

# Louisiana Workers' Compensation Update



## **2010 & 2011 LEGISLATIVE UPDATE**

### **INCREASE IN FINES AGAINST EMPLOYERS WHO DO NOT OBTAIN WORKERS' COMPENSATION INSURANCE**

ACT No. 288 of the 2010 regular session modified the penalties and provides criminal sanctions against employers who fail to obtain or retain Workers' Compensation (WC) insurance and provides for increased criminal files for fraudulent acts involved in obtaining a WC policy. Under LSA-R.S. 23:1170 the maximum cap on the fines for civil violations of \$10,000.00 for a series of violations has been eliminated, other than for the first violation or series of violations. The criminal fines under LSA-R.S. 23:1172, 1172.1, and 1172.2 have been increased to \$250.00 for each day of the violation.

### **AFFIRMATIVE DUTY TO REPORT FRAUD**

ACT No. 3 of the 2010 regular session provides an affirmative duty under LSA-R.S. 23:1172.2(E)(1) on any person, insurer, or self-insurance fund who knows or believes that a false, fraudulent, or misleading statement is "knowingly made" or "knowingly omitted" for the purpose of avoiding, delaying, or reducing the amount of payment of any WC insurance premium to report the information within 60 days of knowledge of the statement to the Office of Workers' Compensation (OWC) on a form promulgated by the Director. This form has not yet been provided by the Director.

### **GREATER ACCESS TO STATE INDEPENDENT MEDICAL EXAMINATIONS**

ACT No. 3 also allows a state independent medical examination (IME) under LSA-R.S. 23:1123 not only for disputes concerning the medical condition of the employee but also employee's capacity to work and medical necessity of the current medical treatment. The ACT also provides for payment of indemnity benefits via electronic transfer, debit card, and direct deposit, in addition to mailing the payments (amending LSA-R.S. 23:1201 and eliminating LSA-R.S. 23:1201.1).

### **CHANGES TO WORKERS' COMPENSATION MEDIATION**

ACT No. 53 of the 2010 regular session changed the law to do away with the required mandatory pretrial mediation and did away with the initial pre-service mediation. It also established new filing procedures for initiation of claims. The new procedure under LSA-R.S. 23:1310.3, requires as part of the initiation of the claim the payment of the filing fee within 5 days of the filing of the 1008 form. The new procedure also requires service by the OWC of the 1008 form upon receipt against the defendants "in any manner provided by law or by certified mail." A request for extension to answer the 1008 beyond the 15 days after service is limited to 10 days. Under the new mediation procedures, mediation will only occur upon joint request of the parties OR upon order of the presiding judge. The parties have a choice of selecting a Louisiana Workforce Commission mediator (with the mediation to be held where that mediator is assigned) or select a private mediator (to be held wherever the parties desire the mediation to be held). The parties, not the mediator, are required to notify the court within 5 days of the mediation that the mediation had in fact been held and what were the results of the mediation. A party who fails to show at the mediation can be fined up to \$500.00 and may also be assessed the costs of the mediation and the attorney's fees of the parties who did appear.

#### **ESTABLISHING MANDATORY ELECTRONIC MEDICAL BILLING**

ACT No. 4 of the 2010 regular session requires the Director to establish rules and regulations for electronic medical billing as well as payment of those medical bills by January 1, 2012. This ACT requires that health care providers provide electronic payments and that insurers accept electronic billing according to the rules promulgated. These rules have not yet been enacted under LAC Title 40 § 101, et seq.

#### **DISCOVERY OF INSURERS**

ACT No. 304 of the 2010 regular session made technical changes allowing disclosure by the Office of Workers' Compensation of the name of an employer, the name of the insurer and/or membership in a group self-insurance fund, including dates of that membership, to third parties upon proper request under LSA-R.S. 23:1293. However, that request can be limited by the OWC if the OWC believes that the requesting party is attempting to obtain lists of insureds from a particular carrier or group self-insurance fund, and is specifically prohibited from disclosing effective dates of coverage for any specific employer or groups of employers.

#### **REQUIREMENT THAT "OPT-OUT" WRITTEN AGREEMENTS BE WITH INSURERS**

ACT No. 120 of the 2010 regular session modified the "opt-out" provision under LSA-R.S. 23:1035 for officers, directors, partners, and members of businesses who own over 10% of the business capital (i.e. stock or units) and/or sole proprietors requiring that the written agreement which elects no coverage under Workers' Compensation must be with an insurer or self-insured group. This provision requires a written agreement between the officer, director, partner, or member and the insurer. In the case where a sole proprietor is the only employee, the proposed change in the law appears to require the sole proprietor to obtain a WC policy in order to agree with the WC carrier that the sole proprietor is not covered under that policy.

## **PROVIDING FOR SOME CHANGES IN APPEAL RULES TO MIRROR REGULAR CIVIL APPEALS**

ACT No. 1051 of the 2010 regular session, which approved an amendment to Article V, Section 8(B) of the Louisiana Constitution, on November 2, 2010; effective December 1, 2010, requires a 5 judge panel in the event of a dissent in a case which appeal modifies or reverses a Workers' Compensation judgment, same is regular civil cases. The prior law did not allow a 5 judge panel to be empanelled for WC cases.

## **PROVISIONS FOR AUDITS OF SELF INSURANCE FUNDS**

ACT No. 794 of the 2010 regular session provides that most self-insuring funds will not be subject to most of the provisions of Title 22, the Insurance Code (but will remain under LSA-R.S. 23:1191 et seq.), but sets up a regulatory scheme by which the Insurance Commissioner has the power to examine, investigate and regulate most self insurers under certain conditions.

## **CHANGES TO SECOND INJURY FUND**

ACT No. 799 of the 2010 regular session provided some substantial changes to the Second Injury Fund Act. The first substantive change is the "Permanent Partial Disability Employee Registry" which is to be maintained by the Louisiana Workforce Commission. The listing on the registry, if and when the registry is created, can act as proof of an employer's knowledge of any pre-existing permanent partial disability for purposes of a Second Injury Fund claim. Permanent Partial Disability has been defined under LSA-R.S. 23:1371.1 as "any permanent condition, whether congenital or due to injury or disease, of such seriousness as to constitute a hindrance or obstacle in obtaining employment, to retention by an employer, or to obtaining re-employment, if the employee becomes unemployed." To date, the registry has not yet been initiated.

## **ADDITIONAL CHANGES TO SECOND INJURY FUND**

LSA-R.S. 23:1371.1 has also been changed to include a definition of "hire and fire authority" for purposes of Second Injury Fund recovery, which has been defined as "the authority of the representative of the employer who plays an integral part in fulfilling the business of the employer with the responsibility to have closely controlled the injured employee regarding his physical conduct and time, as well as providing significant input into the hiring, retention, and firing decisions regarding that employee." This definition will limit the ability of the employer to designate an agent for purposes of an affidavit regarding employee knowledge of the pre-existing condition submitted with any Second Injury Fund claim.

## **MORE CHANGES TO SECOND INJURY FUND**

The sunset provision for the Second Injury Fund has been extended until December 31, 2014. The SIF Board has been authorized to enter into reimbursement agreements with property and casualty insurers, self-insured employers, and group self-insurance funds for overpayments made to the Second Injury Fund. Further, under the listing of presumed permanent partial disability conditions, Chronic

Obstructive Pulmonary Disease, Post Traumatic Stress Disorder, Post Concussive Syndrome, Alzheimer’s Disease, Sickle Cell Anemia, and Joint Replacement Surgery have been added to LSA-R.S. 23:1378.

**EVEN MORE CHANGES TO SECOND INJURY FUND**

The reimbursement schedule and provisions under LSA-R.S. 23:1378 have been reworked to make it more easily understood. The new provisions, effective July 1, 2010, were enacted for purposes of minimum amounts paid by an employer or insurer before SIF reimbursements would kick in, assuming that the SIF claim is accepted. Further, the new provisions provide for reimbursement of vocational rehab benefits in accidents occurring on or after July 1, 2010, which is new. The reimbursement schedule, both prior and current, is as follows:

**SIF BOARD REIMBURSEMENT SCHEDULE**

| Date of injury (trigger date for schedule)                                | Reimbursement Schedule   |
|---|--|
| Before July 1, 2004 and on or after July 1, 2009, but before July 1, 2010 | <p>INDEMNITY:</p> <ul style="list-style-type: none"> <li>• TTD/SEB/PTD After the first 104 weeks of payment of benefits</li> <li>• Death benefits after the first 175 weeks of payment of benefits</li> </ul> <p>MEDICAL:</p> <ul style="list-style-type: none"> <li>• 50% of all reasonable and necessary medical expenses actually paid which exceed \$5,000.00, but no less than \$10,000.00</li> <li>• 100% of all reasonable and necessary medical expenses actually paid which exceed \$10,000.00</li> </ul> |
| On or after July 1, 2004 and before July 1, 2009                          | <p>INDEMNITY:</p> <ul style="list-style-type: none"> <li>• After the first 130 weeks of payment of benefits</li> </ul> <p>MEDICAL:</p> <ul style="list-style-type: none"> <li>• 100% of all reasonable and necessary medical expenses actually paid which exceed \$25,000.00</li> </ul>  |
| On or after July 1, 2010 and before July 1, 2015                          | <p>INDEMNITY:</p> <ul style="list-style-type: none"> <li>• After the first 104 weeks of indemnity</li> </ul> <p>MEDICAL:</p> <ul style="list-style-type: none"> <li>• 100% of all reasonable and necessary medical expenses actually paid which exceed \$25,000.00, including reasonable and necessary Vocational Rehabilitation expenses: If such expenses are directly related to services provided in the actual retention or reemployment of employees</li> </ul>  |

**LAST CHANGE TO SECOND INJURY FUND**

The 2011 session has provided an additional change to the Second Injury Fund under House Bill 502 which allows the Louisiana Second Injury Board, at its discretion, to utilize some of its funding towards paying for rehabilitation services through the Louisiana Rehabilitation Services. The bill passed both the House and Senate after some substantial amendments (including stripping provisions which would have significantly modified LSA-R.S. 23:1226 relating to vocational rehabilitation) and was sent to the Governor for signature on June 24, 2011.

#### **STATUS OF THE MEDICAL TREATMENT GUIDELINES**

In 2009, the Louisiana Legislature enacted LSA-R.S. 23:1203.1 to have the Louisiana Workforce Commission promulgate medical treatment guidelines (MTG) to establish criteria for what is deemed to be medically necessary treatment for any particular work-related injury or condition. The original launch date for the schedule and guidelines was September 30, 2010, but was changed under ACT No. 619 of the 2011 legislative session to January 1, 2011. Pursuant to these rules, the OWC created a medical dispute Form 1009 for any dispute under the guidelines. However, due to concerns regarding the reliability of the guidelines and the apparent failure of the OWC to follow the procedure for properly adopting the guidelines, the Louisiana Association of Self Insured Employers filed an injunction to prohibit enactment of the guidelines and for a writ to have the OWC follow the requirements of LSA-R.S. 23:1203.1. The preliminary injunction was granted and an open meeting, as part of the procedure for adopting the MTG, was held pursuant to the Administrative Procedure Act (LSA-R.S. 49:950 et seq.) on February 28, 2011. The guidelines passed out of the Joint Legislative Labor Committee on May 17, 2011 and were to become law as of June 20, 2011. The Louisiana Association of Self Insured Employers has filed injunctions, including a TRO scheduled for hearing on June 30, 2011, to enjoin the implementation of the guidelines.

#### **STATUS OF THE MEDICAL TREATMENT GUIDELINES, CONTINUED**

All medical providers and insurance carriers (including self insurers) are required to comply with the MTG if and when they go into effect. The guidelines are located in the LAC Title 40 § 2001 et seq. The MTG is to be reviewed at least twice a year by the Director and it takes a legislative hearing to make substantial changes to the guidelines. Changes are already in the works. There are currently eight sections: cervical spine injuries (§2001 et seq.), low back pain (§2013 et seq.), Chronic Pain Disorder (§2101 et seq.), Complex Regional Pain Syndrome (RSD et al)(§2117 et seq.), Carpel Tunnel Syndrome (§2201 et seq.), Thoracic Outlet Syndrome (§2215 et seq.), lower extremity injuries (§2301 et seq.), and shoulder injuries (§2315 et seq.).

#### **STATUS OF THE MEDICAL TREATMENT GUIDELINES, CONTINUED**

A medical provider is supposed to seek authorization for treatment and submit for review the following documents for consideration pursuant to Chapter 27 of Title 40 of the Louisiana Administrative Code concerning Utilization Review (U/R) (note that the medical guidelines have made U/R, which was previously considered to be non-essential but required under the law, now possibly essential):

- 1) The most recent clinical notes;

- 2) A diagnosis with ICD-9 codes;
- 3) The description of the type of service requested;
- 4) Expected length and frequency of treatment;
- 5) Prognosis to include expected outcome of treatment; and
- 6) Any diagnostic testing results and interpretations.

The Office of Workers' Compensation Administration, Medical Services, in a memorandum dated December 22, 2010 (OWCA 2010-12-01) stated that: "In the absence of the submission of such information, the denial of further non-emergency care by the Carrier/self-insured employer should be deemed in compliance with the associated Medical Treatment Guideline." The memorandum also states: "The carrier/self-insured employer shall notify all parties of the request, and of their action on the request, within five business days of receipt of the request."

### **Status of New Hearing Rules**

Changes to the Louisiana Workers' Compensation Hearing Rules took effect on June 20, 2011 and have been published in the June edition of the Louisiana Registry. Some of the changes are merely technical, such as the addition of the definition of "Judicial District" under LAC-Title 40 § 5501, and reflecting the legislative changes to commencement of a claim, the fee schedule for filing, the new filing rules and the new mediation rules under LAC-Title 40 §§ 5507, 5511, 5701, 5813, 5817, 5819, and 6605, to providing a method for judicial recusal under LAC-Title 40 § 5525(D)-(G). Other changes are more substantial, such as LAC-Title 40 § 5705(D) which allows a judge to dismiss a claim, with prejudice, if the claim has been previously dismissed for at least 90 days without prejudice and no good cause has been shown for reinstatement.

### **Status of New Hearing Rules, Continued**

Other substantial changes to the rules reflect the new policy of the Louisiana OWC regarding continuances of hearings, pretrial mediations, and trials, requiring the Judge to grant only one uncontested motion with all other subsequent uncontested motions being solely at the discretion of the Judge under LAC-Title 40 § 6103(D). The changes provide additional time for filing continuances. The new hearing rules also provide for possible stays of proceedings under LAC-Title 40 § 6104.

### **Relevant Bills of the 2011 Legislature Which Did NOT pass**

- House Bill 518 would have require that WC insurers (or their agents) issue a "remittance advice," i.e. an explanation of benefits/denial, etc., on each pharmacy claim for payment. This bill was assigned to the House Labor and Industrial Relations Committee where it died without hearing.
- Senate Bill 143, which would have amended LSA-R.S. 23:1021 to exclude certain types of bonuses from the calculation of the average weekly wage for workers' compensation purposes,

was considered by the Senate Labor Committee on May 31, 2011 and was reported favorably. Possible floor debate was scheduled for June 6, 2011 but was returned to the calendar instead, ending this bill's chances to become a law.

#### Recent Cases



#### Accident & Course & Scope

##### **CLAIMANT'S ACCIDENT DURING SIDE TRIP TO REPAIR VEHICLE FOUND COMPENSABLE**

Claimant's job as a salesperson necessarily required flexible hours and the use of his personal vehicle. While waiting on repairs to his personal vehicle at an auto repair establishment, the Claimant's chair collapsed beneath him and caused injuries that aggravated a pre-existing condition. The Workers' Compensation Judge (WCJ) determined that: "for all intents and purposes, his vehicle was a company vehicle," based upon the fact that a generous allowance was provided to Claimant for the maintenance, that the employer "directed the provider of vehicle repair services," and that the vehicle was essential to the performance of his job duties. The Judge found that Claimant's injury occurred in the course and scope of employment because repairs to his personal vehicle were necessary to the job. The Judge thought this injury was an exception to the general rule of non-compensability of travel to and from work. The appellate court affirmed the decision. Note that no penalties or attorney's fees were awarded at either the trial court or appellate level due to the complexity of issues. Mays v. Deep South Chemical, Inc., 2011-91 (La. App. 3<sup>rd</sup> Cir., 6/1/11) 2011 WL 2135562.

## **SUPREME COURT OVERRULES BOTH LOWER COURTS AND DISMISSES CLAIM REGARDING AN ALLEGED UN-WITNESSED ACCIDENT THAT WAS NOT REPORTED FOR 18 MONTHS**

Claimant sought benefits for an un-witnessed accident that he did not report to his employer for 18 months (after his short and long-term disability benefits had expired). In addition to Claimant's delay in reporting the accident, he told his employer and treating doctors that the injury was not the result of any specific trauma. Rather, he related it to "over use" and "wear and tear," and at other times, he reported he was unsure of the source of his initial pain. Although the WC laws are admittedly construed in favor of claimants, this was a case with no evidence other than Claimant's self-serving and often contradicted testimony that the accident occurred. Although this is seemingly insufficient proof for a case involving an un-witnessed accident, the WCJ found the accident compensable, and even awarded penalties and attorney's fees. The Third Circuit Court of Appeal reversed the award of penalties and fees, but affirmed the ruling in favor of Claimant. The Supreme Court granted an appeal, reversed all findings in favor of Claimant, and dismissed the case with prejudice. The Supreme Court applied well-established law that in un-witnessed accident cases, a claimant must present corroborating evidence other than his testimony, and there must be an absence of evidence discrediting or casting serious doubt on the claimant's version of events. The Court thought much of the evidence casted serious doubt on Claimant's testimony. The Court thought that the lower courts erred in relying on Claimant's self-serving and uncorroborated testimony that his reason for not immediately reporting the accident was that he feared repercussion from his employer. Claimants often cite as an excuse, this "unspoken rule" that employers want a clean accident or OSHA record. In this case, the Court found no basis for Claimant's allegation. ***Ardoin v. Firestone Polymers, L.L.C.***, 2010-0245 (La., 1/19/11) 56 So.3d 215.

## **UNREPRESENTED CLAIMANT PREVAILS!: COURT RELIES HEAVILY ON LACK OF SYMPTOMS BEFORE ACCIDENT TO REFUTE ARGUMENT THAT PRE-EXISTING CONDITION CAUSED NEED FOR SURGERY AND FURTHER REJECTS SMO OPINION REGARDING DURATION OF AGGRAVATION**

Claimant, who represented herself at trial and on appeal, injured her back and neck by falling down stairs in December of 2006. Claimant worked for Greyhound Bus Lines. She admitted that she had been involved in a couple prior car wrecks, and further admitted that her back would hurt occasionally if she lifted unusually heavy luggage. On those occasions, she would take over-the-counter medication and return to work. After the December 2006 accident, she received TTD benefits until March of 2007, at which time she was released to modified work by one of five doctors who examined or treated her. Greyhound offered sedentary employment, but Claimant declined the job, arguing that she was not in a condition to return to work. Eventually, surgery was recommended, and the employer's SMO doctor concurred, but stated his opinion that the need for surgery was related to the pre-existing degenerative condition and not the work accident. No records of prior back and neck injuries were introduced at trial, and there were conflicting opinions among the 5 doctors as to whether Claimant was totally disabled and whether the pre-existing condition or the work injury caused the need for surgery. The WCJ ruled in favor of Greyhound and held that it owed no further benefits beyond the brief period of benefits already paid. Although it was "undisputed that [Claimant] suffers from a degenerative spinal disease," the Fourth Circuit REVERSED. The basis for the court's reversal was primarily the fact that Claimant was asymptomatic before the accident. She essentially had no documented evidence of any neck or back

problems in the seven years before the accident, and no documentation of any problem carrying out her duties that included driving and lifting. Of course, the court noted that pre-existing conditions do not bar claims for compensation benefits as long as the evidence shows that the accident aggravated the condition. Of further interest was the court's clear rejection of the employer's SMO opinion from Dr. Applebaum that Claimant had suffered only a "temporary" soft-tissue aggravation of her pre-existing condition and that such aggravations normally last only 3-6 months. There was no other medical evidence corroborating the statement that Claimant suffered only a soft-tissue injury. Merrill v. Greyhound Lines, Inc. 2010-0834 (La. App. 4<sup>th</sup> Cir., 11/24/10) 52 So.3d 280; *vacated by* 2010-2827 (La., 4/29/11) 60 So.3d 600; *reaffirmed by* 2010-0834 (La. App. 4<sup>th</sup> Cir. 6/29/99) 2011 WL 2581771.

#### **UN-WITNESSED AND UNTIMELY REPORTED "ACCIDENT" NOT FOUND TO BE COMPENSABLE**

Claimant had prior leg and back pain before the alleged incident and there were questions as to whether she had ever reported an event, particularly since the initial medical reports indicated "no trauma." Due to the history of prior complaints, the WCJ refused to apply the presumption that the alleged accident was the cause of her injuries and further found that Claimant failed to meet her burden of proof since her testimony of the un-witnessed accident was controverted by her supervisors (who testified that they did not recall any timely reporting of the alleged accident) and the medical records. West v. Wal-Mart, 2010-2271 (La. App. 1<sup>st</sup> Cir., 6/17/11) 2011 WL 2433654.

#### **EMPLOYER NOT PENALIZED BY GRATUITOUS GESTURE OF PAYMENT: COURT HELD CLAIMANT WAS NOT IN COURSE AND SCOPE ALTHOUGH SHE WAS GETTING PAID BY EMPLOYER WHEN SHE GOT HURT**

Claimant was a sales representative. One of her main accounts was with a restaurant owned and operated by her friend. Claimant and her friend had worked together for the employer several years prior to the accident. On the day of the injury, Claimant got approval by her supervisors to accompany her friend to a mammogram appointment. Claimant was paid for that day, and was not charged for a day off. Prior to attending the appointment, Claimant was injured while leaving a restaurant where she and her friend were having lunch. The WCJ found that Claimant was not within the course and scope of her employment at the time of the accident. Specifically, the Judge held that Claimant was not on a special mission for her employer, but was on a personal mission, placing her injury outside of compensability under Louisiana's Workers' Compensation Act. The Second Circuit Court of Appeal noted that for a mission to qualify as a special mission, and be considered employment-related, as opposed to personal, the employee must be engaged in the direct performance of duties assigned by her employer. "Assigned" is defined as being requested, directed, instructed or required by the employer. As Claimant was not requested, directed, instructed or required by her employer to make the trip, the court upheld WCJ's decision that Claimant was not in the course and scope of her employment at the time of her injury. Biscamp v. Sysco East Texas, 46,182 (La. App. 2<sup>nd</sup> Cir., 4/13/11) 2011 WL 1474439.

#### **TESTIMONY REGARDING AN UN-WITNESSED ACCIDENT THAT WAS NOT CORROBORATED BY CO-WORKERS OR MEDICAL REPORTS WAS NOT CREDIBLE**

The Second Circuit Court of Appeal affirmed the decision of a WCJ that Claimant was not credible in his testimony that he was injured in an accident where the tractor he was driving hit a hole and jarred his

back. Claimant's testimony was deemed not credible primarily because Claimant's co-workers could not corroborate the Claimant's story. The court also cited the lack of medical evidence to support a finding that the Claimant was injured when the tractor that he was riding in hit a hole. The court specifically noted that the medical reports contained a history by the Claimant that he injured his back at work lifting, bending, turning and bounding up and down on a tractor for the past five years. The court further concluded that these descriptions did not meet the definition of an "accident" as set forth in the Workers' Compensation Act. **Davis v. Claiborne Electric Cooperative, Inc.**, 45,806 (La. App. 2<sup>nd</sup> Cir., 12/15/10) 56 So.3d 321.

### **DE NOVO REVIEW DEMONSTRATED CLAIMANT MET BURDEN OF PROOF, BUT REVERSED PENALTIES AND ATTORNEY'S FEES**

Claimant had a work-related accident in 2005 for which she sought continued medical benefits. Claimant had not lost work time due to work accommodations made by the employer until placed on unemployment due to a six month furlough. After returning back to modified duty, Claimant alleged having a subsequent un-witnessed work accident causing her to be unable to work. Claimant failed to make any formal report of the accident but did "report" it to three co-workers. The first acknowledgement in the medical records was nine months later. According to the appellate court, the WCJ improperly allowed a Claimant's witness in rebuttal to provide testimony for Claimant's case in chief, after the defense had rested. As a result, a de novo review of the record was made and the appellate court concluded that Claimant had met her burden of proof of an accident based upon her testimony and that of the remaining record. The appellate court distinguished the case factually from **Ardoin v. Firestone Polymers, L.L.C.**, 2010-0245 (La., 1/19/11) 56 So.3d 215, noting that in the **Ardoin** case the employee continuously denied any alleged accident prior to reporting it eighteen months later. However, based upon the record the Appellate Court found that the employer had reasonably controverted the claim for purposes of penalties and attorney's fees. **Faulkner v. Better Services, Inc.**, 2010-867 (La. App. 5<sup>th</sup> Cir., 5/24/11) 2011 WL 2020732.

### **ACCIDENT DURING SMOKE BREAK CAUSED BY "NEUTRAL" RISK OUTSIDE WAS COMPENSABLE**

Claimant worked as a hairdresser in a Regis salon located inside a Wal-Mart store. Claimant was permitted to take a break and go smoke a cigarette outside the building. She sat on a bench outside the building. When she stood up from the bench, her pant leg was caught on a chain-link fence causing her to trip and fall. The issue was whether this accident occurred during the course and scope of her employment because Claimant was not involved in a work activity and was not "on the clock" when the injury occurred. The employer denied the claim. The trial court awarded benefits, and also awarded penalties and attorney's fees upon finding the employer was arbitrary and capricious in denying the claim. The appellate court AFFIRMED. The court held that it is well-settled that "an employee is protected during work hours, despite minor deviations from instructions or place of work, if what he does could reasonably be contemplated as humanly incidental to his service as an employee and does not unreasonably increase the risk of injury" and that the jurisprudence "has long recognized that an employee typically remains in the course of her employment while she is on a permitted break." The court pointed out a 1946 case in which the court specifically included a smoke break as compensable.

The case might have been decided differently if the employee had wandered off the employer premises. In this case, the employer premises was deemed to include the outside of the building because her work premises was inside Wal-Mart and smoking was not allowed inside. Even though the risk of getting caught in a chain-link fence was not a particular risk of being a hairdresser, the claim remained compensable under the circumstances presented. *Carradine v. Regis Corporation*, 2010-529 (La. App. 3<sup>rd</sup> Cir., 11/3/10) 52 So.3d 181.

#### **FORMER EMPLOYEE DEEMED IN COURSE AND SCOPE WHILE CLEANING OUT HIS OFFICE THREE DAYS AFTER HE WAS TERMINATED**

Employer terminated the employee on a Friday afternoon while employee was working at a location away from his usual office located in another town. Employer agreed that employee could return to his office on Monday morning to pick up his personal belongings. When employee was in the process of retrieving his personal belongings, he allegedly slipped and fell and sustained a serious back injury for which he sought workers' compensation benefits. The WCJ granted, and the appellate court affirmed, Summary Judgment for the employer on grounds that the employee was not in the course and scope at the time of the alleged accident. The Louisiana Supreme Court reversed, noting that the employee is allowed a "reasonable time to wind up his affairs" after being terminated, including time to retrieve his personal belongings. Because he had been granted permission to come back three days later to pick up his property, the employee was in the course and scope when the accident occurred. The Court stated that the relevant factors to consider in determining whether the injury occurred within a reasonable period of time to wind up the employee's affairs are (1) the purpose that prompted him to return and (2) the relationship between that purpose and the conditions surrounding his work. *Ardoin v. Cleco Power, L.L.C.*, 2010-815 (La., 7/2/10) 38 So.3d 264.

#### **OBJECTIVE STANDARD FOR MENTAL/MENTAL CLAIMS**

Claimant was trained as an unarmed security guard. On early New Year's January 1, 2009, she was working her usual shift at a guard shack located at a grain elevator plant in Paulina, Louisiana. She was required to keep watch of who entered the plant near the shack, and sign them in and out. She was also required to report any unusual activity that she observed to her supervisor. Around 1:50 a.m., Claimant saw a driver of a gold car speed into the parking lot, stop under the only functioning light with the motor running, and shine bright lights at the guard shack. The shack was 25 to 30 feet from the road. Claimant was not expecting any vehicles in the lot as the plant was closed for the holiday. She was alone in a closed plant where only one of five nearby lights functioned, and she had no working flashlight. Though normally armed, she did not have her gun. The vehicle remained under the light for approximately 18 to 19 minutes before speeding out onto the road. The person never exited the vehicle. The Claimant was frightened and "freaked out." She reported the activity to her supervisor and the police were called. After the incident, the Claimant, who had pre-existing mental problems, sought treatment and never returned to her job. Claimant filed a disputed claim for benefits. The trial judge found that the incident caused a mental injury, as the incident was a sudden, unexpected and extraordinary stress that aggravated the pre-existing psychological condition, and awarded benefits. The appellate court reversed and rendered judgment dismissing the claim with prejudice. The court reasoned that the extraordinary

nature of the stress is determined from the point of view of the ordinary reasonable person of usual sensibilities, not from the point of view of the Claimant. Under the facts presented by the Claimant, the incident was not an unexpected and extraordinary stress for a security guard. The trial judge erred as a matter of law in failing to use the objective standard. *Fleming v. Garda Sec.*, 2010-1021 (La. App. 5<sup>th</sup> Cir., 5/10/11) 2011 WL 1775859.

### **PRESUMPTION OF ACCIDENT RELATED DISABILITY NOT VIABLE IF SYMPTOMS AFTER ACCIDENT NOT CONTINUOUS**

Claimant sustained a work-related accident but discontinued medical treatment for approximately three years when he sought an opinion from a physician who provided greater disability as well as surgical recommendations. The employer sought an SMO who opined that Claimant's current complaints were not related to the work accident but rather pre-existing conditions. The Claimant filed a Form 1008 Disputed Claim for Compensation claiming permanent and total disability. The WCJ determined that the Claimant's work accident had not aggravated Claimant's pre-existing condition. Claimant attempted to rely upon the presumption that he was in good health prior to the work accident and that there were no subsequent intervening injuries. As noted by both the Judge and the appellate court, in order to "obtain the benefits of this presumption of causation, the plaintiff must show (1) that he was in good health prior to the accident at issue, (2) that subsequent to the accident, symptoms of the alleged injury appeared and continuously manifested themselves afterward, and (3) through evidence, either medical, circumstantial, or common knowledge, a reasonable possibility of causation between the accident and the claimed injury." The key problem with Claimant's evidence was that there was no evidence of continuous manifestation. *Wright v. Town of Oil City*, 46, 247 (La. App. 2<sup>nd</sup> Cir., 5/18/11) 2011 WL 2464167.

### **"ACT OF GOD" A DISTINCTIVE TRAVEL RISK FOR PURPOSES OF THRESHOLD DOCTRINE**

Claimant was leaving the employee parking lot in his private vehicle when a pipe gate propelled by the winds of Hurricane Gustav swung into the roadway. It entered the windshield, striking him on the right shoulder and the back of his head. The Claimant alleged he was temporarily totally disabled from the date of the accident until he was released to modified duty and for supplemental earnings benefits. The employer disputed the claim. The trial court awarded indemnity, medical, penalty and attorney's fees after finding that Claimant sustained an accidental injury in the course and scope of his employment. The employer appealed, arguing that the Claimant was not injured in the course and scope of his employment because he was leaving work at the time of the accident. On appeal, the Third Circuit held that generally injuries sustained while an employee travels to and from are not considered within the course and scope of employment. However, the so called "going-and-coming rule" is subject to several exceptions, including one where the employee's injury occurs in an area immediately adjacent to his place of employment and that area contained a distinct travel risk to the employee ("the threshold doctrine"). The court reasoned that the "threshold doctrine" involves a special risk attributable to the location of the work premises that differs from the risks to which the general traveling public is exposed or that is more aggravated in the area adjacent to the employer's premises than elsewhere. Under this doctrine, an employee who receives an injury not on his or her employment premises while traveling to

and from work, can recover if he or she successfully proves that (1) a distinctive travel risk exists for the employee in going to or coming from work, and (2) the risk exists immediately adjacent to his or her place of work. There was no evidence that the Claimant was on a mission for the employer. The Claimant had completed his shift and was driving his personal vehicle to leave work at the time of the accident. Yet, the trial court found that the accident occurred on the employer's property and the Third Circuit did not find that manifestly erroneous. It did, however, reverse the award of \$8,000.00 in penalties and \$12,000.00 in attorney's fees because the fact that the accident occurred after work hours, outside of the employer's parking lot, and in his personal vehicle, gave rise to legal questions regarding whether the accident was within the course and scope of employment. **Williams v. Pilgrim's Pride Corp.**, 2011-59 (La. App. 3<sup>rd</sup> Cir., 6/1/11) 2011 WL 2135542.

### **SOMETIMES AN ACCIDENT DOES NOT NEED TO BE IDENTIFIED**

Claimant reported his claim six weeks after the time he believed that his injury incurred and could not identify a single, precipitous event causing his injury. Claimant alleged that the repetitive stress and activities of his work as a cement truck driver caused his neck and shoulder injury. Despite the lack of any identifiable event, the WCJ found that Claimant had a work accident and compensable injury, and even awarded penalties of \$6,000.00 and attorney's fees of \$7,500.00. The Third Circuit Court of Appeal affirmed the finding and the award of penalties and attorney's fees, due to the employer and insurer's alleged failure to investigate the claim and authorize benefits. **Cox v. Port Aggregates, Inc.**, 2010-707 (La. App. 3<sup>rd</sup> Cir., 2/2/11) 54 So.3d 1257.

### **STRESS IN PERFORMING POST-KATRINA WORK NOT CONSIDERED AN "ACCIDENT"**

In a claim for death benefits, the Fourth Circuit held that work-related activity during the aftermath of Hurricane Katrina does not constitute an "accident" in and of itself. In that case, the family of a New Orleans police officer who died shortly after undergoing surgery to repair a perforated bowel on November 19, 2005, filed a claim for death benefits alleging that the officer's death was caused by work conditions following Hurricane Katrina. **Doyle v. City of New Orleans Police Department**, 2009-1683 (La. App. 4<sup>th</sup> Cir., 8/10/10) 46 So.3d 197.

### **FLYING A PLANE SIMILAR TO DRIVING A TRUCK FOR PURPOSES OF INDEPENDENT CONTRACTOR STATUS**

The decedent flew planes for several companies and died in a crash while working for the defendant. The widow brought a death benefits claim alleging the manual labor exception to the independent contractor rule (LSA-R.S. 23:1021(6)). The WCJ and the appellate court both found that the decedent's job was mostly driving the plane, not loading and unloading, and was not considered manual labor. The appellate court noted the similarity to the job of an independent truck driver under LSA-R.S. 23:1021(7). **Reed v. LCS Corrections Services, LLC**, 2010-866 (La. App. 3<sup>rd</sup> Cir., 2/2/11) 55 So.3d 992, writ denied 2011-0376 (La., 4/8/11) 2011 WL 2419025.

### **A STATE EMPLOYEE'S EXCLUSIVE REMEDY IS THROUGH LOUISIANA WORKERS' COMPENSATION EVEN IF INJURED OFFSHORE**

Claimant was working for the Louisiana State Department of Wildlife & Fisheries as a Senior Enforcement Agent off the coast of Cameron Parish in the Gulf of Mexico when he was injured. The Claimant filed a lawsuit under the Jones Act alleging a number of deficiencies with the boat, the operation of the boat, and that the boat was not seaworthy. Claimant filed a Motion for Summary Judgment arguing that his exclusive remedy was not in WC, which was granted by the Judge. Thereafter, the employer filed an appeal. The Third Circuit noted that typically a seaman injured during the course of employment can bring a civil suit against his employer. However, since the employer in this case was the State of Louisiana, his exclusive remedy is under WC pursuant to LSA-R.S. 23:1034. The Third Circuit went on to state that there is no conflict with LSA-R.S. 23:1035.2 because the purpose of that statute was to prevent individuals entitled to make federal claims from also making a claim under WC. As a result, the Third Circuit reversed the ruling of the trial court ruling that Claimant's sole remedy was to recover under WC and not as a seaman under the Jones Act. **James v. State Dept. Of Wild-Life & Fisheries**, 2010-399, (La. App 3<sup>rd</sup> Cir., 12/22/10) 54 So.3d 778.

#### **UNDOCUMENTED WORKERS ARE ENTITLED TO COMPENSATION UNDER ACT**

The Claimant was a construction laborer who fell from a roof while performing roofing work for his employer. The Claimant was unable to recover benefits from his employer as it had failed to pay its WC premium and its policy was cancelled. The Claimant then attempted to recover WC benefits from a statutory employer. The statutory employer denied the relationship and further claimed that Claimant was precluded from receiving compensation benefits as he was an undocumented worker at the time of the accident. The Claimant remained in the country after his work visa expired. After sorting out the coverage and statutory employer issue, the WCJ awarded the employee indemnity benefits and all medical expenses related to the work accident pursuant to the fee schedule and vocational rehab, in addition to penalties and attorney's fees. The Third Circuit upheld this decision, reasoning that they had already determined that a direct employer owed an undocumented worker compensation benefits in **Artiga v. M. A. Patout and Son**, 95-1412 (La. App. 3<sup>rd</sup> Cir., 4/3/96), 671 So.2d 1138, finding that there is no express statutory provision excluding undocumented workers from WC coverage. The statutory employer failed to establish why this rule should be applicable only to direct employers. **Rodriguez v. Integrity Contracting**, 2009-1537 (La. App. 3<sup>rd</sup> Cir., 5/5/10) 38 So.3d 511.

#### **DATE CLAIMANT TOLD HE NEEDED SURGERY, RATHER THAN DATE HE FELT "POP" IN HIS NECK AND STOPPED WORKING, WAS DATE OF DISABILITY FOR PURPOSES OF "DEVELOPING INJURY" RULE**

In July 2006, Claimant injured his neck working as a foreman for a construction company. While picking up a cement-filled column, he felt a "pop in his neck" and immediately knew something was wrong. Following the incident, he stopped working for the company and did not return. He reported the incident to his employer, but the claim was denied. Claimant sought treatment of his primary care physician, who instructed him to see a specialist. Approximately three weeks after the accident, Claimant accepted a position at a car wash. During the application process, Claimant informed his new employer of the injury he sustained at his last job and he was placed on light duty at the car wash due to concerns about his neck. In November 2007 (15 months after the accident), Claimant filed suit. Employer alleged the claim was barred by the one-year prescriptive period. In August 2007, less than

one year before suit was filed, Claimant's physician told him that a cervical fusion surgery would be necessary, and such was performed in January 2008. Therefore, Claimant relied on the "developing injury" rule which provides that suit is timely if filed within one year from the date the injury/disability "develops," however, in all instances the suit must be filed within two years of the accident. The court held that even though Claimant knew something was wrong with his neck and did not return to work, the fact that he applied for a position at a car wash three weeks later indicated a lack of disability until August 2007 when his physician informed him that cervical surgery was necessary. Therefore, because the suit was filed within one year of August 2007 and within two years of July 2006, his claim was timely. ***Alfortish v. Roughneck Construction, LLC***, 2009-870 (La. App. 5<sup>th</sup> Cir., 5/11/10) 40 So.3d 1004.

### **INTENTIONAL ACT EXCEPTION TO WORKERS' COMPENSATION EXCLUSIVITY REQUIRES MORE THAN KNOWLEDGE OF DANGEROUS CONDITION**

Decedent's spouse sought an intentional act exception to the WC exclusive remedy based on alleged defective safety practices on a rig platform that caused decedent's death. The Judge of the 26<sup>th</sup> Judicial District Court granted employer's Motion for Summary Judgment and the Court of Appeal of Louisiana, Second Circuit, affirmed noting that for tort recovery to be had the employer's conduct and knowledge had to be "substantially certain" and that "...an employer's mere knowledge that a machine is dangerous and its use creates a high probability that someone will eventually be injured is not sufficient to meet the substantially certain requirement....knowledge and appreciation of a risk does not constitute intent, nor does an employer's reckless or wanton conduct constitute intentional wrongdoing for purposes of the Act..." ***Crockett v. Therral Story Well Service, Inc.***, 45,716 (La. App. 2<sup>nd</sup> Cir., 1/5/11) 57 So.3d 355, *Writ not considered* 2011-0263 (La., 3/25/11) 61 So.3d 650.

### **HORSEPLAY BY FELLOW EMPLOYEES DOES NOT NECESSARILY LEAD TO INTENTIONAL ACT EXCLUSION UNDER THE ACT**

Plaintiff attended a work party after a meeting where her co-workers were chasing each other around with water guns and squirting each other. She did not participate in the sport, but when accosted by two fellow employees, she attempted to grab one of the co-workers in an effort to get them to stop. In her attempt, she slipped and fell onto the floor, injuring her back, neck, and head. She sued in tort, claiming that the squirting was a battery and an intentional act. The Judge for the 24<sup>th</sup> Judicial District Court granted the employer's Motion for Summary Judgment finding that workers' compensation was the exclusive remedy. The Fifth Circuit Court of Appeal affirmed, noting that the testimony elicited showed that the co-employees did not intend an injury, that the act of squirting someone with water was not demonstrated to lead to an injury with a substantial certainty, and thus Summary Judgment was appropriate. ***Bruno v. Bellsouth/The Berry Co.***, 2010-413 (La. App. 5<sup>th</sup> Cir., 1/11/11) 59 So.3d 1265, *writ denied* 2011-0292 (La., 4/1/11) 60 So.3d 1252.

### **THIRD CIRCUIT CONFIRMS NO EXTRATERRITORIAL JURISDICTION OVER WORKERS COMPENSATION MATTERS WHERE CONTRACT OF EMPLOYMENT AND ACCIDENT OCCUR IN ANOTHER STATE**

Claimant met with a rig manager at a drilling site in Westdale, La., who did not discuss a specific job nor make any offer of employment to Claimant but rather, referred Claimant to the Human Resources Office

in Kilgore, Texas to apply for the job. The paperwork, drug test, and a pre-employment physical all occurred in Texas. Claimant injured his lower back while working on a drilling rig in Texas. The WCJ found under LSA-R.S. 23:1035.1 that there was no jurisdiction over the claim to bring the claim in Louisiana. The Court of Appeal of Louisiana, Third Circuit, affirmed the decision. **Hesser v. Nabors Drilling USA, LP**, 2010-741 (La. App. 3<sup>rd</sup> Cir., 12/8/10) 52 So.3d 1095.

#### **COURT REVERSES RULING IN FAVOR OF EMPLOYER ON GROUNDS THAT CLAIMANT WAS A SOLO INDEPENDENT CONTRACTOR COVERED BY THE LA WORKERS' COMPENSATION ACT**

Claimant filed a claim for WC benefits as a result of an accident on January 21, 2008 when he fell from scaffolding while performing carpentry work at the Degas House, a historic museum/guest house which is operated by Degas House, LLC. Defendant, Degas House, LLC and its sole member, David Villarubia, filed a Motion for Summary Judgment seeking to dismiss the claim on the basis that Claimant was not an employee of Degas House and/or Villarubia. Claimant filed a cross Motion for Summary Judgment asserting that he was entitled to compensation benefits, either in his status as an employee or as a solo independent contractor covered by the WC Act because he was engaged in "manual labor" in the ordinary course of defendants' business. The court agreed with the defendants' claims and dismissed the case. The Fourth Circuit reversed the decision and held that Claimant was covered as an independent contractor engaged in manual labor. The Fourth Circuit found that both parties offered evidence in their individual motions for summary judgment which established that the Claimant was an independent contractor who spent a substantial amount of his time in manual labor, and that Claimant's work was an integral part of the defendants' trade, occupation and business. Villarubia hired the Claimant to replace rotten boards in Villarubia's office building, from which he ran the day to day operations of Degas House and managed his commercial real estate holdings. The Fourth Circuit noted that the jurisprudence uniformly defined "manual labor" as work whose "physical" element predominates over the "mental" element of the work and naturally concluded that Claimant, as a carpenter, was engaged in manual labor when he was injured. This left the question of whether Claimant was engaged in the defendants' trade, business or occupation at the time of the accident. In resolving that issue, the court held that in order for the Claimant's work to be considered part of the principal's trade, business or occupation, it must be essential to the ability of the principal to generate his goods, products, or services. The court found for the Claimant because the building on which he was working housed Villarubia's various businesses and the repair and renovation of that building was essential to Villarubia's business operations, and "was part of defendants' day-to-day routine." **Steinfelds v. Villarubia**, 2010-0975 (La. App. 4<sup>th</sup> Cir., 12/15/10) 53 So.3d 1275, *writ not considered as untimely* 2011-0137 (La., 3/4/11) 58 So.3d 466.

#### **HOURS WORKED AT PART-TIME JOB INCLUDED IN COMPUTATION OF AWW ALTHOUGH DISABLING INJURY OCCURRED IN ACCIDENT AT FULL-TIME JOB**

Claimant was injured during the course and scope of her job as a school bus driver, which was her "full-time" job and from which she earned an annual salary, plus extra pay for field trips, etc. Claimant worked part-time at McDonalds, working about 6 hours per day. The bus accident kept Claimant from working either job. The School Board argued that only wages from the full-time bus driving job should

be used in calculating the AWW, based on the wording of the statute—23:1021(12)(a)(i)(bb)—which seemingly indicates that wages from both jobs are combined only when the accident occurs at the part-time job. The court disagreed, stating that the phrase “that employment” in the statute was ambiguous and could reasonably refer to the full-time or the part-time job. *Leger v. Calcasieu Parish School Board*, 2009-1261 (La. App. 3<sup>rd</sup> Cir., 4/7/10) 34 So.3d 1042, *writ denied* 2010-1005 (La., 6/25/10) 38 So.3d 348.

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## **NO FIXED TEST FOR BORROWED SERVANT STATUS**

The Judge for the 19<sup>th</sup> Judicial District Court for the Parish of East Baton Rouge granted defendant's Motion for Summary Judgment, finding the Plaintiff was a "borrowed servant" under LSA-R.S. 23:1031. The Plaintiff was employed as a concrete technician with E. Perez Services and Perez sent him under contract to Boykin Brothers who were performing work for Boh Brothers Construction. Boykin Brothers had immediate and direct control over Plaintiff, provided Plaintiff with equipment, and had contractual authority to fire him. The contract did not provide for a statutory employment relationship. However, based upon the facts of the case the Claimant was considered a borrowed servant, thus WC was the exclusive remedy for the injury. The First Circuit affirmed the ruling but noted that there was no fixed test for borrowed servant status. *Mejia v. Boykin Brothers, Inc.*, 2010-0118 (La. App. 1<sup>st</sup> Cir., 9/10/10) 52 So.3d 82.

## **AWW**

### **ANNUAL AND SICK-LEAVE HOURS ARE NOT EXTRA HOURS ADDED TO THE CALCULATION OF AN HOURLY EMPLOYEE'S AVERAGE WEEKLY WAGE**

Claimant was employed by the Department of Transportation and Development ("DOTD"). He was paid by the hour and earned a bi-monthly wage of \$1,095.76 for 80 hours of work, or \$547.88 for 40 hours per week, working Monday through Friday. During the four weeks prior to the accident, Claimant used 32 hours of annual leave and eight hours of sick leave to make up for hours he did not work. The parties disputed the calculation of the average weekly wage in light of the annual and sick leave that was used in the four weeks before the accident. The WCJ ruled that the Claimant's fringe benefits should be included in the calculation of the average weekly wage as additional hours worked, increasing the AWW. The Third Circuit Court of Appeal reversed the ruling, reasoning that since the Claimant was an hourly employee, the fringe benefits were already utilized in the calculation of his AWW because they were used for hours the Claimant did not actually work. The Louisiana Supreme Court affirmed the appellate court holding that the average weekly wage is to be calculated based on Claimant's status as an hourly employee. The Court specifically held that it was not proper to calculate the average weekly wage using the 26-week method when commissions or bonuses are earned because no part of Claimant's pay was based a unit, commission, or other basis. In addition, the Court noted that any annual and sick leave that was accrued but NOT used should not be included in the calculation because it was not taxable and there was no immediate benefit to Claimant. **Hargrave v. State ex rel. Dept. Of Transportation and Development**, 2010-1044 (La., 1/19/11) 54 So.3d 1102.

### **COURT REJECTS CLAIMANT'S TESTIMONY CONCERNING OVERTIME AND "MOONLIGHTING" WAGES EARNED WITHOUT DOCUMENTARY SUPPORT**

Claimant filed suit disputing the average weekly wage calculation on which the employer based the Temporary Total Disability (TTD) benefits. Claimant was an hourly worker, and the employer's records for one of the weeks used in the calculation showed that Claimant worked only 12.5 hours, although records for the other three weeks showed that he worked full weeks with overtime. Claimant alleged that he worked a full week with overtime in all the weeks and the employer's records were in error. The employer admitted that the actual time cards had been destroyed, and that it had payroll records that had been transcribed from the original time clock records. The employer did have check records showing that Claimant was only paid for 12.5 hours for the week in question. The Claimant did not have any documentary proof of his claim, just the testimony of he and his wife that he worked a full week with overtime for the week in question. The court ruled in favor of the employer due to Claimant's lack of documentary proof. Claimant also alleged that the AWW should have taken into account income from his landscaping business because his work injury resulted in lost income from that job. Again, he offered no documentary proof of what he earned because he was paid in cash, and did not report the income to the IRS. His only proof was his testimony, plus testimony of his wife and a friend who did the landscaping work with him. The court ruled in favor of the employer due to lack of any physical evidence from the Claimant. **Hunter v. James Machine Works, Inc.**, 45,538 (La. App. 2<sup>nd</sup> Cir., 9/22/10) 48 So.3d 1103.

## **SOMETIMES MOONLIGHTING IS NOT MOONLIGHTING**

Claimant drove a school bus for the School Board as well as a school van for mail delivery for the School Board. A School Board member also asked the Claimant to use the van to transport school children to LEAP tutoring and to the New Orleans Chapter of Young organization (NOCY), as well as to transport other people for Jazz Fest. In determining the Claimant's AWW, the School Board did not take into account the extra-curricular activity. The WCJ found that the activities should have been calculated in the overall AWW due to the relationship between the School Board and the NOCY (provision of insurance for transportation), and the direction of the School Board member for the Jazz Fest events and LEAP tutoring. Because of the complexity of the issue, however, the Judge awarded no penalties or attorney's fees. The Fifth Circuit Court of Appeal affirmed the Judge's ruling. **Townsend v. Jefferson Parish School Bd.**, 2010-172 (La. App. 5<sup>th</sup> Cir., 10/26/10) 52 So.3d 128.

## **LEGITIMATE DISPUTE REGARDING THE PRECISE AWW IS NOT JUSTIFICATION TO REFUSE PAYMENT OF ANY INDEMNITY BENEFIT**

Employee, a member of the New Orleans Saints practice squad, was injured at work and determined to be disabled. Due to a dispute as to the proper AWW, the employer did not pay any indemnity benefits. The trial court agreed that the dispute as to the proper AWW was reasonable, thus not entitling the employee to penalties and attorney's fees. The Fifth Circuit Court of Appeal reversed, stating: "[t]he Saints failed to pay any benefits to [Claimant] following his injury, although he was clearly entitled to workers' compensation benefits. Regardless of the dispute concerning the calculation of the average weekly wage, the Saints could have paid benefits to [Claimant] using its own wage calculations pending the final resolution of this matter before the court." Accordingly, the court awarded penalties and attorney's fees for failure to pay the undisputed portion of the indemnity benefits. **Hoffman v. New Orleans Saints**, 2010-391 (La. App. 5<sup>th</sup> Cir., 1/25/11) 56 So.3d 446.

## **AWW OF A SEASONAL EMPLOYEE PAID A COMMISSION IS CALCULATED USING FORMULA APPLICABLE TO COMMISSIONS**

The Claimant worked on a commission basis as a truck driver during sugar cane grinding season. He was paid a commission on each load of sugar cane he hauled. Because he was paid a commission, the court held that the average weekly wage and indemnity rate had to be calculated using the formula for commissions, rather than the formula for seasonal. **Lumpkin v. A.B.E.L. Trucking of Louisiana LLC**, 2010-0054 (La. App. 3<sup>rd</sup> Cir., 6/2/10) 40 So.3d 422, *writ denied* 2010-1543 (La., 10/1/10) 45 So.3d 1104.

## **PRIOR CONSENT JUDGMENT PRECLUDES RE-LITIGATION OF AWW**

Following his work accident in January 1995, the Claimant filed a 1008 Disputed Claim and alleged an average weekly wage of \$520. However, the parties subsequently entered a consent judgment which included the agreement that the employer would continue to pay weekly indemnity benefits in the amount of \$247.50. Twelve years later, in 2009 the Claimant filed another 1008 and alleged that his weekly indemnity had been underpaid due to miscalculation of his AWW. In response, the defendant filed an Exception of Res Judicata based on the earlier settlement and dismissal. The First Circuit Court

of Appeal sustained the exception, explaining, “The WCJ technically erred in failing to sustain the peremptory exception of res judicata, as the compromise agreement and order of voluntary dismissal precluded relitigation of the issue of the amount of weekly indemnity benefits based upon the disputed average weekly wage.” The court noted that the AWW calculation was an integral part of the original agreement. LESSON: Make sure the AWW and TTD rate calculations are correct at the time of any consent judgments or agreements that do not result in full and final dismissal of the case. *Chaisson v. Central Crane Service*, 2010-0112 (La. App. 1<sup>st</sup> Cir., 7/29/10) 44 So.3d 883.

#### **COURT HOLDS THAT SEB SHOULD BE PAID WEEKLY**

This court held that the SEB was owed weekly, despite the SEB statutory provisions providing for monthly calculation. The court cited the WC statute that provides for payment of indemnity benefits at the same interval as wages were paid. In this case, the Claimant was paid weekly. The court held that although SEB was calculated monthly, it was to be paid weekly. The court implicitly held that calculating based on a monthly wage does not mean payment is to be monthly. This holding is in the context of a factual scenario in which SEB was being paid although it was undisputed that Claimant was NOT working. In a factual scenario in which a claimant is working, a very good argument can be made that SEB is not paid until the end of the month for which SEB may be owed because there would be no way of calculating the amount owed until wages are submitted for the prior month. Contrarily, when it is known that a claimant is not working, there is nothing to wait for at the end of the month to make the calculation. SEB will be calculated on zero wages or a hypothetical wage a claimant is choosing not to earn, and therefore, since that is a known figure, the calculation and payment can be made weekly. *Carmouche v. Kraft Foods, Inc.* 2010-401 (La. App. 3<sup>rd</sup> Cir., 4/13/2011) 2011 WL 1376146.

#### **Injury, Medical Causation, & Choice of Physician**

#### **TREATING DOCTOR SAYS CLAIMANT IS RELEASED TO FULL DUTY WITH NO RESTRICTIONS AFTER A PINKY FINGER INJURY, AND DOES NOT NEED PAIN MANAGEMENT—COURT ACCEPTS THE DOCTOR’S DISABILITY OPINION BUT NOT HIS TREATMENT OPINION**

Claimant sustained a “slightly displaced fracture” on his pinky finger on May 30, 2008. The treating doctor, Dr. Bilderback, put the finger in a plastic splint and prescribed medication on June 2. On June 11, Claimant reported a pain level of 10 out of 10. The Dr. found this to be an exaggeration based on examination. On June 25, about one month post-accident, Claimant reported pain at a level 5 and Dr. Bilderback ordered an MRI. On August 18, Dr. Bilderback observed that the fracture had healed, and that Claimant had normal range of motion in his finger with no edema or ulnar nerve pathology. Claimant was given a FULL release on that date. The Dr’s records noted that Claimant was “very resistant to returning to work.” On October 14, Claimant saw a second doctor, Dr. Ritter. Dr. Ritter found that Claimant was at MMI and ordered an FCE. The FCE revealed 8% impairment to the finger and 1% to the hand, that Claimant could perform light/medium duties, and that further therapy was unnecessary. Claimant underwent an impairment evaluation on November 17, and the doctor found and this doctor found no evidence of swelling, despite complaints of such, nor any evidence of RSD. In December, Dr. Ritter refused Claimant’s request for pain medication for the 7-month-old injury, then

referred him to pain management. Claimant saw the pain management doctor on June 5, 2009, a year after the pinky injury, and reported pain at a level 10. The pain management doctor stated that Claimant could “possibly” have RSD and recommended medication, physical and occupational therapy, and nerve blocks. NONE of the doctors ever stated that Claimant was totally disabled from working. Following the FCE and opinion of Dr. Bilderback, the employer offered a job and terminated benefits. The Claimant did not return and filed suit. Incredibly, the WCJ awarded TTD benefits and ordered approval of the pain management treatment, despite the fact that the prior treating physician had found that pain management treatment was contraindicated and that the Claimant should not be treated with narcotic pain relief. The 2nd Circuit found that the WCJ was manifestly erroneous in finding that Claimant was entitled to TTD benefits, noting the obvious evidence that no physician, not even the pain management doctor, provided any opinion that Claimant was totally disabled. However, on the issue of entitlement to pain management treatment, the 2nd Circuit agreed with the WCJ and affirmed the award. Interestingly, the appellate court referred to the often-quoted principle of law that the treating physician’s opinion should be accorded greater weight than that of a doctor who examines the Claimant once or twice, but chose not to follow it. Although the treating doctor and another doctor found no reason for the alleged ongoing complaints of pain, and that no further treatment was needed, the court affirmed the WCJ’s decision to reject these opinions in favor of the opinion of a pain management doctor who saw Claimant once per year post-accident. ***Hodge v. Manpower Temporary Services***, 45,648 (La. App. 2<sup>nd</sup> Cir., 9/22/10) 47 So.3d 1148.

### **ONE BEATS THREE: COURT ACCEPTS SURGERY OPINION OF CLAIMANT’S ORTHOPEDIC DOCTOR OVER THREE OTHER ORTHOPEDIC DOCTORS, ONE OF WHOM WAS COURT-APPOINTED**

Claimant injured her back in February of 2004 lifting a bucket while standing on a ladder. She received conservative treatment for the next 4 years without relief of symptoms. Claimant filed a 1008 in January of 2008 seeking approval for back surgery (a microdiscectomy) that was recommended by Dr. Chris Cenac, Jr., orthopedic surgeon. Defendant denied the necessity of the surgery based on the opinions of orthopedic physicians, Dr. Delmar Walker and Dr. Michael A. LaSalle. Both of these orthopedic doctors recommended weight reduction and exercise, and believed that surgery would not be beneficial in absence of these measures. Because there was a dispute about surgery, the WCJ appointed another orthopedic doctor, Dr. James C. Butler, to render an opinion. Dr. Butler questioned whether surgery would provide Claimant with relief, and instead recommended conservative treatment. Faced with three opinions that surgery was not appropriate, and one contrary opinion, the WCJ ruled that the surgery was reasonable and necessary, and ordered the employer to pay for it. The Judge noted that Claimant had undergone conservative treatment for many years without much improvement. The employer appealed the judgment, and the appellate court affirmed the WCJ’s ruling, stating that the Judge was “not clearly wrong” for choosing Dr. Cenac’s opinion over the opinion of the other three orthopedic doctors. ***Ford v. Sodexo, Inc.***, 2010-0182 (La. App. 1<sup>st</sup> Cir., 8/2/10) 47 So.3d 476.

### **CLAIMANT DEEMED PERMANENTLY DISABLED DESPITE EVIDENCE THAT HE WAS CAPABLE OF WORKING AND DID WORK FOR WAGES DURING A SUBSTANTIAL PORTION OF THE CLAIMED PERIOD OF TOTAL DISABILITY**

The Fourth Circuit Court of Appeal reversed, in part, the granting of Summary Judgment in favor of the employer in a case involving whether the Claimant was permanently and totally disabled. The Claimant claimed entitlement to permanent and total disability benefits, yet the Employer was able to prove that he worked for wages during a substantial portion of the claimed period of disability. The accident at issue occurred in 1991, and the employer paid 520 weeks of benefits. Benefits were terminated in 2001 on the basis that Claimant was capable of working. In converting the Claimant from TTD benefit status to SEB status in 2000, the employer relied on the opinions of four physicians who concluded that the Claimant was capable of working. Further, the employer presented evidence at the hearing on the MSJ that Claimant did work for wages during the years 2003, 2004, 2006 and 2007 and that he was involved in two subsequent non-work related automobile accidents which he admitted aggravated his pre-existing back injury. In defense of the MSJ, the Claimant relied solely on the opinion of his treating physician, Dr. Manale, that he was permanently and totally disabled. The Fourth Circuit acknowledged that the Claimant bears the burden of proving by clear and convincing evidence that he is permanently and totally disabled, but it only affirmed the MSJ for the years 2003 through 2007 when it is undisputed that Claimant worked for wages for various charities. However, the Fourth Circuit reversed the MSJ for those years before Claimant “re-entered employment for wages in 2003 and after he left such employment in 2007” as they found that a genuine issue of material fact existed as to Claimant’s disability status during that time. In its lengthy discussion of the facts, the Fourth Circuit did acknowledge that the employer offered vocational rehab testimony which established that Claimant was cleared to work at various jobs in late 2000/early 2001 by one of the four doctors who had indicated that he could work. The Claimant responded to these vocational rehab efforts by indicating that he had applied for the jobs located by the vocational rehab counselor but there were no job openings. ***Keasley v. Transit Management of Southeast Louisiana***, 2010-0786 (La. App. 4<sup>th</sup> Cir., 12/7/10) 52 So.3d 976.

**MRI SHOWING “RECENT” HERNIATION WAS “DECISIVE” IN OUTWEIGHING SERIOUS DOUBT AND INCONSISTENCIES IN CLAIMANT’S TESTIMONY ABOUT ACCIDENT; BUT COURT REVERSES AWARD OF PENALTIES AND ATTY FEES**

Employer denied compensability of claim based on significant evidence disputing the occurrence of Claimant’s alleged work accident and back injury while lifting a patient at a hospital. The evidence included Claimant’s initial failure to report an injury, and even denial that she suffered a work injury, a serious history of prior back injuries, and inconsistent medical histories given to the doctors about the cause of her symptoms. Nevertheless, the WCJ found in favor of Claimant and awarded penalties and attorney’s fees against the employer. While the appellate court affirmed the decision that Claimant sustained a work-accident, it reversed the decision awarding penalties and attorney’s fees. In affirming the decision concerning the accident, the court noted that despite all the suspicious evidence about the claim, the “decisive” evidence was a doctor’s testimony that an MRI performed after the alleged accident showed a “recent” herniation in that it showed no calcification. Also, the evidence showed that Claimant had not been able to work and had unbearable symptoms since the alleged accident lifting a patient. The court noted that the employer had more than reasonable grounds to suspect that the Claimant’s back injuries predated her employment and that the employer had a reasonable basis to

controvert the claim. **Dugan v. St. Frances Medical Center**, 45,149 (La. App. 2<sup>nd</sup> Cir., 4/14/10) 34 So.3d 1157, writ denied 2010-1114 (La., 9/3/10) 44 So.3d 685.

#### **COURT REJECTS “WORKING IN PAIN” CLAIM (Carmouche Continued)**

Claimant was injured and eventually underwent surgery on his back followed by two years of pain management. One year into the pain management treatment, he was released to sedentary or light duty. The employer’s vocational rehab counselor identified a home-based telephone solicitor’s position available for Claimant. Claimant originally accepted the job, but quit after three days due to substantial pain and being in a medicated state. At that point, the employer reduced benefits to SEB. The trial judge held Claimant’s indemnity benefits could not be reduced to SEB due to the “substantial pain” doctrine in the SEB statute and, therefore, awarded Claimant TTD benefits. The appellate court reversed, and pointed out that proof of substantial pain can be used to argue a claimant is entitled to SEB rather than no benefits at all. However, TTD benefits are only due when a claimant is physically unable to perform the job, regardless of the effects pain may have on their ability to work. TTD benefits are not owed when a claimant is physically able to do the job, but cannot do the job due to substantial pain. Because all of Claimant’s treating physicians, including the state IME physician, opined that Claimant was physically able to perform the job, the court found the employer was entitled to reduce TTD benefits to SEB by taking into consideration the hourly rate of the sedentary job for 40 hours. The dissenting opinion on appeal held that TTD was not owed, but that SEB was owed based on a zero wage earning capacity. **Carmouche v. Kraft Foods, Inc.** 2010-401 (La. App. 3<sup>rd</sup> Cir., 4/13/11) 2011 WL 1376146.

#### **TERMINATION OF INDEMNITY BENEFITS BASED ON SMO OPINION WAS NOT UNREASONABLE WHEN CONTRARY OPINION FROM CLAIMANT’S DOCTOR WAS RENDERED AFTER SMO OPINION**

A bus driver employed to transport disabled persons injured her hip when she tripped over a walker. Her benefits were terminated approximately three months after the accident, based on opinions from the employer’s choice of general physician (Dr. Silva) and orthopedist (Dr. Steiner), that she could return to work as a driver. These opinions were based on injuries allegedly sustained in the work accident. The report from the employer’s orthopedic doctor was provided to Claimant’s family doctor, who prescribed more medical treatment but did not comment on the disability issue. Claimant was then seen by her choice of orthopedic doctor, who stated that Claimant was totally disabled as a result of the work injury. Although benefits were eventually reinstated four months later, the employee filed a 1008 Disputed Claim for Compensation, demanding the 19 weeks during which she received no benefits, along with penalties and attorney’s fees. The Fourth Circuit Court of Appeal affirmed the trial court’s judgment for the employer. Although Claimant’s family doctor and orthopedist found her disabled, the court noted that their opinions were not rendered until after benefits were terminated, and that the family doctor had not addressed disability when he received the report from the employer’s orthopedist. The court concluded: “The WCJ is afforded considerable discretion in evaluating expert testimony, and the decision to accept the testimony of one witness over the conflicting testimony of another can virtually never be manifestly erroneous. We find on the record, taken as a whole, that sufficient credible medical evidence supports the conclusion that the WCJ’s ruling was a reasonable one, and find no manifest error

in the ruling.” *Irving v. Transit Management of Southeast Louisiana, Inc.*, 2010-0360 (La. App. 4<sup>th</sup> Cir., 7/20/10) 44 So.3d 796.

#### **INABILITY TO WORK MUST BE RELATED TO INJURY FOR ENTITLEMENT TO INDEMNITY BENEFITS**

Claimant, a deputy sheriff, injured his hand, pre-Katrina, resulting in three surgeries and a permanent impairment. He was released back to work at modified duty and the Sheriff was able to accommodate the restrictions. However, Claimant was furloughed after Katrina and he alleged an inability to earn at least 90% of his pre-accident wage during the furlough, thus claiming entitlement to SEB benefits. The WCJ and the Fourth Circuit Court of Appeal found that Claimant was entitled to SEB benefits and was further entitled to penalties and attorney’s fees. However, the Louisiana Supreme Court found that Claimant failed to meet his burden of proof of entitlement to SEB benefits. The Court determined that the Claimant had to show that the injury, not other events and concerns, caused the inability to retain his job. In the instant case, the Claimant was let go not due to his injury but as a result of the hurricane and closure of the facility where he worked. *Poissenot v. St Bernard Parish Sheriff’s Office*, 2009-2793 (La., 1/9/11) 56 So.3d 170.

#### **OR DOES IT.... COURT AFFIRMS RARE FINDING OF PERMANENT AND TOTAL DISABILITY BASED ON NUMEROUS NON-WORK RELATED ILLNESSES WORSENERD DUE TO CLAIMANT ABSENCE FROM THE WORKFORCE FOR 10 YEARS**

Claimant’s shoulder injury in 1998 required rotator cuff surgery. The court does not indicate in its ruling that Claimant had any post-surgery problem with his shoulder rendering him totally disabled from all employment. However, Claimant never returned to work after the shoulder surgery for reasons related to numerous other pre-existing medical conditions that worsened after the shoulder surgery, but that did not prevent Claimant from working before the shoulder injury. Claimant sued alleging he was permanently and totally disabled when the employer terminated benefits after payment of 520 weeks. The court determined that Claimant was permanently and totally disabled. The medical evidence in the case was presented via report from Claimant’s treating family doctor and through testimony of the vocational rehab counselor who had a conference with the doctor. The medical evidence was that Claimant suffered pain, weight gain and depression as a result of the shoulder injury and the resulting absence from work associated with the surgery and recuperation. These conditions in turn caused the myriad of other problems that made Claimant unemployable according the vocational rehab counselor. Specifically, the pain, weight gain and depression caused a knee injury, worsened a pre-existing fibromyalgia, rheumatoid arthritis and avascular necrosis, raised Claimant’s blood pressure, complicated a sleep apnea condition, caused memory loss, and a gastroesophageal reflux disease. All these conditions made the Claimant unemployable according to the doctor and vocational rehab counselor. Accordingly, the court found a sufficient relationship to the shoulder injury based on the evidence presented. *Landry v. City of Scott*, 2010-47 (La. App. 3<sup>rd</sup> Cir., 6/2/10) 40 So.3d 428. **NOTE:** It seems the result was due to a very weak case presented by the defense. In other words, the only medical testimony offered was from Claimant’s family doctor, and the court had no other countervailing evidence. However, it points out that a Claimant’s prolonged absence from work can be very risky in terms of a potential permanent and total disability finding.

## **COURT REVERSES JUDGMENT THAT HERNIA WAS WORK-RELATED BECAUSE DOCTOR WOULD NOT USE THE “MAGIC WORDS”**

Claimant had an abdominal surgery in November of 2005. On August 5, 2006, Claimant sustained an injury lifting two five-gallon containers of cleaning fluid. He alleged a back injury and a hernia that was discovered definitively with a CT Scan performed on October 9, 2006. The hernia was an “incisional” hernia, meaning that it originated from the incision site of the 2005 abdominal surgery. The issue was whether the hernia was caused by the August 5, 2006 lifting incident or whether it existed before that date due to the November 2005 surgery. Claimant testified that after recovering from the abdominal surgery in November 2005, he had no pains in the location of the surgery until after the work-related incident at issue in August, 2006. There was no medical evidence of the hernia before August 5, 2006. During a medical visit on August 9, Claimant complained of some abdominal pain in the area of the prior surgery, but there was no clear evidence of a hernia on normal examination. The doctor testified that because Claimant was obese, it would be difficult to entirely rule out a hernia on that date. Claimant reported symptoms of hernia to a therapist on August 23. Claimant’s treating physician testified it “was possible” the hernia was caused by the August 2006 lifting incident. When asked if it “was more probable than not” that the hernia was caused by the August 2006 incident the doctor replied again that it was possible but no way to know for certain without knowing what else happened in the interim. The court denied the hernia claim based on its finding that “in sum, [the treating doctor] never used the magic words that it was more probable than not that lifting containers caused [Claimant’s] incisional hernia.” *Flanigan v. City of Shreveport*, 45,459 (La. App. 2<sup>nd</sup> Cir., 10/27/10) 50 So.3d 938.

## **COURT ACCEPTED PERMANENT AND TOTAL DISABILITY OPINION OF DOCTOR WHO SAW CLAIMANT ONCE, DESPITE CONTRARY OPINION OF CLAIMANT’S TREATING ORTHOPEDIC DOCTOR**

A 61-year-old construction supervisor hurt his back in September of 2003. He was paid TTD benefits for the next 4 years during which time he underwent two surgeries (a laminectomy in 2003 and a fusion in 2004) and ongoing treatment by his orthopedic doctor, Dr. James Butler. In May 2007, Dr. Butler opined that Claimant was capable of engaging in sedentary employment and approved 11 jobs identified by the vocational case manager. Based on the job approvals, benefits were terminated. Claimant admitted that he could drive his pickup truck, shop with his wife, do limited cooking, walk on a treadmill for short periods of time, and help cut his grass if he took breaks, but refused to apply for any of the jobs because of back pain and numbness in his legs and feet. Dr. Butler reported that there was evidence of symptom magnification, as corroborated in an FCE. The trial court denied the claim for disability benefits based on Dr. Butler’s opinion and release to work. However, the appellate court reversed based upon employee’s testimony of substantial pain, and the examination of Dr. Ploger, who examined Claimant on ONE occasion. The court held that because of Claimant’s pain, age and multitude of unrelated conditions, he was unemployable. The court noted that while the treating physician’s opinion was to be given greater weight, the treating physician’s testimony is not irrebuttable and that the trier of fact is required to weigh the testimony of all medical witnesses. *Duplessis v. Tulane University Medical Center*, 2010-0267 (La. App. 4<sup>th</sup> Cir., 8/25/10) 47 So.3d 992.

## **MEDICAL EVIDENCE GENERALLY NECESSARY TO CONTROVERT TESTIMONY OF INJURY**

Claimant alleged injury to his neck, shoulder, and elbow while operating a man lift. Another employee was severely injured in the incident. Claimant reported his injury over a week after the incident and alleged that his complaints of injury were ignored by his supervisors. Claimant had no pre-existing cervical complaints which were found by the employer. Due to any lack of medical information to dispute the injury claim, the WCJ found that Claimant proved that the accident caused him injury, and awarded benefits as well as penalties and attorney's fees. The Court of Appeal of Louisiana, Third Circuit, affirmed and awarded additional penalties and attorney's fees for the appeal. **Weaver v. Southern Erectors, Inc. of Florida**, 2010-783 (La. App. 3<sup>rd</sup> Cir., 12/8/10) 53 So.3d 547.

### **COURT DEFERS TO IME DOCTOR WHO HAD THE BENEFIT OF SURVEILLANCE VIDEO OVER TREATING DOCTOR REGARDING SURGERY**

The two most significant issues that the court addressed in this case were (1) whether back surgery recommended by Claimant's treating physician (Dr. Donald Dietze) was necessary and (2) whether Claimant committed fraud when drug screens given by the treating pain management doctor showed the absence of prescribed drugs despite Claimant's statement he was taking the prescriptions. Regarding the surgery issue, the recommendation for back surgery was disputed by Dr. James Ricciardi, who was appointed by the court to conduct an IME. The court noted that the opinion of the court-appointed IME is to be given "significant" weight, but not necessarily always given more weight than the treating doctor. Specifically, the court noted that the weight given to the IME opinion is based on "the qualifications or expertise of the physician, the type of examination he performs, his opportunity to observe the patient, his review of other physicians' examinations and tests, and any other relevant factors." In this case, a surveillance video was provided to Dr. Ricciardi, which showed the Claimant using a cane when entering and exiting a doctor's office, but not using the cane while walking in a convenience store parking lot with no signs of limping. Another video showed Claimant at a convenience store with his truck, trailer and lawn mower on the trailer and exhibiting no signs of distress. The IME doctor testified that the Claimant's reported pain level of 8 out of 10 was inconsistent with what was seen on the surveillance. The IME doctor also testified that he would not recommend the surgery on a person like Claimant who smoked. Based on this evidence, the court relied on the opinion of the IME that surgery was not warranted. Clearly, the surveillance video was very important in the decision in employer's favor. **Bell v. Mid City Printers, Inc.**, 2010-0818 (La. App. 4<sup>th</sup> Cir., 12/22/10) 54 So.3d 1226.

### **CLAIMANT MUST SUBMIT PROOF OF MILEAGE EXPENSE TO SUPPORT CLAM FOR REIMBURSEMENT**

The headline for this case summary may seem obvious. But in light of the well-established principle of law in WC cases that it is the employer's affirmative obligation to investigate a claim and pay benefits that are due, it may not have seemed so clear. For example, if the employer knows that a claimant has attended medical examinations, the argument could be made that the employer should affirmatively determine what mileage expense is due and pay the claimant. In this case, one of the issues in the 1008 Disputed Claim for Compensation was payment of mileage expense. The Claimant testified at trial that although he had been paid mileage from the time of his 1997 injury through 2006, he had not been paid any mileage since 2006. On cross-examination, and on questioning from the presiding judge, Claimant admitted that since 2006 he had not submitted any documentation to the employer regarding mileage

expense he allegedly incurred. The judge ruled that without any evidence that Claimant submitted the documentation to the employer proving entitlement to reimbursement, the mileage benefit was not owed. **Reese v. Dresser Valve Industries**, 2010-241 (La. App. 3<sup>rd</sup> Cir., 10/6/10)48 So.3d 406.

**APPEAL COURT OVERRULES DEPT. OF LABOR AND WCJ AND ORDERS COURT-APPOINTED IME BASED ON ONE-TIME EXAMINATION BY EMPLOYER SMO THAT CONFLICTED WITH 6-YEAR PRIOR MEDICAL HISTORY**

Claimant suffered a serious back injury in 2003 and remained totally disabled in the opinion of her treating doctor. Claimant was also deemed totally disabled by the Social Security administration in late 2006. In January of 2008, Claimant underwent a second medical opinion (SMO) by a physician of employer's choice. The SMO doctor determined that Claimant suffered from chronic back, buttock and leg pain, and an L4-5 annular tear with stenosis. He recommended that Claimant wean off narcotic medication, start home exercises, cold therapy and Alpha and E-stem therapy. He also concluded that she could return to work with modifications. Contrarily, the treating doctor stated that Claimant had S/l joint dysfunction, that she should continue with formal physical therapy and treatment with Lortab and Darvocet, and that she remained totally disabled. The employer applied to the Dept. Of Labor for appointed IME, but was denied. Employer then filed a Form 1008 asking the WCJ to appoint an IME. The Judge denied the request on grounds that Claimant's "medical history clearly supported [the treating physician's] finding of disability from a fall that resulted in a very 'painful and debilitating'" sacroiliac joint subluxation. The Judge relied on the treating doctor's "frequent and long-term treatment" of the Claimant. However, the appellate court reversed. The court held that despite the long-term treatment history by the Claimant's doctor, the SMO was clearly contrary as to the nature of Claimant's condition, and that is all the statute required to warrant a court-appointed IME. In other words, the WCJ should not have weighed the two opinions to determine which was more reliable, when the only issue was whether they were in dispute. **Christus-Schumpert v. Herrin**, 45, 233 (La. App. 2<sup>nd</sup> Cir., 5/19/10) 38 So.3d 1167.

**EMPLOYER NOT ENTITLED TO UPDATED SMO OF PERMANENTLY, TOTALLY DISABLED CLAIMANT WHEN THE ONLY REASON FOR THE REQUEST IS THE PASSAGE OF A CERTAIN AMOUNT OF TIME SINCE THE LAST SMO**

Claimant was injured in a 1995 work-related accident, and the employer paid benefits for nine years. In 2004, the parties stipulated that the Claimant was permanently and totally disabled (so the employer could take a social security offset), and entered into a judgment for same. In 2009, the employer requested that Claimant undergo an updated evaluation by its choice of physician. Claimant refused, and the employer filed a Form 1008 seeking to compel the examination. The WCJ denied the employer's request and the employer appealed. In affirming the decision of the WCJ, the Second Circuit Court of Appeal noted that the employer could seek a modification of the prior judgment declaring permanent and total disability status based on a change in condition. However, since the employer did not make a showing that Claimant's condition changed since he was adjudicated to be permanent and totally disabled, there was no showing that the request for an evaluation was reasonably necessary as required by law. The only reason given by the employer for the requested updated SMO was that it had been 3 ½

years since the last evaluation by its choice of physician. The Second Circuit rejected that reasoning and noted that since there was no evidence that Claimant's condition had changed, the employer failed to show that the updated SMO was reasonably necessary. It appears that the primary basis for the decision was that Claimant was stipulated to be permanently and totally disabled, and that the court's holding was that the employer should file a motion to modify the judgment, and through that process seek an evaluation. **Marathon Oil Company v. Bowling**, 45,814 (La. App. 2<sup>nd</sup> Cir., 12/15/10) 56 So.3d 328.

#### **EMPLOYER ORDERED TO PAY FOR PSYCHIATRIC EVALUATION WITHOUT ANY DOCTOR REFERRAL— AND—COURT REJECTS FRAUD CLAIM ALTHOUGH CLAIMANT'S DOCTOR'S REPORTS CONTRADICT CLAIMANT'S TESTIMONY**

Claimant suffered a serious hand injury that resulted in amputation of two fingers, and deformity of two other fingers. After more than a year of treatment, including surgery, Claimant requested to be evaluated by a psychiatrist of his choosing. Claimant testified in his deposition that he told his treating doctor that after the accident he suffered sleeplessness due to nightmares and cold sweats, as well as nervous shakes. Claimant also testified he told his doctor about symptoms of depression. On his last visit with the doctor, Claimant stated he asked the doctor for a psychiatric referral but the doctor ignored him. The treating doctor had no record of any of these complaints in his records or request for psychiatric referral, and further testified that he found Claimant to be highly motivated with no indications of psychological problems or depression. The doctor further testified that had such complaints been made, it would be unusual for him to omit such information. However, the doctor confirmed that he was testifying from his records and did not independently say for sure that Claimant did not make the comments. In any event, there was no referral to a psychiatrist, thus prompting the Claimant's 1008 Disputed Claim seeking approval for psychiatric care. The employer denied the claim, and further asserted fraud based on the doctor's testimony as proof that Claimant made false statements concerning his complaints to the doctor. Finding that the employer was essentially attempting to prove a willful false statement based on the absence of a medical record notation, the court held that there was not sufficient proof of fraud. Further, the First Circuit reversed the trial court ruling in employer's favor on the issue of approval of psychiatric treatment. The appellate court held that the only way Claimant could make out a compensable claim for mental injury benefits is to have a psychiatric evaluation. Therefore, the employer was liable for the initial evaluation. **Dangerfield v. Hunt Forest Products, Inc.**, 2010-1324 (La. App 1<sup>st</sup> Cir., 3/25/11) 2011 WL 1258726.

#### **COURT-APPOINTED IME MAY BE GIVEN SURVEILLANCE EVIDENCE**

The Supreme Court of Louisiana recently clarified that a court-appointed IME should "have access to all relevant information, including surveillance material, in order to render an accurate opinion regarding Claimant's medical condition." In this case, the Claimant sought to prevent the employer from providing the IME with a surveillance video and correspondence from Claimant's treating physician. The WCJ had agreed with Claimant that the IME should not have the materials. **Bazile v. Bayou Steel Corporation**, 2010-0982 (La., 7/6/10) 54 So.3d 1092.

## **SUPREME COURT REAFFIRMS EMPLOYER'S RIGHT TO PROVIDE SURVEILLANCE VIDEO TO PHYSICIANS, AND TO TERMINATE BENEFITS BASED ON PHYSICIAN OPINIONS AFTER VIEWING VIDEO**

The Louisiana Supreme Court reversed the rulings of both the WCJ and the Third Circuit who refused to give any credence to videotape surveillance obtained by the employer and provided to the Claimant's treating physician and the SMO physician. The videotape surveillance changed the opinions of those physicians such that they determined that the Claimant was no longer disabled, did not have RSD (a/k/a "complex regional pain syndrome") and was capable of returning to work. In the lower court decisions, the WCJ and the Third Circuit completely disregarded the videotape surveillance as well as the changed opinions of both doctors because they found that the change in the opinions of the physicians was due solely to their review of the surveillance videotape. Claimant was awarded benefits, as well as penalties and attorney's fees. However, the Louisiana Supreme Court ruled that the employer acted appropriately in submitting the surveillance videotape to both physicians and was justified in terminating benefits based on the opinions of both doctors who concluded that because Claimant freely used her left hand in the videotape surveillance, she obviously did not have RSD and therefore had no disability and could return to unrestricted work. The Court noted that the Claimant did not present any evidence which contradicted her treating physician's opinion and the opinion of the employer's SMO that she could return to her pre-injury employment based on the activities which they viewed in that surveillance videotape, and she therefore failed in her burden of providing entitlement to benefits. The Court further ruled that there is no prohibition in statute or jurisprudence preventing an employer from showing surveillance video to a claimant's treating physician or to an SMO doctor. The Court distinguished this case from others which had found an employer to have been arbitrary and capricious in discontinuing benefits based solely on the results of surveillance videotape, finding that the employer in its case did not terminate benefits when it obtained the videotape and instead waited until it obtained medical evidence supporting its position that the employee was no longer disabled from returning to work.

**Iberia Medical Center v. Ward**, 2009-2705 (La., 11/30/10) 53 So.3d 421.

## **CLAIMANT ENTITLED TO CHANGE IN CHOICE OF TREATING PHYSICIAN WHEN TREATING PHYSICIAN REFUSED TO CONTINUE TO PROVIDE CARE**

Claimant's treating physician determined that Claimant's continued shoulder complaints were due to old age and did not need any additional treatment. Claimant sought change in physician of his choosing. It is noted that the SMO had opined that Claimant's complaints stemmed from the work accident. No state IME was sought with regards to medical condition, necessity of treatment, and return to work status. Trial was held on the issue of approving the change of treating physician. The WCJ determined that Claimant met her burden of proof through the SMO opinion and her testimony, and that the treating physician's opinion was tantamount to refusal to provide care. No attorney's fees or penalties were awarded. The appellate court affirmed the judgment. **Dawson v. Terrebonne General Medical Center**, 2010-2130 (La. App. 1<sup>st</sup> Cir., 5/19/11) 2011 WL 1901637.

## **Fraud**

## **FRAUD DISCOVERED AFTER A CONSENT JUDGMENT CANNOT BE ASSERTED AS A DEFENSE**

The employer entered into a consent judgment and dismissal of a pending 1008 Disputed Claim for Compensation on April 16, 2008. Based on what can be determined from the reported decision, at some point thereafter, the employer discovered that Claimant had made misrepresentations that could give rise to forfeiture of benefits under LSA-R.S. 23:1208. Specifically, the employer discovered and alleged that Claimant failed to report post-accident income and denied pre-accident back problems. However, these “misrepresentations” occurred prior to the judgment of April 16, 2008. The appellate court held, on its own motion, that *res judicata* barred the litigation of these issues due to when they arose. **Kepeco Operating, Inc. v. Eubanks**, 2010-1166 (La. App. 3<sup>rd</sup> Cir., 3/9/11) 58 So.3d 1047.

### **COURT REJECTS CLAIMANT’S ARGUMENT THAT LACK OF EDUCATION AND DIMINISHED MENTAL CAPACITY WAS AN EXCUSE FOR HIS WILLFUL FALSE STATEMENTS**

The WCJ granted, and the appellate court upheld, a Motion Summary Judgment dismissing the claim on a finding that Claimant committed fraud by making false statements for the purpose of obtaining benefits under LSA-R.S. 23:1208. Claimant, a truck driver, sustained a minor abrasion to the cornea of his right eye when drilling mud that was being loaded into his truck splashed under his goggles. Claimant was treated by an optometrist, who released him to return to work, with restrictions, for the two-day period following the examination. Although Claimant worked those two days, he continued to complain of pain. Despite additional treatment over the next several weeks and being released to return to full duty, Claimant failed to return to work for over a month. He was then fired for absenteeism. Although Claimant subsequently applied for unemployment benefits, the Administrative Law Judge found he was fired for cause. Claimant then filed a Form 1008. During his deposition, Claimant testified he had only been to an eye doctor once since being hired by the employer, and that visit was only for a routine eye examination. However, medical records from Claimant’s eye doctor showed that four times in the weeks immediately prior to the alleged accident, Claimant complained of symptoms that were similar to those of which he complained subsequent to the accident. The WCJ granted the employer’s Motion for Summary Judgment. On appeal, the Second Circuit considered whether the Summary Judgment evidence was sufficient to show that Claimant willfully made a misrepresentation or false statement for the purpose of obtaining compensation benefits. Claimant argued it would be unfair to hold him responsible for making false statements because he did not understand the questions due to diminished mental capacity. Claimant argued that he did not receive a high school diploma, though he did receive a diploma for completing a program of special education. Claimant’s diploma, however, did not indicate he was a special education student, nor was there any evidence that Claimant suffered from a diminished mental capacity. The court also noted that Claimant intentionally tried to conceal his pre-existing eye problems and the medical treatment he received prior to the accident. **Johnson v. Pinnergy, Ltd.**, 46,188 (La. App. 2<sup>nd</sup> Cir., 04/13/11) 2011 WL 1380061.

### **COURT REAFFIRMS PRINCIPLE THAT NOT ALL LIES, EVEN IF CAPTURED ON VIDEOTAPE, WILL RESULT IN A FINDING OF FRAUD**

Claimant injured her middle and low back in an accident in 2005. After several years, she was diagnosed with reflex sympathetic dystrophy and a spinal cord stimulator was recommended. At some point during the litigation of the claim, Claimant’s deposition was taken and she was asked about her physical

capabilities and video was obtained of the Claimant. The surveillance video depicted Claimant in several activities which she swore in deposition she was unable to do. When shown the video, Claimant admitted she could perform the maneuver, but stated it was painful to do so. In response to the defendant's fraud evidence, the court stated that "although certain of these activities [shown on the video] may contradict [Claimant's] deposition testimony, we do not find that these contradictions rise to the level of willful fraudulent actions intended by [the fraud statute]" and that "mere contradictions between an employee's testimony and surveillance video does not automatically result in [fraud]." Wilczewski v. Brookshire Grocery Company, 2010-1148 (La. App 3<sup>rd</sup> Cir., 03/16/11) 59 So.3d 530.

#### **VIDEO TAPE OF EMPLOYEE OPENING STORE, EMPTYING TRASH AND SANDING NOT SUFFICIENT TO PROVE EMPLOYMENT OR FRAUD**

Video tape was obtained of employee performing activities that would generally be considered "work" for an auto garage while allegedly unable to work and while employer was paying indemnity benefits. During an undercover investigation, the garage owner told the private investigator that Claimant would look at the investigator's car. The garage owner testified at trial, however, that despite the fact that the employee was present during working hours, and may have done some things, he was not an employee and was not paid. Claimant also testified to that effect. The trial court found Claimant and the garage owner credible witnesses and found no evidence of fraud. The appellate court affirmed. Broussard v. Country Club Auto Repair, 2010-1116 (La. App. 3<sup>rd</sup> Cir., 2/2/11) 56 So.3d 1180.

#### **CLAIMANT DID NOT COMMIT FRAUD, DESPITE MULTIPLE PHYSICIAN ACCOUNTS OF EXAGGERATED SYMPTOMS AND MISREPRESENTATIONS OF MEDICAL HISTORY...BIG PENALTIES AND ATTORNEY'S FEES AWARDED**

Claimant fell nine feet from the hood of a front end loader, resulting in nose surgery and replacement of several teeth. Several months later, after returning to work, Claimant quit his job, complaining of ongoing head and neck pain. He was evaluated by an orthopedic surgeon who issued a no-work restriction, diagnosed Claimant with a cervical strain, and also recommended a cervical fusion surgery. The employer issued TTD benefits, but denied authorization for the surgery. Claimant filed suit, seeking authorization for the surgery, indemnity benefits, and penalties and attorney's fees. The employer alleged fraud because Claimant had made multiple misrepresentations regarding prior medical conditions. At trial, Claimant admitted to making mistakes in reciting his medical history to some of his doctors. Employer presented evidence in the form of two doctor's reports, stating the doctors' beliefs that Claimant was intentionally exaggerating and malingering his symptoms. The court found that although Claimant had misrepresented his injuries and some physicians were of the opinion he was exaggerating his symptoms, more weight should be given to his treating physician who recommended surgery. The court held that although inconsistent and erroneous statements were made, there was no evidence to show the statements were made willfully for the purpose of obtaining compensation benefits. Claimant was awarded penalties as well as \$19,000.00 in attorney's fees. Massingill v. Dunham Price Group, L.L.C., 2009-1549 (La. App. 3<sup>rd</sup> Cir., 5/5/10) 38 So.3d 498.

#### **FALSE STATEMENT CONCERNING DRUG TEST NOT CONSIDERED FRAUD Bell v. Mid City Continued....**

Regarding the fraud issue, the evidence revealed that on two occasions Claimant was given random drug screenings by his pain management doctor. The first screening was negative for the prescribed medication, Soma, although Claimant stated that he had taken the drug on the morning of the test. Further, this screening was positive for marijuana. Another screening was performed about a year later and Claimant tested negative for two prescribed drugs, Soma and Valium, although Claimant indicated he took both drugs within a day before the screening. Claimant tested positive for marijuana and amphetamines during this second screening, neither of which was prescribed. The doctor testified that Claimant's statements were inconsistent with the test results, and further that he was concerned the Claimant was selling the prescribed drugs on the street. Claimant had no explanation for the negative screening results. The employer sought a ruling that Claimant had committed fraud based on this evidence. The court rejected this argument and held that "while [the employer] provided speculation as to why [Claimant] made erroneous statements, nothing was presented to show that [Claimant] made any intentional or willful misrepresentation for the purpose of obtaining compensation benefits." In essence, the court found that there was insufficient evidence that Claimant's untruthfulness concerning his failure to take the prescribed drugs was specifically for the purpose of obtaining WC benefits. **Bell v. Mid City Printers, Inc.**, 2010-0818 (La. App. 4<sup>th</sup> Cir., 12/22/10) 54 So.3d 1226.

#### **SOMETIMES FRAUD IS CRYSTAL CLEAR**

Claimant was involved in two motor vehicle accidents, one within the course and scope of his employment and a later one outside the course and scope. Claimant sought to get his physician to change his medical opinion to indicate that the symptoms were as a result of the first work-related accident as opposed to the second accident since it "messed up" his WC claim. The employer filed a claim for LSA-R.S. 23:1208 fraud and won. Claimant was not represented by counsel. Claimant was ordered to pay restitution of all benefits received. **Daniels v. Hemphill Construction Company**, 45,946 (La. App. 2<sup>nd</sup> Cir., 1/26/11) 57 So.3d 428.

#### **UNTRUTHFUL STATEMENTS ON POST-HIRE MEDICAL QUESTIONNAIRES MUST BE SHOWN TO DEPRIVE THE EMPLOYER OF A SIF CLAIM TO WARRANT A FRAUD DEFENSE**

The Third Circuit upheld an award in favor of Claimant despite the fact that Claimant lied on a post-employment medical questionnaire, and he denied he had been involved in an accident on a form signed at the end of the workday on which the alleged accident occurred. The employer paid benefits to the Claimant, but later determined that Claimant lied on his post-employment questionnaire when he denied any previous injuries to his hip and left knee. Employer alleged that they were prejudiced from asserting a Second Injury Fund claim as a result of this falsehood and asserted an LSA-R.S. 23:1208.1 fraud defense. The trial judge found that the employer acted arbitrary and capriciously in terminating benefits and found that benefits were not forfeited, because the employer did not prove that Claimant's failure to admit to his prior injuries would have negatively impacted the employer's ability to make a Second Injury Fund claim if it knew of the prior injuries. Further, the alleged accident at issue was un-witnessed, and Claimant completed a form when the workday was over indicating he had not been in any accident. However, Claimant testified that he told his manager of the accident when it occurred, he was forced to fill out a form at the end of the day denying any work-related injuries that day or he would

not receive his check. It is important to remember that not every untruthful statement on a medical questionnaire will result in a forfeiture of benefits. The Third Circuit noted that the untruthful statement must directly relate to the medical condition for which a claim for benefits is made or it must affect the employer's ability to receive reimbursement from the Second Injury Fund. **Burkett v. LFI Fort Pierce, Inc.**, 2010-1478 (La. App. 3<sup>rd</sup> Cir., 5/4/11) 2011 WL 1661494.

#### **ATTEMPT AT LSA-R.S. 23:1208.1 UTILIZING ASYMPTOMATIC ARTHRITIS CONDITION**

Claimant initially thought he was having a heart attack, due to pain in his shoulder and neck while working. He was later diagnosed with a total rotator cuff tear and aggravation of cervical degenerative disc disease. Claimant had filled out a Second Injury Fund post-hire questionnaire in which he denied any pre-existing arthritis. He did admit to pre-existing medical problems to the WC adjuster but also alleged that he was asymptomatic and had no work restrictions prior to the incident. The employer attempted to utilize a defense based upon LSA-R.S. 23:1208.1 for willful misrepresentation on the post hire medical questionnaire, utilizing the pre-existing arthritis condition, which is a presumptive condition for second injury fund recovery and presumptively disabling. The WCJ found that there was no evidence of symptomatic pre-existing arthritis and further found no prejudice against employer as a result of the Claimant's failure to list that on the Second Injury Fund questionnaire. **Thibodeaux v. Mechanical Construction Co. LLC**, 2010-739 (La. App. 3<sup>rd</sup> Cir., 12/8/10) 52 So.3d 1084.

#### **CLAIMANT'S UNTRUTHFUL DENIAL OF PRIOR LOW BACK INJURY, AND UNTRUTHFUL COMPLETION OF PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE, WARRANTED DISMISSAL OF CLAIM**

The Claimant, a certified nursing assistant, testified that she injured her low back while lifting a patient in the course and scope of her employment for the defendant nursing home. She denied any prior low back injuries. The claim was initially accepted but then denied once the employer obtained medical records documenting similar injuries from a car accident the preceding year. The trial court found that the employee had failed to prove her injuries were caused by the alleged work accident, and that she had forfeited any benefits based on her denial of prior low back injuries. The appellate court affirmed that decision, stating: "[t]he claimant's testimony was contradicted by the medical records, which demonstrated that after her 2006 auto accident, claimant experienced low back pain that continued until a number of months before her alleged work accident. The medical evidence dispels any contention that claimant did not exhibit symptoms of back pain before the accident at Whispering Pines. In addition, the WCJ heard the testimony and specifically found that claimant lacked credibility in failing to admit in court her prior complaints of back pain during multiple doctor visits. Based upon the evidence contained in the record, we cannot say the WCJ was clearly wrong in finding that the claimant failed to satisfy her burden of proving by a preponderance of evidence that her current medical condition was caused by a work accident in May 2007." **Brewer v. Whispering Pines Nursing Home**, 45,217 (La. App. 2<sup>nd</sup> Cir., 6/23/10) 42 So.3d 1029.

#### **Credits & Offsets**

#### **COURT UPHOLDS THE CONSTITUTIONALITY OF STATUTE REQUIRING FORFEITURE OF BENEFITS WHILE INCARCERATED**

Claimant injured his back and legs while working for employer as part of an inmate work-release program. At the time of the incident, Claimant was living in a halfway house. For about four weeks after the incident, Claimant was totally disabled and during such time remained in the halfway house. Because of Claimant's confinement in the halfway house, employer did not pay any indemnity benefits during the period of total disability relying on LSA-R.S. 23:1201.4, which provides that a claimant forfeits his/her right to compensation benefits during any period of incarceration unless the claimant proves he/she has dependents who rely on a compensation award for support. Claimant filed suit and alleged that the statute was unconstitutional, especially as applied to him since he was part of a work-release program and resided in halfway house. The court upheld the constitutionality of the statute, even as to claimants who reside in a halfway house and are working for an outside employer. The court held that these individuals are still deemed "incarcerated." ***Blackledge v. Sol's Pipe & Steel, Inc.***, 46,148 (La. App. 2<sup>nd</sup> Cir., 03/23/11) 59 So.3d 564.

#### **COURT ORDERS "PERMANENT" CREDIT AGAINST SEB AMOUNT DUE BASED ON JOB THAT ONLY EXISTED FOR A BRIEF PERIOD OF TIME**

Claimant worked as a kitchen manager for a church, and injured her left wrist, preventing her from performing her usual duties. She was totally disabled for a period of time, and then released to light duty. The employer offered her a position within the light duty restrictions working 30 hours per week at the same pay rate as the kitchen manager supervising other kitchen employees. The job would pay 75% of her average weekly wage and, therefore, the employer agreed to pay SEB based on the difference in pay. Claimant did not accept the offer, and then shortly after the position was offered, the only two kitchen workers who Claimant would be supervising quit their jobs. Claimant argued that because there was no one to supervise, the offered light duty job no longer existed and, therefore, her indemnity benefits should be reinstated based on the full indemnity rate. The court rejected this claim and granted employer a permanent reduction of SEB. The court held that "there is no requirement under the law that the employer showed continued availability of the job for an indefinite period of time." The court further pointed out that had the job offered a pay rate equaling 90% of Claimant's pay, her claim would have been defeated altogether rather than merely reduced. ***Morrison v First Baptist Church of West Monroe***, 45,277 (La. App. 2<sup>nd</sup> Cir., 5/19/10) 36 So.3d 1201.

#### **COURT HOLDS THAT IN SEB DISPUTE, EMPLOYER CANNOT RELY ON CLAIMANT'S "LACK OF EFFORT" IN SEEKING EMPLOYMENT TO SHIFT ITS BURDEN**

SEB disputes are often the subject of litigation, especially in the last 10-12 years following the court's attempt to prevent what it called "sham" vocational rehab that was being carried out simply to terminate benefits rather than get Claimant back to gainful employment. The rule is that it is a claimant's initial burden to establish that he/she cannot earn 90% of the average weekly wage due to the work injury, but that the burden is then shifted to the employer to show wage earning capacity if the claimant meets that initial burden. Deciding when a claimant has met his/her initial burden is not always easy. What often occurs is that the court finds the claimant has met his/her burden simply by showing that there are restrictions following the work injury that did not exist before, and that the employer has not offered suitable employment paying 90% of the AWW in response to those restrictions. A typical

dispute that further arises concerns the employee's failure to seek employment. In this case, the court plainly held that "it is the employer who bears the burden of proving job availability and claimant's post-injury earning capacity, and the employer cannot shift this burden to the employee by pointing to his lack of effort in seeking post-injury employment." The court further pointed out that the employer can meet its burden with or without the employee's cooperation. *Polkey v. Landworks, Inc.*, 2010-0718 (La. App. 1<sup>st</sup> Cir., 10/29/10) 2010 WL 4272730.

#### **COURT DENIED CLAIM THAT A MODIFIED JOB EXCEEDED EMPLOYEE'S RESTRICTIONS WHEN SHE DID NOT EVEN ATTEMPT THE JOB**

Employee was injured when a filing cabinet fell and hit her hip. She was released to work with restrictions by her treating physicians. Employer documented offering Claimant a modified job position which had been approved by her treating physician. Claimant refused to attempt the modified job, claiming that the job entailed duties outside of the doctors' restrictions. Both the trial court and First Circuit held that because employee did not even try to job, she could not claim the job exceeded her restrictions and, therefore, the employer's termination of indemnity benefits was proper. *Coleman v. Walter Industries, Inc.*, 2010-1145 (La. App. 1<sup>st</sup> Cir., 2/11/11) 56 So.3d 1258. **NOTE:** This case highlights the importance of getting the doctor's approval of an offered job.

#### **DESPITE PHYSICIAN APPROVAL OF JOBS, COURT FINDS TTD BENEFITS IMPROPERLY CONVERTED TO SEB AND IMPROPER CREDIT TAKEN**

Claimant was a firefighter who injured his back at work. Claimant sought and received TTD benefits and medical treatment. Dr. Landreneau, the initial treating physician, discharged Claimant from his treatment but referred Claimant to Dr. Ardoin for pain management. At the time of vocational rehab was conducted, jobs were submitted to Dr. Landreneau for review and approval and he approved some of the jobs with light duty restrictions. Claimant's indemnity benefits were subsequently converted to SEB benefits and a credit was taken for the jobs approved by Dr. Landreneau. The WCJ and the appellate court determined that because Dr. Landreneau had discharged Claimant from his care that he was no longer a treating physician and thus his approval of the jobs was not sufficient for purposes of either conversion to SEB benefit nor for any reduction in benefits. The appellate court implied that approval of the jobs must come from a treating physician as opposed to a former treating physician or SMO, despite no language in *Banks v. Indus. Roofing & Sheet Metal Works, Inc.*, 9602840 (La., 7/1/97) 696 So.2d 551, requiring same. *Olivier v. City of Eunice*, 2010-1433 (La. App. 3<sup>rd</sup> Cir., 6/8/11) 2011 WL 2200039.

#### **DIFFICULTY WITH DISTINGUISHING LEAVING THE JOB DUE TO WORK-RELATED INJURY OR RETIREMENT**

Claimant was a police officer who had a work-related knee injury which caused him to be off work and on restricted duty for some time. Months before his retirement eligibility, he was returned to full duty, but alleged that he was continuing to have problems with his knee. Neither the medical evidence nor his co-workers and superiors supported his contention that he left the job as a result of his knee complaints as opposed to opting out for regular retirement. In fact, his supervisor referred him to

become a process server, which would be physically more demanding on the knee (Claimant alleged lasting only a couple of weeks in that position). The WCJ weighed the issues of the Claimant's credibility and found in favor of the employer. The appellate court affirmed. **Tusa v. City of Kenner Police Dept.**, 2010-791 (La. App. 5<sup>th</sup> Cir., 5/10/11) 2011 WL 1775898.

#### **EMPLOYER GETS DOLLAR-FOR-DOLLAR CREDIT AGAINST INDEMNITY AND MEDICAL BENEFITS IF EMPLOYEE SETTLES TORT SUIT WITHOUT APPROVAL**

As recently as February 23, 2011, in **Mercer v. Nabors Drilling USA, L.P.**, 2010-1092 (La. App. 3<sup>rd</sup> Cir., 2/23/11) 57 So.3d 1217 (*writ granted* 2011-0591 (La., 5/20/11) 2011 WL 2438386), the Third Circuit was continuing to hold that an employer is not entitled to a credit for future medical benefits even when an employee settles a tort suit without approval of the employer. More recently, in March 2011 the Supreme Court handed down a decision representing a significant, favorable development for employers in the area of an employer's credit for unapproved settlements of third party tort suits. In this case, the employee came in contact with a live electrical wire, which caused significant injuries, and brought a tort suit against the utility provider. The employer intervened in the tort suit, which was later settled at mediation. The employer did not attend, but provided the mediator with the amount of its lien and agreed to accept that amount, minus one-third representing attorney's fees. The employee settled the tort suit for over \$4,000,000. Thereafter, the employer moved to terminate benefits due to failure to secure written approval of the settlement. The WCJ determined that the employer had given written approval and it was entitled to a credit for the balance of the settlement funds, but that the credit only applied to future disability and not the cost of his future medical treatment. The Third Circuit affirmed based on its prior decisions in this area of the law. However, the Supreme Court applied the text of the 1989 revision to LSA-R.S. 23:1102 as written. In relevant part, that statute states, "If a compromise with such third person is made by the employee or his dependents, the employer or insurer shall be liable to the employee or his dependents for any benefits under this Chapter which are in excess of the full amount paid by such third person, only after the employer or the insurer receives a dollar for dollar credit against the full amount paid in compromise..." The Court held the employer "should receive a credit against all future workers' compensation benefits, including future medical expenses, which are or may become due to claimant." **City of DeQuincy v Henry**, 2010-0070 (La., 3/15/11) 2011 WL 880377.

#### **WHERE AN EMPLOYER AGREES TO THE SATISFACTION OF ITS LIEN IN SETTLEMENT OF A THIRD PARTY TORT SUIT, THE "BUY BACK" PROVISIONS OF R.S. 23:1102 ARE SATISFIED – City of DeQuincy**

The Supreme Court handed down another interesting holding in the **City of DeQuincy** case discussed above. When an employee settles his or her tort suit arising out of the work accident against the third party tortfeasor without the employer's written consent, the general rule is that the employee has forfeited his/her right to any further WC benefits. However, the employee has the option to "buy back" the right to future compensation "upon payment to the employer or insurer of the total amount of compensation benefits, and medical benefits previously paid to or on behalf of the employee, exclusive of attorney's fees arising out of the compromise..." LSA-R.S. 23:1102. The Supreme Court reaffirmed the principle that where the employer's existing lien is satisfied through the settlement of the third party suit, the failure of the employee to secure written approval of the settlement is moot because the "buy

back” provision of R.S. 23:1102 has already been satisfied. *City of DeQuincy v Henry*, 2010-0070 (La., 3/15/11) 2011 WL 880377.

#### **\$750.00 STATUTORY CAP APPLICABLE WHEN NO AUTHORIZATION FOR TREATMENT SOUGHT**

Claimant was found to be injured and was ordered to undergo a neurological work-up. Claimant and employer both took steps sought to obtain same to no avail. Claimant subsequently obtained an MRI without first seeking authorization from employer. The WCJ ordered full reimbursement of the MRI (\$1,800.00) which Claimant paid for the MRI, but the appellate court found that since Claimant failed to seek authorization, the employer was entitled to the statutory cap under LSA-R.S. 23:1142 and Claimant was only entitled to \$750.00 of the MRI costs. *Brown v. East Carroll Parish Police Jury*, 45,851 (La. App. 2<sup>nd</sup> Cir., 12/22/10) 56 So.3d 1052.

#### **THE LOUISIANA SUPREME COURT RULES THAT PPO CONTRACT DISCOUNTS ARE NOT ILLEGAL**

The Louisiana Supreme Court has resolved the issue of whether PPO contracts violate the Louisiana Workers’ Compensation Act (LWCA) with a recent decision effectively reversing the decisions of a number of appellate courts holding that any agreement that provides for payment less than the fee schedule is invalid. The Court specifically rejected these earlier appellate court rulings invalidating PPO contracts in WC cases, and instead chose to follow the rulings of a number of Louisiana federal court decisions which have held that the LWCA does not prohibit a health care provider from agreeing to charge and from receiving discounted rates below the fee schedule for services they provide to WC claimants. Unfortunately, however, expect to see further PPO decisions affecting the WC arena because of certain notice provisions in the PPO statutes that were not followed by employers/insurers when PPO discounts were utilized in compensation patients. This Supreme Court decision simply stated that PPO contracts were not per se invalid in the WC arena, but did not address whether the PPO statute had been followed properly in compensation cases. *Agilus Health v. Accor Lodging North America*, 2010-0800 (La., 11/30/10) 52 So.3d 68.

#### **Procedure**

#### **FORMAL REQUEST TO MODIFY PRIOR CONSENT JUDGMENT IS REQUIRED TO TERMINATE BENEFITS**

Employer and employee entered into a consent judgment in 2005 acknowledging the compensability of the claim and an agreement to pay TTD benefits. Employer, based upon new medical and other evidence, terminated benefits in 2006. Employer did not file a motion with the court to modify the judgment until 2008. The appellate court found that the consent judgment was a binding non-appealable judgment and that it was incumbent upon employer to obtain a modification/termination of the consent judgment before terminating benefits. The court upheld the WCJ’s finding that benefits were terminated retroactive to the filing of the modification only and also upheld the award of 24% of the past due benefits in penalties based on penalty section that applied to failure to pay a court judgment, in addition to \$10,000.00 in attorney’s fees for failure to pay benefits from 2006 until the consent judgment was modified. *Cobb v. Lafayette Parish School Board*, 2010-430 (La. App. 3<sup>rd</sup> Cir., 11/3/10) 49 So.3d 597.

## **REQUEST TO MODIFY JUDGMENT IS NOT CORRECT PROCESS TO CONTEST CALCULATION OF AWW, WHICH SHOULD HAVE BEEN CONTESTED VIA APPEAL AFTER THE TRIAL OR VIA A MOTION FOR NEW TRIAL**

In this Fourth Circuit case, the court held a request for modification of a prior judgment awarding indemnity benefits was NOT the proper vehicle to contest the alleged incorrect calculation of Claimant's average weekly wage. Rather, the court held that Claimant should have requested a new trial, filed a motion or action for nullity, appealed the judgment, or asserted the miscalculation in answer to the employer's appeal. Modifications of judgments are designed for changes in an order based on a change in circumstances after the original judgment. That is not the case with an average weekly wage determination. Claimant's average weekly wage cannot change after the accident date. The court further noted that Claimant had stipulated to the erroneous calculation of his average weekly wage during the trial, making it the law of the case and binding on the trial court. *Peters v. Greyhound Lines, Inc.*, 2010-0969 (La. App. 4<sup>th</sup> Cir., 11/17/2010) 52 So.3d 229, writ denied 2010-2769 (La., 2/4/11) 57 So.3d 316.

## **CLAIMANT ENTITLED TO SEEK MODIFICATION OF JUDGMENT- BUT PROOF OF TOTAL AND PERMANENT DISABILITY NOT THERE**

Claimant entered into a consent judgment with her employer. She later attempted to overturn the judgment, which was unsuccessful, but also in the alternative attempted to modify the judgment to reflect alleged total and permanent disability status. The Court of Appeal of Louisiana, Fourth Circuit, noted that the Claimant was allowed under LSA-R.S. 23:1310.B. to show a change in condition which would modify the judgment. The appellate court noted that "[t]he employee is not permitted to relitigate his original condition but must show a change in his compensable condition, such as progression, deterioration, or aggravation of the condition, achievement of a disabling character by a previous asymptomatic complaint, appearance of new and more serious features, or failure to recover within the time originally predicted." The WCJ found that Claimant's physicians had not indicated any change in symptom complaints and no change in her work release. The appellate court upheld the dismissal of the request for modification due to lack of proof of change in condition caused by the work accident. *Williams v. Orleans Parish School Board*, 2010-1441 (La. App. 4<sup>th</sup> Cir., 2/9/11) 61 So.3d 48.

## **CIVIL ACTION SERVED AGAINST STATUTORY EMPLOYER INTERRUPTS PRESCRIPTION AGAINST THIRD PARTY TORTFEASORS**

Plaintiff filed an action against the statutory employer and later added Pipe Services as a defendant, well after prescription had run. The statutory employer, after Pipe Services had been served, filed a Motion for Summary Judgment and was granted a dismissal. Pipe Services filed an Exception of Prescription alleging that since the statutory employer was immune from tort exposure, prescription should not have been interrupted upon service of the statutory employer. The Louisiana Supreme Court opined that the source of solidary liability is immaterial. Since both the direct and statutory employers are solidarily liable to the Plaintiff, and because employers are solidarily liable with third party tortfeasors, and because service was timely had on the statutory employer, even though not in a court with subject

matter jurisdiction, prescription was timely interrupted. *Glasgow v. Par Minerals Corp.*, 2010-2011 (La., 5/10/11) 2011 WL 1759845.

### **SERVICE OF THE PROPER PARTY MATTERS**

A health care provider filed a Form 1008 Disputed Claim for Compensation in connection with medical services provided to an employee of Fat Hen Grill. In the Form 1008 the employer was listed as “K & W Diners, LLC d/b/a Fat Hen Grill,” due to the fact that K & W Diners, LLC had registered Fat Hen Grill as a service mark with the Louisiana Secretary of State. Service and Citation was had on the diner at the actual location. Unfortunately, the service mark was registered 17 days after the work accident, and in subsequent hearings to annul a default judgment evidence was presented showing that K & W Diners, LLC never did business as Fat Hen Grill, did not own, operate, or employ anyone at the Fat Hen Grill (the actual diner operating under that name had no insurance, of course). The WCJ denied the Motion to Annul the Judgment based upon to lack of service and citation of K & W Diners, LLC. The Court of Appeal of Louisiana, Fifth Circuit, reversed, finding that service and citation was not proper on K & W Diners, LLC, and that the actual owner of Fat Hen Grill did not have apparent authority to bind K & W Diners, LLC under LSA-C.C. Art. 3021 since K & W Diners, LLC did not perform any act which would cause the health care provider to believe the actual owner of the diner was the mandatary. *Jefferson Parish Hosp. Service Dist. v. K & W Diners, LLC*, 2010-767 (La. App. 5<sup>th</sup> Cir., 4/12/11) 2011 WL 1416386.

### **PRESCRIPTION PERIOD FOR PENALTIES/ATTORNEY’S FEES IS THE SAME AS THE PRESCRIPTION PERIOD FOR THE INDEMNITY OR MEDICAL CLAIM TO WHICH IT IS RELATED**

Disagreeing with the First Circuit Court of Appeal (Baton Rouge area), the Fourth Circuit Court of Appeal (New Orleans area) has agreed with the Third Circuit (Lake Charles and central Louisiana areas) regarding the prescriptive period applicable to penalties and fees claims. In this case, the WC insurer paid medical bills in an amount less than the Fee Schedule in July 2006 and Touro hospital filed a 1008 in May 2009 alleging untimely and deficient payment. The defendants alleged the suit was untimely based on a First Circuit decision, *Craig v. Bantek West, Inc.*, 2003-2757 (La. App. 1<sup>st</sup> Cir., 9/17/04) 885 So.2d 1234, which held that penalties and fees in connection with untimely payment of indemnity benefits (TTD) prescribes one year from the date of underpayment. Instead of simply holding that the case by Touro was timely under the First Circuit decision because the limitation period for medical benefits is three years instead of one year, the Fourth Circuit went further. It held that any claim for penalties and attorney’s fees is timely as long as the claim for the indemnity or medical benefit to which it is related is timely, meaning that there is not separate prescription period for penalty and attorney’s fee claims. In a case in which indemnity was paid continuously for five years, for example, a claimant could “timely” file a dispute over an alleged indemnity benefit in the first year, and be able to timely assert a penalty/attorney fee claim. *Touro Infirmary v. The Fisk Corporation*, 2010-0105 (La. App. 4<sup>th</sup> Cir. 7/28/10) 44 So.3d 874. See also *Farley v. City of New Orleans*, 2011-0301 (La. App. 4<sup>th</sup> Cir., 5/20/11) 2011 WL 2020567.

### **PRESCRIPTION ON OCCUPATIONAL DISEASE CLAIM BEGINS TO RUN WHEN EMPLOYEE IS OFFICIALLY TERMINATED**

Claimant worked at a chicken processing plant since 1979. Claimant had a long history of carpal tunnel syndrome and fibromyalgia, that were known to be work-related, and she underwent surgical procedures in December, 2003 and January, 2004. She did return to work after the procedures. In February of 2008, Claimant's condition worsened, and she was taken completely off work by her physician on February 11, 2008. She was released to return to work in May of 2008, but with restrictions that she should no longer work in a cold environment, and this was at odds with her usual job. She was refused a position by her employer, and was further told in a letter dated May 14, 2008 that she would need to produce medical clearance to perform all her usual duties by May 21, 2008. Claimant was not able to produce the medical clearance and she was officially terminated in a letter dated July 24, 2008. Claimant filed suit for benefits on May 19, 2009. The employer argued that the prescriptive period had expired because Claimant had not worked since February of 2008, and therefore the suit was not filed within one year of the date when all three relevant time periods in an occupational disease claim had accrued. Specifically, a suit for occupational disease must be filed within one year of the date that the following conditions all exist: 1) the date the disease manifests itself (2003); 2) the date the employee knew or had reasonable grounds to believe that the disease was work-related (2003); and 3) the date disability began, which the employer argued was February of 2008 since that was the last time Claimant worked. (It is important to note that the employer had not paid any WC benefits to trigger the three-year prescription period.) The WCJ found in favor of the employer and dismissed the claim. But the Court of Appeal REVERSED, and found that the date of actual termination, i.e. July 24, 2008, was the date of disability, NOT the date the Claimant was originally taken off of work. Thus, the claim was timely. **Hawkins v. Pilgrim's Pride Corp.**, 2010-402 (La. App. 3<sup>rd</sup> Cir., 11/3/10) 49 So.3d 1069, writ denied 2010-2675 (La., 1/28/11) 56 So.3d 958.

#### **DEADLINE FOR PENALTIES FOR ENFORCEMENT OF JUDGMENT EXPIRE AFTER APPEAL DEADLINE**

A final judgment was entered in favor of the Claimant on April 13, 2009 but was not paid by one of the party defendants until July 10, 2009. On June 26, 2009 the Claimant filed a Motion to Enforce the Judgment requesting penalties and attorney's fees as well as alleged past due benefits pursuant to LSA-R.S. 23:1201.G., which requires payment of a final non-appealable judgment within 30 days. The WCJ found that the appeal delays had not expired as of the time of the payment (90 days from the date the judgment was rendered) and the Fifth Circuit agreed with the Judge's analysis. **Moreno v. Landaverde Construction, LLC**, 2010-471 (La. App. 5<sup>th</sup> Cir., 12/14/10) 53 So.3d 687.

#### **SETTLEMENT RELEASING EMPLOYER FROM ALL CLAIMS PRECLUDED EMPLOYEE FROM PURSUING CLAIM FOR UNRELATED SECOND INJURY THAT OCCURRED ON SAME DATE AS FIRST INJURY**

Employee's claim for benefits arising out of a neck injury which occurred the same day that he was bitten by a spider was ruled to be resolved when he accepted a settlement and that settlement was properly approved by the WCJ to include all claims for benefits that he possessed up to the time of the settlement. The pro se Claimant alleged that he sustained two separate injuries on the same day, December 9, 2004. The first injury occurred when he was cleaning out a storage shed and was bitten by a spider on his left hand. He allegedly also suffered two ruptured discs in his neck on that day from heavy lifting. The plaintiff settled his claim with the employer at a settlement conference on March 13,

2009, but the neck injury had not yet been asserted. During that conference, the Claimant alleged that the WCJ did not tell him that he was settling all of his claims against the employer and that he did not intend to settle his neck injury claim. The appellate court held that because the settlement documents stated that Claimant was releasing the employer from any and all claims for benefits that had arisen prior to the date of the settlement conference, the neck injury claim was precluded although it had not been asserted. Once the procedural requirements have been complied with and an order approving a compromise settlement has been entered by the WCJ, it is conclusive and cannot be set aside except for fraud, misrepresentation or ill practices. The court noted that the failure of a WCJ to have a settlement discussion with an unrepresented employee may give rise to a cause of action for nullity of the settlement, but in this case, the Claimant had not alleged that such a discussion did not take place. Instead, Claimant alleged that the WCJ did not inform him that he was settling his claim for benefits arising from a neck injury sustained on the same day as a spider bite injury. **Smith v. Isle of Capri Casino & Hotel**, 2010-0161 (La. App. 1<sup>st</sup> Cir., 9/10/10) 47 So.3d 642.

#### **AN EMPLOYER MAY FILE A 1008 EVEN WHEN PAYING ALL BENEFITS TO CHALLENGE THE COMPENSABILITY OF A CLAIM – NO PENALTIES OR ATTORNEYS FEES AWARDED**

Some WC courts in Louisiana have refused in years past to hear a claim if there is technically no dispute pursuant to LSA-R.S. 23:1314, i.e. a claim in which the employer has and is paying all benefits, but wants to find out if perhaps it should not be paying benefits under some defense it may have. In this case, the employee began his career with the Bossier City Fire Department in 1972 where he worked for several years before working for the Bossier Sheriff's Office, Corrections Division. He retired from the Fire Department in 1993 with chest pains and high blood pressure. Once working for the Sheriff's Office he continued to suffer with breathing problems, swollen legs, high blood pressure, hyperlipidemia, Type 2 diabetes and mild obesity. After paying the employees medical benefits for four years, the City filed a Form 1008 requesting a declaratory judgment as to the cause of the employee's heart and lung disease and sleep apnea. The WCJ denied the former fire fighter's claim for penalties and attorney's fees, finding that the employer should not be assessed with penalties in a case in which it filed the 1008 to raise the question as to medical causation and attempting to establish that any indemnity claim was prescribed. The appellate court upheld the ruling of the WCJ finding that while it is unusual for the employer to initiate the claims process, they believe that this was a better alternative than terminating benefits unilaterally – a decision that probably would have been viewed as arbitrary and capricious. **City of Bossier v. Colvin**, 45, 278 (La. App. 2<sup>nd</sup> Cir., 5/19/10) 36 So.3d 1207.

#### **Proof Needed to Sustain Exception of Subject Matter Jurisdiction Is More Than A Filed Longshore Claim**

Claimant was an equipment operator and fell from a gang plank which had been rigged from a barge to the cherry picker he was operating. From the facts developed it was not clear whether the accident occurred over navigable waters or the loading dock. Claimant's first attorney filed a Longshore claim but Claimant fired his first attorney and hired a new attorney, who filed a WC claim. The insurer filed a declinatory exception of no subject matter jurisdiction (i.e. longshore as opposed to WC) which was denied because no evidence was presented to determine whether a longshore was appropriate. No

consideration was apparently given regarding the admission against interest due to the Claimant's original longshore filing. The Court of Appeal of Louisiana, Third Circuit affirmed the WCJ's denial of the exception. *Julien v. Dynamic Industries Inc.*, 2010-520 (La. App. 3<sup>rd</sup> Cir., 11/3/10) 52 So.3d 174.

#### **OBJECT LESSON: DON'T FORGET TO INTRODUCE THE EVIDENCE**

Claimant sustained an injury in 2005 and filed suit, claiming benefits were not paid timely, which was dismissed due to lack of proof. Claimant re-filed claiming that his indemnity was prematurely terminated. The employer filed an Exception of Res Judicata but failed to introduce the entire record of the prior suit. The WCJ, relying upon the first record which had not been introduced granted employer's exception. The Court of Appeal of Louisiana, First Circuit, overturned the ruling and remanded the case for further consideration due to lack of evidence that the Claimant's claim was precluded by the dismissal of the first action. *Middleton v. Livingston Timber, Inc.*, 2010-1203 (La. App. 1<sup>st</sup> Cir., 2/11/11) 57 So.3d 590.

#### **NULLIFICATION OF JUDGMENT REQUIRES PROOF OF FRAUD OR ILL PRACTICES**

Claimant had alleged exposure to unknown chemicals in 2001 but entered into an oral settlement pursuant to LSA-R.S. 23:1272.B. in 2004. Claimant then sought to obtain additional benefits claiming that the insurer had committed fraud or ill practices and requested that the prior judgment be set aside. The WCJ granted the employer's Motion for Res Judicata and denied the Motion to Nullify citing no evidence of fraud or ill practices presented. The appellate court affirmed. *Hood v. Cajun Constructors, Inc.*, 2010-0845 (La. App. 1<sup>st</sup> Cir., 2/11/11) 57 So.3d 595.

#### **MEDICAL NECESSITY GENERALLY NOT AN ISSUE FOR SUMMARY JUDGMENT**

Claimant allegedly sustained a work-related injury to her left hip and left hand. She was released back to work with significant restrictions, but apparently able to earn at least 90% of her pre-accident wage. Her treating physician discussed a prescription for a foam mattress to relieve hip pain which was apparently never requested from either the employer or insurer. All physicians appeared to issue contrary statements with regards to the need for any additional medical treatment, including possible surgery, on the hand. Claimant was laid off when the employer went bankrupt and began to collect unemployment benefits. The insurer filed a Motion for Summary Judgment alleging that Claimant had received all benefits she was currently entitled to and to dismiss the 1008 filed for the foam mattress and possible change in choice of physician. The WCJ granted the Motion but the Second Circuit reversed, noting the need to allow Claimant to present evidence as to the medical necessity of the mattress and change of treating physician. *Taylor v. Plastech Engineered Products, Inc.* 45,846 (La. App. 2<sup>nd</sup> Cir., 12/15/10) 56 So.3d 356.

#### **Penalties & Attorney's Fees (and other sanctions & costs)**

#### **THE PRICE TAG ON "ARBITRARY AND CAPRICIOUS" IS ON THE RISE**

The Fifth Circuit Court of Appeal (Jefferson Parish area), recently affirmed an attorney fee award of \$30,000 to Claimant's attorney, in addition to \$6,000 in penalties. These amounts were awarded by a

WCJ in a District 7 case, which sits in Harahan, La. The appellate court pointed out that the amount of an attorney's fee award by a workers' compensation judge is left to the discretion of the judge and is subject to the "manifest error" standard, meaning the amount will not be increased or reduced unless there is no reasonable basis in the record for the award. In other words, even if there are also reasonable grounds for a smaller amount, the appellate court cannot choose between two reasonable findings and overturn the compensation judge's award. The appellate court pointed out that there was a "reasonable" basis for the \$30,000 award because the case had persisted for several years, and the trial record consisted of several volumes of pleadings and trial testimony, and numerous exhibits. Rastegar v Magnolia School, Inc. 10-176 (La. App. 5<sup>th</sup> Cir., 10/12/10) 51 So.3d 47.

#### **FAILURE TO PAY ALL MILEAGE REIMBURSEMENT RESULTS IN ATTORNEY FEE OF ALMOST \$20,000.00**

Claimant's thumb was injured in a work accident and he underwent surgery for same. Claimant was able to return to work at a modified job. A second surgery, a fusion, was required but indemnity benefits were not paid neither immediately before the surgery nor after. Employer asserted that Claimant was able to return to modified duty and had accommodated Claimant's post surgical restrictions after both surgeries. No penalties were awarded on the indemnity issue but Claimant was found entitled to indemnity from the date of the second surgery. \$19,575.00 in attorney's fees were awarded to Claimant in addition to one penalty of \$2,000.00 for failing to pay all of the mileage reimbursement (paid 40 miles instead of 43 miles). Additional attorney's fees of \$2,000.00 were awarded on appeal by the Third Circuit, upon affirmation of the lower ruling. Broussard v. Louisiana Radio Communications, 2010-840 (La. App. 3<sup>rd</sup> Cir., 2/2/11) 54 So.3d 1274.

#### **TIMING IS EVERYTHING - KNOWLEDGE AT THE TIME OF DENIAL, NOT SUBSEQUENT KNOWLEDGE WILL DETERMINE WHETHER THE CLAIM IS REASONABLY CONTROVERTED**

Employee was hired and provided employer full knowledge of his prior back injuries including five lumbar surgeries. Three days after work accident lifting a board, Claimant was seen in the emergency room, and there were serious questions as to whether the employee provided truthful information regarding prior injuries and treatment to the treating physicians. The trial court found no fraud despite the discrepancies. The Second Circuit Court of Appeal upheld the finding that no fraud was committed, and confirmed the award of attorney's fees and penalties for the employer's denial of the claim despite the possibility that the employee's less than truthful statements to the doctors could be reasonable grounds to controvert the claim. Because the denial, as stipulated at trial, was made before the employee's failure to inform the treating physicians and was apparently based upon the employer's opinion that the employee was merely treating for his pre-existing condition, the award of fees and penalties was warranted. Dombrowski v. Patterson-UTI Drilling Co., 46,249 (La. App. 2<sup>nd</sup> Cir., 4/13/11) 2011 WL 1380064.

#### **PENALTIES AND FEES AWARDED DESPITE "FLIP FLOP" BY CLAIMANT'S OWN TREATING DOCTOR ON WHETHER DISPUTED INJURY WAS WORK-RELATED**

Claimant sustained an un-witnessed accident that caused an elbow injury and also an alleged neck injury. The neck injury was the only disputed injury at trial. The employer's choice of orthopedic

physician stated that Claimant's neck injury was not related to the alleged accident. Initially, Claimant's treating physician disagreed, BUT changed his mind shortly thereafter and agreed with the employer's doctor that the neck injury was not related. After Claimant's treating orthopedist performed surgery regarding the elbow injury, and it failed to alleviate Claimant's complaints of neck pain, the doctor changed his opinion again to his original opinion that he neck injury was related to the accident. Claimant was seen by yet another orthopedic physician at the employer's request, who agreed with the employer's first choice of doctor that the neck injury was not related to the alleged work injury. Finally, the employer asked Claimant to be examined by a neurologist, who wanted additional testing, which was denied by the employer. The Second Circuit Court of Appeal affirmed the trial court award in favor of Claimant, and awarded penalties and attorney's fees despite the fact that two doctors stated the injury was not work-related, and Claimant's doctor agreed for only a limited time. The court focused on the fact that at the time the final decision was made to deny neck treatment, the treating doctor's opinion was that the injury was work-related. The court was also not impressed with the employer's refusal to approve testing recommended by its own neurologist. **Hofler v. J.P. Morgan Chase Bank N.A.**, 46, 047 (La. App. 2<sup>nd</sup> Cir., 01/26/11) 57 So.3d 1128.

#### **PENALTIES AND FEES AWARDED BECAUSE EMPLOYER FAILED TO OFFER PROOF OF SOME OTHER CAUSE FOR DISPUTED INJURY**

While helping a co-worker lift a 150 lb. driveshaft of a truck, Claimant alleged an accidental injury to his arm/elbow on February 23, 2009. He claimed he notified his co-worker, but the co-worker testified that he did not learn of the injury until two days later, which was when Claimant first sought medical treatment at a hospital emergency room. The objective medical evidence at that time of the elbow injury was swelling and a contusion, but no fracture. Two days later, Claimant saw another doctor who diagnosed tendonitis. Six weeks later on April 11, Claimant went back to the emergency room and was diagnosed with epicondylitis. Claimant sought no further treatment until June, at which time he was diagnosed with post-traumatic shoulder discomfort, lateral and medial epicondylitis and upper extremity complex pain syndrome. He was then deemed disabled from working. The claims adjuster testified that she decided to deny the claim because of inconsistencies among the statements by Claimant, and co-workers, and information in the medical records. The WCJ awarded judgment in favor of Claimant, and also awarded penalties and attorney's fees based on the adjuster's unreasonable denial of the claim. The Court of Appeal affirmed and held that "it was unreasonable for [the employer] to deny [Claimant] was injured, absent indication of some other cause of the objective findings." **NOTE:** This case highlights the difficulty in denying a claim, even when there are conflicting stories especially between Claimant and the only eyewitness, when there is no other explanation for the objective findings of injury. **Rougeau v Gottson Construction Co.**, 2010-1082 (La. App. 3<sup>rd</sup> Cir., 2/9/11) 57 So.3d 576.

#### **PENALTIES AND FEES MAY BE IMPOSED ON AN EMPLOYER FOR FAILING TO FULLY INVESTIGATE AN EMPLOYEE'S CLAIM, EVEN THOUGH CLAIMANT ASSERTED THAT HE WAS NOT FILING A WORKERS' COMPENSATION CLAIM.**

Employee was injured when a tool struck him in the groin. Following the injury, the employee sought treatment from his family physician for complaints of pain, bladder control, and other problems. The employee was contacted by an insurance adjustor, but told the adjustor that he was treating with his family physician under his own insurance coverage and hedged whether he was treating for a work-related injury. Two months after the accident the employee was terminated and filed a 1008 Disputed Claim for Compensation against his employer. However, the employer denied his claim because it had already closed his compensation file due to the fact that the employee told three people, including the insurance adjustor, that he was not pursuing his treatment under WC. The Third Circuit ruled that the trial court did not err in awarding penalties and attorney's fees to the employee, noting a continuing duty to investigate. The appellate court stated: "An employer avoids the imposition of penalties and attorney's fees by satisfying its continuing obligation to investigate, assemble, and assess factual information prior to its denying benefits." The appellate court held that the filing of a 1008 should have prompted the employer to further investigate the employee's claim as to the nature of the injury and compensability of same despite the prior assertions that he was not seeking WC medical benefits. **Green v. National Oilwell Varco**, 2010-1041 (La. App. 3<sup>rd</sup> Cir., 4/27/11) 2011 WL 1561789.

#### **PENALTIES AND ATTORNEY'S FEES AWARDED FOR FAILURE TO NOTIFY OFFICE OF WORKERS' COMPENSATION OF CHANGE IN INDEMNITY STATUS**

Employer converted Claimant's benefits from TTD to SEB benefits without any contemporary medical examination, and failed to pay any indemnity for a period of 39 months (there was no indication whether any Form 1020's were or were not submitted to Claimant). The defense entered into a stipulation to the above facts and to the fact that no notice had been provided to the Office of Workers' Compensation pursuant to LSA-R.S. 23:1201(H). The WCJ found that the conversion was a discontinuance of benefits pursuant to LSA-R.S. 23:1201(I) and found the discontinuance to be arbitrary and capricious due to the lack of notice. The appellate court affirmed the award of penalties and attorney's fees. **LeBlanc v. Excel Auto Parts**, 2011-58 (La. App. 5<sup>th</sup> Cir., 6/1/11) 2011 WL 2135515.

#### **CHANGE IN CHOICE OF TREATING PHYSICIAN DID NOT PROVIDE DEFENSE TO PENALTIES AND ATTORNEY'S FEES**

Claimant in his Form 1008 Disputed Claim for Compensation requested treatment from a general physician but no approval had been obtained from the employer by the time Claimant's new counsel requested treatment with an orthopedic physician. There was a delay in approval of the orthopedic physician and Claimant sought and obtained penalties and attorney's fees for that issue, amongst others. The employer attempted to assert that LSA-R.S. 23:1121(B)(1). only required approval of change of choice of physicians in the same specialty, not different fields of treatment. However, both the WCJ and Court of Appeal found that because there was no approval of the initial treating physician the provision did not apply. **McGee v. Brand Services, Inc.**, 2010-0370 (La. App. 4<sup>th</sup> Cir., 4/18/11) 2011 WL 1474306.

#### **MAXIMUM PENALTY POST 2003 AMENDMENT IS \$16,000.00, NOT \$8,000.00 PER THIRD CIRCUIT**

Claimant was allegedly paid the improper indemnity rate and then indemnity benefits were discontinued allegedly without cause. The WCJ awarded \$8,000.00 in penalties for the multiple violations of the underpayment pursuant to LSA-R.S. 23:1201(F) and \$8,000.00 for the arbitrary and capricious discontinuance of indemnity pursuant to LSA-R.S. 23:1201(I), for a total of \$16,000.00. The Third Circuit Court of Appeal found that penalties were appropriately awarded under both provisions of the law, but reduced the violation of LSA-R.S. 23:1201(F) to \$2,000.00, determining that the claim was for the original miscalculation, which was later remedied, as opposed to every individual underpayment. **Russell v. H & H Metal Contractors, Inc.**, 2011-27 (La. App. 3<sup>rd</sup> Cir., 6/1/11) 2011 WL 2135471.

#### **ORDER OF APPROVAL TRUMPS RECEIPT AND RELEASE- CLAIMANT ENTITLED TO PENALTIES AND ATTORNEY'S FEES AS WELL AS THE COST OF PAST DUE MEDICAL BILLING NOT PAID BY EMPLOYER BUT INCURRED PRIOR TO THE TIME OF THE SIGNING OF THE ORDER OF APPROVAL**

Claimant entered into a full and final consent judgment with her employer and subsequently received billing and collection letters for medical services which had been referred by employer's physician. Claimant sought payment of the outstanding bills (there were two) as well as penalties and attorney's fees for failure of employer to timely pay. The employer attempted to rely upon the receipt and release which appeared to absolve the employer from payment of any outstanding past, present, and future medical benefits as well as penalties and attorney's fees. The WCJ initially granted employer's Motion for Summary Judgment but the appellate court found that the receipt and release was ambiguous and did not exclude any liability for pre-settlement medical billing which had been approved and was outstanding. The court further found that because the Order of Approval did not waive any future penalties and attorney's fees, that the Claimant was entitled to seek penalties and attorney's fees for the employer's failure to timely pay the outstanding medical bills thirty days from the date of the order of approval despite the release language. **Tyson v. Thompson Home Health**, 2010-1040 (La. App. 3<sup>rd</sup> Cir., 3/16/11) 59 So.3d 509.

#### **SANCTIONS FOR MULTIPLE FILINGS AFTER DISMISSAL WITH PREJUDICE UPHOLD**

Claimant's initial Complaint Form 1008 Disputed Claim for Compensation went to trial in 1993 and was dismissed with prejudice. Claimant later filed another Form 1008 in 1998 from the same 1989 accident which was voluntarily dismissed by then current counsel for Claimant. Claimant filed a third Form 1008, also related to the same accident, in March of 2010. Employer filed Exceptions of Res Judicata and Prescription as well as a Motion for Sanctions under LSA-C.C.P. Art. 863. The Claimant sought to claim fraud in the dismissal of the initial Form 1008, but introduced no evidence of any alleged fraud. The WCJ sustained the exceptions and awarded sanctions of \$500.00. The Third Circuit affirmed the dismissal and found that the sanctions award was the lowest acceptable award for the multiple filings. **Zeno v. Flowers Baking Co.**, 2010-1413 (La. App. 3<sup>rd</sup> Cir., 4/6/11) 2011 WL 1273145, *rehearing denied* May 11, 2011.

#### **WITNESS FEES TAXED AS COSTS IN WORKERS' COMPENSATION CASE**

Claimant had pre-existing headaches, vision problems, neck problems, depression and obesity. While working at a school cafeteria, she was injured when a hanging thirteen pound iron mixing bowl fell on

her. Medical investigation showed the neck complaints stemmed from bilateral Carpel Tunnel Syndrome which the physicians (treating and second medical) opined were not related to the work accident. The two physicians also agreed that any aggravation to Claimant's pre-existing condition had resolved within one year's time. The WCJ found that the Claimant was not entitled to continued benefits based upon the physicians' deposition testimony. The appellate court sustained the judgment. As part of the trial, the employer had called medical case managers as witnesses and sought to obtain costs against Claimant for expert witness fees pursuant to LSA-R.S. 13:4533 and LSA-C.C.P. Art. 1920 and those costs, in the amount of \$750.00, were assessed to Claimant by the WCJ. The Second Circuit found that while the assessment of fees was proper, that medical case managers were fact witnesses not experts and remanded the case for calculation of the witness fees pursuant to LSA-R.S. 13:3671.

**Dunlap v. Madison Parish School Board**, 46,139 (La. App. 2<sup>nd</sup> Cir., 4/13/11) 2011 WL 1380022.

### **INTEREST ON SETTLEMENT AMOUNT NOT DUE DURING 30-DAY PERIOD TO PAY SETTLEMENT FUNDS**

The employee filed a disputed claim for compensation seeking indemnity, medical benefits, statutory penalties, and attorney's fees under La. R.S. 23:1201(F) after suffering a lower-back injury. The parties agreed to a settlement that was judicially approved on August 20, 2009. Within thirty days of judicial approval, the employer paid the amount due under the settlement to the Claimant and an additional amount directly to the medical facility at which she had treated. Inventively, the Claimant's attorney filed a later disputed claim alleging that the employer had not paid the full amount of the settlement within 30 days because no interest for the days between judicial approval of settlement and the dates on which payment was made. The attorney sought the twenty-four percent penalty under La. R.S. 23:1201(G). The issue was tried on cross-motions for summary judgment and the WCJ held that interest was not due because the settlement agreement did not indicate the parties anticipated payment on the day of judicial approval or indicate payments would include interest. The appellate court affirmed this ruling. **Hunter v. Maximum Group Behavioral Services, Inc.**, 2010-0930 La. App. 4<sup>th</sup> Cir. 3/16/11) 2011 WL 907554.

### **FULL RECOVERY OF MEDICAL EXPENSES PAID BY MEDICAID CAN BE HAD BY CLAIMANT, PER THE THIRD CIRCUIT**

Claimant alleged exposure to chemicals at his work environment allegedly causing acute myeloid leukemia. Before his death he incurred substantial medical billing which was paid by Medicaid in the amount of \$625,168.27. Both the WCJ and the appellate court found that the money can, and in this case should, be paid directly to the Claimant's dependants, as opposed to being paid to the State. The appellate court claimed that LSA-R.S. 23:1212 does not prohibit directing the payment despite noting the statutory language that payment by Medicate shall be subject to recovery by the state against employer and insurer. Writs to the Louisiana Supreme Court have been applied for in this matter.

**Benoit v. Turner Industries Group, LLC**, 2010-1460 (La. App. 3<sup>rd</sup> Cir., 5/4/11) 2011 WL 1661442.

### **EMPLOYER REQUIRED TO PAY MEDICAL BILL AFTER SETTLEMENT EXECUTED, BUT \$750 CAP APPLIED**

This case should remind employers/carriers and their attorneys to make sure that a settlement agreement includes unequivocal provisions that a claimant is responsible for all past and future medical

bills, or if the agreement includes the obligation of the employer to pay medical expenses up to the time of the settlement, then it should include only those medical bills for treatment known by the employer, and for which treatment was authorized. In this case, the settlement provided that the employer would pay all outstanding medical bills incurred up to the signing of the Order of Approval. After the settlement was signed, a \$2,041 chiropractic bill was discovered. The bill was for treatment for which approval was not sought by the Claimant or the chiropractor, and the employer denied responsibility for any of the bill. The court held that the employer was obligated to pay the bill, but would only have to pay \$750 because the care was for non-emergency treatment and prior approval was not sought from the employer. ***Mackie Roofing v Robinson***, 2010-289 (La. App. 5<sup>th</sup> Cir., 10/26/10) 52 So.3d 141.

#### **AMBULATORY SURGERY CENTER WINS APPEAL ON ISSUE OF REIMBURSEMENT SCHEDULE AMOUNT**

The health care provider, a licensed ambulatory surgery center, had approval for the three outpatient procedures (bilateral transforaminal epidural steroid injections) in question. Billing was submitted in the amount of \$30,900.00 (\$10,300.00 per injection). The TPA of the employer and insurer issued a check and an Explanation of Benefits (EOB) indicating a discount due to usual and customary charges, and paid only \$10,500.00 (\$3,500.00 per procedure). The Office of Workers Compensation, upon application, indicated that the provisions of the LAC-Title 40 § 2507 would apply (i.e. 10% discount of covered charges) which would leave a balance due of \$17,310.00. The health care provider filed a Form 1008 Disputed Claim for Compensation requesting reimbursement of the remaining sum and for penalties and attorney's fees. The employer again asserted the defense of usual and customary, but failed to provide any evidence or testimony of experts to demonstrate that the charges were in excess of local prevailing charges. The WCJ found that the Office of Workers' Compensation had not provided a more specific reimbursement schedule for the outpatient procedure and as a result LAC-Title 40 § 2507 would apply. The Judge also found that the employer failed to controvert and failed to demonstrate that the charges were not usual and customary and awarded \$6,000.00 in penalties and \$2,500.00 in attorney's fees. The appellate court affirmed the judgment and awarded an additional \$1,000.00 in attorney's fees for the work on appeal. ***Avenue Surgical Suites v. Jo Ellen Smith Convalescent Center***, 2011-0026 (La. App. 4<sup>th</sup> Cir., 5/18/11) 2011 WL 1938398.

