Lex and Verum

The National Association of Workers' Compensation Judiciary

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NAWCJ President's Page

By Hon. Jim Szablewicz*

Happy New Year everyone! I hope you enjoyed the holidays and were able to spend time with your family, friends and loved ones.

I begin 2019 with a very different perspective. In early December, I was injured in an accident (not work-related). The details are unimportant save for the fact that I am most fortunate in that the result could have been far worse. Indeed, change a few circumstances here, a few seconds there and I may not be writing this. I suspect that many of you have suffered and endured far worse and I'm certain we have all seen numerous cases where the injuries sustained by workers were catastrophic. But for me this was a life-changing event. For the first time in my almost 57 years on this planet I found myself hospitalized. This was also the first time in all of those years that I have broken any bones. In an instant I went from living a comfortable life full of abilities that I took woefully for granted to one of discomfort and limited mobility.

While I routinely consider such injuries and many far worse in my work as an adjudicator, I confess that I never really gave much thought to the day-to-day impact they have on the person injured and those around them. In most disputed cases, those things simply are not relevant to the issues requiring a decision. But they certainly are relevant to the person experiencing them. Beyond the inconvenience of attending multiple medical appointments and the boredom that ensues from sitting around the house for weeks on end there is the sheer effort, and the unbelievable amount of time, it takes to do even the most mundane daily activities. I sit and wonder how those with far worse injuries than mine manage to cope for weeks or months on end in their unexpectedly new states of existence.

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Those thoughts have lifted me from an initial stage of frustration and self-pity to one of newfound resolve. Yes, there will be many things that I cannot do for a time, either at all or in the way I was accustomed to doing them, but there is much I can do or that I can learn to do differently as I recover. And there's the magic word that suddenly has taken on new meaning for me. Recover. Well-known workers' compensation commentator and blogger Bob Wilson has long called for our industry to recognize and rename the "injured worker" as a "recovering worker." And now I get it. Rather than seeing myself as limited by the temporary disabilities resulting from my injuries, I am focused on meeting the challenges of my recovery.

So too I think are the majority of the workers whose cases come before us for a decision. They typically do not get to voice the daily struggles and demands of recovery to us directly. It is a part of their story we do not usually hear even when they want to tell us about it. But it is no less a part of their story than how their accidents occurred. While I do not suggest that we should let that part of their story influence our decision-making on the legal issues presented to us, I commend all of us to remember that it is there.

And so I look forward to this new year with a new sense of compassion and determination. I wish the same for all of you. As my dear friend and mentor, the late great Roger L. Williams, would say, "Onward and upward!"

In This Issue

Save the Date!

On Monday, April 1st, 2019, the IAIABC and NAWCJ will be hosting a Judges' Program during The IAIABC Forum 2019 in San Diego, California.

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How Many Slices are in a Twelve-Inch Pie?

Hon. Wesley Marshall *

How many slices are in a 12-inch pie? It depends on how you cut it. The Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)[1] has become an everyday fixture in the settlement of workers' compensation claims. To comply with the Medicare Secondary Payer provisions, parties allocate proceeds to WCMSAs to protect Medicare's future interest.[2] WCMSAs provide injured workers with funds sufficient to pay anticipated medical costs otherwise payable by Medicare.[3]

Is it permissible for an attorney who settles a workers' compensation claim to receive a fee based on the value of sums allocated to a WCMSA? A survey of cases around the country revealed a few conflicting interpretations based upon policy considerations. But, what was most impressive was the deafening silence of the courts and regulators on this issue over the past five years.

A simple example would be a $100,000 lump sum settlement of future indemnity and medical exposure. It allocates $5,000 to a WCMSA. Would it be proper for the attorney to claim an attorney's fee quantified by the $100,000? Or should it be based upon $95,000? Things get much trickier when the settlement is $100,000 but the WCMSA is $90,000 of that sum. Presuming a 20% attorney's fee, the parties would fund the WCMSA, the claimant's attorney would get the $10,000 residual and the claimant would still owe his attorney another $10,000. For giving up his right to future indemnity and medical expenses, the claimant would only receive the benefit of the WCMSA and would still be in the red. That doesn't seem equitable.

This is still new ground. If you are an employer, insurer, injured worker, or attorney, you will more likely than not encounter this issue. And if you are a regulator, you may need to address it through case law, regulation, or informal policy.

The WCMSA Framework

As explained in a leading case, "until 1980, Medicare paid for services without regard to whether they were also covered by an employer group health plan. As a cost-cutting measure, however, Congress eventually enacted a series of amendments designed to make Medicare a 'secondary' payer with respect to such plans."[4] The amendments, known as the "Medicare as Secondary Payer" ("MSP") statute, are codified at 42 U.S.C. § 1395y.

The MSP statute precludes Medicare from paying for medical services to the extent that they have been made, or can reasonably be expected to be made, promptly under an applicable workers' compensation law. *See* 42 U.S.C. § 1395y(b)(2)(A). This exclusion is also embodied in the Code of Federal Regulations (the Code), which expressly embraces workers' compensation within the types of payments subject to reimbursement to Medicare. *See* 42 C.F.R. § 411.20(a)(2). Specifically, this regulation provides:

> (2) Section 1862(b)(2)(A){ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under . . . ; (i) Workers' compensation.

Another decision noted, "the Central Office of the Centers for Medicare and Medicaid Services (CMS), as authorized by Congress, has promulgated regulations specifically intended to carry out the mandate of the MSP amendment."[5]

For example, 42 C.F.R. § 411.46 establishes that all parties in a workers' compensation case have a duty to protect Medicare's interests when resolving workers' compensation cases that include future medical expenses. Specifically, it states:

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> (a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.
> (b) Lump-sum compromise settlement.
>
> (1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.
>
> (2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under
> workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition. [....]
>
> (d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement-
>
> (1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.
>
> (2) Exception. lf the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

According to the Workers' Compensation Medicare Set-Aside Arrangement WCMSA Reference Guide, "the goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work injury related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost. WCMSAs may be funded by a lump sum or may be structured, with a fixed amount of funds paid each year for a fixed number of years, often using an annuity."[6]

CMS is focused on making sure Medicare's interest is fully protected. Therefore, it says in its Reference Guide that an individual may not use WCMSA funds to "pay for ... attorney costs for establishing the WCMSA."[7]

But CMS has not offered guidance as to whether attorney's fees can be based on settlement amounts allocated to WCMSAs.

Developing Case law

The California Workers' Compensation Appeals Board (WCAB) has issued conflicting opinions. In *Pratt v. Wells Fargo Bank,* the WCAB advised that the proper method for calculating a reasonable fee award for settlement of a workers' compensation claim should not include sums paid to set up and fund the applicant's WCMSA. The Board reasoned that this was proper because the claimant did not necessarily place herself in a more advantageous position by settling her medical award.[8]

Two years later, in *Viole v. Lockheed Martin*,[9] the WCAB did an about face. An attorney sought reconsideration of an administrative law judge's decision that he was not entitled to attorney fees based on the costs of setting up and funding the injured worker's WCMSA seed money and annuity. The WCAB found the attorney's $90,000 fee request was approximately 14% of the settlement value. After accounting for the MSA, the claimant had a cash balance of $159,124.94.

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The WCAB rejected the argument that the injured worker did not benefit from the MSA. It noted the injured worker's medical award was subject to limitations including the adversarial process and medical treatment guidelines prescribed by statute.[10] Also, it noted that an annuity for non-Medicare covered medical expenses would be payable to the injured worker's estate if a residual balance existed at death and certain conditions were met. Finally, the court noted that but for the MSA, the case might not have settled.[11]

A New Jersey Superior Court decision offered a detailed explanation of why attorney fees can be awarded from a Medicare Set Aside Trust created after the successful trial of a negligence action. The court in *Hinsinger v. Showboat Atlantic City*,[12] suggested that the same analysis applied to both liability and workers' compensation actions. The plaintiff's attorney argued that there was no law in place regarding deducting attorney fees from MSAs. Through statutory interpretation, the court interpreted the Medicare Secondary Payer Act's regulation, 42 C.F.R. § 411.37, as applying to both recovery of conditional payments and to funds recovered through settlement or judgment for future medical expenses. It held that both would permit a reduction of the amount recovered because of procurement costs.[13]

The court also interpreted Medicare's May 7, 2004 directive that it did not allow administrative expenses or attorney costs, "specifically associated with establishing the Medicare set-aside arrangement."[14] The court said this meant funds, "incurred in the act of setting up the trust. It does not apply to attorneys' fees incurred in procuring funds in a civil suit, a portion or all of which may or may not end up in a Medicare set aside trust."[15] Finally, the court determined that an award of attorney fees from the trust amount was equitable.

Otherwise, Medicare would avoid paying its fair share of the costs of litigation and plaintiffs would pay not only their own share but Medicare's as well. Requiring plaintiffs to forfeit an unfair, or even the total, amount of a recovery for Medicare's benefit alone would deter Medicare beneficiaries injured by the tortious acts of others from pursuing lawful claims.[16]

In *Benoit v. MMR Group, Inc.*,[17] a Louisiana appeals court held that attorney fees incurred to procure a settlement or judgment could not be deducted from money allocated to a Medicare Set Aside Trust. The court used a contract interpretation approach. The settlement agreement provided that the funds in the WCMSA could "only be used for payment of medical services related to the work injury that would normally be paid by Medicare"; they could not be used to pay attorney fees. The words used were clear, unambiguous, and defined the purpose for which the funds could be used.[18]

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A 2012 Illinois case touched on this issue. *In re Marriage of Washkowiak*[19] involved a property settlement agreement relating to the dissolution of a marriage. The wife was entitled to receive a percentage of the "net proceeds" of the husband's workers' compensation case, which had not settled at the time of the divorce. The workers' compensation case settled for $365,000 and a $70,000 WCMSA. The husband argued that the nature of the WCMSA precluded it from being part of the "net proceeds" of the workers' compensation case. The Appellate Court of Illinois disagreed and held it was. The court noted that the lump sum settlement and the WCMSA allocation were not "separate funds to be dealt with individually." It pointed out that the claimant could pay his former spouse the amount owed from his lump sum proceeds and still fund the WCMSA. It also recognized that while the WCMSA funds were retained by the claimant, he was not obligated to use them.[20]

A different result was obtained in *Williford v. N.C. HHS.*[21] There, a North Carolina appeals court held that a petitioner's WCMSA funds were restricted and were not a countable resource for determining her eligibility for Medicaid. The workers' compensation settlement agreement prohibited her from using WCMSA funds for support or maintenance. The fact that the funds were not restricted by the bank where they were deposited was not relevant to deciding whether they were legally restricted.[22]

Anecdotally, several state workers' compensation systems appear to not allow attorney's fees based on WCMSA amounts. In the alternative, maybe it is just that attorneys do not request them in the interest of fairness. Either of these can be implied from some cases. *Flores v. Keener*,[23] a Georgia appeals case, addressed a fee dispute between attorneys. The Georgia State Board of Workers' Compensation and the attorneys all appeared to agree that attorney's fees should be based only on a lump sum amount and not the WCMSA.

In Virginia, like most states, the workers' compensation commission approves settlements. In *Ashley v. Asplundh Tree Expert* Co.,[24] a Deputy Commissioner approved a settlement but reduced an attorney's fee request to a percentage of the amount actually received by the claimant. The attorney's fee did not represent the value of a WCMSA. The claimant's attorney appealed. With carefully crafted language the Commission affirmed, stating,"[w]e do not find the circumstances in this particular case warrant an increase in the attorney's fees based upon the MSA portion of the settlement."[25]

Informal Policies and Practices

In Virginia, the Workers' Compensation Commission must determine if a settlement is in the claimant's best interest.[26] It also has exclusive statutory jurisdiction to approve attorney's fees.[27] The Virginia Commission's settlement review staff indicated that they did consider attorney's fees based on MSA allocations in some cases where the fee request is adequately justified. They also reported that some cases involved settlements for a WCMSA value only. On occasion, the employer and insurer agreed to pay an additional amount equal to a reasonable attorney's fee for the claimant.

An inquiry with my colleagues in Florida confirmed that attorneys are recovering attorney's fees at settlement which include the value of WCMSA allocations. The state statute for setting attorney's fees indicates they should be based on the "value of benefits obtained." The thinking is that the WCMSA amounts are benefits obtained and ergo are a reasonable consideration.

Upon request, the International Association of Industrial Accident Boards and Commissions (IAIABC) conducted a voluntary survey of jurisdictions in May 2018. The IAIABC inquired whether states permitted attorney's fees based on WCMSA amounts. Fourteen states responded. The results confirmed that a majority of states do not have either regulations or case law addressing the viability of attorney's fee awards from, or on account of, WCMSA settlement components. A majority of states also indicated that the practice was for attorneys not to seek attorney's fees based on WCMSA funds.

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Analysis

One thing is clear: there is no federal guidance on whether an attorney's fee for settlement of a workers' compensation claim may be calculated by including WCMSA funds. The CMS Reference Guide states the cost of establishing the WCMSA may not be charged as a cost to it. But the New Jersey Court in *Hinsinger* distinguished the cost of establishing the WCMSA from the attorney's actions in procuring a settlement of a claim. No federal case or regulation addresses this question.

Some state court decisions allow attorney's fees to be calculated by including WCMSA funds. There are persuasive reasons. It may be inequitable to limit attorney's fees by giving Medicare a "free ride" either directly or indirectly. Denying consideration of WCMSA amounts could create an incentive for attorneys to refuse cases of Medicare beneficiaries, causing them disadvantage relative to other litigants. This could frustrate the goal of industry paying its fair share for workplace accidents. Some courts view the award of an attorney's fee at settlement as compensation - in whole or in part - for the entire sum of work performed by the attorney on the claim. It could be unfair to reduce arbitrarily the amount of a reasonable attorney's fee based upon allocation of part of a settlement imposed to protect the future interest of a governmental agency. The need for a WCMSA should not create a disincentive for qualified attorneys to pursue legitimate cases.

Refusing to allow attorney's fees based on WCMSA allocations has its merits. The WCMSA funds are not a resource from which a fee can be paid. Therefore, any additional amount would have to be paid from an injured worker's residual recovery. There is a sense of robbing Peter to pay Paul. Where the WCMSA represents a substantial portion of the overall settlement, allowing attorney's fees for the WCMSA could deplete most, or even all, of the injured worker's settlement proceeds. In addition, the WCMSA funds are encumbered. Practically or formally, they are held in trust.

Courts or regulators could craft a formula which would grant some consideration to attorney's fees on account of WCMSAs. A likely component would be factoring the relationship between the amount of the WCMSA and the total settlement. The higher the WCMSA component, the smaller fraction of non-WCMSA proceeds could be used for attorney's fees. Nevertheless, any regulation would have to balance carefully the need for attorneys in the system and for them to be compensated fairly against the ultimate conclusion that a settlement is in an injured worker's best interest.

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Interesting Workers' Compensation Blogs

Law Professor's Blog
http://www.lawprofessorblogs.com/

Managed Care Matters
http://www.joepaduda.com/

Tennessee Court of Compensation Claims
https://tncourtofwcclaims.wordpress.com/

Workers' Compensation
http://workers-compensation.blogspot.com/

From Bob's Cluttered Desk
http://www.workerscompensation.com/compnewsnetwork/from-bobs-cluttered-desk/

Workers' Comp Insider
http://www.workerscompinsider.com/

Maryland Workers' Compensation Blog
http://www.coseklaw.com/blog/

Wisconsin Workers' Compensation Experts
http://wisworkcompexperts.com/

Twelve-Inch Pie, from Page 7.

The landscape has been quiet since 2012 - over five years. With increasing scrutiny from CMS, and the widening frequency of WCMSAs as integral settlement components, the lack of development in the case law is unusual. It seems likely that litigants and lawyers have resorted to various mechanisms to avoid controversy and balance the interests at play. If so, that is a good thing. Information risk induces transaction costs. And, for transaction cost economics, adaptation is the central problem of economic organization.[28]

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Endnotes on Page 31.

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* Wesley Marshall serves as a Commissioner of the Virginia Workers' Compensation Commission. He has served on the Commission since 2012 and was reappointed in January 2018. Previously, he was in private practice for 23 years, primarily representing plaintiffs in workers' compensation, employment, and other civil litigation. He serves on the IAIABC Dispute Resolution Committee and enjoys writing and speaking on workers' compensation and other legal subjects.

The foregoing was originally published December 2018 in the International Association of Industrial Accident Boards and Commissions' *Perspectives*. It is republished here with permission.

Funny Lawyer Questions

LAWYER: Could you see him from where you were standing?
WITNESS: I could see his head.
LAWYER: And where was his head?
WITNESS: Just above his shoulders.

LAWYER: You don't know what it was, and you didn't know what it looked like, but can you describe it?

Pennsylvania Secretary of Labor Appoints Director for Workers' Compensation Office of Adjudication

Secretary of Labor and Industry Jerry Oleksiak appointed Judge Joseph DeRita Director for the Workers' Compensation Office of Adjudication. Director DeRita was formerly a Workers' Compensation Judge at the Allentown office. Prior to that, Judge DeRita represented injured workers for 30 years as a partner at the firm of Shor, Levin and DeRita, PC in Jenkintown, Pa and later as a sole practitioner before assuming the bench.

He graduated from St. Joseph's University in Philadelphia with a BA in Industrial Relations in 1983. Judge DeRita earned his JD from Widener University School of Law in 1987, and an LL.M. in trial advocacy from the Temple University School of Law in 2005. He earned the Workers' Compensation Law Certified Specialist in 2013 from the PBA Workers' Compensation Law Section.

Judge DeRita brings a wealth of experience and knowledge to the office. He has stressed the importance of maintaining professionalism and independence of the Workers' Compensation judiciary. He also seeks ways to inspire the WCOA staff.

Away from the job, he is an avid freshwater fisherman, golfer, fitness buff and Philadelphia sports fan. He is looking forward to fishing the Susquehanna River, having already mastered the Delaware River smallmouth bass population, when the weather turns warmer this spring.

We wish him well in his new position.

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2018's Top 10 Workers' Compensation Cases

Thomas A. Robinson, J.D.*

In the Foreword of our forthcoming *Workers' Compensation Emerging Issues Analysis*, 6th Edition [LexisNexis], due out in a few weeks, I note that in contrast to 2017, this year has been relatively calm for the workers' compensation world. I caution that such quiet times will likely not continue and that 2018 might, therefore, appropriately be characterized as "the quiet before the storm." In spite of the lack of overall turbulence, there have been some important court decisions in our field of interest this year. I take this opportunity to highlight what I think are the 10 most important workers' comp decisions **so far** in 2018. The order presented is somewhat random. As I have said in previous years, "importance"—like beauty—is in the eye of the beholder. If you have a different list, by all means, share it with me.

Oklahoma High Court OKs Use of "Current Edition" of *AMA Guides*

The sections of Oklahoma's Administrative Workers' Compensation Act (AWCA) that require use of the "current edition" of the AMA's Guides to the Evaluation of Permanent Impairment to determine PPD do not violate the Constitution, held a divided Supreme Court of Oklahoma in *Hill v. American Medical Response*, 2018 OK 57, 423 P.3d 1119 (2018). At first blush, the decision would appear to be in total conflict with that of the 2017 opinion of the Pennsylvania Supreme Court in *Protz v. Workers' Comp. Appeal Bd.* (*Derry Area School Dist.*), 161 A.3d 827 (Penn. 2017), which generally held that the use of similar language in the Keystone State's Act constituted an unconstitutional delegation of legislative authority to the AMA. A close reading of the majority opinion shows, however, a considerable level of consistency in the reasoning applied by the majorities of the two state supreme courts.

Kansas Court Strikes Down Use of *AMA Guides, 6th Ed.*

In the second important 2018 decision on use of the AMA Guides, 6th Edition, the Court of Appeals of Kansas, in *Johnson v. U.S. Food Serv.*, 427 P.3d 996 (Kan. Ct. App. 2018), struck down as unconstitutional the use of the 6th Edition for measuring permanent impairment of injured workers under the state's Workers' Compensation Act (the Act). The court acknowledged that the Kansas Legislature could substitute a statutory remedy for one available at common law and that it had done so to a large extent with its passage of the state's Act. The Court stressed, however, that due process required that the substitute provide "an adequate remedy for the common-law remedy that has been abolished" [Court Syllabus, ¶ 3]. The Court concluded that following the relatively recent statutory amendments requiring use of the 6th Edition of the AMA Guides for injured workers who suffer a permanent impairment on or after January 1, 2015, the Act no longer provides such an adequate substitute remedy.

At least until such time as an appeal is heard by the Supreme Court of Kansas, the 4th Edition of the Guides must be utilized. It is important to note that the Court of Appeals here did not find the entire Act unconstitutional—only the use of the 6th Edition. This raises the obvious question of whether any other current provisions of the Kansas Act would fail to pass muster if challenged.

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California High Court Narrows Rule for Classification of Workers as Independent Contractors

In a decision that continues California's trend toward allowing the designation of a worker as an independent contractor only under rare circumstances, the Golden State's Supreme Court held that in determining whether to classify workers as employees or as independent contractors *for purposes of California's wage orders*, the state's "suffer or permit to work" standard requires a hiring entity asserting independent contractor status to establish each of the three factors of the "ABC test": i.e., to show that a worker is free from its control, performing work outside the usual course of its business, and customarily engaged in independent work [see *Dynamex Operations West, Inc. v. Los Angeles County Superior Court*, 4 Cal. 5th 903, 416 P.3d 1, 232 Cal. Rptr. 3d 1, 83 Cal. Comp. Cases 817 (2018)]. While the decision has no direct impact in workers' compensation cases, only a myopic employer can ignore the decision.

The pressing issue to be resolved is whether the relatively straight-forward ABC standard applies to workers' compensation cases, or must parties utilize the much more complex multi-factorial analysis set for the California Supreme Court's workers' compensation case of *S.G. Borello & Sons, Inc. v. Department of Industrial Relations* (1989) 48 Cal.3d 341, 769 P.2d 399, 256 Cal. Rptr. 543, 54 Cal. Comp. Cases 80, continues to control in workers' compensation proceedings. In *Perkins v. Knox*, 2018 Cal. Wrk. Comp. P.D. LEXIS 490 (Oct. 23, 2018), a panel of commissioners with the Workers' Compensation Appeals Board (WCAB) concluded that the *Dynamex* decision was only to be applied in one specific context, California wage order disputes. The panel added that the *Dynamex* decision did not overturn *Borello* and found that the *Borello* standard continues to apply to workers' compensation disputes. California experts note that *Perkins* is just one panel decision. It was signed, however, by the Chairwoman of the WCAB.

Maine Employer Need Not Pay for Injured Worker's Medical Marijuana

In a case of first impression within the state, the Supreme Judicial Court of Maine, in a 5-2 decision, held that an employer may not be required to pay for an injured worker's medical marijuana use [*Bourgoin v. Twin Rivers Paper Co., LLC*, 2018 ME 77, 187 A.3d 10 (2018)]. Indicating that it was deciding the case on "narrow" grounds, the majority reasoned that there was a "positive conflict" between the federal law, as found in the Controlled Substances Act (CSA), and the Maine Medical Use of Marijuana Act (MMUMA) [see Opinion, ¶ 1] and that under such circumstances, the CSA preempted state law.

Reviewers Under California's Utilization Review Procedure Enjoy Immunity from Tort Liability

Under the exclusive remedy provisions contained in Cal. Labor Code § 3602, utilization reviewers performing services under the state's workers' compensation utilization review process enjoy immunity and may not be sued by injured workers, held the Supreme Court of California in *King v. Comppartners, Inc.*, 5 Cal. 5th 1039, 423 P.3d 975, 236 Cal. Rptr. 3d 853, 83 Cal. Comp. Cases 1523 (2018).

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Accordingly, where a utilization reviewer denied a treating physician's request to continue prescribing a certain medication — Klonopin — the employee could not maintain a tort action against the utilization reviewer based upon allegations that the reviewer caused additional injuries by denying the request without authorizing a weaning regimen or warning him of the possible side effects of abruptly ceasing the medication.

Earlier, a California Court of Appeal had concluded that the tort claim was not preempted because it did not directly challenge the reviewer's medical necessity determination, but rather had alleged that the reviewer owed the injured worker a duty of care and had failed to provide necessary medical care to the worker. The Supreme Court stressed that in performing their statutory functions, utilization reviewers effectively stood in the shoes of employers. As such, reviewers were to be provided with the same immunity from tort liability as employers.

Worker's "Undocumented" Status May Be Considered in Determining Degree of Permanent Disability

In *Marquez v. Pierce Painting, Inc.*, 164 Idaho 59, 423 P.3d 1011 (2018), the Supreme Court of Idaho, in a split decision, held that an injured worker's "undocumented" status may be considered in determining his or her level of permanent disability under the plain wording of Idaho Code Ann. §§ 72-425 and 72-430. Pursuant to those statutes, *all* personal and economic circumstances that diminish the ability of the claimant to compete in an open labor market must be considered when determining whether an injured employee is entitled to permanent disability benefits. The Court held that the Commission's failure to take the claimant's undocumented status into account was error. The Court refused to address the specific weight to be given to a claimant's undocumented immigration status. The dissent argued that the multiple illegal acts of both the claimant and the employer should not be ignored.

Oklahoma's Tort Immunity Provision Favoring Oil and Gas Wells Struck Down as Unconstitutional

In *Strickland v. Stephens Prod. Co.*, 2018 OK 6, 411 P.3d 369 (2018), the Supreme Court of Oklahoma held that 85A Okl. St. § 5, which provides operators and owners of oil and/or gas wells with extended immunity in tort actions filed against them by plaintiffs where those plaintiffs are injured at the well site and are employed by other firms, is unconstitutional as an impermissible special law under Art. 5, § 59 of the Oklahoma Constitution. Under the wording of the statute, an operator or owner of an oil or gas well is deemed to be an "intermediate or principal employer" (essentially the same as a statutory employer in most other states) for any services performed at the drill site with respect to work-related injuries sustained by workers whose immediate employer was hired by the operator or owner.

Among the arguments presented on behalf of well owners and operators was their contention that they needed "certainty" regarding their tort liability exposure. The Oklahoma high court observed that employers in other industries would also like such certainty. It was not afforded to them. Giving such favorable treatment to well owners and operators was constitutionally impermissible.

Alaska's High Court Upholds Total Bar of Recovery for Non-Dependent Parents of Deceased Employees

The Supreme Court of Alaska, in *Burke v. Raven Elec.*, 420 P.3d 1196 (Alaska 2018), affirmed the constitutionality of the state's broad exclusive remedy provision [Alaska Stat., § 23.30.055] that bars a parent from pursuing any tort recovery against an employer whose negligence causes the death of his or her employed child even in those instances in which the parent fails to qualify for workers' compensation benefits because he or she was not dependent upon that child for support at the time of the injury or death. The holding, while consistent with other similar cases around the nation, seems to go against the basic rule that exclusivity applies only where some right to benefits is afforded under the state Act.

Alabama Accountant's Fatal Shooting by Disgruntled Former Client Found Compensable

In a case with a bizarre fact pattern, an Alabama appellate court affirmed an award of workers' compensation death benefits to the surviving spouse of an accountant who was stalked and then shot to death because her assailant blamed the accountant for tax problems in his business [*Lawler & Cole CPAs, LLC v. Cole*, 2018 Ala. Civ. App. LEXIS 115 (July 13, 2018)].

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Construing Ala. Code § 25-5-1(9) and relevant case law, the appellate court agreed that the murder, although an intentional act on the part of the murderer, amounted to an accidental injury (death) arising out of the employment.

The Road Less Traveled: Wisconsin Court of Appeals Shuns Majority Rule Re: Borrowing Employer's Tort Immunity

Based, at least in part, on the court's so-called "literal" reading of a Wisconsin statute [Wis. Stat. § 102.29(6)(b)1.], the Court of Appeals of Wisconsin, in *Ehr v. West Bend Mut. Ins. Co.* (*In re Estate of Rivera*), 2018 Wisc. App. LEXIS 16 (Jan. 9, 2018), held that a worker employed by one firm and assigned to a borrowing employer may proceed in tort against that borrowing employer (referred to in some jurisdictions as the "special employer") for injuries sustained in the course and scope of the employment, so long as the worker has not already sought workers' compensation benefits from the borrowing employer.

In its decision, the Court adopted a position in opposition to the vast majority of jurisdictions, which generally bar tort actions by a temporary (i.e., "lent") employee against the borrowing or special employer [see *Larson's Workers' Compensation Law* §§ 67.01, 100.01, 111.04]. The majority position is illustrated by another 2018 decision from Montana, *Ramsbacher v. Jim Palmer Trucking*, 2018 MT 118, 391 Mont. 298, 417 P.3d 313 (2018).

***** Thomas A. Robinson, Durham, N.C., received his B.A., cum laude, for both Economics and History, in 1973 from Wake Forest University, his J.D. in 1976 from Wake Forest University School of Law, where he served as Managing Editor, Wake Forest Law Review, and his M.Div. in 1989 from Duke University Divinity School. From 1976 to 1986, Mr. Robinson was in private practice, where he focused on workers' compensation defense work. From 1987 to 1993, he was research and writing assistant to Professor Arthur Larson. From 1993 until December 2014, Mr. Robinson worked closely with Lex Larson as senior staff writer for Larson's Workers' Compensation Law (LexisNexis) and Larson's Workers' Compensation, Desk Edition (LexisNexis). Since January 2015, Robinson has assumed the role of co-author of those treatises with Mr. Larson. He is a contributing author or editor to five other LexisNexis workers' compensation publications. Robinson also serves on the executive committee of the Larson's National Workers' Compensation Advisory Board (LexisNexis). His award-winning blog, The WorkComp Writer, can be accessed at http://www.workcompwriter.com/.

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Book Note

Lyme:
The First Disease of Climate Change

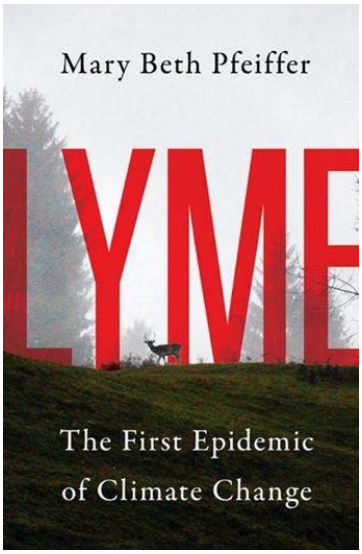
by Mary Beth Pfeiffer; Island Press. 2018. 288 pp.
https://www.thefirstepidemic.com/

By Hon. David Torrey*

In this book, the author, a journalist, explains Lyme Disease, posits that the medical establishment has improperly rejected the proposition that the malady can become chronic, and theorizes that the spread of the disease is due to climate change. The book, in detailing what she calls the "four myths" about Lyme Disease, supplies the attorney with a wealth of information with which to prepare for cross-examination of a physician who cleaves to the view of most experts, who insist that the condition is easy to test for, diagnose, and treat; and who reject the proposition that it can become a long-term problem for victims. The book treats occupational injury contraction only briefly, though the author does reference veterinarians, highway workers, and soldiers-in-training as individuals who are at high-risk for incurring the disease.

Like at least one other reviewer (*Times Literary Supplement*, 9.21.2018), this reader was unable to say that the author makes out her case that a conspiracy exists to quash research into the disease; the plausibility of such an effort seems weak, and the purported arrogance and villainy of the medical establishment seems overstated.

Still, the book is a *tour de force* of critical thinking about how medicine and society have responded to what appears to be an increasingly hazardous medical condition. It is valuable reading for the workers' compensation specialist. In this regard, Lyme Disease is a challenge for both the insurance industry which underwrites risks and the lawyers who seek to obtain benefits for disease victims. Employers and insurers, in general, deny claims when causation is not obvious, and are wary of claims of chronic conditions that are suspected of having their genesis in non-work-related and/or superseding maladies. These two anxieties are at a high pitch in the Lyme Disease debate. Further, experts apparently differ over whether current testing for Lyme Disease is dependable. The author spends a whole chapter on this latter issue.



The accuracy of diagnosis, and physician cynicism over the authenticity and cause of chronic problems, are major themes of Pfeiffer's book. Rarely does a chapter pass without accounts of physicians purportedly misdiagnosing Lyme, instead ascribing chronic problems to such things as fibromyalgia, chronic fatigue syndrome, malingering as to school attendance, and modern-day neurasthenia (the accusation is that chronic Lyme is a "middle-class malady"). These are all phenomena of workers' compensation claims handling and litigation.

Lyme Disease is incurred by the bite of a tick which is itself infected by the bacteria *Borrelia burgdorferi. See* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2440571/. The main culprit is the Blacklegged Tick, a species of anthropod parasite that, given our rapidly warming planet, is expanding its range northward deeper into the U.S., particularly the northeast. Pennsylvania, indeed, is a jurisdiction which is said to have an increased number of infections every year.

It is notable that the bite of the tick is not communicating to the victim venom, as with the bite of a snake or spider. Instead, the tick itself has incurred the bacteria from feeding off of the blood of mammals like infected deer and mice, and even of birds.

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Disease of Climate Change, from Page 14.

It is deer that are the most visible culprit. Suburban sprawl continues its remorseless extension into wooded areas, and fewer predators exist to cull the herds. The result is a burgeoning deer population which in turn infects the ticks who are so voracious for their blood – and which in turn infect humans. The disease can be highly debilitating, though physicians believe that antibiotics, particularly a course of doxycycline, can cure most cases. *See* https://www.hopkinsarthritis.org/arthritis-info/lyme-disease/lyme-disease-treatment/.

It is on this point, however, that significant dispute among physicians exist. The author charges that the condition has been "minimized, underestimated, and politicized to the point that doctors" fear treating it aggressively with antibiotics. The Centers for Disease Control and the Infectious Diseases Society of America (IDSA) in this regard, reject the proposition that the condition can be chronic, and have established restrictive, evidence-based guidelines that should be followed in identifying and treating the malady. (As to the CDC, see https://www.cdc.gov/lyme/diagnosistesting/index.html.)

Members of the International Lyme & Associated Diseases Society, on the other hand, believe that Chronic Lyme exists, and argue for long-term use of antibiotics as the remedy. They argue that Lyme should be taken much more seriously, and caution that the disease can cause injury to an individual's central nervous system.

As foreshadowed above, the author posits that four myths surround Lyme Disease. These are (1) that Lyme is overdiagnosed; (2) that Lyme Disease Testing is reliable; (3) that Lyme Disease is hard to contract; and (4) that Lyme Disease is easy to treat. Pfeiffer seeks to debunk these myths in her book, which has the added feature of 20 pages of references. Many resources exist about Lyme Disease, particularly online, but the workers' compensation specialist will be well-prepared for encounters with claims in this area by a close examination of Ms. Pfeiffer's critique.

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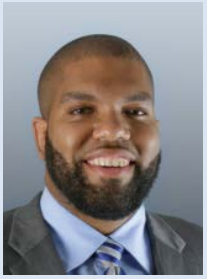
* Dave Torrey has been a Workers' Compensation Judge in Pittsburgh, PA, since January 1993. He teaches the workers' compensation law courses at the University of Pittsburgh School of Law. He is a Past-President of the National Association of Workers' Compensation Judiciary (www.NAWCJ.org), and is Secretary of the College of Workers' Compensation Lawyers. His treatise on Pennsylvania Workers' Compensation, published by Thomson-Reuters, is in its Third Edition. His most recent book is David B. Torrey, ed., *The Centennial of the Pennsylvania Workers' Compensation Act: A Narrative and Pictorial Celebration* (Pennsylvania Bar Association 2015). A recent publication is Torrey (Book Review), "*John Henry Wigmore and the Rules of Evidence: The Hidden Origins of Modern Law*," Workers' First Watch, p.34 (WILG, Winter 2017).

Governor Raimondo Nominates Two Judges

NewPortRI.com has reported that Governor Gina Raimondo has nominated Keith A. Cardoza Jr. and Susan Pepin Fay to fill vacancies on the Workers' Compensation Court. Fay succeeds Judge Hugo Ricci and Cardoza succeeds Judge Debra Olsson.



Keith A. Cardoza Jr.

Cardoza has represented employers, employees, insurance carriers and third-party administrators in all aspects of workers' compensation claims in Rhode Island and Massachusetts. He graduated in 2010 from Roger Williams University School of Law.

Susan Pepin Fay

Fay has represented employers and insurers before the Rhode Island Workers' Compensation Court, the Massachusetts Board of Industrial Accidents and the U.S. Department of Labor. She earned her law degree in 1993 from Suffolk University Law School.

(R)Evolutions in Medical Determinations

David Langham*

IMR an Overview

Florida Tax Watch recently issued a report *Keeping Workers' Compensation Premiums Low through Independent Medical Review*.[1] It noted that in terms of workers' compensation insurance premiums, Florida is currently "33rd among the 50 states and District of Columbia," and notes the impact that recent constitutionality court decisions could have on those premiums. It advocates that "the success of the IMR program in California" suggests that program should be considered in Florida.

The report says California has the highest premium in the country, at "$3.24 for every $100 of payroll," compared to Florida's rate of just over half that, $1.66. It notes that "soaring drug prices are driving up health care costs," and cites specific examples of rising prices in recent years. And the costs are projected to continue to rise for all of "national health spending" over the near term.

Last April WorkCompCentral.com published *The Conundrum of Medical Inflation*,[2] which further supports that medical costs are increasing at rates well in excess of inflation generally. Tax Watch reports that medical costs are significant in Florida, noting "only Louisiana, North Carolina, and Alaska have higher healthcare costs." There is also reference to the "legal fees associated with workers' compensation claims," and to the 2017 OJCC Annual Report.[3] Tax Watch correlates the speed of medical determinations with the volume of attorney fees. For those who wish to review the latest, the 2018 OJCC Annual Report[4] has also now been published. It documents continued increase in attorney fees.

It explains that the California Legislature sought to control system costs, and enacted Independent Medical Review (IMR) in 2012. This is a "non-judicial process" that resolves "disputes about the medical treatment of injured workers." It is tied to a separate but "related process" called Independent Bill Review (IBR) similarly facilitating reimbursement dispute resolution.

In the IMR process, a worker dissatisfied with care, or seeking different or more care, makes a request. That request is subjected initially to Utilization Review (UR), which could result in provision or denial of the requested care. If denied, then the worker can request IMR. In that process, "professionals use principles of 'evidence-based' medicine to determine whether the requested care is medically necessary."

Tax Watch notes that the organization performing the IMRs, the "IMRO" "decided that the disputed service was medically necessary and appropriate 91.6 percent of the time" in 2016. It also notes that a significant majority of reviews upheld the determination of the UR process (denial). Those two statements are difficult to reconcile. Notably, the California "Division of Workers' Compensation has also adopted an evidence-based drug formulary." A formulary has been discussed in Florida,[5] but none has been adopted, or even formally proposed.

Similarly, California has adopted, and recently updated, its Medical Treatment Utilization Schedule (MTUS).[6] These California medical treatment guidelines were developed by the American College of Occupational and Environmental Medicine (ACOEM). The MTUS are codified "treatment guidelines and rules for determining what is reasonable and necessary medical care." These regulations are "based on principles of evidence-based medicine." Thus, the UR process compares what is requested to the MTUS. Then, if review is sought, the IMR similarly compares the request to the MTUS. Both processes have identical objective criteria against which to measure a request.

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Tax Watch says that there would be considerable financial savings if Florida adopted IMR. It notes that IMR cost $345 to $390 to $515 each (depending on the claimed issues). IMR process costs "are paid by employers." It notes that the IMR resolution takes no more than 30 days, compared to the potential of 210 days afforded for OJCC trial in the Florida statutes. In 2018, the actual OJCC average time was 211 days to trial and an additional 15 days from trial to final order. The OJCC process affords both employee and employer with a full measure of due process, discovery, and confrontation of witnesses.

Tax Watch says that at the $390.00 rate for IMR, the petitions litigated before the OJCC in 2016 would have cost $22.6 million. In 2016-17, however, the overall cost per petition in Florida was not $390, but only $244[7]. However, it also emphasizes the savings in time (30 days to resolution), "PFB processing costs," and "a sizable reduction in attorney fees." It sees the potential of "reducing or eliminating the Office (of Judges of Compensation Claims) or reassigning some or all of the 31 judges to hear other pending cases at the Division of Administrative Hearings."

There are various topics intertwined in this proposal that bear discussion. First, Florida has not thus far shown any interest in either treatment guidelines or a formulary. The Tax Watch discussion seems to support that both UR and IMR, as they exist in California, are dependent upon adoption of these objective standards. That consensus is supported by conversations about IMR with Californians. There is consensus that IMR could not viably process without standards.

According to the National Institute of Health, Clinical Practice Guidelines[8] "are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." In other words, for a particular malady or diagnosis, there are pre-determined treatments that are deemed appropriate. The UR and IMR processes rely on that medical diagnosis-based consensus to decide if requested care is appropriate for a particular patient. Is it possible that some of the California medical savings is based not upon UR/IMR, but upon the existence of published, clear, guidelines and formulary definitions as to what is or is not appropriate?

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If such guidelines were adopted in Florida, would that aid employers in making decisions about care, in a UR process? Would that "evidence-based" decision-making lead to fewer petitions being filed? Would the outcome of filed petitions before judges and mediators be more predictable? Would that "standard-based" process result in cost savings from less employer/carrier UR analysis, fewer petitions, and less litigation? If the guidelines produced those results, would a corresponding savings in attorney fees naturally follow, through resolution in the existing litigation system?

Similarly, would a list of medications that are covered in workers' compensation (a "formulary" according to Medicare[9]) afford some objective standard for decisions regarding claims for medication? Would that "evidence-based" decision making regarding medication likewise increase predictability and transparency, and perhaps expedite the resolution or adjudication of disputes?

Two legal points merit preliminary mention. First, there are many disputes that would likely remain for adjudication despite IMR. The term "compensability" as it is used in IMR would address whether a condition is or is not related to an event, or whether particular care is or is not appropriate. However, it would not address whether or not some specific alleged accident or exposure occurred. Those disputes would remain. Further, according to the 2017-18 OJCC Annual Report,[10] over 30% of petitions included a claim for temporary partial disability, slightly less sought temporary total, fewer still sought determination of the average weekly wage, permanent disability benefits, and other non-medical issues. Some system for resolution of those disputes would likely remain despite IMR.

The second legal point mentioned by some is the "detached" or "impersonal" nature of IMR. There is no "hearing" or confrontation in that process. Documents are submitted by the worker seeking care and by the employer. The IMR decision is based upon those documents. There is no cross-examination or determination of credibility. There are those who see that as a due process issue, although there is precedent concluding that IMR affords sufficient due process.

IMR and Due Process

In 2015, the California First District Court of Appeal decided *Stevens v. Workers' Compensation Appeals Board*.[12] It includes some history of California statutory changes in 2004 and again in 2012. The 2004 changes created UR and required the adoption of the MTUS treatment guidelines.

California UR, the *Stevens* Court noted, is not bilateral. The UR decision can be challenged by the injured worker, but not by the employer. For employers, the UR process is binding. If UR determines requested care to be appropriate, it must be provided, and the employer has no recourse except to provide it, no review, re-review or appeal. The Court explained that thereafter the 2013 statutory changes "built off the 2004 legislation and established a new procedure, 'Independent Medical Review,' (IMR), to resolve workers' challenges to UR decisions."

Ms. Stevens challenged the "the constitutionality of the IMR process." The arguments included violation of separation of powers, the state Constitution's requirements that workers' compensation decisions be subject to review and the system "accomplish substantial justice," and principles of due process. The Court was not convinced of any of these grounds, and concluded that California IMR is constitutional.

As to the challenges related specifically to the California Constitution, the Court noted that "the Legislature has ***plenary powers*** over the workers' compensation system under article XIV, section 4 of the state Constitution." (Emphasis added). Furthermore, the Court concluded that IMR affords the injured worker with sufficient due process as guaranteed by the Fifth and Fourteenth Amendments to the U.S. Constitution. Essentially, the Court concluded that the ability to provide written argument to the physician throughout the IMR process was sufficient in that regard, considering the overall process.

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Ms. Stevens' July 2013 claim was for four medications and provision of a home health aide following a work accident. Notably, the Court discusses "compensability" of the claimed benefits, but there was no dispute regarding "the general proposition that Stevens suffers from pain and other ailments and is entitled to receive" medical care. The UR process involved review by "a board-certified anesthesiologist," who denied the requests in "an extensive, nine-page" decision, sent to Ms. Stevens.

The Court's recitation of the grounds for denial focus on the medical purpose and efficacy of the four medications (Ativan, Flexeril, diclofenac cream, and hydrocodone). The UR physician's conclusions and denial were essentially that other alternative treatments would be better, or at lqeast should be tried before the claimed medication. Ms. Stevens disagreed, and asked for a UR evaluation with "a different 'Physician Adviser,'" a "re-review." Ms. Stevens was afforded and took "the opportunity to submit additional evidence for the (second) internal review."

A second "board-certified anesthesiologist" reviewed the request for care. For the re-review, Ms. Stevens submitted "a seven-page report by Dr. Jamasbi dated August 14, 2013, addressing" the first UR decision/denial. The second UR physician nonetheless also denied "the request for the four medications." The denial was similarly provided to Stevens in a written, nine-page report. This illustrates how the UR process affords the injured worker two opportunities to submit evidence, the initial UR and an "internal review" that involves a second physician, and can include additional documents. Further, it illustrates how determinations are communicated in detail to the patient.

On the basis of the second UR denial, Ms. Stevens sought an IMR. She was allowed to, and did, again submit additional medical documentation for the IMR review. Thus, there were a total of three opportunities for the employee to submit documentation. The IMR "final determination" was issued "in February 2014," and upheld the UR denial of home health aide and the four medications, based on the MTUS and formulary.

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The denial did not identify "the IMR physician," but stated the IMR reviewer was "Board Certified in Pain Management, had a subspecialty in Disability Evaluation, was licensed to practice medicine in California, . . . had been in active clinical practice for more than five years, and was currently working at least 24 hours a week in active practice." It remains unknown who this physician was. Some question the motivation of concealing the identity. The IMR determination "became" the determination of the Director of the Division of Workers' Compensation (director) as a matter of law. (§§ 3206, 4610.6, subd. (g)). That legal function made the IMR decision "state action" for the purpose of the due process discussion and analysis.

The injured worker appealed the IMR/Director decision to the Workers' Compensation Board (in California there is an administrative review process for all workers' compensation decisions). The Board denied that appeal and affirmed the IMR/Director, noting Ms. Stevens had not proven "one or more of five grounds for appeal listed by the Legislature in section 4610.6(h)[13] by clear and convincing evidence." There, the Legislature provided specific reasons for which the IMR could be disregarded by the Board. As regards the "clear and convincing," there are those who find the California IMR similar in that regard to the Florida Expert Medical Adviser process in Section 440.13(9), Fla. Stat.[14] This evidentiary standard is not uncommon.

The *Stevens* Court reiterated that the California Constitution "gives the Legislature 'plenary power ... to create ... and enforce a complete system of workers' compensation.'" The use of "plenary"[15] suggests "absolute or unqualified" power. Some suggest that is a distinction relevant to Florida's consideration of IMR, as there is no similar Florida grant of "plenary" power, affording such unfettered authority regarding workers' compensation. However, the discussion below regarding Louisiana may temper that argument.

Notably, in enacting the "IMR process," the California Legislature made specific findings as to the "then-existing system of resolving disputes about treatment requests." It concluded the process:

> was 'costly, time consuming, and did not uniformly result in the provision of treatment that adhered to the highest standards of evidence-based medicine, and this adversely affected the health and safety of workers injured in the course of employment.'

It reached similar conclusions regarding the pre-IMR process for appointment of "qualified medical evaluators (QME) to examine patients and resolve treatment disputes."

The *Stevens* Court stressed the independence of the IMR providers, the requirement of adherence to the MTUS, and the requirement for detailed decisions regarding requested reviews. The availability of appellate review by the Board, for specific grounds, also affords a level of due process according to the Court, although its power is limited to ordering a new IMR. And, ultimately, the decision can be reviewed "in the Court of Appeal" as in *Stevens*, but notably the record may not include all of the documents involved in the various medical reviews (as occurred in *Stevens*). Each of these was found to include elements of due process.

The Court concluded that "both workers and employers benefited from the 2004 and 2013 reforms." Primarily, the Court noted the speed and efficiency of decisions, the UR finality when in favor of the employee, and the reduced "insurance costs by creating uniform medical standards and reducing litigation." Thus, at least arguably, the benefit of "standards" is again perhaps less about IMR than it is MTUS, UR, and perhaps the California pharmacy formulary.

The Court concluded that Ms. Stevens' California Constitution challenges failed because of the plenary authority granted to the Legislature. It explained that grant of power was intended to "remove all doubts as to the constitutionality of then-existing [workers'] compensation laws." The Court concluded that the evolution of this "plenary power" clause "compels the conclusion that Section 4 supersedes the state Constitution's due process clause with respect to legislation passed under the Legislature's plenary powers over the workers' compensation system."

The Court was equally unmoved by the "principles of due process under the federal Constitution." It noted that "to prevail on a federal due process claim, plaintiffs must show that the state deprived them of a property or liberty interest without affording sufficient notice and opportunity to be heard." The Court expressed some doubt that such a decision as to appropriateness of medical care either "constituted state action" or "implicated a protected property interest."

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It conceded that the specific due process issue has not been settled by the United States Supreme Court, and discussed some other medical necessity determinations, noting similarities and distinctions. In light of that uncertainty, the *Stevens* Court proceeded with review assuming that both "state action" and a "protected property interest" were present, so as to implicate the due process clause (of the Fourteenth Amendment by direct application, or potentially the Fifth Amendment subject to selective incorporation).

The Court concluded that Ms. Stevens was "afforded ample process" in the IMR process, but more. It found the ability to submit documentation and written explanations through UR and IMR persuasive. And, the Court balanced the constraints (seemingly "confrontation" and "cross-examination") against a "governmental interest" previously determined to be "strong," as regards other medical decision (in group health) IMR processes in California. It noted that ultimately, "the risks of erroneous deprivations under the workers' compensation system appear to be fewer, and certainly no more, than the risks under the" other California IMR process previously upheld.

The Court specifically rejected the argument that due process was violated by the anonymity of the IMR physician. The physician is a "decision maker" and not an adversary. Some find the anonymity curious. What is the point of decision maker anonymity? If it serves a purpose, would the same end be accomplished by depriving injured workers and employers of knowing which workers' compensation judge adjudicated their dispute? The Court found no legal protection for a party "to cross-examine such decision makers." The person making an "initial decision" ("a clinician [that] determines that the treatment is medically unnecessary") might be subject to such examination, "to discover what that basis was." But, the Court explained, in California workers' compensation, patients "are given detailed explanations of the reasons for a denial" and "given multiple opportunities to submit evidence and challenge those decisions." That combination and amalgamation of process, it concluded, is sufficient.

The *Stevens* Court also rejected due process concerns centered on the limited nature of available appeal. First, it noted that whether the "due process clause" guarantees "any review" is unclear. It concludes there may be no constitutional right to appeal. Furthermore, the Court concluded that "the IMR process is itself a review." And, furthermore, it found efficacy in "the Board's authority to review an IMR determination," despite the statutory limitations. The real limitation on the patient, according to the Court, is "the MTUS." (There was no challenge to the foundational MTUS or formulary in *Stevens*).

Notably, one ground of the due process challenge was that the IMR statutory time limits are not subject to any "meaningful enforcement procedures." The process is intended to be completed within 30 days. But, the Court concluded that failure of the IMR to comply with such a time constraint did not invalidate the IMR outcome. The 30 day limit is "instructive," "directory," but not mandatory. That suggests that while IMR is intended to be more rapid, its promise may be illusory in some situations. Of note, the Florida courts have repeatedly concluded that the time constraints upon Judges of Compensation Claims holding hearings and making decisions are similarly "directory."[16]

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Stevens is not the last California word regarding due process concerns. In September 2018, the California Fourth District Court of Appeal rendered *Barri v. Workers' Compensation Appeal Board*.[17] This is not an IMR analysis or decision, but it refers to *Stevens* in the context of due process. In *Barri*, the challenge instead involved a medical provider seeking payment (in California that is called a "lien"). The government cited *Stevens* and the "plenary power" in support of its actions. Though the Court ultimately concluded the government action was appropriate in *Barri*, it expressed reservations as to the extent of the "plenary power." It noted:

> "The Legislature cannot *carte blanche* exercise its plenary powers and create legislation (1) unnecessary to the workers' compensation system or that (2) conflicts with the federal due process clause."

Thus, while the concerns raised in *Stevens* and *Barri* were not found violative of due process, the *Barri* Court suggests that due process remains a factor to consider even in light of the "plenary" provision of California's Constitution. What precisely that would require or preclude remains unclear. However, there is suggestion that "plenary" is perhaps not altogether unrestricted.

There will seemingly now be debate of Florida adopting the IMR process. Some will argue that California first instituted UR and the MTUS, and that should be a primary step. Though Florida has heard debate of treatment guidelines over the past decade, neither such guidelines nor a medication formulary have been adopted (or, some argue, even seriously considered). IMR would ultimately be dependent upon the existence of each of these critical elements.

There will likely be debate of the importance of "plenary" authority. Some will find the presence of that language critical in the *Stevens* analysis. They may argue that without that authority, the IMR process fails to satisfy the other protections of the Florida Constitution. Notably, Florida does not have such a "plenary" power provision. Others, may argue that the *Stevens* Court focus on "plenary" occurred only because that language is in the California constitution, but that the Court could have (or would have) reached the same decision if "plenary power" did not exist, merely upon other grounds.

There will also likely be some discussion of the persuasiveness of *Stevens* as an appellate decision. Some will argue that this is not a decision of California's highest court. The California Supreme Court did not review it. The United States Supreme Court was asked to review, but declined. *Stevens v. California Workers' Compensation Appeals Board*, 137 S.Ct. 384 (2016). Proponents of this argument may point to the many Florida District Court decisions that concluded attorney fee constraints in Section 440.34 were constitutional in the years leading up to the Florida Supreme Court decision to the contrary in *Castellanos v. Next Door Company*.[18]

In response, there will also likely be those who find the *Castellanos* argument unpersuasive. Some find that decision an unsupportable deviation from the standards of constitutional review. Arguably, the *Castellanos* Court did not address constitutionality following the expected precedential process, but inferred a "presumption" neither stated nor, they argue, appropriately demonstrated there. The *Castellanos* critics may perhaps argue that the dissent there was more persuasive and that a different result might well come from the Florida Court having a second chance in the future to review such a case. In that regard, the argument may be that the string of District Court cases were in fact correctly decided, and the *Castellanos* Supreme Court majority conclusion is atypical or aberrant, and therefore an erroneous, result.

Any or all of these arguments might be worthy of consideration or at least discussion. And, the arguments would likely require years of litigation and consideration. The constraint on Florida attorney fees passed in the 2003 reforms were litigated for over 13 years, a period of instability and uncertainty. Potentially, therefore, the next decade of Florida workers' compensation could be as interesting as the last, in the event that IMR is selected as the Legislature's chosen path.

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(R)Evolution in Medical , from Page 22.

The Louisiana Medical Dispute Solution

In October 2018 the Louisiana First Circuit Court of Appeal rendered its decision in *Barber v. Louisiana Workforce Commission, et. al*.[19] This followed a trial court permanent injunction that precluded the Commission and its agents "from applying and/or enforcing certain statutory provisions and regulations regarding the medical treatment schedule authorization and dispute resolution procedures."

The Court recited that the dispute originated from 2009 legislative amendments to the Louisiana workers' compensation statute. The purpose was "to establish meaningful guidelines for the treatment of injured workers." This is similar to the Medical Treatment Utilization Schedule (MTUS)[20] enacted by California, discussed above. Louisiana elected not to adopt any group's (ACOEM) guidelines, but instead created its own.

The Louisiana Legislature mandated the adoption of treatment guidelines and a new medical determination process. The Office of Workers' Compensation (OWC) created guidelines and defined a process for determination of medical disputes. Disputes were to be administratively determined by "a medical director employed by the OWC and administrative appeals therefrom to the OWC judges." On those grounds, a constitutional challenge was filed.

In June 2015, the trial court concluded that the treatment guidelines and regulations were "unconstitutional as violative of the Due Process Clause of the Fourteenth Amendment to the United States Constitution and Louisiana Constitution Article I, Section 2." It found fault in terms of specificity, "both substantive and procedural due process," and that the change "violates the separation of powers doctrine." The trial court therefore issued a "preliminary injunction" and precluded the state from "applying and/or enforcing" the treatment guidelines. *See Another Unconstitutional Statute*.[21]

The trial court was reversed in October 2015 by the Louisiana Supreme Court.[22] It concluded that "the constitutional issue was not properly raised in the trial court." It identified other flaws in the trial court decision and therefore transferred the appeal to the Appellate Circuit Court for review of the judgement. This blog was critical[23] of that trial court for allowing lawyers in the case to draft the court's decision; drafting orders is the judge's job. In June 2016,[24] the appellate court reversed the trial court injunction.

The matter thus returned to the trial court for consideration of the merits of the claims of constitutional infirmity. In March 2017, the trial court judgment was entered again "permanently enjoining, restraining, and prohibiting defendants from applying and/or enforcing" the treatment guidelines and process. The Court also:

> enjoined, restrained, and prohibited the defendants from allowing anyone to attempt to communicate with judges of the OWC regarding pending workers' compensations claims.

The OWC judges were directed by the trial court to make decisions regarding medical claims based only upon "the facts and law presented to them on the record." This communication prohibition is consistent with both judicial independence and the prohibition on ex-parte communications with judges.

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Two Judges Named for CWCL Induction

The College of Workers' Compensation Lawyers (CWCL) announced its class of 2019, 41 attorneys. The College of Workers' Compensation Lawyers has been established to honor those attorneys who have distinguished themselves in their practice in the field of workers' compensation. Members have been nominated for the outstanding traits they have developed in their practice of twenty years, or longer.

Hon. Daniel G. Foote of Indianapolis was appointed to the Indiana Worker's Compensation Board for a four-year term beginning in October 2005 and was recently reappointed to serve a second term. Mr. Foote hears worker's compensation and occupational disease cases in the northeastern district of Indiana and hears administrative appeals with his fellow Board members.

Hon. Neal Pitts is a member of the NAWCJ Board. He practiced workers' compensation and personal injury in Orlando, Florida prior to his appointment by Governor Charlie Crist. He was a member of Phi Kappa Phi; Phi Alpha Delta, Willis Society, and Ohio Northern Law Review, 1977-1978.

(R)Evolution in Medical, from Page 23.

The Circuit Court of Appeal addressed the separation of power complaint. It noted that the new legislative process, of review by the "medical director," was a significantly more rapid process than had previously existed. There was testimony regarding the overarching theme of workers' compensation, an:

> affirmative duty to provide all reasonable and necessary medical treatment and provides that such treatment shall be delivered in an efficient and timely manner.

The court recited the purpose and restraints of delegated legislative authority and separation of powers. It explained legislative delegation, the ability of an agency to promulgate rules generally, and the specific promulgation authority stated in statute. Ultimately, the Court concluded that the OWC Director's adoption of guidelines and procedure were not violative of the separation of powers clause.

Turning to due process, the Court explained:

> Substantive due process may be broadly defined as the constitutional guaranty that no person shall be arbitrarily deprived of his life, liberty, or property.

Focusing on the substantive, the Court concluded that a "claim for workers' compensation benefits" is a "property interest" protected by due process (note this is perhaps a more conclusive statement than the California court's assumption of a property interest). But, the Court agreed with the OWC contention that the regulations and guidelines were

> rationally related to the legitimate government interest of protecting injured workers from undergoing medically unnecessary treatment and doctors from rendering services without compensation.

Thus, the Court concluded the challengers had not proven "that the tacit denial provisions are unconstitutional."

The Court rejected the challengers' claims that the regulations were "fatally vague" and thus a violation of due process. The Court explained that the standard for vagueness is "when a person of ordinary intelligence does not have a reasonable opportunity to know what is prohibited" or a law which does not include "a standard to prevent arbitrary and discriminatory application." The Court concluded that the challengers did not demonstrate the regulations in this instance are "unconstitutionally vague," but conceded that there could be multiple interpretations.

Specifically regarding the process of medical denials being reviewed by the "medical director and thereafter to an OWC judge," the Court addressed the challenger's allegations that procedural due process is not afforded as "an injured worker is not provided an opportunity to be heard at any level." That is, there is no hearing. And, there is no opportunity to "object to information or documents," or any opportunity before the Medical Director to "present evidence, examine witnesses, or be informed as to what information or documents have been submitted to the medical director." This is centered more clearly on confronting evidence.

The Court explained that this challenge was one of "procedural due process." That right is to "be heard at a meaningful time and in a meaningful manner." How much procedural process is "due" is dependent upon the situation; as the Court noted, it is "a flexible standard." The Court concluded that in an "administrative action, the judicial model of an evidentiary hearing is neither required nor even the most effective method of decision making in all circumstances," citing the United States Supreme Court. Some adjudicators and attorneys will express strong feelings about the efficacy of an evidentiary hearing.

The Court concluded the opportunity "to present their case" must be "meaningful," but not necessarily a hearing. It cited the legislative intent and a "rational policy choice by the legislature" to determine medical necessity in advance "to avoid case-by-case disputes and variations and to streamline the process." Some will find the dismissal of that necessity for "case-by-case" antithetical to American liberties and protections. Ultimately, the Court concluded "the private interest affected by the statutory and regulatory provisions at issue is substantial," but that the procedure for medical determinations by the Medical Director was not shown to violate procedural due process. It specifically noted that there is the right to review by an OWC judge that includes the right to present "additional evidence." Notably, in the Louisiana model, the identity of the Medical Director is known. The Louisiana medical decisions at issue are all from that singular director, not from a physician selected from a panel and shrouded in anonymity.

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(R)Evolution in Medical, from Page 24.

Admittedly, the legal standard in the OWC judge review proceeding is "clear and convincing evidence." In Louisiana, "clear and convincing":

> means to demonstrate that the existence of the disputed fact is highly probably, in other words, much more probable than not.

Thus, to prevail on review, a party would have to demonstrate that the Medical Director conclusion is "highly probably" incorrect, or unsupported. This is important because it means a worker faces a significant burden in seeking an OWC judge's alteration of the Medical Director decision. That the burden is heightened does not diminish the due process afforded, but it necessarily implicates the measure of process afforded.

Of note, the same "clear and convincing" evidence standard has been adopted in regards to the opinions of Expert Medical Advisors (EMA) in Florida, *See* section 440.13(9)(c), Fla. Stat., and the California Board review of IMR determinations. The application of that evidentiary standard is a recurring theme in these alternative medical decision-making processes.

The *Barber* Court acknowledged that the challengers did not agree with the procedural process adopted by the Legislature. However, it noted that disagreement "does not establish that the process itself is arbitrary." The medical decision-making process outlined by the Louisiana Legislature was thus upheld by the Court of Appeal as regards all challenges raised in *Barber,* an outcome not inconsistent with the California Court conclusion in *Stevens v. Workers' Compensation Appeals Board.*[25] A notable distinction, however, is that the Louisiana decision is not predicated upon a specific state constitutional provision or "plenary power," as mentioned in *Stevens*.

The singular important point on which the *Barber* Court affirmed the trial court regarded the evaluation of OWC judges' performance and perceptions of interference with judicial independence. The plaintiffs had challenged the Medical Director determination process, but had also alleged that the Office of Workers' Compensation (OWC) performance evaluation process, meetings with judges to "direct OWC judges on how they should rule in certain situations," and "permitting *ex parte* communications from attorneys" violated due process and separation of powers. Though there was testimony that administrators were cautioned not to direct judges as to how they should rule in a case, the Court held that "an independent and honorable judiciary is indispensable to justice in our society." It conceded that OWC judges are not part of the judiciary, but acknowledged their judicial function. Thus, though not patently a separation of powers issue, there existed a potential for an impression of executive effect on judicial determination. The Court stated that due process guarantees require the "essential" element of "an impartial decision-maker."

As such, the Court affirmed the trial court

> judgment permanently enjoining defendants from allowing anyone to attempt to communicate with OWC judges regarding pending workers' compensation claims.

Thus, administrative oversight of the finder of fact, the "non-judiciary" adjudicator, is not wholly precluded. However, the decision-making process of the administrative judge has to be protected from both interference and the implication of interference or imbalance. This is consistent with the fundamental principle of judicial independence, which every adjudicator must individually strive to maintain. The Court, however, did not address administrative oversight of the Medical Director. Nor did it address the potential that ex parte communication might similarly occur between the Medical Director, administration officials, or attorneys.

Thus, in Florida, a debate may soon begin as to implementation of IMR or a similar non-judicial medical decision process. There will be debate of whether and how such a process should be designed and deployed. There will be discussion of California, Louisiana, and possibly other similar efforts. The subjects of due process, confrontation, and evidence will undoubtedly be discussed. The issue will be of interest to the system constituents (employees and employers) as well as a variety of ancillary individuals such as doctors, lawyers, insurance carriers, and more.

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Endnotes on Page 31-32.

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* David Langham is the Deputy Chief Judge of Compensation Claims in Florida.

From the Pages of workcompcentral

Devices to Fight Opioid Crisis get Boost from FDA

By Elaine Goodman
Tuesday, December 4, 2018

New devices intended to help address the opioid crisis - ranging from a digitally controlled pill dispenser to a deep transcranial magnetic stimulation system - may soon be on the market, following their selection as winners of the FDA's opioid innovation challenge. The Food and Drug Administration selected eight devices as winners of the challenge, from a pool of about 250 applications submitted by medical device developers. The challenge winners will receive increased feedback from the FDA's Center for Devices and Radiological Health, guidance for clinical trial development plans, and expedited review.

The selected proposals include devices intended to treat opioid use disorder, detect and treat overdose, dispense medication and treat pain, CDRH said in announcing the winners. Mark Pew, senior vice president of product development and marketing for Preferred Medical, said the "vast majority" of injured workers on opioids are not addicted to the drugs, so devices such as the iPill dispenser, which controls the number of pills dispensed to a patient and was one of the opioid challenge winners, might not have a lot of applicability in workers' comp. "What prevents a patient from taking one pill or the bottle of pills - absolutely nothing!" the company says on its website.

But Pew said other devices that won the innovation challenge, intended to help control pain, may be more interesting for workers' comp. Still, the workers' comp industry isn't known for innovation, Pew said, and so even if the devices receive FDA approval, payers will likely remain reluctant to cover them. Eventually, workers' comp medical treatment guidelines will need to address use of the devices, he added.

But some insurers have been willing to test therapies that may help reduce the use of opioids. The Travelers Cos. announced in March that it is collaborating with Cedars-Sinai on a clinical trial to test virtual reality as a treatment for pain. The trial will look at whether the treatment can reduce pain following an orthopedic injury and help patients return to work more quickly.

A virtual reality device from Silicon Valley-based startup CognifiSense Inc. is among the eight winners of the FDA's innovation challenge. The company says its product differs from other virtual reality therapies in that it doesn't merely distract the user from pain, but specifically targets the brain's "neuroplasticity," or ability to change over time. Another innovation challenge winner was Avanos, for a pain therapy device. The company's website says it makes products to manage surgical pain without narcotics and treat chronic pain with radio frequency techniques.

BrainsWay Ltd. won the opioid innovation challenge for a system that delivers deep transcranial magnetic stimulation, intended to treat opioid use disorder. On its website, BrainsWay says it introduced the first FDA-cleared, non-invasive medical device for treating obsessive-compulsive disorder. That device also uses deep TMS.

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Fight Opioid Crisis, from Page 26.

An opioid prediction service from Milliman was another winner of the innovation challenge. The company has participated in research that looks at demographics, and physical and mental health factors, that were associated with opioid abuse or dependence after patients filled an initial opioid prescription.

The other winners of the innovation challenge were Masimo Corp., for an overdose detection device; ThermoTek Inc., for its NanoTherm and VascuTherm systems; and Algomet Rx Inc., for a rapid drug screen.

The opioid innovation challenge, announced in May, was open to products in any stage of development, from concept to testing. The FDA said it expects the winners will eventually submit formal applications to the agency. "The review of these applications will be expedited to minimize review times," the agency said. "However, patient safety is our No. 1 priority and all product applicants will still be held to the FDA's gold standard and required to meet the applicable standard of safety and effectiveness."

Pew said he could understand the rationale for streamlining the approval process for devices aimed at curbing the opioid crisis. The FDA noted in its announcement that more than 72,000 Americans died last year from drug overdoses, including illicit drugs and prescription opioids. However, Pew said, streamlining product review could circumvent some of the quality control process. "You might not necessarily get a clear picture of what the long-term upsides or downsides might be," he said.

Ideas to combat the opioid crisis previously approved by the FDA include a nerve-stimulation device to reduce withdrawal symptoms. The NSS-2 Bridge device from Innovative Health Solutions Inc. received marketing authorization in November 2017. The small electrical device is placed behind a patient's ear and stimulates branches of certain cranial nerves, potentially relieving opioid withdrawal symptoms such as sweating, gastrointestinal upset, agitation, insomnia and joint pain. In September, Innovative Health Solutions was awarded $200,000 for the device as part of the Ohio Opioid Technology Challenge. Several opioid treatment centers have also started using the device, the company said.

Implications of Affordable Care Act Ruling for Work Comp Debated

By Elaine Goodman
Wednesday, December 19, 2018

Following years of debate over the impact of the Affordable Care Act on workers' compensation, the work comp industry is now considering the flip side of the question after a federal judge in Texas on Friday shot down the law. U.S. District Judge Reed O'Connor ruled that the Affordable Care Act is unconstitutional because Congress eliminated the penalty for failure to comply when it changed federal tax law. Without the individual mandate, the remainder of the ACA can no longer stand, he said.

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Affordable Care Act, from Page 27.

It remains to be seen whether the ruling will be upheld on appeal. The case is expected to wind up at the U.S Supreme Court.

But the ruling is fueling speculation about what impact a repeal of the ACA would have on the workers' comp industry. Some say the ACA has brought benefits to workers' comp that would be lost. "Research consistently finds that the ACA's expansion of health insurance has resulted in workers' compensation insurance paying for less medical treatment than it would otherwise pay for," said Marcus Dillender, senior economist with the W.E. Upjohn Institute for Employment Research in Kalamazoo, Michigan. "Repealing the ACA would likely lower health insurance coverage and lead to workers' compensation insurance paying for more care."

However, the extent of the cost savings from the ACA isn't totally clear, Dillender said. Some evidence suggests that employees with health coverage under the ACA will use their health insurance to get treatment for minor workplace injuries, but still turn to workers' comp for more severe injuries. An overturning of the ACA may also have an impact on medical provider behavior. "In theory, a sudden and unanticipated end to the ACA would likely lead to cost shift into workers' comp," said Robert Hartwig, director of the Center for Risk and Uncertainty Management in the University of South Carolina's Darla Moore School of Business.

Providers would be looking "everywhere possible" to make up for revenues lost if the ACA disappears, Hartwig said, and top targets would likely be workers' comp, Medicaid and Medicare. Although the ultimate fate of the Affordable Care Act remains to be seen, Hartwig noted that the federal individual mandate for health insurance will be eliminated in the new year. This is one reason the take-up rate for ACA coverage is down for next year, he said.

Although the reduction in ACA coverage could have an impact on workers' comp, Hartwig predicted that the effect would be "too subtle to discern," at least in 2019. Joe Paduda, principal of Health Strategy Associates, said he's not expecting any near-term impact on workers' comp from last week's ruling, which he predicted would be overturned by the higher courts. In the meantime, the Trump administration has chosen to continue administering all other parts of ACA. Paduda called the ruling from the Texas judge "ludicrous." "For example, the judge's statement that removing the individual mandate somehow invalidates the entire ACA- everything from Medicaid expansion to drug regulations to clinical outcomes research - is nonsensical," he said.

The Affordable Care Act has done much to "rationalize" the health care system, said Frank Neuhauser, a University of California, Berkeley, researcher. And workers' comp has benefited from the efforts to control cost and utilization in the wider health care system, he said. "These changes would be upended by throwing out the entire law," said Neuhauser, who predicted O'Connor's ruling would not be upheld.

The Property Casualty Insurers Association of America has previously expressed concerns that efforts to dismantle the Affordable Care Act could have a substantial impact on workers' comp. Decreases in the number of people with health insurance due to elimination of the individual mandate is one concern, Trey Gillespie, PCIAA's assistant vice president for workers' compensation, said in June. And "future repeal of the ACA or new amendments to the ACA could result in individuals leaving the private health market and shifting medical costs to government programs and workers' compensation," he said.

The Affordable Care Act withstood a 2012 legal challenge when the Supreme Court ruled 5-4 that the individual mandate was a legitimate exercise of Congress' taxing power. Then, in late 2017, Congress passed a reform package that eliminated the tax penalty for not having health insurance, beginning in 2019. That change to the law sparked legal challenges by conservative state attorneys general, said Edward Fensholt, senior vice president and director of compliance services at Lockton. "In short order, 20 states resurrected the challenge to the individual mandate," Fensholt said in a white paper. "The states' argument was simple: If the individual mandate tax was all that stood between the mandate and its status as an unconstitutional exercise of federal power, and the tax is now gone, then of course the mandate must now fall as unconstitutional."

O'Connor agreed. The judge also concluded that the individual mandate "is essential to and inseverable from the remainder of the ACA," and without it, the ACA must fall. "The federal trial court's ruling presents a very real existential threat to the ACA in its entirety," Fensholt said during a webinar on Tuesday.

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Affordable Care Act, from Page 28.

Fensholt predicted that the case would end up with the Supreme Court, where Chief Justice John Roberts would again be the swing vote on the Affordable Care Act. Fensholt expects Roberts to side with liberal justices in the case, who are likely to decide that the ACA can continue without the individual mandate.

Meanwhile, several states - Massachusetts, New Jersey, Vermont and the District of Columbia - have adopted their own individual mandates for health insurance. The Vermont law takes effect in 2020. And states that have reportedly been considering an individual mandate are California, Connecticut, Hawaii, Maryland, Minnesota, Rhode Island and Washington.

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The articles on pages 26-29, *Devices to Fight Opioid Crisis Get Boost From FDA* and *Implications of Affordable Care Act Ruling for Work Comp Debated* were originally published on WorkCompCentral.com and are reprinted here with permission. The NAWCJ gratefully acknowledges the contributions of WorkCompCentral to the success of this publication and the NAWCJ.

IAIABC Forum

San Diego

April 1, 2019

On Monday, April 1st, 2019, the IAIABC and NAWCJ will be hosting a Judges' Program during The IAIABC Forum 2019 in San Diego, California. This half-day program will feature a comparative law panel with representatives from across the country. Don't miss this chance to share ideas and learn from your peers from other jurisdictions.

Registration for The Forum is now open. Registrants for The Forum are welcome to participate in the Judges' Program. Visit: https://www.iaiabc.org/forum.

A detailed agenda for the Judges' Program along with stand-alone registration will be available soon at www.iaiabc.org.

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Endnotes from 12 Inch Pie, Pages 3-8.

[1] WCMSAs have moved from protologism to neologism, but the terminology is inconsistent. Some refer to WCMSAs as "arrangements," "accounts," or "agreements." They are referred to interchangeably as "WCMSAs" or "MSAs": The lack of consistent verbiage illustrates how WCMSAs were an "aftermarket" creation, used to estimate an unliquidated and contingent potential future statutory obligation.

[2] The MSA allocates a portion of injured workers' compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay. *Aranki v. Burwell*, 151 F. Supp. 3d 1038, 1040 (D. Ariz. 2015).

[3] "Medicare set-asides are prudent in settlements for future medical expenditures in the workers' compensation context." *Sipler v. Trans Am Trucking, Inc.*, 881 F. Supp. 2d 635, 638 *(D.* N.J. 20 12).

[4] *N.Y. Life lns. Co. v. United States*, 190 F. 3d 1372, 1373 (Fed Cir. 1999) (quoting *Health Ins. Ass'n of Am. v. Shalala*, 306 U.S. App. D.C. 104, 23 F. 3d 412, 414 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147, 130 L. Ed 2d 1064, 115 S.Ct. 1095(1995)).

[5] *Frazer v. Transcon. Ins. Co.*, 374 F. Supp. 2d 1067, 1073 (N.D. Ala. 2005).

[6] CNTRS. FOR MEDICARE & MEDICAID SERVS., COBR Q1 2018-V2.7, WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT (WCMSA) REFERENCE GUIDE, § 3.0, 4. (Mar. 19, 2018).

[7] *Id.* at § 17.5.

[8] W.C.A.B. No. ADJS 79864 (Oct. 1, 2010). 2010 Ca. Wrk. Comp P.D. LEXIS 499.

[9] W.C.A.B. Nos. ADJ3845272 and ADJ1335789 (June 22, 2012), 2012 Ca. Wrk. Comp. P.D. LEXIS 320

[10] *Id.*

[11] *Id.*

[12] *Hinsinger v. Showboat Atl. City*, 420 N.J. Super. 15, 17, 18 A. 3d 229, 230 (Super. Ct. 2011).

13 *Id.* at 21-22.

Endnotes from 12 Inch Pie, Pages 3-8.

[14] *Id.* at 20. The current Civil WCMSA Reference Guide provides, "You may not use the WCMSA account to pay for: . . . attorney costs for establishing the WCMSA." *See* Cntrs. for Medicare & Medicaid Servs., COBR Q1 2018-v2.7, Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, § 17.5, 57. (Mar. 19, 2018).

[15] *Supra*, note 12 at 20.

[16] *Id.* at 21.

[17] *Benoit v. MMR Grp., Inc.*, 146 So. 3d 207 (2014).

[18] *Id*. at 209. *But see Pitre v. Bessette Dev. Corp.*, 126 So. 3d 869 (La. App. 3rd Cir. 2013) (granting increase of attorney's fees based on entire work on claim where hearing judge limited award to 20% of lump sum and 20% of WCMSA seed amount but none of WCMSA annuity).

[19] *In re Marriage of Washkowiak*, 966 N.E.2d 1060 (2012).

[20] *Id*. at 1065.

[21] *Williford v. N.C. HHS*, 792 S.E.2d 843, 845 (N.C. Ct. App. 2016).

[22] *Id*. at 853.

[23] *Flores v. Keener*, 302 Ga. App. 275, 275, 690 S.E. 2d 903, 904 (2010).

[24] *Ashley v. Asplundh Tree Expert Co.*, JCN VAOOOO 1055367 (Apr. 4, 2017).

[25] *Id*. at 4.

[26] Va. Code § 65.2-701 (C).

[27] Va. Code § 65.2-7 J4.

[28] Williamson, 0., Transaction Cost Economics: How it Works; Where It Is Headed, DE ECONOMIST Vol. 146, No. 132 (Apr. 1998).

Endnotes from (R)Evolution, Pages 16-25.

[1] *Keeping Workers' Compensation Premiums Low through Independent Medical Review*, Florida Tax Watch, https://floridataxwatch.org/Research/Full-Library/ArtMID/34407/ArticleID/18646/Keeping-Workers-Compensation-Premiums-Low-Through-Independent-Medical-Review; last visited December 18, 2018.

[2] Langham, *The Conundrum of Medical Inflation*, WorkCompCentral, http://workcompcentral.blogspot.com/2018/04/the-conundrum-of-medical-inflation_24.html; last visited December 18, 2018.

[3] Langham, *2017 OJCC Annual Report*, Florida Office of Judges of Compensation Claims, https://fljcc.org/JCC/publications/reports/2017OJCCAnnRpt/OJCC%202017%20Annual%20Report/; last visited December 18, 2018.

[4] Langham, *2018 OJCC Annual Report*, Florida Office of Judges of Compensation Claims, https://fljcc.org/JCC/publications/reports/2018AnnualReport/OJCC%20Annual%20Report%202017-18/; last visited December 18, 2018.

[5] Langham, *A Florida Formulary*, Florida Workers' Compensation Adjudication Blog, December 27, 2016; https://flojcc.blogspot.com/2016/12/a-florida-formulary.html; last visited December 18, 2018.

[6] *Medical Treatment Utilization Schedule*, California Department of Industrial Relations; https://www.dir.ca.gov/dwc/MTUS/MTUS.html; last visited December 18, 2018.

[7] Langham, *supra*, note 3.

[8] *Clinical Practice Guidelines*, National Institute of Health, National Center for Complimentary and Integrative Health, https://nccih.nih.gov/health/providers/clinicalpractice.htm; last visited December 18, 2018.

[9] Medicare, *What Drug Plans Cover*, https://www.medicare.gov/drug-coverage-part-d/what-drug-plans-cover; last visited December 18, 2018.

Endnotes from (R)Evolution, Pages 16-25.

[10] Langham, *supra*, note 4.

[11] *See* Langham, *Another Unconstitutional Statute - and It's not Florida*, Florida Workers' Compensation Adjudication Blog, July 1, 2015; https://flojcc.blogspot.com/2015/07/another-unconstitutional-statute-and.html; last visited December 18, 2018.

[12] *Stevens v. Workers' Compensation Appeals Board*, 241 Cal.App.4th 1074 (Cal. Ct. App. 1st 2015), https://caselaw.findlaw.com/ca-court-of-appeal/1716864.html; last visited December 18, 2018.

[13] California Code, Labor Code - LAB § 4610.6; https://codes.findlaw.com/ca/labor-code/lab-sect-4610-6.html; last visited December 18, 2018.

[14] Section 440.13(9), Fla. Stat.; https://www.flsenate.gov/Laws/Statutes/2011/440.13; last visited December 18, 2018.

[15] Miriam Webster, Plenary: "1: complete in every respect: ABSOLUTE, UNQUALIFIED." https://www.merriam-webster.com/dictionary/plenary; last visited December 18, 2018.

[16] *See AT&T Wireless v. Frazier*, 871 So. 2d 939 (Fla 1st DCA 2004); *Brown v. Pumpian*, 504 So. 2d 481 (Fla. 1st DCA 1987). *See also Miller v. Oolite Industries, Inc.*, 336 So. 2d 1152 (Fla.1976); *Scottie-Craft Boat Corp. v. Smith*, 336 So. 2d 1150 (Fla.1976).

[17] *Barri v. Workers' Compensation Appeal Board*, 28 Cal.App.5th 428 (Cal. Ct. App. 4th 2018), http://www.courts.ca.gov/opinions/documents/G054838.PDF; last visited December 18, 2018.

[18] *See* Langham, *Castellanos is Decided by Supreme Court*, Florida Workers' Compensation Adjudication Blog, April 26, 2016; https://flojcc.blogspot.com/2016/04/castellanos-is-decided-by-supreme-court.html; last visited December 18, 2018.

Endnotes from (R)Evolution, Pages 16-25.

[19] *Barber v. Louisiana Workforce Commission, et. al.*, NUMBER 2017 CA 0844, Louisiana District Court of Appeal, First Circuit, October 18, 2018; (this has not been released for publication yet, and is therefore subject potentially to change); http://www.la-fcca.org/opiniongrid/opinionpdf/2017%20CA%200844%20Decision%20Appeal.pdf; last visited December 18, 2018.

[20] California Department of Industrial Relations, Medical Treatment Utilization Schedule, https://www.dir.ca.gov/dwc/MTUS/MTUS.html; last visited December 18, 2018.

[21] Langham, *supra*, note 11.

[22] *Barber v. Louisiana Workforce Commission*, 221 So. 3d 38 (La. 2017); https://caselaw.findlaw.com/la-supreme-court/1863282.html; last visited December 18, 2018.

[23] Langham, *supra*, note 11.

[24] *Barber v. Louisiana Workforce Commission*, 2016 WL 3150176 (La. 2017)(not designated for publication); https://www.leagle.com/decision/inlaco20160603220; last visited December 18, 2018.

[25] *Stevens v. Workers' Compensation Appeals Board*, 241 Cal.App.4th 1074 (Cal. Ct. App. 1st 2015), https://caselaw.findlaw.com/ca-court-of-appeal/1716864.html; last visited December 18, 2018.

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