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FOCUS ON ARKANSAS LAW

Does an employer have to rehire an injured worker?

By: Catherine Goodnight, Attorney

A client recently posed a question to me that I am sure frustrates a lot of Arkansas employers. This employer had an injured employee who could not return to her previous position at the company due to physical restrictions following her work-related injury. The injured worker wanted to take a different position at the company that she was not necessarily qualified to do, and the employer did not really see her as the best candidate for the job. His questions to me were, "Do I have to create a job for her? And do we have to rehire her?"

In true lawyer fashion, my answer was, "It depends." Unfortunately, in this case, that really is the best and only answer.

There can be recovery for wage loss when an employee cannot return to his or her previous employment. This benefit, or penalty as it were, derives from § 11-9-505(a) (Repl. 2002) regarding wage loss liability that can be imposed upon an employer who unreasonably refuses to return an employee to work when there is work available within the employee's physical and mental limitations. The liability for such wage loss is for a period up to one year, and is paid in addition to other benefits.

However, there is a bit more to it than that. There is a four-part test for seeking additional benefits for wage loss. The burden is upon the injured employee to prove entitlement. The first element is that the injured employee must have sustained a compensable injury, covered under workers' compensation. Second, the employee must show that there is work available at his or her current employer within his or her physical and mental limitations. Third, the employer must refuse to allow the employee to take another available position or job within those limitations. Finally, the employee must show that such refusal

by the employer is unreasonable. While this test is several years old now, it is still the foundation for analysis of unreasonable refusal by an employer and entitlement to this benefit (or penalty) by the employee.

At first glance, this four-part test sounds pretty straightforward. While I'm sure the court intended the test to help more clearly lay out the requirements to allow or even defend a wage loss claim, the analysis is often very fact intensive, with the focus usually falling on the second and fourth elements. What is an unreasonable refusal? How do you determine if work is available for the injured worker to be considered for re-employment? Do you have to create a new position or make special accommodation to put this person back to work at your company?

If you take a step back, the idea behind the statute is not a bad one. We want people to get back to work and to be productive. After all, this is the same statute that addresses vocational rehabilitation. Also, we do not want employers that do not re-employ people simply because of an injury. And let's face it, there are employers who would see an injury as a golden opportunity to let go of a less-than-desirable employee. So what power, if any, does an employer have to refuse to rehire an injured employee when he or she cannot go back to a previous position following injury?

The case law gives us some guidance. A reasonable refusal to hire an injured employee cannot be that someone more qualified applied for an available position. The refusal must have some real factual basis. The statute also, on its face, allows an employer to follow written rules on seniority or a collective bargaining agreement with rules on seniority in determining if work is available for the injured employee.

There also is a rub between availability of work and the element of reasonable refusal that goes to the interplay between the employer and the injured employee. The case law tells us that there must



Catherine Goodnight,
Evans & Dixon Senior Associate

actually be work available at the employer, not just the potential for there to be work in the future or just other positions that the injured employee would like to undertake. Further, if there is work available, the injured employee must be willing to apply

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Brown v. Cassens Transport RICO Case

By Robert N. Hendershot and Michael Karr, Attorneys

Recently, the Federal Court of Appeals for the 6th Circuit allowed RICO claims of several workers' compensation claimants to avoid dismissal and proceed. Some have called this decision "landmark" and "of immense national significance," but how important is it actually? What does it mean for us in Missouri, Illinois and Kansas? And what is RICO?

RICO is a federal law that was initially intended to ease Mafia prosecutions. Although principally a criminal statute, RICO also allows a private citizen harmed by the actions of an organization of defendants to file a civil suit against its members. In order to assert a civil RICO claim, a plaintiff must allege that (1) the defendants participated in the operation or management (2) of an enterprise (3) through a pattern (4) of racketeering activity. Essentially, a RICO plaintiff needs to show that defendants organized together to commit at least two acts that are indictable under numerous state or federal laws.

So how did RICO become an issue in workers' compensation? The Brown Plaintiffs were six former employees of Cassens Transport whose claims had been denied by Cassen's insurer under the Michigan workers' compensation act. They alleged that Cassens, its insurer, and an IME physician had organized to deny them workers' compensation benefits by means of mail and wire fraud. Specifically, they alleged that the insurer deliberately selected and paid unqualified doctors to supply fraudulent medical opinions that would support the denial of workers' compensation benefits, and that they used the mail and telephones to make fraudulent communications with each other in order to set up their scheme.

Initially, this claim was dismissed, with the courts finding that Plaintiffs had failed to meet an additional requirement related

to their allegation of mail fraud – reliance on the defendant's misrepresentations. The dismissals were appealed to the U.S. Supreme Court, but before the case was heard, the Supreme Court issued a decision in another case removing the reliance element.

Based on the Supreme Court ruling, the 6th Circuit Court of Appeals found that the Plaintiff's RICO allegations should not have been dismissed, and their suit could proceed. To overrule the previous dismissal, the Court of Appeals had to find that the Plaintiffs had stated claims making out their RICO case. The Court found that by grouping the allegations of the Plaintiffs, they had successfully pled that Cassens and their insurer worked together over the telephone and mail to deny the Plaintiffs workers' compensation benefits to which they were entitled, through use of their IME doctor's fraudulently produced reports. The Court found that Plaintiffs also had successfully pled how they were wronged by the defendants – they were deprived of their benefits and had to incur attorney fees and medical expenses.

The Court also found that RICO was not preempted by state law. Federal law forbids the application of another federal law from preempting any state law enacted for the purpose of regulating insurance. The 6th Circuit found that Michigan's workers' compensation law was not designed to regulate insurance, but instead was a regulation of the employment relationship designed to replace tort law. Essentially, the Court stated that workers' compensation benefits are not insurance, and thus, Michigan's Act did not regulate insurance.

What does the Brown decision mean? This remains to be seen. The Court of Appeals simply returned the case to the District Court to proceed with the case. Until a trial takes place and the full facts are developed, it is impossible to say what this case means. For now, insurers should take care in their communications with their insured's and with IME physicians. In the meantime, Evans & Dixon will continue to monitor developments in this case. ■

Medicare Is Coming To Your Neighborhood

The SCHIP Extension Act of 2007

By James B. Kennedy, Attorney

In 2001, the Centers for Medicare & Medicaid Services (CMS) began to actively enforce the then already 20-year-old Medicare as Secondary Payer Act. Since the first fateful memo that the Deputy Director issued in July 2001 through the multiple memos that followed, the MSPA has become a major obstacle to the disposition of workers' compensation cases involving claimants who are also Medicare recipients. The need to establish a Medicare Set-Aside trust has become a major cost driver in many cases; most often, but not always, those that involve an allegation of permanent total disability. Thus far, CMS has targeted the workers' compensation

industry almost exclusively but effective July 1, 2009, that will all change.

On this date, the Medicare, Medicaid SCHIP Extension Act of 2007 will require every workers' compensation carrier, self-insurer, liability insurer, including self-insurers and no fault plans, and Group Health Plans to report every settlement or payment to a Medicare or Medicaid beneficiary to CMS on a quarterly basis regardless of the amount of the payment.

These requirements are known as the Mandatory Insurance Reporting (also referred to as Section 111 reporting) provisions of the Act and require every Responsible Reporting Entity to register on a set schedule prior to July 1, 2009. Although a Third Party Administrator can act as an agent to one or more RREs, TPAs are not RREs by definition.



Reporting will be by electronic data transfer between the RRE and the CMS' Coordination of Benefits Contractor through the contractor's secure Web site.

Keep in mind that this reporting contemplates settlements, satisfactions of awards or judgments or other payments to Medicare or Medicaid beneficiaries. However, determining if a particular individual is a Medicare beneficiary may not be an easy task, particularly if CMS ends up not being able to implement its plan of allowing RREs direct query access to CMS to determine a claimant or plaintiff's Medicare status. (Should we mention problems or conflicts with HIPPA on this issue?)

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Defending employers and insurers in Missouri, Illinois, Kansas, and Arkansas.



CASE VERDICTS

Compiled by Michelle M. Symank, Attorney

Jeff Lewis v. DaimlerChrysler

FACTS: In this Missouri workers' compensation case, Claimant sought past medical expenses, temporary total disability, permanent total disability benefits, and future medical care for cervical dystonia. Claimant alleged that in April of 2002, he was working as an assembly floater when an unmanned material cart crashed into him pushing him to the floor. The plant dispensary doctor did not find any objective abrasions, lacerations or bruises during an immediate physical exam. Claimant eventually came under the care of Dr. Gragnani for pain in his neck, low back, left hip, and left foot. Dr. Gragnani found no muscle spasms in the spine and normal range of motion in the cervical spine. Despite employee's claims of cervical spasms forcing his head laterally to the shoulder, in July 2002 Dr. Gragnani noted significant sunburn on both sides of Claimant's neck during an examination. Claimant reported riding his Harley motorcycle the previous weekend. Claimant's cervical and lumbar x-rays and MRIs were negative. He was placed at maximum medical improvement on August 28, 2002. Thereafter, Claimant sought significant unauthorized treatment by way of trigger point and cervical Botox injections (offered through the Mayo Clinic), Percocet and Valium, and was reportedly diagnosed with post-traumatic torticollis. Dr. Gragnani reevaluated Claimant in 2006 and found no permanent injury as a result of the work incident, noting Claimant's complaints were all subjective and nonphysiologic.

FINDINGS: Claimant's non-certified medical-legal reports were excluded from evidence because they did not comply with the requirements set forth in Section 287.210.7. ALJ Hart found Claimant's fleeting changes in his range of motion and ability to ride a motorcycle all weekend were entirely inconsistent with the history offered to doctors and at complete odds with his complaints. She found the numerous caveats in Claimant's testimony made him not credible. ALJ Hart concluded an incident occurred at work, but it did not rise to the level of an "accident" as defined by law. Further, ALJ Hart found Dr. Gragnani's opinions well reasoned and persuasive. Without any credible proof of medical causation, Claimant's request for benefits was denied.

Robert W. Haeckel represented the client, DaimlerChrysler

Michael Huller v. VIP Property

FACTS: In this Missouri workers' compensation case, the claimant sought permanent disability benefits and future medical care. Claimant, a 38 year old laborer, was injured when a two-story wall fell on top of him, pinning him to the ground. He experienced immediate severe back pain. Dr. Strang of Springfield Neurological & Spine Institute diagnosed burst fractures at L1 and L5 requiring surgery. A second surgery was performed to remove the hardware. Following the second surgery, Claimant was provided permanent restrictions, but could return to work full duty. Dr. Woodward, also of Springfield Neurological & Spine Institute, found Claimant reached maximum medical improvement, sustained a permanent partial disability of 18% of the body as a whole, and did not need future medical care. Dr. Koprivica opined in behalf of Claimant he reached maximum medical improvement, sustained a permanent partial disability of 30% of the body as a whole, and felt he would require future medical treatment.

FINDINGS: Although ALJ Wilson agreed with Dr. Koprivica's disability rating of 30% of the body as a whole, he denied Claimant's request for future medical care. He favored the opinions of Claimant's treating physicians and found future medical care was not necessary in order to cure and relieve Claimant from the effects of the injury.

Karen Johnson represented client, VIP Property Management Co. And Missouri Employers Mutual Insurance

Norman Fowler v. Custom Coatings

FACTS: In this Missouri workers' compensation case, Claimant, a union painter, alleged a left elbow injury after lifting a five gallon bucket of paint. Claimant's supervisor testified Claimant told him he hurt his arm when he picked up a bucket of paint, but he had pain in his arm before. At his deposition, Claimant denied any prior problems with his left upper extremity. Following his deposition, Employer/Insurer obtained extensive VA Hospital medical records documenting a history of left lateral elbow and forearm complaints. After reviewing the VA records, both medical experts changed their opinions to find Claimant aggravated a preexisting condition, drastically reducing their ratings of permanent partial disability related to the work injury.

FINDINGS: ALJ Dierkes found Claimant had substantial significant left upper extremity problems prior to the date of injury. He determined Claimant repeatedly lied about the absence of any such prior problems, bringing all of Claimant's testimony into doubt due to his lack of veracity. Based upon the testimony of Claimant's supervisor, ALJ Dierkes found Claimant exacerbated his preexisting extensor tendon rupture resulting in a permanent partial disability related to the date of injury of 3% of the left upper extremity at the elbow. Claimant was only awarded medical expenses associated with the treatment provided by St. Mary's Health Center, the authorized treatment immediately following the injury. All other past and prospective medical expenses were denied.

Elizabeth Shocklee represented the client, Custom Coatings and Amerisure Mutual Insurance Company

James Hanks v. Crawford County Road District #1

FACTS: In this Missouri workers' compensation claim, the employee's widow alleged that her husband's work activities as a mechanic performing brake repairs exposed him to asbestos, causing him to develop asbestosis, ultimately resulting in his death from lung cancer in 2004. Claimant had worked as a mechanic for the County Road district for 21 years. He also smoked approximately 2 packs a day for 20 years, stopping in 1978. The experts agreed that the claimant had pulmonary fibrosis (lung scarring). Claimant's expert, Dr. A. Tepper, testified that pulmonary fibrosis, coupled with a history of asbestos exposure, was sufficient to support a diagnosis of asbestosis. He stated Claimant's work involved significant asbestos exposure and caused the pulmonary fibrosis which contributed to Hanks' lung cancer, respiratory failure, and death. Employer/Insurer's expert, Dr. R. Bruce, disagreed. He testified that, in the absence of a biopsy showing the presence of asbestos fibers in the lung tissue, a diagnosis of asbestosis required additional findings on exam and x-ray consistent with asbestos related disease. The most important of these findings is pleural plaque (thickening of the lung tissue). Dr Bruce testified that it would be extraordinarily unusual to have asbestosis without pleural plaque. Multiple high resolution CT scans of Hanks' lungs showed no such finding. Additionally, Dr. Bruce testified Hanks' CT scans showed rapid progression of his lung disease which was not

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CASE VERDICTS

typical of asbestosis. Hanks had pulmonary fibrosis and pulmonary fibrosis can be caused by asbestos exposure, however, there are other causes of the condition. In the overwhelming majority of cases, the cause of pulmonary fibrosis is unknown. Dr Bruce testified the changes shown on Hanks' scans were much more characteristic of idiopathic pulmonary fibrosis. Finally, Dr. Bruce testified the asbestos fibers Hanks' was allegedly exposed to as a mechanic would have become too small as the result of heat and friction to be retained in the lung and cause asbestosis.

FINDINGS: ALJ Holden denied Claimant's claim for permanency benefits and past medical expenses. In so finding, ALJ Holden found Dr. Bruce, a board certified pulmonologist, more credible. Particularly convincing was Dr. Bruce's explanation why there were insufficient markers of asbestosis in this case. This decision was affirmed by the Labor and Industrial Relations Commission on 11/18/08.

George T. Floros represented the client, Crawford County Road District #1 and Gallagher Basset Services

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for the position and meet all qualifications required of other applicants. The case law also instructs employers that it is not just the claimant who must make an effort in finding available work. Some of the burden falls on the employer. There is at least one case that states that it is not enough for the employer to just notify the claimant of several other lower paying positions available for which the claimant may or may not choose to apply. The employer should make some effort to help relocate the employee within the company if, again, work is available and the employee is willing to apply.

So, does an employer have to create an entirely new position simply to accommodate an injured employee who cannot return to his or her previous position? No. However, if there is a way to re-employ that employee with another position, an effort should be made to get them back to work. An Arkansas employer who has written rules with regard to promotions and seniority and written qualifications for each position within the company, is taking a step in the right direction to protect itself against a claim for additional benefits under this statute. ■

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Medicare Is Coming...

This law is clearly intended to see that no case is handled, and certainly no case is settled, without Medicare's interests being adequately protected. Here "protection" means both the satisfaction of exiting conditional payment claims as well as the coordination of future medical benefits. Also, the Act contains penalties that are in addition to those that are currently contained in the MSPA.

The implications, particularly in personal injury litigation, are staggering. Think, for example, in terms of litigation involving dozens of plaintiffs or multiple defendants, or issues involving apportionment or attribution or policy limitations. However, although MMSEA may turn out to be a paperwork nightmare, the more daunting challenge will be the need now to comply with MSPA in auto cases, product liability cases, toxic tort litigation and medical

malpractice. Indeed any type of case where some company will be called upon to pay some claimant or plaintiff's medical bills, a claimant or plaintiff who also happens to be a Medicare beneficiary.

The bottom line then is that the passage of MMSEA means that the requirement, and the resulting burden, of protecting Medicare's interests will now be spread to all entities that are liable to compensate individuals for personal injuries, liability that includes paying or reimbursing medical expenses which Medicare (or Medicaid) has already paid or for which they would otherwise be liable to pay.

CMS continues to accept inquires and comments submitted to their dedicated Web site www.cms.hhs.gov/MandatoryInsRep. That Web site also contains an ever increasing fund of information on the Act, RRE registration, teleconference events and now the Interim Record Layout information. ■

Hot Off The Press!

Evans & Dixon, L.L.C. Expands into Arkansas

Evans & Dixon L.L.C. has further expanded its Midwest reach by offering services in Arkansas. The firm is extending its legal defense service in workers' compensation to offer assistance and services to a wider clientele base, with plans to add civil liability and labor and employment law in the future. Evans & Dixon attorneys already cover Missouri, Kansas and Central/Southern Illinois and are eager to expand services to the entire state of Arkansas.

"Our attorneys have recently received several requests from clients to represent them in Arkansas," said Greg Godfrey, CFO.

"This announcement is our response to their needs and a continuation of our efforts to expand throughout the Midwest."

For more information:

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Notice something different about our newsletter? We've changed our format and we'd like to know what you think.
Send your comments to: Andrea Shomidie, Marketing Manager at ashomidie@evans-dixon.com or by phone at 314-552-4115

To Our Readers:

As we kick off the new year, I would like to thank all of our clients and friends for their continued support. Looking back at 2008, I am proud to say Evans & Dixon has expanded its efforts and we are offering more services to our clients. In response to our clients needs, we've added a Labor & Employment law practice group. I'm also proud to announce we are now serving clients in Arkansas. Currently our focus in Arkansas is on workers' compensation, but we hope to add Civil Litigation Defense and Labor & Employment law to our list of services offered to our Arkansas clients.

In regards to recent workers' compensation news, we will continue to monitor the progress of the 2005 legislative changes. We have already seen fewer reported injuries filed with the Missouri Division of Workers' Compensation. In the next year, we hope to receive better clarification from the courts on the interpretation of the statute and the constitutionality of the 2005 changes.

In these tough economic times, we understand that now more than ever how important it is for us to be your partner in success. We will continue to find new ways cost-effectively serve you and all of your business needs. Again, thank you for your support.

Best Regards,

Timothy M. Tierney, Partner
Workers' Compensation Practice Group Leader

*“We will
continue to find
new ways
to cost effectively
serve you
and all of your
business needs.”*