New York Appellate Summaries

- Workers' Compensation -

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Cory A. DeCresenza concentrates his practice on workers' compensation litigation, drawing from significant experience in general and appellate litigation. He has experience handling trials at the New York State Workers' Compensation Board, including lay and medical testimony on all issues of controversy, entitlement to indemnity or medical benefits, fraud issues, and extensive administrative appeals experience. Cory has advised clients on all aspects of workers' compensation claims handling, from claims filing through closure by settlement or alternative disposition, with a focus on early, cost-effective claims resolutions.

Another significant portion of Cory's practice involves drafting appeals and rebuttals to the New York State Supreme Court, Appellate Division, Third Department and Court of Appeals 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. Cory has been recognized as a Rising Star by the Upstate New York Super Lawyers and is a contributor to Law360. When not practicing law, Cory enjoys cooking, baking, and playing with his two rambunctious border collies, Hazel and Mona.

Practice Areas

- Workers' Compensation
- Appellate Practice

Honors

- Upstate New York *Super Lawyers*, Rising Star, 2014-2023

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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, Bola subsequently garnered experience spanning close to a decade in complex defense litigation and appeared regularly before all superior courts of record in Nigeria, including the apex Supreme Court. In more recent years, Bola has focused his practice on providing counsel and representation to clients at all stages of workers' compensation litigation — from intake to trial and appeal. Bola also defends employment liability, discrimination and civil rights/public sector claims in federal court. Thoroughness and passion are the hallmarks of Bola's litigation approach.

Bola's span of experience is extensive and his scope of knowledge is considerable. He graduated with Merit from Swansea University, Wales, United Kingdom 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.

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COURT OF APPEALS CASE

SELECTED APPELLATE CASES FROM THE THIRD DEPARTMENT AND COURT OF APPEALS

(2nd Half of 2022-1st Half of 2023)

We hope you find this summary of the appellate-level cases pertaining to New York Workers' Compensation proceedings for the second half of 2022 and first half of 2023 useful.

These summaries are meant to be a carrier-centric 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. 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

July 2022

Strohscein v. Safespan Platforms Inc.

Topics: Section 114-a Fraud.

The Holding: Board's finding of a lifetime discretionary ban on benefits affirmed.

The Facts: Claimant, an iron worker, had a claim established for a right biceps tendon tear and expanded to include consequential nerve palsy. Claimant presented at both treating physicians' appointments and IME visits with substantial difficulty using the arm including gripping, lifting, repetitive usage, and use of a brace. Surveillance on the day of his IME, however, showed claimant subsequently not using the brace, shaking out a car mat, performing engine maintenance including a fluid change, and carrying food with the right hand without any apparent restriction.

The Law: It is long settled that the issue of Section 114-a is committed to the Board's sound discretion and so long as the Board's determination is supported by substantial evidence, it will be affirmed.

The Takeaway: Surveillance on the date of an IME can be a powerful tool in litigation where claimants are malingering or exaggerating symptoms as they can take away the argument that claimant was simply having a "good day" when they are seen acting in a manner inconsistent with the purported disability. While one day of surveillance isn't usually enough to build a solid fraud claim, catching activities such as this on video may sometimes be enough to support a claim under Section 114-a.

Barretta v. PAL Environmental Safety

Topics: Medical Marijuana

The Holding: Board properly found that claimant's variance was approved for medical marijuana.

The Facts: Claimant, a fire proofer, had an established claim for the back, legs, hips, and right foot with a 2014 date of disablement. Claimant reported intractable pain despite surgery (to unspecified sites), conservative modalities, and narcotic medications. Claimant's physician requested a prescription for medical marijuana which the carrier denied on the basis that the same was not approved by the FDA.

The Law: The Board's decision in this matter followed the day after *Quigley v. Village of East Aurora* which found that the Compassionate Care Act was not pre-empted by federal law and medical marijuana is an accepted variance from the MTG's. Consequently, the variance was properly affirmed.

The Takeaway: Attempts to argue that medical marijuana should not be approved based on federal will fall on deaf ears. While requests for the same should be thoroughly investigated, carriers would do well to accept that medical marijuana in certain cases may be a safer and potentially more cost-effective treatment option than other modalities.

September 2022

Leon v. Monadnock Construction Inc.

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

The Holding: Board's finding that claimant sustained a causally-related accident affirmed.

The Facts: Claimant, a construction worker, alleged multiple causally-related injuries stemming from a January 2020 fall from a scaffold. Notably, claimant testified through an interpreter. The carrier challenged the establishment based on its IME conclusions and based on "varying narratives" regarding the mechanism of injury. Notwithstanding the existence of evidence that could support a contrary conclusion, the Board's determination is supported by substantial evidence and is affirmed.

The Law: Whether an accident arises out of and in the course of employment is a determination within the Board's discretion and it will be affirmed if supported by substantial evidence.

The Takeaway: The Section 21 presumption is a substantial aid to any claimant's arguments and the Board is receptive to arguments that minor variations in the discussion of the mechanism of injury are not fatal to a claim particularly in cases such as these where a claimant needs an interpreter. Here, the Court's summary of the conflicting evidence is a bit thin, however, it is instructive of the extremely high burden that must be met to overturn a credibility call on appeal, even where there is credible alternative evidence.

Vaughan v. Heritage Air Systems

Topics: Death Claim

The Holding: Finding that decedent sustained a causally-related death as a result of exposure affirmed.

The Facts: Decedent worked as a sheet metal working from September 1997-March 1998, but retired in 1998 due to unrelated medical conditions attributed to service in the Vietnam war. In 2000, he commenced treatment for breathing issues and was subsequently diagnosed with COPD which worsened until his death in 2017 due to cardiopulmonary arrest due to COPD. Claimant's expert opined that claimant sustained that decedent died due to COPD due to "prolonged exposure to multiple construction related dusts and noxious gases," leading cliamnat to filed a claim in January 2019 for death benefits. The carrier obtained an IME which opined that his death was "directly associated" with exposure to subsequences and that a "causally-related death cannot be denied." The WCLJ established the claim and Board affirmed.

Although the carrier maintained that decedent's statements were not credible, the Board was permitted credit the living claimant's testimony regarding claimant's work and exposure and the treating physician's report (as well as the IME's opinion) as sufficient to establish the claim over the carrier's exception that the opinions were "speculative."

The Law: It is axiomatic that the formal rules of evidence generally are not stringently applied in NY WCB and WCL Section 118 permits declarations of deceased employees concerning an accident to be sufficient to establish the claim where they are supported by additional circumstances or evidence.

The Takeaway: Given that both the claimant's physician and seemingly the carrier's IME provided causal relationship, obtaining a reversal of the claim on the facts given by the Third Department appeared to be a difficult task. Absent evidence of fraud or misrepresentation in statements where both a treating physician and IME concur in a medical opinion, that opinion is likely to stand at the Board.

Lyman v. New York State Canal Corp

Topics: Permanency

The Holding: Board's conclusion that claimant's condition was amenable to a PPD/LWEC or non-schedulable condition affirmed.

The Facts: Claimant, a motorized snow operator, sustained a low back and right foot injury due to January 2018 slip and fall. Claimant underwent a right posterior tibial tendon surgical procedure. Claimant's treating physician opined a 65% SLU of the foot based on losses of ROM and the carrier's IME opined a 20% SLU of the foot. On testimony, however, claimant's doctor ultimately opined that claimant met the criteria for a PPD/LWEC given ongoing chronic pain symptoms and chronic swelling (though there was pre-existing chronic lymphedema which already restricted some ROM). The WCLJ, however, concluded that claimant had a chronic painful condition with ongoing swelling of the right foot and assessed a marked PPD/LWEC.

The Law: Ordinarily, injuries to the extremities tend to resolve by scheduled loss of use and injuries to the spine or head generally resolve by PPD/LWEC. However, there are occasional claims that fall outside of these categories. Under Section 1.6 of the Guidelines of Determining Impairment, certain conditions including chronic swelling or pain may constitute a PPD/LWEC. More often than not, this usually involves a claim for CRPS/RSD or a non-union following surgery, however, certain cases involving persistent ongoing symptoms may result in a classification.

The Takeaway: Although infrequent, the case serves as a reminder that even SLU claims are to be treated seriously, particularly where there is a high level of ongoing symptoms and any of the factors in Section 1.6 of the permanent impairment guidelines may be applicable.

October 2022

Cotterell v. Trinity Health Corporation

Topics: Section 28

The Holding: Claim for right hip injury not barred under Section 28.

The Facts: Claimant, a resident assistant, was injured on September 13, 2015 "while making beds" and filed a claim in October 2015 for a low back claim which was established. In 2018, the WCLJ concluded that claimant had PFME for a right hip injury based on reported from the treating physician that following back treatment, a right hip MRI revealed a labral tear. The carrier obtained an IME maintaining that the hip pain was not due to the labral tear but due to a pre-existing condition and argued that the hip was barred under Section 28.

The Law: While Section 28 generally requires claims for compensation to be filed within two years after the accident, the Board is empowered to review the documents in the file to determine whether a claim is being made and the Board is empowered to make factual determinations. Here, medical reports including within two years after October 2015 noted both bilateral hip pain or pain radiating into the hip and claimant's treating physician opined that it was not uncommon for a back condition to "mask" a hip condition. As claimant could not have filed a claim for the hip until it was identified and diagnosed, Section 28 does not bar the claim.

The Takeaway: Section 28, like its companion, Section 18, has numerous loopholes to the standard language that claimants have two years to file a claim for benefits. Here, the reports in the Board file referring to pain in an additional site that was not claim were substantial evidence that the Board could rely on to determine that the hip was not time-barred, particularly where there was some confusion as to diagnosis between the back and hip. Nonetheless, claims for additional injury sites outside of two years from a date of accident should be thoroughly scrutinized.

Vicente v. Finger Lakes DDSO

Topics: Extreme Hardship Redetermination

The Holding: Claimant met the burden for an extreme hardship reclassification under Section 35(3).

The Facts: Claimant sustained a causally-related right shoulder and low back injury in 2007 and was classified with an 87.5% PPD/LWEC per stipulation in 2009 worth 475 weeks of benefits. Claimant issued a timely request for a hardship redetermination before benefits expired in 2018. Claimant was re-classified to a permanent total disability. The carrier appealed, arguing there was insufficient evidence for the Board to evaluate the application, particularly since claimant did not show what he would expect to receive from SSD following exhaustion of benefits.

The Law: Under Section 35(3), where a claimant makes a timely application for re-classification in the year prior to exhaustion of capped PPD benefits, a claimant may apply for an extreme

hardship redetermination. The Board may consider claimant's assets, expenses, household income, and any other factors. Here, the Board evaluated claimant's SSD/public assistance income and his monthly expenses. While the Board should ordinarily also review the full amount of SSD benefits after the WC benefits cease, the claimant's evidence that after his deduction for medical insurance premiums left claimant with $24 per month from SSD revealed that it was unlikely that increased SSD benefits would alleviate claimant's financial hardship. The Board also properly evaluated claimant's age, education (high school diploma), physical work history, and lack of ability to engage in vocational retraining.

The Takeaway: Hardship redeterminations are fact-specific determinations which require that claimant produce all evidence regarding income and expenses, including information regarding SSD earnings. The same factors that act as aggravating factors in LWEC determinations will be reviewed at the time of any such application when they are only likely to have worsened with advancement of age and length of time out of the workforce. Settling claims prior to the expiration of PPD/LWEC capped benefits when possible is preferred to avoid these types of claims.

Koratzanis v. US Concrete Inc.

Topics: Section 114-a

The Holding: Determination that claimant violated Section 114-a with mandatory but no discretionary penalty affirmed.

The Facts: Claimant, a concrete mixer truck driver, had an injury in October 2017 involving the bilateral knees and right leg, foot, and ankle. The claim was also amended to include the left hip and a consequential low back. The carrier raised a Section 114-a violation alleging that claimant had authored and self-published books on Amazon while receiving benefits. The WCLJ rescinded benefits from June 2018 (first publication) to September 2020 when the hearing was held, but declined to issue a further penalty. Both parties appealed to the Board – claimant argued his publishing was de minimis and carrier sought a permanent disqualification. The Board albeit modifying the end date of the discretionary penalty to November 2020.

The Law: Failure to disclose work activities may constitute a Section 114-a penalty as an omission of a material fact. The Board is vested with the authority to make a fact finding determination on Section 114-a and in addition to the mandatory penalty of forfeiture of benefits attributable to the fraud, has the discretion to implement a discretionary penalty as to future benefits. A discretionary penalty will be upheld unless it is "so disproportionate to the offense as to be shocking to one's sense of fairness, thus constituting an abuse of discretion."

Here, claimant did not challenge the finding on appeal at the Third Department that he violated Section 114-a. The carrier maintained that since claimant first published in June 2018, he must have been working on his book before the publication and seeking a discretionary penalty of all benefits.

There was no evidence in the record as to when started writing between October 2017 and publication in June 2018 as the carrier did not inquire. Consequently, the Board's mandatory

penalty was affirmed. As to the discretionary penalty, while claimant did not disclose the publishing, he did not affirmatively attempt to hide it such as using a pen name and disclosed the activities on questioning. Consequently, the Board's leniency was not an abuse of discretion.

The Takeaway: The case is interesting for a few reasons. It serves a reminder that social media searches can sometimes be useful. While it is uncommon for injured workers to publish novels post injury, stranger things have happened and carriers can sometimes learn useful information for fraud purposes. Further, it is a reminder that not all fraud is created equal. While a mandatory penalty is set based on the amount of benefits received due to the fraud, the discretionary penalty is just that – discretionary. Factors such as a claimant not attempting to obfuscate fraud or work activities or claimant receiving minimal benefits may militate against no or a short period of forfeiture of benefits. Not all fraud claims will constitute lifetime bans.

Molander v. New York City Transit Authority

Topics: Indemnity Benefits

The Holding: Board determination that claimant was not entitled to lost time benefits affirmed.

The Facts: Claimant was a mason who had an established claim for obstructive airway disease, GERD, upper respirator disease, sleep apnea, and PTSD. Claimant started treating in 2013, but worked full duty from September 2015-February 2020, and he continued to smoke one pack her day. Claimant spirometry results were normal in 2017-2018. In August 2018, claimant was convicted of an alcohol related driving offense which resulted in his NY driver's license being suspended on January 23, 2020. One day before his license was revoked, he went to an occupational medicine specialist who opined that claimant should be put on light duty to "limit his exposure to dust as it has been triggering an exacerbation of his symptoms." The employer had no such work in February 2020, and claimant stopped working. In March 2020, the employer had a disciplinary proceeding against claimant for not maintaining a valid license. The WCLJ declined to award benefits following February 2020 based on incredibility of the claimant and lack of sufficient evidence of a worsening of his condition.

The Law: Generally, a claimant who voluntarily withdraws from the labor market is not entitled to benefits unless it caused or contributed to the withdrawal and whether the withdrawal is voluntary is a factual determination. Claimant here was required to prove by "competent" medical evidence that he had to leave work due to his injuries. The Board was within its discretion to conclude that claimant was not credible in leaving work due to his disability given his five year employment, lack of evidence of objective worsening of symptoms, and the revocation of claimant's license. Claimant additionally failed to provide additional records as to his self-reported testimony that he was told his lung capacity was "no longer good" and his doctor testified that his assessment of disability largely rested on claimant's subjective complaints, despite claimant's condition previously being stable and claimant's ongoing smoking.

The Takeaway: There are rare instances where a claimant's physician's reliance on claimant's self-serving testimony render that opinion not entitled to credit. Had claimant not been involved in a licensure and employment issue, it's possible that this case could have gone the other was as a

discretionary call, even with no objective evidence of claimant's worsening of his condition. However, when a claimant takes themselves out of work or a doctor opines a flare-up of a condition with no objective rationale for the same, a carrier may challenge claimant's entitlement to benefits.

November 2022

Trombino v. FMB Inc.

Topics: Coverage

The Holding: Board decision that Liberty Mutual liable for claim instead of ACE American affirmed.

The Facts: Claimant, an iron worker, filed a claim for multiple lung issues and listed FMB Inc. as his employer in September 2016. The Board initially indexed the claim against Phoenix Ins. Co., who challenged coverage. Per Board coverage investigation, the Board's Enforcement Unit identified ACE American or Liberty as the potential carriers, and the Board then indexed against Liberty. Liberty appeared and challenged the claim on substantive grounds, including lack of coverage. Claimant testified in July 2017 that FMB was his last employer and discussed his time period and physical lobations at work. Liberty's lay witness did not appear at the hearing, however, and Liberty did not raise coverage at the hearing. Following depositions, the claim was established by the WCLJ for multiple conditions and the claim was established for a PTD. Again, Liberty did not raise coverage in memoranda.

On administrative appeal to the Board, Liberty maintained that its policy did not cover the location where claimant was working for FMB. The Board rejected the evidence for failing to comply with 12 NYCRR 300.13 and rescinded the PTD finding, but otherwise affirmed. On appeal to the Full Board, the Board Panel stated in its discretion it would treat the evidence of lack of coverage as a request to reopen and remitted on coverage. The Board reopened the hearing and ACE American was placed on notice as a potential carrier. ACE maintained under laches that Liberty should be barred from raising proper carrier. The WCLJ and Board agreed.

The Law: Laches can apply in workers' compensation cases where this is an "inexcusable delay in raising the defense of noncoverage together with actual injury or prejudice." Here, although the policy indeed did not cover claimant's work location, Liberty did not pursue that defense until after the claim was established. Consequently, ACE was prejudiced by its inability to assert any defenses as the claim was established, Laches barred Liberty's argument that it was not the proper carrier.

The Takeaway: While it is a common refrain among practitioners that "carriers cannot waive coverage" or the Board cannot "create coverage where there is none," recent caselaw the last few years has chipped away at this line of thinking. Where a carrier accepts a claim and administers them if they are the proper carrier for a substantial period of time and thereby deprives the allegedly correct carrier of an ability to present a defense, that carrier may very well be stuck with the file depending on the specific circumstances of the claim, even in the absence of proper coverage.

Yearwood v. Long Island University

Topics: Occupational Disease

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

The Facts: Claimant, an associate university dean, sought treatment for bilateral hand, wrist, and thumb pain on September 3, 2020 and was diagnosed with an occupational disease from repetitive stress including carpal tunnel syndrome, hand "derangement," and tendonitis. Claimant filed a claim for repetitive stress involving the hands, shoulders, and knees, but PFME was found for the wrists/CTS/thumbs only. The carrier's IME concluded claimant had bilateral thumb/hand strains and recommended an EMG to rule out CTS. At the hearing, however, claimant testified that in 2014 she had sought treatment from another physician and had an EMG test. The WCLJ established the claim for the wrists/CTS/thumbs and set a date of disablement on September 3, 2020 (first treatment). On administrative appeal, the Board reversed citing claimant's failure to report her treatment history and failed to establish a causally-related disease.

The Law: Claimant has the burden of proving by competent medical evidence a causally-related condition and the Board is free to reject opinions as insufficient where they are not informed by an accurate summary of claimant's medical history. Here, the record did not reflect that the claimant told her doctor or the IME regarding the prior treatment and in fact, claimant declined to provide the IME with past medical history, writing in a questionnaire "as attorney, not completing." The Board could rationally conclude that claimant and the medical evidence were not entitled to credit. Notably, the Third Department added in a footnote that the carrier and Board did not address Section 114-a fraud.

The Takeaway: The Board and Third Department have in recent years been somewhat more receptive to contentions in occupational diseases that the medical evidence is insufficient where there are gaps in the medical opinions stemming from a lack of discussion of prior treatment or the practitioner's lack of detailed knowledge of claimant's work activities. Here, it is unknown why claimant declined to offer information regarding her prior treatment – if she had disclosed it and testified to no symptoms or treatment since 2014, it is possible the claim may have been established. However, claimant's failure to provide an accurate medical history supported the denial of the claim and notably treaded the line on Section 114-a fraud.

Jones v. New York City Transit Authority

Topics: RB-89 Forms

The Holding: Board properly declined to review claimant's appeal under 12 NYCRR 300.13.

The Facts: Claimant, a train conductor for the NYCTA, sustained an August 2019 injury to the left wrist. The employer raised the issue of Section 114-a fraud due to failure to disclose work activities and imposed mandatory and discretionary penalties. The claimant filed an RB-89 seeking reversal, and the Board declined to review it, citing 12 NYCR 300.13 for an incomplete

Box 15 response which indicated only "[a]n exception to the WCLJ's finding was made at the last hearing held on 01/08/2021." The hearing date referenced on the RB-89 was actually incorrect as the finding was made on a different date.

The Law: Regulations permit the Board to create reasonable rules and procedures consistent with the WCL, including 12 NYCRR 300.13 which requires proper completion of the appellate forms submitted by the Board. In cases of such failure, the Board has the discretion to deny review. Here, Box 15 was incomplete on two grounds – the objection listed an incorrect date and the substance of the objection was not specified. Consequently, the Board could deny review.

The Takeaway: Although denials on this ground are down from prior years, parties on both sides of the table are reminded of the need to properly complete the RB-89 form. Box 15 is a notorious trap – although specified as one question in one Box, as the Third Department notes, it is a compound question requiring both the date of the exception and the basis of the exception. It is extremely easy to miss one of these items in that box. Unless and until the Board clarifies the compound question in a subsequent iteration of the RB-89 form, proper completion of this form is crucial.

Nunez v. Young Men's Christian Association of Greater New York

Topics: Further Causally-Related Disability

The Holding: Board determination that claimant had no further causally-related disability after March 24, 2019 affirmed.

The Facts: Claimant, a maintenance worker, had a July 2018 claim involving the hand, head, and back. On March 24, 2019, however, claimant bent down to pick something up at home and became "paralyzed and couldn't move." Claimant did not return to work the next day and subsequently had an MRI showing a herniation at L4-5 and bulge at L5-S1. On July 30, 2019, he resigned from his job, citing his diagnoses and illness. In October 2019, the claim was established for the low back, but the carrier disputed awards and treatment after the March 2019 incident. Following depositions, the WCLJ found that the incident "exacerbated" the workplace condition and awarded TTD benefits from March 2019-April 2021. The Board reversed, finding that claimant submitted insufficient and incredible evidence of ongoing disability.

The Law: There is no "presumption of continuing disability" under the WCL – it is claimant's burden to prove ongoing disability and the Board has discretionary fact-finding power in this matter. Here, claimant testified that he hadn't returned to work since March 2019 and initially used sick days to call off following the bending over incident. Moreover, the claimant did not disclose the incident at home to an IME, nor that he was working until the incident. Additionally, claimant did not disclose to the treating physician the incident at home nor that he had returned to work prior to that point. Consequently, while physicians had opined that the disability was related to the incident, they were based on inaccurate histories and the Board could conclude no ongoing disability.

The Takeaway: Subsequent or interim injuries are often termed as "exacerbations" by the Board and generally do not break the causal nexus between an initial injury and ongoing symptoms. Notably, the WCLJ did initially find a simple exacerbation in the first decision. Overcoming that argument is a difficult burden – here, however, claimant was apparently working until the incident at home, took sick time off, and failed to disclose the incident to his doctor and IME – essentially, the perfect storm to give the Board the basis to conclude that the ongoing disability was not related as these factors all pointed towards a new incident. Additional evidence that can be used may also include a change in diagnostic findings.

December 2022

Wein v. Burnt Hills Ballston Lake Schools

Topics: Labor Market Attachment

The Holding: Board determination that claimant was not entitled to indemnity benefits affirmed.

The Facts: Claimant, a high school PE teacher, sustained an April 2016 injury to the right shoulder, right elbow, neck, and tooth with a concussion and post-concussive syndrome. Claimant was cleared to return to work in November 2017. At that time, the claimant's doctor noted that claimant was "improving nicely" and would be seen only as needed. However, claimant stopped working due to unrelated medical issues and returned from that position in June 2018. The Board discredited claimant testimony that her doctor released her to return to work "as a favor" so she would not lose her job. Claimant returned to a different employer in August 2019 as an adjunct professor and sought RE awards. Despite restrictions including no use of the right shoulder above shoulder high and no repetitive motion of the neck and a 15-20 lb. restriction, claimant focused her job search only in the physical education field and she testified she had not sought full time work or sought vocational rehabilitation. The WCLJ found a voluntary removal from November 2017 until the August 2019 return to work. On administrative appeal, the Board reversed the finding that claimant was entitled to awards following August 2019.

The Law: Claimants bear the burden of demonstrating that their injury caused or contributed to the loss in earnings and the Board is vested with discretion to resolve this dispute within its fact-finding capability. The Board's decision here was supported by substantial evidence.

The Takeaway: Reduced earnings claims can be somewhat nebulous gray areas where a departure from work is related to the injury and depending on the quality of claimant's reattachment to the labor market. Again, this is another "perfect storm" case – claimant here apparently stopped working as a high school PE teacher due to unrelated causes and then returned to work in what would seem to be a physically demanding field without searching for alternative or even full-time employment or using vocational services. Nearly every factor pointed in the carriers favor and notably, the initial determination still went in claimant's favor. The reasons for a claimant's departure from work or reduction in earnings should be reviewed for causal relationship.

Pierre v. ABF Freight

Topics: COVID-19

The Holding: Establishment of claim for COVID-19

The Facts: Claimant, a freight delivery driver, filed a claimant as a result of contraction of COVID-19. The carrier maintained that COVID-19 was not covered under the WCL and that the injury did not occur in the course of employment. Claimant here testified that he had an upper respiratory infection in March 2020 and returned to work on April 2, 2020. Claimant left to make deliveries but then was instructed to return because the facility would be closing due to a "major" outbreak of COVID requiring that it be closed for 1 week. On April 6, 2020, he was diagnosed with COVID. The record did not demonstrate how many employees had COVID, but numerous other employees did and one even passed away as a result. The union shop steward maintained about seven people reported COVID. There was no protective equipment and meetings were held in groups of 15-20 multiple times per week, with no precautions taken in a breakroom. Claimant also testified he did not go to the store, restaurants, or use public transportation and had no contact people other than his wife and son.

The Law: The Third Department has concluded that contraction of COVID qualifies as an "unusual hazard, not the natural unavoidable result of employment" and can thus be compensable. Whether an accident occurred is within the Board's fact finding province and will be affirmed if supported by substantial evidence. It is not required that claimant be able to pinpoint the exact date on which the incident occurred. Here, the testimony supported the conclusion that claimant contracted the disease at work.

The Takeaway: First, please stay tuned for further developments in this area. Our firm has filed an appeal at the Third Department challenging the "prevalence" standard of review at the Board. Second, note that the "prevalence" standard was not applied here – the Third Department appears to have applied an accidental injury test and affirmed the Board's finding based on the testimony that COVID-19 was actually in the workplace and spread to many people without use of protective equipment. The law surrounding COVID claims is not entirely set in stone and carriers should carefully investigate all avenues of possible exposure, use of protective equipment, and claimants' medical sequalae from COVID diagnoses. For more, see also the claim of *Holder v. Office for People with Development Disabilities*.

January 2023

Bakerian v. Washington County

Topics: Minor's Wage Expectancy; Protracted Healing Period; Laches

The Holding: Board determination that claimant failed to timely raise minor's wage expectancy affirmed, but matter remitted to determine issues of TTD/PHP.

The Facts: Claimant was a CAN who sustained injuries to the left shoulder in 2008 and 2009. There were numerous hearings on TPD/TTD and permanency before claimant was assessed with a 40% SLU of the arm in 2015 worth 124.8 weeks of TTD. As prior payments exceeded that amount, the matter was closed. Five years later, claimant obtained new counsel seeking reopening on the issue of minor's wage expectancy and raising the issue of protracted healing period. The carrier raised laches with respect to MWE and argued that PHP would not change the finding that benefits exceeded SLU such that the issue was moot. That finding was affirmed.

The Law: Laches can bar a party from raising an issue where there is an unreasonable and unexplained failure to pursue the issue. Here, the claimant knew as early as 2010 that this issue could have been pursued as the employer submitted a payroll projection of wage expectancy. However, since there was no explanation for the unreasonable delay in raising this issue and claimant did not show that the SLU would increase based on the MWE. However, in this case the Board erred in not remitting the matter to determine issues of TTD/TPD for calculation of PHP.

The Takeaway: Regarding MWE, it is somewhat unclear why claimant's counsel would have pushed the issue if it would not have resulted in additional benefits moving. However, MWE is an easy to miss issue as claimants who sustain injury before 25 yet are over the age of 18 are not often considered "minors" in layman's terms. The more notable issue is the PHP concern. Some claimant's counsels, particularly in the downstate area, routinely push for awards to be tentative rate or "TR" – this can create headaches at the time of permanency with retroactive requests for benefits or, alternatively, surprise issues of PHP at permanency. When possible, obtaining firm findings of TTD/TPD is preferred during litigation or the issue should be resolved at the time of permanency.

February 2023

Rios v. Rockaway Contracting Corp.

Topics: New Evidence

The Holding: Board properly declined to consider new evidence.

The Facts: Claimant alleged that while working for employer Rockaway Contracting Corporation in 2018 he sustained an injury. At an initial hearing May 2019, two other potential employers, Fast Track Drywall and Ibanez Construction Services Corporation were identified. In December 2019, claimant testified that he was working for Rockaway who paid him in cash, though he also received three checks from Ibanez. Ibanez' president was listed as a witness for the hearing, but did not appear. Ultimately, Rockaway was found to be the responsible employer in a December 16, 2019 decision. Eight days later on December 24, 2019, Rockaway submitted affidavits from Ibanez's president and foreperson that claimant worked for Ibanez. The Board declined to consider these affidavits as there was no explanation as to why they were not submitted.

The Law: The Board's regulations require that if an appealing party wishes to introduce new evidence, there must be an affidavit explaining what the evidence is **and** why it could not have been submitted earlier. Here, the explanation that the employer was "unable to obtain the

additional evidence in advance of the hearing" was insufficient as Ibanez was on notice and Rockaway failed to detail any attempts to contact Ibanez.

The Takeaway: There are few, if any, Board deadlines that can be trifled with. Any and all that is to be used to challenge the claim should be submitted with a pre-hearing conference statement at least 10 days before the hearing or there is a chance it may not be used in litigation, no matter how valuable the evidence. Belated submission of evidence without a rational explanation (i.e. here, if Ibanez had been contacted and refused to provide the information) is unlikely to be met with success – here, even to the point where a potentially improper employer and its carrier may have been stuck with the claim.

Marcellino v. National Grid

Topics: Permanency

The Holding: Board properly concluded that claimant did not sustain a causally-related SLU of the elbow.

The Facts: Claimant was a millwright mechanic who sustained an injury the to the back, neck, left thumb, left elbow, and left hand(CTS) stemming from an April 8, 2015 accident. Claimant underwent a left wrist CTS release, ulnar nerve release, and left thumb trigger release. In 2017, claimant's doctor opined a 30% SLU of the left elbow, 25% SLU of the left wrist, and 30% SLU of the left thumb. Claimant was classified with a PPD, but as he was working at pre-injury wages, he received no further benefits. On reopening in August 2020, an IME physician opined that claimant had no ROM deficits and had no SLU other than 15% for the left CTS and claimant's treating physician stood by his 2017 opinion. Notably, the IME did not evaluate the elbow. The WCLJ credited the IME and found 15% of the left hand for the CTS, but 0% SLU of the elbow or thumb.

The Law: Generally, the finding of whether a claimant has a permanent disability and the severity of the same are matters committed to the Board's discretion and will be affirmed if supported by substantial evidence. Here, claimant's argument that because he offered the only SLU opinion on permanency it was entitled to credit failed. The Board could rationally discredit the treating physician's opinion based on the fact that the treating physician's prior ROM examinations demonstrated minimal ROM deficits at the elbow. Similarly, the Board could discredit the 30% SLU opinion of the thumb as the treating physician did not measure the ROM in the thumb in 2017 and prior ROM deficits were negative.

The Takeaway: Carriers can in certain instances waive an IME on permanency in cases where, as here, there is an inexplicable and substantial drop in ROM between treating physician's notes just before permanency and at a final SLU evaluation. Whether the argument will successful depends on the severity of the difference, how long ago the last treatment or measurement was, and relative credibility of the doctor and claimant, but unexpectedly poor function at an SLU examination should be measured against prior medical notes and evaluations.

Gomez v. Board of Managers of Cipriani

Topics: Out-of-State Treatment

The Holding: Board determination that carrier was not liable for treatment bills reversed and remitted.

The Facts: Claimant sustained a 2017 injury involving multiple orthopedic and psychological disorders. In February-May 2021, claimant submitted bills for treatment from New Jersey providers as claimant also resided in New Jersey. The carrier argued that the Board had not authorized the physician (who was also licensed in New York) to provide the treatment. The Board Panel affirmed.

The Law: Generally, a claimant injured in New York is entitled to treatment by providers licensed in New York and authorized by the Board to treat claimants. However, claimants who are injured in New York but reside in other statements are also entitled to receive treatment and the Board's regulations could not have been intended to prohibit all out of state treatment. Here, claimant resided and treated in New Jersey. While 12 NYCRR 323.1 provides that New York physicians must obtain Board authorization, the Third Department concluded that this regulation was not intended to apply to out-of-state physicians as this would be contrary to the "economic and humanitarian" objectives of the WCL.

The Takeaway: Out-of-state treatment and providers often present thorny billing and logistical issues. It is uncertain to this author whether this decision has been further appealed as resting at least in some part on a "humanitarian" reading of a regulation, however, the Third Department has made its position clear that for out-of-state claimants using out-of-state providers, carriers cannot dispute bills solely on the basis of lack of Board authorization.

March 2023

Wilber v. Hamister Group, LLC

Topics: Permanency; Labor Market Attachment

The Holding: Board determination that claimant was not entitled to demonstrate labor market attachment or respond to light duty job offer following classification affirmed.

The Facts: Claimant was an LPN who sustained injury in May 2017 and she was classified with a 70% PPD/LWCE in January 2020. Nine months later, the employer offered part-time work purportedly within claimant's restrictions which the claimant rejected. The carrier requested a hearing to suspend benefits. Both the WCLJ and Board determined that claimant was not required to show ongoing attachment to the labor market and denied the request.

The Law: Under 15(3)(w), in cases of PPD, compensation is payable "without the necessity for the claimant who is entitled to benefits at the time of classification to demonstrate ongoing

attachment to the labor market." Here, when claimant was classified per stipulation, there was no finding that she had voluntarily withdrawn – consequently, she did not need to show ongoing LMA.

The Takeaway: The amendment to 15(3)(w) effectively ended a long period of carriers attempting to raise post-classification LMA, sometimes as a basis to try to leverage a settlement. In cases involving PPD/LWEC, LMA should be adjudicated before or at the time of classification – once a PPD/LWEC stipulation or decision is made, if claimant is entitled to awards at that time, claimants have no responsibility to look for work or respond to light duty offers to demonstrate ongoing entitlement to awards.

April 2023

Delaney v. John P. Picone, Inc. et al

Topics: Occupational Disease; Apportionment

The Holding: Board determination that John P. Picone and its carrier were liable for claim affirmed.

The Facts: Claimant, a 30-year construction laborer, filed a claim for benefits in January 2019 alleging an occupational disease involving the arms and hands. He listed at that time John P. Picone Inc. as his employer. He previously commenced treatment in December 2018 for the hands/arms. John P. Picone's IME found causal relationship to claimant's employment. During the course of litigation, claimant failed to appear at one point with the file closed. Sometime before reopening in January 2021, claimant started working for Jett Industries Inc. Jett's carriers were placed on notice and pointed the finger back at John P. Picone as the proper carrier. Claimant testified that he worked for John P. Picone for four years, ending in April 2019 and that in August 2019, he started working for Jett doing similar work. The WCLJ set December 19, 2018 as a date of disablement and found that John P. Picone and its carrier were liable. The Board affirmed.

The Law: First, the Board has substantial discretion in setting date of disablement under Section 28 for occupational diseases and is not "required to give preference to certain events over others." Here, the Board's determination to set date of disablement as first treatment with causal relationship instead of the date of a subsequent surgery was not irrational. Second, although John F. Picone argued that under Section 44, the last employer in a line of employments to which the disease is attributable to (i.e. here, Jett) should be liable. However, Section 28 is a statute of limitations provision and marks the date of disablement and Section 44 is a reimbursement statute for prior employers – essentially, Section 44 grants the liable employer on the date of disablement a right of recovery, it does not serve to amend the date of disablement.

The Takeaway: Regarding date of disablement, arguably the most common date used is first treatment at which an indication of causal relationship is made. The Board has very wide discretion in setting this, however, and can alternatively choose first lost time or first treatment generally. The more interesting piece of this case is the Section 44 argument. John P. Picone had a valid point that claimant was still employed in the occupation which generated his disease,

however the Court's reading of the statutes makes sense – the occupational disease arose and the date of disablement was set within John P. Picone's coverage period. Consequently, John P. Picone would have a right of Section 44 recourse against previous employers in the same line of business. In addition, it may also have an argument that the claim should be apportioned as a matter of law outside of Section 44 at a later point in the litigation, however, this would be outside of Section 44.

Feldman v. New York City Transit Authority

Topics: Treating vs. IME Physician

The Holding: Board disallowance of claim and determination that claimant's physician's report was in actuality an independent medical report and subject to Section 137 affirmed.

The Facts: Claimant was a subway car inspector and repairperson who alleged contraction of COVID based in part on the notice of a physician who testified that she had examined claimant for the purpose of providing an opinion as to whether claimant's illness was work related and her report was not submitted in accordance with Section 137.

The Law: Under Section 137 and 12 NYCRR 300.2, it was undisputed that the reason claimant was examined was for the purposes of an evidentiary opinion as to causal relationship. Consequently, the report was actually an IME and should have been filed in accordance with that statute. While there was an argument that the physician was excepted from Section 137 as part of an occupational health clinic network under 12 NYCRR 300.2(b)(4), the contention was not raised for the first time until appeal and could not be addressed on appeal.

The Takeaway: The question of whether a treating physician's opinion is really an IME in disguise most often crops up in death claims or claims involving exposures to diseases or toxic materials where the sole purpose of the examination is to provide an opinion on causal relationship. Opinions in such case should be scrutinized for potential preclusion under Section 137 or whether they come from a network exempted from these requirements.

Holder v. Office for People with Developmental Disabilities

Topics: COVID-19

The Holding: Decision disallowing claim for COVID affirmed.

The Facts: Decedent was a house manager who he began suffering COVID symptoms on March 13, 2020, two days after leaving for a vacation on March 11, 2020 before ultimately passing away from COVID in late March 2020. Claimant brought a claim for COVID-19. The WCLJ established the claim, but Board Panel reversed finding a lack of evidence of "prevalence."

The Law: COVID-19 contraction can qualify as an "unusual hazard, not the natural and unavoidable result of employment" and is thereby a compensable condition, but whether there was a compensable accident is a question of fact by the Board. The Third Department cited to Board guidance noting that this can be demonstrated by "a specific exposure to COVID-19 or prevalence

of COVID-19 in the work environment so as to prevent an elevated risk of exposure." Here, claimant provided no evidence of COVID-19 in the workplace/group home where claimant worked and the employer presented testimony that decedent was the first known infection. Consequently, the claim was disallowed.

The Takeaway: As noted above, the caselaw in this area remains under development and is the subject to an appeal by this Office. Here, although the Third Department applied the prevalence standard unlike in *Pierre*, the standard was not met for lack of evidence of the same. Again, in similar claims, carriers should carefully investigate all avenues of possible exposure, use of protective equipment, and claimants' medical sequalae from COVID diagnoses.

May 2023

Serrata v. Suffolk County Police Dept

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

The Holding: Board's determination that claimant's accident did not arise out of and in the course of employment reversed.

The Facts: Claimant, a detective sergeant, was scheduled to work 9:00 a.m. to 5:00 p.m. and was on standby from 1:00 a.m. to 9:00 a.m. At 4:15 a.m., claimant received a call about a grand larceny and that a suspect was being held. As part of his duties, claimant used his personal vehicle to travel to the police precinct to pick up his service vehicle to travel to the crime scene. En route in his personal vehicle, he was rear-ended. The WCLJ established the claim, but the Board reversed, finding that the accident did not arise out of and in the course of his work activities and that the "special errand" exception did not apply.

The Law: While injuries resulting from travel to and from work are generally not covered, if the claimant is engaged in a "special errand," the claim may be compensable. This can be satisfied by a showing that claimant undertakes a work-related errand and has altered his or her "usual geographical or temporal scheme of travel" and if the employer both "encouraged the errand and obtained a benefit from the employee's performance of the errand." Here, while there was testimony that claimant's overtime pay did not start until he checked out a service vehicle, claimant was engaged in the process of command and coordination of a criminal investigation – even though this was his usual route to the office, this was outside of his normal travel time given the early morning hours and his work activities.

The Takeaway: Given the remedial nature of the WCB, the Board will often credit claimant explanations that their activities were taken for (or encouraged by) the employer and find that certain claims involving travel or work activities outside of the usual course are compensable. Claims from accidents arising during travel outside of working hours should be especially scrutinized and all facts obtained.

DiMeo v. Trinity Health Corporation

Topics: Injury; Cardiovascular Events

The Holding: Board decision disallowing claim reversed.

The Facts: Claimant was an outpatient PT aide on light duty assignment due to a prior injury. In July 2020, while discussing a potential change in assignment with her supervisor, claimant sustained shortness of breath, chest pain, sweating, and nausea. She left work and was diagnosed with a myocardial infarction. She filed a claim alleging that the heart attack was due to work-related dress. The WCLJ established the claim, but the Board reversed and disallowed on the basis that there was no "physical injury."

The Law: Case law is clear that the occurrence of a myocardial infarction itself does constitute a physical injury. Notably, the "sole" medical evidence was from claimant's cardiologist which was that claimant's heart attack was related to work. Consequently, the Board was not free to conclude that claimant did not merely sustain "mild emotional distress."

The Takeaway: While mental stress claims generally evaluated as to whether the claimant there sustains any stress above and beyond the usual work environment, a heart attack is certainly a different animal and may constitute a physical injury. Obtaining a contrary IME on the issue of causal relationship is often a prudent decision.

June 2023

Cush v. Tully Construction Co.

Topics: New Injury

The Holding: Board determination that claimant sustained a new compensable injury affirmed.

The Facts: Claimant had a prior 2007 claim involving the neck for which he had a cervical fusion surgery in 2011 and treated monthly. In 2019, claimant alleged a slip and fall resulting in, inter alia, a neck injury. The carrier maintained that the neck condition was not related the 2019 incident, but to the prior claim. The WCLJ established the claim for an aggravation of the neck.

The Law: The Board is empowered to determine the issue of causal relationship and the Board is vested with authority to make credibility calls that will be upheld if supported by substantial evidence. Here, the 2019 incident resulted in claimant proceeding to an unscheduled visit and claimant's treating physician maintained that the diagnostic studies had changed and worsened following the 2019 incident. Moreover, claimant was able to return to work prior 2019, but was taken out of work following the subsequent incident.

The Takeaway: Prior injuries nearly always present thorny issues to be resolved at the Board. Carriers would do well to understand that the mere existence of either a prior injury/accident or a subsequent injury/accident is going to be a lock for apportionment. Obtaining all medical records from prior or subsequent incidents and obtaining an IME opinion is the best strategy for reviewing potential apportionment issues.

Pernice v. Harlan Electric Company

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

The Holding: Claimant, notwithstanding consumption of alcohol, sustained a compensable accident.

The Facts: Claimant was a lineman who sustained injury when a bucket truck, driven by one of claimant's coworkers who was intoxicated at the time of the incident, tipped over. The claim was denied on the basis that claimant also drank alcohol at lunch, despite company policy not to do so. The WCLJ concluded that claimant was acting within the course and scope of his employment and because claimant was not the driver of the bucket truck, his injury was not barred under Section 10(1). The Board affirmed.

The Law: Momentary deviations from the normal work routine will not defeat a claim and it is within the Board's fact-finding authority to determine whether the claimant's actions were "purely personal pursuits" outside of the normal course of employment. Here, claimant confirmed that he drank "a beer and a half" at lunch while on standby for work, claimant was on the clock, and claimant was in the bucket truck after improperly using his personal vehicle to go to lunch. Claimant was also a passenger, not a driver, and although the driver was intoxicated and speeding, the initial medical report indicated that claimant was "alert" and "not intoxicated."

The Takeaway: The Board has very wide authority to determine whether an accident arises out of and in the course of employment. Here, the claimant was on the clock, in a work vehicle, and traveling to a worksite. Notwithstanding the driver's intoxication, this will yield a compensable claim – the analysis may be different if the claim involved the driver and the accident was occasioned solely by intoxication, but the claimant's passenger status resulted in application of a different analysis.

Harris v. Department of Environmental Protection

Topics: Section 137

The Holding: Board's finding that claimant's doctor was acting as an IME affirmed.

The Facts: Claimant had a compensable 2019 claim involving the right extremity. In July 2020, claimant's physician filed a C-4.3 opining SLU. Following the doctor's testimony, the carrier raised a question as to whether the doctor was acting as an IME and should be precluded. The WCLJ did not address the issue in awarding an SLU, but the Board ultimately precluded the IME.

The Law: An attending physician is a provider who has "primary responsibility for treating" the injury or illness. Here, the physician did not treat claimant for his injuries – he merely provided an evidentiary opinion on MMI/SLU. Although claimant alleged that he had seen the physician twice, one of these notes was not in the record, and the other was a note indicating only that claimant should "continue taking medications as prescribed." Here, as there was no evidence that the report was properly served under Section 137, it should be precluded.

The Takeaway: This issue rarely comes up, however, carrier should evaluate situations where claimants obtain permanency opinions from physicians other than their normal treating doctors – in these limited cases, the report may potentially be viewed as an IME in disguise and potentially precludable under Section 137.

Attreed v. Five Star Electric Corporation

Topics: Labor Market Attachment

The Holding: Board determination that claimant was not entitled to awards reversed and case remanded.

The Facts: Claimant sustained a compensable injury to the bilateral knees on 6/13/20. He returned to work four days later and then filed a claim in July 2020 before stopping work in September 2020 due to the injury. The claim was established in April 2021 and lost time awards made. At a hearing on 9/27/21, the carrier raised voluntary removal/LMA and claimant was directed to produce evidence of LMA and awards continued. On 10/25/21, claimant testified that he worked with a union and he was laid off in November 2020 due to downsizing and that he underwent surgery five days prior to the hearing on 10/20/21 and had not looked for work prior to the surgery. The WCLJ continued awards from the September 2021 hearing through the 10/20/21 surgery and thereafter. On appeal, the Board reversed, finding that claimant had not shown his withdrawal from the labor market was due to his disability and vacated awards after the 9/27/21 hearing.

The Law: "The Board has held that the appropriate date of a finding of no labor market attachment is not the date the issue is raised, but rather the date that evidence showing a lack of labor market attachment is submitted." While the issue was raised 9/27/21, the testimony and evidence occurred on 10/26/21. Consequently, the Board should not have suspended awards from between the 9/27/21 and 10/25/21 hearings. Case remanded for further consideration.

The Takeaway: There are certainly many divisions in standardization of Board procedure. Anecdotally, some WCLJ's will address LMA as of the date that the issue is raised at a hearing or as of the date of an RFA and others will always bring awards to date until testimony is given. However, the Court has set that the date of testimony/given evidence is the applicable date for suspension. Given that claimant had surgery prior to the applicate LMA consideration date, the claimant in this case may have an argument on remand that awards should have continued.

COURT OF APPEALS

October 2022

Green v. Dutchess County BOCES

Topics: Post-Death Permanency Awards

The Holding: Third Department determination that claimant was entitled to balance of decedent's post-death PPD benefits reversed.

The Facts: In *Green* (2020), the Third Department reviewed the statutory language in Section 15 of the workers' compensation law and acknowledged that while SLU and PPD awards were in some respects treated differently under the law and that entitlement to a PPD was generally supported by a wage loss "caused by the established injuries," this system "unfairly deprives an injured worker's surviving spouse and/or children of the remaining cap weeks that were established, set and fixed at the time of classification." The Appellate Division further reasoned that "if an injured worker dies without any reduced earnings, or while at preinjury wages, his or her surviving spouse and/or children would forever be deprived of any benefits because the deceased worker never sustained, and could no longer establish, a causally-related reduction in wages." For carriers, the counter-argument apart from the terms of the statutes, was that death permanently superseded a presumption of causally-related wage loss and prevented any opportunity for an injured worker to return to work in any capacity and that it was unfair to pay out the remaining benefits on a speculative basis.

The Law: The Court of Appeals in *Green* (2022) reversed the Third Department's decision and stated that Section 15 did not provide for payment of the unaccrued benefits of a PPD. While there was no dispute that any PPD award up until the date of death was owed to the injured worker's estate/dependents, Section 15's language and legislative history make clear that SLU awards required "fact-specific individual calculations based on the impairment of wage-earning capacity," but PPD awards were payable "'during the continuance of such permanent partial disability,' but 'subject to reconsideration on the degree of such impairment by the Board.'"

The Court noted that in contrast to SLU awards, a PPD award was "by its terms, subject to reduction and suspension" and that the rate and duration of a PPD benefit was subject to potential change. Moreover, the Court also highlighted that 2009 statutory amendments allowing claimants to elect SLU awards to be taken as a lump sum were not extended to PPD awards and if the legislature meant to do so, it could have. In response to the Third Department's finding regarding the alleged inequity regarding the treatment of the two types of awards, the Court noted that there was simply a lack of any legislative intent to "eliminate all distinctions between the two forms of awards" and opined that if there was to be a change made to how PPD awards were paid, this would be best left to the Legislature.

The Takeaway: After the brief period of confusion following the Third Department's decision in 2020, the historical standard has returned – if a classified claimant with a PPD/LWEC passes as of unrelated causes, the decedent's beneficiaries are not entitled to the balance of a PPD award.

Note that this only applies to PPD/LWEC cases where the death is unrelated – if the death is caused or contributed to the underlying compensable condition or the claim involves a potential SLU, different rules will apply. Further, this is also assuming that no further action is taken by the legislature in response to some of the language in the Court's decision.