correct in reversing the denial of treatment. Likewise the court agreed that the WCJ was not clearly wrong in denying claimant's demand for penalties and attorney fees. *Nevertheless, the court awarded claimant $2,500 in attorney fees for work on appeal*.

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Matthews vs. Louisiana Home Builders SIF, WCA 13-1260 (La. App. 3 Cir. 3/12/14) [Attorneys – Mark Riley (C), Stephen Broyles (D); WCJ – Johnson; Panel – Keaty, Painter, Conery]

Affirmed WCJ's judgment denying claimant's appeal of Medical Director's decision.

Claimant's treating physician, Dr. Heard, recommended a cervical MRI and neurodiagnostic studies. The treatment was denied by the Medical Director. Dr. Heard submitted two more requests for the treatment, both of which were again denied. The Medical Director noted: "Appeal of a Form 1009 decision is through the 1008 process, not repetitive filing of Form 1010 and 1009. See prior MGD for further review."

The WCJ denied claimant's appeal of the decision. The appellate court affirmed, stating: "*Rather than supplementing his initial Form 1009 to comply with the explicit provisions of the Guidelines regarding what testing had to be done and what documentation had to be submitted to garner approval of the requested medical treatment, Dr. Heard filed duplicative Form 1009s without heeding the Medical Director"s advice to first document the results of the conservative treatment that he had initially recommended to Matthews. While we realize that the Guidelines provide*

that MRIs are useful tools in the diagnosis of injuries to the cervical spine and shoulder, La.R.S. 23:1203.1(I) provides that medical care and treatment must be 'in accordance with the medical treatment schedule.' Because none of the Form 1009s submitted by Dr. Heard complied with the dictates prescribed by the Guidelines, Matthews did not meet her burden of proof under La. R.S. 23:1203.1(K)."

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Vital v. Landmark of Lake Charles, 2014-96 (La. App. 3 Cir. 6/4/14) [Attorneys – Tina Wilson (C), Lawrence Frieman (D); WCJ – Bushnell; Panel – Genovese, Saunders (Conery dissents)]

Affirmed WCJ's decision overturning Medical Director's denial of surgery.

MRI indicated a possible labrum tear. Claimant's pain was not resolved by therapy and injection. Treating ortho diagnosed a partial rotator cuff tear and recommended surgery. Defendants' SMO disagreed, recommended psychiatric evaluation, and released claimant to light duty.

The Medical Director concluded that surgery was not necessary under the MTG. He reached the same decision after a second request, and the decision was upheld by the WCJ. A third request was also denied by the Medical Director, who concluded that the medical records had not changed from the prior two denials.

The WCJ concluded that the third denial was clearly contrary to the MTG, noting the failure of conservative treatment and stating: "*Conservative treatment has failed. The treating physician, Dr. Brent Cascio[,] opined that arthroscopic lysis of adhesion is warranted for Darlene Vital to regain functionality, due to failure of all conservative therapy; therefore[,] he has identified functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or working activities*." The court of appeal found that the WCJ applied the correct standard of review and that the record provided a reasonable basis for her decision.

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Spikes v. Louisiana Commerce & Trade Ass'n, 2013-919 (La. App. 3 Cir. 7/2/14) [Attorneys – Maria Anna Losavio ©, Stephen Broyles (D); WCJ – Bushnell; Panel – Pickett, Genovese, Keaty]

Affirmed WCJ's judgment denying medical treatment, penalties, and attorney fees.

Claimant injured her back in a compensable accident, ultimately undergoing lumbar surgery. Her treating orthopedist referred her to a psychologist, who recommended biofeedback, group psychotherapy, psychological testing, and individual psychotherapy to address claimant's pain syndrome; and to a pain management physician. The defendant denied the treatment recommended by the psychologist. That decision was upheld by the OWC Medical Services Division, although the case was not reviewed by the Medical Director or the Associate Medical Director. Defendant initially denied the request for pain management treatment pending a 1010/1009 review, but ultimately approved it after the OWC clarified that the MTG did not apply to such requests.

The court of appeal affirmed the WCJ's denial of the requested treatment, as well as penalties and attorney fees, as follows: (1) The court rejected claimant's contention that the MTG were inapplicable based on the date of her accident, per the decision in *Church Mutual vs. Dardar*; (2) The clear and convincing standard of review for 1009 decisions as set forth in La. R.S. 23:1203.1 did not apply because the treatment recommendation was not reviewed by the Medical Director or the Associate Medical Director; (3) WCJ did not err in admitting evidence not submitted to the Medical Director, in light of "uncertainty" concerning the applicability of the MTG; (4) WCJ was not clearly wrong in denying the treatment recommended by claimant's psychologist based on evidence indicating that it was not necessary; (5) WCJ was not clearly wrong in denying penalties and attorney fees based on defendant's initial denial of a pain management evaluation, in light of uncertainly concerning the need for a 1010 and because the defendant approved the evaluation once the OWC issued a bulletin clarifying the issue. (6) WCJ did not err in denying claimant's request for court costs, since the WCJ denied most of the relief requested by claimant.

***

Davis vs. Boise Cascade Company, WCA 14-156 (La. App. 3 Cir. 10/1/14) [Attorneys – Maria Losavio ©, Charles Farr (D), WCJ – Braddock; Panel – Genovese, Pickett, Keaty]

Affirmed WCJ's judgment assessing $2,000 penalties each based on defendant's denial of a discogram and lumbar surgery were proper, where defendant proceeded with a 1009 appeal despite UR approval of the treatment

Barker vs. Lemic Insurance, WC 14-301 (La. App. 3 Cir. 10/8/14) [Attorneys – Chris Roy ©, David Butler (D); WCJ – Braddock; Panel – Saunders, Ezell, Painter]

Affirmed WCJ's denial of medical treatment.

Claimant was injured in 2005 when he was knocked off of a scissor lift at work. He began psychotherapy shortly thereafter. In 2012, the employer/insurer denied further psychotherapy and medication, prompting a series of Disputed Claims for Medical Treatment. In each instance, the OWC Medical Director denied the treatment and the WCJ affirmed that decision.

On appeal, the Third Circuit cited the Supreme Court's decision in *Church Mutual vs. Dardar* to hold that the proposed treatment was subject to the MTG. In addition, noting that the prior treatment had not facilitated claimant's return to work, the court affirmed the trial court's conclusion that the Medical Director was not clearly wrong in concluding that the treatment was contrary to the MTG.

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Mouton vs. Lafayette Parish Sheriff, WC 13-1411 (La. App. 3 Cir. 10/15/14) [Attorneys – Mark Riley (C), James Hollier (D); WCJ – Johnson; Panel – Pickett, Gremillion, Keaty]

Affirmed WCJ's decision upholding Medical Director's denial of treatment.

Claimant was injured in 2001, but had continued working as a private investigator. For several years he had received weekly physical therapy/massage therapy treatments. In 2012, the employer denied further therapy, prompting a disputed claim for medical treatment. The Medical Director concluded that the treatment was not in accordance with the MTG. Claimant acknowledged that the MTG did not generally contemplate the treatment so long after his injury, but argued that a variance was appropriate because the treatment allowed him to maintain his level of function. The WCJ affirmed the denial.

On appeal, the court initially noted that the WCJ's decision was necessarily fact intensive and therefore subject to a manifest error standard of review. Applying that standard, the court concluded that the WCJ was not clearly wrong in affirming the denial of treatment.

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Aisola v. Beacon Hosp. Mgmt., Inc., 2013-1101 (La. App. 4 Cir. 4/2/14) [Attorneys – Robert W. Booksh ©, Jeffrey Warrens (D); WCJ – Warrens; Panel – Jenkins, Tobias, Lombard]

Modified and affirmed WCJ's decision overturning defendant's denial of medical treatment.

Claimant was injured shortly after the MTS became effective. MRI showed a herniated lumbar disc. Claimant's treating physician recommended a lumbar MRI, which was denied based on utilization review. Claimant did not seek review by the Medical Director. A second request for the ESI was also denied, again with no review. A subsequent SMO did not specifically comment on the proposed injection but found that claimant was not a surgical candidate. However, an IME recommended the ESI and an FCE before evaluating claimant's work capacity. A second MRI confirmed the disc herniation, and claimant's doctor recommended the ESI again. Claimant was allowed to see her choice of neurosurgeon for a single visit. He recommended ESI's and facet blocks with fluoroscopic guidance. Defendant's UR physician found that the MRI did not show any progression of the HNP, and denied the requests. After the neurosurgeon appealed the denial, the Medical Director concluded that based on the submitted records, the recommended treatment was not in accordance with the MTS. Claimant appealed the denial, also requesting reinstatement of her TTD and continued treatment with her neurosurgeon. Following trial, the WCJ reversed the Medical Director's denial of the neurosurgeon's treatment recommendations, ordered claimant to attend an FCE, and ordered defendant to reinstate vocational rehabilitation upon completion of the FCE.

On appeal, the Fourth Circuit held (1) defendant waived any objection to evidence beyond the information submitted to the Medical Director (IME report) by failing to object at trial; (2) WCJ's erred in concluding that the IME was "per se" proof that the proposed treatment was reasonable and necessary; however, the error was harmless in light of other evidence submitted; (3) the WCJ's decision was reviewed under manifest error standard, where the proceedings consisted of a full trial on the merits, involved hundreds of pages of exhibits and two days of testimony, and post-trial briefs. The court found that the WCJ was not clearly wrong in finding that the proposed treatment was reasonable and necessary under the MTS, and that the Medical Director's decision to the contrary was clearly wrong. Regarding claimant's answer to the appeal, the court also held (4) Claimant was entitled to $5,000 attorney fee for work on appeal; (5) WCJ's denial of request for pain management or psychiatric treatment as premature was not error, where claimant did not file a motion for such treatment and it was not before the court; and (6) Claimant was entitled to an additional $2,000 penalty based on defendant's denial of her choice of neurosurgeon, pursuant to La. R.S. 23:1201(F); (7) WCJ was not authorized to order an FCE where the issue was not before the court. The court also remanded the matter to the WCJ to assess an additional attorney fee for denial of treatment with the neurosurgeon.

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Soniat vs. Crown Buick, 14-CA-489 (La. App. 5 Cir. 12/16/14) [Attorneys – Anthony Millazo (C), Wade Langlois (D); WCJ – Dunn; Panel – Johnson, Chehardy, Windhorst]

Affirmed WCJ's award of $6,000 penalties and $8,000 attorney fees for failure to reasonably controvert ESI's, and awarded an additional $2,500 fee for work on appeal, despite employer's compliance with MTG process.

Claimant suffered a compensable back injury. His doctor recommended ESI's, which defendant initially denied, prompting a 1008. However, the injections were ultimately approved based on an IME and the matter proceeded to trial limited to the issue of penalties and attorney fees. The evidence reflected that two orthopedists and a pain management physician had recommended ESI's. An SMO disagreed, and the defendant denied them based on insufficient showing of radiculopathy. The issue was submitted to the OWC Medical Director who deemed the injections unnecessary in the absence of sufficient documentation. Claimant filed his 1008 two days later. After an IME agreed with the treating doctors, the employer approved the injections.

Regarding the claim for penalties/fees, defendant argued that it had complied with all procedures under the MTG. The appellate court disagreed, stating: "***The mere fact the Medical Director subsequently agreed with Crown Buick's decision to deny the injections neither exonerates Crown Buick for its improper actions nor protects it from the assessment of penalties and attorney fees under La. R.S. 23:1201(F).*** *The proper inquiry in determining whether to impose penalties and attorney fees on an employer is whether the employer had an articulate and objective reason to deny benefits at the time it took action; in other words, whether the employer reasonably controverted the requested medical treatment at the time of its initial refusal."*

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Wilson v. Broadmoor*, LLC,* 14-694 (La. App. 5 Cir. 3/11/15) [Attorneys – Greg Unger (C), Frank Towers (D); WCJ – Dunn; Panel – Chehardy, Murphy, Liljeberg]

Affirmed WCJ's decision reversing the OWC Medical Director's denial of treatment, excluding UR report from non-Louisiana licensed physician, and awarding penalties and attorney fees.

Claimant injured his back in a compensable fall. His treating physician recommended a lumbar laminectomy which the payer denied based on a utilization review by an out-of-state physician. The Medical Director agreed, concluding that the treatment was not within the MTG, and the claimant filed a 1008 appealing the decision. Following an expedited hearing, the WCJ concluded that the UR report was not competent evidence since the reviewing physician was not licensed in Louisiana. Reviewing the balance of the evidence, the court found that the Medical Director was

clearly wrong in finding that the proposed surgery was contrary to the MTG. The court of appeal affirmed, finding no legal or factual error.

***

Arrant v. Wayne Acree PLS, Inc., 49,698 (La. App. 2 Cir. 4/15/15) [Attorneys – Daniel Street (C), Jeff Warrens (D); WCJ – Jones; Panel – Pitman, Caraway, Garrett]

Affirmed WCJ's decision finding (1) medical bill was paid timely, (2) authorization for a neurosurgical exam was timely, and (3) appeal of medical director's denial of treatment filed more than fifteen days after the decision was untimely.

Claimant injured his back in a compensable vehicle accident. He initially consulted a PI attorney, who scheduled an appointment with an orthopedist. The PI attorney eventually referred claimant to a WC attorney, who filed disputed claims seeking penalties and attorney fees and contending that the insurer, LWCC, failed to properly pay for and/or authorize medical treatment. Following trial on the merits, the WCJ rendered a decision in favor of the employer/insurer. The court found that (1) Defendants received a disputed medical bill on October 17, 2013, and paid it November 30, 2013, within the 60–day requirement of La. R.S. 23:1201(E)(1); (2) claimant failed to appeal the medical director's denial of treatment within fifteen days as required under LAC40:2715(K), and thus, the appeal was untimely; and (3) LWCC approved a request for examination by a neurosurgeon within thirty days after receiving the request, i.e. within the statutory delay.

The court of appeal found no manifest error, specifically noting that the OWC has authority to promulgate rules to implement the MTG, and that the delays provided in LAC 40:2715 "comport with the legislature's intent" to provide treatment in an "efficient and timely manner." Further, regarding timely payment, the court stated: "*A demand by a claimant for reimbursement for out-of-pocket expenses is insufficient to trigger a reimbursement obligation. Once the LWCC received the proper form on October 17, 2013, it timely reimbursed the funds on November 30, 2013, which was within the 60–day requirement of La. R.S. 23:1201(E)(1).*"

Gales v. Whole Food Co., 2013-1492 (La. App. 4 Cir. 4/22/15), 165 So. 3d 1052 [

Reversed WCJ's grant of prematurity exception, finding that nutrients provided to claimant were not subject to the treatment guideline process.

Claimant was shot and paralyzed in 2001, in the course and scope of his employment for defendant. For many years thereafter, defendant had provided him with a nutrient called *Isosource 1.5 calorie with Benefiber*. Delivery of the product was stopped in 2013, in favor of a substitute product. Claimant asserted the substitute was unsuitable. In response to a disputed claim, defendant filed an exception of prematurity contending that claimant failed to exhaust the administrative process under R.S. 23:1203.1. The WCJ granted the exception.

The appellate court reversed. Recognizing the Louisiana Supreme Court's decision in *Church Mutual vs. Dardar*, the court concluded that the guideline process did not apply because there was no new request for the product, merely a decision by the defendant to use a substitute in place of the nutrient they had been providing for years.

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Thomas v. Marsala Beverage Co., 50,062 (La. App. 2 Cir. 9/30/15) [Attorneys – Allan Placke (C), Donald Anzelmo (D); WCJ – Jones; Panel – Garrett, Caraway, Drew]

Affirmed WCJ's decision reversing the associate medical director's denial of an epidural steroid injection.

Claimant suffered a low back and neck injuries due to an undisputed work accident. His pain management physician recommended a lumbar epidural steroid injection. Defendant denied the treatment based on an SMO. The OWC associate medical director concluded that in the absence of documentation that the procedure was being done to facilitate active therapy, the treatment was contrary to the medical treatment guidelines.

Claimant appealed to the WCJ. In addition to previously submitted records, he offered the deposition of the treating pain management physician. The WCJ reversed the denial of treatment. The court of appeal affirmed, noting that the post-1009 deposition of the pain management doctor "provided a straightforward, commonsense, and cogent explanation for why the ESI treatment recommended by Dr. Forte was medically necessary."

The court also stated: "***We cannot help but note that, in this particular case, more than 18 months have now lapsed from the time the treatment was requested and the rendition of this opinion. Whether this is efficient and timely is certainly debatable***."

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Prince v. Superior Energy Servs., L.L.C., 2015-728 (La. App. 3 Cir. 12/16/15) [Attorneys - Bret C. Beyer, Sr. (C), Michael E. Parker (D); WCJ – Johnson; Panel – Genovese, Thibodeaux, Savoie]

Reversed WCJ's denial of benefits, finding legal error in the trial court's reliance on SMO and IME opinions, noting that previously provided treatment relied on by those physicians was contrary to the treatment guidelines.

Employee suffered a low back injury when he jarred his feet and back at work. He was initially seen by the defendant's orthopedist who ordered an MRI two days post-accident. That doctor diagnosed a lumbar strain and prescribed conservative care. Claimant subsequently selected his own orthopedist. That doctor recommended another MRI several months later. Defendant denied the request and recommended an IME. The IME concluded that claimant suffered a strain due to the work accident, which should have resolved. He did not attribute any ongoing symptoms to the accident. Accordingly, defendant terminated further benefits. A second MRI was performed despite the denial of benefits, and claimant continued seeing his orthopedist who recommended a discogram.

Following trial on the merits, the WCJ ordered defendant to pay for the second MRI but otherwise denied benefits based on the SMO and IME opinions. The appellate court reversed. The court concluded that the WCJ committed legal error in crediting the SMO and IME opinions, noting that initial treatment and particularly the initial MRI ordered by the SMO, were contrary to the medical treatment guidelines. Conducting a *de novo* review, the court concluded that the treating physicians recommendations were in accordance with the medical treatment guidelines and therefore entitled to greater weight. It ordered defendant to reinstate indemnity benefits and provide the medical treatment recommended by the treating physician. In addition, the court assessed a $2,000 penalty for defendant's denial of the second MRI, a $2,000 penalty for denial of a psych evaluation pending a discogram, and a $2,000 penalty for termination of TTD benefits, plus attorney fees of $6,000 through appeal.

THURSDAY, JANUARY 21 ST

4:00 PM – 5:00 PM

Issues concerning medical fee schedules in workers' compensation

Issues Concerning Medical Fee Schedules in Workers' Compensation

Trends and Considerations

Francine Johnson
VP, Regulatory Consulting and Analysis

1

Did you ever think you would be considered a workers' compensation fee schedule expert?

2

What We Will Cover

- Current trends in state fee schedules
- Explore differences in methodology and rules
- Considerations, pros/cons of reimbursement methodologies
- Important tips and considerations for evaluating and developing a fee schedule
- Where Louisiana fits in development of fee schedules

3

1938
First Medical and Surgical Fee Schedule

Florida - Medical treatment was furnished at a cost not to exceed $250.00, unless there was surgery and then the maximum expense would be $500.00.

4

Fee Schedules – Why?

- Defines coding, rules and pricing for medical services
- Provides an understanding to the provider and payor of requirements and expectations
- Defines the utilization of services
- Typically provides less disputes and potentially an informal process for resolution of disputes

5

Ultimately

- Controlling costs
- Affecting behavior
  - by the provider and by the payor
- All of which can affect care and outcomes to the injured worker

6

Trends in Fee Schedules

1 Medicare-Based Fee Schedule

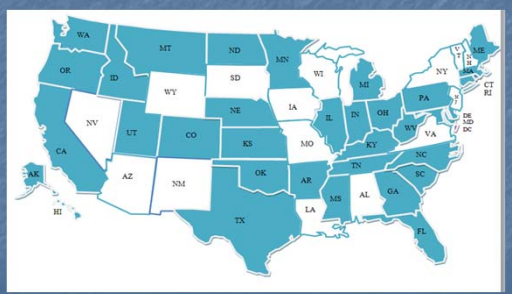
7

Medicare Based

- RBRVS — Resource-Based Relative Value Scaleused for professional services
- CMS – Centers for Medicare and Medicaid Services
- DRG – Diagnostic Related Groups – used for pricing Inpatient Bills

8

RBRVS-Based



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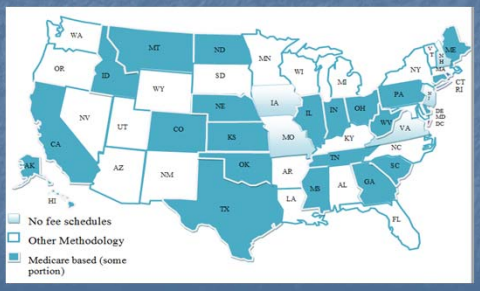
Medicare-Based Facility



Solid blue - At least some portion of facility fee schedule is based on Medicare

10

Other Methodologies

- Proprietary
  - Use of state-based programs – Medicaid
  - Use of state-based data for evaluation and calculation of final allowances
- Percentile of benchmark data
- Cost to charge ratios, % of charge

11

Type of Schedules – Inpatient

# of Jurisdictions	Type of Schedule
1	Per diems
6	Per diems – separate pay implants
9	CMS
10	CMS- Implants separate pay
5	Cost to Charge
1	Cost to Charge – Implants pay separate
5	% of billed charge
1	% of billed charge- Implants pay separately
5	Other
8	No Fee Schedule

12

Pros & Cons - Medicare

Pros
- Public domain information
- Market basket updates = good baseline for medical prices
- Established updates

Cons
- Some rules are not compatible with WC needs
- Pricing may not be adequate to cover more complex needs of WC
- Negative perception from the medical community/associations
- Lack of training in the marketplace
- Complex calculations require experts within the jurisdiction for disputes

Unknowns
- Shift from fee-for-service to value-based-payments

13

Pros and Cons - Other Methodologies

- Charge-based – cost-to-charge ratios, percent of charge
  - Pro: easy to administer
  - Con: not a cost containment methodology
- Proprietary
  - Pros: perception of jurisdictionally-specific metrics, potential for more buy-in from stakeholders
  - Con: may be expensive to administer and maintain updates

14

Considerations for Change

- High medical costs, driven by overutilization (too low fees or too high?)
- Poor Return-to-Work outcomes
- Increasing number of medical disputes or cost of medical disputes due to processes
- Regulatory considerations –
- Poor Access to Care

15

Louisiana Statistics

- From 2007 to 2011, hospital outpatient charges increased at an annual rate of 9.4%, before stabilizing somewhat in 2012. Nonhospital outpatient charges increased at 5.8% per year*
- While costs for many non-hospital services, such as emergency treatment, E&M visits, and physical medicine have remained steady, fees for pain management injections (subject to BR billing) increased by almost 60% from 2002 to 2013*

* COMPSCOPE™ MEDICAL BENCHMARKS FOR LOUISIANA, 16TH EDITION

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Louisiana Statistics cont'd

- Louisiana's medical costs/claim are 32% higher than a 17-state median
- Louisiana's inpatient fees are 40% below the median, while outpatient fees are 60% above the median
- "BR" Codes for many pain management procedures have resulted in uncontrolled pricing, skyrocketing when compared to other professional services
- From 2006 to 2012, outpatient surgical costs grew by over 60%*

* COMPSCOPE™ MEDICAL BENCHMARKS FOR LOUISIANA, 16TH EDITION

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Louisiana Hospital Payments Reflect Reimbursement Regulation

- Hospital outpatient reimbursement: conflicting provisions
  - Fee schedule sets reimbursement at 90 percent of billed charges
  - Workers' compensation statute calls for reimbursement based on the mean of usual and customary charges
  - Conflicting provisions have produced substantial litigation and, in some cases, payors may have paid the higher of the amounts to avoid potential costly penalties for underpayment
- Hospital inpatient reimbursement is based on a per diem amount, which is SMSA and medical/surgical specific
- Ongoing policy debate focused on revisions to the hospital and nonhospital reimbursement approach

41
WCRI

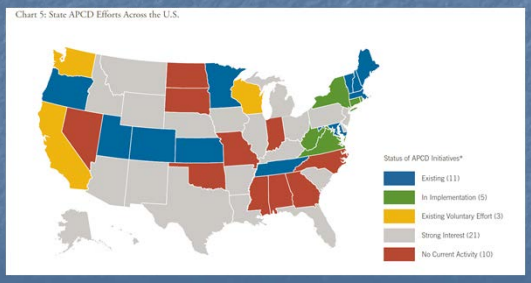
18

Transparency

- There is a significant move across the US to provide for more transparency in Healthcare costs to consumers
- This is at a state level as well as within large commercial payers such as Aetna
- Websites for consumers to allow for broader understanding of their plans (think high deductibles)
- Transparency allows better communication and clear expectations
- Would transparency in pricing in LA make a difference in outcomes, disputes and costs to the overall system?

19

All Payors Claim Database



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Data Comparison Study for Louisiana

21

Data Used in Study

- Data used is a subset of Coventry bill review data
- Dates of service July 1, 2013 – September 30, 2014
- All dates of injury
- Workers' compensation claims only
- Total bills, lines, charges, fee schedule allowances
- No duplicate bills included
- Last version of bill includes all adjustments
- 760,044 bills
- $756,835,410 charges
- $366,921,418 allowance

Codes that drive 80% of charges= cost drivers

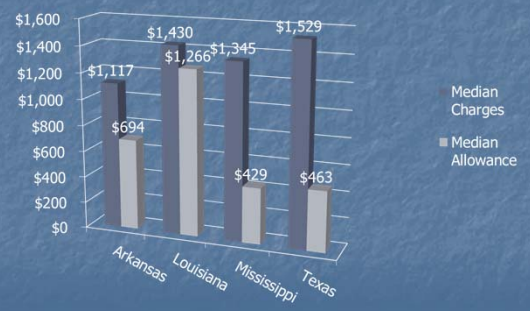
Note: 20% of remaining charges can have large impact

22

% of Total Bills, Charges/Allowance

% of bills / % $'s	Louisiana	Arkansas	Mississippi	Texas
Professional Bills	92.1%	86.9%	87.2%	94.2%
Professional Charge	49.0%	43.1%	44.3%	52.2%
Professional Allow	48.0%↓	41.6%↓	60.7%↑	64.1%*↑
Outpatient Bills	**7.6%**	12.7%	12.5%	5.5%
Outpatient Charge	**35.6%**	37.5%	42.2%	27.0%
Outpatient Allow	**45.6%*↑**	40.3%↑	26.5%↓	17.5%*↓
Inpatient Bills	**0.3%**	0.4%	0.3%	0.3%
Inpatient Charges	**15.4%**	19.4%	13.5%	20.8%
Inpatient Allow	**6.4%*↓**	18.1%↓	12.8%↓	18.4%↓

Hospital Outpatient Median Comparisons



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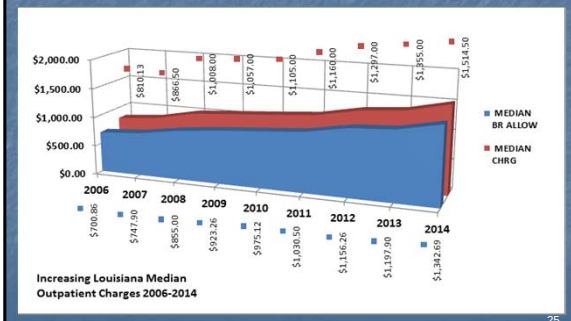
Median Charges Year Over Year Outpatient Hospital



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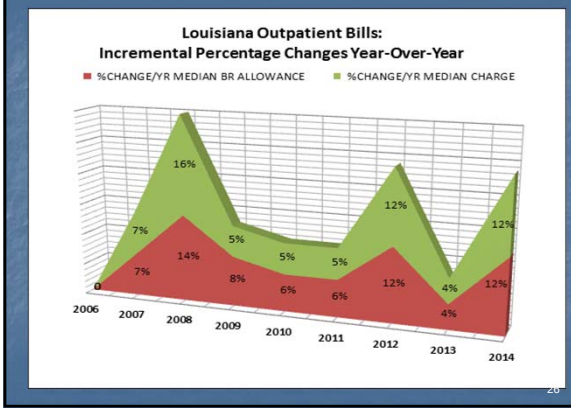
Louisiana Outpatient Bills: Incremental Percentage Changes Year-Over-Year



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Categories Driving Cost by Top Ten Codes

Category	Top 10 code #lines	Top Code charges	Top Code Allowance
Physical Therapy (97110,97140, 97140,97010)	60,712	$4,064,569	$3,512,202
E & M (99213, 99214, 99203, 99204)	26,545	$3,841,443	$2,464,449
Misc. Supplies. (99070)	4,858	$1,634,582	$1,373,156
Lab (80101)	2168	$1,201,670	$1,179,065

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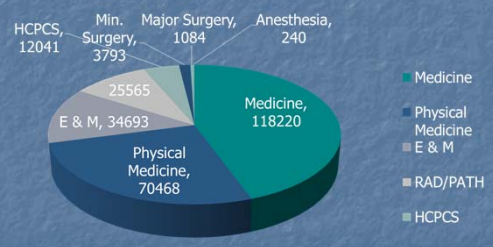
Drivers by Utilization



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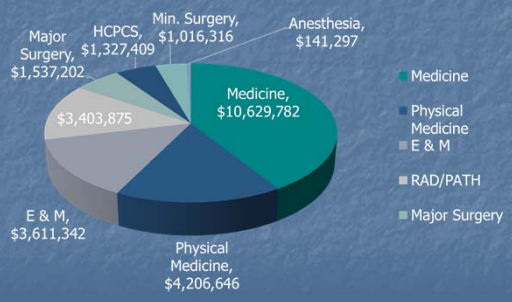
Drivers by Allowance



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Avoid a Tug of War

30

Medicare Application

- Current % of Medicare ranges from 110% to well over 200%+ in some states
- For RBRVS, % can vary widely within a professional fee schedule by the conversion factors applied
- Texas uses Medicare RVUs with a conversion factor that is roughly **157%** for most professional services (56.20), and **197%** for surgeries performed in facility settings (70.54)
- Arkansas uses **117%** (41.76) for anesthesia, **195%** (70.00) for surgery, and **124%** (44.28) for general medicine including E & M

31

Variables to Consider When Adopting Medicare or Any Methodology

- What do you want to incentivize
  - Primary care
  - Conservative care
- What do you want to avoid
- Unknown values
- Inability to price services
- Over utilization due to the wrong values either high or low

What works for the needs of the injured worker?

32

Suggestions

- Use data to identify drivers of medical cost – utilization of care
- Build an infrastructure that mirrors standards that general healthcare uses – don't reinvent the wheel
- Introduce evidence-based medicine
- Obtain medical expertise
- Measure outcomes
- Include all stakeholders in the discussion

33

SUGGESTIONS

- Know what your end goal is
- Keep as straightforward and simple as possible.
- Do not leave rules or guidelines open ended
- Develop with updates in mind – Medicine and procedures are continually changing

Keep the end in mind – Positive outcomes for injured workers'

34

Questions?

35

FRIDAY, JANUARY 22 ND

8:00 AM – 9:00 AM

A panel discussion on vocational rehabilitation and solutions to Louisiana's disability problem

HOW CAN WE HELP INJURED WORKERS' RETURN TO WORK?

A Panel Discussion on Improving Vocational Rehabilitation and Other Options

Larry S. Stokes, Ph. D.

Hon. Diane R. Lundeen

Gregory J. Hubachek, Esq.

Michael E. Parker, Esq.

Patrick F. Robinson

Carmouche v. Kraft Foods, Inc., 2010-401 (La. App. 3 Cir. 4/13/11) 62 So. 3d 889, writ denied, 2011-0930 (La. 6/17/11) 63 So. 3d 1044 [Attorneys – Robert Schoenfeld (C), Kevin

Affirmed WCJ decision that vocational rehabilitation consultant's inability to identify employment was not a sufficient basis to justify employer's selection of a new consultant, absent good cause for a change similar to that required to change treating physicians.

***

Olivier v. City of Eunice, 2010-1433 (La. App. 3 Cir. 6/8/11) 66 So.3d 1244 [Attorneys – Kevin Camel (C), Randall Keiser (D); WCJ – Ourso]

Reversed WCJ's judgment reducing claimant's indemnity benefits from TTD to SEB, finding improper vocational rehabilitation.

Claimant suffered two herniated lumbar discs but could not have surgery due to a heart condition. TTD had been reduced to SEB based on several light duty jobs approved by his neurosurgeon, despite the fact that some of the positions were not available and the jobs were not submitted to claimant's pain management doctor or cardiologist. Claimant applied for all of the jobs and was told by several employers he was not qualified and/or the job was not actually available. He did not receive any interviews or job offers.

***

Lewis vs. Temple Inland, No. 2011 CA 0729 (La. App. 1 Cir. 11/9/11) [Attorneys – Jennifer Poirier (C), Leslie Hodge (D); WCJ – Warren]

Reversed WCJ award of penalty for failure to commence voc rehab, finding that 1201(F) does not provide for such penalties.

****

Carrier vs. City of Eunice, 11-748 (La. App. 3 Cir. 12/7/11) [Attorneys – Michael Miller (C), John Wilkes, III (D); WCJ – Lowery; Panel – Pickett, Amy, Painter]

Affirmed WCJ's decision to defer conversion of indemnity benefits from TTD to SEB, finding that voc rehab provided to claimant was at best, "formulaic and bureaucratic."

****

Briscoe vs. McNeese, 11-872 (La. App. 3 Cir. 12/7/11) [Attorneys – Marc Zimmerman (C), Elizabeth Hollins (D); WCJ – Lowery; Panel – Decuir, Genovese, Keaty]

Affirmed WCJ's order of vocational rehabilitation, finding that it was sufficiently plead via claimant's demand for "all benefits to which [claimant] is entitled" even though voc rehab was not specifically demanded in the 1008, but reversed $2,000 penalty awarded for failure to provide rehabilitation.

***

Hargrave vs. State of Louisiana, 11-836 (La. App. 3 Cir. 12/21/11) [Attorneys – Michael Miller (C), Sylvia Fordice (D); WCJ – Johnson; Panel – Cooks, Saunders, Gremillion]

Affirmed WCJ's decision ordering vocational rehabilitation subject to the limitations set forth in *Crain Bros., Inc. v. Richard*, 02-1342 (La. App. 3 Cir. 4/9/03), 842 So.2d 523. In *Crain Bros.*, the court allowed the WCJ to condition rehabilitation on certain requirements proposed by claimant's attorney. The *Hargrave* court agreed but noted that certain of the conditions, e.g. certification that no one else had provided rehab services, were inappropriate under the circumstances of the case.

***

Richard vs. Calcasieu Parish School Board, 11-469 (La. App. 3 Cir. 12/28/11) [Attorneys – Mark Zimmerman (C), Chris Trahan (D); WCJ – Lowery; Panel – Genovese, Painter, Saunders]

Affirmed WCJ's decision reinstating TTD and awarding $7,000 attorney fee based on employer's improper reduction of TTD to SEB per Banks and Chellette. Although the voc rehab consultant obtained job approval from claimant's treating physician, he admitted that he was unaware of a letter from the doctor stating that it was "medically necessary" that claimant be able to take breaks in order to perform even sedentary work. Thus, the trial court concluded and the court of appeals agreed that the identified jobs were not within claimant's physical restrictions.

Notably, the court affirmed the WCJ's denial of penalties citing the trial court's reasoning that "this is a situation where an employer holds in one hand an approval of a potential job, and in the other hand has a piece of paper from the self-same physician which just doesn't mesh with the first document." However, the court affirmed the attorney fee award and awarded an additional $3,500 for work on appeal, stating: "Ms. Richard did prevail at trial which is consistent with the WCJ's award of a reasonable attorney fee."

***

***Hargrave vs. State of Louisiana*, 2012-C-00341 (La. 10/16/12) [Attorneys – Michael Miller (C), Sylvia Fordice (D); WCJ – Johnson]**

Reversed WCJ's and Third Circuit's decision ordering vocational rehabilitation subject to the limitations set forth in *Crain Bros., Inc. v. Richard*, 02-1342 (La. App. 3 Cir. 4/9/03), 842 So.2d 523.

In *Crain Bros.*, the court allowed the WCJ to condition rehabilitation on certain requirements proposed by claimant's attorney. Noting the post-Crain amendments to La. R.S. 23:1226, the Supreme Court found no justification for the conditions imposed by claimant's attorney, stating:

> ***"[W]e conclude the hearing officer manifestly erred in determining that the conditions set forth in the letter agreement were reasonable or necessary. La. Rev. Stat. 23:1226(B)(3)(a) sets forth a procedure by which an employee may file a claim with the Office of Workers' Compensation if a dispute arises regarding the quality of the services of the vocational counselor or the necessity for such services. As the Interiano court reasoned, there is no requirement in La. Rev. Stat. 23:1226 that a vocational rehabilitation counselor must agree to certain conditions prior to providing vocational rehabilitation services. Certainly absent any showing by the claimant that there is an actual dispute as to the provision of services or the quality thereof, requiring the counselor to abide by such conditions, even if intended as a prophylactic measure, necessarily resorts to speculation and conjecture as to the future actions of the counselor. Accordingly, the OWC hearing officer and the court of appeal erred in requiring the vocational rehabilitation counselor to agree to certain conditions prior to the performance of rehabilitation services in the absence of an evidentiary showing that there was an actual dispute as to the quality of the services of the vocational rehabilitation counselor or the necessity for such services."***

***

Roy vs. Schilling Distributing, WCA-13-0242 (La. App. 3 Cir. 10/16/13) [Attorneys: Jan Barber (C), Renee Willis (D); WCJ – Johnson; Panel: Thibodeaux, Pickett, Gremillion]

Reversed WCJ's reduction of indemnity benefits based and reinstated SEB at zero earning capacity, finding the defendant's vocational rehabilitation to be inadequate.

Claimant suffered a compensable back injury. Pending surgery, diagnostic testing indicated possible cardiac issues. Claimant's physicians recommended an angiogram to complete the assessment, which was denied by the defendant as unrelated to the work accident. The

surgery was cancelled and claimant's physician opined that without it, claimant was at MMI and limited to sedentary work. Defendant then converted his indemnity benefits to monthly SEB. Vocational rehabilitation subsequently identified ten jobs, nine of which were approved by claimant's physician (even though he had not seen him for almost a year). Defendant then terminated indemnity benefits. After claimant's doctor retired, he selected the defense SMO neurosurgeon as his choice. That doctor recommended the same surgery previously recommended. Defendant approved the surgery as well as the diagnostic angiogram, and agreed to reinstate claimant's benefits in exchange for dismissal of any penalty/fee claim regarding the prior denial of the angiogram. The matter went to trial on the voc rehab issue. The WCJ found that eight of the nine approved jobs were not "available" for various reasons. Nevertheless, based on the one remaining job, the court held that the termination of benefits was proper.

On appeal, the court first noted that the defendant's conversion from TTD to SEB was not raised as an issue at trial and would not be considered on appeal. However, with not insubstantial criticism of the "questionable" and "far less than laudable" vocational rehabilitation effort, the court concluded that the trial court erred in finding that the defendant had shown any wage earning capacity and ordered that claimant's SEB be reinstated at zero earning capacity. The court affirmed the denial of penalties and attorney fees, noting that it was "reluctant" to find that the termination of benefits was arbitrary and capricious.

***

Allen v. Affordable Home Furnishings, 2014-338 (La. App. 3 Cir. 10/1/14) [Attorneys - Michael B. Miller (C), Sean Rastanis (D); WCJ – Morrow; Panel – Painter, Saunders, Ezell]

Affirmed WCJ's judgment reducing claimant's indemnity benefits by 50% pending cooperation with vocational rehabilitation.

Claimant refused to participate in vocational rehabilitation after the voc rehab consultant would not agree to conditions imposed by claimant's attorney, prompting employer to file a motion to compel and to reduce benefits pursuant to La. R.S. 23:1226.

Citing Hargrave vs. State, 100 So.3d 786 (La. 10/16/12), the court of appeal held (1) that the WCJ correctly reduced claimant's benefits by 50% per §1226, (2) questions posed to the rehab consultant regarding signing a contract prepared by claimant's attorney were not relevant to the issue of claimant's refusal to participate in rehabilitation, and (3) the WCJ acted reasonably and within her discretion in requiring both attorneys to copy each other on correspondence submitted to the rehab consultant.

***

Willis Knighton Health Sys. v. Sims, 49,967 (La. App. 2 Cir. 6/24/15) [Attorneys - James Caldwell (C), Walter Salley (D); WCJ – Robinson; Panel – Brown, Lolley, Pitman]

Affirmed. WCJ's judgment reducing claimant's indemnity benefits by 50% for failure to cooperate with vocational rehabilitation.

Claimant injured his back in 2006, and underwent a two-level lumbar fusion. The WCJ ultimately ordered him to participate in a GED program as recommended by voc rehab and approved by the treating physician. Claimant failed the entrance exam for the program, and the rehab consultant directed him to enroll in remedial classes. Claimant failed to enroll in the remedial courses and the defendant filed a motion to reduce his benefits by 50% pursuant to La. R.S. 23:1226. Subsequent to filing of the motion, claimant's physician stated that "I do not think attending school is in [his] best interest." Nonetheless, the WCJ reduced benefits retroactive to filing of the motion.

The court of appeal affirmed, noting that while the treating physician's opinion is generally entitled to great weight, the WCJ did not err in considering the reversal of the doctor's original opinion.

***

Hargrave v. Diaz, 2015-189 (La. App. 3 Cir. 10/28/15) [Attorneys – Michael Miller (C), Stephen Glusman (D); WCJ – Johnson; Panel – Saunders, Thibodeaux, Amy]

Affirmed WCJ's decision dismissing claim to replace vocational rehabilitation consultant based on fraud.

Claimant filed a disputed claim contending that the voc rehab consultant assigned by the employer committed fraud and should be removed. Specifically, claimant asserted that the consultant violated R.S. 23:1208 by meeting with the employer without claimant or his attorney present.

The court of appeal held (1) WCJ's refusal to let claimant's attorney question the consultant regarding proposed conditions was not wrong, since the consultant's opinion as to whether he could/should comply with the conditions was not relevant in light of the Supreme Court's decision in Hargrave vs. State. (2) WCJ was not wrong in finding that the consultant did not violate R.S. 23:1208, where claimant failed to show specific misstatements regarding meetings with between the consultant and the employer or the treating physician. (3) Claimant made no showing warranting the removal of the vocational rehabilitation consultant.

***

Clark v. Sedgwick CMS, 2015-277 (La. App. 3 Cir. 11/25/15) [Attorneys – Kevin Camel (C), Matthew Fontenot (D); WCJ – Palermo; Panel – Keaty, Pickett, Savoie]

Reversed WCJ's award of full SEB in part and remanded for further consideration of employee's earning capacity.

Employee injured his back lifting a case of radios at work. An MRI showed three herniated lumbar discs, and claimant subsequently underwent surgery. He continued to report some residual pain. Defendant converted TTD to reduced SEB based on several positions identified through vocational rehabilitation and approved by the treating physician. The employee had applied for all of the positions and had contacted over 100 additional prospects without success. The rehab consultant noted that there was "stiff competition" in the job market. Following trial, the WCJ awarded SEB at the full TTD rate, concluding that "there was no showing that jobs were available" to the claimant when his benefits were reduced.

The court of appeal reversed, noting that the WCJ had incorrectly focused on job availability "at the time [defendant] reduced benefits. Applying the *Banks* analysis and conducting a de novo review, the court found that the defendant had identified several jobs that fit the claimant's restrictions, were in his geographical area, and were available when claimant was notified of their existence. The court stated that "physician approval is not required for the employer to meet its burden under Banks." Accordingly, the judgment was reversed to the extent it found defendant failed to prove available employment. The case was remanded to the WCJ to determine claimant's earning capacity.

Judge Savoie concurred, but voiced concerns over the vocational rehabilitation process and the Banks standard. "While the law is clear that actual job placement is not necessary, there should be a component of the test that includes whether the employee has a reasonable chance of placement in the position."

Why can't we get people back to work faster?

Reform vs. Reframe

1983

2016

"Broken System"

Needs a tune up, but that's maintenance not a breakdown

The Rehabilitation Counseling Perspective

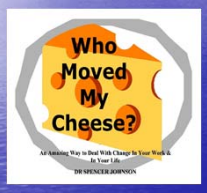
Rehabilitate vs. Habilitate

Rehabilitate

Habilitate

Worker's Compensation and the Shifting Burden

Who Moved My Cheese (The Story)



- The story of how we react to change
- Change is hard!
- New cheese

Rename to Reframe

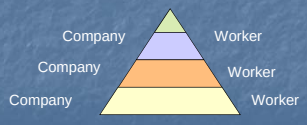
- The worker's retention after accidental injury act
- The do the right thing and do things right act

Vocational Rehabilitation Under the Act

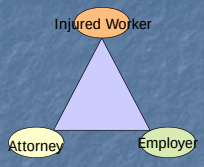
- Reactive = Return to work goal – ASAP
- Period between injury and return to work – Critical Time

Vocational Rehabilitation Under the Act

- Proactive = Set-up return to work expectation when hiring
- Communicate expectations



Triangulation



- Injured worker, Employer, Attorney
- Add carrier, adjuster, rehab counselor, judge, physicians, etc.

Return to Work/Transitional Work Programs

- Develop a return to work/transitional work plan model and give it to all employers so that they can develop their own return to work plan
- Make sure it is in the company's Worker's Compensation Rehabilitation Company Policy

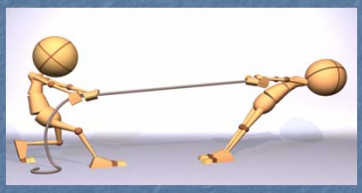
After Transitional RTW/Modified Duty Plan

if No Success

Establish Return to Work Plan, Goals and Outcomes

- Outsource vocational rehab based on the current rules and goals of vocational rehab
- Empower the injured worker, let the injured worker identify tasks toward return to work

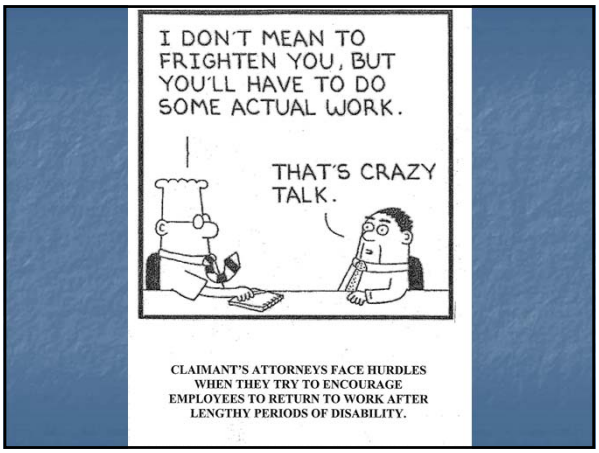
Avoid a Tug of War



Conduct Real Vocational Rehabilitation and... If All Else Fails

- Make sure VRCs follow the act
- Be honest
- If worker doesn't want to undergo an evaluation agree to that, identify jobs, conduct labor market research, and settle the case – You can lead a horse to water..
- If attorney helps the process, what is the downside?
- If insurance company carrier does their part – stay out of the way
- If the VRC is just milking the system, cut them off – fire them!
- Example: No jobs month after month - Fire the VRC!

Develop a list of Approved Independent VRC's appointed by the Worker's Comp Administration



Two people turn to each other and one clinches their fist, closes it, and the other tries to get them to open their hand. They are given 10 seconds.

FRIDAY, JANUARY 22 ND

9:00 AM – 10:00 AM

A primer on Jones Act and LHWCA

JURISDICTION UNDER U.S. MARITIME PERSONAL INJURY LAW

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I. THE THRESHOLD QUESTION: JURISDICTION

In most instances, jurisdiction may not be an issue in state comp cases. However, it is important for state comp practitioners to recognize when jurisdiction may be in question. This is particularly so with regard to workers in an oilfield setting who may work on land but also on platforms and vessels in state waters and on the Outer Continental Shelf. By definition, workers who are seamen or Longshoremen will not qualify for coverage under Louisiana state comp law. Thus in some instances it may be necessary to consider these jurisdictions in arriving at the conclusion that state comp law does or does not apply to any particular claim.

II. THE TEST FOR SEAMAN STATUS

In most cases, seaman status will not be a question. For example, deckhands or captains aboard commercial fishing vessels or offshore service vessels typically will qualify for seaman status. However, if the worker has a history of working aboard vessels, oil production platforms, and land, it will be necessary to evaluate that person's work history to determine if he or she qualifies as a seaman. The courts have established a three part test as follows:

A worker will be a "seaman" if he or she is:

(1) More or less permanently assigned

(2) To a vessel or fleet of vessels in navigation

(3) And contributes to the mission or function of the vessel (i.e., works aboard it)

(1) The first element: more or less permanently assigned

-Technically, a temporary worker aboard a vessel should not be considered a seaman. Likewise, passengers on vessels, such as workers taking a crew boat to and from a platform, will not be considered seamen.

-The thirty per cent rule: When does a worker's *work time* aboard vessel rise to the level of "more or less" permanency? The courts have not specified an exact amount of time, but the general rule of thumb is that a worker must spend at least 30% of his or her time aboard a vessel or fleet of vessels in navigation to qualify as a seaman. However, the courts have held that this is not necessary in all cases (divers are the notable exception because typically they spend all of their work time aboard vessels or diving from vessels).

-In offshore service companies, where the worker typically has assignments to many different jobs, on platforms, jackups, barges, and on land, the courts look to the entirety of the worker's history, unless the job of injury is a new assignment, in which event the courts look to the job the

seaman was doing at the time of injury. (EXAMPLE: the worker was a desk clerk but then reassigned to be an offshore rigger - the court would consider only his offshore rigging time, not the desk clerk time.)

-The U.S. Fifth Circuit has held that if the worker had a break in employment of at least four months, the court should consider only the latest stint of employment in determining whether vessel time is sufficient for seaman status. *Complaint of Patton-Tully Transp. Co., 797 F.2d 206, 210 (5th Cir. 1986).* (EXAMPLE: the worker works for the employer for a year, is laid off for 8 months and works elsewhere, returns to the employer and two months later is injured - you would consider only the last two months, not the time spent in the first stint of employment.)

-NOTE: The worker need not be aboard the vessel at the time of the accident to be considered a seaman. A person who qualifies as a seaman and is injured while on land but while still in the service of the vessel is entitled to seaman remedies (for instance, seaman making a supply run in a company vehicle gets into a car accident caused by the negligence of his co-worker driver—injured worker has full remedies available to seamen).

(2) <u>The second element:</u> <u>a vessel or fleet of vessels in navigation</u>

-Generally, vessels are crafts that are capable of flotation and navigation and are used to carry goods and/or people over water. A vessel

taken out of service does not give rise to seaman status for workers even though it has flotation capability if it has not been used for navigational purposes and was not being so used at the time of injury (such as a houseboat or drilling rig that has been stationary for a lengthy period of time).

-Special purpose crafts used in oil exploration are considered vessels: such as drilling barges, air boat drilling units, semi-submersible drilling rigs, and jackup drilling rigs. In light of the *Lozman* houseboat case decided by the U.S. Supreme Court in January 2013, the focus of the inquiry is whether the particular unit/rig is intended to carry goods and people over water. See, *Lozman v. City of Riveria Beach, FL*, 133 S.Ct. 735 (2013). A houseboat or a drilling rig that rarely moves except at great expense and is primarily designed to be used as living quarters (in the case of the houseboat) or as a work platform (in the case of the drilling rig) should not be considered a vessel.

-EXAMPLES: In *Simoneaux v. Star Enterprises*, 1994 WL 660443 (E.D. La. 1994), the court denied a motion for summary judgment on seaman status in an airboat case. The court found that there was a factual issue as to whether the boat was used in navigable waters. However, in *In Re Destiny Drilling (USA), Inc.,* 184 F3d 816 (5th Cir. 1999), where there was no dispute that the airboat was used only in marshy areas, the court

denied seaman status because the airboat had not been used in navigable waters.

Traditional vessel, with thanks to Rembrandt

Vessel or work platform?

THE NOBLE DRILLER – A SEMI-SUBMERSIBLE DRILLING RIG

-“Fleet” doctrine—a worker is considered a seaman if he or she spends the appropriate amount of time working aboard a “fleet” of vessels. In order to be considered a “fleet”, the vessels must be under common ownership. EXAMPLE: welder or caterer who spends all of his work time aboard Global jackups and drilling barges would be considered assigned to the Global fleet.

-Vessel must be navigable. If taken out of navigation, the worker is not a seaman, but may be a Longshoreman (ship repairer, etc.).

(3) The third element: contributes to the mission or function

-The individual must work aboard the vessel. A worker who sleeps and eats aboard a vessel but does not work aboard vessel should not be considered a seaman. EXAMPLE: worker does all of his work on platform, goes to adjacent vessel at night to eat and sleep - should not be considered a seaman.

SEAMAN'S REMEDIES:

If the worker qualifies as a seaman, he or she has the following rights of action:

(a) A claim for maintenance and cure against the employer

(b) A claim for negligence against the employer

(c) A claim for unseaworthiness against the vessel owner

III. JURISDICTION UNDER THE U.S. LONGSHORE AND HARBOR WORKERS COMPENSATION ACT

Two bases for a worker to be covered by the LHWCA – the Act itself, found at 33 USC 901, et seq, and the Outer Continental Shelf Lands Act, found at 43 USC 1331, et seq.

A. The LHWCA: Ship Repairers, Ship Builders, Longshoremen, other "maritime workers"

Two distinct criteria for a worker to be covered by the LHWCA: the employee's job "status" must be covered by the LHWCA and the injury must occur on a covered "situs". This is referred to as the "status/situs" test.

(1) The "Status" Test

-Certain persons are automatically excluded*, as follows:*

A) Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work;

(B) Individuals employed by a club, camp, recreational operation, restaurant, museum, or retail outlet;

(C) Individuals employed by a marina and who are not engaged in construction, replacement, or expansion of such marina (except for routine maintenance);

(D) Individuals who (i) are employed by suppliers, transporters, or vendors, (ii) are temporarily doing business on the premises of an employer described in paragraph (4), and (iii) are not engaged in work normally performed by employees of that employer under this Act;

(E) Aquaculture workers;

(F) Individuals employed to build, repair, or dismantle any recreational vessel under sixty-five feet in length;

(G) A master or member of a crew of any vessel; or

(H) Any person engaged by a master to load or unload or repair any small vessel under eighteen tons net;

if individuals described in clauses (A) through (F) are subject to coverage under a State workers' compensation law.

-Certain persons are definitely <u>included</u>, as follows:

- *Any person engaged in maritime employment, including any longshoreman or other person engaged in longshoring operations, and*

- *Any person engaged as a harbor worker, including ship repairers, shipbuilders, and ship breakers*

-Issue: How much time is enough time?

Courts have held that an employee need not spend all of his or her time in "maritime activity" to satisfy the status test. For instance, in one Fifth Circuit case, Bienvenu v. Texaco, 164 F3d 901 (5th Cir. 1999), *the worker spent 8.3% of his time working aboard vessels (not as the master or member of the crew), and the court found that to be a sufficient amount of time for the LHWCA to govern the claim. Note also that under the rule of* Bienvenu*, a worker who is transiently or fortuitously aboard vessel (for example, as a passenger in transit from platform to shore), is NOT covered by the LHWCA. You must still inquire into work history to figure out if he or she spent at least part of his/her time engaged in "maritime activity" (i.e, working aboard vessels).*

(2) Situs- 903(a)

- Injury must occur "upon the navigable waters of the United States"

- Covered sites include: work on a vessel, adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing or building a vessel.

B. Outer Continental Shelf Lands Act: the second basis for the LHWCA to apply

-The OCSLA makes the LHWCA applicable to "any injury occurring *as the result of* operations conducted on the Outer Continental Shelf for the purpose of exploring for, developing, removing, or transporting by pipeline the natural resources, or involving rights to the natural resources, of the subsoil and seabed of the Outer Continental Shelf." 43 USC 1333(b)(emphasis added)

-Until 2012, there was a split among the federal circuits as to whether the worker had to be injured on the Shelf at the time of the accident for the OCSLA to apply. The Fifth Circuit applied a strict situs test – the worker had to be injured on the Shelf for the Act to apply. The Third Circuit applied a much broader "but for" test, focusing on whether the accident would have occurred were it not for the worker's employment on the Outer Continental Shelf. The Ninth Circuit applied a "substantial nexus" test.

-In Pacific Operators Offshore v. Valladolid, 132 S.Ct. 680 (1/11/2012), the U.S. Supreme Court rejected the strict situs requirement and the "but for" test, overruling the Fifth Circuit and Third Circuit lines of cases. Instead, the Court adopted the Ninth Circuit test and held that the OSCLA applies if the worker is injured while doing work that has a "substantial nexus" to operations on the OCS. According to the Court, the accident must bear a "significant causal link" to the employer's operations on the Shelf.

-Question: does a car accident on land (course and scope not at issue) give rise to OCSLA jurisidction where the employee is en route to a dock to catch a boat to an OCS platform? The issue is currently in litigation. In one decision from this past year, *Boudreaux v. Owensby & Kritikos, Inc., BRB No. 2015-0117*, ALJ Kennington ruled that a car accident was compensable under the OCSLA. This decision is now being appealed by LWCC to the Benefits Review Board, and an appeal to the Fifth Circuit may follow. In another recent case, *Anthony Grabert v. Benton Energy Services*, ALJ Price ruled that a car accident on land does not have a significant causal link to an employer's offshore operations, and therefore OCSLA does not apply. The claimant has filed a petition for the Benefits Review Board to review this decision.

(3) Longshoreman's remedies: include a workers comp remedy against the employer that may in some instances be more generous than a state comp remedy and a right of action under 33 UCS 905(b) against the vessel owner for negligence.

JURISDICTION UNDER U.S. MARITIME PERSONAL INJURY LAW

by Henry LeBas, Attorney-at-Law

THE TEST FOR SEAMAN STATUS

A WORKER WILL BE A “SEAMAN” IF HE OR SHE IS:

(1) MORE OR LESS PERMANENTLY ASSIGNED
(2) TO A VESSEL OR FLEET OF VESSELS IN NAVIGATION
(3) AND CONTRIBUTES TO THE MISSION OR FUNCTION OF THE VESSEL (I.E. WORKS ABOARD IT)

TRADITIONAL SEAMAN

TRADITIONAL CAPTAIN

SEAMEN?

TRADITIONAL VESSEL

VESSEL?

THE LONGSHORE ACT: TWO BASES FOR JURISDICTION

1. THE ACT ITSELF: 33 USC 901, et seq

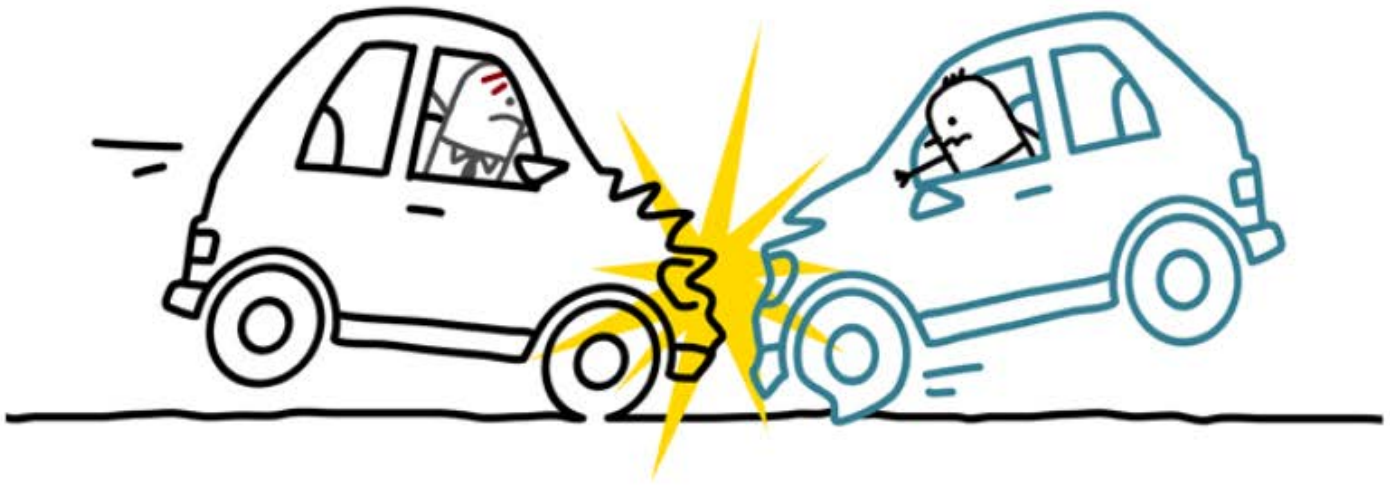
    (a) Status;

    (b) Situs

2. THE OUTER CONTINENTAL SHELF LANDS ACT, 43 USC 1333(b)

Did the worker's injury occur on the Shelf or bear a significant causal link to the employer's operations on the Shelf?

How far landward does jurisdiction extend?



FRIDAY, JANUARY 22 ND

10:30 AM – 11:30 AM

Is the preliminary determination process working?

R.S. 23:1201.1 – THE 1002 PROCESS AND SAFE HARBOR

Effective date: August 1, 2013

Act 337 of 2013 Regular Session is remedial, curative, and procedural and applies retroactively and prospectively
Failure to comply with any provision shall result in loss of Penalties and Attorney fee protections
Failure to comply with provisions is not itself considered a failure to reasonably controvert benefits

NOTE: Payor includes: Employer, Insurer, Third Party Administer, or Self-Insured Fund

GETTING THE 1002 PROCESS STARTED

When using the 1002 process to qualify for Safe Harbor, each step must be performed to get Penalties and Attorney Fee protection on those issues:

1) Initial payment of compensation
   - Payor prepares and sends the initial payment 1002 to Employee (and if represented by an attorney via fax to Employee's attorney)
   - Payor is to send the initial payment 1002 to the Employee and attorney on the same day as the 1st payment of compensation (indemnity) is made (i.e. 1002 and the payment must go out on the same day)
   - Send copy of 1002 to OWC within 10 days of when initial payment of indemnity is sent to Employee or faxed to Employee's representative
2) Modification, Suspension, Termination, Controversion (MSTC) of compensation or medical benefits
   - Payor prepares and sends MSTC 1002 to the Employee by **certified mail** to the address where the Employee is receiving benefits, on or before the effective date (1002 Form #7) of the MSTC
   - Payor must send the MSTC 1002 to the Employee's attorney via fax on the same day as sent to the Employee
   - Payor sends a copy of the MSTC 1002 to OWC on the same business day as sent to Employee/Employee's representative

Statute includes:
1. Safe Harbor
2. Preliminary Determination
3. Expedited Summary Proceeding

2 Step Process for penalties and attorney fee protection:
1) Safe Harbor Compliance
2) PD Hearing

PRIMA FACIE PRESUMPTION OF COMPLIANCE

- If the 1002 is faxed to the Employee's attorney, then that proof shall be prima facie evidence of compliance with the requirements of Section A (1-5)
- This presumption must be asserted by the Payor.
- The burden of proof then shifts to Employee to show that Payor did not follow Section A (1-5).
- If Payor establishes prima facie evidence of compliance with proof of fax to Employee's attorney, then Payor is not required to provide proof that the 1002 was sent to the Employee and OWC, unless and until the Employee rebuts the presumption with proof of non-compliance.
- The Employee will usually uncover this rebuttal evidence through discovery to obtain specific dates of compliance.
- Even if Payor is granted presumption of compliance, he must still provide proof of compliance with Section (I)

HOLD ON, YOU HAVEN'T PROVEN COMPLIANCE YET……

OUTSIDE THE PRIMA FACIE PRESUMPTION

- Section (I) lays out an additional step that must be met to receive Safe Harbor protections
- This requirement is outside the prima facie presumption of compliance established with proof that the 1002 was faxed to the Employee's attorney
- Payor still needs to prove completion of this step for Safe Harbor protections
- If the Employee files a 1008 and the Payor requests a Preliminary Determination hearing in his Answer, the Payor must provide to Employee/Employee's attorney all documentation relied on in making the 1002 decision within 10 days of making the PD request.
- Failure to do so will disqualify Payor from penalties and attorney fee protections

GETTING THE 1002 PROCESS STARTED

OPTION 1:

Claim accepted as compensable **OR**
Claim accepted subject to further investigation and subsequent controversion

Initial payment 1002

1. Prepare and send 1002 to Employee or Employee's attorney on day 1st payment of compensation made
2. Send copy to OWC w/in 10 days of sent to Employee or faxed to Employee's attorney

After a 1008 is filed, Payor requesting PD hearing must provide to Employee/Employee's attorney all documents relied on in formulating 1002 decision within 10 days of the PD request (i.e. the Answer)

Modification, Suspension, Termination, Controversion 1002

1. Prepare and send to Employee by certified mail to address receiving benefits, on or before effective date of MSTC
2. Send copy to Employee's attorney by fax on same day as sent to Employee
3. Send copy to OWC on same business day as sent to Employee/Employee's attorney

After a 1008 is filed, Payor requesting PD hearing must provide to Employee/Employee's attorney all documents relied on in formulating 1002 decision within 10 days of the PD request (i.e. the Answer)

OPTION 2:

Claim Accepted but no 1002 or 1002 improperly executed

Trial/No Safe Harbor/No PD Hearing

OPTION 3:

Claim Denied

Trial/No Safe Harbor/NO PD Hearing

NOTE: Late payments of indemnity benefits or medical benefits are not 1002 issues.

NOTE: The language of the Answer is important. A general denial of all issues could be seen as a denial of the claim from the onset and thus disqualify the Employer from the P&A protections. The Employer would then have to prove the claim had been accepted or accepted subject to investigation.

WHEN THE EMPLOYEE DISAGREES WITH THE 1002

1) Employee/Employee's attorney must notify Payor of disagreement by returning the Basis of Disagreement form (page 3 of Form 1002) **OR** by sending a Letter of Amicable Demand to Payor, providing the amounts of compensation Employee feels is appropriate or describing whatever relief is being sought by Employee

****Employee cannot file 1008 until the Basis of Disagreement/Letter of Amicable Demand has been sent to Payor****

2) If Payor provides demanded benefits, including arrearages, within 7 business days of receiving the Basis of Disagreement/Letter of Amicable Demand, then no penalties and attorney fees (P&A) for 1002 issues
3) If Payor does not provide demanded benefits within 7 business days, then Employee can file a 1008 or file amended 1008 if Employee already has a claim pending (See Exception of Prematurity box below)

****Employee cannot file 1008 until after the 7 business days the Payor has to comply with the Basis of Disagreement/Letter of Amicable Demand****

4) If prescription on claim will run during the 7 day waiting period, the Employee may file the 1008 without waiting the full 7 days; Payor still has all 7 days to provide demanded benefits to avoid penalty and attorney fees

Employee disagrees with 1002

Employee sends Basis of Disagreement or Letter of Amicable Demand to Payor

Payor has 7 days to provide demanded benefits

Employee can file 1008/amended 1008 if Payor does not provide demanded benefits within 7 days

Exceptions of Prematurity:

1. Employee files 1008 without returning Basis of Disagreement/Letter of Amicable Demand to payor
2. Employee not waiting 7 business days after sending Notice of Disagreement/Letter of Amicable Demand before filing 1008

****Both can be waived by the Payor to allow the 1008 to go forward****

REQUESTING A PRELIMINARY DETERMINATION (PD) HEARING

1) Payor requests PD hearing in Answer or Amended Answer (if claim was already pending prior to 1002)
2) Payor also files a Motion and Order to set a Telephone Status Conference (TSC) and attaches a copy of the 1002 and notice of disagreement/letter of amicable demand (per Hearing Rule) (also a good idea to attach to the 1002 initiating indemnity benefits when subsequent 1002 at issue)
3) **Payor requesting PD must provide all documents relied on in formulating the 1002 within 10 days of PD hearing request to the Employee or Employee's attorney (i.e. within 10 days of filing its Answer, look to file stamp on Answer) → additional step outside of Subsections A-E that must be performed to be in compliance for Safe Harbor protections that is outside the potential prima facie presumption of compliance**
4) The court has 15 days to set a TSC with the Judge/Judge's designee from the date the Answer/Amended Answer and Motion to set TSC is filed
5) The PD hearing is set within 90 days of the TSC with possible extension of 30 days for good cause shown (max = 120 days from TSC) (incumbent upon Payor to insure time delays are not exceeded)

TELEPHONE STATUS CONFERENCE DETAILS FOR SAFE HARBOR/PD HEARING

1) Scope of discovery is limited to issues raised on 1002
2) Deadline for any discovery is 30 days before the PD hearing (see Hearing Rule)
3) Parties must exchange evidence 15 days before the PD hearing, with copies of the exhibits, exhibit lists, and memorandum sent to the Judge
4) A scheduling order is to be sent to the parties within 3 days of the TSC
5) The scheduling order includes: a list of issues to be determined, the date of the scheduled hearing, the discovery deadline, the exchange deadline, and the deadline to submit exhibits and memorandum to the court

****TIP: May be a good idea to question the parties whether compliance is in dispute – compliance can be waived ****

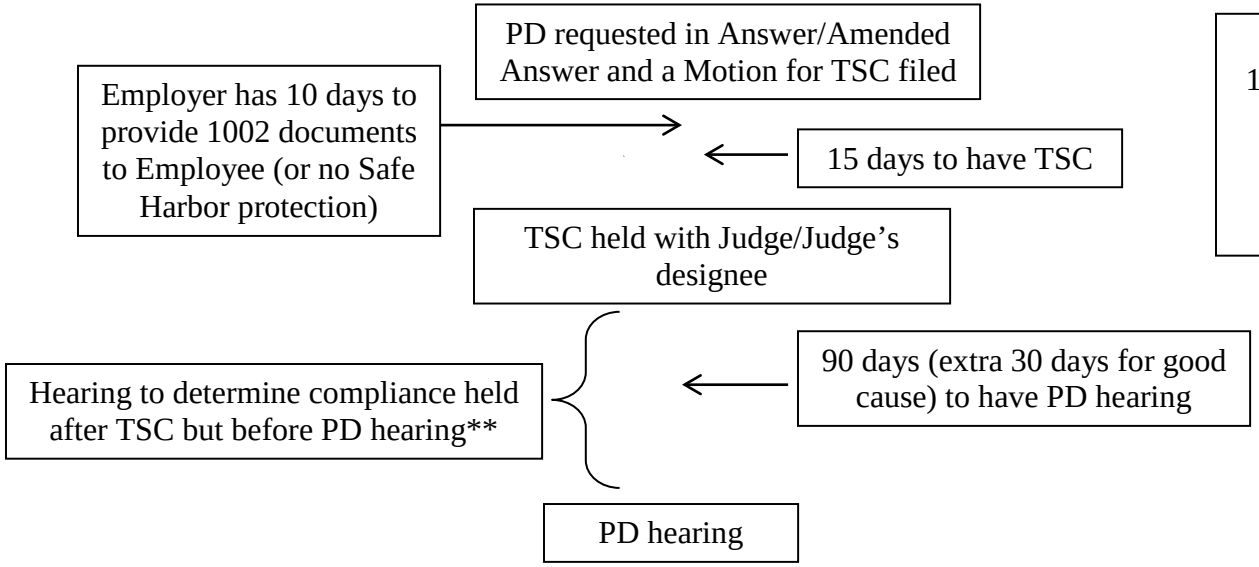
HEARING TO DETERMINE COMPLIANCE

1) Hearing can be via Rule to Show Cause (RTSC) or any other hearing held pursuant to the Section (i.e. an expedited hearing or the PD hearing)
2) Judge will determine if Payor is in compliance with Safe Harbor provisions (i.e. did Payor jump through all the appropriate hoops)
3) **This determination is only necessary if the Employee is disputing compliance –can be waived by the Employee**
4) If payor is not in compliance, do not proceed to PD hearing; do not render a PD decision. Render judgment on compliance (safe harbor) only

AT THE PD HEARING

1) The PD hearing is a contradictory hearing, where all parties have the opportunity to present evidence
2) Physician testimony can be introduced by certified records or deposition. The parties may agree to allow uncertified medical records and physician reports into evidence
3) Witnesses may testify at the hearing or by deposition, if agreed to by both parties
4) Judge has 30 days to render decision and forward decision to the parties
5) The parties shall receive notice, with the PD decision, of their options to accept or reject the findings and if the court does not receive written notification within 15 days (Hearing Rules) of further action by the parties, the court will close the file or proceed to trial on the merits on all remaining issues

FROM REQUEST TO HEARING



****NOTE:**

1) Compliance hearing can be held on day of PD hearing
2) Compliance Hearing can be held as a RTSC, an expedited hearing, or at PD hearing

PD Hearing

1. Employer accepted claim and requested PD
2. Employer accepted claim subject to investigation and requested PD
3. Safe Harbor compliance either waived or met
4. Go to PD Hearing

Going to trial/No PD Hearing

1. Employer denied claim
2. Employer accepted claim but does not request PD
3. Employer accepted claim, requested PD, but does not qualify
4. Go to Trial

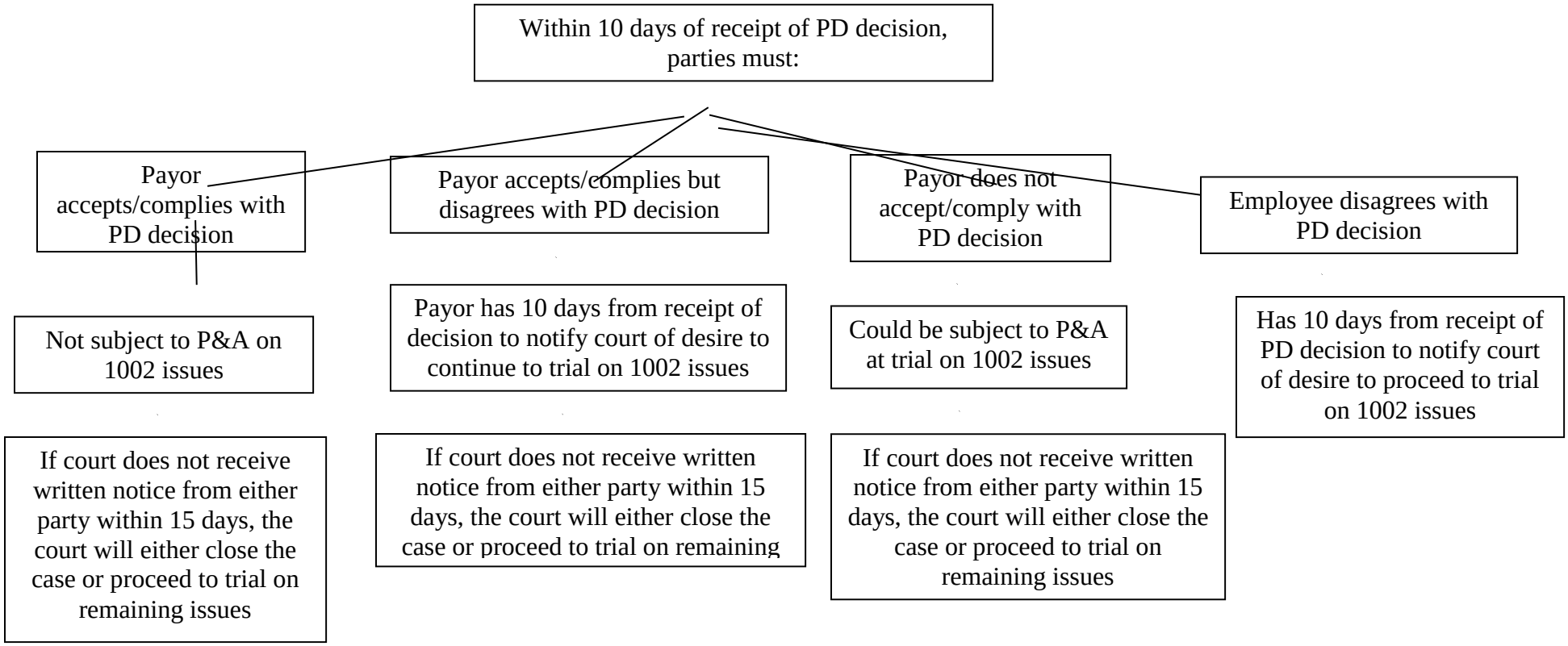
AFTER THE PD HEARING

1) Within 10 days of the mailing of the court's decision, the Payor must either:
   - Accept and comply with the PD decision regarding initial payment or MSTC of benefits and mail revised 1002 to Employee/Employee's rep along with payment and arrearages due
     ****If Payor accepts and complies within 10 days, then not subject to P&A on 1002 issues****
   - Notify Employee/Employee's rep in writing that Payor does not accept the court's decision
     ****If Payor does not accept and comply within 10 days, then may be subject to P&A on issues arising from PD at trial on the merits****
2) **Payor** can accept and comply but disagree with determination. Payor shall notify the court of desire to proceed to trial on PD issues within 10 days of receipt of PD decision
3) If **Employee** disagrees with PD decision, then Employee can notify court of desire to proceed to trial on PD issues within 10 days of receipt of PD decision. If Payor has accepted and complied with the decision, Payor can still litigate all issues including PD issues if Employee disagrees and requests a trial on PD issues
4) **Alternatively, if the court does not receive written notice from either party within 15 days regarding any further action, the court will close the file or proceed to trial on the merits on the remaining issues (Hearing Rule)**
5) Payor who accepts and complies but does not proceed to trial on PD issues retains right to controvert future matters

**** WCJ's determination shall not be considered an order concerning benefits due requiring modification nor considered res judicata of PD matters****

****Acceptance of PD decision is not considered an admission by Payor****

AFTER THE PD HEARING, CONT.



EXPEDITED SUMMARY PROCEEDINGS (EXSP)

WCJ's ruling in hearing conducted as ExSP and considered an order of court and not requiring further trial on the merits

What can be heard as an Expedited Summary Proceeding?

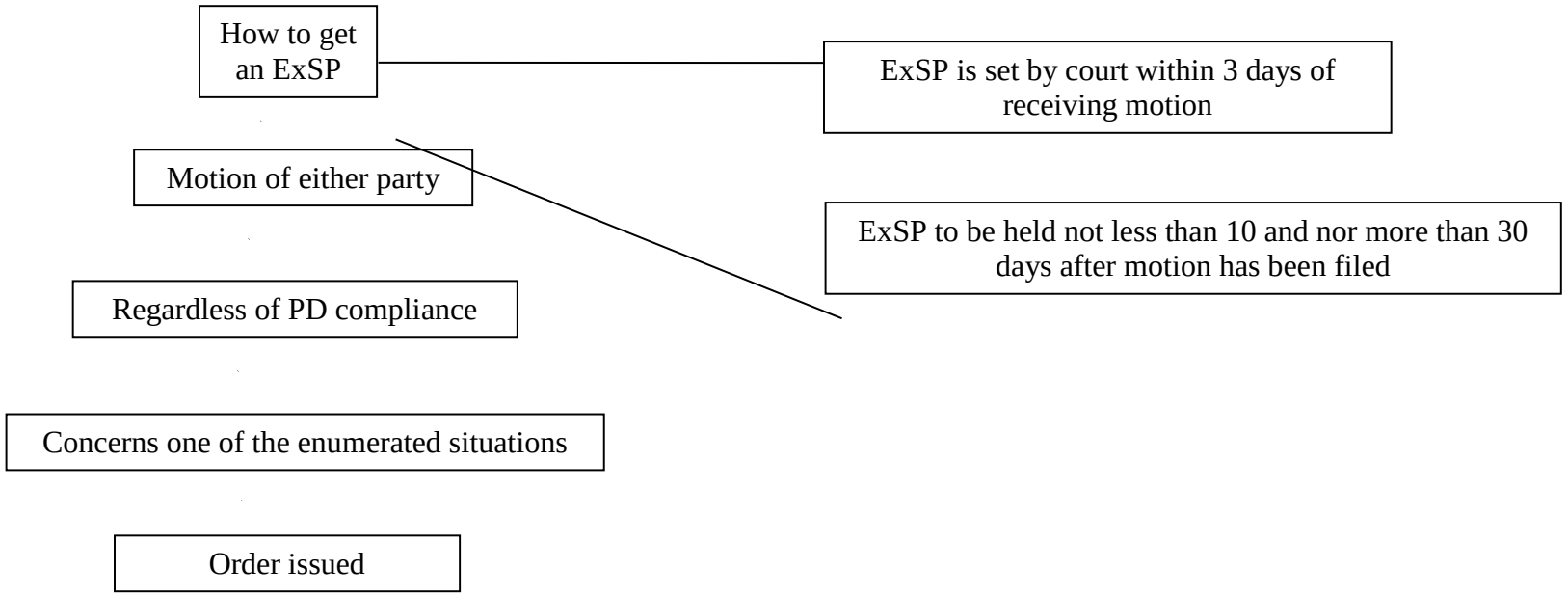
If the 1002 concerns any of the following, then either party can, by motion, request an ExSP, whether or not they are entitled to a PD hearing:

- Employee seeks choice of physician pursuant to R.S. 23:1121(B)(1) → Choice of Physician
  - WCJ shall order payor to authorize Employee's choice of physician unless payor can show good cause for refusal
- Employee filed claim pursuant to R.S. 23:1226(B)(3)(a) → voc rehab
  - Payor refuses to provide voc rehab services or there is a dispute with the work of the counselor – Court determines if there is a need for voc rehab services or court will assess quality of services provided by the counselor
- Payor seeks to compel Employee to sign choice of physician form pursuant to R.S. 23:1121(B)(5)
  - Payor may suspend Employee's medical benefits until Employee complies. The suspension shall be made in accordance with R.S. 23:1201.1(A-E)
- Payor seeks to compel Employee to submit to a medical exam pursuant to R.S. 23:1124 → SMO/IME
  - Payor may suspend right to compensation until Employee complies. The suspension shall be made in accordance with R.S. 23:1201.1(A)(4-5)
  - No compensation is payable in respect to period of suspension
- Payor seeks Employee to return Form 1025 or Form 1020 → Certificate of Compliance or Monthly Report on Earnings
- Employee seeks to have suspension lifted for failing to comply with R.S. 23:1121(B)(1) → Choice of Physician
- Employee seeks to have suspension lifted for failing to submit to medical exam → SMO/IME, R.S. 23:1124
- Employee seeks to have suspension lifted for failing to comply with R.S. 23:1208(H) → Certificate of Compliance or Monthly Report on Earnings
  - Employee failed to return the appropriate forms indicating any other earnings received to the payor within 14 days of receipt if Employee has received Workers' Comp benefits for more than 30 days
  - Suspension shall be made in accordance with R.S. 23:1201.1(A-E)
  - Employee shall be entitled to all of the suspended benefits after the form has been provided to the payor, if otherwise eligible for benefits
- Employee seeks to have suspension lifted for failing to comply with voc rehab → R.S. 23:1226(B)(3)(a)
  - If Employee refuses to comply with voc rehab, the payor may reduce weekly compensation by 50% for each week of refusal. The reduction of benefits shall be made in accordance with R.S. 23:1201.1(A-E)

SETTING AND HEARING AN EXPEDITED SUMMARY PROCEEDING

1) The Expedited Summary Proceeding is set within 3 days of receiving the motion; Generally, the hearing is to be held not less than 10 and no more than 30 days after motion filed – specific time deadlines can be found in the respectively referenced statute
2) The Court is to send notice of hearing to both parties at same time and in same manner
3) Hearing conducted as a RTSC
4) Judge can order Employee to sign choice of physician form, submit to medical exam, or provide Form 1025 or Form 1020 unless Employee can show good cause for refusal. If good cause is shown for refusal, Judge can order any suspension or reduction to be lifted and Payor is to pay any arrearages. If no good cause shown for refusal, Judge can order any suspension or reduction to continue until Employee complies
5) Payor who is entitled to a PD and complies with the order issued in ExSP hearing within 10 calendar days is not subject to P&A on 1002 issues

ExSP AT A GLANCE



POSSIBLE ExSP SCENARIOS:

1. Just ExSP issue
2. An ExSP issue + 1002 issue
3. An ExSP issue + 1002 issue + non 1002 issue
4. An ExSP issue + non 1002 issue

INDEX OF ABBREVIATION:

1) OWC – Office of Workers' Compensation
2) MSTC – Modification, Suspension, Termination, and Controversion 1002 Form
3) P&A – Penalties and Attorney Fees
4) PD – Preliminary Determination
5) TSC – Telephone Status Conference
6) ExSP – Expedited Summary Proceeding
7) RTSC – Rule to Show Cause

Created by: Judge Elizabeth Lanier and Marie DeFusco, Mediator
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Updated as of: December 30, 2015

R.S. 23:1201.1

The 1002 Process and Safe Harbor

Prepared by: Judge Elizabeth Lanier for the 6th Annual LWC
Educational Conference in Baton Rouge, Louisiana

Panel Members: Judge Sheral C. Kellar, Judge Elizabeth C. Lanier, Joseph H. Jolissaint and B. Scott Cowart

23:1201.1

- Effective Date: August 1, 2013
- Remedial, Curative, Procedural and applies retroactively and prospectively
- Failure to comply with any provision shall result in loss of Penalties and Attorney Fee protections
- Failure to comply with provisions is not itself considered a failure to reasonably controvert benefits
- Payor includes: Employer, Insurer, Third Party Administrator, or Self-Insured Fund

Getting the 1002 process started…

- Initial Payment of Compensation
  - Claim is accepted or accepted subject to investigation and subsequent controversion
  - Send the initial payment 1002 to Employee (if Employee represented, fax to Employee's attorney)
  - Send initial payment 1002 to Employee/attorney on the same day as the 1st payment of compensation (indemnity) is made
  - Copy of 1002 sent to OWC within 10 days of when initial payment sent to Employee or faxed to Employee's attorney

Getting the 1002 process started…

- Modification, Suspension, Termination, Controversion (MSTC) of Compensation or Medical Benefits
  - Claim is accepted or accepted subject to investigation and subsequent controversion
  - Send MSTC 1002 to Employee by certified mail to address where Employee receiving benefits, on or before the effective date
  - Payor must send the MSTC 1002 to the Employee's attorney via fax on the same day as sent to the Employee
  - Payor sends a copy of the MSTC 1002 to the OWC on the same business day as sent to Employee/Employee's attorney

Prima Facie Presumption of Compliance

- If the 1002 is faxed to the Employee's attorney, then that proof shall be prima facie evidence of compliance with the requirements of Section A(1-5)
- Must be asserted by the Payor
- If shown, burden of proof shifts to Employee to show Payor did not follow Section A (1-5)
- Rebuttal evidence usually found through discovery to obtain specific dates of compliance
- If payor establishes prima facie evidence of compliance with proof of fax to Employee's attorney, then Payor is not required to provide proof that 1002 was sent to Employee and OWC, unless and until the Employee rebuts the presumption with proof of non-compliance

Necessary proof that is outside the Prima Facie presumption of compliance

- If the Employee files a 1008 and the Payor requests a Preliminary Determination hearing in his Answer, the Payor must provide to Employee/Employee's Attorney all documentation relied on in making the 1002 decision within 10 days of making the PD request
- Failure to provide documentation will disqualify Payor from penalties and attorney fee protections
- This step is not included in the prima facie presumption of compliance that Payor can use. Payor still needs to prove that he sent documentation to the Employee/Employee's attorney

Employee disagrees with the 1002

- Employee notifies Payor of disagreement by returning the Basis of Disagreement form attached to the 1002 OR by sending a Letter of Amicable Demand
- Payor has 7 business days from receipt to provide demanded benefits – no penalties/attorney fees
- If Payor does not provide benefits within 7 days, Employee can file 1008 or amend a currently pending 1008
- 1008 will be premature if:
  - Employee does not send Basis of Disagreement/Letter of Amicable Demand prior to filing 1008
  - Employee does not wait 7 days after sending Basis of Disagreement/Letter of Amicable Demand before filing 1008
  - BOTH PREMATURITY DEFECTS CAN BE WAIVED BY PAYOR TO ALLOW 1008 TO GO FORWARD

How to get a Preliminary Determination Hearing

- Payor requests PD Hearing in Answer or Amended Answer
- Payor files a Motion and Order to set a Telephone Status Conference and attaches a copy of the 1002 and Notice of Disagreement/Letter of Amicable Demand (Hearing Rule)(It is also a good idea to attach the 1002 for the initial payment of indemnity along with any 1002 at issue)
- Payor provides all documents relied on in making 1002 decision to Employee/Employee's Attorney within 10 days of making PD request

Timeline from Request to Hearing

- Requested in Answer/Amended Answer
- Payor has 10 days to provide documents to Employee
- Court has 15 days to set a TSC with Judge/Judge's designee from date Answer and Motion is filed
- Hearing to determine compliance with Safe Harbor procedures held prior to PD hearing
- PD hearing within 90 days of TSC, with possible 30 day extension for good cause (120 days max)
  - If Payor allows the PD hearing to be set past the 120 day deadline without objection, potential waiving P&A protections
  - If Payor raises an objection to a date set beyond 120 days, requests an earlier date but the court can not accommodate, up to Appellate Court to determine if P&A is waived

Telephone Status Conference

- Held with Judge or Judge's designee
- To set Rule to Show Cause to determine Safe Harbor Compliance – prove all procedural hoops jumped through and Payor is entitled to a PD Hearing
- Scope of discovery limited to 1002 issues and discovery deadline is 30 days prior to PD hearing with parties exchanging evidence 15 days prior to PD hearing, with copies sent to the Judge (Hearing Rule)
- Scheduling order sent out within 3 days of TSC outlining: issues to be determined, date of hearing, discovery deadline, exchange deadline, pre-hearing memo deadline and deadline to submit evidence/exhibits to the court

Compliance hearing

- Rule to Show Cause is set only if Employee is disputing initial compliance – did the Payor follow proper procedure when processing the 1002s. If it is determined that the Payor complied with proper procedure, then the Payor can proceed to a PD Hearing.
- The Safe Harbor/Compliance hearing may be held as a separate Rule to Show Cause; may be set on the same day as the PD hearing but held prior to the PD hearing; or held on the same day as an expedited hearing
- The PD Hearing may be held immediately after the Safe Harbor hearing or may be held in a separate hearing.

Preliminary Determination Hearing

- Contradictory hearing where all parties have opportunity to present evidence
- Judge has 30 days to render and forward a decision to the parties
- The parties can either accept or reject the PD decision. If the court does not receive written notice within 15 days (Hearing Rules) of a party's intent for further action on the 1002 issues, the court will close the file or proceed to trial on any remaining issues

Options after the PD Hearing

- Within 10 days of mailing of court decision, Payor must either:
  - Accept and comply with decision and mail revised 1002 to Employee/Attorney along with payment and arrearages due – if complies, no P&A on 1002 issues
  - Notify Employee/Attorney in writing that Payor does not accept the court's decision
- If payor accepts and complies but disagrees with decision, must notify the court of desire to proceed to trial on 1002 issues within 10 days of receipt of PD decision
- If payor disagrees but fails to comply with decision within 10 days of receipt, then may be subject to P&A at trial on 1002 issues

Important Note

- 23:1201.1 (K)(1) – (5) gives the Payor 10 days from either the mailing or the receipt of the decision to take the desired action on the 1002 issues
- Hearing Rule 5507(D)(5) gives the parties 15 days to provide written notice to the court about any further action that they wish to take regarding the 1002 issues

Expedited Summary Proceedings

- If the 1002 concerns any of the following:
  - Employee seeking Choice of Physician under 23:1121(B)(1)
  - Employee seeks vocational rehabilitation under 23:1226(B)(3)(a)
  - Payor seeks to compel Employee to sign Choice of Physician form under 23:1121(B)(5)
  - Payor seeks to compel Employee to submit to medical exam under 23:1124
  - Payor seeks Employee to return Form 1025 or Form 1020
  - Employee seeks suspension lifted for failing to comply with 23:1121(B)(1)
  - Employee seeks suspension lifted for failing to submit to medical exam
  - Employee seeks suspension lifted for failing to comply with 23:1208(H)
  - Employee seeks suspension lifted for failing to comply with vocational rehabilitation

Setting an Expedited Summary Proceeding

- Either party can, by motion, request an expedited summary proceeding, whether or not they are entitled to a PD hearing
- Court must set the Hearing within 3 days of receiving the motion. Generally, the hearing is to be held not less than 10 and nor more than 30 days after the motion is filed
- The court sends notice to both parties at the same time and in the same manner
- Note: the statute says either party can file the motion for expedited summary proceeding. The statute does not say a 1008 must be filed with the motion. Nor does the statute say there must be a pending dispute(1008) in order for the Payor to file the motion for expedited summary proceeding.
- Note: Attorney Fees can be assessed at a summary proceeding per La. CCP.

Some Case Law on the 1201.1 process…

- *JoAnn Albert v. Strategic Restaurant Acquisition Co.*
  - 168 So.3d 504 (1st Circuit)
- *Tracy Bowie v. Westside Habilitation Center*
  - 150 So.3d 371 (3rd Circuit)
- *Gannon Bertrand v. G-Force Transportation, LLC*
  - 154 So.3d 741 (3rd Circuit)
- *Cassandra Aisola v. Beacon Hospital Management, Inc*
  - 140 So.3d 71 (4th Circuit)

Points to Ponder…

- Since the 1002 process discusses the word "Payor", which can include an SIF or a TPA, can these entities now be sued?
- Can P&A be assessed on an expedited hearing under 1201.1(K)(8)?
- Can an expedited hearing under 1201.1(K)(8) qualify for a preliminary determination hearing?
- How does the burden of proof shift when the Payor faxes a copy of the 1002 timely to the Employee's attorney?
- Can the Employee just sit back and do nothing at the Safe Harbor hearing because the burden of proof is on the Payor to show that it qualifies for safe harbor?
- Must the Payor's Safe Harbor qualification be decided first before you can proceed with the PD hearing?

More Points to Ponder…

- What can be waived in the 1002 process?
- How technical does the judge have to be when interpreting the 1201.1 statute?
- Does the Employee have to ask for a Rule to Show Cause to dispute the Safe Harbor qualification or can the Employee wait until the day of the hearing to dispute qualification?
- How does the Payor prove the elements of Safe Harbor so that it can proceed with the PD hearing? Do you need the adjuster to testify, give a depo, is an affidavit enough, or just submit adjuster notes?
- Is an initial payment 1002 needed if no indemnity is being paid and only paying medicals? If no, and disability status changes and indemnity is to start being paid, when must the Payor send the 1002 for indemnity?

FRIDAY, JANUARY 22 ND

11:30 AM – 12:30 AM

Recent jurisprudence

LOUISIANA WORKFORCE COMMISSION
OFFICE OF WORKERS' COMPENSATION

SUMMARY OF LOUISIANA WORKERS' COMPENSATION JURISPRUDENCE FOR 2015

Patrick F. Robinson
Office of Workers' Compensation
PRobinson@lwc.la.gov

TABLE OF CONTENTS

SUPREME COURT DECISIONS

Clavier v. Coburn Supply Co., 2014-2503 (La. 3/6/15) [Attorneys – Michael Miller (C), Patrick Cole (D); WCJ – Johnson]

> **Denied** claimant's writ application for review of a decision allowing employer to select the facility for an FCE recommended by SMO physician.
>
> Note that three justices dissented (Knoll, Hughes, Crichton), and would have granted the writ and reversed for the reasons set forth by Judge Genovese in his dissent at the appellate court. Judge Genovese concluded that nothing grants the employer the right to select the FCE, and recommended remanding the matter to the WCJ to appoint the FCE provider.

Stanley v. Airgas-Sw., Inc., 2015-0274 (La. 4/24/15), 171 So. 3d 915 [Johnson, Weimer, Hughes dissenting]

> **Granted writs and reversed** the denial of employer's motion for summary judgment re intentional tort/immunity.
>
> Plaintiff was injured in a work-related accident, when a cylinder exploded as one of his co-workers attempted to fill it with compressed gas. The cylinder was marked as defective, but the co-worker failed to see this marking. In support of summary judgment, the employer introduced undisputed testimony from the co-worker that was unaware of the defect and did not intend to injure anyone.
>
> In reversing the lower courts' denial of summary judgment, the Supreme Court stated: "*Although Airgas may have been negligent or even grossly negligent in allowing the defective cylinder to be refilled, it was not inevitable that plaintiff would be injured as a result. To the contrary, the testimony of plaintiff's co-worker establishes that if he had seen the marking on the cylinder, he would not have attempted to fill it*."

Arrant v. Graphic Packaging Int'l, Inc., 2013-2878 (La. 5/5/15), 169 So. 3d 296

> **Affirmed** appellate court decision holding that employees' gradual noise-induced hearing loss caused by exposure to hazardous levels of noise constituted an "occupational disease" within meaning of the Workers' Compensation Act, precluding employees from maintaining tort action against employer.

ACCIDENT

Tubre v. Auto. Club of S. California, 2014-0859 (La. App. 4 Cir. 2/4/15) (La. Ct. App. Feb. 4, 2015) [Attorneys - Patrick Patrick (C), Scott Davis (D); WCJ – Varnado; Panel – McKay, Bagneris, Tobias]

> **Affirmed** WCJ's denial of benefits based on failure to prove a compensable accident.
>
> Claimant allegedly aggravated a prior back injury when he slipped and fell at work. The accident was unwitnessed. Claimant presented three witnesses who generally testified that he

complained of back pain on or about the accident date. Claimant did not report the alleged accident to the employer until the following day, after he learned a supervisor intended to speak with him concerning improprieties. At that time he told the employer that he had injured his back at work and would not be coming in. He was terminated at that time. Claimant had been receiving treatment for back pain for several years. Although they did document the alleged accident, the medical records did not reflect any substantial change in condition.

The court of appeal concluded that the WCJ was not clearly wrong in finding that the claimant failed to prove a compensable accident. Further, the court found that the medical evidence failed to show any aggravation of claimant's pre-existing back condition.

Sorile v. Lott Oil Co., 2014-1156 (La. App. 3 Cir. 3/4/15) [Attorneys – Joseph Bailey (C), John Rabalais (D); WCJ – Braddock; Panel – Genovese, Peters, Ezell]

Affirmed WCJ's judgment rejecting 1208 fraud defense and finding that claimant proved occurrence of unwitnessed accident and entitlement to benefits, but denying penalties and attorney fees.

Claimant allegedly injured his back at work. He applied Bengay and continued working. Two days later he developed acute back pain, again at work. ER records reflected that he reported the onset of his pain at home. Claimant did not report the work accident until several days later, when he presented to a neurosurgeon. He explained that the initial questions concerned when his acute pain began, rather than the initial injury. In addition, he believed the initial injury was a minor muscle pull that would resolve on its own. His wife corroborated his testimony.

The WCJ found claimant to be credible and concluded that he proved a compensable work accident. The court rejected defendant's fraud defense based on claimant's pre-accident failure to report minor muscle pulls several years earlier, noting lay and medical testimony distinguishing those injuries from claimant's work injury. The appellate court found no manifest error.

Hayward v. Boh Bros. Const. Co., LLC, 14-860 (La. App. 5 Cir. 3/25/15) [Attorneys - J. Casey Cowley (C), Richard Vale (D); WCJ – Dunn; Panel – Chehardy, Gravois, Liljeberg]

Affirmed WCJ's award of benefits, penalties, and attorney fees.

Claimant, a carpenter, had worked for defendant for 12 years. He suffered a back strain in 2012 but returned to full duty. Four months later, he felt a a pop in his back and a sharp pain in his right leg after bending over to tighten a bolt. He reported the incident to his supervisor who instructed him to lie down in his truck. Claimant requested medical treatment but the supervisor did not follow up. Claimant had his parents drive him to his family doctor that day. He reported back pain radiating down his right leg. For the next ten days he worked light duty. An MRI taken two weeks post-accident showed lumbar disc herniations at multiple levels, and edema indicating recent trauma. Claimant's doctor related the new complaints to the recent work accident. Defendant terminated claimant pending a full duty

release. At trial, claimant's supervisor denied that claimant reported the injury. However, he also could not recall speaking to claimant by telephone that evening, despite phone records to that effect. An SMO agreed that claimant was limited to light duty but could not say that the injury was related to the specific work accident.

The WCJ found a compensable accident and awarded benefits, penalties and attorney fees. The appellate court affirmed, finding that claimant met the burden of proof under the Supreme Court's *Bruno* standard. Moreover, noting the WCJ's credibility determination, the court found that the award of penalties and attorney fees was reasonable.

Bridges v. Gaten's Adventures Unlimited, L.L.C., 2014-1132 (La. App. 1 Cir. 4/2/15), 167 So. 3d 992 [Attorneys - Daren Sarphie (C), Rchard J. Voelker (D); WCJ- Thompson; Panel – Crain, McDonald, Holdridge]

Reversed WCJ's award of disability benefits, penalties and attorney fees, despite finding a compensable unwitnessed accident.

Claimant, a part-time bus driver for the defendant bus company, injured her low back while lifting a child onto the bus. She did not mention the injury to anyone and finished the trip. The company office was closed by the time she returned that evening. She returned the next morning but was unable to locate her supervisor. She continued to have sharp back and leg pains over the weekend, and went to the emergency room. She testified that she reported the accident to ER personnel, although the records did not note such.

The following Monday, she reported the accident to her supervisor, who told her to see a doctor. She went her to another emergency room and returned with paperwork for the employer. The supervisor told her to contact the company's insurer but did not provide any contact information. Claimant requested treatment with a neurosurgeon, which was never approved. Two months after the accident, she began working as a sitter for a "senior care" center. The WCJ found that claimant suffered a compensable accident and awarded TTD for the period from the accident until she began working as a sitter, and SEB thereafter, along with medical benefits, penalties and attorney fees.

The court of appeal affirmed the finding of a compensable accident, despite discrepancies in the initial medical records. The court rejected the employer's position that there were no "objective findings" of an injury, noting that the statutory definition of injury "contains no requirement of objective findings or symptoms." It concluded that the WCJ was not clearly wrong in finding that the accident caused the claimant's injury.

However, the court reversed the award of TTD benefits. It noted that only one medical report addressed restrictions, and that report confirmed that claimant was capable of light duty. Thus, she was not entitled to TTD. With regard to SEB, the court stated that the record established only that the claimant could not return to her job of injury. It concluded that such was insufficient to prove entitlement to SEB.

Garcia v. Rouses Enter., Inc., 15-7 (La. App. 5 Cir. 5/14/15), 170 So. 3d 1157 [Attorneys - Miguel A. Elias (C), Christopher M. Landry (D); WCJ – Dunn; Panel – Wicker, Johnson, Windhorst]

Affirmed WCJ's denial of benefits based on claimant's failure to prove a compensable accident.

Claimant, a stock clerk for the defendant grocery store, claimed he felt pain in his waist, right thigh, and low back while moving a box at work. The incident was not witnessed. Claimant did not report the accident until nine days later, after consulting an attorney who referred him for medical treatment. In addition, claimant was "not forthcoming" concerning injuries suffered in a car accident a year and a half before he was hired by the defendant.

The WCJ found that claimant failed to prove a compensable accident under the *Bruno* standard, and the court of appeal found no manifest error.

Gibson v. Resin Sys., Inc., 2015-299 (La. App. 3 Cir. 10/7/15), 175 So. 3d 1141 [Attorneys - Marc Zimmerman (C), Eric J. Waltner (D); WCJ – Lowery; Panel – Pickett, Keaty, Savoie]

Affirmed WCJ's finding of a compensable accident and award of benefits, but reversed award of penalties and attorney fees.

Claimant allegedly injured his back at work in an unwitnessed accident. Defendant denied a compensable accident, relying on various alleged inconsistencies including questions concerning the accident date. *Inter alia*, claimant did not work on the date claimed in the 1008, and did not perform the activities he claimed on the amended accident date. He also initially failed to tell anyone at work that he had been injured on the job, nor did he note an injury in the employer's "injury log." Medical records were inconsistent.

The WCJ noted that the claimant "did at times struggle with some demeanor difficulties on the stand" and seemed "unable to provide readily comprehensible responses." Nonetheless, the court concluded that he met his burden of proving a compensable accident, and further awarded penalties and attorney fees.

"Reviewing all of the evidence," the court of appeal concluded that the record was sufficient to support a compensable accident. The court also rejected the defendant's contention that the trial court erroneously expanded the pleadings by allowing claimant to testify to alternative accident dates. However, the court found that the WCJ committed manifest error in awarding penalties and attorney fees, finding that the defense, although unsuccessful, was reasonable.

Marshall v. Courvelle Toyota, 2015-218 (La. App. 3 Cir. 10/7/15), 175 So. 3d 1069 [Attorneys - Christopher Philipp (C), H. Douglas Hunter (D); WCJ – Johnson; Panel – Peters, Ezell, Gremillion]

Reversed WCJ's denial of benefits, finding that evidence was sufficient to prove a compensable accident.

Employee allegedly injured his back helping to lift a transmission in the course and scope of his employment. His supervisors did not observe any apparent pain and the claimant did not

report the incident until five days later. He was then taken to an emergency room for treatment and restricted from work for a week. He returned the next Monday and continued working for several weeks, before filing a disputed claim for compensation seeking indemnity and medical benefits, penalties and attorney fees. Following trial, the WCJ concluded that the claimant failed to prove a compensable accident.

The court of appeal reversed, finding manifest error and stating: *"[I]t is not at all uncommon for an employee to initially ignore what appears to be a minor discomfort at the time to avoid appearing as a malingerer in the eyes of an employer. Discovery later that the minor event has manifested itself into a much more serious medical condition, does not preclude recovery of workers' compensation benefits. In this case, after recovering from the flu and realizing that his back discomfort was not associated with that event, Mr. Marshall reported the event to his supervisor at the first available moment. Additionally, even though Courvelle Toyota made much of Mr. Thompson's testimony that Mr. Marshall worked as normal through January 23, 2014, Ms. Freese's January 27, 2014 note reveals that Mr. Marshall's co-workers were aware that he was complaining of back pain."* The court awarded $8,000 in penalties and $16,385.17 for attorney fees.

Galiano v. Lucky Coin Mach. Co., 15-101 (La. App. 5 Cir. 10/14/15) [Attorneys - Brian Guillot (C), Frank R. Whiteley, III (D); WCJ – Dunn; Panel – Windhorst, Johnson, Murphy]

Reversed WCJ's award of benefits, finding that claimant failed to prove an accident.

Pool Table Technician began experiencing low back pain in August of 2013, but continued working for the next two months without reporting any symptoms to his employer because he feared termination. In late October of 2013, he had several jobs requiring heavy lifting. Thereafter, he experienced intense back pain. He informed his supervisor that he needed to see a doctor, but did not reference an accident. The supervisor said he was needed at work and had to give one week notice to take off. Claimant eventually saw his family doctor but still did not report an accident.

The WCJ concluded that the series of lifting incident in late October of 2013 constituted a work accident. The court of appeal held that the trial court committed manifest error, and that the record cast serious doubt on the claimant's version of the accident. Accordingly, claimant failed to prove an accident under the *Bruno vs. Harbert International* standard.

Harvey v. Sol's Pipe & Steel, Inc., 50,114 (La. App. 2 Cir. 10/28/15) [Attorneys - Louis Scott (C), Robert Dunkelman (D); WCJ – Jones; Panel – Calloway, Brown, Drew]

Affirmed WCJ's decision dismissing claim based on claimant's failure to prove a compensable injury.

Claimant with a history of shoulder complaints allegedly injured his shoulder at work. He claimed he reported the accident to two supervisors, both of whom denied any such report. In deposition, claimant denied prior shoulder problems. He also changed the accident date from 2011 to 2010, prompting an exception of prescription. However, the exception was denied

when claimant reasserted the 2011 date at the hearing. After trial on the merits, the WCJ found that claimant failed to prove an accident.

The court of appeal affirmed, finding that claimant presented contradictory evidence regarding any accident.

Mills v. Boasso Am. Corp., 2015-0515 (La. App. 4 Cir. 11/18/15) [Attorneys - John Fox (C), Scott Winstead (D); WCJ – Kellar; Panel – Tobias, Belsome, Dysart]

Reversed WCJ's grant of employer's motion for summary judgment asserting that claimant could not prove a compensable accident.

Claimant injured his back in 2000, and had occasional problems with it thereafter. MRI's showed varying degrees of disc pathology. In 2010, a physician interpreted a study as showing a large herniation at L5-S1, and bulging discs elsewhere. Claimant received several ESIs but was never told he was disabled prior to the alleged work accident.

On 11/30/10, claimant felt a pop in his back and shooting pain in his legs while lifting a box at work. He was taken to the hospital where MRI showed a "broad-based right paracentral extruded disc" at L4-5. Shortly thereafter he underwent disc surgery.

Claimant was awarded SSDI benefits in June of 2012, retroactive to October 12, 2010 (pre-work accident). Defendant terminated indemnity benefits in January of 2013, when the claimant allegedly rejected a job offer, prompting a disputed claim in April of 2013. In response to the 1008, defendant filed a motion for summary judgment contending that claimant could not prove that the alleged work accident aggravated his pre-existing condition. The motion noted that according to Social Security award, the claimant was actually disabled prior to the accident.

The WCJ granted the motion. The court of appeal reversed, finding genuine issues of material fact. The court noted that the SSDI award was based on social security rules, and despite the prior injuries and treatment, the claimant had returned and was able to continue until his accident.

AFFIRMATIVE DEFENSES

(1) *Willful Intent to Injure*

(2) *1208 Fraud*

Edwards v. Se. Freight Lines, Inc., 2014-871 (La. App. 3 Cir. 2/4/15) [Attorneys - David Bruchhaus (C), John Rabalais (D); WCJ – Lowery; Panel – Thibodeaux, Genovese, Kent]

Affirmed WCJ's grant of employer's motion for summary judgment based on 1208 fraud.

Claimant allegedly injured his back and legs while unloading a steel beam at work. He denied prior back problems to physicians and in a recorded statement to the insurer.

Subsequent discovery showed multiple prior accidents including treatment up to the day before the alleged work accident.

The WCJ granted summary judgment and the court of appeal affirmed, stating "*the record contains six volumes containing almost 1300 pages of documentation, plus a box of exhibits. The evidence overwhelmingly shows prior accidents, injuries, pain, and treatment involving Mr. Edwards' low back and neck, which he repeatedly denied*." The trial court judgment did not address restitution and the court of appeal declined to award such, noting that any benefits paid to the claimant were minimal.

Varnado v. Sanderson Farms, Inc., 2014-1305 (La. App. 1 Cir. 3/6/15) [Attorneys – Jennifer Valois (C), Jeffrey Mandel (D); WCJ – Thompson; Panel – Welch, Pettigrew, Chutz]

Affirmed WCJ's decision rejecting 1208 fraud defense.

The employer contended that the claimant had overstated his mileage reimbursement claim by fraudulently using his estranged wife's address as his residence. The appellate court found that the WCJ was not clearly wrong in rejecting the fraud defense, noting the claimant's limited education and limited understanding of the workers' compensation system.

Carrier v. Harrington, 2014-1027 (La. App. 3 Cir. 4/8/15) [Attorneys – Michael Miller (C), Kirk Landry (D); WCJ – Johnson; Panel – Cooks, Pickett, Gremillion]

Affirmed WCJ's decision rejecting claimant's 1208 fraud claim against a vocational rehabilitation consultant.

Attorney asserted a 1208 fraud claim against a vocational rehabilitation consultant, asserting that the consultant had made various misrepresentations during the rehab process. The court of appeal noted that the rehab consultant was entitled to the same strict interpretation of 1208 provided to claimants. The court concluded that the WCJ was not clearly wrong in crediting the consultant's testimony that she did not make any willful misrepresentations, nor did she do anything to defeat the claim for compensation.

Rachal v. Wal Mart Corp., 2015-97 (La. App. 3 Cir. 6/3/15), 165 So. 3d 441 [Attorneys - George Flournoy (C), R. O'Neal Chadwick, Jr. (D); WCJ – Braddock; Panel – Ezell, Thibodeaux, Gremillion]

Affirmed WCJ's rejection of 1208 fraud defense, finding that minor inconsistencies in claimant's testimony regarding prior injuries was insufficient to prove a willful misrepresentation intended for the purpose of collecting benefits.

Malone-Watson v. Strategic Restaurants, 2014-1191 (La. App. 1 Cir. 6/11/15), 176 So. 3d 417 [Attorneys - Kathleen M. Wilson (C), Goeffrey A. Mitchell (D); WCJ – Ourso; Panel – Holdridge, McDonald, Crain]

Affirmed WCJ's grant of employer's motion for summary judgment asserting 1208 fraud.

Claimant testified in deposition, taken seven months post-accident, that her work injury caused pain rated at "8 or 9" on a ten-point scale. She denied carrying anything heavier than a loaf of bread and denied driving. In support of its motion, the defendant offered surveillance video taken around the time of the deposition, showing claimant driving and using her arm without limitation. The WCJ concluded that claimant had misrepresented her injury in violation of R.S. 23:1208 and granted the motion.

The court of appeal affirmed. The court first noted that claimant had not objected to any of the evidence offered in support of the motion, and it was thus admitted. The court then concluded that the surveillance video was sufficient to prove that claimant's deposition testimony was a willful misrepresentation of her condition in violation of R.S. 23:1208, and affirmed the summary judgment.

Wiltz v. Luba Worker's Comp., 2015-145 (La. App. 3 Cir. 10/7/15), 175 So. 3d 1046 [Attorneys - Janice Hebert Barber (C), Matthew William Tierney (D); WCJ – Lanier; Panel – Saunders, Thibodeaux, Amy]

Affirmed WCJ's award of restitution under R.S. 23:1208, but amended and reduced the amount.

Claimant, the owner of a concrete business, allegedly injured his back lifting a tool at work. In a recorded statement, he admitted to one minor back injury previously, and denied any prior vehicle accidents. Thereafter, the insurer began paying medical and indemnity benefits. Six months post-accident, a claims survey indicated that the employee had at least two prior auto accidents where he made claims and was represented. He had undergone multiple MRIs for his low back and various lumbar disc injuries. When claimant refused an offer to settle the claim, the insurer terminated benefits for fraud, prompting a disputed claim.

Following trial on the merits, the WCJ ruled for the employer and ordered claimant to reimburse 54K in benefits. The court of appeal affirmed the decision, rejecting claimant's contention that his misstatements were innocent errors. The court noted medical evidence from prior claims, including a doctor's deposition taken just four months before the work accident, which indicated that claimant was aware of and misrepresented the severity of his prior injuries. [The court noted that it would have preferred for the WCJ to identify the specific statements on which restitution was based, rather than merely referencing a "plethora of false statements."

However, the court reduced the amount of restitution from 54K to 12K, stating: *"[I]n order for a payment to be eligible to be ordered paid back as restitution, it must have occurred both after the willful, fraudulent conduct transpired for the purpose of obtaining benefits and before or up to the employer becoming award of the fraudulent conduct.*" The court concluded that restitution was limited to payments made between the date of claimant's recorded statement and the date of the claims survey revealing the prior claims.

(3) 1208.1 Fraud

Lavalais v. Gilchrist Const. Co., LLC, 2014-785 (La. App. 3 Cir. 2/4/15) [Attorneys – Maria Losavio (C), L. Lyle Parker (D); WCJ – Braddock; Panel – Conery, Saunders, Pickett]

Affirmed WCJ's denial of 1208.1 defense, and award of benefits, penalties and attorney fees.

Claimant was injured in an undisputed accident. It was also undisputed that he completed a SIF form untruthfully regarding prior injuries. Nonetheless, the WCJ rejected the employer's 1208.1 fraud defense.

The court of appeal affirmed, stating: "*Mr. Lavalais' neck, back, and knee were previously injured and were 'more susceptible to re-injury' from a subsequent accident such as the one at issue. All of the medical evidence indicates that Mr. Lavalais did sustain an aggravation of a preexisting condition in his neck, back and knee, and that more likely than not made him more susceptible to re-injury in those areas. However, according to* Wise *and* Taylor, *the employer must meet an even higher standard in order to escape liability.* ***It must prove that Mr. Lavalais' injury was either 'inevitable' or 'very likely to occur.' None of the doctors testified that Mr. Lavalais' re-injury was 'inevitable' or 'very likely to occur,' within the plain wording of the applicable jurisprudence."***

(4) Intoxication

Joseph v. Georgia Pac., LLC, 2015-0227 (La. App. 1 Cir. 9/18/15) [Attorneys - Bryan D. Fisher (D), John J. Rabalais (D); WCJ – Ourso; Panel – Higginbotham, Pettigrew, Crain]

Reversed WCJ's grant of employer's motion for summary judgment based on intoxication defense in a claim for death benefits.

Employee died in an unwitnessed accident. Lab work was positive for marijuana, with THC levels of 1.3 ng/mL, triggering the statutory presumption. The employee's surviving children filed a disputed claim for death benefits. The employer responded with a motion for summary judgment asserting intoxication. In opposition to summary judgment, the survivors offered deposition testimony from co-workers indicating that the decedent did not appear intoxicated prior to the accident. The WCJ granted the motion.

The court of appeal reversed. Recognizing the presumption of intoxication, the court concluded that in light of the co-employee depositions, there were genuine issues of material fact as to whether the decedent was intoxicated and whether the intoxication caused his accident.

ATTORNEY FEES

Conner v. Bridgefield Cas. Ins. Co., 2015-621 (La. App. 3 Cir. 12/9/15) [Attorneys - Michael B. Miller (C), Matthew W. Tierney (D); WCJ – Bushnell; Panel – Peters, Cooks, Amy

Affirmed WCJ's award of medical and indemnity benefits, penalties, and attorney fees, but reduced award of costs, and awarded additional attorney fees on appeal.

Claimant slipped and fell at work. The WCJ awarded SEB at zero earning capacity, plus 23K in attorney fees, 8K in penalties for multiple denials of mileage, and $2,247.25 in expenses. In affirming the award, the court of appeal rejected the defendant's contention that statutory attorney fees were only due on the issues for which penalties were assessed (mileage).

AWW

Barbier v. Kraft Foods, 2014-872 (La. App. 3 Cir. 2/4/15) [Attorneys – Michael Miller (C), Leslie Hodge (D); WCJ – Johnson; Panel – Genovese, Thibodeaux, Savoie]

Affirmed WCJ's decision finding that claimant, a sales representative for Kraft Foods, was a salaried rather than an hourly employee, despite the fact that her pay stub reflected hourly wages.

The court stated: "*In the present case, the record, specifically Ms. Barbier's check stubs, supports the WCJ's determination that Ms. Barbier was a salaried employee earning $36,417.00 per year. As such, the minimum amount that she would receive per week was $700.33. This amount was owed to Ms. Barbier even if she worked less than forty hours in any given week. Additionally, Ms. Barbier's annual salary included payment for time that she was not working for holidays, vacation, and sick leave.* ***The fact that her pay is expressed in hourly terms on her pay stubs does not negate her status as a salaried employee****."*

Groover v. Lafitte's Boudoir, Inc., 2014-0926 (La. App. 4 Cir. 3/18/15) [Attorneys – Thomas Genusa (C), Jeremy Berthon (D); WCJ – Lundeen; Panel – Dysart, Landrieu, Ledet]

Affirmed WCJ's denial of SEB and award of penalty and attorney fee, **vacated and remanded** for a recalculation of AWW and TTD.

Claimant injured his shoulder in an altercation with a co-worker. He was paid a salary of $400 per week, but testified that he also received tips of $60 per day. An employee performing the same job testified similarly. (1) The WCJ concluded that claimant failed to prove the tips with any specificity and set the AWW at $400. The appellate court disagreed, finding that the testimony was sufficient to prove payment of "other wages." Nonetheless, the court found insufficient evidence to calculate the correct AWW under R.S. 1021(13)(d) and remanded the case to the WCJ for that purpose (and corresponding recalculation of TTD). (2) The court affirmed the WCJ's denial of SEB, noting evidence that the claimant worked in various capacities after his accident. It concluded: "[I]t is impossible to determine from the record whether Mr. Groover has been unable to earn ninety percent of his pre-injury wage." Thus, claimant failed to meet his initial burden under 1221(3). (3) The court rejected defendant's position that the WCJ's generic award of future medical treatment was improper, since such treatment is provided by law. (4) The court affirmed the WCJ's award of penalties and attorney fees, noting that the defendant asserted an initial aggressor defense without properly investigating the claim and taking statements from the only eyewitness.

Turner v. Lexington House, 2014-1264 (La. App. 3 Cir. 4/15/15) [Attorneys – George Flournoy (C), Morgan Levy (D); WCJ – Braddock; Panel – Thibodeaux, Ezell, Conery]

Affirmed WCJ's award of TTD benefits, penalties, and attorney fees.

Claimant, an admissions coordinator at a nursing home, was struck by a door at work shortly after having hip replacement surgery. She was taken off work and underwent exploratory surgery to check the status of the implant. The joint was found to be intact, but the treating physician concluded that the accident had aggravated her pre-existing condition precluding her from working. A year post accident, the employer sent "a list of random duties" to the treating and SMO physician. Both doctors checked off tasks and recommended an FCE. The surgeon also wanted an impairment rating and the SMO recommended a motorized scooter. Thereafter, the employer sent a job description as a nurse aid training instructor which was initially approved by claimant's physician. He subsequently withdrew the approval. Nevertheless, the employer terminated benefits, prompting a disputed claim.

At trial, the WCJ decided numerous issues in favor of the employer regarding the timely approval of treatment. However, he also reinstated TTD, recalculated claimant's AWW, ordered reconstructive surgery, approved certain medications, and awarded five penalties and attorney fees.

On appeal the court held: (1) Based on the medical evidence, the WCJ was not clearly wrong in reinstating TTD rather than SEB, particularly since SEB was never raised by the defendants until appeal; (2) WCJ was not wrong in applying a forty hour presumption to claimant's AWW, since she was only working reduced hours temporarily at the time of her accident due to her prior hip surgery; (3) WCJ properly ordered reconstructive surgery for a painful fat necrosis at the incision site of claimant's hip surgery. The court rejected defendant's position that the surgery was merely "cosmetic" and noted that defendant's brief quoted §1221(4) as it existed prior to 1983; (4) WCJ properly ordered defendant to pay for treatment/medication for her depression, which became worse after the work accident; (5) WCJ properly awarded 4K penalty for arbitrary termination of benefits under §1201(I), given that claimant's medical were not terminated; (6) WCJ properly awarded $2,000 penalty for failure to pay TTD at the correct rate, $2,000 for failure to authorize reconstructive/revision surgery, $2,000 for failure to authorize depression medication, and $2,000 for failure to authorize FCE recommended by treating and SMO physicians, per §1201(F); and (7) WCJ properly awarded $15,000 in attorney fees, which would be increased by 5K for work on appeal.

Augusta v. Audubon Zoo, 2015-0300 (La. App. 4 Cir. 9/23/15) 176 So. 3d 616 [Attorneys - Christopher R. Schwartz (C), John W. Ellinghausen (D); WCJ – Varnado; Panel – Lobrano, McKay, Belsome]

Affirmed WCJ's calculation of AWW.

Claimant suffered a compensable knee injury. The only issue for trial was AWW. At the time of his accident, claimant was paid an annual salary of $33,000. However, he had been demoted four months prior to his accident, with a resulting 10K decrease in annual salary.

He asserted that his AWW should be based on his total salary over the 52 weeks preceding the accident. The appellate court rejected that contention and affirmed the WCJ's calculation based on the annual salary in effect at the time of the accident.

CAUSATION

Miley v. Bogalusa Fire Dep't, 2014-1113 (La. App. 1 Cir. 3/6/15) [Attorneys - Floyd J. Falcon (C), Christopher Moody (D); WCJ – Thompson; Panel – Higginbotham, Whipple, McClendon]

Affirmed WCJ's judgment finding that firefighter's paroxysmal supraventricular tachycardia (PSVT) was compensable under the Heart and Lung Statute (HLS), La. R.S. 22:2581, and that claimant had not retired for purposes of limiting SEB claim to 104 weeks.

The defendant fire department asserted that claimant's condition was congenital, noting that he did not experience chest pains until 2010 and had a family history of heart problems, and that none of the experts testified that the condition was more probably than not related to claimant's work as a firefighter.

However, noting the statutory presumption of causation in the HLS, the court of appeal affirmed the WCJ's decision noting that it is the defendant's **"onerous burden" to prove that the condition was not caused, aggravated, or accelerated by his employment, and that the defendant failed to do so**. The court also rejected defendant's position that claimant's refusal of heart surgery was unreasonable and disqualified him from benefits. Finally, the court rejected defendant's position that claimant's receipt of retirement benefits disqualified him beyond 104 weeks of SEB, stating that "unemployment caused solely by employment injury is not considered 'retirement' for purposes of terminating SEB payments."

Buchanan v. LUBA Workers' Comp., 2014-1000 (La. App. 3 Cir. 2/4/15) [Attorneys – Somer Brown (C), Eric Waltner (D); WCJ – Bushnell; Panel – Gremillion, Peters, Amy]

Affirmed WCJ's award of benefits, $8,000 penalties, and $12,625 attorney fees, for aggravation of pre-existing injury.

Claimant, who had a prior rotator cuff surgery, injured her shoulder when a section of duct work fell a few inches and struck her. A co-worker verified the incident but not claimant's report of immediate pain. Claimant reported the incident immediately to supervisors because she was aware of a co-worker who failed to do so and had problems with his claim. The supervisors testified that claimant denied any injury and refused treatment. Conversely, claimant said she did not seek treatment because the supervisors told her she did not qualify for workers' compensation. Claimant worked three more days until the job was completed and she was laid off. She did not seek treatment for over three months, again allegedly because the supervisors told her the injury was not compensable. Her orthopedist diagnosed cervical disc and rotator cuff injuries. An IME diagnosed a contusion but said he could not claimant was not injured in the accident to any degree of medical certainty. A third orthopedist concluded that the incident did not cause any injury or aggravation, and a bio-mechanical expert retained by the defendant agreed.

The WCJ concluded that claimant proved a compensable aggravation of her pre-existing shoulder injury and awarded medical and indemnity benefits, along with $8,000 in penalties and $12,625 in attorney fees. The appellate court affirmed, finding no manifest error.

Strother v. City of Marksville-Police Dep't, 2014-581 (La. App. 3 Cir. 2/11/15) [Attorneys – Anthony Salario (C), Christopher Phillipp (D); WCJ – Braddock; Panel – Keaty, Gremillion (Conery dissents regarding award of penalties and attorney fees]

Affirmed WCJ's award of benefits, penalties and attorney fees.

Claimant was hired by defendant as a police officer in 2010. He underwent a pre-employment physical, at which time he disclosed a prior lumbar fusion due to a 2009 work injury with a prior employer. He had been released to return to work, although he continued to report some back symptoms. Shortly after being hired by defendant, he injured his low back while boxing during a training exercise at the police academy. He was treated and released to work two months later, albeit again with some ongoing back pain. He was assigned to light duty, but then terminated by the police department due to his prior lumbar fusion. He did not receive any workers comp benefits thereafter.

Claimant filed a disputed claim, which was consolidated with a pending claim concerning the 2009 back injury. He eventually settled the 2009 claim for $25,000, reserving his right to proceed against the police department re the subsequent injury.

The WCJ concluded that claimant aggravated his pre-existing back injury in the boxing incident, and that the aggravation (rather than the original injury) was the cause of his ongoing symptoms and disability. The court awarded indemnity and medical benefits, along with $4,000 in penalties and $8,500 in attorney fees. The court of appeal found no manifest error and affirmed.

Ruebush v. Office of Risk Mgmt., 2014-1107 (La. App. 3 Cir. 4/8/15), 160 So. 3d 659 [Attorneys – Marcus Zimmerman (C), H. Douglas Hunter (D); WCJ – Bushnell; Panel – Amy, Cooks, Saunders, Conery, Savoie]

Affirmed WCJ's award of medical and indemnity benefits, penalties, and attorney fees to a nurse who developed complex regional pain syndrome, despite contrary medical opinions.

Claimant, a nurse at the defendant nursing home, alleged that she was struck in the hand/wrist by an aluminum walker. She subsequently resigned due to the stressful nature of the position. Her hand initially improved and she began working at a hospital, her condition subsequently worsened, resulting in swelling and discoloration of the hand. A physician at the hospital referred her to an orthopedic surgeon who ultimately diagnosed CRPS. The employer paid some medical benefits but denied treatment with a pain management physician. An FCE indicated claimant could perform light duty.

Following trial, the WCJ awarded eight months of TTD followed by ongoing SEB, along with medical benefits, $4,000 in penalties, and $18,000 in attorney fees.

The appellate court affirmed. (1) The court found that the WCJ was not clearly wrong in accepting the pain management physician's diagnosis of CRPS, rejecting the defendant's position that the physician's opinion should be rejected because claimant had already selected an orthopedist as her treating physician. (2) The court rejected defendant's position that claimant was not entitled to reimbursement of co-payments made to her orthopedist even though the orthopedist had been fully paid once the carrier because aware of the charges. (3) WCJ was not clearly wrong in awarding TTD during the eight month period that claimant's pain management physician opined she was totally disabled. (4) WCJ was not clearly wrong in awarding SEB after the pain management physician released claimant to light duty, in the absence of any evidence concerning available light duty positions within the restrictions. (5) Penalty award was not clearly wrong in light of evidence reflecting that the employer relied on one doctor's opinion and failed to consider other reports supporting the CRPS diagnosis.

Mangiaracina v. Avis Budget Grp. Inc., 14-949 (La. App. 5 Cir. 5/14/15), 170 So. 3d 1113 [Attorneys - Michael R. Delesdernier (C), Patrick F. Cole (D); WCJ – Dunn; Panel – Murphy, Johnson, Chaisson]

Affirmed WCJ's award of benefits based on aggravation of a pre-existing injury.

Claimant, a retail rental and sales agent, was injured when her chair fell. She had a pre-existing injury to her left shoulder but testified that it had not limited her ability to work prior to the accident. Claimant's physician opined that the accident worsened the injury. Nevertheless, an adjuster for the defendant advised claimant that the condition was considered pre-existing and not covered under workers' compensation. Claimant ultimately required surgery paid through her health insurer.

The court of appeal affirmed the WCJ's award of benefits, finding that the preponderance of the evidence showed that the fall aggravated claimant's pre-existing shoulder injury and required surgery. The court rejected defendant's contention that the $750 applied to medical treatment, noting that the cap does not apply where compensability is denied.

Summers v. Ritz-Carlton New Orleans, 14-800 (La. App. 5 Cir. 5/28/15), 171 So. 3d 329 [Attorneys - Patrick Keating (C), Lance S. Ostendorf (D); WCJ – Dunn; Panel – Windhorst, Gravois, Chaisson]

Affirmed WCJ's finding of an accident but reversed award of indemnity and medical benefits beyond one month, as well as penalties and attorney fees.

Claimant, a nail technician for the defendant hotel, allegedly slipped and fell in an unwitnessed accident. She claimed she hit her head and entire left side. She reported the incident to her supervisor and filled out an accident report. She was treated at an occupational medicine clinic the next day. The defendant denied the occurrence of a compensable accident and asserted that claimant filed the dispute only after she was terminated for cause two months post-accident.

The court of appeal affirmed the finding of a compensable accident, noting that no evidence was submitted to refute the claimant's testimony regarding her fall. The court agreed that the fall caused a contusion to claimant's head and a mild concussion, causing headaches for approximately one month. However, the court concluded that claimant failed to prove that

any subsequent headaches were related to the accident, noting that she did not seek further treatment until four days after she was terminated. In addition, the court also reversed the trial court's finding that claimant's left shoulder, left hip, left knee, or low back were injured due to her fall, stating: "*None of the medical records independently stated claimant's shoulder pain was causally related to this accident. In fact, the medical records established claimant had pre-existing neck and shoulder injuries. Claimant was not entitled to the rebuttable presumption [of causation] and failed to prove by a preponderance of the evidence her shoulder was injured in this accident*."

The appellate court also reviewed the trial court's award of indemnity benefits for several distinct periods. In each instance, it found that claimant failed to prove an inability to work or a loss of earning capacity related to her work accident/injury. The court also found that medical benefits were limited to treatment provided in the month after the accident, and remanded the matter to the WCJ to specify the precise medical expenses to be reimbursed. In light of the above, the court also found the WCJ was manifestly erroneous in assessing penalties and attorney fees.

Dillard's, Inc. v. Nichols, 14-740 (La. App. 5 Cir. 5/28/15), 171 So. 3d 307 [Attorneys – Joseph Albe (C), Azelie Shelby (D); WCJ – Dunn; Panel – Windhorst, Chehardy, Gravois]

Reversed WCJ's decision (following new trial) finding that subsequent auto accident was a compensable aggravation of work injury.

Retail employee slipped and fell while going to lunch. She was treated and released to work without restriction after one week. Two weeks later she rode in a Mardi Gras parade and attended a ball. Three weeks after that, she was going to a follow up medical appointment when she was involved in a motor vehicle accident. The employer filed a disputed claim contending that the MVA was an intervening event. Claimant filed a dispute contending that the MVA was a compensable aggravation of her work injury.

Following trial, the WCJ awarded indemnity and medical benefits for one week post-accident, but found that claimant failed to prove that any subsequent disability was caused by the work accident. Claimant requested and the WCJ granted a new trial, but no new evidence was offered. Nevertheless, the court issued a new judgment finding that the automobile accident was compensable and awarding the claimant ongoing benefits.

The court of appeal reversed and reinstated the original judgment. The court stated that a nonwork-related automobile accident "is ordinarily a separate and intervening cause, and not a natural or expected consequence of the original work-related injury." The claimant had already been released to work without restriction, and the fact that she was en route to a doctor's appointment did not alter that conclusion.

Rachal v. Wal Mart Corp., 2015-97 (La. App. 3 Cir. 6/3/15), 165 So. 3d 441 [Attorneys - George Flournoy (C), R. O'Neal Chadwick, Jr. (D); WCJ – Braddock; Panel – Ezell, Thibodeaux, Gremillion]

Affirmed WCJ's judgment awarding medical and indemnity benefits, and rejecting employer's 1208 fraud defense.

Employee with a history of back injuries fell at work. She was referred to an orthopedist by the emergency room. The orthopedist released her to work after one week. She selected a different orthopedist who disabled her and ultimately recommended surgery. The employer contended that claimant's disability was due to pre-existing injuries, and further, that she had committed fraud by misrepresenting her prior condition. At trial on the merits, the WCJ allowed claimant to offer letters concerning mileage requests which had not been disclosed to the defendant. Following trial, the court rendered judgment for claimant, awarding medical and indemnity benefits, along with penalties of $8,000 and attorney fees of $15,000.

The court of appeal affirmed. Regarding causation, the court found that the WCJ was not clearly wrong in finding that the fall aggravated claimant's pre-existing condition. The court noted medical testimony indicating that she was able to work before her fall, and that afterwards, her symptoms began radiating to her legs. Likewise, medical testimony concerning claimant's inability to work after her fall supported the trial court's award of SEB, in the absence of any evidence from defendant concerning available jobs.

The court rejected defendant's fraud defense, finding that inconsistencies in claimant's testimony were minor and insufficient to show fraud. The court noted that the claimant had never denied prior injuries. The court further held that the WCJ was within its discretion in allowing claimant to offer letters not previously disclosed prior to trial, since such were relevant to the general claim for penalties and attorney fees.

DeBlanc v. Albertsons, L.L.C., 2013-2064 (La. App. 1 Cir. 6/17/15) [Attorneys - James E. Shields (C), Katherine Loos (D); WCJ – Thompson; Panel – Higginbotham, Whipple, McClendon]

Affirmed WCJ's judgment awarding benefits based on aggravation of pre-existing injury.

Claimant, a produce clerk for the defendant, had a long history of low back pain. He allegedly aggravated the injury while lifting a box at work. The employer paid benefits for several years before filing a disputed claim denying causation. Following trial on the merits, the WCJ found that claimant proved a compensable aggravation of his pre-existing injury and awarded benefits.

The appellate court affirmed. The court noted medical evidence acknowledging the claimant's medical history. However, it noted that he was able to return to work after each of the prior incidents of back pain, but unable to do so following the work accident. The court concluded that there was a reasonable basis supporting the WCJ's finding that the accident aggravated claimant's pre-existing injury and required the surgery recommended by his physician.

Marshall v. Town of Winnsboro, 50,255 (La. App. 2 Cir. 11/25/15) [Attorneys – Daniel Street (C), Brian Bowes (D); WCJ – Jones; Panel – Lolley, Caraway, Moore]

Affirmed WCJ's award of indemnity and medical benefits, penalties and attorney fees, finding a compensable aggravation of claimant's pre-existing back injury.

A supervisor with the defendant water company suffered "several" back injuries during his 33 years with the employer. He had always recovered with treatment and returned to work doing heavy labor. On November 1, 2012, he injured his back pulling a rod out of the ground. Three crew members confirmed he was in visible pain and unable to work the rest of the day. He returned to work in a limited capacity but was unable to perform heavy labor. Claimant saw his family doctor, who had treated him previously. The doctor noted a "gradual onset" and did not record any particular accident as the cause. He referred claimant to a neurosurgeon after an MRI showed multiple bulging lumbar discs.

Claimant saw a neurosurgeon two months post-accident. He reported the initial onset of back pain after a work accident in the early 1990s. Claimant returned to the doctor in May of 2013 with low back pain radiating to his legs. The neurosurgeon ultimately limited claimant to sedentary work. He could not quantify the impact of the alleged accident but agreed that such a trauma could worsen claimant's pre-existing degenerative condition. He noted that a comparison of pre- and post-accident lumbar MRI's showed some worsening.

A second neurosurgical exam was "essentially normal." However, the SMO noted "some aggravation" demonstrated on the MRIs, but recommended only OTC meds and permanent light duty. Claimant was disabled by his treating doctor as of September 2013 and ultimately underwent back surgery. The employer/carrier denied the claim, noting *inter alia* that the claimant had retired pursuant to the civil service DROP program, prompting a disputed claim.

After trial, the WCJ awarded indemnity benefits, along with a $500 penalty and $2,000 in attorney fees. The court of appeal affirmed, finding sufficient evidence to support a compensable aggravation of claimant's pre-existing back condition. The court also rejected defendant's condition that claimant had retired from the workforce, stating: "*The fact that an employee may receive some form of pension… in connection with his retirement from a job because of disability does not constitute retirement under La. R.S. 23:1221(3)(d)(iii).*"

Rixner v. E. Jefferson Gen. Hosp., 15-143 (La. App. 5 Cir. 9/23/15), 176 So. 3d 677 [Attorneys – Pro Se (C), Charles Taylor (D); WCJ – Dunn; Panel – Johnson, Gravois, Murphy]

Affirmed WCJ's award of indemnity benefits, but reversed award of penalties and remanded for further consideration of medical benefits.

Claimant, a registered nurse, allegedly suffered three separate work accidents. She initially injured her back moving a patient in December of 2011. In October of 2012, she slipped and fell, injuring her right knee and back. In December of 2012, she suffered left arm pain while turning a patient. Claimant had suffered several prior spine injuries due to motor vehicle accidents. She received periodic treatment for neck and back pain leading up to her work accidents, but had declined surgery. The last treatment was four months prior to her first work accident.

The employer contended that claimant's disability was not caused by her work accidents, and that any work-related aggravation had completely resolved. Following trial on the merits, the WCJ awarded TTD benefits and all medical expenses arising from the three work accidents, along with a penalty of $8,000.

The appellate court affirmed the award of benefits, noting that "*although claimant manifested cervical and lumbar symptoms prior to the first work-related accident, they were neither immediate nor disabling*." Further, the medical evidence "*sufficiently demonstrated a reasonable possibility of a causal connection…; thus, the presumption of causation attached*." Accordingly, the trial court was not clearly wrong in finding a compensable aggravation of the pre-existing injury. However, noting *inter alia* that pre-and post-accident diagnostic studies were unchanged, the court found that the award of penalties was manifest error. In addition, the court remanded the matter for a determination of the exact dollar amount of medical expenses owed by the defendant.

LeBlanc v. Wal-Mart Stores, Inc., 2015-558 (La. App. 3 Cir. 11/4/15) [Attorneys – Michael Miller (C), Keith Landry (D); WCJ – Morrow; Panel – Conery, Pickett, Ezell]

Affirmed WCJ's award of TTD benefits, medical benefits, penalties, and attorney fees.

Employee was injured in an undisputed accident when a 18-wheeler struck her left side at work. The employer disputed whether the accident caused the claimed injuries, asserting that the claimant only mentioned left knee and shoulder injuries at the time of the accident. However, the employer's report of injury completed shortly after the incident referenced "sprain/multiple body parts."

Multiple physicians generally agreed that the incident caused or could have caused claimant's injuries. She was released to sedentary work. She attempted to perform a part-time job for the defendant but was unable to continue after two weeks, after which her doctor again restricted her from work. Thereafter, an IME maintained that she could perform sedentary work. No further sedentary job was offered by the defendant.

Lay testimony reflected that the claimant was a long-time employee of Walmart. Several co-workers testified that she did not complain of injuries prior to the accident, but was visibly injured afterwards. Following trial on the merits, the WCJ rendered judgment for the claimant, finding that her injuries were caused by the accident and awarding TTD benefits, medicals. The court concluded that Walmart reasonably controverted claims for neck and back injuries, but awarded penalties and attorney fees for other errors including miscalculation of the AWW, late payment of indemnity benefits, and failure to pay medical benefits.

On appeal, the court concluded:

(1) The medical and lay evidence supported the WCJ's causation decision. *Inter alia*, regarding objections concerning the reliability of the treating orthopedist's opinion on causation, the court noted that the defendant failed to object to introduction of the doctor's certified records at trial.
(2) Employees signing a notice prior to seeing the defendant's doctor, acknowledging her right to choose her own doctor, did not make defendant's doctor her choice of physician.
(3) WCJ correctly included bonuses in calculating claimant's AWW, as such payments are not "fringe benefits," and the employer's failure to include such warranted a $2,000 penalty.

(4) Payment of TTD on a monthly rather than a bi-weekly basis justified $2,000 penalty, where claimant was previously paid bi-weekly.
(5) Failure to initiate TTD benefits for almost three months after receiving notice that claimant's physician had disabled her warranted a $2,000 penalty.

Conner v. Bridgefield Cas. Ins. Co., 2015-621 (La. App. 3 Cir. 12/9/15) [Attorneys - Michael B. Miller (C), Matthew W. Tierney (D); WCJ – Bushnell; Panel – Peters, Cooks, Amy

Affirmed WCJ's award of medical and indemnity benefits, penalties, and attorney fees, but reduced award of costs, and awarded additional attorney fees on appeal.

Claimant slipped and fell at work. She was initially treated for a left leg/knee injury requiring a knee replacement. She later claimed injuries to her right leg and back, which her original doctor concluded were not related to the work accident. A different physician related the right leg and back to the fall, but the employer denied compensability for those injuries.

The WCJ rendered judgment finding that the right knee and low back complaints were related to the accident. She awarded SEB at zero earning capacity, plus 23K in attorney fees, 8K in penalties for multiple denials of mileage, and $2,247.25 in expenses.

The court of appeal noted that the dispute centered primarily on interpretation of medical evidence. The medical opinions differed as to when claimant initially complained of right knee and low back pain, and the impact of certain pre-existing conditions. The court concluded that the WCJ was not clearly wrong in finding that the claimant's fall caused her right knee and back injuries, stating: *The evidence is clear that prior to her accident, Ms. Conner was performing her job duties with Jennings Hospital and was working a full schedule."*

The court also rejected the defendant's contention that statutory attorney fees were only due on the issues for which penalties were assessed (mileage). It did find that the WCJ erred in awarding costs expended by claimant's attorney for telephone calls, photocopies, postage, travel, and for the conference with claimant's doctor, and reduced the cost from $2,247.25 to $419.26. However, it awarded an additional $5,000 in attorney fees for work performed by claimant's attorney on appeal.

CHOICE OF PHYSICIAN/SMO'S/IME'S

LeBlanc v. Wal-Mart Stores, Inc., 2015-558 (La. App. 3 Cir. 11/4/15) [Attorneys – Michael Miller (C), Keith Landry (D); WCJ – Morrow; Panel – Conery, Pickett, Ezell]

Affirmed WCJ's award of TTD benefits, medical benefits, penalties, and attorney fees. In response to defendant's contention that claimant had already had one choice of physician, the court held that the employee's signing a notice prior to seeing the defendant's doctor, acknowledging her right to choose her own doctor, did not make defendant's doctor her choice of physician.

COURSE AND SCOPE

Theriot v. Full Serv. Sys. Corp., 2014-1199 (La. App. 3 Cir. 5/27/15), 166 So. 3d 1190 [Attorneys - Paul J. Cox (C), Elizabeth Lynn Finch (D); WCJ – Bushnell; Panel – Savoie, Cooks; Gremillion dissenting]

Affirmed WCJ's judgment that parking lot accident occurred in the course and scope of employment.

Casino employee injured her neck in a vehicle accident that happened prior to her shift, but while she was searching for a parking place at work. The WCJ rendered judgment finding that the accident occurred in the course and scope of employment. The court stated that claimant "had arrived at work when the accident occurred. She was neither going nor coming from work. She was at work, and she was on the employer's premises. The parking conditions of a casino with thousands of patrons are necessarily complex and unique.... It is clear that in the process of parking her car in the place closest to the employee entrance where her supervisors directed her to park, she was struck by a L'Auberge employee's vehicle."

The court of appeal affirmed, and awarded an additional $3,000 attorney fee for work on appeal.

Maxwell v. Care Sols., Inc., 50,088 (La. App. 2 Cir. 9/30/15) [Attorneys - C. Daniel Street (C), Donald J. Anzelmo (D); WCJ – Jones; Panel – Brown, Drew, Calloway]

Affirmed WCJ's judgment that accident occurred in course and scope of employment, but remanded for additional proceedings regarding the denial of TTD benefits.

Claimant, a caregiver for elderly and disabled people, usually worked 8-5. On the day of the accident though, her client complained of chest pains. Per the employer's protocol and instructions from the 911 operator, she accompanied the client to the hospital. The client asked her to take some items home and inform his wife of his condition. Claimant intended to do so but was mugged while walking back to her vehicle in the hospital parking lot.

Following trial, the WCJ concluded that claimant suffered a compensable accident, but denied indemnity benefits due to the lack of expert evidence indicating an inability to work. The court also assessed a $2,000 penalty and $8,000 in attorney fees for defendant's failure to provide medical benefits.

The court of appeal affirmed the finding that the accident occurred in the course and scope of employment. The court rejected defendant's contention that the claimant volunteered to accompany the client to the hospital, concluding that she was on a "special mission" pursuant to her employment. The court agreed that the defense was unreasonable and affirmed the award of penalties and attorney fees. With regard to indemnity benefits, the court noted that the claimant was unable to establish any disability because the defendant had improperly denied her medical treatment. Concluding that a "grave injustice" would result from denial of TTD, the court remanded the matter to the WCJ for additional evidence regarding disability.

DEATH BENEFITS

Estate of Belaire v. Crawfish Town USA, 2015-180 (La. App. 3 Cir. 12/9/15) [Attorneys – Jeff Speer (C), Eric Waltner (D); WCJ – Lanier; Panel – Thibodeaux, Cooks, Saunders; Amy and Pickett, dissenting]

Reversed WCJ's grant of summary judgment in a claim alleging the employee's death was caused by an overdose of medication prescribed as a result of a work accident.

Employee was prescribed medication for chronic pain allegedly due to a November 2010 work accident. She died in April of 2013. On May 20, 2013, the coroner issued a death certificate listing the cause of death as an accidental overdose of prescription medication. Defendant denied the claim, prompting survivors to file a disputed claim on May 7, 2014, seeking death benefits. The WCJ granted summary judgment, finding that the survivors could not establish causation and that the claim was prescribed.

The court of appeal reversed. Applying the doctrine of *contra non valentum*, the court concluded that the one year prescriptive period did not start until the survivors knew of their cause of action, i.e. when the coroner issued the death certificate identifying the cause of death. In addition, the court concluded that the coroner's conclusion regarding the cause of death was sufficient to create a genuine issue of material fact. The matter was remanded to the trial court for further proceedings.

EMPLOYMENT RELATIONSHIPS

Driesse v. Nat'l Oilwell Varco, LP, 2014-125 (La. App. 3 Cir. 1/14/15)

Tort suit. **Reversed** district court's judgment in part regarding employment relationship between the parties.

Plaintiff employee filed a suit against alleged employer, for whom he worked through a staffing agency, claiming sexual harassment under the Louisiana Employment Discrimination Law (La. R.S. 23:302), and for general negligence. The plaintiff asserted that several co-workers had verbally and sexually harassed him over several months prior to his termination. The employer filed a motion for summary judgment, contending that it was not an employer as defined under the LEDL, but that it was immune from negligence under La. R.S. 23:1032. The trial court granted the motion on both counts.

The court of appeal reversed with regard to the LEDL, noting that the employee was under the defendant's control and that the defendant paid his wages, albeit through an intermediary staffing agency. Applying a similar analysis, the court concluded that the defendant was an employer for purposes of workers' compensation, and affirmed the MSJ regarding 1032 immunity. "*For public policy purposes, we cannot countenance a situation where an employer is allowed to disclaim its status as an employer for any purpose that avoids liability while rushing to wrap itself in the protections afforded to an employer in the LWCA."*

Louque v. Scott Equip. Co., LLC, 15-43 (La. App. 5 Cir. 4/29/15), 170 So. 3d 335 [Attorneys – Robert Faucheux, Jr. (P), Timothy Hurley (D); Trial Court – 29th JDC; Panel – Chehardy, Windhorst, Liljeberg]

Reversed trial court's grant of no cause exception filed by defendant in wrongful death case.

Decedent was killed when equipment being loaded by a forklift rolled off a flatbed trailer. His survivors sued, inter alia, the owner of the site where the accident occurred. The owner responded with an exception of no cause, contending it was a statutory employer and immune from tort liability. The trial court granted the exception.

The court of appeal reversed. The court found that a provision in procurement agreement between the buyer of non-skilled maintenance services and contractor providing those services, granting statutory employer status to buyer or any of its subsidiaries or affiliates with regard to contractor's employees who performed services for buyer, did not confer statutory employer status to owner of accident site since the owner was not listed in the agreement as an affiliate or subsidiary, but as merely a location for services

Wilfred v. A. Serv. Cab Co., 2014-1121 (La. App. 4 Cir. 5/27/15), 171 So. 3d 1007 [R. Ray Orrill (C), Matthew R. Richards (D); WCJ- Varnado; Panel – Belsome, McKay, Lombard]

Affirmed WCJ's denial of death benefits, finding that the decedent taxi cab driver was not an employee of the defendant.

Decedent was robbed and killed while driving a cab. His surviving daughter asserted that he was presumed to be an employee of the decedent cab company, or alternatively, an independent contractor performing manual labor. The record established that while the decedent submitted an "employment application," it was not a true employment application and was used only for informational purposes. The defendant did not pay wages to the decedent. Instead, the decedent paid a weekly fee to access the defendant's dispatch system and goodwill. Defendant did not preclude drivers from servicing other customers, nor was there any formal termination or discipline process. The agreement could be terminated at the will of either party. While the defendant provided a training manual to drivers, it was primarily to ensure compliance with parish ordinances and compliance was rarely enforced. The decedent rented his cab from a third party, and the defendant provided insurance and paid for inspection stickers.

The WCJ found and the court of appeal agreed that the defendant "did not exercise the necessary control over the decedent's work so as to constitute an employment relationship." Accordingly, the appellate court affirmed the trial court's judgment dismissing the claim.

Berard v. The Lemoine Co., LLC, 2015-152 (La. App. 3 Cir. 7/8/15), 169 So. 3d 839 [Attorneys – C. Roan Evans (P), Foster Nash (D); Trial Court – 15th JDC; Panel – Peters, Conery, Savoie]

Tort Suit. **Affirmed** district court's grant of summary judgment, finding that plaintiff was the defendant's statutory employee.

Employee was injured when he fell through skylight while working on renovation of building. He sued the owner of the building and the general contractor. The general contractor filed a motion for summary judgment, arguing that it was the employee's statutory employer, and was therefore immune to tort liability.

The district court granted the motion and the court of appeal affirmed based on the "two contract" theory of statutory employment, despite observing that "*to hold Lemoine immune from tort liability … conflicts with both the spirit and purpose in creating the doctrine*." The court stated that the fact that the employee's direct employer was recognized as an independent contractor did nothing to change the relationship between the employee and the general contractor. [Note discussion of the basis for workers' compensation: "*Workers' compensation legislation was enacted in the early decades of the twentieth century, not to abrogate existing tort remedies that afforded protection to workers, but to provide social insurance to compensate victims of industrial accidents because it was widely believed that the limited rights of recovery under tort law were inadequate to protect these individuals.*"]

Whotte v. Int'l Paper Co., 2015-362 (La. App. 3 Cir. 10/21/15), 177 So. 3d 149, 149-50 [Attorneys – John Whaley (C), Herschel E. Richard, Jr., (D); Trial Court – Tenth JDC; Panel – Conery, Cooks, Genovese]

Tort suit. **Affirmed** trial court's grant of summary judgment in favor of statutory employer.

Subcontractor's employee brought personal injury action against general contractor, claiming that he sustained chemical burns to his feet and ankles while constructing scaffolding inside a boiler at contractor's plant. The trial court entered summary judgment in favor of contractor. The court of appeal affirmed, holding that contractor was employee's statutory employer for purposes of workers' compensation benefits, and thus contractor was immune from suit under workers' compensation exclusivity provision.

EVIDENCE

Wilson v. Broadmoor, LLC, 14-694 (La. App. 5 Cir. 3/11/15) [Attorneys – Greg Unger (C), Frank Towers (D); WCJ – Dunn; Panel – Chehardy, Murphy, Liljeberg]

Affirmed WCJ's decision reversing the OWC Medical Director's denial of treatment, excluding UR report from non-Louisiana licensed physician, and awarding penalties and attorney fees.

Claimant injured his back in a compensable fall. His treating physician recommended a lumbar laminectomy which the payer denied based on a utilization review by an out-of-state physician. The Medical Director agreed, concluding that the treatment was not within the MTG, and the claimant filed a 1008 appealing the decision. Following an expedited hearing, the WCJ concluded that the UR report was not competent evidence since the reviewing physician was not licensed in Louisiana. Reviewing the balance of the evidence, the court found that the Medical Director was clearly wrong in finding that the proposed surgery was contrary to the MTG. The court of appeal affirmed, finding no legal or factual error.

Rachal v. Wal Mart Corp., 2015-97 (La. App. 3 Cir. 6/3/15), 165 So. 3d 441 [Attorneys - George Flournoy (C), R. O'Neal Chadwick, Jr. (D); WCJ – Braddock; Panel – Ezell, Thibodeaux, Gremillion]

Affirmed WCJ's decision to allow claimant to introduce letters regarding mileage requests not disclosed to the defendant prior to trial.

Employee with a history of back injuries fell at work. The employer disputed compensability and asserted a fraud defense. At trial, the claimant offered several letters regarding mileage requests. Defendant objected to the letters because they had not been produced during discovery. The trial court overruled the objection but allowed defendant fifteen days to offer responsive evidence concerning payment of the requests. No such evidence was offered and the court assessed a $2,000 penalty for each request.

The court of appeal affirmed, holding that the WCJ was within its discretion in allowing claimant to offer letters not previously disclosed prior to trial, since such were relevant to the claim for penalties and attorney fees asserted in the pleadings.

Loucious v. Crest Indus., 2015-690 (La. App. 3 Cir. 12/16/15) [Attorneys - Malcolm X. Larvadain (C), Skylar J. Comeaux (D); WCJ – Braddock; Panel – Saunders, Peters, Keaty]

Affirmed WCJ's grant of summary judgment dismissing an occupational disease claim, finding that an attorney-prepared report signed by a physician was not "competent evidence" for purposes of defeating summary judgment.

Employee claimed he developed compartment syndrome in his right arm less than two months after defendant hired him as a welder. The employer filed a motion for summary judgment asserting that the employer could not rebut the statutory presumption against causation. Employee filed an untimely opposition to the motion, including a purported medical record prepared by his attorney in which a physician checked "yes" as to whether the condition was more probably than not related to the employment.

The WCJ denied a motion to strike the opposition but nevertheless granted summary judgment noting that nothing in the medical record indicated that the physician "*has any idea what the specific job functions and duties of [employee] was. And that's the burden of proof that [employee] has to establish*."

On appeal, the court noted that per statute, it was presumed that the employee's condition was not related to his employment. Addressing the employee's opposition, the court stated: "[T]*he document is not a certified copy of a medical report, a deposition, or an oral examination in open court, as is required to admit expert medical testimony into the workers' compensation court. Moreover, it is not sworn. Thus, the document is not competent evidence and has no evidentiary value. Therefore, it cannot be considered in challenging Appellees' motion for summary judgment. Because the document does not constitute competent evidence and Appellant has produced no other evidence to rebut the statutorily mandated presumption that the alleged occupational disease was not "contracted in the course of and arising out of such employment," with Crest, we find that Appellant failed to establish that he would be able to satisfy his evidentiary burden of proof at trial."*

HEALTHCARE PROVIDER CLAIMS

Crescent City Surgical Care Ctr. Facility, LLC v. Beverly Indus., LLC, 2014-0552 (La. App. 4 Cir. 3/25/15) [Attorneys - Paul A. Lea, Jr. (HCP), Robert J. May (D); WCJ – Lundeen; Panel – Dysart, Lombard, Landrieu, (Belsome and Jenkins dissenting)]

Affirmed WCJ's decision denying outlier status to healthcare provider.

Employee suffered a compensable injury and ultimately underwent a laminectomy and three-level fusion requiring a three day hospitalization. The carrier paid the applicable per diem but denied the provider's request for special reimbursement consideration. The OWC Medical Director recommended reimbursement for the implants used in the surgery plus 20%, but found that the documentation failed to show outlier status. The WCJ agreed.

On appeal, the court found that the plaintiff failed to prove it was either an automatic outlier, or that the case was "atypical in nature due to the case acuity causing unusually high charges compared to the provider's usual mix." The court noted that the mere fact that charges exceed the average case, even by "several hundred percent," is not the sole consideration in deciding outlier status. "It is the atypical nature and acuteness of the case… which determines whether a given case meets the outlier standard." Finding no manifest error, the court affirmed the WCJ's decision.

Naron v. LIGA, 49,996 (La. App. 2 Cir. 9/9/15), 175 So. 3d 475 [Attorneys – C. Daniel Street (C), Jeff Napolitano (D); WCJ – Jones; Panel – Drew, Caraway, Brown]

Reversed WCJ's judgment ordering carrier to fully reimburse employee's choice of pharmacy for prescription drugs provided to the claimant.

Employee suffered a compensable injury. He initially received prescription medication via a pharmacy card issued by the carrier. At some point a prescription was declined and he was told the coverage had expired. His attorney referred him to Injured Workers Pharmacy, which issued prescriptions for approximately six months at a cost of 7K. The carrier informed IWP that the employee should be using his prescription card, but IWP disregarded the notice, and subsequently sought reimbursement for the full amount of the expenses. The WCJ ruled in favor of IWP.

The court of appeal reversed. The court rejected jurisprudence from other circuits stating that the employer has the choice of pharmacy, citing its prior decision in *Brown vs. KTBS* (employee had right to select vendor for wheelchair). However, the court concluded that IWP was an out-of-state provider. Pursuant to La. R.S. 23:1203, an employee may use an out-of-state provider only if the services are provided at comparable costs charged by in-state providers. The court noted that IWP had charged $559.62 for the same prescription which had previously been dispensed by an in-state pharmacy for $39.88.

Lafayette Bone & Joint Clinic v. Guy Hopkins Const. Co., 2015-284 (La. App. 3 Cir. 10/21/15), 177 So. 3d 142 [Attorneys – Thomas Filo (HCP), Jeffrey Napolitano (D); WCJ – Morrow; Panel – Savoie, Pickett, Keaty]

Reversed WCJ's decision limiting healthcare provider reimbursement to $750, and awarded full reimbursement plus penalties and attorney fees.

Claimant was injured in a compensable accident. The carrier notified the treating physician that it would no longer reimburse him for medication he dispensed to the employee, and asked that he direct the employee to a retail pharmacy. At the time, the company had already paid more than $750 to the provider. The carrier's PBM sent a prescription card to all of the company's claimant's "suggesting but not requiring" that they use the card. The PBM did not notify the employee that it would no longer pay for physician-dispensed medications.

The WCJ rendered judgment limiting the provider's reimbursement to $750 and denying penalties and attorney fees. The court of appeal reversed holding that because the carrier had already paid and thus authorized treatment over $750, it could not rescind the authorization. Notably, citing its decision in *Rebel Distributors vs. LUBA*, the court stated: "*Rebel does not suggest that separate authorization for medication dispensed in connection with authorized office visits over $750.00 is required*." In addition to full reimbursement, the court awarded the healthcare provider a $2,000 penalty and $3,750 in attorney fees.

HEART RELATED/PERIVASCULAR INJURIES

INCARCERATION

INSURANCE COVERAGE

Jones v. Clesi Foundations, L.L.C., 2015-0157 (La. App. 1 Cir. 11/3/15) [Attorneys - Joseph Albe (C); Michael S. Coyle (D); WCJ – Thompson; Panel – McDonald, McClendon, Theriot]

Affirmed WCJ's grant of summary judgment finding that workers' compensation insurance policy was properly cancelled.

Employee obtained a default judgment against his employer as the result of an October 25, 2012 work accident, and then a judgment accelerating payment. After learning that the employer was insured, he amended his claim to name the insurer. The insurer asserted that notice of cancellation had been sent on October 10, 2012, advising the employer that the coverage would be cancelled at 12:01 a.m. on October 25th in the absence of payment of the premium. However, it failed to send 20-day notice of the cancellation to the OWC as required under LAC 40:I:1703.

The WCJ noted that La. R.S. 22:1267 specifically governs cancellation of workers' compensation insurance policies, and requires only that 10-days' notice of cancellation be given to the insured. The statute takes precedence over administrative rules. Because the insurer complied with the statute, the court of appeal agreed that the policy was not in effect

at the time of claimant's accident and summary judgment in favor of the insurer was appropriate.

JURISDICTION

Hernandez v. Louisiana Workers' Comp. Corp., 2015-118 (La. App. 3 Cir. 6/3/15), 166 So. 3d 456 [Attorneys – Craig Little (C), Gregory E. Bodin (D), Eric Waltner (D), Denis Juge (D); WCJ – Lanier; Panel – Cooks, Amy, Genovese]

Affirmed WCJ's denial of exception to subject matter jurisdiction.

Employee was injured while cutting timber to be used in construction of a boat ramp being built on Bayou Teche, a navigable waterway. At the time of the accident, he was working in a grassy area that was thirty to one-hundred feet from the ramp. In response to a disputed claim, defendant filed a subject matter jurisdiction exception, contending that the accident was subject to the LHWCA. The WCJ denied the exception.

The court of appeal affirmed. The court initially found that the evidence failed to show that the boat ramp was a "pier" as defined under the LHWCA, precluding defendant from proving the situs portion of the jurisdictional analysis. Further, the court agreed that the claimant's work was director toward land and was not maritime employment for purpose of establishing covered status under the LHWCA.

Johnson v. ACE Am. Ins. Co., 2015-0277 (La. App. 4 Cir. 9/23/15), 176 So. 3d 609 [Attorneys - D. Steven Wanko, Jr. (C), Kelly Walsh (D); WCJ – Lanier; Panel – Tobias, Lombard, Landrieu]

Vacated WCJ's decision granting employer's exception of lack of subject matter jurisdiction, and remanded the matter to the trial court pending a determination that the claimant was able to receive benefits under the LHWCA.

Claimant, a mechanic for the defendant, was injured in a work related boat collision. The employer was insured for both state comp and LHWCA but with separate insurers. Claimant filed a disputed claim with the OWC. The WCJ dismissed the claim with prejudice, finding that the accident was not covered under the state comp act. She did not specifically address whether it was covered under the LHWCA, noting the potential for various federal remedies.

The court of appeal vacated the judgment and remanded the matter, stating: "*While we recognize that a trial court has wide discretion to control and move its own docket, we find the WCJ abused that discretion in dismissing Mr. Johnson's claim prior to the rendition of a definitive determination that Mr. Johnson was receiving, or is eligible to receive, federal compensation benefits for his work-related injury, which would in turn preclude his eligibility to receive state compensation benefits under the LWCA. Accordingly, we vacate the OWC judgment and remand the matter to the OWC with instructions not to hear Mr. Johnson's case until such time as a definitive judgment has been rendered by the federal court on whether Mr. Johnson qualifies for benefits under the LHWCA or other similar federal statute.*"

Williams v. Morris Transp., 50,054 (La. App. 2 Cir. 11/18/15) [Attorneys – John Bruscato (C), Cole Smith (D); WCJ – Jones; Panel – Caraway, Drew, Garrett]

Reversed WCJ's denial of out-of-state employer's jurisdictional exception.

Employee was injured in a Mississippi car accident while driving a truck for an Arkansas based employer. He applied for and received benefits under Arkansas law, but then filed a disputed claim for Louisiana benefits. The employer asserted an exception of lack of subject matter jurisdiction.

At a hearing on the exception, the employee testified that he had worked for the defendant previously and called the company from Louisiana to see if he could come back to work for them. Based on a telephone conversation with the safety director, he understood that he was hired. His wife dropped him off at the company's office in Arkansas the next day, where he signed a driver qualification form but did not recall taking a driving or drug test. He started work the same day.

The safety director recalled the telephone conversation but denied hiring the claimant. She and the company president testified that a driver could not be hired before signing the driver qualification form. The WCJ denied the exception, finding that a contract of hire had been perfected over the telephone.

The court of appeal granted defendant's writ application and reversed. Citing R.S. 23:1035.1, the court stated that claimant's employment was not localized in Louisiana. Further, noting that the claimant had initiated the telephone call and was required to sign the federally mandated driving form at the company office in Arkansas, the court concluded that the contract was not made in Louisiana. Therefore, the Louisiana OWC did not have jurisdiction over the matter.

MEDICAL BENEFITS

Turner v. Lexington House, 2014-1264 (La. App. 3 Cir. 4/15/15) [Attorneys – George Flournoy (C), Morgan Levy (D); WCJ – Braddock; Panel – Thibodeaux, Ezell, Conery]

Affirmed WCJ's award of TTD benefits, penalties, and attorney fees.

Claimant, an admissions coordinator at a nursing home, was struck by a door at work shortly after having hip replacement surgery. She was taken off work and underwent exploratory surgery to check the status of the implant. The joint was found to be intact, but the treating physician concluded that the accident had aggravated her pre-existing condition precluding her from working. A year post accident, the employer sent "a list of random duties" to the treating and SMO physician. Both doctors checked off tasks and recommended an FCE. The surgeon also wanted an impairment rating and the SMO recommended a motorized scooter. Thereafter, the employer sent a job description as a nurse aid training instructor which was initially approved by claimant's physician. He subsequently withdrew the approval. Nevertheless, the employer terminated benefits, prompting a disputed claim. At trial, the WCJ decided numerous issues in favor of the employer regarding the timely approval of

treatment. However, he also reinstated TTD, recalculated claimant's AWW, ordered reconstructive surgery, approved certain medications, and awarded five penalties and attorney fees.

On appeal the court held: (1) Based on the medical evidence, the WCJ was not clearly wrong in reinstating TTD rather than SEB, particularly since SEB was never raised by the defendants until appeal; (2) WCJ was not wrong in applying a forty hour presumption to claimant's AWW, since she was only working reduced hours temporarily at the time of her accident due to her prior hip surgery; (3) WCJ properly ordered reconstructive surgery for a painful fat necrosis at the incision site of claimant's hip surgery. The court rejected defendant's position that the surgery was merely "cosmetic" and noted that defendant's brief quoted §1221(4) as it existed prior to 1983; (4) WCJ properly ordered defendant to pay for treatment/medication for her depression, which became worse after the work accident; (5) WCJ properly awarded 4K penalty for arbitrary termination of benefits under §1201(I), given that claimant's medical were not terminated; (6) WCJ properly awarded $2,000 penalty for failure to pay TTD at the correct rate, $2,000 for failure to authorize reconstructive/revision surgery, $2,000 for failure to authorize depression medication, and $2,000 for failure to authorize FCE recommended by treating and SMO physicians, per §1201(F); and (7) WCJ properly awarded $15,000 in attorney fees, which would be increased by 5K for work on appeal.

Arrant v. Wayne Acree PLS, Inc., 49,698 (La. App. 2 Cir. 4/15/15) [Attorneys – Daniel Street (C), Jeff Warrens (D); WCJ – Jones; Panel – Pitman, Caraway, Garrett]

Affirmed WCJ's decision finding (1) medical bill was paid timely, (2) authorization for a neurosurgical exam was timely, and (3) appeal of medical director's denial of treatment filed more than fifteen days after the decision was untimely.

Claimant injured his back in a compensable vehicle accident. He initially consulted a PI attorney, who scheduled an appointment with an orthopedist. The PI attorney eventually referred claimant to a WC attorney, who filed disputed claims seeking penalties and attorney fees and contending that the insurer, LWCC, failed to properly pay for and/or authorize medical treatment. Following trial on the merits, the WCJ rendered a decision in favor of the employer/insurer. The court found that (1) Defendants received a disputed medical bill on October 17, 2013, and paid it November 30, 2013, within the 60–day requirement of La. R.S. 23:1201(E)(1); (2) claimant failed to appeal the medical director's denial of treatment within fifteen days as required under LAC40:2715(K), and thus, the appeal was untimely; and (3) LWCC approved a request for examination by a neurosurgeon within thirty days after receiving the request, i.e. within the statutory delay.

The court of appeal found no manifest error, specifically noting that the OWC has authority to promulgate rules to implement the MTG, and that the delays provided in LAC 40:2715 "comport with the legislature's intent" to provide treatment in an "efficient and timely manner." Further, regarding timely payment, the court stated: "*A demand by a claimant for reimbursement for out-of-pocket expenses is insufficient to trigger a reimbursement obligation. Once the LWCC received the proper form on October 17, 2013, it timely*

reimbursed the funds on November 30, 2013, which was within the 60–day requirement of La. R.S. 23:1201(E)(1)."

Gales v. Whole Food Co., 2013-1492 (La. App. 4 Cir. 4/22/15), 165 So. 3d 1052 [

Reversed WCJ's grant of prematurity exception, finding that nutrients provided to claimant were not subject to the treatment guideline process.

Claimant was shot and paralyzed in 2001, in the course and scope of his employment for defendant. For many years thereafter, defendant had provided him with a nutrient called *Isosource 1.5 calorie with Benefiber*. Delivery of the product was stopped in 2013, in favor of a substitute product. Claimant asserted the substitute was unsuitable. In response to a disputed claim, defendant filed an exception of prematurity contending that claimant failed to exhaust the administrative process under R.S. 23:1203.1. The WCJ granted the exception.

The appellate court reversed. Recognizing the Louisiana Supreme Court's decision in *Church Mutual vs. Dardar*, the court concluded that the guideline process did not apply because there was no new request for the product, merely a decision by the defendant to use a substitute in place of the nutrient they had been providing for years.

Mangiaracina v. Avis Budget Grp. Inc., 14-949 (La. App. 5 Cir. 5/14/15), 170 So. 3d 1113 [Attorneys - Michael R. Delesdernier (C), Patrick F. Cole (D); WCJ – Dunn; Panel – Murphy, Johnson, Chaisson]

Affirmed WCJ's award of benefits, rejecting $750 cap on medicals where the employer denied compensability.

Claimant, a retail rental and sales agent, was injured when her chair fell. She had a pre-existing injury to her left shoulder but testified that it had not limited her ability to work prior to the accident. Claimant's physician opined that the accident worsened the injury. Nevertheless, an adjuster for the defendant advised claimant that the condition was considered pre-existing and not covered under workers' compensation. Claimant ultimately required surgery paid through her health insurer.

The court of appeal affirmed the WCJ's award of benefits, finding that the preponderance of the evidence showed that the fall aggravated claimant's pre-existing shoulder injury and required surgery. The court rejected defendant's contention that the $750 applied to medical treatment, noting that the cap does not apply where compensability is denied.

Landry v. Petroleum Helicopters, Inc., 2015-108 (La. App. 3 Cir. 6/3/15), 165 So. 3d 1269 [Attorneys - Jeffery F. Speer (C), Patrick A. Johnson (D); WCJ – Morrow; Panel – Gremillion, Thibodeaux, Ezell]

Affirmed WCJ's decision capping penalties at $8,000 and denying medical benefits for attendant care provided by employee's wife.

Employee suffered a serious brain injury due to a 1997 work accident, which *inter alia*, affected his impulse control. A life care plan estimated future care costs of approximately 14 million dollars, including $13,360,000 for attendant care provided by claimant's wife. Following trial on the merits, the WCJ awarded several penalties for various infractions, but capped the penalties at $8,000 based on the 2003 amendment to R.S. 23:1201(F). The court also denied reimbursement for attendant care provided by the claimant's wife.

Claimant appealed, asserting that the $8000 cap should not apply because some of the employer's infractions occurred prior to the 2003 amendment to the statute. The court of appeal rejected that contention, agreeing with the employer that a stipulated judgment agreed to by the parties in 2007 which addressed attorney fees was res judicata as to any such claims arising prior to the amendment. The court also agreed with the WCJ that the claimant's wife did not have the formal training required by the administrative code to support reimbursement for the care she provided.

MTG DECISIONS

Wilson v. Broadmoor, LLC, 14-694 (La. App. 5 Cir. 3/11/15) [Attorneys – Greg Unger (C), Frank Towers (D); WCJ – Dunn; Panel – Chehardy, Murphy, Liljeberg]

Affirmed WCJ's decision reversing the OWC Medical Director's denial of treatment, excluding UR report from non-Louisiana licensed physician, and awarding penalties and attorney fees.

Claimant injured his back in a compensable fall. His treating physician recommended a lumbar laminectomy which the payer denied based on a utilization review by an out-of-state physician. The Medical Director agreed, concluding that the treatment was not within the MTG, and the claimant filed a 1008 appealing the decision. Following an expedited hearing, the WCJ concluded that the UR report was not competent evidence since the reviewing physician was not licensed in Louisiana. Reviewing the balance of the evidence, the court found that the Medical Director was clearly wrong in finding that the proposed surgery was contrary to the MTG. The court of appeal affirmed, finding no legal or factual error.

Thomas v. Marsala Beverage Co., 50,062 (La. App. 2 Cir. 9/30/15) [Attorneys – Allan Placke (C), Donald Anzelmo (D); WCJ – Jones; Panel – Garrett, Caraway, Drew]

Affirmed WCJ's decision reversing the associate medical director's denial of an epidural steroid injection.

Claimant suffered a low back and neck injuries due to an undisputed work accident. His pain management physician recommended a lumbar epidural steroid injection. Defendant denied the treatment based on an SMO. The OWC associate medical director concluded that in the absence of documentation that the procedure was being done to facilitate active therapy, the treatment was contrary to the medical treatment guidelines.

Claimant appealed to the WCJ. In addition to previously submitted records, he offered the deposition of the treating pain management physician. The WCJ reversed the denial of treatment. The court of appeal affirmed, noting that the post-1009 deposition of the pain

management doctor "provided a straightforward, commonsense, and cogent explanation for why the ESI treatment recommended by Dr. Forte was medically necessary."

The court also stated: "***We cannot help but note that, in this particular case, more than 18 months have now lapsed from the time the treatment was requested and the rendition of this opinion. Whether this is efficient and timely is certainly debatable***."

Prince v. Superior Energy Servs., L.L.C., 2015-728 (La. App. 3 Cir. 12/16/15) [Attorneys - Bret C. Beyer, Sr. (C), Michael E. Parker (D); WCJ – Johnson; Panel – Genovese, Thibodeaux, Savoie]

Reversed WCJ's denial of benefits, finding legal error in the trial court's reliance on SMO and IME opinions, noting that previously provided treatment relied on by those physicians was contrary to the treatment guidelines.

Employee suffered a low back injury when he jarred his feet and back at work. He was initially seen by the defendant's orthopedist who ordered an MRI two days post-accident. That doctor diagnosed a lumbar strain and prescribed conservative care. Claimant subsequently selected his own orthopedist. That doctor recommended another MRI several months later. Defendant denied the request and recommended an IME. The IME concluded that claimant suffered a strain due to the work accident, which should have resolved. He did not attribute any ongoing symptoms to the accident. Accordingly, defendant terminated further benefits. A second MRI was performed despite the denial of benefits, and claimant continued seeing his orthopedist who recommended a discogram.

Following trial on the merits, the WCJ ordered defendant to pay for the second MRI but otherwise denied benefits based on the SMO and IME opinions. The appellate court reversed. The court concluded that the WCJ committed legal error in crediting the SMO and IME opinions, noting that initial treatment and particularly the initial MRI ordered by the SMO, were contrary to the medical treatment guidelines. Conducting a *de novo* review, the court concluded that the treating physicians recommendations were in accordance with the medical treatment guidelines and therefore entitled to greater weight. It ordered defendant to reinstate indemnity benefits and provide the medical treatment recommended by the treating physician. In addition, the court assessed a $2,000 penalty for defendant's denial of the second MRI, a $2,000 penalty for denial of a psych evaluation pending a discogram, and a $2,000 penalty for termination of TTD benefits, plus attorney fees of $6,000 through appeal.

MENTAL INJURIES

MODIFICATION

Numa C. Hero & Son v. Leleux, 2015-305 (La. App. 3 Cir. 10/28/15) [Attorneys – Michael Miller (C), Stephen Glusman (D); WCJ – Morrow; Panel – Savoie, Pickett, Keaty]

Affirmed WCJ's modification of judgment from TTD to SEB at zero earnings.

Per a 2005 consent judgment, claimant was awarded TTD. In 2010, the treating physician recommended but claimant declined lumbar surgery. An SMO in 2012 found that claimant could work without restrictions. Claimant was unable to complete a FCE recommended by

the IME due to blood pressure issues. After the IME recommended sedentary work restriction, the employer sought modification of the disability status. The WCJ granted modification and converted indemnity benefits to SEB at zero earnings.

The court of appeal affirmed. Citing R.S. 23:1310.8, the court agreed that claimant's condition was now permanent rather than temporary, representing a change in condition or circumstance. It stated that the statutory language "*is broad and does not limit the requisite change in conditions to a physical change in the claimant's condition*." The court concluded that the claimant's condition had stabilized such that he no longer required treatment. Thus, TTD was no longer appropriate. The court rejected as "contrary to Louisiana law "the claimant's contention that the WCJ could not consider his condition as he appeared at trial. Likewise, the court held that the WCJ was not clearly wrong in giving more weight to the IME opinion.

Olivier v. Olivier Builders, 2015-217 (La. App. 3 Cir. 11/18/15) [Attorneys - Michael Miller (C), Mark Ackal (D); WCJ – Johnson; Panel – Amy, Gremillion, Conery; Thibodeaux and Saunders dissenting]

Affirmed WCJ's modification of claimant's disability status from TTD to SEB

Claimant, a self-employed carpenter, was declared TTD after a 2003 work accident. The employer/carrier filed a motion to modify the prior judgment, asserting that he was no longer totally disabled and his benefits should be reclassified as SEB. Claimant asserted there was no change in circumstances, and that the medical evidence was limited to the opinions of the same physicians whose opinions were cited in the original judgment.

The WCJ granted the motion and converted claimant's benefits to SEB based on zero earning capacity. The court found that the medical evidence now showed that the claimant was capable of light duty. Claimant appealed and filed an exception of *res judicata* in the appellate court.

The appellate court denied the res judicata exception, noting that workers' compensation judgments are subject to modification under R.S. 23:1310.8, based on changes in circumstances. The court concluded that the evidence supported the WCJ's decision, stating: "*We especially note that, subsequent to the 2008 trial, additional imaging studies were obtained and Mr. Olivier was examined by multiple doctors, including twice by the IME physician, Dr. Beurlot. Perhaps most importantly, Mr. Olivier testified that he was able to perform various tasks around the house, including such potentially strenuous jobs as mowing the lawn and changing the oil in his vehicles*."

OCCUPATIONAL DISEASE

Mulder v. Jefferson Parish Hosp. Serv. Dist. No. 2, 14-805 (La. App. 5 Cir. 3/25/15) [Attorneys - William H. Beaumont (C), Jacqueline G. Griffith (D); WCJ – Dunn; Panel – Murphy, Johnson, Liljeberg]

Reversed WCJ's award of benefits, penalties, and attorney fees.

Claimant, a nurse, alleged that she "developed chronic bilateral bicipital tendonitis/distal biceps tendinopathy as a result of repetitive lifting" at work. The 1008 listed an accident date of April 30, 2013. However, claimant and her husband testified that there was no single event that caused her symptoms. Her treating physician testified that it was "well within the realm of possibility" that her condition was caused by her work, and ultimately related 100% of her symptoms to her job. However, he admitted that he had not treated any other nurses for similar complaints. The WCJ found a compensable accident and awarded benefits, penalties, and attorney fees. On appeal, claimant acknowledged that the finding of an accident was error but asserted that she sustained a compensable occupational disease.

The appellate court rejected the argument, finding claimant failed to show her condition resulted from or was peculiar to the nature of her work. The court also rejected claimant's contention that the defendant admitted a compensable OD in its answer, noting that the issue was listed in claimant's own pretrial statement and in an amended answer filed shortly before trial.

Allensworth v. Grand Isle Shipyard, Inc., 15-257 (La. App. 5 Cir. 10/28/15) L. Eric Williams, Jr. (C), Raymond S. Maher, Jr. (D); WCJ – Kellar; Panel – Gravois, Chehardy, Liljeberg]

Affirmed WCJ's decision that claimant failed to prove non-Hodgkins lymphoma was caused by workplace exposure to benzene.

Claimant alleged he developed non-Hodgkins' lymphoma due to cleaning storage tanks at a shipyard, in the course and scope of his employment. Claimant's oncology expert testified by affidavit that the condition was, in whole or in part and more probably than not, related to benzene exposure. Defendant's expert testified that while there is an association between benzene and non-Hodgkins lymphoma, it does not reach the level of scientific causation.

The court of appeal affirmed. Stating that a finding of occupational disease requires expert testimony, the court found that the WCJ was not clearly wrong in giving more weight to the defendant's expert. The court noted that the claimant's expert never personally examined him and relied only on the claimant's affidavit, medical records and other discovery to reach his opinion. He also failed to note that the claimant had Hepatitis-C, a known cause of non-Hodgkins lymphoma.

Although acknowledging that the absence of causation made the issue moot, the court also held that the WCJ was not manifestly wrong in finding that the claimant failed to prove he was permanently and totally disabled. It noted that claimant relied heavily on a determination from the Social Security Administration, which itself relied on a medical report concerning claimant's disability while he was receiving treatment. There were no contemporaneous medical records to support the disability claim at the time of the workers' compensation trial.

Loucious v. Crest Indus., 2015-690 (La. App. 3 Cir. 12/16/15) [Attorneys - Malcolm X. Larvadain (C), Skylar J. Comeaux (D); WCJ – Braddock; Panel – Saunders, Peters, Keaty]

Affirmed WCJ's grant of summary judgment dismissing an occupational disease claim, finding that an attorney-prepared report signed by a physician was not "competent evidence" for purposes of defeating summary judgment.

Employee claimed he developed compartment syndrome in his right arm less than two months after defendant hired him as a welder. The employer filed a motion for summary judgment asserting that the employer could not rebut the statutory presumption against causation. Employee filed an untimely opposition to the motion, including a purported medical record prepared by his attorney in which a physician checked "yes" as to whether the condition was more probably than not related to the employment.

The WCJ denied a motion to strike the opposition but nevertheless granted summary judgment noting that nothing in the medical record indicated that the physician "*has any idea what the specific job functions and duties of [employee] was. And that's the burden of proof that [employee] has to establish*."

On appeal, the court noted that per statute, it was presumed that the employee's condition was not related to his employment. Addressing the employee's opposition, the court stated: "[T]*he document is not a certified copy of a medical report, a deposition, or an oral examination in open court, as is required to admit expert medical testimony into the workers' compensation court. Moreover, it is not sworn. Thus, the document is not competent evidence and has no evidentiary value. Therefore, it cannot be considered in challenging Appellees' motion for summary judgment. Because the document does not constitute competent evidence and Appellant has produced no other evidence to rebut the statutorily mandated presumption that the alleged occupational disease was not "contracted in the course of and arising out of such employment," with Crest, we find that Appellant failed to establish that he would be able to satisfy his evidentiary burden of proof at trial."*

OFFSETS/CREDIT

Nitcher v. Northshore Reg'l Med. Ctr., 2014-1291 (La. App. 1 Cir. 9/18/15) [Attorneys - Steven Wanko, Jr. (C), Foster P. Nash, III (D); WCJ – Thompson; Panel – Higginbotham, Pettigrew, Crain]

Reversed WCJ's decision reducing employer's reverse SS offset based on attorney fees deducted from workers' comp indemnity payments.

Claimant received PTD benefits and SS disability benefits. Employer sought an offset per 23:1225(A). The WCJ allowed the offset but reduced it by the 20% of weekly indemnity benefits approved as attorney fees. The appellate court reversed, holding that the employer was entitled to the full offset.

Hill v. Fresenius Med. Care NA, 50,291 (La. App. 2 Cir. 11/18/15) [Attorneys – Allen Cooper (C), Eric Buerger (D); WCJ – Robinson; Panel – Garrett, Moore, Pitman]

Affirmed WCJ's decision awarding employer an offset for disability benefits received by the claimant under an employer-funded disability insurance policy.

Claimant suffered compensable bilateral carpal tunnel syndrome. Defendant paid TTD benefits but terminated the payments in March of 2013. Claimant began receiving long-term disability benefits under an employer-funded policy. In August of 2013 she filed a disputed claim. In response, inter alia, the employer asserted that it was entitled to an offset based on the disability benefits. Claimant argued that the disability insurer had demanded reimbursement of the payments based on her receipt of social security benefits, but acknowledged that she had not repaid the money and hoped ultimately to keep at least a portion of it.

The WCJ awarded SEB, a $2,000 penalty and $8,000 in attorney fees, but allowed employer the offset. Claimant appealed the offset issue. The court of appeal affirmed, agreeing with the trial court that if/when claimant returned the disability benefits, she could seek to modify the judgment.

PENALTIES

McCombs v. G.L. Jones Const., Inc., 49,541 (La. App. 2 Cir. 1/14/15) [Attorneys – Pamela Grady (C), Isaac E. Khalid (D); WCJ – Robinson; Panel – Pitman, Stewart, Drew]

Reversed WCJ's award of penalty and attorney fee for failure to authorize medical treatment with claimant's choice of physician.

Claimant injured his foot while working as a welder. His employer convinced him to claim unemployment in lieu of workers' compensation in order to avoid lost time claim, and agreed to pay for his medical treatment. Claimant received unemployment for approximately eight months post-accident, and the employer paid for treatment by its choice of physician. Claimant was not released by the physician, but stopped treating at some point. He ultimately filed a disputed claim demanding medical and indemnity benefits. The WCJ denied the claim for indemnity, finding that claimant failed to prove any ongoing disability beyond the termination of his UE benefits. However, the court found that the employer failed to authorize treatment with a physician of claimant's choice, and awarded such treatment. In addition, recognizing that claimant had not specifically requested statutory penalties/attorney fees, the court nevertheless awarded such benefits, citing jurisprudence that courts should "ferret out" such claim when appropriate. The employer appealed the penalty/attorney fee award.

The Second Circuit reversed that portion of the judgment, citing La. C.C.P. art. 861's requirement that items of special damage must be specifically plead. The court further noted that in the nine months between when he stopped treatment and the filing of the disputed claim, the claimant never specifically communicated a request for additional treatment to the employer.

Brown v. AM Logging & Alternative Serv. Concepts, LLC, 2014-1491 (La. App. 1 Cir. 6/18/15), 175 So. 3d 426 [Attorneys - Isaac H. Soileau, Jr. (C), John A. Keller (D); WCJ – Thompson; Panel – Theriot, Guidry, Drake]

Affirmed WCJ's decision denying claimant's motion to accelerate benefits under R.S. 23:1333, denying penalties/attorney fees under R.S. 23:1201(I), finding that claimant's neck symptoms were not related to his work accident, and denying request for penalties/attorney fees under R.S. 23:1201(F).

Claimant was injured in 2005. In 2010, the OWC rendered a judgment finding the injury was compensable and awarding benefits. The employer appealed, and in August of 2011, the judgment was affirmed in relevant part. The parties subsequently filed a motion to release the 50K appeal bond, with $14,543 of the bond being paid to the claimant in full satisfaction of the past due payments. The WCJ signed the order approving that motion in November of 2011.

Thereafter, claimant filed another disputed claim contending that the employer failed to timely pay indemnity benefits owed under the judgment. He sought 1201(I) penalties/fees and acceleration of benefits under 1333. He further asserted that he was entitled to medical treatment for neck and thoracic pain caused by the accident, and claimed 1201(F) penalties/fees based on defendant's failure to approve such treatment.

The appellate court affirmed the WCJ's decision, concluding: (1) claim for untimely benefits was precluded under the doctrine of res judicata, in light of the order approving the release of the appeal bond and payment to the claimant; (2) claimant was not entitled to acceleration of payments where the defendant had not missed six consecutive payments; (3) WCJ was not clearly wrong in finding that claimant's neck injury was pre-existing and unrelated to his work accident, in light of medical evidence to that effect; and (4) Claimant was not entitled to penalties/fees for denial of his request to select an orthopedist to treat his thoracic complaints, where he had already selected an orthopedist to treat rib complaints related to the thoracic injury.

Rixner v. E. Jefferson Gen. Hosp., 15-143 (La. App. 5 Cir. 9/23/15), 176 So. 3d 677 [Attorneys – Pro Se (C), Charles Taylor (D); WCJ – Dunn; Panel – Johnson, Gravois, Murphy]

Affirmed WCJ's award of indemnity benefits, but reversed award of penalties and remanded for further consideration of medical benefits.

Regarding the $8,000 penalties awarded to the claimant, the appellate court noted that the defendant based its decisions on various medical reports indicating that the claimant had returned to her baseline level of function. It concluded that the defendant "*had articulable and objective reason to deny benefits."*

Gibson v. Resin Sys., Inc., 2015-299 (La. App. 3 Cir. 10/7/15), 175 So. 3d 1141 [Attorneys - Marc Zimmerman (C), Eric J. Waltner (D); WCJ – Lowery; Panel – Pickett, Keaty, Savoie]

Affirmed WCJ's finding of a compensable accident and award of benefits, but reversed award of penalties and attorney fees.

Claimant allegedly injured his back at work in an unwitnessed accident. Defendant denied a compensable accident, relying on various alleged inconsistencies including questions concerning the accident date. *Inter alia*, claimant did not work on the date claimed in the 1008, and did not perform the activities he claimed on the amended accident date. He also initially failed to tell anyone at work that he had been injured on the job, nor did he note an injury in the employer's "injury log." Medical records were inconsistent.

The WCJ noted that the claimant "did at times struggle with some demeanor difficulties on the stand" and seemed "unable to provide readily comprehensible responses." Nonetheless, the court concluded that he met his burden of proving a compensable accident, and further awarded penalties and attorney fees.

"Reviewing all of the evidence," the court of appeal concluded that the record was sufficient to support a compensable accident. The court also rejected the defendant's contention that the trial court erroneously expanded the pleadings by allowing claimant to testify to alternative accident dates. However, the court found that the WCJ committed manifest error in awarding penalties and attorney fees, finding that the defense, although unsuccessful, was reasonable.

LeBlanc v. Wal-Mart Stores, Inc., 2015-558 (La. App. 3 Cir. 11/4/15) [Attorneys – Michael Miller (C), Keith Landry (D); WCJ – Morrow; Panel – Conery, Pickett, Ezell]

Affirmed WCJ's award of TTD benefits, medical benefits, penalties, and attorney fees.

Employee was injured in an undisputed accident when a 18-wheeler struck her left side at work. The employer disputed whether the accident caused the claimed injuries, asserting that the claimant only mentioned left knee and shoulder injuries at the time of the accident. However, the employer's report of injury completed shortly after the incident referenced "sprain/multiple body parts."

Multiple physicians generally agreed that the incident caused or could have caused claimant's injuries. She was released to sedentary work. She attempted to perform a part-time job for the defendant but was unable to continue after two weeks, after which her doctor again restricted her from work. Thereafter, an IME maintained that she could perform sedentary work. No further sedentary job was offered by the defendant.

Lay testimony reflected that the claimant was a long-time employee of Walmart. Several co-workers testified that she did not complain of injuries prior to the accident, but was visibly injured afterwards. Following trial on the merits, the WCJ rendered judgment for the claimant, finding that her injuries were caused by the accident and awarding TTD benefits, medicals. The court concluded that Walmart reasonably controverted claims for neck and

back injuries, but awarded penalties and attorney fees for other errors including miscalculation of the AWW, late payment of indemnity benefits, and failure to pay medical benefits.

On appeal, the court concluded:

(1) The medical and lay evidence supported the WCJ's causation decision. *Inter alia*, regarding objections concerning the reliability of the treating orthopedist's opinion on causation, the court noted that the defendant failed to object to introduction of the doctor's certified records at trial.
(2) Employees signing a notice prior to seeing the defendant's doctor, acknowledging her right to choose her own doctor, did not make defendant's doctor her choice of physician.
(3) WCJ correctly included bonuses in calculating claimant's AWW, as such payments are not "fringe benefits," and the employer's failure to include such warranted a $2,000 penalty.
(4) Payment of TTD on a monthly rather than a bi-weekly basis justified $2,000 penalty, where claimant was previously paid bi-weekly.
(5) Failure to initiate TTD benefits for almost three months after receiving notice that claimant's physician had disabled her warranted a $2,000 penalty.

Taylor v. Hanson N. Am., 2015-0729 (La. App. 1 Cir. 12/23/15) [Attorneys - Matthew W. Tierney (C), Frank R. Whiteley (D); WCJ – Thompson; Panel – McDonald, McClendon, Theriot]

Affirmed WCJ's dismissal of claim for penalties and attorney fees due to alleged untimely payment of a consent judgment.

Parties entered a consent judgment whereby the defendant agreed to pay a $7,000 penalty and $7,000 attorney fee. The agreement was agreed to between the parties on November 19, and a consent judgment was signed on December 1. Defendant issued payment on December 26. Claimant filed a 1201G motion for penalties and attorney fees, contending that the payment was untimely because it was issued more than thirty days after the agreement was made between the parties.

The WCJ denied the motion. The court of appeal affirmed, noting that the record failed to include any evidence of an agreement prior to December 1. Thus, the claimant failed to prove there was a settlement "reduced to writing and signed by the parties."

PERMANENT PARTIAL DISABILITY

Dupard v. MMR Constructors, Inc., 2015-0019 (La. App. 1 Cir. 9/18/15) [Attorneys - William R. Mustian (C), Phillip E. Foco (D); WCJ – Ourso; Panel – McClendon, McDonald, Theriot]

Affirmed WCJ's award of PPD benefits for scarring to her knee, but reduced the award from 25 weeks to ten weeks, noting that the trial court's award was more than the claimant would have received for the loss of a finger or toe, both of which unlike the subject scarring, included loss of function.

PRESCRIPTION

Alexander v. Med. Staffing Network, Inc., 49,774 (La. App. 2 Cir. 5/20/15), 166 So. 3d 386 [Attorneys - Mary S. Bylsma (C), Robert A. Dunkelman (D); WCJ – Robinson; Panel – Stewart, Pitman; Brown dissenting]

Affirmed WCJ's grant of employer's prescription exception.

Claimant injured her back on August 5, 2010, while lifting a patient. She was treated and released to sedentary work on August 10, 2010. The employer offered a position within the restrictions but claimant did not return to work. In November of 2010, the carrier issued two TTD checks to claimant's original attorney. However, shortly thereafter, she advised the attorney that the checks were issued erroneously. The attorney agreed to return one check that had not been deposited, and refunded the other from his trust account. Claimant did not file a disputed claim until July of 2012, prompting the employer's prescription exception.

The WCJ concluded that the erroneous payment of TTD, as acknowledged by claimant's original attorney, did not interrupt prescription. The appellate court affirmed, holding that the voluntary return of the erroneously issued checks had the legal effect of nullifying them.

Shailow v. Gulf Coast Soc. Servs., 2015-91 (La. App. 3 Cir. 6/10/15), 166 So. 3d 1239 [Attorneys - Marcus Zimmerman (C), Eric Waltner (D); WCJ – Lowery; Panel – Thibodeaux, Ezell, Gremillion]

Affirmed WCJ's judgment awarding benefits, but reversed denial of prescription exception on medical benefits.

Claimant was injured in a work related motor vehicle accident. She eventually settled with the tortfeasor. She continued to work for a year post-accident before terminating her employment and filing a disputed claim. The employer filed an exception of prescription, which the WCJ denied. Following trial on the merits, the WCJ concluded that the tortfeasor's voluntary payment interrupted prescription of the medical claim, and that the claim was filed within one year of the development of claimant's injury. The court further found that claimant suffered a compensable injury entitling her to indemnity and medical benefits, as well as penalties and attorney fees.

The court of appeal reversed the denial of the prescription exception for medical benefits. Recognizing that the tortfeasor and the employer were solidarily liable, the court nevertheless held that in the absence of a formal suit against the tortfeasor, the legal system was not put "into motion" by a voluntary settlement payment, for purposes of interrupting prescription. The court affirmed the denial of prescription on indemnity benefits, finding that the claimant's disability did not develop until she was no longer able to work. Accordingly, the claim filed shortly thereafter was timely even though it was more than one year post accident.

Borja v. St. Bernard Parish Government, 2015-CA-0435 (La. App. 4 Cir. 12/9/15) [Attorneys – Joyce Young (C), David Parnell (D); WCJ – Dunn; Panel – Bagneris, Love; McKay dissents in part]

Affirmed WCJ's grant of employer's prescription exception.

Employee, a firefighter, filed a disputed claim in March of 2004 claiming knee and thumb injuries due to a 2002 accident. He also alleged "Heart and Lung." The employer admitted the knee injury but denied knowledge of any thumb injury or heart/lung claim. The matter was settled and dismissed in 2008. Claimant continued to receive medical benefits through 2009, and SEB through August of 2013. After exhausting SEB, he filed a new dispute in November of 2013, claiming "knees, heart and lung" as his injuries.

The WCJ granted exceptions of res judicata regarding the knee injury, and prescription regarding the heart and lung claim, and claimant appealed.

The court of appeal noted that the claim for medical benefits was prescribed on its face since the disputed claim was filed more than three years after the last payment of medical benefits in 2009. The court rejected claimant's contention that a subsequent payment under his group health insurance interrupted prescription, concluding that any claim for medical benefits had prescribed.

The court also agreed with the employer's position that payment of SEB benefits for claimant's knee injury did not interrupt prescription of total disability benefits for a heart and lung injury, stating *"[E]ven though Mr. Borja may have an ongoing claim for his 2002 knee injury which ended in August 2013, that claim does not have any effect on the accrual of prescription for a separate and distinct occupational disease claim for a heart and lung condition*." [Judge McKay dissented with the decision regarding the heart/lung claim].

PRELIMINARY DETERMINATIONS/LA R.S. 23:1201.1

PROCEDURE/MISCELLANEOUS

Gavarrette v. Home Team Prods., LCI, 2015-0358 (La. App. 4 Cir. 9/23/15) [Attorneys - Roberto L. Costales (C), Wayne J. Fontana (D); WCJ – Varnado; Panel – Belsome, McKay, Lobrano].

Affirmed WCJ's assessment of $250 in sanctions based on improper pursuit of a motion that had become moot. The court of appeal affirmed the sanction but amended the judgment to assess it against claimant's attorney, rather than the claimant.

PERMANENT TOTAL DISABILITY

Davis v. General Motors, 49,645 (La. App. 2 Cir. 2/26/15) [Attorneys – Pro Se (C), Martin Lattier (D); WCJ – Robinson; Panel – Moore, Brown, Caraway]

Affirmed WCJ's denial of PTD benefits.

Claimant injured both shoulders in 1999 while working for the defendant automobile plant. She underwent shoulder surgery in 2000 and 2005, and never returned to work. In addition to her shoulder injuries, she suffered from multiple other maladies, both physical and psychological. The employer terminated indemnity benefits after 520 weeks, prompting the disputed claim for PTD. Medical records showed very little recent treatment of the work injury. An FCE and SMO agreed that claimant could perform some work. However, voc rehab concluded that claimant was unemployable due to the combination of her overall physical condition and low academic test scores.

Following trial on the merit, the WCJ concluded that the claimant failed to prove her ongoing disability was caused by her work injuries rather than her multiple other health issues and subsequent accidents, and denied benefits. The court of appeal affirmed, finding no manifest error.

Young v. City of Gonzales, 2014-1299 (La. App. 1 Cir. 3/12/15) [Attorneys – Michelle Sorrells (C), Christopher Moody (D); WCJ – Lanier; Panel – McClendon, Whipple, Higginbotham]

Affirmed WCJ's award of PTD but **reversed** award of penalty and attorney fee.

Claimant suffered a compensable fall in 2000 while working as a clerical employee for a city police department. She suffered failed back syndrome despite multiple surgeries, and continued to complain of chronic back pain radiating to her legs, for which she took pain medication. Substantial vocational rehab efforts were unsuccessful in returning claimant to work. However, indemnity benefits were terminated in 2011, based on the treating physician's approval of jobs identified in a labor market survey. The treating physician testified that he cleared claimant for sedentary work but questioned whether she could perform any sustained employment. Claimant retained a voc rehab expert who opined that it was unrealistic to expect any employer to hire the claimant. Thereafter, claimant's doctor issued a report and gave a supplemental deposition stating that claimant was PTD. An SMO concluded that claimant could perform sedentary work. An IME agreed that claimant could perform sedentary work, but questioned whether she could do so on a sustained basis.

The appellate court concluded that the WCJ was not clearly wrong in finding that claimant was PTD. However, the court reversed the award of penalties and attorney fees, noting contradictory evidence regarding claimant's work capacity and finding that the defense of the claim was reasonable.

Royals v. Town of Richwood, 49,582 (La. App. 2 Cir. 4/29/15), 165 So. 3d 1075 [Attorneys – C. Daniel Street (C), Brian Bowes (D); WCJ – Jones; Panel – Stewart, Brown, Lolley]

Affirmed WCJ's denial of PTD benefits, finding that claimant's disability was not due to her work injury.

Claimant, a high school resource officer, twisted her knee in 2002 in a compensable accident. She ultimately underwent total knee replacement. In 2005, her doctor released her to her prior job. Per prior judgments, she had been awarded SEB which was terminated after 520 weeks. The evidence showed that claimant suffered from multiple medical issues, but failed to show that the conditions were related to her work accident/injury.

The court of appeal found that the WCJ was not clearly wrong in finding that claimant's current disability was unrelated to her work injury.

Stelly v. CNA Ins. Co., 2015-379 (La. App. 3 Cir. 10/21/15), 177 So. 3d 159, 159-60 [Attorneys - Howard C. Dejean (C), Eric K. Buerger (D); WCJ – Palermo; Panel – Genovese, Cooks, Conery]

Reversed WCJ's decision that claimant was TTD and awarded PTD.

67 year old claimant "with a significant medical history" suffered a compensable injury in 2005. He underwent unsuccessful voc rehab. In 2014, he filed a disputed claim seeking PTD status, along with penalties and attorney fees. Claimant subsequently filed a motion for summary judgment, since both his doctor and the defendant's doctor had declared him PTD. The motion was deferred to trial on the merits. Following trial, the WCJ denied claimant's motion for summary judgment. Further, while acknowledging that the medical evidence reflected PTD status, the court awarded TTD benefits pending an FCE and vocational rehabilitation.

The court of appeal affirmed the denial of summary judgment, noting that the issue od disability status required a credibility determination which is inappropriate for summary judgment. However, the court reversed the award of TTD benefits and concluded that the claimant was PTD. The court noted that the WCJ had found that claimant was able to engage in "some physical activities," but held that the proper standard is whether he can "engage in any self-employment or occupation for wages of any kind." Based on the record, the court found he could not.

Allensworth v. Grand Isle Shipyard, Inc., 15-257 (La. App. 5 Cir. 10/28/15) L. Eric Williams, Jr. (C), Raymond S. Maher, Jr. (D); WCJ – Kellar; Panel – Gravois, Chehardy, Liljeberg]

Affirmed WCJ's decision that claimant failed to prove non-Hodgkins lymphoma was caused by workplace exposure to benzene. In *dicta*, acknowledging that the absence of causation made the issue moot, the court stated that the WCJ was not manifestly wrong in finding that the claimant failed to prove he was permanently and totally disabled. It noted that claimant relied heavily on a determination from the Social Security Administration, which itself relied on a medical report concerning claimant's disability while he was receiving treatment. There were no contemporaneous medical records to support the disability claim at the time of the workers' compensation trial.

RES JUDICATA

Brown v. AM Logging & Alternative Serv. Concepts, LLC, 2014-1491 (La. App. 1 Cir. 6/18/15), 175 So. 3d 426 [Attorneys - Isaac H. Soileau, Jr. (C), John A. Keller (D); WCJ – Thompson; Panel – Theriot, Guidry, Drake]

Affirmed WCJ's decision denying claimant's motion to accelerate benefits under R.S. 23:1333, denying penalties/attorney fees under R.S. 23:1201(I), finding that claimant's neck

symptoms were not related to his work accident, and denying request for penalties/attorney fees under R.S. 23:1201(F).

Claimant was injured in 2005. In 2010, the OWC rendered a judgment finding the injury was compensable and awarding benefits. The employer appealed, and in August of 2011, the judgment was affirmed in relevant part. The parties subsequently filed a motion to release the 50K appeal bond, with $14,543 of the bond being paid to the claimant in full satisfaction of the past due payments. The WCJ signed the order approving that motion in November of 2011.

Thereafter, claimant filed another disputed claim contending that the employer failed to timely pay indemnity benefits owed under the judgment. He sought 1201(I) penalties/fees and acceleration of benefits under 1333. He further asserted that he was entitled to medical treatment for neck and thoracic pain caused by the accident, and claimed 1201(F) penalties/fees based on defendant's failure to approve such treatment.

The appellate court affirmed the WCJ's decision, concluding: (1) claim for untimely benefits was precluded under the doctrine of *res judicata*, in light of the order approving the release of the appeal bond and payment to the claimant; (2) claimant was not entitled to acceleration of payments where the defendant had not missed six consecutive payments; (3) WCJ was not clearly wrong in finding that claimant's neck injury was pre-existing and unrelated to his work accident, in light of medical evidence to that effect; and (4) Claimant was not entitled to penalties/fees for denial of his request to select an orthopedist to treat his thoracic complaints, where he had already selected an orthopedist to treat rib complaints related to the thoracic injury.

Toliver v. Entergy Servs., Inc., 49,954 (La. App. 2 Cir. 6/24/15) [Attorneys – Pro Se (C), Michael DuBos (D); WCJ – Robinson; Panel – Drew, Moore, Pitman]

Affirmed WCJ's grant of *res judicata* exception.

Claimant was injured in 1993 and received benefits until they were terminated in 2011. In 2012, the parties executed a full and final settlement of the claim, which was approved by a WCJ. Claimant was represented in the settlement and signed an affidavit stating that she had read an understood it. However, in 2014 she filed a disputed claim pro se.

The WCJ granted the employer's exception of res judicata. The court of appeal affirmed, finding that the claim arose from the same facts as the 2012 settlement.

Richard v. Quality Const. & Prod., LLC, 2014-987 (La. App. 3 Cir. 11/4/15) [Attorneys – Jennifer Valois (C), Skylar Comeaux (D); WCJ – Morrow; Panel – Ezell, Cooks, Gremillion]

Affirmed the WCJ's denial of employer's *res judicata* exception based on another state's denial of benefits, where employee had not instituted or participated in the other state proceedings.

Louisiana resident was injured in a car accident while working in North Dakota. The North Dakota workers' compensation administrative body found that the accident resulted from

claimant's use of drugs and alcohol. That decision was not appealed or challenged. Claimant subsequently filed a disputed claim for compensation in Louisiana. He asserted he never pursued a claim in North Dakota, nor did he receive notice of such. The WCJ denied defendant's res judicata exception.

On appeal, the employer asserted that the North Dakota decision was entitled to full faith and credit under the U.S. Constitution, and that it was res judicata regarding the Louisiana claim. The claimant denied participating in the North Dakota proceedings and contended that he never received notices sent to his Louisiana address because he was still receiving treatment in Minnesota.

Distinguishing the case from the earlier decision in *Early vs. R&J Technical Services*, and on remand from the Louisiana Supreme Court, the court noted that North Dakota did not have jurisdiction to adjudicate the employee's rights under Louisiana Workers' Compensation Act. Further, the court noted that "exceptional circumstances" justified relief from res judicata, specifically the claimant's inability to participate in the North Dakota proceedings.

SETTLEMENTS

Louisiana Commerce & Trade Ass'n, SIF v. Williams, 2014-1680 (La. App. 1 Cir. 6/5/15) 174 So. 3d 696 [Attorneys - Richard D. McShan (C), Stephen W. Glusman (D); WCJ – Thompson; Panel – Theriot, Guidry, Drake]

Affirmed WCJ's judgment incorporating Medicare set-aside in settlement over claimant's objection.

Claimant was injured in a forklift accident at work. He filed a tort suit against the forklift company which he subsequently settled. Thereafter, he and his employer agreed to settle his workers compensation claim for reimbursement of benefits paid by the comp carrier and funding of an MSA. However, claimant failed to provide information needed for approval of the MSA for two years. Ultimately, the WCJ approved the MSA prepared by the employer and approved by CMS in the amount of 61K, despite claimant's objection to the MSA. The court of appeal affirmed, finding that the WCJ did not abuse her discretion in incorporating the MSA into the approved the settlement.

Bracken vs. Payne & Keller, 2014 CA 0637 (La. App. 1 Cir. 8/10/15) [Attorneys – Peggy Robinson (C), Kirk Landry (D); WCJ – Ourso; Panel – Guidry, Theriot, Drake]

Affirmed WCJ's decision denying the claimant's motion to annul a 1999 judgment approving a full and final settlement.

Claim arose from an alleged chemical exposure in 1996. Claimant settled a tort suit and his workers' compensation claim in 1999, and the settlement was approved by a WCJ. Nonetheless, claimant filed a disputed claim in 2005, contending that his attorneys misled him. The WCJ granted exceptions of prescription and imposed sanctions on the claimant. The appellate court affirmed, but noted in a footnote that claimant could seek nullification of the 1999 judgment. Accordingly, in 2013 claimant filed a motion to annul the prior judgment which the WCJ denied.

Construing the decision as a grant of an exception of no cause, the appellate court affirmed. The court stated that claimant's allegations of misrepresentation by his prior attorneys *"[do] not constitute a vice of form pursuant to La. C.C.P. art.2002, but rather is a vice of substance under La. C.C.P. art.2004. Further, an action to annul a judgment based on alleged fraud or ill practices cannot be collaterally attacked in the existing proceedings, but must be brought by a direct or new and separate proceeding in the court that rendered the judgment sought to be annulled. Thus, Mr. Bracken's motion to annul was not properly before the OWC, and, the OWC did not err in failing to consider the motion."*

In addition, the court concluded that claimant's development of cancer allegedly related to his original exposure was incorporated in the 1999 settlement and did not justify a new trial. The court rejected the defendant's demand for damages due to frivolous appeal, stating "*we cannot say that he does not seriously believe in the position that he advocates.*" (Note - Theriot would award damages for frivolous appeal.)

SUPPLEMENTAL EARNINGS BENEFITS

Harris v. City of Bastrop, 49,534 (La. App. 2 Cir. 1/14/15) [Attorneys – Daniel Street (C), Johnny Huckabay, II (D); WCJ – Jones; Panel – Garrett, Caraway, Moore]

Affirmed WCJ's decision denying claim for PTD and alleged underpayment of SEB.

Claimant, a fireman, injured his knee in 2001while removing a smoldering mattress. He received 52 weeks of statutory sick leave, after which the employer initiated TTD. In August of 2002, the employer converted the indemnity benefits to SEB based on two jobs identified via vocational rehabililtation. In 2011, the claimant filed a disputed claim, contending that his SEB had been reduced improperly based on the 2002 voc rehab, and that he was PTD. The WCJ found that only one of the 2002 positions was appropriate, but that this was to the claimant's detriment since the position paid a higher wage than the average of the two jobs used by the employer. Based on medical evidence reflecting that claimant was capable of at least sedentary work, particularly the opinion of claimant's own doctor, she also denied the PTD claim.

The court of appeal found that the SEB analysis was not clearly wrong, noting that the employee had apparently sabotaged attempts to return to work by immediately informing potential employers of and apparently exaggerating his use of pain medication. Likewise, the court agreed that the employee failed to meet the heightened burden of proof regarding PTD.

Carambat v. City of New Orleans Police Dep't, 2014-0810 (La. App. 4 Cir. 2/4/15) [Attorneys – Theodore Alpaugh, III (C), Craig Mitchell (D); WCJ – Varnado; Panel – Jenkins, Belsome, Bonin]

Reversed WCJ's grant of employer's MSJ, finding genuine issues of material fact concerning claimant's ability to return to work.

Claimant suffered a compensable injury in 2007. He eventually returned to work, but suffered another work accident in 2010 that aggravated the injury. The employer initiated

TTD. A vocational rehabilitation consultant identified five jobs, three of which were approved by claimant's physician. However, the doctor issued a subsequent report limiting claimant to sedentary work provided the commute time did not exceed fifteen minutes. Defendant converted benefits to SEB based on the voc rehab, asserting that claimant had at least some work capacity that precluded TTD. In addition, benefits were reduced per the earning capacity provided by the lowest paying job approved by the physician.

In response to claimant's 1008, the employer filed a motion for summary judgment which the WCJ granted. The court of appeal concluded that the treating physician's testimony was conflicting, and that there was a genuine issue of fact as to whether claimant's TTD was properly reduced to SEB. Accordingly, summary judgment was improper.

Miley v. Bogalusa Fire Dep't, 2014-1113 (La. App. 1 Cir. 3/6/15) [Attorneys - Floyd J. Falcon (C), Christopher Moody (D); WCJ – Thompson; Panel – Higginbotham, Whipple, McClendon]

Affirmed WCJ's judgment finding that firefighter had not retired for purposes of limiting SEB claim to 104 weeks. The court rejected defendant's position that claimant's receipt of retirement benefits disqualified him beyond 104 weeks of SEB, stating that "unemployment caused solely by employment injury is not considered 'retirement' for purposes of terminating SEB payments."

Bridges v. Gaten's Adventures Unlimited, L.L.C., 2014-1132 (La. App. 1 Cir. 4/2/15), 167 So. 3d 992 [Attorneys - Daren Sarphie (C), Rchard J. Voelker (D); WCJ- Thompson; Panel – Crain, McDonald, Holdridge]

Reversed WCJ's award of disability benefits, penalties and attorney fees, despite finding compensable accident.

Claimant, a part-time bus driver for the defendant bus company, injured her low back while lifting a child onto the bus. She did not mention the injury to anyone and finished the trip. The company office was closed by the time she returned that evening. She returned the next morning but was unable to locate her supervisor. She continued to have sharp back and leg pains over the weekend, and went to the emergency room and reported the accident to ER personnel.

The following Monday, she reported the accident to her supervisor, who told her to go to the doctor. She went her to another emergency room and returned with paperwork for the employer. The supervisor told her to contact the company's insurer but did not provide any contact information. Claimant requested treatment with a neurosurgeon, which was never approved. Two months after the accident, she began working as a sitter for a "senior care" center. The WCJ found that claimant suffered a compensable accident and awarded TTD for the period from the accident until she began working as a sitter, and SEB thereafter, along with medical benefits, penalties and attorney fees.

The court of appeal affirmed the finding of a compensable accident, despite some discrepancies in the initial medical records. The court rejected the employer's position that there were no "objective findings" of an injury, noting that the statutory definition of injury

"contains no requirement of objective findings or symptoms." It concluded that the WCJ was not clearly wrong in finding that the accident caused the claimant's injury.

However, the court reversed the award of TTD benefits. It noted that only one medical report addressed restrictions, and it confirmed that claimant was capable of light duty. Thus, she was not entitled to TTD. With regard to SEB, the court stated that the record established only that the claimant could not return to her job of injury. It concluded that such was insufficient to prove entitlement to SEB.

Sanchez v. Caesar's Entm't, Inc., 49,864 (La. App. 2 Cir. 6/24/15), [Attorneys - Mark Manno (C), Robert Dunkelman (D); WCJ – Robinson; Panel – Pitman, Williams, Garrett]

Affirmed WCJ's decision denying indemnity benefits but reversing medical director's denial of lumbar ESIs.

Claimant injured her back and hip when she slipped and fell at work in 2011. She immediately reported the accident but continued working, although she testified that she missed some time due to pain caused by the injury. She received conservative medical care and briefly received indemnity benefits for several weeks when she was disabled by her orthopedist, but then returned to work. In 2013, she consulted a pain management doctor who recommended epidural steroid injections. The OWC medical director found that the treatment was contrary to the medical treatment guidelines. After the treatment was denied, the pain management doctor disabled claimant from work and she filed a disputed claim for compensation.

Following trial on the merits, the WCJ concluded that the evidence failed to show any entitlement to disability benefits, but reversed the denial of the ESI. The court of appeal affirmed, finding that the WCJ was not clearly wrong in rejecting the pain management physician's opinion concerning claimant's disability, given that the orthopedist who treated her for a year post-accident did not support any ongoing disability. The court noted that claimant failed to offer any evidence substantiating her claim that she missed work due to her pain. The court also agreed that the WCJ was not clearly wrong in reversing the denial of ESIs, noting that under the medical treatment guidelines, such are appropriate when more conservative measures have failed.

Andrews v. Thrasher Const. Co., 2015-0666 (La. App. 1 Cir. 11/9/15) [Attorneys – Kaleisha Lattice Nelson (C), Kirk Landry (D); WCJ – Laramore; Panel – Guidry, Holdridge, Chutz]

Vacated WCJ's award of SEB and remanded for further proceedings.

Journeyman allegedly injured his wrist, elbow, arm, shoulder, knees and back when he fell from scaffolding. He returned to work at some point but was fired after a fight with a co-worker. Following trial on the merits, the WCJ found that claimant's right shoulder and lumbar injures were the only remaining issues. The court found the injuries compensable and authorized continued treatment per the medical treatment guidelines. The court also awarded ongoing SEB based on zero earnings, and approved a functional capacity evaluation as recommended by the IME physician. The defendant appealed the award of SEB.

On appeal, the court rejected defendant's assertion that the claimant's termination precluded SEB. The court noted that defendant did not offer any evidence that the claimant had violated any specific policy. Claimant, whom the WCJ deemed very credible, denied any fault in causing the fight. The court also disagreed with the defendant's assertion that the WCJ skipped the claimant's initial burden in the SEB analysis. The court noted that defendant's SMO physician and the IME physician both recommended an IME to determine claimant's functional level. It concluded that in the absence of the FCE, the WCJ had insufficient information to determine SEB entitlement, and remanded the case for further proceedings.

Meche v. Gray Ins. Co., 2015-465 (La. App. 3 Cir. 11/12/15) [Attorneys – Mark Riley (C), William Parker, III (D); WCJ – Palermo; Panel – Gremillion, Genovese, Keaty]

Affirmed WCJ's award of SEB in part, but reversed award of SEB after date on which claimant performed heavy labor for a neighbor.

Claimant, a valve pressure tester, injured his back in an unwitnessed accident, while swinging a sledge hammer. He subsequently received conservative care from a general practitioner. Although an MRI was normal, claimant was referred to an orthopedic surgeon who disabled him and recommended physical therapy. Another orthopedist recommended a thoracic MRI which was denied by the employer/carrier. The third orthopedist provided restrictions, and prescribed medication for erectile dysfunction which he related to the injury. The employer denied the medication.

An IME found that claimant could perform sedentary to light duty. The employer offered a light duty position and terminated indemnity benefits. Claimant attempted the light duty job for two days but left due to pain. He returned to his doctor but did not report the attempt to return to work. Subsequent EMG testing was normal. Claimant admitted to performing heavy manual labor for several months in the summer of 2014, helping a neighbor erect an awning and assisting a flooring contractor. He earned $470 in these jobs and did not report them to his doctor.

Claimant eventually filed a disputed claim. After trial, the WCJ found a compensable accident and awarded SEB at zero earning capacity through July of 2014, and based on actual earnings thereafter. The court further ordered defendant to pay for claimant's ED medication.

The court of appeal affirmed the finding of an accident, finding nothing to discredit claimant's account despite the absence of witnesses. The court also found that the light duty position offered by the defendant was inadequate to reduce benefits in the absence of approval by the claimant's doctor. However, the court concluded that the WCJ erred in awarding benefits after July of 2014, given the absence of any objective injury on the diagnostic tests and claimant's admission that he performed heavy labor. The court affirmed the award of ED medication in the absence of any medical evidence contrary to the treating doctor's opinion that it was related to the work injury. Finally, the court awarded an additional $2,000 in attorney fees, finding that the claimant was "largely successful" in defending the judgment on appeal.

McCoy v Kendall &. W.A. Co., 50,187 (La. App. 2 Cir. 11/25/15) [Attorneys – Daniel Street (C), Frank Carrol (D); WCJ – Jones; Panel – Calloway, Pitman, Caraway]

Affirmed WCJ's award of SEB.

Claimant, a tree cutter, was injured when a tree fell on him and fractured his skull. He was hospitalized for several days and continued treating with his family doctor for headaches and numbness/weakness in his right arm. Two months post-accident the doctor noted an indented scar on claimant's head, left-sided headaches, and numbness/weakness of the right hand. An FCE showed that claimant would perform heavy work.

A neuro SMO found that "something separate and apart from the accident may have caused some disability," and noted claimant's pre-existing scoliosis. Cervical and brain MRI's were normal. The SMO released claimant to work. His family physician agreed with the SMO but disagreed with the heavy work capacity referenced in the FCE and imposed some restrictions. The employer offered claimant a position as a groundsman, and terminated benefits when he did not respond. The company denied a subsequent request from the claimant to return to work, based on the SMO's opinion that his pre-existing conditions precluded that work.

After trial, the WCJ awarded ongoing SEB. The court of appeal affirmed, noting that claimant was able to perform his full duties prior to his work accident. The court concluded that the evidence was sufficient to support the trial court's conclusion that the accident aggravated claimant's pre-existing condition. Likewise, the court affirmed the SEB award, noting that claimant was not released to work by his doctor until after the defendant offered him the groundsman position.

Marshall v. Town of Winnsboro, 50,255 (La. App. 2 Cir. 11/25/15) [Attorneys – Daniel Street (C), Brian Bowes (D); WCJ – Jones; Panel – Lolley, Caraway, Moore]

Affirmed WCJ's award of indemnity and medical benefits, penalties and attorney fees, rejecting contention that receipt of a pension constituted retirement, and stating: "*The fact that an employee may receive some form of pension… in connection with his retirement from a job because of disability does not constitute retirement under La. R.S. 23:1221(3)(d)(iii).*"

Clark v. Sedgwick CMS, 2015-277 (La. App. 3 Cir. 11/25/15) [Attorneys – Kevin Camel (C), Matthew Fontenot (D); WCJ – Palermo; Panel – Keaty, Pickett, Savoie]

Reversed WCJ's award of full SEB in part and remanded for further consideration of employee's earning capacity.

Employee injured his back lifting a case of radios at work. An MRI showed three herniated lumbar discs, and claimant subsequently underwent surgery. He continued to report some residual pain. Claimant's AWW was $727.37. Defendant initially paid TTD, but reduced the payments to SEB at the rate of $244.89 shortly after claimant was declared at MMI, based on several positions identified through vocational rehabilitation and approved by the treating physician. The employee had applied for all of the positions and had contacted over 100 additional prospects without success. The rehab consultant noted that there was "stiff competition" in the job market.

Following trial, the WCJ awarded SEB at the full TTD rate, concluding that "there was no showing that jobs were available" to the claimant when his benefits were reduced.

The court of appeal reversed, noting that the WCJ had incorrectly focused on job availability "at the time [defendant] reduced benefits. Applying the *Banks* analysis and conducting a de novo review, the court found that the defendant had identified several jobs that fit the claimant's restrictions, were in his geographical area, and were available when claimant was notified of their existence. The court stated that "physician approval is not required for the employer to meet its burden under Banks." Accordingly, the judgment was reversed to the extent it found defendant failed to prove available employment. The case was remanded to the WCJ to determine claimant's earning capacity.

Judge Savoie concurred, but voiced concerns over the vocational rehabilitation process and the *Banks* standard. "*While the law is clear that actual job placement is not necessary, there should be a component of the test that includes whether the employee has a reasonable chance of placement in the position*."

TEMPORARY TOTAL DISABILITY

Bridges v. Gaten's Adventures Unlimited, L.L.C., 2014-1132 (La. App. 1 Cir. 4/2/15), 167 So. 3d 992 [Attorneys - Daren Sarphie (C), Rchard J. Voelker (D); WCJ- Thompson; Panel – Crain, McDonald, Holdridge]

Reversed WCJ's award of disability benefits, penalties and attorney fees.

Claimant, a part-time bus driver for the defendant bus company, injured her low back while lifting a child onto the bus. She did not mention the injury to anyone and finished the trip. The company office was closed by the time she returned that evening. She returned the next morning but was unable to locate her supervisor. She continued to have sharp back and leg pains over the weekend, and went to the emergency room and reported the accident to ER personnel.

The following Monday, she reported the accident to her supervisor, who told her to go to the doctor. She went her to another emergency room and returned with paperwork for the employer. The supervisor told her to contact the company's insurer but did not provide any contact information. Claimant requested treatment with a neurosurgeon, which was never approved. Two months after the accident, she began working as a sitter for a "senior care" center. The WCJ found that claimant suffered a compensable accident and awarded TTD for the period from the accident until she began working as a sitter, and SEB thereafter, along with medical benefits, penalties and attorney fees.

The court of appeal affirmed the finding of a compensable accident, despite some discrepancies in the initial medical records. The court rejected the employer's position that there were no "objective findings" of an injury, noting that the statutory definition of injury "contains no requirement of objective findings or symptoms." It concluded that the WCJ was not clearly wrong in finding that the accident caused the claimant's injury.

However, the court reversed the award of TTD benefits. It noted that only one medical report addressed restrictions, and it confirmed that claimant was capable of light duty. Thus, she was not entitled to TTD. With regard to SEB, the court stated that the record established only that the claimant could not return to her job of injury. It concluded that such was insufficient to prove entitlement to SEB. In addition, the court stated that while claimant's hours as a sitter were such that her wages were less than 90% of her AWW at times, there was no evidence that this was due to her injury, precluding SEB.

Turner v. Lexington House, 2014-1264 (La. App. 3 Cir. 4/15/15) [Attorneys – George Flournoy (C), Morgan Levy (D); WCJ – Braddock; Panel – Thibodeaux, Ezell, Conery]

Affirmed WCJ's award of TTD benefits, penalties, and attorney fees.

Claimant, an admissions coordinator at a nursing home, was struck by a door at work shortly after having hip replacement surgery. She was taken off work and underwent exploratory surgery to check the status of the implant. The joint was found to be intact, but the treating physician concluded that the accident had aggravated her pre-existing condition precluding her from working. A year post accident, the employer sent "a list of random duties" to the treating and SMO physician. Both doctors checked off tasks and recommended an FCE. The surgeon also wanted an impairment rating and the SMO recommended a motorized scooter. Thereafter, the employer sent a job description as a nurse aid training instructor which was initially approved by claimant's physician. He subsequently withdrew the approval. Nevertheless, the employer terminated benefits, prompting a disputed claim. At trial, the WCJ decided numerous issues in favor of the employer regarding the timely approval of treatment. However, he also reinstated TTD, recalculated claimant's AWW, ordered reconstructive surgery, approved certain medications, and awarded five penalties and attorney fees.

On appeal the court held: (1) Based on the medical evidence, the WCJ was not clearly wrong in reinstating TTD rather than SEB, particularly since SEB was never raised by the defendants until appeal; (2) WCJ was not wrong in applying a forty hour presumption to claimant's AWW, since she was only working reduced hours temporarily at the time of her accident due to her prior hip surgery; (3) WCJ properly ordered reconstructive surgery for a painful fat necrosis at the incision site of claimant's hip surgery. The court rejected defendant's position that the surgery was merely "cosmetic" and noted that defendant's brief quoted §1221(4) as it existed prior to 1983; (4) WCJ properly ordered defendant to pay for treatment/medication for her depression, which became worse after the work accident; (5) WCJ properly awarded 4K penalty for arbitrary termination of benefits under §1201(I), given that claimant's medical were not terminated; (6) WCJ properly awarded $2,000 penalty for failure to pay TTD at the correct rate, $2,000 for failure to authorize reconstructive/revision surgery, $2,000 for failure to authorize depression medication, and $2,000 for failure to authorize FCE recommended by treating and SMO physicians, per §1201(F); and (7) WCJ properly awarded $15,000 in attorney fees, which would be increased by 5K for work on appeal.

Maxwell v. Care Sols., Inc., 50,088 (La. App. 2 Cir. 9/30/15) [Attorneys - C. Daniel Street (C), Donald J. Anzelmo (D); WCJ – Jones; Panel – Brown, Drew, Calloway]

Affirmed WCJ's judgment that accident occurred in course and scope of employment, but remanded for additional proceedings regarding the denial of TTD benefits.

With regard to TTD, the appellate court noted that the claimant was unable to establish any disability because the defendant had improperly denied her medical treatment. Concluding that a "grave injustice" would result from denial of TTD, the court remanded the matter to the WCJ for additional evidence regarding disability.

TORT IMMUNITY

Cador v. Deep S. Equip. Co., 2014-1371 (La. App. 1 Cir. 3/6/15)

Tort suit. **Reversed** trial court's grant of employer's exception of no cause of action, finding that the plaintiff's petition was sufficient to state a cause of action against the employer for intentional tort.

The plaintiff, who was struck by a forklift, alleged that the employer "violated OSHA regulations… [and] knowingly and intentionally subjected him to a dangerous process, instrumentality, or condition within business operations, with the knowledge that the harm to plaintiff was a substantial certainty or possibility."

VOCATIONAL REHABILITATION

Willis Knighton Health Sys. v. Sims, 49,967 (La. App. 2 Cir. 6/24/15) [Attorneys - James Caldwell (C), Walter Salley (D); WCJ – Robinson; Panel – Brown, Lolley, Pitman]

Affirmed. WCJ's judgment reducing claimant's indemnity benefits by 50% for failure to cooperate with vocational rehabilitation.

Claimant injured his back in 2006, and underwent a two-level lumbar fusion. The WCJ ultimately ordered him to participate in a GED program as recommended by voc rehab and approved by the treating physician. Claimant failed the entrance exam for the program, and the rehab consultant directed him to enroll in remedial classes. Claimant failed to enroll in the remedial courses and the defendant filed a motion to reduce his benefits by 50% pursuant to La. R.S. 23:1226. Subsequent to filing of the motion, claimant's physician stated that "I do not think attending school is in [his] best interest." Nonetheless, the WCJ reduced benefits retroactive to filing of the motion.

The court of appeal affirmed, noting that while the treating physician's opinion is generally entitled to great weight, the WCJ did not err in considering the reversal of the doctor's original opinion.

Hargrave v. Diaz, 2015-189 (La. App. 3 Cir. 10/28/15) [Attorneys – Michael Miller (C), Stephen Glusman (D); WCJ – Johnson; Panel – Saunders, Thibodeaux, Amy]

Affirmed WCJ's decision dismissing claim to replace vocational rehabilitation consultant based on fraud.

Claimant filed a disputed claim contending that the voc rehab consultant assigned by the employer committed fraud and should be removed. Specifically, claimant asserted that the consultant violated R.S. 23:1208 by meeting with the employer without claimant or his attorney present. The court of appeal held (1) WCJ's refusal to let claimant's attorney question the consultant regarding proposed conditions was not wrong, since the consultant's opinion as to whether he could/should comply with the conditions was not relevant in light of the Supreme Court's decision in *Hargrave vs. State*. (2) WCJ was not wrong in finding that the consultant did not violate R.S. 23:1208, where claimant failed to show specific misstatements regarding meetings with between the consultant and the employer or the treating physician. (3) Claimant made no showing warranting the removal of the vocational rehabilitation consultant.

Clark v. Sedgwick CMS, 2015-277 (La. App. 3 Cir. 11/25/15) [Attorneys – Kevin Camel (C), Matthew Fontenot (D); WCJ – Palermo; Panel – Keaty, Pickett, Savoie]

Reversed WCJ's award of full SEB in part and remanded for further consideration of employee's earning capacity.

Employee injured his back lifting a case of radios at work. An MRI showed three herniated lumbar discs, and claimant subsequently underwent surgery. He continued to report some residual pain. Defendant converted TTD to reduced SEB based on several positions identified through vocational rehabilitation and approved by the treating physician. The employee had applied for all of the positions and had contacted over 100 additional prospects without success. The rehab consultant noted that there was "stiff competition" in the job market. Following trial, the WCJ awarded SEB at the full TTD rate, concluding that "there was no showing that jobs were available" to the claimant when his benefits were reduced.

The court of appeal reversed, noting that the WCJ had incorrectly focused on job availability "at the time [defendant] reduced benefits. Applying the *Banks* analysis and conducting a de novo review, the court found that the defendant had identified several jobs that fit the claimant's restrictions, were in his geographical area, and were available when claimant was notified of their existence. The court stated that "physician approval is not required for the employer to meet its burden under Banks." Accordingly, the judgment was reversed to the extent it found defendant failed to prove available employment. The case was remanded to the WCJ to determine claimant's earning capacity.

Judge Savoie concurred, but voiced concerns over the vocational rehabilitation process and the *Banks* standard. "*While the law is clear that actual job placement is not necessary, there should be a component of the test that includes whether the employee has a reasonable chance of placement in the position*."