



this issue

Labor: NLRB Upholds Picketing Standards	1
Workers' Compensation: Taking Advantage of the Handicap Reimbursement Program.....	2-3
Labor: Use of Independent Contractors under the NLRA	4
Workers' Compensation: How to Use the Drug Statute Effectively at Hearing	5
Employment: Preparing for an Influenza Pandemic and Complying with Workplace Laws and Regulations.....	6-7
Workers' Compensation: Does the Court of Common Pleas have Jurisdiction to Hear Appeals Concerning the Reactivation of Workers' Compensation Claims?.....	7
Workers' Compensation: Legalized Extortion: The Hidden Cost of Litigation	8
Workers' Compensation: Supreme Court of Ohio Addresses Termination of Temporary Total Disability Benefits.....	9

Attorneys

Alan G. Ross
 Brian K. Brittain*
 Evelyn P. Schonberg**
 Anthony A. Baucoco
 Scott Coghlan
 Chad A. Fine
 Scott W. Gedeon
 Ryan T. Neumejer
 Nick A. Nykulak
 Carol D. Strassman*
 Michael K. Zbawiony

Paralegals

Renee M. Mezera
 Lorraine J. Geiger
 Arlene M. Golias
 Carla E. Kihorany
 Elizabeth A. Krusinski
 Rosanne M. Slivka
 Lori A. Williamson

Firm Administrator

Mary Ann Kuilder

LABOR: NLRB Upholds Picketing Standards

by Nick A. Nykulak

Picketing by a labor union is a protected activity under the National Labor Relations Act (NLRA), but in order for the picketing to be lawful, labor unions must strictly adhere to certain rules when “neutrals” are involved. Under the NLRA, labor unions may peacefully picket to inform the public that they have a dispute with an employer and may properly inform the employers’ employees, material men, suppliers and business visitors of that dispute.

In 1950, the National Labor Relations Board (NLRB) decided Moore Dry Dock, which established the standards a labor union must follow in order for picketing to be lawful. Under Moore Dry Dock, a labor union, at a minimum, must strictly limit all picketing activity to times when the primary employer is on the jobsite and engaged in its normal business operations at the jobsite. A labor union must also strictly limit picketing activity to places reasonably close to the location of the jobsite. Lastly, the picketing activity must disclose clearly to the public and those on the jobsite that the union’s dispute is with the primary employer.

The employer that the labor union has a “dispute” with is considered the “primary,” and all other employers are considered “neutrals” to the dispute. It is unlawful for any labor union to purposely “mesh” a neutral into the dispute with a primary by threatening the neutral with pickets or other unlawful conduct that has an “objective” of having the neutral cease doing business with the primary. Consider the scenario where a union official threatens a general contractor, by stating that unless the “neutral” general contractor replaces the non-union subcontractor (the primary) with a union subcontractor, the union “will shut this job down with

pickets.” This is an example of an unlawful statement that would subject the union to an unfair labor practice charge. If monetary damages result from the unlawful picketing activities, or the primary is removed from the jobsite due to the unlawful threat, the general contractor and/or the subcontractor (or any other person/entity that is harmed) may recover such damages in federal district court from the labor union making the unlawful threats.

In a very recent decision, the NLRB reaffirmed its previous holdings that “unqualified” threats to picket a jobsite (i.e., threats made to a neutral which fail to state that any picketing on the jobsite will be limited to and directed at only the primary with whom the union has a dispute) are unlawful under the NLRA. The NLRB held that a union official’s statement made to a neutral general contractor that the union would picket “unless” demolition work at the jobsite was performed by a union contractor instead of a non-union subcontractor clearly demonstrated the union’s unlawful secondary objective of forcing the neutral general contractor to cease doing business with the primary non-union subcontractor. As such, the NLRB continues to hold that any threats, restraint or coercion that are designed to force or require a neutral employer to cease doing business with the primary, including unqualified threats to picket the entire jobsite, remain unlawful under the NLRA.

A union’s picketing activities are subject to many more constraints than are discussed in this article. Should you have any questions about a threatened or actual picketing activity, please do not hesitate to contact Nick Nykulak or Alan Ross.

This Publication is intended to inform clients and friends about labor and employment matters of current interest. The matters included were not given exhaustive treatments due to space limitations. This abridged information should not be construed as legal advice and is not a substitute for legal counsel. This publication is not intended to create, and receipt of it does not constitute, an attorney relationship.

*OSBA Certified Specialist Workers’ Compensation
 **OSBA Certified Specialist Labor & Employment

WORKERS' COMPENSATION: Taking Advantage of the Handicap Reimbursement Program

by Anthony A. Baucio

As a state-funded employer doing business in Ohio, you absolutely need to know everything you can about the Bureau of Workers' Compensation's Handicap Reimbursement Program.

Unless your company has previously benefitted from utilizing this employer-friendly program in the past, you may not be knowledgeable about it or fully understand the extent that this program can lower the cost of a claim, thereby reducing your premiums. Now, more than ever, it is important to take full advantage of the Handicap Reimbursement Program.

So, what is a handicap reimbursement and how can your company benefit from one? Let's start with a hypothetical (but all too common) situation:

As a state-funded employer, one of your employees is injured on the job and subsequently files a workers' compensation claim. The claim is initially allowed for a lumbar sprain. The claimant remains off work and begins receiving temporary total disability compensation. As part of the claimant's treatment, he undergoes an MRI scan of the lumbar spine. The MRI reveals two herniated discs, in addition to a fairly severe arthritic condition of the lumbar spine. The claimant's treating physician believes that the arthritic condition likely pre-existed the injury. Eventually, the claim is additionally allowed for the two herniated discs. The claimant remains disabled and eventually has to undergo surgery to address his herniated discs. The operative report becomes available and, upon review, you see that the claimant's attending physician made note of the severe arthritic condition of the claimant's lumbar spine. The claimant remains off work for another six months post-surgery before finally returning to work. At this point, the claims costs are simply astronomical. A year of temporary total disability compensation has been paid. Extensive medical bills have been paid. There is also a significant reserve attached to the claim. There is no doubt that this claim is going to have a significant impact on your premiums. What, if anything, can be done to lower these claim costs? This is where it literally "pays" to understand the Handicap Reimbursement Program.

Here's what you (and your attorney) would look for to see if a handicap reimbursement is possible:

The law defines a "handicapped employee" as an employee who is afflicted with or subject to any physical or mental impairment, or both, whether congenital or due to an injury or disease, of such character that the impairment constitutes a handicap in obtaining employment or would constitute a handicap in obtaining reemployment if the employee should become unemployed. The actual "impairment" causing the alleged handicap must be one of the twenty-five conditions specifically noted in the law. The three most common impairments (or conditions) noted in the law are arthritis, diabetes and cardiac disease. There must always be clear evidence of the condition in the medical records. Evidence of the condition can usually be found in medical records (both prior to and subsequent to the injury) such as office notes, diagnostic tests and operative reports.

Furthermore, there must be clear evidence that the condition pre-existed the claimant's industrial injury. Again, look to the medical records for evidence of whether or not the condition pre-existed the injury. The claimant's treating physician may have offered an opinion. However, it is often necessary to obtain a record review from an independent physician to offer an opinion as to whether or not the condition pre-existed an injury. This is usually necessary when there are no medical records prior to an injury, and the post-injury medical records are unclear as to this point.

Additionally, it is necessary to demonstrate that the pre-existing condition contributed to the length and difficulty of the claimant's recovery from his injury. Again, look to the medical records for evidence of this. It is often necessary for an independent physician to offer an opinion on this issue as well. An independent physician can review the claim and opine, for instance, that the condition contributed to a 75% delay in the claimant's recovery from his injury. This would translate into a 75% handicap reimbursement.

Lastly, in order to pursue a handicap reimbursement, the appropriate type of compensation must have been paid in the claim; that is, either temporary total disability

compensation (or salary continuation), permanent total disability compensation, death benefits and/or scheduled loss awards.

In our example above, should we pursue a handicap reimbursement? The answer is yes!

First, the claimant clearly has evidence of impairment (arthritis is one of the twenty-five conditions) as per the MRI scan and the operative report. However, it is also important to keep in mind that MRI scans, operative reports and other medical records might not specifically mention the word "arthritis." Arthritis often goes by many different names and the Handicap Reimbursement Unit is very particular as to what constitutes arthritis and what does not, for purposes of granting a handicap reimbursement.

Second, the arthritis likely pre-existed the industrial injury. The treating physician actually believes that it did. Although there are no prior medical records, the MRI scan was performed soon after the claimant's injury and revealed severe arthritis. It is likely to be accepted that the severe arthritis developed over time and pre-existed the claimant's injury, as opposed to developing in the short time subsequent to the injury. This is when an independent physician's opinion, subsequent to a record review, becomes useful as well. Obviously, it would be nice to have medical records prior to the industrial injury that show a pre-existing condition, but those records might not exist! When they do exist, it is obviously very clear evidence of a pre-existing condition. When they don't exist, you may need an outside opinion.

Third, the claimant's pre-existing (and severe) arthritis likely contributed to a delay in the claimant's recovery from his injury. How much of a delay, though? It is important to review the claimant's medical records to get an understanding of the treatment history and the impact of the arthritis on his recovery. Again, this is where a record review from an independent physician comes in handy. For purposes of our hypothetical situation, let's say our physician recommended a 75% handicap reimbursement due to the impact of the claimant's pre-existing arthritic condition.

Fourth, the claimant was clearly paid temporary total disability compensation, so

Continued on Next Page...

WORKERS' COMPENSATION: Taking Advantage of the Handicap Reimbursement Program *continued*

the appropriate type of compensation was paid in the claim.

So, in our example, we seem to have met all the elements to pursue a handicap reimbursement. This matter should be referred to your attorney, if it has not been already, to proceed with the filing of an application for a handicap reimbursement.

At this point, it is important for your attorney to compile any and all medical documentation that supports a handicap reimbursement. As mentioned above, it is recommended to obtain a record review from an independent physician. The physician should provide a report addressing the above-referenced issues and provide an actual percentage recommendation.

Your attorney should then proceed with filing an application for a handicap reimbursement with the Bureau of Workers' Compensation (BWC). There is a specific form for this. The application must be fully completed or it may be dismissed. Your attorney should make sure to attach all relevant claim and medical documentation to the application, in addition to the independent physician's report. A brief summary concerning the mechanism of injury, allowed conditions, claims costs and relevant medical documentation may also be attached. Remember, it is wise to file for a handicap reimbursement before a claim enters your experience (two years

post-injury). However, you have until June 30th of the sixth year after the date of injury to file an application. Also, remember that once you receive a handicap reimbursement for one condition, you cannot re-file another application for the same condition in an effort to get your reimbursement increased. You can file additional application(s), however, for other conditions that have not yet been granted a handicap reimbursement.

Once the application is filed, the BWC's Handicap Reimbursement Unit will process the application and schedule an informal conference with a BWC attorney. This may be conducted in person or over the telephone. You must indicate which you prefer on your application. At the conference, your attorney will argue on your behalf and assert that a handicap reimbursement should be granted in the claim, meaning that the BWC should charge a certain percentage of the claim costs to the statutory surplus fund, as opposed to the employer's experience. Basically, in our example above, we would rely upon the medical documentation and the opinion of our independent physician and ask for a 75% handicap reimbursement. If granted, this would mean that the employer is now only responsible for approximately 25% of the claim costs. Please note that handicap reimbursement awards only reduce temporary total disability compensation, permanent total disability compensation, death benefits, medical bills and a claim's reserve.

At the end of the informal conference, the BWC attorney will decide whether or not to award a handicap reimbursement in the claim. If awarded, the BWC attorney may rely upon your independent physician's recommendation, or issue what he deems an appropriate award. This decision may be then be appealed to the Industrial Commission of Ohio if a higher percentage is desired. After exhausting your administrative options through the Industrial Commission, you may then appeal to the Tenth District Court of Appeals if a higher percentage is still desired.

So, in our example, say we are granted a 75% handicap reimbursement from the BWC attorney. Considering that our independent physician recommended this percentage, we probably would not appeal. How important is a handicap reimbursement in this example? Very simply, the employer went from having 100% of the claim costs on their experience and from facing a probable premium increase, to having only approximately 25% of the claim costs on their experience, with much less of a premium impact, if any!

Do not hesitate to contact Tony or any of the other workers' compensation attorneys at RBS with questions concerning the BWC's Handicap Reimbursement Program or other ways to minimize your company's workers' compensation costs.

Employers Score Jury Verdicts in Workers' Compensation Litigation

On March 9, a Perry County jury returned a unanimous verdict in favor of Americare, Inc., a self-insured employer. Americare was represented by RBS Attorney Scott Coghlan. At issue was Americare's appeal of an order of the Industrial Commission that allowed an injured worker's claim for aggravation of pre-existing spinal stenosis. The jury verdict overturned the allowance of the claim, thus entitling Americare to reimbursement from the state surplus fund of all compensation and benefits paid which will exceed more than \$40,000. *Chapman v. Americare, Inc., et al.*, Perry County Case No. 08-CV-117.

On July 1, a Cuyahoga County jury returned a 6-2 verdict in favor of Harborside Healthcare Corp., a self-insured employer. Harborside Healthcare was represented by RBS Attorneys Scott Coghlan and Scott Gedeon. At issue was an injured

worker's appeal of an order of the Industrial Commission that denied her claim for a cervical sprain and aggravation of pre-existing cervical stenosis. The injured worker's claim had been previously allowed for low back and psychological conditions; however, the jury's verdict denying the claim for additional degenerative neck conditions will help prevent a claim for permanent total disability. *Murray v. Harborside Healthcare, Corp., et al.*, Cuyahoga County Case No. CV-08-670995.

If you have questions regarding workers' compensation litigation, please contact Scott Coghlan at (216) 447-1551.

LABOR: Use of Independent Contractors under the NLRA

by Michael K. Zbawiony

In a recent decision involving FedEx, the United States Court of Appeals for the District of Columbia Circuit reinforced the right for businesses to operate using independent contractors over employees. The Court declared an “entrepreneurial” standard for the “independent contractor” test under the National Labor Relations Act (NLRA), in place of the multi-factor common-law test. Prior to the Court’s decision, the National Labor Relations Board (NLRB) had declared that FedEx committed an unfair labor practice by refusing to bargain with the Teamsters, finding that the single-route drivers are employees rather than independent contractors.

The Court took this matter on appeal and split 2-1, finding as a matter of law that the FedEx drivers are independent contractors under the common-law test adopted under the NLRA, thereby vacating the NLRB’s order that would have forced FedEx to negotiate with the Teamsters. The decision was split down party lines. Judge Janice Rogers Brown, an appointee of George W. Bush, and Judge Stephen F. Williams, a senior judge appointed by Ronald Reagan, signed the majority. Judge Merrick B. Garland, an appointee of Bill Clinton, dissented, writing that the drivers should be considered employees rather than independent contractors.

The majority opinion opened by observing the instability of the Court’s long chain of authority construing the 10-prong common law test meant to separate employees from contractors. The majority concluded that the former standard often leads to odd results (a cook who is an employee, despite the fact that the employer does not “control” the cooking). The Court adopted the single standard of “whether

the position presents the opportunities and risks inherent in entrepreneurialism.” Further, the Court stated that where the employer exercises control over the employee, so long as it is pursuant to a mandated law such as DOT, OSHA, or for public safety reasons (employee uniforms), it does not alter the independent contractor relationship.

For example, FedEx disassociates itself



from any control over the drivers’ hours of work, routes or even the use of the FedEx truck (provided that the logo is covered when it is not used for FedEx deliveries). Drivers can hire and pay their own staffs. Drivers can assign at law their contractual rights to their routes, without FedEx’s permission. The logical result is they can sell, trade, give, or even bequeath their routes, which is an unusual feature for an employer-employee relationship. The Court’s majority rejected the NLRB’s findings that the opportunity for profit is minuscule and that the company dictates the routes.

In a strongly worded dissent, Judge Garland criticizes the collapsing of the common-law test into a single standard. Judge Garland stated that the case law does not support the adoption of the

single “entrepreneurialism” approach and that Supreme Court, Circuit and NLRB precedent stands against the adoption of this standard.

The Court’s recent decision is likely not the end of this battle. Ken Hall, the director of the Teamsters’ package division, criticized the ruling stating, “[w]e are confident that the decision will not survive review by the full court or by the U.S. Supreme Court...

[w]e remain committed to those FedEx drivers who have sought the protection of a legitimate collective bargaining agreement to improve their lives.” An appeal to the U.S. Supreme Court is likely.

FedEx Ground Package System, Inc. has two operating divisions: the Ground Division and the Home Delivery Division (or FedEx Home), which operates 300 stand-alone terminals throughout the United States and shares space in an additional 200 Ground Division facilities, employing

about 4,000 drivers nationwide with responsibility for over 5,000 routes. Union membership has been declining since 1983 and only 12% of the American workforce is unionized today. This decision likely saved FedEx hundreds of millions of dollars in labor cost, had the decision gone the other way and forced FedEx to bargain with the Teamsters.

As always, do not hesitate to contact Mike Zbawiony, Nick Nykulak or Alan Ross with any and all labor-related questions or concerns.

WORKERS' COMPENSATION: How to Use the Drug Statute Effectively at Hearing

by Carol D. Strassman

Most Ohio employers are familiar with the drug statute found in section 4123.54 of the Ohio Revised Code. However, there appears to be ongoing confusion as to how to effectively use this statute at hearings before the Industrial Commission of Ohio. Ohio workers' compensation law has always provided that an injury is not compensable when the proximate cause of the injury is the employee's intoxication or drug use. The burden had previously been on the employer to provide medical evidence of proximate cause. The new drug statute shifts the burden of proof to the employee if the requirements of the statute are met. Then, the employer has a rebuttable presumption that the employee's intoxication or drug use is the cause of the injury.

The requirements of the statute include that the employer must post written notice to employees that the results of a chemical test or the refusal to submit to a chemical test may affect the employee's eligibility for workers' compensation benefits. The requirements also include that a qualifying chemical test be administered within eight hours for alcohol and within thirty-two hours for controlled substances and that the level meets the amounts as set forth in the statute.

The misunderstanding among employers occurs in the definition of a qualifying chemical test. The drug testing will be defined as a qualifying chemical test if it is administered under at least one of the following conditions:

- ❖ The employer had reasonable cause to suspect the employee may be intoxicated or under the influence of a controlled substance;

- ❖ At the request of a police officer;
- ❖ At the request of a licensed physician not employed by the employer.

Since there is rarely evidence from a police officer or physician, this means that without "reasonable cause," a positive drug result alone will not be sufficient to use the drug statute to an employer's benefit. The employer must have reasonable cause drawn from specific objective facts and reasonable inferences. This can include direct observation (including slurred speech or odor of alcohol), a pattern of



abnormal conduct or erratic behavior, a report of alcohol or drug use by a reliable and credible source, or repeated or flagrant violations of safety or work rules.

Employers should be aware the statute specifically states that it shall not be construed to affect the rights of an employer to test employees for alcohol or controlled substance abuse. However, employers must be aware that without "reasonable cause," a positive drug test standing alone will be insufficient to trigger the rebuttable presumption under the drug statute.

Additional evidence may then be needed at hearing. Positive drug test results should always be reviewed on a case-by-case basis. We often recommend a medical report be obtained analyzing the claimant's specific metabolites and rendering an opinion as to whether the alcohol or drug use was in fact the proximate cause of the injury. The mechanism of injury itself is important to such a determination. Obtaining the claimant's specific metabolites from the drug testing may be difficult, but can be accomplished through an Industrial Commission subpoena. If the employer has a medical opinion opining

the claimant's specific drug or alcohol use was in fact the proximate cause of the injury, the claim has a much better chance of being disallowed at hearing. A medical opinion on actual proximate cause is sometimes necessary due to the fact it is often extremely difficult to prove to a hearing officer that the employer had "reasonable cause" to suspect the employee may be intoxicated or under the influence of a controlled substance at the time of the injury.

In practical terms, this means positive drug results should be viewed on a case-by-case basis, taking into account the mechanism of injury and the specific drug involved. When the hearing goes forward, it may be necessary to have the human resources representative in attendance.

Your company should never assume that an employee's positive drug screen will automatically result in disallowance of the claim. Please contact Carol or any of the workers' compensation attorneys at RBS to discuss the implications of an employee's positive drug screen and for additional information concerning the intricacies of the drug statute.

EMPLOYMENT: Preparing for an Influenza Pandemic and Complying with Workplace Laws and Regulations

by Ryan T. Neumeyer

An influenza pandemic refers to a worldwide outbreak of influenza among people when a new strain of the virus, such as H1N1, emerges that has the ability to infect humans and spread from person to person. People might not have a natural immunity to the new strain during the early phases of an influenza pandemic, so the disease often spreads rapidly among the population. According to the Centers for Disease Control and Prevention (CDC), in the event that H1N1 becomes a pandemic, business and other employers will play a key role in protecting employees' health and safety.

To assist businesses, industries and other employers in this effort, both the CDC and OSHA have developed planning guidelines; be sure to visit these at www.osha.gov/dsg/topics/pandemicflu and www.pandemicflu.gov/plan/workplaceplanning/index.html. According to OSHA, employers and employees should use these planning guidelines to help identify risk levels in workplace settings and implement appropriate measures such as good hygiene, cough etiquette, the use of personal protective equipment and staying home from work when ill. In addition, employers should reduce the frequency, proximity and duration of contact between people (both employees and customers) to reduce the opportunity for spreading a virus. Specifically, OSHA has suggested the following precautions be implemented in every workplace in the case of a pandemic:

- ❖ Encourage sick employees to stay home. Such absences may qualify for leave under the FMLA;
- ❖ Encourage employees to wash their hands frequently with soap and water, or sanitizer if soap and water are not available. Encourage employees to avoid touching their nose, mouth and eyes;
- ❖ Provide customers and the public with tissues and trash receptacles, in addition to a place to wash or disinfect their hands;
- ❖ Encourage employees to cover their coughs and sneezes with tissues. Encourage employees to wash their hands or use hand sanitizer after they sneeze or cough;
- ❖ Avoid close contact with co-workers and customers (maintain separation of at least

six feet). Avoid shaking hands and always wash hands after contact with others;

- ❖ Discourage employees from using other employees' phones, desks, offices or other work tools and equipment;
- ❖ Use e-mail and phones to communicate as much as possible. Minimize meetings. When meetings are necessary, avoid close contact by keeping separation of at least six feet where possible. Ensure that there is proper ventilation in the meeting room;
- ❖ Reduce all visitors to the workplace as much as possible. If family visitors are allowed on site, the employer should consider restricting or eliminating that option during an influenza pandemic.

In areas where transmission of H1N1 or another similar virus has been confirmed and where crowded settings or close contact with others cannot be avoided, the use of dust mask respirators should be considered and may be required. Dust masks rated N95 or higher should be used by employees who are unable to avoid close contact with infected individuals. Please note that OSHA defines "close contact" as being within six feet. In the event of a pandemic, healthcare workers must wear such masks. Failure of an employer to require the use of dust masks under those circumstances could result in an OSHA citation for violation of the agency's Respiratory Protection Standard, which requires employers to pay for and provide appropriate respirators when necessary to protect the health of their employees.

In addition to addressing safety concerns that will arise during a pandemic, employers must avoid potential liability as they respond to the crisis. The U.S. Equal Employment Opportunity Commission (EEOC) has issued technical guidance regarding influenza pandemics entitled "ADA-Complaint Employer Preparedness for the H1N1 Flu Virus," available at www.eeoc.gov/facts/h1n1flu.html. Generally, the technical guidance focuses primarily on employers' rights to make medical inquiries and require medical examinations of applicants and employees. With respect to applicants, the EEOC notes that the ADA operates normally to preclude all disability-related questions and medical exams until after a conditional offer has been made. With respect to current

employees, who can be required to respond to medical inquiries or undergo medical exams only if they are job-related and consistent with business necessity? Arguably, a pandemic would provide sufficient justification to require employees to receive a medical exam to determine whether they are infected. Further, the ADA always allows voluntary exams, provided that an employer complies with the confidentiality requirements of the ADA. Also, the EEOC has recommended a model survey that could be issued to all employees in preparation for a pandemic. The model survey is available in the above link.

In addition, it is unlikely that H1N1 (given that it is an acute short-term condition) would create a reasonable accommodation issue under the ADA (even with the expanded definition of "disability" under the new Amendments to the ADA) unless the sickness left the employee with a lingering condition that was disabling. Rather, it is more likely that those who are infected or suspected of being infected may be able to prove that they were regarded as being disabled. Practically speaking, infected employees must be treated the same as non-infected employees under the ADA, so long as they are physically and mentally able to effectively perform the essential functions of the job (with or without a reasonable accommodation). If an infected employee poses a direct threat to his or her own safety or the safety of others, however, the ADA does not prevent an employer from placing the employee on leave. An employer who has concerns about a threat posed by a specific employee should obtain solid medical authority regarding the risk posed by the employee before relying on health risks in making employment decisions.

Another issue may arise where an employee who has another condition which may affect their immune system (HIV for instance) wants to wear a mask. As discussed above, there may be circumstances where masks are required. However, if masks are not required, it may be a reasonable accommodation to allow an employee to wear a mask.

Finally, under the ADA, all employees' medical information must be maintained separately from their personal information and not be disclosed to others except under a strict "need-to-know" basis. This usually means the employee's direct management, human resources, medical personnel, or

Continued on Next Page...

EMPLOYMENT: Preparing for an Influenza Pandemic and Complying with Workplace Laws and Regulations *continued*

the government when it is investigating compliance with ADA. The ADA does not authorize disclosure of medical information to co-workers. An employer taking steps to prevent or contain H1N1 should do so while making every effort to avoid disclosing the identity of any individuals who have H1N1 or its symptoms, or who were exposed to the virus.

Depending on the severity of an individual's illness, a case of H1N1 most likely will be considered an FMLA-qualifying "serious health condition" that would allow an

employee of a covered employer (generally, an employer with 50 or more employees) to take job-protected FMLA leave, with healthcare benefit continuation, to care for himself or a close relative (a parent, spouse or child). Employers should make sure that they are up to speed on FMLA leave policies and procedures, including when to recognize a condition as FMLA-qualifying in the absence of a specific employee request for FMLA leave, and what forms to use to document FMLA leave (updated per the new FMLA regulations). If an extremely cautious employer requires an employee to take time

off work even though such employee does not have H1N1 or symptoms related thereto, the time away from work cannot be charged as FMLA time or under the employer's sick leave policy.

Please be sure to contact Ryan Neumeyer or Lynn Schonberg if you have any questions or if you need any further information regarding protecting your employees from a pandemic and complying with workplace regulations and laws.

WORKERS' COMPENSATION: Does the Court of Common Pleas have Jurisdiction to Hear Appeals Concerning the Reactivation of Workers' Compensation Claims?

by Chad A. Fine

The Eighth District Court of Appeals in Cuyahoga County recently addressed the issue of whether or not a Court of Common Pleas has jurisdiction to hear appeals from Industrial Commission orders on whether or not to reactivate inactive workers' compensation claims.

By way of background, section 4123.512 of the Ohio Revised Code grants jurisdictional review to the Court of Common Pleas for decisions involving a Claimant's right to participate in the Ohio Bureau of Workers' Compensation fund, but not for decisions that relate to the extent of the Claimant's injury. In other words, the Industrial Commission's decision to either grant or deny additional benefits under an already existing claim is not subject to an appeal to the Court of Common Pleas. In a recent decision, the Eighth District Court of Appeals found that issues concerning reactivation of workers' compensation claims are "right to participate" issues, rather than "extent of disability" issues. Consequently, the Eighth District held that decisions regarding the reactivation of claims may be appealed to the Court of Common Pleas.

In the specific case before the Eighth District, an employee was injured in the course and scope of his employment when he fell and sustained an injury to his left wrist. He then filed for workers' compensation benefits and the claim was allowed for a sprain of the left wrist. The injured worker received medical treatment until May 2004 when he returned

to work. Between July 2004 and June 2007, the Claimant did not seek further medical treatment for his left wrist and the claim became inactive. However, in July 2007, the injured worker sought medical treatment when he began experiencing pain in his left wrist. The Claimant's doctor requested that the claim be reactivated and that the Claimant receive an orthopedic consultation. The Claimant then filed a request with the Bureau of Workers' Compensation to reactivate his claim.

In September 2007, a hearing was held in front of the Industrial Commission of Ohio on the Claimant's request to reactivate his claim. The District Hearing Officer denied the Claimant's request to reactivate his claim. The Claimant appealed the decision, which was affirmed by a Staff Hearing Officer. A subsequent appeal to the Industrial Commission of Ohio affirmed the denial of the injured worker's request for reactivation.

In February 2008, the Claimant filed a Complaint in the Cuyahoga County Court of Common Pleas pursuant to Ohio Revised Code 4123.512 and appealed the Industrial Commission's decision not to reactivate his claim. The Employer filed a motion to dismiss the complaint for lack of subject matter jurisdiction on the ground that the injured worker was appealing a decision that affected the extent of disability, rather than his right to participate in the Ohio Bureau of Workers' Compensation fund. The trial court granted the Employer's Motion to Dismiss.

The trial court's decision to dismiss the case for lack of subject matter jurisdiction was appealed to the Eighth District Court of Appeals. The Eighth District Court of Appeals applied a prior decision which held that the Court of Common Pleas has jurisdiction to hear a Claimant's appeal to a Staff Hearing Officer's decision which "forecloses further benefits to the Claimant." This previous court held that decisions which foreclose further benefits to a Claimant actually work to bar the Claimant from further participation in a workers' compensation fund and are therefore "right to participate" cases rather than "extent of disability" cases. Similarly, the Eighth District decided that the Claimant was denied further treatment for his left wrist sprain because the Hearing Officer determined there was no need for treatment. The Industrial Commission effectively barred the Claimant from further participation in the Ohio Bureau of Workers' Compensation fund for his claim. Therefore, the Eighth District held that the Court of Common Pleas has jurisdiction to hear appeals from the Industrial Commission that concern reactivation of claims.

Is one of your company's previously inactive claims coming back into the picture? Feel free to contact Chad or any of the workers' compensation attorneys at RBS to discuss the many issues surrounding the reactivation of a previously inactive claim.

WORKERS' COMPENSATION: Legalized Extortion: The Hidden Cost of Litigation

by Scott Coghlan

A client called me the other day expressing shock at being sued by an employee whose workers' compensation claim had been denied by both the Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio (IC). My client asked me why the employee would file his claim into court when it had been denied at both administrative hearings before the IC. My response to him was "legalized extortion."

I went on to explain that it is common practice for a claimant to file a denied claim into the court of common pleas in order to effectuate a settlement, despite the fact that the claim may be suspect and completely denied. The claimant's attorney advises his client that the claim has no value unless a court appeal is filed. By paying a small filing fee (\$100 in Cuyahoga County), the claim remains alive and now has settlement value. This is particularly true with claims filed against state-funded employers.

Once a claim moves into court, the Ohio Attorney General's Office (AG's Office) represents the BWC and, in turn, the state workers' compensation fund. In virtually all cases, the AG's Office will enter into settlement negotiations. This occurs for a few reasons. First, the BWC uses settlements to remove claimants from the workers' compensation system. It does this by requiring that the claimant settle all claims he may have, regardless of whether those claims are the subject of the litigation. Second, the AG's Office simply has too heavy a caseload to take each claim to trial. Third, litigation is expensive and it is often not cost-effective to defend each case to its conclusion.

Unfortunately, employers often get caught in the middle of the litigation. Although a workers' compensation court appeal is often viewed as simply a claim to participate in the state fund for a specific medical condition, the employer is required to be named as a defendant, because the allowance or settlement of the claim can negatively impact the employer's workers' compensation premiums. This is where "legalized extortion" comes into play.

Assume a scenario where the AG's Office and the claimant agree to settle a completely denied claim for \$5,000. However, the employer has been advised by its third-party administrator that a \$5,000 settlement will ultimately cost the Employer an extra

\$10,000, over time, in premium payments. The employer won't also agree to settle the claim because to do so, in essence, is to agree to increased premiums based upon a completely denied claim. In this situation, the AG's Office usually turns over the defense of the claim solely to the employer. This means the AG's Office will not participate in the trial, nor assume any of the costs of litigation.

To make matters worse, the Ohio Revised Code requires the BWC to charge the cost of the stenographic deposition of the claimant's medical expert witness against the employer if the claimant is successful in court. Likewise, if the claimant is successful in court, the Code requires that the cost of any legal proceedings (including attorney's fees to the claimant's attorney) be taxed against the employer if it contested the right of the claimant to participate in the state fund. By statute, the attorney's fee cannot exceed \$4,200.

The term "cost" with respect to "any legal proceedings" includes nearly every expense the claimant incurs in prosecuting his workers' compensation claim in court. The term includes the fee paid by the claimant to file the claim in court, as well as any other charges levied by the court, such as a jury deposit or document filing fees. The term also includes the fee that the claimant's medical expert charges to provide deposition trial testimony. \$1,500 to \$2,000 is not an unusual deposition fee. In addition, the term includes the cost of videotaping the medical expert's deposition and the cost of replaying the videotaped deposition at trial. These charges range from \$500 to \$1,000. It also includes the cost of a court reporter recording the medical expert's testimony and transcribing it to written form. \$350 to \$900 is a typical charge from a court reporter. Moreover, a successful claimant can recover the cost of his obtaining a copy of his own deposition transcript, or that of any other fact witness. In fact, one court has held that a claimant's attorney can recover his mileage incurred traveling to take the defense medical expert's deposition.



Basically, if a jury finds in favor of the claimant and ultimately allows the claim for a specific medical condition, the employer is not only responsible for its own costs and attorney's fees, but also the claimant's costs and a portion of the claimant's attorney's fees.

Let's look back at the settlement scenario we previously discussed. The employer's initial financial exposure from the proposed \$5,000 settlement was \$10,000, due to increased premiums. If the claimant is successful in court, the claim will now be allowed and the premium impact will likely be much greater than \$10,000 when all is said and done. As a result of the cost and fee shifting provisions set forth above, the employer must also factor in the claimant's costs and attorney's fees into the defense analysis. The employer's potential exposure could increase another \$10,000. Remember, the employer must also factor in payment of its own attorney fees and litigation costs. Suddenly, settlement seems a more plausible option for those employers faced with the uncertainty of litigation.

The cost and fee shifting provisions are a primary reason why meritless workers' compensation claims are filed into court. The unpredictability of juries combined with the potential financial exposure to state-funded employers typically results in the settlement of workers' compensation claims appealed into court.

If your company has questions regarding workers' compensation litigation or would like to discuss strategies to minimize the impact of appealed claims, please do not hesitate to contact Scott Coghlan or Scott Gedeon in the RBS workers' compensation litigation department.

WORKERS' COMPENSATION: Supreme Court of Ohio Addresses Termination of Temporary Total Disability Benefits

by Scott W. Gedeon

In a recent decision, the Supreme Court of Ohio clarified the circumstances under which temporary total disability benefits may be terminated on the basis of “permanency.”

In the matter before the Supreme Court, the claimant was receiving temporary total disability benefits and the medical evidence indicated that the claimant had not yet reached a level of maximum medical improvement (MMI) with respect to the allowed conditions. However, the claimant’s treating physician opined that the claimant was “permanently unable to return to her former position of employment.” Based upon this representation, the employer sought to terminate the claimant’s temporary total disability benefits under the Supreme Court’s prior decision in Ramirez.



Under Ramirez, the Supreme Court held that temporary total disability benefits are not properly payable when any one of three things occurs: 1) the claimant returns to work; 2) the claimant’s treating physician makes a written statement that the claimant is capable of returning to his former position of employment; or 3) the temporary disability has become permanent. In the instant matter before the Supreme Court, the employer argued that termination of temporary total disability benefits was appropriate under the third prong of Ramirez.

The Industrial Commission of Ohio rejected the employer’s argument that the treating physician’s statement required termination of temporary total

disability benefits. The Court of Common Appeals likewise failed to find the employer’s argument persuasive.

The matter was subsequently appealed to the Supreme Court. The Supreme Court held that the physician’s statement was insufficient to terminate temporary total disability benefits. The Supreme Court determined that subsequent legislative and administrative efforts of the General Assembly and Industrial Commission made it clear that Ohio law no longer viewed “permanency” in terms of “ability to return to the former position of employment,” as did the Supreme Court in Ramirez.

Rather, the Supreme Court announced that temporary total disability benefits could only be terminated when the underlying medical condition (and not the

claimant’s inability to return to the former position of employment) had reached a permanent state. Therefore, the Supreme Court instructed that MMI was the only standard by which temporary total disability benefits could be terminated on the basis of permanency.

This recent decision by the Supreme Court of Ohio unfortunately hampers an employer’s ability to terminate a claimant’s temporary total disability benefits. Is one of your employees unable to return to his former position of employment with your company due to an injury? It may be time to contact Scott Gedeon or any of the workers’ compensation attorneys at RBS to discuss the options available to your company!

Upcoming Events

RBS Attorney Speaking Engagements

September 22 – Lynn Schonberg will be speaking on the topic of “Creating Wage and Hour Strategies that Work” at a seminar in Cleveland for the National Business Institute.

For more information, please contact Melody at [216] 447-1551

6480 Rockside Woods Blvd. S
Suite 350
Cleveland, OH 44131

216-447-1551
www.rbslaw.com