New York Appellate Summaries

- Workers' Compensation -

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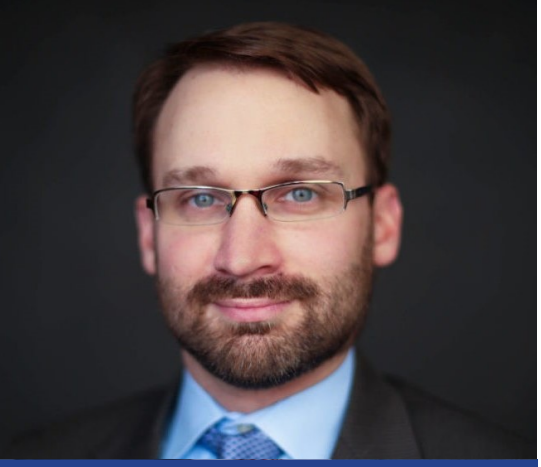

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Cory A. DeCresenza concentrates his practice on workers' compensation litigation, drawing from his significant experience in general and appellate litigation. He has experience handling trials at the New York State Workers' Compensation Board, including lay witness testimony and medical testimony on the issues of accident, notice, and causal relationship; period and extent of disability; entitlement to medical benefits under the board's Medical Treatment Guidelines; and fraud. He has advised clients on all aspects of workers' compensation claims handling and litigation, from inception of a claim (whether controverted or accepted by the carrier) to recommending resolution through settlement or alternative resolution. Cory has also drafted numerous appeals to the New York State Workers' Compensation Board Panel.

Another significant portion of Cory's practice involves drafting appeals and rebuttals to the New York State Supreme Court, Appellate Division, and Third Department appealing decisions over and above the Workers' Compensation Board level.

Prior to entering private practice, Cory was a clerk for the New York State Appellate Division, Fourth Department. He has extensive experience analyzing and writing about the latest rulings, developments, and trends impacting the defense of workers' compensation claims.

RECOGNITION

Upstate New York *Super Lawyers,* Rising Stars 2014-2020

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Recognized as one of the "top 40 under 40" lawyers in New York by the National Black Lawyers in 2019, Bola Awujoola has advised and represented corporate entities and individual clients at various levels of the dispute resolution process. While starting as an in-house counsel for a global corporate services firm, based in Lagos, Nigeria, where he counseled corporate executives and administrators on numerous legal issues, including tax law, regulatory compliance, contracts, and commercial transactions, he has in more recent years focused on providing counsel and representation to clients at all stages of workers' compensation litigation -- from intake to trial and appeal. Thoroughness and passion are the hallmarks of Bola's litigation approach. An approach he has refined in his years of practice at all levels of the Nigerian court system.

Bola's span of experience is extensive and his scope of knowledge is considerable. He graduated with Merit (*magna cum laude*) from Swansea University, Wales where he earned his Master's in International, Commercial and Maritime Law. He also holds a Bar Qualifying Certificate from the Nigerian Law School and a Bachelor of Laws (LL.B) from Olabisi Onabanjo University, Nigeria.

Bola is a member of the Nigerian Bar Association.

RECOGNITION

National Black Lawyers, "Top 40 Under 40" (New York), 2019

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SELECTED APPELLATE CASES FROM THE THIRD DEPARTMENT AND COURT OF APPEALS

We hope you find this summary of the appellate-level cases pertaining to New York Workers' Compensation proceedings for 2021 useful. These summaries are meant to be a carrier-centered review of the appellate cases that act as binding precedent on the Workers' Compensation Board. Garden variety, repetitive, and hyper-specialized cases are not summarized here and it should be noted that all cases have their own individual fact patterns which may impact how or even whether a particular set of statutes or cases apply to a given matter. Consequently, these summaries are intended for general use only and are not intended as legal advice or instruction and you should discuss questions of law with your legal representative.

APPELLATE DIVISION, THIRD DEPARTMENT SUMMARIES

JANUARY 2021

Hamill v. Orange County Sheriff's Department

Topics: Voluntary Retirement, Attachment to the Labor Market, Reduced Earnings

The Holding: Claimant is not entitled to reduced earnings awards based on voluntary retirement.

The Facts: Claimant sustained a 2008 back injury while working as a sergeant supervisor and ultimately retired as a captain in September 2017 (including receipt of a retirement incentive package), alleging that his retirement was in part due to his back injury. The employer maintained that claimant's retirement was voluntary and not causally-related to the disability. The WCLJ found that claimant's retirement was not due to the disability, but found he re-attached to the labor market by working part-time employment in November 2018 as a delivery driver for a medical marijuana company. The carrier appealed.

The Law: Claimants who voluntarily retire must demonstrate that their loss of wage earning capacity is adversely affected by the compensability disability and show their earnings were not caused by factors totally unrelated to the disability. Here, the carrier proved that claimant worked for nine years following his injury and that his decision was motivated by economic factors, including the retirement package. The Court found that, although he claimed that his disability restricted the types of positions available to him after his voluntary retirement, the claim was undermined by the fact that claimant was able to perform the administrative work required of a captain for many years after sustaining his work-related injury.

The Takeaway: In retirement cases, the facts must be carefully analyzed to determine what the primary reason was for claimant's departure from the workforce. In select cases, this may be a determinative factor as to whether a claimants' subsequent return to work (particularly if part-time and with more restrictions) will entitle him or her to reduced earnings.

Jean-Pierre v. Brookdale Hospital Medical Center

Topics: Ingress/Egress, Assault

The Holding: Claimant's assault claim is compensable.

The Facts: Claimant worked at a hospital complex in Brooklyn and after finishing her shift, was assaulted by an unknown assailant 15 minutes after her shift ended after she left the emergency department, crossed Rockway Parkway, and was assaulted on a public sidewalk near the hospital's urgent care center. Following the assault, claimant fell in a grassy area that was part of the hospital complex. The Board focused on the location of the assault "within the employer's multi-building complex" and that she fell onto the grassy area owned by the employer, and thus still on the employer's premises when she was assaulted, such that her injuries occurred within the

precincts of her employment. The Court found that the Board's decision was supported by substantial evidence and affirmed it.

The Law: An assault on an employee after end of shift and during egress from the work site, but while still on any part of the employer's property, may still be compensable.

The Takeaway: The rules on both assault claims and claims arising from injuries on the outskirts of an employer's property are both fact-intensive scenarios which should be thoroughly investigated for facts including the precise start/end time of the work date, location of the accident, and the identity (if known) of all involved – all will factor into the Board's analysis. For example, the outcome might have been different if the motive of the assault was personal to the employee, as opposed to an attack by an unknown assailant or whether the attack occurred further off property.

Sudnik v. Pinnacle Environmental Corp.

Topics: Asbestos, World Trade Center Claims, Causal Relationship

The Holding: Claimant failed to prove a causally-related claim for kidney cancer due to asbestos exposure.

The Facts: The claimant worked as an asbestos handler from 1999-2012 and filed his first claim in 2014 alleging kidney cancer due to asbestos exposure and a second claim in 2017 asserting kidney cancer, PTSD, and depression as a result of exposure to toxins while cleaning ventilation ducts for six weeks in buildings near the WTC site following the 2001 terrorist attacks. The 2014 claim was disallowed and, subsequently, the 2017 claim was established by the WCLJ, but disallowed following Board review. The claimant's treating physician, Dr. Gruscinska, testified that the cancer was related to the WTC exposure, but failed to articulate the factual basis for this determination and did not rule out a 15-year smoking history or the claimant's asbestos exposure in the disallowed claim. An IME which found causation in the Claimant's first claim was considered by the Board and found to be insufficient to establish the requisite causal connection in the second claim.

The Law: The Board is empowered to make factual and credibility determinations which will be upheld by the Third Department if supported by "substantial evidence." The claimant bears the burden of proving a causally-related disability with evidence "supported by a rational basis and must not be based upon a general expression of possibility." In certain circumstances where a claimant's medical evidence is sufficient to establish a claim, a contrary medical opinion may not be requested to disallow a claim.

The Takeaway: While the bar of "substantial evidence" is fairly low, doctors in testimony should be held to the task of explaining with some specificity the basis of their opinion on causal relationship, particularly when there are other plausible explanations for an injury or illness. WCLJs will sometimes establish a claim because an IME doctor "concedes" causation but sometimes, as here, carriers are able to argue that an IME report which does not properly explain the theory of causation will still be insufficient to establish a claim.

Lewandowski v. Safeway Environmental Corp.

Topics: World Trade Center Claims

The Holding: The Board properly disallowed claim for COPD, but erred in failing to set the date of disablement at the "most beneficial" date per WCL Section 164.

The Facts: In 2002, claimant was a union asbestos worker who participated in cleanup operations. He was advised by a union doctor in 2004 that he had lung, stomach, and psychiatric issues as a result of that work and continued to work with the union until 2015 when he stopped working due to panic attacks triggered by observing steel I-beams. He filed a claim alleging multiple issues and PFME was found for COPD, GERD, and PTSD. The claim was initially disallowed by the WCLJ on the basis of the carrier's IME finding no causal relationship and claimant's limited work at the WTC site. On appeal in 2016, the Board modified, finding no causally-related COPD, establishing GERD, and remanding for further development on Article 8-A and PTSD.

Subsequently, in a 2017 reserved decision, the claim was established for GERD and PTSD with a date of accident of July 1, 2002 (last date worked in cleanup operations) and April 27, 2009 date of disablement (first documented treatment). Average weekly wage was set without prejudice. The Board later rescinded the establishment of PTSD without prejudice and established for agoraphobia with panic disorder and set AWW based on the April 27, 2009 date of disablement. Following further proceedings over the course of two years, PFME was again found for COPD based on a report from the same doctor who diagnosed that condition and both COPD and PTSD were established. Claimant additionally applied to re-set date of disablement to December 4, 2015 (first finding of a causally-related disability) and to modify average weekly wage, although both requests were declined. Both parties appealed those decisions, with the carrier maintaining that COPD should not have been established as the issue was previously decided on substantially the same evidence and claimant maintained that average weekly wage should have been re-set. On administrative appeal, the Board agreed with the carrier and disallowed the COPD claim as the records offered no further explanation on causal relationship than when the COPD claim was first disallowed and declined the application to reissue average weekly wage.

The Law: Regarding disallowance of the COPD, the Board's credibility call on the weight of medical evidence will be entitled to credit where it is supported by substantial evidence and the claimant's argument that a finding that there was no causal relationship to COPD was not tantamount to a disallowance was without merit. However, the Board should have entertained claimant's application to reopen the issue of date of disablement and average weekly wage. Per WCL Section 146, the Board is statutorily required to select the date of disablement in WTC claims that is "most beneficial" to the claimant and the Board appeared not to have considered the statutory mandate. Here, AWW was initially set without prejudice, creating no bar to revisiting the issue. Consequently, the matter was remanded for further development on date of disablement and AWW.

The Takeaway: WTC claims are much trickier on average on nearly every issue, including dates of accident/disablement, causal relationship, average weekly wage, and accident/occupational disease. When taking a history on WTC claims, obtain all possible information on claimant's

rescue, recovery, and cleanup operations, subsequent work history, and medical history as any or all of these histories may impact the primary issues. The Board's authority is statutorily circumscribed on the issue of date of disablement.

FEBRUARY 2021

King v. New York City Parks and Recreation

Topics: Procedural Issues, Appeals; Section 123

The Holding: The WCLJ's decision to reverse a prior finding that Section 123 applied was rejected as the Board, not the WCLJ, is vested with the power to modify or rescind an award or decision.

The Facts: Claimant had a 1996 right knee injury for which he received awards until June 1997. Knee surgery was authorized in 1998, but claimant failed to appear at a hearing in 2000 and the file was marked NFA in 2002 when claimant never secured updated medical evidence. Knee surgery was again authorized in 2017 and claimant underwent the surgery on September 8, 2017. Claimant sought awards, but the carrier challenged the same based on Section 123. The WCLJ found that there was a true closing in a December 13, 2017 decision and denied indemnity. The Board Panel in an April 16, 2018 decision denied review as the RB-89 form was incomplete and noted that the December 13, 2017 decisions "REMAINS IN EFFECT." No appeal was taken to the Full Board or Third Department. Subsequently, in May 2018, the matter returned to calendar to address a variance denial and the WCLJ rescinded his December 13, 2017, found there was no "true closing" as surgery was an "open issue" and directed post-surgical awards. On administrative review, the Board found that the WCLJ lacked authority to rescind the decision as it was the Board, and not the WCLJ which had the authority to modify the decision.

The Law: Decisions of the WCLJ are deemed the decisions of the Board unless the Board modifies or rescinds such decision under Section 150(b). In denying review, the WCLJ's December 13, 2017 decision became the Board's decision and under Section 23, an award or decision is final unless modified on appeal. Claimant was permitted to appeal the Board's decision denying review of his application to the Full Board or Third Department, but failed to do so. In these circumstances, the WCLJ's decision became the decision of the Board. Additionally, only the Board has continuing jurisdiction to modify or change an award or decision "as in its opinion may be just" and the WCLJ has no such corresponding authority.

The Takeaway: This case implicates the rarely occurring provision under Section 123 that if the date of the accident is over 18 years old, it has been 8 years since the last indemnity payment, and the case is "truly closed," all further indemnity may be barred. Moreover, the case demonstrates that a WCLJ's power to revisit prior findings is limited by the Board's rules and decisions implicating modifications of decisions that were not specifically designed to be "without prejudice" or "held in abeyance."

Grimaldi v. Suffolk County Department of Health

Topics: Average Weekly Wage, Permanency, Concurrent Awards

The Holding: The Board erred in using the lower AWW from a 2008 SLU claim in calculating the PPD award in claimant's higher average weekly wage claim from 2007.

The Facts: Claimant, a CNA, sustained a right hip/right ankle claim in 2007 and the claim was later amended to include the low back. While working for a subsequent employer in 2008, claimant sustained a compensable right knee injury. Liability was apportioned equally between the 2007 and 2008 injuries. In 2014, claimant was found to have a 75% PPD/LWEC in the 2007 injury, a 10% SLU of the right leg in the 2008 claim, and that apportionment terminated as of December 23, 2013 at which time the 2007 claim was fully liable for awards in the 2007 claim. Average weekly was $944.19 in the 2017 claim and $533.40 in the 2008 claim. On appeal, the Board applied the lower AWW from the 2008 claim to the PPD award in the 2007 file.

The Law: The wage earning capacity of an injured worker in cases of TPD or PPD shall be determined by actual earnings, but where the claimant has more than one claim, each of the carriers is liable for its portion of the award based on the wage, if higher, received by the claimant at the time of the latest injury – however, if the wage at the time of the first injury is higher than that in the second injury claim, awards are calculated by using the wage earned at the time of each injury, subject to the apportionment percentage. Here, the 2008 claim was closed on the 10% SLU with apportionment terminated effective in 2013; consequently, under these circumstances, the Board erred in using the AWW from the 2008 claim.

The Takeaway: Claimants with multiple active files pose potentially problematic issues in connection with apportionment, awards, and assessment of average weekly wage. Information is key in these claims, particularly if the multiple claims are among multiple different employers/carriers – in those cases, OC-110a forms should be obtained allowing access to the same to allow for review of AWW and to allow for easier access to medical records in connection with permanency IMEs.

Hughes v. Ferreria Construction Company

Topics: Section 114-a Fraud

The Holding: Assessment of Section 114-a penalties including mandatory penalty and discretionary penalty affirmed.

The Facts: In 2017, claimant was a flagger at a construction site when she was struck by a motor vehicle, sustaining injuries to her neck and back. PFME was found for a concussion, post-concussion syndrome, and the left shoulder with IME and development of the record directed. The carrier raised Section 114-a during the course of the litigation, the Board found no violation of Section 114-a and amended the claim to include the left shoulder and post-concussion syndrome. On administrative appeal, the Board modified, finding: that the left shoulder and post-concussion syndrome were properly established; that there was no remaining causally-related disability for those sites; that there was no further causally-related disability for the neck or back; and that claimant violated Section 114-a resulting in mandatory penalties and a discretionary penalty barring her from all further indemnity benefits. The Section 114-a finding was supported by the

fact that claimant failed to disclose a 2010 neck and back injury, multiple doctors' findings that symptoms did not match the clinical findings (including a facial droop that resolved on claimant's distraction, an unexplained left foot drop, though claimant was seen dragging her right foot at an examination), and exaggerated claims of numbness and weakness.

The Law: Regarding the issue of further causally-related disability, the Board was entitled to credit the IME of the carrier finding the same and the claimant's treating neurologists' opinion that the post-concussion syndrome has resolved. Regarding Section 114-a, mandatory and discretionary penalties may be assessed for false statements or representations as to a material fact, including exaggeration of symptoms or injuries and the giving of false injury/symptom histories.

The Takeaway: While the causal relationship issue here is run-of-the mill albeit affected by the fraud claim, the more interesting issue is Section 114-a. Over the last few years, carriers have seen mixed success at the Third Department regarding Section 114-a fraud as this is an issue within the Board's considerable discretion. This claim certainly seems to represent a high point of symptom exaggeration coupled with a failure to disclose a pertaining prior claim. To the extent that commonalties may be taken among fraud claims addressed by the Third Department, where the Board's decision is more detailed in documenting the rationale for heightened Section 114-a penalties, the odds of the penalty being overturned are lesser.

Storms v. BOCES Erie No. 1

Topics: Employer Reimbursement of Indemnity

The Holding: Employer waived right to reimbursement for wages paid.

The Facts: Claimant sustained a compensable injury on March 22, 2018 and remained out of work at an October 22, 2018 hearing. The employer disputed the claim, but continued to pay claimant's wages for a period of time before the hearing. At the hearing itself, the claimant was awarded benefits at a temporary partial disability rate from March 23-October 22, 2018 "with credit to the employer for any wages paid." The claimant after the hearing filed a letter indicating that his attorney was unaware until after the hearing that there was no reimbursement request and claimant's counsel filed a request for an amended decision. Both parties appealed and the Board modified, finding that the employer did not file a timely reimbursement request and waived any right to reimbursement. In this case, neither the C-11 nor the SROI-EP constituted a sufficient request for reimbursement and mere notice to the board that "full wages are being paid" is insufficient.

The Law: Under 25(4)(a), if an employer has made advance payment of compensation, it is entitled to reimbursement out of an unpaid installment or installments provided that the reimbursement claim is filed before the award is made and may be lost if the claim is untimely. While oral request for reimbursement at a hearing may be enough in some cases, relying on a C-11 or SROI-EP alone invites potential waiver of reimbursement.

The Takeaway: The best strategy to secure reimbursement is, before any awards are made or in response to a first proposed decision addressing awards prior to a hearing, to file a separate

correspondence on employer letterhead requesting full reimbursement under Section 25 of the workers' compensation law, setting out the dates of payment, weekly rates of payment, and total amount paid to memorialize the request. The Board also has a Form C-107 that can be used to request reimbursement to the employer.

Sharipova v. BNV Home Care Agency, Inc.

Topics: Accident Arising Out of and in the Course of Employment

The Holding: Board reversed, claimant found to have sustained an accident arising out of and in the course of employment.

The Facts: Claimant was a live-in health attendant providing 24 hour per day care to one client. She alleged that on October 29, 2019, she escorted her client in a wheelchair for a walk. It was not uncommon for claimant to take her client on 4 to 5 hour walks where the client had no scheduled appointments. During the walk, claimant stopped at her personal physician's office to pick up paperwork required by her employer to confirm whether the doctor would accept the client's medical insurance. On exiting, the claimant slipped and fell on the wheelchair ramp, sustaining injuries. The WCLJ initially established the claim, finding it was a momentary deviation from route work duties. The carrier appealed, and the Board reversed, agreeing with the carrier's contention that it was a purely personal pursuit in violation of the employer's alleged protocol prohibiting personal activities during work-hours and that claimant's testimony that there were two purposes to the trip should be discounted.

The Law: Generally, to be compensable, injuries must both arise out and in the course of employment, meaning that the risk must be connected to the employment, flowing from it as a natural consequence and occur during the claimant's work activity. A purely personal pursuit not within the scope of employment may be exceeded, but the test is a fact-based analysis as to whether the activity is "reasonable and sufficiently work related." Here, the evidence adduced (i.e. the employer witness was not informed that claimant had a mixed purpose for going to the doctor and no answer as to whether the claimant was able to take personal time given the 24-hour per day assignment) was insufficient to show a deviation from employment.

The Takeaway: Deviations from employment are purely fact-driven scenarios. The more a claimant can show that the alleged deviation was tied to a work-related purpose, the higher the chances of the claim being established or affirmed on appeal.

Peck v. The Donaldson Organization

Topics: Section 114-a Fraud

The Holding: Finding that claimant violated Section 114-a and discretionary penalty of a lifetime bar on indemnity benefits affirmed.

The Facts: Claimant sustained a 2013 low back injury and underwent surgery in 2015 at which time he was deemed unable to work. In January 2018, permanency was put off as claimant was

considering a spinal cord stimulator trial. In November 2018, the carrier raised Section 114-a citing video evidence. The evidence showed claimant shopping and pushing a full grocery cart, using a self-checkout kiosk, loading a car, loading grocery bags, shoveling snow and using a roof rake to clean snow off his house, and performing construction related tasks (carrying lumber and a ladder, using a screw gun, hammering, installing roof flashing, and climbing up and down a ladder). The WCLJ initially found no Section 114-a violation based apparently on claimant's admission that he was the person depicted in the video and claimant's testimony that he did this work in 15-30 minute intervals as supported by pain medication. The Board reversed and imposed a lifetime indemnity ban as claimant's presentation in the video was inconsistent with his presentation to physicians, including limping and using a cane, the doctors' assessments he was unable to "lift, push, or pull," and the carrier's IME found that claimant was exaggerating his symptoms.

The Law: Section 114-a provides for mandatory and discretionary penalties where a false statement or representation as to a material fact is made, including feigning of a disability or exaggeration of symptoms. The Board's fact-finding power is broad regarding Section 114-a will be affirmed when supposed by "substantial evidence." Here, the Board's determination that claimant's misrepresentation of his physical capacity was significant enough to warrant penalties was supported by the video.

The Takeaway: What constitutes fraud in terms of misrepresentation of physical ability is always a fact-specific scenario depending on an analysis of claimant's pre-injury capabilities, post-injury activities, and post-injury medical reporting. The greater the disparity between what claimant's medical records appear to show claimant's residual capacity and what surveillance video shows, often the higher chances of obtaining a Section 114-a finding and significant penalties.

Clancy v. Park Line Asphalt Maintenance

Topics: Occupational Disease, Pre-Existing Conditions

The Holding: Board's decision reversed, claimant sustained a compensable aggravation of a pre-existing condition.

The Facts: In 2000, claimant was diagnosed with bilateral carpal tunnel syndrome and herniated cervical discs. Subsequently, she received SSD benefits for her neck condition at it was deemed permanently and totally disabling. Claimant underwent a series of neck surgeries starting in 2003 and carpal tunnel surgery in 2006. Claimant ultimately returned to work for the employer of record full time in 2006 as an office manager, which required extensive typing. Claimant continued to treat for her neck and carpal tunnel conditions in 2011, 2013, 2014, and 2017 and returned to work with light duty restrictions. Claimant filed a claim in 2018 for the hands and neck, alleging that her symptoms began worsening in 2016 and she stopped working in June 2018 as her doctor advised that her job could be the cause of worsening symptoms. During development of the record, claimant's treating physicians opined that claimant's job duties were exacerbating her condition and the IME (who was unaware of claimant's job duties) testified that her conditions were pre-existing and unrelated to work. The WCLJ disallowed the claim as the condition was pre-existing and disabling. The Board upheld, finding that that although claimant was able to work at her pre-

injury job, she was unable to perform work at any and all employment such that claimant must have had some degree of disability.

The Law: To establish an occupational disease based on aggravation of a pre-existing condition, it must be shown that the condition was "dormant and nondisabling" and that a distinctive feature of claimant's employment exacerbated the condition so as to cause disability which did not previously exist. In this particular case, none of the restrictions placed on claimant during the pre-claim surgeries actually prevented her from her work. Consequently, the Board erred in finding that the condition was "disabling, in a compensation sense, prior to the date of disablement" and the fact that claimant was generally symptomatic prior to the return to work was insufficient reason to bar the claim.

The Takeaway: Obtaining apportionment or disallowances to pre-existing condition in the New York workers' compensation arena is difficult. Even on a seemingly favorable fact pattern (numerous surgeries impacting the same sites of injury claim and light duty restrictions), the Third Department still found a compensable disease on the basis that claimant's individual job duties were not impacted, even though claimant's capacity to work in the greater job market in general clearly appears to have been impacted. To set files up for the best chance of success on apportionment or disallowance based on prior conditions, particularly in occupational disease claims, obtain a full history of claimant's prior medical condition and obtain a detailed IME on the issue supported by all obtainable prior records and description of claimant's past and current work activities.

Green v. New York City Department of Correction

Topics: *Genduso*, Permanency

The Holding: Claimant's award for SLU attributable to elbow precluded by greater SLU award for the shoulder.

The Facts: Claimant had a 2016 claim for the right shoulder injury resulting in a 17.5% SLU for the arm. In 2017, he had a right elbow claim for which competing permanency reports opined a 15% SLU or 7.5% SLU for the right elbow. In further proceedings, the WCLJ concluded that either the 15% or 7.5% SLU for the elbow were lesser than the 17.5% SLU for the arm and that no further permanency award was due. The decision was affirmed by the Board.

The Law: Under Section 15(3), the Board may make permanency/SLU awards to certain enumerated body parts and an SLU is an award for the permanent physical and functional impairment to the extremity. Compensation for impairment to separate parts of the same member are reflected in the overall SLU. Here, the elbow and shoulder are both parts of the same member, the arm. Consequently, given that the elbow SLU opinions are both less than the 17.5% SLU of the arm, no further awards are due.

The Takeaway: The Third Department has issued a string of decisions affirming the 2018 *Genduso* decision. Following that case, it is more important than ever to secure information regarding prior

claims involving the same appendage (such as the knee/hip, shoulder/elbow) to review whether credit may be taken for prior permanency awards.

Neely v. New York City Department of Correction

Topics: *Genduso*, Permanency

The Holding: Claimant's prior SLU awards for the arm and leg yield an offset against a subsequent permanency award for the same site of injury.

The Facts: Claimant had a 2014 claim for the left knee and left shoulder for which he received a 20% SLU of the arm and a 15% SLU of the left leg. In December 2017, claimant had another injury involving the left shoulder, left knee, and left ankle and by agreement, claimant was awarded an additional 3.75% SLU of the arm and 5% SLU of the left foot. Claimant had his third claim in June 2017 in between those two claims impacting the left shoulder, left elbow, left wrist, left hand, and left hip and was found to have a 10% SLU of the left arm and 15% SLU of the left leg for that claim. The Board concluded that he was not entitled to any additional SLU award based on the prior SLU's/*Genduso*.

The Law: As in *Genduso*, and *Green*, successive SLU's involving the same appendage (i.e. hip/knee are part of the leg, elbow/shoulder are part of the arm) will result in the carrier potentially liable for the subsequent permanency award entitled to a credit.

The Takeaway: In cases where a claimant has received a prior permanency award, it is recommended to obtain access to those files to determine whether a credit may be taken for prior permanency awards.

Chrostowski v. Pinnacle Environmental Corporation

Topics: Section 28, Occupational Disease

The Holding: Date of disablement improperly set and modified to first medical report discussing causal relationship of claimant's occupational disease to work activities.

The Facts: Claimant, an asbestos handler, alleged repetitive stress injuries to the left shoulder, both wrists, and both knees in January 2018. The Board initially disallowed the claim as time-barred setting date of disablement as March 17, 2009 finding that claimant knew or should have known that his condition was causally-related to his employment. While the medical reports filed showed that claimant's respiratory conditions were related to his work at the World Trade Center site for which a separate claim was filed, that claimant had progressive neck and back pain, and certain symptoms pertaining to the neck and hands were noted, none of the reports discussed causal relationship until January 2018.

The Law: Generally, a claim for an occupational disease must be filed within two years of the date of disablement and after the claimant "knew or should have known" that the disease was due to work and the Board is vested with significant latitude in determining date of disablement.

The Takeaway: The Board has over the recent years eroded the "should have known" portion of Section 28 and has often found date of disablement effective at the first date of a medical report tying the occupational disease to claimant's work activities. Full discovery of prior treatment (if any) is recommended in any OD claim.

Quigley v. Village of East Aurora

Topics: Pain Management, Medical Marijuana

The Holding: Variance for medical marijuana granted.

The Facts: Claimant was a police officer with two claims – one involving a concussion and the right shoulder, elbow, and wrist, and the other involving his low back. Claimant was subsequently diagnosed with CRPS of the right arm and found permanently partially disabled with liability appointed between both claims. Over time, claimant treated with opioid medications but in 2018, his provider certified him for use of medical marijuana in connection with Public Health Law, Article 33, Title V-a (the Compassionate Care Act). Consequently, the provider filed an MG-2 for medical marijuana. The WCLJ and Board approved the MG-2 and directed the carrier to pay for treatment. The carrier appealed, arguing that marijuana was a controlled substance regulated by federal law and that the Compassionate Care Act was pre-empted.

The Law: The requirement that a carrier be directed to pay for medical marijuana does not require the carrier to manufacture, distribute, or possess marijuana, but to reimburse claimant for the monetary costs associated with the same and does not subvert federal anti-drug agenda. Moreover, the carrier's argument that it would be potentially exposed to criminal or civil liability for "aiding and abetting" drug use was unavailing. Nothing in Public Health Law 3368(2) prevents the Board from requiring carriers to issue payments to claimants and the claimant's medical evidence detailing claimant's symptoms and other modalities of treatment warranting authorization of the medication.

The Takeaway: Given the Third Department's 9-page decision, this summary is but a brief review of the arguments made therein. The Third Department's rejection of the federal law and analogous state law prescriptions pertaining to marijuana signal that New York is joining the growing national trend to legitimize medical marijuana as an available treatment option and as New York moves towards legalized possession of cannabis, it is worth monitoring the rise of medical marijuana as a treatment option in lieu of other modalities or medications.

MARCH 2021

Maldonado v. Doria, Inc.

Topics: Causal Relationship

The Holding: Substantial medical evidence supports the finding of causal relationship.

The Facts: Claimant had a 2018 injury involving the left ankle while descending a staircase at work. During treatment, he was fitted with a boot and elastic supports. While at home approximately a month later, he had syncope, shortness of breath, and chest pain. He was diagnosed with a pulmonary embolism/DVT of the lower left extremity and hospitalized for 22 days. The claim was amended to include the PE/DVT as related. Subsequently, further proceedings were conducted on the issues of major depression, post-traumatic stress disorder, and cardiac arrest with the claim established for all three conditions. The carrier appealed the cardiac arrest finding, arguing that cardiac arrest should be narrowly defined as synonymous with death and that the WCLJ improperly used a broader definition of a sudden loss of blood flow resulting from the heart's failure to pump.

The Law: To prove causal relationship, the claimant must prove through competent medical evidence causal relationship between the injury and his employment and the determination will be affirmed if supported by substantial evidence. In essence, the Board's use of one definition of cardiac arrest against another was more or less academic as there was sufficient medical evidence that the PE/DVT resulted in cardiac issues requiring the treatment.

The Takeaway: The case serves as an example of the Board's wide latitude in determining issues of causal relationship and the Third Department's review standard of substantial evidence. While a full defense was warranted given the circumstances and given the potential liability for subsequent cardiac issues and the specter of a potential consequential death claim (all spiraling out of an ankle claim), the issue of causal relationship is difficult to overturn on appeal at any level.

Behan v. Career Start, Inc.

Topics: Permanency, Loss of Wage Earning Capacity

The Holding: Findings of permanency and 60% PPD/LWEC affirmed.

The Facts: In 2013, claimant was a maintenance mechanic and sustained a right inguinal hernia while lifting a heavy object. In 2018, permanency proceedings were directed and ultimately, following claimant's testimony, he was assessed with a 60% PPD/LWEC, sedentary work capacity, and a date of permanency as the date of the hearing resolving the issue of permanency. The PPD/LWEC finding was supported by an IME finding that claimant was at MMI, had a moderate-to-marked physical impairment, and had a sedentary work capacity wit a 10 lb. lifting limit along with claimant's testimony that he was 57, was a lifelong machine maintenance person, had an HVAC certification and some technical school training, basic computer skills, ability to drive, and ability to perform light duty housework.
The Law: In cases where PPD/LWEC is applicable, the Board must determine LWEC by reviewing the nature and degree of the impairment along with claimant's functional capabilities and vocational history (including age, education, training, skills, and English proficiency). Here, the Board was free to credit the evidence that he had a residual sedentary work capacity. Moreover, while the pro-se claimant wished for permanency to commence effective the first date of permanency, the Board did not err in setting the date of permanency at the hearing at which permanency was resolved.

The Takeaway: PPD/LWEC determinations are inherently-fact based turning on analysis of the claimant's specific functional and vocational history, the injury sustained therein, and even the geographic location of the claimant given the relative work available in the locale where claimant was injured. Obtaining claimant's job application/resume and any other information from the employer prior to permanency proceedings may help to guide questioning in this area and practitioners should explore all potentially beneficial PPD/LWEC topics during permanency proceedings to secure the best possible outcome if a stipulation or settlement cannot be reached.

Ranieri v. Xerox Corporation

Topics: Section 114-a Fraud

The Holding: Board's rescission of a lifetime discretionary ban on indemnity affirmed.

The Facts: Claimant had a 2016 work related injury involving both shoulders. In 2018, the carrier raised the issue of Section 114-a fraud based on a failure to report a return to work. Claimant was found to have snowplowed several driveways on February 7, 2018. The truck belonged to a landscaping business that claimant previously worked for and whose owner was a friend. Claimant testified that the owner let him use the truck as a favor in exchange for claimant plowing the driveways of people who had contracts with the owners' business. Despite that work, claimant responded on a March 21, 2018 questionnaire that he had not worked for the last 6 months. Claimant maintained that it was not fraud as claimant was "doing it to repay a favor and not getting paid for it." The WCLJ assessed both a mandatory penalty and a discretionary penalty of all future indemnity. The Board modified, finding that the discretionary penalty was unwarranted.

The Law: The imposition of a discretionary penalty on Section 114-a is within the Board's discretion and the determination will only be overturned if the Board abused its discretion as a matter of law.

The Takeaway: In addition to the imposition of Section 114-a being within the Board's discretion, the imposition and severity of the discretionary portion of a fraud penalty is also a finding to which the Third Department will generally defer. Here, given that claimant was apparently not being paid for the work being done and potentially based on the fact that the work being performed was largely sedentary, the Board declined to issue a lifetime Section 114-a indemnity bar.

Holness v. City College

Topics: Ingress/Egress, Accident Arising Out of Employment

The Holding: Claimant's injuries did not arise out of and in the course of employment.

The Facts: Claimant was a laborer who performed tasks on a college campus. On June 21, 2018, following completion of his shift, he was walking along a public sidewalk 160 yards from where he clocked out in front of an administration building when he struck his foot on a raised piece of concrete, resulting in injuries to the foot and toes. The claimant testified that the employer maintained the location of the fall, but no evidence was presented that the route chosen by claimant

served a business purpose or was a recommended route of egress. The WCLJ established the claim, but the Board reversed.

The Law: Generally, accidents occurring outside of work hours and in public areas away from the workplace are not compensable and, under the "going and coming" rule, injuries occurring while traveling to and from work are not compensable. However, where the injury occurs while near the employer's area, there is a "gray area" where the risks of street travel merge with the risks of employment. Where injuries occur in such an area, the injury could be compensable if (1) there was a special hazard and (2) there was a close association of the access route with the location permitting the "conclusion that the accident happened as an incident and risk of employment." Here, the Board's determination that there was no special hazard incidental to claimant's employment or evidence that the employer recommended use of the walkway was supported by substantial evidence.

The Takeaway: Ingress/egress cases turn on a variety of factors including how far the injury occurred from the employer's premises, the nature of the risk, who maintains the area where claimant fell, and whether the employer recommended, encouraged, or obtained benefit from use of the ingress/egress area. On receipt of any claims for injuries arising at the edge of or just beyond the employer's premises, obtaining this information is necessary to build a successful defense.

Abdallah v. New York City Transit Authority

Topics: Section 18 Notice

The Holding: Determination that claimant did not timely report an injury affirmed.

The Facts: Claimant alleged that he suffered an August 17, 2018 knee injury when someone bumped into him while descending a staircase in the building where he worked. Claimant's job responsibilities included controverting workers' compensation claims on behalf of the employer such that he was aware of the 30-day notice requirement. He first sought treatment four days later and two subsequent notes did not mention that the injury was work related. He did not give written notice until October 15, 2018 and did not file his claim until November 19, 2018.

The Law: Under Section 18, a claimant must generally give written notice of the claim within 30 days, though late notice can be excused by the Board on some grounds, including where, among others, notice could not be given, the employer or its agent had knowledge of the accident, or the employer did not suffer any prejudice. The Board is not required to excuse a claimant's failure to give timely written notice even if one of these grounds is proven; the matter rests within the Board's discretion. The claimant's argument here that he did not think the injury was "serious" enough to warrant reporting was unavailing, especially since contemporaneous medical reports did not record any history of a work accident.

The Takeaway: The Section 18 defense of 30 days' notice of an injury is fraught with gaps and loopholes for claimants to avoid this statutory requirement. However, any injury in which the employer indicates that more than 30 days elapsed between the injury occurrence and reporting should be thoroughly investigated for this possible defense. Importantly, medical records of

contemporaneous treatments should be investigated and obtained to cross-reference with the claimant's claim and testimony.

Morales v. Lopez and 271 Realty

Topics: Accident Arising Out of and in the Course of Employment

The Holding: Board's decision to disallow claim affirmed.

The Facts: Claimant alleged that on August 11, 2017 he fell while performing work and injured his left hand, left wrist, and left leg. Claimant's initial medical notes, however, indicated that his pain started due to falling on uneven pavement in the street prior to arrival which contradicted later medical records about the occurrence of the injury. The WCLJ disallowed the claim finding that claimant was incredible and the Board affirmed, additionally rejecting the claimant's attempt to submit a notarized statement of an alleged co-worker who saw the fall.

The Law: Regarding credibility on the accident itself, the Board is vested with substantial discretion to credit the claimant's or carrier's evidence and there was no abuse of discretion evident in this case. Similarly, the claimant offered no sufficient excuse as to why the sworn statement could not have been submitted before the WCLJ's decision.

The Takeaway: While credibility is a call often made in favor of claimants at the Board level, obtaining a full accounting of claimant's medical history is always recommended as prior conflicting evidence of a mechanism of injury can be used to dispute claims.

Dunleavy v. Federated Fire Protection

Topics: Section 114-a Fraud, Loss of Wage Earning Capacity

The Holding: Third Department affirmed the Board's refusal to impose a lifetime ban on indemnity or modify PPD/LWEC percentage following Section 114-a finding.

The Facts: Claimant, a steamfitter, filed a claim in 2013 for an occupational disease to the neck following 30 years of installing sprinkler systems. In an IME in 2015, claimant maintained a "total interference" with his hobbies and recreational activities and he maintained that he had "zero range of motion of the neck." During permanency proceedings, claimant filled out a vocational data form where he listed pipefitter and steamfitter as his only occupation. Following the issue of Section 114-a being raised, claimant testified that he was also a member of a fire department in 2012, that he could not play 18 holes of golf, did not do "too much" work at his father's home on Fire Island, and could not recall using a weedwhacker or Sawzall. The carrier's surveillance material however showed claimant golfing 18 holes and using power tools to perform landscaping. The treating physician did not respond to a review of the surveillance materials and the IME commented that none of his opinions would change on impairment, though claimant "underestimated his own activities compared to his actual capabilities." The WCLJ imposed a mandatory penalty of April 14, 2015 (the date of the IME) to October 17, 2018 as a mandatory

penalty and a lump-sum discretionary penalty of $10,000 which was modified on administrative appeal to the Board to an additional period of time matching the mandatory penalty.

The Law: The scope of a Section 114-a penalty rests with the Board and permanent disqualifications are generally assessed when the deception was "egregious or severe or there was a lack of mitigating circumstances." The review standard is whether the Board abused its discretion. The Third Department declined to hold that claimant's conduct was so egregious as to warrant a lifetime ban on indemnity and taking into account the claimant's age, work experience, education, and English proficiency, the finding of a 65% PPD/LWEC was affirmed.

The Takeaway: In some cases even with solid evidence, the Board and Third Department may affirm a discretionary penalty of less than lifetime indemnity benefits. While the listed evidence in this case (misrepresentation regarding golf and landscaping activities and range of motion of the neck) may have seen a different outcome if a lifetime ban on indemnity was assessed by the WCLJ, the case illustrates a worthwhile lesson – in cases where the Section 114-a falls short of the "egregious or severe" misrepresentation, seeking a 114-a penalty with a discretionary penalty of a set amount of years may be an easier argument to make before the WCLJ than risking an unsuccessful argument for a lifetime ban.

Shyti v. ABM

Topics: Ingress/Egress, Breaks, Accident Arising Out of the Course of Employment

The Holding: Board's decision to find an accident arising out of and in the course of employment affirmed.

The Facts: Claimant was an office cleaning worker whose schedule was 5:00 p.m. to 12:30 a.m. with one "15 minute relief/lunch period" per day that placed no restrictions on what she could do with that period. On the date of the injury, claimant was on her 15 minute break, left the building, and crossed the street to smoke a cigarette and head to a pizza parlor when she slipped and fell on the sidewalk across the street from the building where she was employed. The WCLJ and Board Panel disallowed the claim, but the Full Board reversed and established the claim.

The Law: Regarding compensability, an accident must arise out of and in the course of employment. Where claimants are engaged in a brief "coffee break" that do not represent a significant deviation from employment (as opposed to a longer "lunch break"), if there is a lack of interruption of employment and the employee's activity is deemed reasonable and work-related, the claim may be compensable. In this case, the claimant's 15 minute break was "reasonable and sufficiently work-related" such that substantial evidence supported the Board's decision.

The Takeaway: This case is likely near the outer edge of compensability given that claimant had left the premises on break, however, the facts that the relief period was short and more akin to a "coffee break" and that the accident occurred just across the street from the workplace yielded in this case a fairly close call. Additionally, the claimant testified that she and her coworkers were not allowed to smoke in front of the building where they worked and that they had been instructed

by the building supervisor to go across the street to smoke. The case is a useful guidepost in determining whether short deviations from employment may be deemed compensable.

APRIL 2021

Kristl v. Rome City School District

Topics: Permanency

The Holding: Board's decision that claimant had a 32.5% PPD/LWEC and was not entitled to indemnity benefits until labor market attachment was re-established was affirmed.

The Facts: Claimant, a director of support services, sustained a 2010 injury to the neck, bilateral shoulders, and top four teeth. Claimant raised the issue of reduced earnings in June 2017 when claimant retired. The Board credited the carrier's pain management IME indicating a "B" level impairment and a sedentary work capability. The LWEC testimony also adduced that claimant had "extensive education and work experience." Following a hearing, the Workers' Compensation Law Judge classified claimant as having a permanent partial disability with a cervical spine condition of B severity, as well as a shoulder condition, and found that claimant had a 32.5% loss of wage-earning capacity. However, the Workers' Compensation Law Judge found that claimant was not currently entitled to causally-related reduced earnings because she voluntarily withdrew from the labor market as of the time of her retirement and was not entitled to indemnity benefits until such time as she established reattachment to the labor market.

The Law: In PPD/LWEC cases, the Board must consider the nature and degree of the medical impairment, functional ability/loss, and non-medical vocational factors such as education, skill, training, age, and literacy. Here, there was no evidence that the Board failed to properly consider these factors and substantial evidence supports the 32.5% finding. Additionally, the Third Department declined to rule on the issue of potential entitlement to indemnity awards in the absence of a final decision on the issue.

The Takeaway: While not all the facts on PPD/LWEC are discussed herein, the case serves as a reminder that there are numerous factors to be considered in LWEC litigation. A residual sedentary work capacity due to a spinal impairment may yield a much lower PPD/LWEC figure for a lifelong office worker who can return to work at a desk than a lifelong manual laborer. Moreover, the case demonstrates that even if a claimant can in theory return to his or her pre-injury work, a PPD/LWEC is intended to discuss claimant's overall ability to return to the labor market in general – even where a claimant has or can return to pre-injury work, some level of PPD/LWEC may be appropriate to account for those positions that the worker can no longer potentially return to.

Sanchez v. Jacobi Medical Center

Topics: PPD, Permanency, Indemnity Awards

The Holding: Decision modified and remanded for further consideration of awards.

The Facts: The claimant was injured in 2008 and sustained injuries to the neck, back, right shoulder, and right leg. In 2012, claimant was classified with a 50% PPD/LWEC, entitling him to 300 weeks of benefits at $211.56 per week. In 2014, claimant underwent a spinal surgery and claimant requested file reopening based on the surgery. In June 2014, the claimant was awarded retroactive TTD benefits to the date of surgery and continuing. In September 2014 based on differing medical opinions on degree of disability, awards reverted back to the tentative PPD rate where they remained until a further surgery in December 2015. Claimant again requested a hearing and awards were increased to TTD again retroactive to the second surgery before tentative rates were reinstated as of September 2016. In October 2017, the employer suspended benefits on the argument that 300 weeks of indemnity had been paid. Claimant maintained that the TTD periods and TR periods should not count against the 300 week cap and that claimant needed to be reclassified for the TR periods. The WCLJ concluded that the TTD benefits paid did not count against the cap and re-classification proceedings were necessary with both parties to produce evidence of permanency. The Board initially affirmed the WCLJ's decision, but subsequently rescinded that determination and found that all periods that a claimant receives awards post-classification count towards the cap, reduced claimant's awards back to the $211.56 PPD rate, and found that the request for reclassification was untimely as benefits exhausted in November 2017.

On first appeal to the Third Department, the Court found that TTD benefits did not count towards the cap and that when a PPD claimant has a "setback or exacerbation . . . that results in a reclassification of a temporary total disability," the PPD is displaced and the cap is tolled while the claimant is TTD. The Court also vacated the determination that the request for reclassification was untimely based on Section 15(6-a) finding that reclassification could be sought at "any time." Following that decision, the Board reclassified claimant with a PPD with the same $211.56 weekly rate for all of the TR periods following surgeries (September 2014-December 2015; September 2016-November 2017) and for portions of the post-surgical periods, which ultimately extended claimant's 300 week cap to August 1, 2018. Claimant appealed.

The Law: Regarding the PPD rate immediately post surgeries, the Third Department agreed that the Board improvidently reclassified the TR rates to PPD rates based on medical notes discussing degree of disability but not discussing permanency while claimant's physicians indicated a TTD. Additionally, re-setting certain post-surgical periods back to the PPD rate instead of the documented TTD rate without a hearing was improper. Consequently, the decision to that end was not supported by substantial evidence and required further development of the record.

Regarding the PPD rates set as of September 2016, following the 2015 surgery, the Third Department concluded that these periods were supported by substantial medical evidence, finding that the claimant had reached maximum medical improvement.

The Takeaway: The *Jacobi* decision is a significant change in post-PPD caselaw. While in the past, it was a cleaner and neater result for all awards to be made at the PPD rate, the Third Department has tossed this schema aside in favor of a model which reopens litigation on the rate of awards post-PPD classification resulting in additional work and costs for both carriers and claimants. The key takeaway is that a classification is no longer the end of the story on rates. Significant post-classification changes in condition (such as surgeries or exacerbations) may yield

a toll of the PPD rate and an increase in awards which does not count towards the cap. As the caselaw develops, one wonders whether garden variety exacerbations (such as tweaks of the back) taking a claimant out of work or increasing disability for brief periods may fall into this category. In any PPD file where there is a significant change in condition or a doctor increases their opinion to total, it is recommended that you scrutinize whether an IME is needed to build a record to oppose a subsequent request for an increase to TTD or potential reclassification.

Volpe v. Dan Tait, Inc.

Topics: Settlements

The Holding: Section 32 settlement null and void.

The Facts: In 2014, decedent Volpe sustained multiple direct injuries when he fell from a ladder and during the course of his claim, additional conditions were established. Claimant was classified with a PTD in June 2016 with wage benefits of $494 per week for life. In June 2018, he negotiated a settlement which would close indemnity for $156,000. The settlement was submitted to the Board, but rejected as it did not include all established conditions. A revised settlement agreement was sent and on June 27, 2018, a notice of approval was sent indicating that it was deemed submitted to the Board on July 3, 2018 allowing all parties 10 days to withdraw from the settlement and that the settlement would become final on July 14, 2018 if no objections were received. Decedent died on July 5, 2018 due to cardiac arrest and the carrier was notified on July 16, 2018. On July 20, 2018, the carrier filed an RFA seeking to cancel the settlement. On July 31, 2018, the Board rescinded its approval finding that the death nullified the agreement. Claimant, decedent's widow, objected. The WCLJ ruled that claimant's death during the 10-day window nullified the agreement.

The Law: An agreement to settle is not final and binding on the parties unless approved by the Board and there is a 10-day waiting period that occurs prior to final, deemed approval. Here, although the request to disapprove the settlement was not received during the 10-day window, the carrier was not notified of claimant's death until after the 10 days expired and could not have made a timely request. Consequently, the Board could properly determine that the decedent's death rendered the agreement "unfair, unconscionable, or improper as a matter of law."

The Takeaway: In the extraordinarily rare situation that a claimant dies before final approval of a settlement, a timely request for disapproval may be successful depending on when the carrier discovers the claimant's passing and when the request is made.

Farrula v. SUNY at Stony Brook

Topics: Voluntary Retirement, Attachment to the Labor Market, Reduced Earnings

The Holding: Claimant is not entitled to reduced earnings based on voluntary withdrawal from the labor market.

The Facts: Claimant was certified nursing assistant when she sustained injuries to her neck and back in 1989. Claimant underwent causally-related lumbar spine surgery and she was classified in October 1996 with a PPD and awarded reduced earnings. In 2006, after 12 years of unemployment, she obtained a clerical position with the DMV. In 2016, she had causally-related neck surgery and then returned to work six months later at regular duties. She continued to work and treat symptomatically. In October 2018, claimant retired from her position. The parties litigated the question of voluntary withdrawal from the labor market. Claimant was noted to have work on a "fairly consistent" basis for years with the DMV and testified that the disability did not significantly interfere with her work. Moreover, claimant opted for a regular service retirement without pursuing a disability retirement and failed to adduce any medical evidence from a doctor advising her to retire. The WCLJ found that claimant's retirement was due in part to the injury and directed reduced earnings awards. The Board reversed, finding that claimant's retirement was not occasioned by her injuries and rescinded awards.

The Law: A PPD claimant is entitled to reduced earnings in cases where the reduction in earnings power is due to the disability and for PPD claimants, an inference may be taken that reduced earnings resulted from the disability. However, where a claimant voluntarily retires and the disability did not cause or contribute to it, awards may be denied. This is a factual determination by the Board.

The Takeaway: The circumstances under which a claimant retires before seeking PPD/RE awards should be carefully monitored. Before conceding to any awards or deciding to litigate, discover all possible information regarding the claimant's age, work history, the method of claimant's retirement, and the medical recommendations leading up the same to come to an informed decision on the appropriateness of litigation.

Rivera v. Joseph A. Balkan, Inc.

Topics: Voluntary Retirement, Attachment to the Labor Market, Reduced Earnings

The Holding: Claimant was not entitled to indemnity awards based on voluntary withdrawal from the labor market.

The Facts: Claimant was a heavy equipment operator who suffered a back injury in March 2017. Claimant worked off and on post injury before going out of work from July 2017-December 2017. He returned to work on December 4, 2017 and stayed there until May 29, 2018 alleging an exacerbation of a back injury. The employer's HR representative testified that claimant informed her that he had an exacerbation, and although he appeared to a health care facility for an initial evaluation and was told he could not return to work, he subsequently did not return to the facility and did not return calls by the employer to discuss his work status which was considered no-call/no-show. Later, the claimant called and advised he would not return to work and requested his accrued vacation time. He did not provide any medical notes directing him to retire from his employment and had a partial disability. The WCLJ concluded that claimant voluntarily removed himself from the labor market. The Board affirmed.

The Law: As noted above in *Farrula* and others, the determination as to whether a departure from the workforce was voluntary or not rests within the Board's discretion.

The Takeaway: The employer's documented efforts in reaching out to claimant and the claimant's failure to document a necessity for him to retire from his position while partially disabled supported the Board's findings that he was not entitled to indemnity benefits.

Canela v. Sky Chefs, Inc.

Topics: Attachment to the Labor Market, Light Duty Offer

The Holding: Claimant could properly refuse to accept the employer's light duty offer for lack of specificity and demonstrated attachment to the labor market.

The Facts: Claimant, a caterer, sustained a back injury in May 2018 and was receiving TPD awards. The carrier raised the issue of labor market attachment. The employer wrote claimant a December 2019 letter after he was cleared for light duty work assuring it would provide a "safe work environment" and advising that his job would be in jeopardy if he did not coordinate a return to work, but the letter did not discuss a specific position with restrictions. Although the WCLJ concluded that claimant voluntarily withdrew from the labor market. The Board rescinded that determination and found that claimant was entitled to awards.

The Law: Whether a claimant's failure to accept a light duty offer constitutes a voluntary withdrawal from the labor market is a factual issue for determination by the Board. Given the lack of detail as to the light duty being offered, the Board could conclude that this was not a sufficient offer of a return to work. Moreover, although a contrary result could be been warranted, claimant's two dozen online applications for work that he was "mostly qualified to perform" and not "obviously incompatible" with his restrictions was sufficient to show attachment.

The Takeaway: Employers offering light duty to injured workers with restrictions should be careful to specifically tailor the available work and offer. Specifically, the work being offered should be within the claimant's medical restrictions and the light duty offer letter should spell out the hours and physical duties to be performed. The letter should be sent to claimant's counsel, claimant, and the Board (preferably via certified mail with return receipt requested) to support an evidentiary basis of a good-faith job offer. The LMA question in this one appeared to be a closer issue given some of the language in the decision, however, the case demonstrates that the Third Department will generally defer to the Board on factual calls such as whether claimant sufficiently attempted to look for work.

Osorio v. TVI, Inc.

Topics: Occupational Disease, Date of Disablement

The Holding: Board decision establishing date of disablement affirmed.

The Facts: Claimant was a pricing clerk for a retail store who filed a claim in April 2015 for repetitive stress injuries to the neck, back, and both arms. Per C-3 claim form, onset of the symptoms was "to be established" and in May 2015, an orthopedic surgeon indicated diagnosis and an onset of May 21, 2015, the date of the examination. Claimant had complained of intermittent neck, back, and shoulder pain in 2012 and 2014 and underwent PT. She was told in 2012 that the neck pain could "possibly" be related to work, but claimant neither lost time from work and was not definitively told until May 2015 that her condition was causally related. The carrier alleged that the claim was time barred as she first experienced pain in 2012. The WCLJ set date of disablement as May 21, 2015 and the Board affirmed.

The Law: Under Section 28 of the Workers' Compensation Law, a claim for an occupational disease must be filed within two years after the date of disablement and when the claimant knew or should have known that the disease was due to the nature of the employment. Potential dates may include the first causally-related treatment, first diagnosis that the condition is work related, the date that claimant lost time from work due to the disability, or the date that the claimant was advised to stop working due to the disability. The Board is not bound to select the earliest possible date. Here, the mere suspicion of work-relatedness in 2012 does not demonstrate that she knew or should have known that the diagnoses were work related and deferring to the Board's latitude regarding disablement, the decision was affirmed.

The Takeaway: The Board is generally given a very free hand in determining date of disablement in occupational disease claims. While determinations that claims are time-barred because the claimant "should have known" that the occupational disease was related to work exist, the overall trend for the Board is to select a date where a doctor first informs the claimant that their condition was caused by their work activities – mere suspicion or symptoms arising before that time is generally insufficient to warrant a bar of the claim under Section 28.

Morano v. Hawthorn Health Multicare Center

Topics: Pain Management

The Holding: Carrier must continue to pay for medications that claimant was taking prior to injury of record.

The Facts: In May 2014, claimant had a work-related injury to the back, resulting in three subsequent surgeries. In May 2019, the claimant's medical provider filed a variance from the Non-Acute Pain Management Guidelines for Lyrica in addition to claimant being prescribed Lyrica. The carrier disputed the same arguing that the claimant had been prescribed the medications for a month before the injury of record. Based on the pain management provider's testimony that even though the medications were prescribed before the injury, they would be needed to treat the pain caused by the work injury, the WCLJ and Board both directed the carrier to pay for the medications.

The Law: Under Section 13(a), the employer or carrier are generally require to pay for the cost of medical treatment "for such period as the nature of the injury or the process of recovery may

require." Although the carrier's IME found that the medications were not related, the Board was entitled to resolve that credibility determination.

The Takeaway: As always, obtaining apportionment or avoiding treatment or awards based on pre-existing conditions is an uphill battle generally in New York workers' compensation. The case serves as an example of how carriers may be liable even for medications prescribed prior to an injury of record when the subsequent injury would have ultimately created a need for the medication.

Takacs v. Kraft Foods Group, Inc.

Topics: Section 114-a Fraud, Labor Market Attachment

The Holding: Claimant did not violate Section 114-a in conducting her job search.

The Facts: In 2015, claimant stopped working for the employer due to a causally-related back condition. The claimant filed C-258 forms and other information documenting her work search abilities. The carrier submitted a job search verification challenging the veracity of claimant's job search and highlighting that some of the job searches could not be verified and that others were supported by someone else's resume. Claimant responded that she did not know how the resumes under a different name were submitted based on a lack of computer-savviness and maintained she submitted job searches to each employer.

The Law: Under Section 114-a, a claimant who makes a false statement or representation as to a material fact shall be disqualified from receiving compensation attributable to the false statement or representation. The Board is empowered to make the findings of fact to determine whether claimant's actions were knowing and intentional. Although there was evidence submitting a contrary result here, the Board was free to find no Section 114-a violation.

The Takeaway: A vendor-supplied job search verification can be a powerful tool in labor market attachment litigation. While the Board found in this case that the multiple "mistakes" claimant made in connection with her job search did not rise to fraud, the Court conceded that there was evidence to the contrary. Under the facts of an individual claim, a claimant's misrepresentation as to job search may support a Section 114-a finding.

Young v. Acranom Masonry Inc.

Topics: Section 114-a Fraud

The Holding: Finding that claimant violated Section 114-a affirmed, but lifetime ban on indemnity overturned.

The Facts: Claimant, a forklift operator, sustained a compensable injury to his back in May 2018. He received indemnity benefits from May 2018-June 2019 while his doctor opined a TTD. Claimant, however, returned to work for a different employer in April 2019 without reporting the same. During Section 114-a proceedings, claimant conceded that he did not inform anyone of his

return to work and the surveillance video showed claimant working on vehicles, bending, stooping, lying on the ground, and lifting a trailer. The WCLJ and Board found a Section 114-a penalty and assessed a discretionary lifetime ban on indemnity.

The Law: Whether the claimant violated Section 114-a is a factual determination by the Board. Here, the claimant's failure to report a return to work and the video supported a Section 114-a finding. However, judicial review of a penalty is limited to whether the penalty imposed is an abuse of discretion and disproportionate to the offense. Here, the Court reversed the lifetime ban on the basis that claimant was "forthright in his testimony that he returned to work," the Board did not previously advise claimant he needed to report a return to work, he claimed dire financial straits, claimant maintained 80% relief from an epidural block just before the surveillance, and there was no medical testimony on disability as IMEs found a mild-to-moderate disability.

The Takeaway: Given the fact that claimant was caught on video returning to work without disclosing the same and the claimant was engaging in activities greater than what his doctors (albeit not the IME) believed was in accordance with his disability, the Court predictably upheld the Section 114-a violation. The Court appears to have been fairly lenient regarding the penalty here – given the existence of the video surveillance, only a foolhardy claimant would continue to deny a return to work in light of the possibility that a carrier had video of claimant working. Consequently, it is somewhat difficult to see the mitigating factors in this case from a carrier perspective.

MAY 2021

Ozoria v. Advantage Management Association

Topics: Causally-Related Disability, Medical Treatment

The Holding: Determination that C-4 authorization request for surgery should be denied rescinded and matter remanded for further record development.

The Facts: Claimant sustained a 2017 injury to the neck and back and was treated with various modalities. In January 2018, claimant's treating physician found she was totally disabled and recommended a referral to a spinal surgeon. Claimant thereafter was seen by an IME who found no further disability. In November 2018, the WCLJ directed depositions of the treating physician and IME on FCRD. In December 2018, a second treating physician, filed a C-4AUTH request for a neck surgery. That request was denied per peer review reports of Drs. Cash and Storrs. Following the depositions of the initial two doctors, the WCLJ issued a decision on November 7, 2018 finding no further causally-related related disability and that after reviewing the reports of Drs. Cash and Storrs, the C-4AUTH should be denied. The decision was affirmed by the Board. Claimant appealed, arguing that the Board should have granted cross-examination of Drs. Cash and Storrs on the issue of the surgical denial as that issue was not joined when litigation was set in November 2018.

The Law: While no substantial caselaw is discussed in this matter, the Court's determination rested on the issue of due process. Here, the Court opined that the initial litigation was set on the

issue of FCRD, not surgical authorization. Given that the claimant was not given an opportunity to submit contrary medical evidence or cross-examine Drs. Cash or Storrs and the issue of FCRD was "separate from the issue of whether she was a proper candidate for surgery," the Board should have provided the claimant the opportunity to cross-examine the physicians or submit medical evidence.

The Takeaway: The Court here appears to have bifurcated the questions of further disability and need for surgery. While the claimant had a valid due process issue in that they were not properly afforded an opportunity to properly litigate the C-4AUTH, the Board's finding that claimant had no further disability would seem to yield the necessary conclusion that a subsequent surgery would also be unrelated. Either way, proper controversy of treatment requests remains best practice even when issues such as further disability are being litigated.

Matteliano v. Trinity Health Corporation

Topics: Medical Treatment

The Holding: Board determination authorizing lumbar fusion surgery affirmed.

The Facts: Claimant sustained a 2015 injury involving her left knee and left leg and a 2018 injury also involving her lower back with the left knee and left leg "combined" into the 2018 claim. In January 2019, claimant's doctor requested a multi-level lumbar fusion and an external bone growth stimulator, which involved three stages – a lateral lumbar interbody fusion at L3-L5, an anterior lumbar interbody fusion with instruction at L5-S1, and a posterior fusion with instrumentation and laminectomy from L3-S1. The carrier denied this surgery based on its IME. The WCLJ denied the surgery, but the Board ultimately approved the same based on claimant's failure of conservative care.

The Law: The Board was presented with a credibility determination between the IME's opinion and a treating physician's opinion regarding medical necessity for a surgery. The IME opined that the surgery was too aggressive given claimant's young age, that claimant needed further pain management following a failed L5-S1 laminotomy, and that the surgery was inappropriate as there was no documented instability, stenosis, or herniation. The claimant's treating physician opined that the initial laminotomy was only to resolve right leg symptoms, that claimant's other conservative care failed, and that there was discogenic back pain and pressure on the nerve roots which was increasing over time. Given a conflict in medical opinion, the Board is vested with the inherent authority to resolve the conflicting medical evidence, and the Court will usually defer to the Board's findings in this regard. The Court also placed emphasis on the fact that the Board has the authority to promulgate medical treatment guidelines, such that the question of whether a particular medical treatment is appropriate under the guidelines and should be authorized is a factual issue for the Board to resolve, and its determination in this regard will be upheld if supported by substantial evidence.

The Takeaway: This decision serves as a reminder that sometimes the Guidelines are reduced to just that – guidelines. In cases where the claimant may not meet each criteria for a surgical request,

litigation and a detailed explanation from the treating physician demonstrating medical necessity of a deviation from the Guidelines may nonetheless result in treatment outside of the Guidelines.

Djukanovic v. Metropolitan Cleaning LLC

Topics: Subrogation, Section 29

The Holding: Board determination that claimant was barred from receiving further workers' compensation benefits under Section 29 affirmed.

The Facts: Claimant sustained a causally-related injury and had a concurrent third-party action related to those injuries. In May 2015, claimant filed a stipulation of discontinuance with prejudice. In February 2016, the workers' compensation carrier suspended payments after learning that the third-party action was discontinued without its consent. The WCLJ initially found that the carrier improperly stopped payments and reimplemented 20 weeks of awards with a penalty, but did find that the claimant forfeited future benefits. On further appeals, the Board ultimately concluded that the carrier was entitled to suspend benefits on the date that claimant discontinued her third-party action. Claimant appealed, arguing that there was no substantial chance of success of victory in the third-party action.

The Law: When a claimant pursues a third party action in connection with a workers' compensation claim, Section 29 provides that a carrier has a lien against the third-party recovery for compensation and medical expenses already paid. A claimant is required to either procure the carrier's consent or obtain a court order to settle a third-party action and maintain entitlement to benefits. Here, regardless of the claimant's argument that the third-party suit would not be successful, this was speculative and the carrier's consent was required regardless. Additionally, the Board's rescission of the penalty was also warranted as claimant forfeited her right to benefits when she entered the stipulation without carrier's consent.

The Takeaway: In cases where the claimant has a third-party action, it is recommended that notice be given to claimant reserving all rights under Section 29 and that periodic monitoring of claimant's third-party action be implemented. A claimant's failure to obtain consent regarding settlement or discontinuance of the third-party action may suspend their entitlement to further workers' compensation benefits.

Fisher v. Erie County Sheriff's Department

Topics: Apportionment, Permanency

The Holding: Board's finding of no apportionment affirmed.

The Facts: In 2004, 12 years prior to the injury of record, claimant had a right knee injury in a motor vehicle accident. Prior treatment included surgery, but ended in 2011. Claimant subsequently had a compensable 2016 right knee surgery and underwent subsequent surgery. At permanency, the WCLJ concluded that claimant had a 50% SLU of the leg, 75% attributable to the 2016 injury and 25% related to the prior MVA. On administrative appeal, the Board modified,

finding no apportionment to the 2004 incident. The Board relied on the facts that the treating physician who opined apportionment had not reviewed any prior medical records and opined that an opinion would be speculative and that the carrier's IME opined apportionment, but did not specifically comment on whether claimant's prior condition would have resulted in an SLU.

The Law: Generally, apportionment to a pre-existing condition that was not the result of a compensable injury is not applicable if the claimant was "able to effectively perform his or her job duties at the time of the work-related accident despite the pre-existing condition." Under *Scally*, however, if the pre-existing condition would have resulted in an SLU finding, apportionment may be applicable.

The Takeaway: Apportionment to pre-existing conditions in New York is a generally difficult task. However, in cases involving extremities where the claimant sustained an injury or underwent treatment that may have been amenable to an SLU, *Scally* provides a limited exception. The carrier's IME, in addition to reviewing the prior records, should specifically comment on whether the prior condition would have resulted in an SLU to support apportionment proceedings.

Casey v. United Refining Company of Pennsylvania

Topics: Mental Health Claim, Accident Arising Out Of and in the Course of Employment

The Holding: Claimant did not suffer a compensable mental injury.

The Facts: Claimant, who had a prior history of depression and anxiety, filed a claim for work-related mental stress. Claimant, a store manager, conceded that she previously had to eject unruly customers from the premises. On January 3, 2019, a customer used vulgar language while talking on his cell phone. When a cashier asked the customer not to do so, claimant also told the customer to leave or she would call the police. The customer refused and threatened claimant with physical harm. The customer then left, re-entered the store, and was convinced to leave by another customer. The customer who made the threat was apprehended by the police. Claimant continued to work until a few days later when she began to experience anxiety, sleeplessness, and difficulty concentrating. She filed a claim alleging mental stress. Claimant testified regarding her symptoms and fear that the customer had a gun and the employer's evidence showed that claimant had received training on handling similar situations and two other situations where claimant resolved difficult issues (including a heroin overrose and a loiterer with a stolen vehicle). The WCLJ established the claim for PTSD with depression/anxiety. On appeal, the Board reversed finding that there was no compensable claim under WCL Section 2(7) as claimant did not experience stress greater than similarly situated workers.

The Law: Mental injuries may be compensable under 2(7), but the claimant must demonstrate that the stress they experienced was "greater than that which other similarly situated workers experienced in the normal work environment." This is a factual determination to be determined by the Board. Here, the claimant was not physically assaulted and the situation presented to claimant was not "vastly different" from stressful situations a manager of a 24-hour convenience store could expect.

The Takeaway: Mental stress claims have a much higher bar for claimants to meet. What constitutes a valid mental stress claim will vary between workplaces – what constitutes action or language beyond the pale at an office setting may be common at a construction site. In such claims, coworkers are generally needed to testify to the incident(s) in question along with the general workplace environment.

Kornreich v. Elmont Glass Company

Topics: Section 114-a Fraud

The Holding: Section 114-a fraud finding and lifetime ban on indemnity affirmed.

The Facts: Claimant sustained a 2007 work-related injury to the neck and back which was later amended to include a consequential depressive disorder. In 2014, claimant pleaded guilty to "attempted promoting gambling in the first degree." During the plea, he conceded that he worked with others to advance unlawful gambling activity, including receipt of more than five bets totaling $5,000 in one day. The carrier raised 114-a fraud, citing claimant's completion of work activity forms submitted between 2011-2014. Claimant testified that he was a gambling addict and that he merely placed bets with bookmakers but did not act as a bookmaker himself. The WCLJ found a Section 114-a penalty and lifetime ban on indemnity based on claimant's assertions that he had not performed work for himself or others on a paid or unpaid basis on work activity reports between September 22, 2011 and April 14, 2014. The Board affirmed.

The Law: As noted previously, false presentations and misrepresentations such as a non-disclosed return to work may constitute fraud. The Board was within its discretion to decline to credit claimant's self-serving testimony.

The Takeaway: Fraud comes in a variety of different forms and receipt of money through illegal activities can also potentially constitute "work" such that a Section 114-a fraud finding can be supported by the same.

Rho v. Beth Israel Medical

Topics: Section 28

The Holding: Claim barred under Section 28.

The Facts: Claimant, a patient care associate, filed a claim in April 2010 alleging work-related injuries while assisting a patient in 2005. The *pro se* claimant failed to appear at the first hearing at which time the case was marked NFA and nearly seven years later asked to reopen the claim with untimely filing excused due to mental incompetency. Although claimant was diagnosed with various psychological disorders allegedly stemming from insomnia and anxiety due to working the night shift, claimant maintained that her symptoms began on July 5, 2005, her last day of work, and the record reflected that she should have known no later than 2006 that her condition was related to employment. Following hearings in July 2018-August 2019, the claim was found to be time-barred.

The Law: Claimants have two years from the date of disablement and when they knew or should have known that their condition was related to the nature of their employment. While there is a provision in WCL Section 115 that tolls statute of limitations against mentally incompetent persons, it is only available to those who are unable to protect their legal rights due to an overall inability to function in society. Notably, claimant did not even invoke this Section until the matter was on appeal and did not offer any proof in this regard.

The Takeaway: The tolling provision due to incompetency rarely appears in workers' compensation claims, but may serve to toll the statute of limitations in certain rare circumstances. Any claim brought more than two years after the date of accident/disablement should be reviewed for the defense of untimely filing.

Dewald v. Fiorella's Landscaping

Topics: Labor Market Attachment, *Bacci*

The Holding: Claimant not attached to the labor market.

The Facts: Claimant sustained a 2014 injury to the neck and back and received temporary disability awards periodically over time with stretches of periods of no medical evidence of a disability. In 2017, claimant had no recent medical evidence, but an IME opined a moderate partial disability. Claimant's awards were suspended in September 2017 for lack of updated medical evidence. In 2019, claimant sought reinstatement of awards and produced medical evidence that he was totally disabled. The Board declined to issue awards citing a lack of labor market attachment.

The Law: The Board concluded that the prior finding of a temporary partial disability was not "disturbed" from 2017 and that the Board's finding of a temporary partial disability "is the requirement that claimant provide evidence of his attachment to the labor market," particularly after the carrier raised the issue previously. Claimant failed to submit any evidence or seek an opportunity to prove LMA at the Board level, so the suspension of awards was appropriate.

The Takeaway: While there is some gray area in the caselaw depending on how and when the labor market attachment issue is raised, a finding of a temporary partial disability is one tacit indication to a claimant that they must maintain an attachment to the labor market to remain entitled to awards. *Matter of Bacci* notably also remains alive and well – if claimant is not attached to the labor market prior to a period of total disability, the TTD report alone will not serve to remedy the claimant's failure to remain attached to the labor market.

Gandurski v. Abatech Industries, Inc.

Topics: Hearing Loss, Occupational Disease

The Holding: Board determination that claimant did not sustain a causally-related occupational disease affirmed.

The Facts: In April 2002, claimant left his profession as an asbestos handler/removal after 13 years. From 2002-2019, claimant worked as a union organizer. In 2019, he filed an OD claim for binaural hearing loss due to exposure to loud notice while he was an asbestos handler. The claim was challenged on grounds including causal relationship. Claimant testified that he had no hearing loss prior to working asbestos where he was purportedly exposed to loud machinery and his medical evidence maintained that after he left employment, he was in a "non-noise environment as an office worker." On further testimony, however, it was alleged that claimant had right ear hearing loss for 30 years due to an accident and that in his work as a union organizer, he visited various construction sites and attended 15 loud protest demonstrations. The WCLJ and Board disallowed the claim based on lack of causal relationship, citing the lack of an accurate medical history pertaining to noise exposure.

The Law: An occupational disease is a "disease resulting from the nature of employment and contracted therein" and claimant must show a recognizable link between the condition and feature of their occupation. Additionally, to prove causal relationship, a physician must signify a probability of the underlying cause supported by a rational basis. Here, the Board found that the claimant's inaccurate medical history rendered his doctor's opinion on causation incredible.

The Takeaway: As always, obtaining a full and accurate medical history from claimant is key to obtaining the best possible outcome. Here, claimant's apparent failure to disclose all of his medical (and vocational) history to his doctors likely resulted in the WCLJ taking an adverse inference regarding claimant's credibility.

Goutremout v. County of Oswego

Topics: Contact with Physicians

The Holding: Board did not err in disallowing death claim and discounting claimant's evidence due to appearance of improper contact.

The Facts: Claimant's husband passed away after sustaining a heart attack at work, resulting in a claim being filed for death benefits. Although a peer review IME found causal relationship, it was later precluded based on procedural filing issues. The decedent's treating physician also issued a C-64 form opinion causal relationship. During depositions, it was revealed that claimant's counsel had *ex parte* communications with both physicians, including the IME meeting with claimant's counsel for an hour before the deposition and treating physician reviewing the medical records with counsel for 15 minutes before completing the C-64 form. In decision following memoranda of law, the WCLJ indicated that the *ex parte* communication was "extensive," issued no weight to either opinion, and disallowed the claim.

The Law: Under Section 13-a(6), the improper influence or attempt to influence a medical opinion is prohibited and under Section 137, if a request for information regarding a claimant is received, the IME shall submit a copy of the same to the Board within 10 days. Moreover, Subject Number 046-124 prohibits even the "appearance of attempting to influence" a medical opinion and allows

a WCLJ to ascribe no weight to the opinion. In light of these provisions, the Board could reasonably ascribe no weight to the opinions and disallow the claim.

The Takeaway: *Ex parte* communications with medical professionals on substantive matters are strongly prohibited. The rules are heightened further for IMEs in which substantive requests for information must be disclosed to the Board subject to the opinion being given no weight or stricken.

Napolitano v. City of Batavia

Topics: Section 18 Notice

The Holding: Finding that claimant failed to give timely notice under Section 18 affirmed.

The Facts: Claimant was a fire chief and EMT for the employer who filed a claim in April 2019 as a result of a work-related slip and fall in December 2018. Based on his position, claimant advised subordinates to file timely reporting and claimant had received a prior SLU award for both knees, suggesting familiarity with workers' compensation claim. Although claimant testified that he tried to "muscle through it," he also conceded that the alleged injury became progressively worse over time. Although the WCLJ established the claim, the Board reversed finding no timely notice under Section 18.

The Law: Under Section 18, timely written notice should be given within 30 days unless the Board excuses the same because notice could not be given, the employer/agent had actual knowledge, or the employer did not suffer any prejudice and it is the claimant's burden to prove lack of prejudice. Here, the Board properly found that claimant did not given written notice and the claimant failed to prove a lack of prejudice, particularly given his heightened knowledge as to the workers' compensation system.

The Takeaway: While the Board often excuses untimely notice based on one of the enumerated exceptions, there are certain cases where the Section 18 defense is successful. In any claim where timely written notice is not given of an injury and the employer denies any knowledge of the claim, this defense should be considered.

JUNE 2021

Gaylord v. Buffalo Transportation Inc.

Topics: Professional Employment Organizations (PEO's)

The Holding: PEO carrier liable for non-leased employee of uninsured company.

The Facts: Claimant was working for a bus driver for Buffalo Transportation Inc. ("BTI") when he was struck by a car while crossing a street at the end of his shift in February 2018. He filed a claim alleging that BTI was the employer who hired him in 2016. In September 2017, BTI had entered into a personnel leasing agreement with Southeast Personnel Leasing, Inc. ("SPLI").

Under that agreement, BTI outsourced certain HR responsibilities to SPLI, including securing "workers' compensation coverage for its worksite employees either in its own name or in [BTI's] name." SPLI obtained a policy from an insurance carrier, State National Ins. Co. ("SNIC"). When it was alerted of claimant's filing, SNIC denied the claim on the basis that BTI was responsible to provide coverage. Claimant testified that he was hired and paid by BTI and did not have any dealings with SPLI. SPLI and SNIC did not present any witnesses, but argued that their coverage only extended to insured employees expressly leased to BTI and that claimant here was hired by BTI before it ever even contracted with SPLI. The WCLJ and Board both concluded that SPLI was statutorily obligated to cover the claimant's injuries.

The Law: The Third Department concluded that under Labor Law 916, when a PEO contracts with a client, it "agrees to co-employ all or a majority of the employees providing services for the client," including provision of workers' compensation coverage. While SPLI discharged its duty in having coverage through SNIC, the question is whether that policy would cover to claimant, who was hired before the PEO agreement was ever secured. Generally, workers' compensation insurance policies "extend to all employees who are employed during the policy period in question and not shown to be excluded" and ambiguities are resolved in favor of the insured. Although an endorsement specified that coverage was to be afforded to only "leased employees" who went through SPLI's employment process and a list of employees purportedly from SPLI was submitted, the policy at issue indicated "All Other Employees & Drivers" and did not exclude any individual employees and there was no evidence that the list was a part of the policy or affirmatively discussed with affidavits or testimony that this list was exhaustive. Moreover, the language of the statute did not preclude a finding that SPLI could be a co-employer of claimant and that SPLI would be obligated to provide coverage. Since BTI had no coverage, the Board could rationally conclude SPLI was liable.

The Takeaway: By virtue of the wording of certain statutes pertaining to PEO liability and through recent findings in the last few years, the Board and Court have signaled an intent to hold PEO companies liable for the omissions of their member companies who fail to secure separate coverage for workers obtained not through a PEO. The unfairness on its face of holding the PEO carrier liable for an employee that was hired by the member company before it ever even entered into a contract with the member here is substantial.

However, the decision does give a useful roadmap to setting the ground for future challenges. Apart from having underwriting review for possible language changes to the PEO agreement, the Court has suggested that it is willing to entertain affirmative evidence in support of whether a particular employee was "leased" or a "worksite employee" and entitled to coverage. Consequently, potential practices to consider going forward are incorporation of a list of leased employees into the policy, periodic reviews with the employer as to what employees are intended to be covered by the PEO, maintenance of a periodically-updated list of employees that are intended to be covered (and keeping any documentary evidence of discussions of this list), and provision of affirmative testimony from the PEO company as to the onboarding process and confirmation that the claimant at issue never went through the PEO's process. This list is not intended as a definitive game plan for a successful denial in a similar claim, however, the important point from this case is that PEO carriers may need to review their policy procedures and evidence being offered in analogous claims to potentially mount a stronger defense.

Bodisch v. New York State Police

Topics: World Trade Center Claim

The Holding: Board determination that claimant was not a participant in rescue, recovery, or cleanup operations was reversed.

The Facts: Claimant, a state trooper, was assigned to a vehicle checkpoint at the intersection of West Street and Canal Street from January 31, 2002-February 6, 2002 where he cleared vehicles for entry and exit from Ground Zero. He registered his participation in 2007 and in 2018 filed a claim due to exposure to toxins at the WTC site. The WCLJ initially concluded that the claim was compensable and established for GERD and Barrett's esophagus, but the Board reversed, finding that claimant's activities were not covered under Article 8-A tolling Section 28 and that claimant failed to prove a causally-related accident or occupational disease.

The Law: Initially, claimant failed to demonstrate a recognizable link between his work activities per se and his condition, notwithstanding the environmental conditions. Consequently, claimant did not legally prove an occupational disease. Regarding Article 8-A, however, this is to be liberally construed to provide relief for workers in the aftermath of the September 11, 2001 attacks, but the Board has required that claimant prove connection to "rescue, recovery, or cleanup." Here, claimant's work allowing vehicles through the checkpoint was a sufficient tangible connection to the rescue, recovery, and cleanup operations. Consequently, the claim should not have been barred under Section 28 and the matter remanded.

The Takeaway: In conjunction with the liberal and humanitarian aims of the WTC regulations, what constitutes "rescue, recovery, and cleanup" may be broadly determined. Activities intimately tied to direct rescue, recovery, and cleanup operations may, as here, be found to be sufficiently related.

Seeber v. City of Albany Police Department

Topics: Mental Health Claim

The Holding: Board decision disallowing claim under Section 2(7) affirmed.

The Facts: Claimant, a police officer, responded to a call involving the arrest of three individuals and was subsequently interviewed by Internal Affairs as part of an investigation into the incident. Claimant was suspended from employment and informed he would receive a written notification of charges. Claimant sought mental health treatment stemming from his suspension and submitted a claim for stress, anxiety, and PTSD. The claim was disallowed by the WCLJ as the stress resulted from a lawful personnel decision involving a disciplinary action.

The Law: Where a mental health claim is alleged solely as a result of a direct consequence of a lawful personnel/disciplinary action, the same will be disallowed under Section 2(7).

The Takeaway: The facts are somewhat scant in this decision, but under 2(7) if the claimant is alleging a mental health issue as a result of a lawful personnel decision or disciplinary decision (often, the decision to investigate a claimant's activities at work, demotion, or termination), the claim should be barred under Section 2(7).

Scano v. DOCCS Taconic Correctional Facility

Topics: Abatement

The Holding: Board decision to abate and disallow a claim affirmed.

The Facts: Claimant was the spouse of decedent whole filed a claim on his behalf. Decedent allegedly was directed to move a car in a snowy parking lot which caused his boots and socks to become wet, leading to frostbite and a wound on his left foot. Decedent sought treatment two weeks later and was found to have a necrotic infection. Decedent was admitted to the hospital where he was diagnosed with diabetes, underwent surgeries to remove a toe, and developed renal failure and anemia. Decedent filed a claim approximately one month after the accident and the claim was continued for claimant's testimony and attendance at an IME. Decedent, however, passed away before either event could occur. The matter continued with testimony of the claimant-widow and a peer review IME of claimant's medical records. The carrier argued that the record could not be properly developed given decedent's death and given prejudice as it could not explore the claim with an IME. The carrier maintained that the claim should have abated at claimant's death. The WCLJ and Board agreed and disallowed the claim.

The Law: Where a claimant dies before his claim can be adjudicated, the Board has the discretion to continue proceedings, resolve any controversies, and if appropriate, make an award of benefits, however, this must be weighed against all parties rights to due process and the essential elements of a "fair trial," including examination of witnesses, inspection of documents, and offering of evidence. In certain cases during a claimant's death, the record may be so undeveloped or the carrier so hindered that a carrier may be denied basic due process. Here, the lack of ability for anyone to testify what happened on claimant's work activities on the date of accident coupled with the issue of claimant's diabetic condition potentially resulting in significant issues was enough to show prejudice as the carrier could not cross-examine decedent regarding the events on the day of injury and could not have him physically examined by their medical expert.

The Takeaway: In the rare instance that a claimant dies after filing a claim, but before the record is developed, if the carrier's litigation position is so hindered as to prevent any reasonable opportunity to discover the basic facts of the claim, the claim may be disallowed under the theory of "abatement."

Ringelberg v. John Mills Electric

Topics: Section 114-a Fraud

The Holding: Board's finding that claimant violated Section 114-a affirmed.

The Facts: Claimant sustained a 2008 injury to the neck, back, and groin. In 2017, the carrier disclosed surveillance evidence and further proceedings ensued. Litigation demonstrated that on the date that claimant was surveillance, he attended an IME and was assessed with a 75% impairment and sedentary work capacity. On exam, claimant declined getting onto the examination table and gait testing. He also used a cane and walked stooped over with a slow pace. Surveillance video showed claimant arriving at the IME with a similar presentation, but 45 minutes later is seen at a store without a cane/brace, walking at a normal pace, pushing a shopping cart, and driving. Similarly, video on the date of a hearing showed claimant walking and acting normally before the hearing and then using a cane later that day at the hearing. Ultimately, in an IME addendum, the IME changed his opinion to a mild 25% disability. Claimant testified that his condition "fluctuates" and that he took pain pills between the gaps in surveillance. The WCLJ assessed a mandatory penalty and on appeal, the Board modified to include a ban on lifetime indemnity benefits. Claimant appealed.

The Law: As noted previously, when a claimant feigns a disability or makes a material misrepresentation of fact, it is within the Board's discretion to determine a Section 114-a violation. Here, claimant's "egregious" misrepresentation of his capacity warranted both the Section 114-a finding and a lifetime ban on indemnity.

The Takeaway: In cases of misrepresentation of physical capacity, surveillance is going to be one of the best available tools to prove the same. Targeting known dates of activity such as medical appointments and IMEs is the best way to have the highest chance of obtaining surveillance of claimant activity and can occasionally show stark contrasts in ability such as in this case.

Jagiello v. Air Tech Lab, Inc.

Topics: Concurrent Awards

The Holding: Board decision that claimant was entitled to concurrent awards affirmed.

The Facts: Claimant had two claims - an established occupational disease claim that became disabling in 2017 and a prior World Trade Center claim. In the WTC claim, claimant's awards were $400 in TPD benefits. The parties disputed what amount of awards he was entitled to in the OD claim. In the OD claim, claimant's entitlement to awards but for the WTC claim would be $480.71 per week. The claimant argued that the statutory cap in his OD claim was $870.61 per week based on the date of disablement and not $801.62 such that he should have received $470.61 per week in benefits. The WCLJ and Board determined that claimant could not receive a concurrent award in excess of $801.32 per week, so it limited the award in the OD claim to $401.32.

The Law: In concurrent award claims for successive injuries, a claimant is not entitled to receive compensation in excess of the statutory maximum rate in effect at the time of the later date of disablement. Additionally, the claimant was correct that the statutory maximum rate for the date of disablement in the OD claim was $870.61, however, because claimant was awarded benefits at the TPD rate, the appropriate award is "two-thirds of the difference between his average weekly wages before the latest accident and his earning capacity after the accident in the same or other

employment." Since 2/3 of claimant's AWW on the date of disablement was $801.32, the totality of claimant's awards could not exceed that TTD rate.

The Takeaway: The verbiage used by the Third Department is somewhat difficult to decipher, but it appears that claimant attempted to seek awards in excess of his TTD rate in the second OD file, citing the statutory maximum award for the date of disablement ($870.61) instead of applying a maximum limit of $801.32 (the TTD rate in the second file). All files with concurrent awards and earnings could be carefully scrutinized to ensure that claimant is not receiving more than the statutorily-limited and/or temporary total indemnity award.

Bugianishvili v. Aliiance Refrigeration Inc.

Topics: Permanency, Apportionment

The Holding: Finding of permanent total disability affirmed.

The Facts: Claimant, a mechanic, filed a claim for benefits when he was exposed to toxic gas while working in a poorly-ventilated basement. The claim was established for multiple respiratory ailments and was amended to include PTSD and major depression. The WCLJ concluded that claimant had a permanent total disability based on the carrier's IME opining the same.

The Law: The carrier's IME provided "substantial evidence" that claimant sustained a permanent total disability. Additionally, the Board did not err in determining that apportionment proceedings were not needed 2016 claim in which claimant sustained burns that played "no apparent role" in his disability. Moreover, the Board did not "abuse its discretion in declining to allow further development of the record on claimant's condition before rendering its decision."

The Takeaway: Where non-irrational evidence supports a Board determination that a claimant has a permanent total disability, the Board determination has a high chance of being affirmed on appeal, even in the absence of substantial record development on the LWEC factors, especially when the medical evidence finding a permanent total disability is an IME report, as the carrier has no right to cross examine their IME doctor, and a claimant will logically waive cross examination of the IME doctor in this instance. Where the same injury by itself is sufficient to render a claimant PTD irrespective of other claims which have resolved or are non-disabling, apportionment additionally may be unavailable.

JULY 2021

Galatro v. Slomins, Inc.

Topics: Consequential Injury, Section 137

The Holding: Board's decision concluding that there was insufficient evidence of a consequentially-related condition affirmed.

The Facts: In 2013, claimant sustained a causally-related left knee injury and underwent an arthroscopic procedure. During surgical recovery, claimant complained of chest pain and underwent two cardiac stent procedures. Claimant sought to amend the claim to include a consequential myocardial infarction based on the report of Dr. Lester Ploss. Following development of the record, the report of Dr. Ploss was precluded on a Section 137 violation and the consequential injury claim was disallowed based on the IME of Dr. Jonathan Sumner. In lieu of appealing, the claimant obtained a second report in 2017 from Dr. Ploss based on a re-examination. The Board denied the claim based on res judicata, but the Third Department remitted for further development. The Board ultimately credited the opinion of Dr. Sumner and concluded that the 2017 report was insufficient. The Third Department concluded that the Board's determination was supported by sufficient evidence.

The Law: Board determinations on the issues of causal relationship, particularly following full development on the issues, are generally entitled to deference.

The Takeaway: Notably, the preclusion of Dr. Ploss' initial report serves as a reminder that in cases where it appears that there is a one-off visit for an opinion on causal relationship by a claimant, in certain circumstances this may be viewed as an IME subject to Section 137. Otherwise, the case serves as a reminder that issues of causal and consequential relationship are generally deferred to the Board if there is sufficient non-irrational evidence in support of the same.

Decandia v. Pilgrim Psychiatric Center

Topics: Section 28

The Holding: Board's disallowance of claim for lack of timely filing under Section 28 affirmed.

The Facts: Claimant was a safety and security officer alleged that while on patrol in 2013, he was bitten by two ticks. He filed a claim stemming from the incident nearly six years later. The WCLJ initially established the claim for Lyme disease as the claim was filed within two years of the diagnosis. The Board reversed, finding that the claim was filed untimely and that there was insufficient evidence of causal relationship.

The Law: The Third Department found that because claimant failed to file a claim within two years of the tick bite, which allegedly gave rise to the disease, the claim was untimely under Section 28. Moreover, the medical records which showed that claimant had further tick bites in 2017 and multiple tests for Lyme disease were inconclusive or negative. Claimant's evidence that there "appear[ed] to be a cause and effect relationship" was insufficient.

The Takeaway: While this case differs from a traditional orthopedic occupational disease in which claimants do get the benefit of a potential two-year deadline from the date when they were first diagnosed with a disease, where there is a discrete event giving rise to an alleged injury or illness, carriers should investigate whether the claim is filed within two years of the known event. Moreover, as always, where there is substantial non-irrational evidence supporting the Board's conclusion on the issue of causal relationship, it will generally be undisturbed.

Herris v. United Parcel Service, Inc.

Topics: Causal Relationship, Death Claim

The Holding: Claim for death benefits disallowed based on lack of sufficient evidence of causal relationship.

The Facts: Claimant's wife (decedent) had coronary artery disease leading to a heart attack and multiple surgeries (including to repair the sternum and chest wall) prior to a 2006 work-related incident where she injured her chest while lifting a package. Decedent underwent multiple surgeries involving her shoulder, knee, and back that were related and developed consequential depression. Decedent was assessed with a PPD. In 2014, claimant collapsed and died at home, leading to a consequential death claim. At trial, evidence was adduced that decedent died after a night of heavy drinking and a potential narcotic overdose, but no autopsy was performed and the death certificate did not list a cause of death, but claimant relied on a doctor's note that the underlying injuries led to pain and emotional trauma that caused the substance abuse issues. The Board discredited that opinion in favor of the IME who found that although the death may have been connected to substance abuse issues, it could have also been solely related to the underlying coronary artery disease and that the evidence did not permit a definitive finding one way or another.

The Law: Here, the Board's determination that the IME who opined that the evidence was insufficient to determine causal relationship was supported by substantial evidence.

The Takeaway: In rare circumstances where there is a substantial lack of evidence on causal relationship, it can be enough for an IME to put forth that opinion explaining why. In those cases, the Board is empowered to look past a speculative opinion on causal or consequential relationship and conclude that even though an IME has merely posited an alternative theory of injury, there is an overall lack of sufficient evidence to make a finding of causal relationship.

Cadme v. FOJP Service Corporation

Topics: Ingress/Egress, Accident Arising Out of Employment

The Holding: Decision finding that claimant accident arose out of and in the course of employment affirmed.

The Facts: Claimant, a food-service worker, sustained injuries while walking to the hospital prior to the start of his work shift. The WCLJ and Board concluded under *Husted* that there was a "special risk" and that the location of the injury was such that an inference could be taken that it was a risk of employment. Specifically, the claimant parked on the western side of Route 9W, a public roadway, to access the hospital's dock entrance which was not a location for parking and there was no cross-walk. Claimant and other food workers typically parked at that location and it was a hazardous location to cross given the lack of a cross-walk. The loading dock was not generally used by the public.

The Law: Accidents must arise out of and in the course of employment to remain compensable. While there is a general rule that accidents occurring outside of work hours in public areas are not compensable, where the accident occurs near the claimant's employment, there is a "gray area where the risks of street travel merge with the risks attendant with employment." In those cases, injuries may be compensable if: (1) there is a "special hazard" at that point and (2) a "close association of the access route with the premises" which allows a conclusion that the risk was tied to employment. In this case, the parking lot was generally used by workers and the entryway generally not used by the public. Given these factors, along with the close proximity of the injury to the workplace, the Board's determination on the issue of accident was supported by the evidence.

The Takeaway: While there is a blanket rule that accidents occurring off work hours and on public property are not compensable, consistent with the humanitarian objectives of the workers' compensation board and *Husted* rules, the Board will examine the proximity of the location of the accident, whether the public uses the ingress/egress route, and the nature of the hazard at the location to determine whether a special exception applies. Accidents occurring off-premises before or after normal work hours should be scrutinized carefully for potential defenses.

Cardona v. DRG Construction LLC et al

Topics: PEO Liability

The Holding: PEO did not adduce sufficient evidence that the claimant was "not a leased employee."

The Facts: Claimant was part of a construction crew who sustained injury when a building collapsed. During litigation, a question arose as to whether claimant employed by subcontractor DRG Construction LLC or its PEO, Avitus, which had a contract with DRG for payroll and human resources responsibilities. The Board concluded that there was sufficient evidence of an employee-employer relationship between claimant and DRG, but the issue was whether Avitus could be liable under the Professional Employer Act.

The Law: The Third Department concluded that under Labor Law 916, a PEO is required to provide coverage for "worksite employees" who have a relationship with the PEO client. In this case, an addendum indicated that Avitus was "co-employ[ing] all or a majority" of DRG's employees. While there was a list of employees that was covered, the evidence did not clearly show that the list was meant to be exclusive and the policy naming DRG indicated "Building Raising or Moving – All Employees – All Operation to Completion & Drivers." Consequently, there was insufficient evidence that claimant was not a leased employee.

The Takeaway: PEO's that have clients who hire workers without express permission and documentation run a risk in New York as to potential coverage for employees they neither leased nor even knew existed. The Board and Third Department have expressed little pause in finding PEO's vicariously liable under these circumstances, however, cases such as *Cardona* have shown that there is some willingness to review the legal issue of whether a particular employee that the PEO may not have been aware of was a "leased employee." As this is a relatively new area of

caselaw, practitioners defending PEOs would do well to monitor the emerging evidentiary standards regarding PEOs.

AUGUST 2021

No Reported Workers' Compensation Decisions

SEPTEMBER 2021

McLean v. Time Warner Cable

Topics: Variance Requests, Medical Marijuana

The Holding: Variance for treatment of injuries by medical marijuana supported by substantial evidence.

The Facts: Claimant sustained a work-related injury to the low back in 2013. In 2018, claimant's pain management provider filed an MG-2 requesting medical marijuana which was denied by the carrier, prompting review. The WCLJ initially denied the variance, but the Board reversed on the basis that the treating provider had documented sufficient proof. The employer appealed. The Third Department affirmed, finding that claimant's medical note that claimant suffers from lumbar disc degeneration, radiculopathy, and spondylosis with pain at 8/10, that claimant had failed other medications (including narcotics), that claimant failed other modalities (PT, massage therapy, injections, chiropractic), and that claimant's pain reduced to 2/10 with the medication along with an improvement in ADL's was sufficient to warrant authorization of the medication.

The Law: Medical marijuana is authorized as a treatment under Public Health Law Section 3360 for chronic pain. The claimant's physician bears the burden of proof of establishing that the medication is warranted, necessary, and reasonable.

The Takeaway: Medical marijuana is legally permitted in New York and challenges based solely on its legality under federal law or in other areas of law will not meet with success. This medication should be treated the same as other medications, including a review of whether other medications/treatment under the applicable pain management guidelines are more appropriate and whether it provides objective, demonstrable, and substantial relief to warrant ongoing prescription.

Leduc v. Northeaster Clinton CSD

Topics: Section 18

The Holding: Board determination that claimant failed to provide timely notice under Section 18, but that there was insufficient evidence that the carrier was prejudice was affirmed.

The Facts: Claimant was a custodian for a school district for approximately five years. In February 2018, when manipulating a rolling cart with another employee which was caught in snow, claimant sustained a right shoulder injury. In June 2018, she sought treatment as she continued to have

symptoms. Claimant was diagnosed with a right shoulder rotator cuff tear. Claimant reported the claim to her supervisor in July 2018 and filed a claim in August 2018 before having surgery in September 2018. The claim was denied on the basis that it was not timely reported. The WCLJ found that there was no evidence that the carrier was prejudiced by the untimely notice and found that the claim should be established.

The Law: Under Section 18, a claimant has 30 days to provide written notice unless (1) notice could not be given; (2) the employer or its agent has knowledge of the accident; or (3) the employer did not suffer any prejudice. It is the claimant's burden to prove a lack of prejudice and within the Board's discretion to determine whether one of these exceptions applies. Here, the fact that the snow and ice melted did not significantly interfere with the employer's investigation as it could have investigated the area where the incident occurred for other defects, the claimant's co-worker corroborated the story in a written statement, and the carrier had "time" to have an IME prior to the surgery. Consequently, the Board did not abuse its discretion in excusing late notice.

The Takeaway: While Section 18 appears to be a strong defense on paper, the Board and Court will often stretch to find reasons to not apply this rule. The decision does not make clear when the co-worker corroborated claimant's story, however, the Court's rationale that the employer could have investigated months later for defects that may have impacted snow/ice levels or that the carrier should have obtained an IME in the span of the two months the claim was filed pre-surgical shows that the law is liberally construed in claimants' favor.

Hughes v. Mid Hudson Psychiatric Center

Topics: Scheduled Loss of Use, Apportionment

The Holding: Finding that claimant was entitled to a schedule loss of use award affirmed, but apportionment to non-work related prior injury was vacated.

The Facts: In December 2016, claimant sustained a right knee injury and underwent partial medial/lateral meniscectomies and synovectomy. In August 2018, his orthopedist found that he sustained a 45% SLU of the right leg. The carrier's IME agreed with the 45% SLU, but found that 60% of the SLU was apportionable to a prior non-compensable injury that resulted in six surgeries to the knee. When apprised of the prior injury (from 1976), the treating physician opined that 30% of the SLU was attributable to the prior injury. The WCLJ credited the IME and imposed a 45% SLU, 40% related to the 2016 injury. On appeal to the Board, the Board concluded that claimant had a 45% SLU of the right leg, but found that claimant's surgery under the 1996 Guidelines would have qualified claimant for a 17.5% SLU, such that the awardable SLU was 27.5%.

The Law: "As a general rule, apportionment is not applicable as a matter of flaw where the preexisting condition was not the result of a compensable injury and the claimant was able to effectively perform his or her job duties at the time of the work-related accident despite the pre-existing condition" (*Bremner*), but an exception does exist where if the prior injury would have resulted in an SLU and was "disabling in a compensation sense," apportionment may apply (*Scally*). Here, there were no records of diminished ROM or limitations of claimant's ability to use the knee such that the apportionment opinion was speculative. While the Board attempted to

craft an SLU from the 1976 injury based on the type of surgery claimant had previously, there were insufficient records demonstrating the same.

The Takeaway: Apportionment to non-workers' compensation related injuries is extremely difficult in New York. In cases where the claimant had a prior non-compensable injury which would have resulted in an SLU, it is imperative to obtain any and all medical records to support a *Scally* apportionment claim.

Bigdoski v. Baush & Lomb

Topics: Occupational Disease

The Holding: Determination that claimant had an occupational disease involving the bilateral shoulders and right elbow affirmed.

The Facts: Claimant worked for the employer for several months doing typing, telephonic, and clerical work and developed pain in the right elbow and bilateral shoulders. The WCLJ credited claimant's expert that claimant began experiencing pain at that job and developed bilateral shoulder impingement and lateral epicondylitis. The carrier did not obtain conflicting medical evidence. Evidence showed that claimant's workstation was ergonomically appropriate.

The Law: The Board was empowered to credit the claimant's treating physician that the claimant's typing and clerical activities resulted in an occupational disease involving shoulder impingement and lateral epicondylitis.

The Takeaway: Although the medical science is questionable on the matter, the New York Workers' Compensation Board has long accepted occupational diseases in which the medical provider indicates that conditions such as carpal tunnel or epicondylitis are due to clerical or office type work.

Flowers v. Alekm Plumbing, Inc.

Topics: 15(3)(v)

The Holding: Claimant was not entitled to supplemental benefits under 15(3)(v).

The Facts: In 2012, claimant sustained injury while moving a manhole cover. In 2016, he received an SLU of 85% involving the right hand. In 2019, claimant moved to reopen the claim based on a treating physician's note that he could not return to gainful employment due to the wrist injury and claimant sought benefits under 15(3)(v). The WCLJ initially concluded that claimant was entitled to additional benefits, but the Board reversed, finding that claimant did not demonstrate that the impairment of his earning capacity is "due solely" to the established injury. The Board based this finding on claimant's testimony that he had "bad knees," limited education, and an inability to use a computer.

The Law: In cases involving an SLU over 50%, additional compensation may be due if claimant can establish that there is an ongoing impairment to earning capacity due "solely" to his injury. This is a factual determination for the board. Here, the Board's determination that the additional factors (claimant's knees, education, and inability to use a computer) were also hindrances to claimant's earning capacity.

The Takeaway: In claims where there is an SLU over 50%, it is sometimes advisable to see if claimant will waive 15(3)(v) benefits in exchange for a negotiated SLU benefit. However, in cases where this does not occur and a claimant seeks additional benefits, carriers should investigate all potential impacts on claimant's earning capacity besides the established SLU to avoid further benefits.

Valdez v. Delta Airlines, Inc.

Topics: Occupational Disease

The Holding: Finding that claimant had an occupational disease was affirmed.

The Facts: Claimant filed a claim in 2019 alleging that a uniform she began wearing in 2018 caused certain ailments, including dermatitis, lymphadenopathy, and reactive airway disease. The Board affirmed.

The Law: To show an occupational disease, a claimant must prove a recognizable link between his or her occupation and a distinctive feature of employment. Although claimant had a prior allergy to hair dyes and dermatitis, the Board could credit claimant's testimony that her symptoms worsened on use of the uniform and eased on use of a different uniform. Moreover, claimant's doctor noted that she continued to be exposed to the chemical as co-workers continued to use the uniform.

The Takeaway: Board determinations on credibility are extremely difficult to overturn. While the claimant appears to have had a similar pre-existing condition, the Board is entitled to credit a claimant and treating physician's testimony that pre-existing conditions are exacerbated by environmental or other work conditions.

OCTOBER 2021

Williams v. Orange & White Markets

Topics: Section 114-a

The Holding: Finding that claimant violated Section 114-a and penalties affirmed.

The Facts: Claimant, an HVAC technician, sustained a right hand injury in May 2014. The claim was also amended to include the right index finger and right CRPS as well as exacerbation of anxiety/depression. While at an IME, claimant's wife filled out a form discussing his medical history. The form asked about subsequent injuries in which claimant's wife wrote "back pain."

Claimant, however, had a rollover MVA in June 2014 resulting in multiple injuries, including a right arm abrasion. The carrier alleged a Section 114-a violation based on claimant's failure to disclose the MVA. Ultimately, the Board assessed discretionary penalty of all indemnity benefits following the accident and a discretionary penalty of all indemnity benefits.

The Law: The Board is vested with wide discretion in terms of imposition of penalties. Here, the Board was empowered to find that the failure to disclose the MVA was an act of fraud and to discredit claimant's wife's explanation that she did not understand the meaning of the word "subsequent" in light of answers elsewhere in the questionnaire and her limited college experience. The Board's imposition of a lifetime penalty was warranted.

The Takeaway: What constitutes fraud is a bit of a sliding scale. Here, claimant (and his wife's) failure to disclose the intervening motor vehicle accident impacting his injury was a serious enough omission that the Board could reasonably impose a Section 114-a penalty and bar lifetime benefits.

Degennaro v. H. Sand & Co., Inc.

Topics: Section 29

The Holding: Board finding that claimant failed to obtain carrier's consent to settle third party action.

The Facts: Claimant had a 2004 injury involving the back and knees. He ultimately settled a third party action with Travelers for $1.6 million. The carrier was permitted to suspend payments and claimant was directed to produce the closing statement and proof of carrier's consent. Travelers advised claimant that the carrier had a workers' compensation lien. Claimant issued a check to the carrier for $63,333. The claimant subsequently believed that the carrier had been overpaid and sought reimbursement from the workers' compensation carrier. The carrier denied multiple allegations, including that it had consented to the third-party settlement. Following a hearing, the WCLJ concluded that the carrier consented to the settlement by virtue of cashing the check for $63,333. The Board reversed, concluding that claimant failed to obtain consent and was barred from receipt of benefits under Section 29.

The Law: When a claimant has a third-party action, the carrier has a lien which requires claimant to obtain written consent or a compromise order from a court. Claimant has the burden of proving that this was done. Here, the carrier was aware that there was a settlement and cashed the check, but there was no evidence that the carrier consented to the agreement or that the claimant obtained a *nunc-pro-tunc* order approving settlement. The record did not show that the carrier "actively participated" in the negotiations and the mere satisfaction of the lien was insufficient to defeat Section 29.

The Takeaway: While the carrier's receipt of the funds addressing its lien was notable, the case demonstrates that the Section 29 requirement that claimant obtain written consent or a *nunc-pro-tunc* order is inflexible and that a claimant who does not obtain the same in connection with a settlement risks their entitlement to further benefits.

Arias v. U.S. Concrete, Inc.

Topics: Permanency

The Holding: Finding of permanent total disability affirmed.

The Facts: Claimant, a maintenance worker, alleged multiple injuries as a result of being struck by a car. The claim was established for the jaw, neck, back, right shoulder, and PTSD. In 2019, he raised the issue of a TBI and requested a finding of a PTD. The WCLJ classified claimant with a PTD based on the IME and treating physician's notes regardless of the TBI issue based on a lack of a meaningful distinction between the notes and denied the carrier's request for cross-examination. The claimant's medical evidence was a 29% SLU of the right arm, 25% loss of use of the jaw, D impairment for the neck, F impairment of the lumbar spine, and L impairment of the brain and functional capabilities of less than sedentary and inability to drive a vehicle with occasional ability to sit/stand/grasp. The IME found a 20% SLU of the arm, an E impairment of the neck, F impairment of the low back, less than sedentary work, and no ability to engage in multiple functional tasks. Specifically, the IME concluded that he could never lift, carry, push, pull, bend, kneel, stoop, squat, or drive.

The Law: To establish a PTD, the claimant must demonstrate a total disability and inability to participate in gainful employment. The Board is empowered to weigh the evidence and determine whether the claimant's residual functional abilities leave him or her able to return to work. The difference between the treating and IME physician's opinions in this case was not so significant to raise an issue of claimant's ability to return to work given the numerous restrictions given by the IME.

The Takeaway: In cases where the unanimous permanency evidence demonstrates a "less than sedentary" work capacity, carriers should brace for a high degree of permanency. This case ultimately turned on the scope of claimant's profound restrictions including an inability to engage in nearly all potential functions on the functional capability evaluation form. Overturning a WCLJ's credibility determination on PPD/LWEC/PTD is an extremely high bar requiring significant error on the WCLJ's part.

NOVEMBER 2021

Taylor v. Buffalo Psychiatric Center

Topics: Permanency, Requests to Reopen

The Holding: Board empowered to reopen issue of permanency where finding was erroneously made on uncontroverted medical evidence.

The Facts: Claimant had a December 2014 left shoulder claim resulting in a shoulder surgery. The claimant's C-4.3 form indicated a 15% SLU of the arm, though the narrative itself set forth a 35% SLU based on a rotator cuff tear, distal clavicle excision, and loss of internal/external rotation.

The carrier accepted the 15% SLU and that was imposed in May 2016. Subsequently, in September 2016, claimant sustained a second left shoulder injury. While reviewing the medical records, claimant's counsel requested to reopen the December 2014 claim in the interest of justice and sought a 35% SLU. The Board denied the application.

The Law: Generally, the Board's decision to grant or deny reopening or rehearing is subject to an abuse of discretion standard. Here, the Board abused its discretion in denying the reopening. The only medical evidence on permanency was a 35% SLU when considering the narrative and it was error for the Board to impose the 15% SLU. The carrier additionally failed to obtain a contrary IME. Consequently, the Board should have reopened.

The Takeaway: The Board is generally vested with wide discretion to reopen matters. Where, as here, the Board clearly misconstrued evidence before it, reopening is likely, although it is unclear why the Board refused to do so of its own accord in this claim.

Phillips v. Milbrook Distributor Services

Topics: Extreme Hardship Redetermination, Sections 15/35

The Holding: Claimant's request for hardship redetermination denied, but matter remitted to address claimant's request for reclassification.

The Facts: Claimant, a merchandiser, sustained an injury in 2007. The claim was established ANCR neck, back, adjustment disorder, and depression. He was classified with an 85% PPD/LWEC in 2010, entitling him to 450 weeks of benefits. In August 2018, prior to the capped benefit running, claimant filed a C-35 seeking an extreme hardship redetermination based on financial hardship. The WCLJ found that claimant failed to demonstrate extreme financial hardship and any unusual or unexpected expenses. During the administrative appeal, four of claimant's doctors filed C-27 forms maintaining that claimant was totally disabled (three of them after the expiration of claimant's benefits cap). The Board concluded that claimant had not submitted sufficient evidence of a change in condition and declined to consider the three untimely reports.

The Law: In considering a request for an extreme hardship determination, the Board was required to consider claimant's assets, monthly household income, and monthly expenses. Here, while claimant's indemnity benefits were to end, claimant's SSD was to increase by $775 per month and his monthly rent would be reduced by 50% as a result of the reduction of benefits. The Board also identified unspecified expenses that were "unnecessary." However, the Board erred in not considering the three reports that were generated following claimant's expiration of benefits. Under Section 15, the claimant may at any time reclassify disability based on a change in condition under *Sanchez v. Jacobi Medical Center*. Here, claimant must be afforded an opportunity be heard on reclassification.

The Takeaway: Two important notes here. First, obtaining an extreme hardship redetermination is a difficult process requiring close scrutiny of all of claimant's expenses. Any and all evidence of claimant's income and expenditures should be brought to light during trial. Second, the Third

Department adheres to *Sanchez v. Jacobi Medical Center* steadfastly. While it used to be that the awards to claimants classified with a PPD were set in stone, that decision throws much unpredictability into the PPD system. Carriers must be on guard for post-classification TTD periods (such as following a surgery) or remain on guard against alleged "changes in condition." This provides some consternation in setting reserves but remains the current law of the land as the Third Department has upended the relative former stability of a PPD classification.

Quinn v. Pepsi Bottling Group, Inc.

Topics: Special Funds Reimbursement

The Holding: Carrier is not entitled to reimbursement.

The Facts: Claimant sustained a 2005 left foot injury later amended to include the back and reflex sympathetic dystrophy. In 2009, claimant was paid $145,000 to settle indemnity-only and Special Funds Conservation Committee (SFCC) agreed to reimburse the carrier $83,200 in exchange for a waiver of Section 25-a. In 2019, the employer sought a hearing based on a lack of reimbursement from the Special Funds Group (the Board's successor to the SFCC). The Board's SFG maintained no entitlement to reimbursement as there was no request for reimbursement within one year of the payment. The WCLJ found that the indemnity-only agreement contained no language pertaining to Section 15(8)(h)(2)(B) and although the Board Panel agreed, the Full Board reversed and found no requirement to pay.

The Law: Here, although the indemnity-only Section 32 settlement agreement did not address the one-year reimbursement request under 15-8, there was no reason to conclude that the agreement was not subject to such an agreement and SFCC was not a party to the indemnity-only settlement proceeding or that it was put on notice that the settlement agreement was paid.

The Takeaway: The carrier's failure to request the reimbursement until so long after the payment of the indemnity-only proceeds certainly weighed against the carrier here, but since the closure of Special Funds Section 15-8 and Section 25-a, carriers who still have files for which this relief was granted would do well to periodically monitor and audit ongoing reimbursement requests for timeliness.

Richards v. Allied Universal Security

Topics: Accident Arising Out of and In the Course of Employment

The Holding: Finding affirmed that claimant did not sustain an injury arising out of and in the course of employment.

The Facts: Claimant worked for a security company between April-June 2017. Claimant maintained that he sustained injury moving oxygen tanks in June 2017. Claimant did not file a claim until July 2018. The WCLJ disallowed the claim for lack of timely notice and the Board affirmed on administrative appeal based on a finding that claimant did not sustain an accident.

The Law: Claimants are required to demonstrate that an accident arose out of and in the course of employment and the factual determination that an accident did not occur will not be disturbed if supported by substantial evidence. Here, the Board was free to discredit claimant's account of the injury based on the purported weight of the tanks, that claimant did not treat for approximately one year after the incident, that two of his doctors could not ascribe causal relationship, and that claimant's doctor who opined causal relationship relied solely on claimant's discredited testimony.

The Takeaway: The Board's fact-finding power is generally broad and its findings will generally be undisturbed. This remains true even when the facts are found not in claimant's favor.

Ortiz v. Calvin Maintenance

Topics: Section 114-a

The Holding: Decision that claimant violated Section 114-a and was disqualified from future indemnity benefits affirmed.

The Facts: Claimant, a laborer, sustained a 2009 work related injury involving the head, neck, back, and a consequential psychiatric disorder. He was found to have no further disability related to the claim in 2012. In June 2013, he sustained another injury when a light fixture fell on him involving the right forearm, right shoulder, neck, back, right elbow, left shoulder, adjustment disorder, DVT, and pulmonary embolism. The carrier in the 2013 raised Section 114-a as claimant did not disclose the 2009 injury. The Board concluded that claimant failed to disclose the prior injuries.

The Law: The Board is vested with wide discretion to find the existence of a Section 114-a violation and set the appropriate mandatory and discretionary penalties therefrom. A claimant's omission of material information does constitute a knowing and false statement or misrepresentation. In this case, claimant's failure to disclose the injuries was sufficient to support the penalty. He failed to disclose the injury to multiple IME's and although he disclosed the injury to one doctor, he did not discuss the full nature of the injury. The Board was free to discredit claimant's allegations of a language difficulty. Further, the penalty of all future indemnity benefits was appropriate in light of the egregious nature of the violation.

The Takeaway: Failure to disclose significant prior injuries which impact the current claim is a solid basis for a potential Section 114-a ground. Always review the issue of fraud with your attorney to discuss whether the omission is sufficiently "material" for the purposes of Section 114-a.

Uridales v. Durite Concepts Inc/Durite USA

Topics: Occupational Disease

The Holding: Board's finding that claimant did not sustain a causally-related occupational disease affirmed.

The Facts: Claimant, a construction worker, alleged that he developed various respiratory ailments due to occupational exposure to epoxy and chemicals. Claimant testified that he worked for the employer 16-17 hours per day, 6-7 days per week for 9 years and that he worked with epoxy "all the time" with minimal mask usage. The employer's president testified that claimant worked on and off a few days per week and was responsible for cleaning the premises. Further, he testified that claimant did not engage with epoxy as he was not qualified to do so, that claimant did not report any breathing difficulties, and that claimant was terminated because he was trying to organize other employees to sue the company.

The Law: The Board is vested with the wide discretion to credit or discredit witnesses on the issue of occupational disease and causal relationship. While the claimant provided testimony and his doctors found causal relationship based on claimant's statements, the Board was free to discredit claimant's testimony and his doctors' opinions accordingly.

The Takeaway: In occupational disease claims, having solid employer witness testimony is crucial to raising a successful defense. While claimant's testimony and medical evidence was sufficient prima facie evidence to proceed and would likely have been enough to establish if no significant rebuttal testimony was credited, the presentation of evidence that claimant never complained of the condition he claimed existed and was terminated for reasons unrelated to employment helped the carrier here refute the claim.

Richman v. New York State Workers' Compensation Board

Topics: Accident Arising Out of and in the Course of Employment

The Holding: Finding that claimant did not sustain a causally-related injury affirmed.

The Facts: Claimant, a WCB claims examiner, filed a claim on 7/25/18 alleging a right shoulder injury in a fall occurring on 1/19/18. Claimant did not seek treatment until 8/27/19, 19 months post-injury. Although the WCLJ established, the Board reversed and found no sufficient credible evidence of a causally-related condition.

The Law: The existence of a compensable accident is a question of fact to be resolved by the Board and the finding will not be disturbed if supported by substantial evidence. Here, the Board could reasonably conclude that claimant failed to submit timely medical evidence to corroborate claimant's accident. The Board was free to discredit claimant's testimony that she was too "busy" to seek medical care for 19 months and claimant failed to explain why she did not file the claim until 7 months later. Moreover, claimant's medical evidence reported a fall at work, but also discussed degenerative changes and osteoarthritis and failed to specify if the alleged fall caused or exacerbated those conditions.

The Takeaway: A claimant's failed to timely report an injury or obtain medical evidence within a relatively short period of time after the incident will help support a denial on the issue of causal relationship or the wholesale existence of an accident.

Gorbea v. Verizon New York Inc.

Topics: Request for Reconsideration, Service of Appeals

The Holding: Board abused its discretion in denying claimant's request for review as untimely based on evidence in the record.

The Facts: Claimant, who was unrepresented, alleged a work-related exacerbation of a pre-existing psychological condition. The WCLJ disallowed the claim in October 2018 on the basis that claimant's stress was no greater than those similarly situated employees. Claimant's administrative appeal was filed in April 2019, though claimant also alleged that she had filed a timely appeal in November 2018, return receipt requested. Claimant produced a receipt signed by someone which noted "11/20" and a tracking printout confirming mailing an item to the Board. The Board Panel and Full Board rejected the appeal.

The Law: As claimant appealed from the Full Board determination, the review standard is whether the Board abused its discretion. Here, the Board appears to have considered the return receipt, but failed to review or discuss the tracking information submitted by claimant which "would appear to give rise to the presumption that she mailed an appeal in November 2018" that may have been timely received but "misplaced." Claimant's additional submission of a return receipt from her April 2019 submission also appeared to match the November 2018 submission. Consequently, the Board abused its discretion in denying the appeal on timeliness grounds.

The Takeaway: As scanning delays or missed documents are not unheard-of at the Board, the case shows the value of holding onto any evidence of timely transmission of appeals and other documents.

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Whitney v. Pregis Corp.

Topics: Home Health Aide Services, Medical and Travel Reimbursement

The Holding: Claimant is entitled to reimbursement for home health aide service and matter remitted for proper calculation of the same.

The Facts: Claimant had an established claim for the low back, right hip, head, TBI, post concussive syndrome, cognitive impairment, and hydrocephalus stemming from a 2013 slip and fall. In 2017, following litigation, claimant was found to need 24-hour health care. That determination was initially apportioned between claimant's unrelated multiple sclerosis condition and the claim, but the Third Department reversed the apportionment finding. In 2019 during permanency litigation, the carrier maintained that the need for home health care services was related to the MS and that updated medical evidence of necessity was needed. In December 2019, claimant was deemed permanently totally disabled and the WCLJ reiterated the 2017 decision that claimant needed 24-hour care.

The Law: The carrier's failure to appeal the 2017 decision that 24-hour care was needed rendered that decision final and there was no indication that a directive to reimburse claimant's family for periods of care negated the same. It is within the Board's authority to determine the reasonable value of the home health care services provided based upon the adduced evidence. Here, the Board did not weigh such evidence, so the matter must be remitted for the same

The Takeaway: Although the issue is infrequent, in cases where home health care services are necessary, family members may step into the shoes of other health care providers when qualified and able. Barring an agreement between the parties, the Board will direct reimbursement to family members for provision of such services, though the carrier is entitled to evidence demonstrating that the same is being provided.

King v. New York State Department of Corrections

Topics: Reduced Earnings

The Holding: Board determination that claimant was not entitled to reduced earnings following 6/22/14 reversed.

The Facts: In 2006, claimant sustained a work-related claim involving the back. Claimant was employed with DOCS and concurrently employed with a restaurant as a baker and waitress, resulting in an increased AWW. Claimant returned to work for DOCS in June 2007, but was unable to return to work at the restaurant. Claimant subsequently received reduced earnings awards and in 2009 was classified with a 37.5% PPD. On 6/22/14, claimant stopped working for the DOCS and was granted a disability retirement due to unrelated causes and had not returned to work. The WCLJ and Board suspended claimant's reduced earnings award based on her retirement for DOCS. Claimant appealed.

The Law: The issue of whether reduced earnings are related to a work-related injury is a factual one for the Board's resolution and although a PPD classification permits an inference that a subsequent loss of wages is related to the disability, if the wage loss is due to age, economic conditions, or other factors, the award may be denied. Here, given that the claimant left DOCS for unrelated reasons, the Board could conclude that no reduced earnings from that employment were related, but the Board failed to consider claimant's entitlement to reduced earnings or wages due to her restaurant position and failed to properly consider application of whether claimant needed to demonstrate LMA in light of 15(3)(w).

The Takeaway: In cases involving concurrent employment, monitoring claimant's ability to return to work and/or reason for leaving one or both jobs must be closely monitored by the parties and the Board. Where claimant is unable to return to one job due to the work related disability, causally-related wage loss may be appropriate even if there is a return to work at the concurrent position.

Reith v. City of Albany

Topics: Psychological Injury

The Holding: Board's decision rejecting uncontroverted medical testimony reversed, matter remitted for further development.

The Facts: In 2018, claimant filed a claim for benefits alleging PTSD stemming from "countless horrific, work-related emergency situations" as a firefighter over multiple decades. The claim was established for PTSD by the WCLJ, but the Board reversed, finding that the 2017 amendments to Workers' Compensation Law Section 10(3) did not apply and that claimant's proof was insufficient to establish a psychological injury. On administrative appeal, the Board issued a decision advising that the claimant could use Section 10(3), but then disallowed on the basis of causal relationship.

The Law: Prior to Section 10(3)(b) being enacted in April 2017, a claimant seeking to establish a psychological injury was required to show that the stress was "greater than that which other similarly situated workers experienced in the normal work environment." The statutory amendment, however, negated that requirement for certain first responders filing mental stress claims. In this case, claimant testified to witnessing multiple events (a suicide, triple homicide, car accident fatalities, and other more graphic incidents) which led him to seek treatment in January 2018. Here, claimant's medical evidence from a treating psychologist that his PTSD was causally-related to his work activities was sufficient evidence to proceed, even though the opinion did not discuss with specificity all of the traumatic events.

The Takeaway: The 2017 amendment to Section 10 eased the evidentiary burden on first responders alleging mental health claims. In such claims, these individuals will have a much lesser standard to prove a mental health/stress type claim.

COURT OF APPEALS SUMMARIES

Green v. Dutchess County

Topics: Permanency, Awards, Death Claim

The Holding: "Motions for leave to appeal dismissed upon the ground that the order sought to be appealed from does not finally determine the proceeding within the meaning of the Constitution and is not an order of the type provided for in CPLR 5602 (a) (2)." This denial leaves in place the Third Department's determination that a decedent's family can collect the balance of a PPD award.

The Facts: Decedent had a 2007 claim for his right leg for which he was classified in 2012 with a 51% PPD/LWEC, resulting in an award of 350 weeks. At the time of classification, claimant was working with reduced earnings. Those payments were made until March 2018 when claimant passed away as a result of unrelated reasons. Counsel for the decedent requested that claimant (claimants' surviving child, as there was no spouse) receive the balance of claimant's PPD award under 15(4)(c). The WCLJ and Board found that claimant's widow and child were not entitled to

such award for the balance of 38.8 weeks of benefits. On appeal, claimant argued that 15(4) should be applied to both SLU and PPD files.

The Law: WCL Section 15 provides for compensation for four types of disabilities, PTD, TTD, PPD, and TPD awards. At permanency, awards are generally divided in SLU or PPD claims. SLU awards are generally made to compensate for permanent loss of earning power or capacity due to an impairment to a body member, and PPDs arise generally from injuries to body sites not specified in 15(3)(a-u). While an SLU award is not allocable to any particular period of disability and is independent of any time lost from work (under *Taher v. Yiota Taxi*), PPD awards under 15(3)(w) require classification and assessment with a number of weeks of benefits. In cases where a claimant passes due to unrelated causes, 15(4) provides that an award may be payable to additional persons under 15(4)(a-d), including 15(4)(c) which provides that awards may be made to surviving children in certain cases. Here, the Third Department concluded that since 15(3) refers to both SLU/PPD files and 15(4) refers back to that section, it found no basis to "distinguish" SLU and PPD awards regarding the statutorily-enumerated persons' right to receive the benefits. The Court acknowledged that a PPD award is calculated by determining future loss caused by the established injuries and that in death, a claimant can no longer establish a causally-related reduction in earnings, however, this "unfairly deprives an injured worker's surviving spouse and/or children of the remaining cap weeks" and in cases where a claimant passes without having reduced earnings or ongoing awards, the "surviving spouse and/or children would forever be deprive of any benefits because the deceased worker never sustained, and could no longer establish, a causally-related reduction in wages." The Third Department also supported its conclusion by finding that the 2007 amendments to the Workers' Compensation Law sought to bring more "parity" between SLU and PPD claims.

The Takeaway: The Court of Appeals' rejection of the appeal in this case as non-final is puzzling. The Third Department upended decades of well-established law that while posthumous schedule awards can be made to an estate or surviving dependents, PPD awards were not. The Third Department noted the obvious tension in that unlike a lump sum SLU award, PPD awards are paid out over time, contingent on a claimant's ongoing entitlement to the same (including labor market attachment requirement until this was recently no longer made necessary post-classification or demonstration that reduced earnings are related to the disability. Consequently, the Third Department's decision in effect equalized an SLU award (one fixed lump sum based on a review of claimant's physical impairment at the time of permanency) with a PPD which by its nature is awarded over time and depending upon a variety of factors. The *Green* decision in theory creates an award and entitlement to a claimant's family where a PPD claimant dies of unrelated causes, even if claimant never loses a time from work. PPD files that carriers could at one time comfortably close based on no lost time are subject to reopening based on a claimant's passing, even where it is completely unrelated to the claim are now potential time-bombs of liability and reserves long ago set may need to be revisited.

Given that the Court of Appeals is the final word in New York on workers' compensation law interpretation, a full decision would have been useful for all parties in determining whether this radical new application of PPD law will withstand further judicial appeal, but for now, *Green* remains the law of the land. However, as the Court of Appeals did not make any definitive

pronouncements on the merits of the case, there is still an opportunity for a similar issue to be taken to subject the decision to further determination.

Youngjohn v. Berry Plastics Corporation

Topics: Permanency, Awards, Death Claim

The Holding: In the limited circumstance where a decedent passes away of unrelated causes after being assessed with an SLU and has no qualifying spouse, child or dependent, under 15(4)(d), recovery to the claimant estate is limited to any prior award not paid (i.e. the "unaccrued" portion of the SLU) and reasonable funeral costs.

The Facts: In December 2014, decedent sustained an injury involving the right shoulder and left elbow for which he received TPD benefits. In 2016, both decedent's treating physician and the IME obtained permanency opinions. In March 2017, before permanency could be resolved, he passed away as a result of an unrelated heart issue. Decedent had no surviving spouse or qualifying children or dependents. The parties agreed that claimant had a 55% SLU of the left arm, 45% SLU of the right arm, and 23 weeks of protracted healing, but the dispute became whether the estate was entitled to the full SLU award as a lump sum or only that portion of the SLU award that "accrued" before the date of death with the remainder capped to reasonable funeral expenses under Section 15. The WCLJ granted the full award and the Board modified, finding that the amount payable was limited solely to the funeral expenses. On appeal to the Third Department, the Court affirmed the Board's determination to direct payment of the accrued portion of the SLU award—that is, the number of weeks between the date of the accident and the date of death, multiplied by the weekly rate of the award—to the deceased worker's estate, along with reasonable funeral expenses. Claimant appealed to the Court of Appeals.

The Law: SLU's are statutorily prescribed awards for loss of wage earning power ascribed to loss of function to certain enumerated body parts. Multiple statutory provision come into play regarding an estate's entitlement to benefits following a claimant's death and generally Section 33 states that any compensation due at the time of death is payable to the estate. Notwithstanding the fact that the Legislature amended the Workers' Compensation Law to allow for lump sum SLU awards, however, the various provisions under Section 15 provide that in cases where a claimant dies before imposition of an SLU award is made, the award remains limited to the "accrued" portion of the SLU plus reasonable funeral costs under 15(4)(d) as that section was not altered by the Legislature. Any remedy to any perceived unfairness to the estate needs to be remedied by the Legislature. (Notably, there was one concurring opinion in which one Judge concurred in the result on the basis that there was no evidence that decedent "opted for a lump sum payment" via a signed, written request).

The Takeaway: Cory DeCresenza appeared for the carrier in this quirky fact pattern in oral arguments before the Court of Appeals. Initially, the outcome on one hand seems to conflict with *Green* which seemingly allows estate to collect the balance of an unaccrued PPD award. However, given the strict statutory schema presented here, we believe the outcome was the proper one. In the limited case where there is no qualifying spouse or dependent qualified to receive the SLU award, the SLU award is limited. Only the "accrued" portion of the SLU is due with the remainder

of the benefits capped off by reasonable funeral expenses given the jurisdiction of the claim. In practice, this means that in similar fact patterns, the SLU award commences at TTD periods on the date of the injury. If the claimant passes before the TTD period is exhausted, the balance that would have been owed after the date of death is capped by the funeral expenses. If, however, the TTD period starting from the date of injury ends before the date of death, the entirety of the award may be due to the estate. While this is an extremely uncommon situation, the Court affirmed long-standing rules in calculation of the SLU award in similar circumstances.

Verneau v. Consolidated Edison *and* Rexford v. Gould Erectors and Riggers

Topics: Death Claims, Section 25-a

The Holding: Liability for subsequent death claims cannot be transferred back to 25-a.

The Facts: In both claims, the claimants had established claims in which liability was, while the claimants were living, transferred to Special Funds, Section 25-a. Both had compensable conditions that contributed in whole or in part to the claimants' passing. In *Verneau*, claimant had several asbestos-related conditions and in *Rexford*, claimant had a heart-related condition. When the claimants passed and their relatives brought claims, the carriers who had transferred liability for the living claims to Section 25-a argued that liability for the death claims should also transfer to Section 25-a.

The Law: It is undisputed that Section 25-a(1-a) closed all new claims following January 1, 2014. Here, under the statute, the fund is closed to "a claim," which suggested that the liability to be transferred for a "single claim at the time of application." Consequently, the statute prohibits the transfer of liability for claims that accrued after the cut-off date. Here, the "claims" that were sought to be transferred were new and distinct claims that arose after January 1, 2014 stemming from the death following closure of the 25-a fund. Consequently, these files cannot be transferred to Section 25-a.

The Takeaway: Although there was a dissenting opinion disagreeing with the majority, the decision concludes in no uncertain terms that in claims where there has been a transfer to a Special Fund, a "new claim" arising from a subsequent death will not be referred back to the Special Fund. Given the wind-down of Section 25-a and 15-8, remaining issues tend to be infrequent and this would seem to resolve one of the largest open questions following the Special Funds' closure.