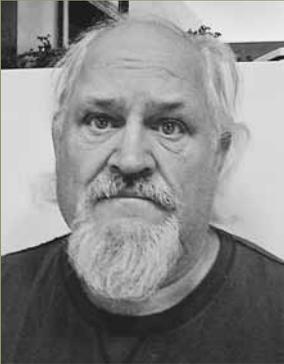


NEW YORK STATE INJURED WORKERS SPEAK OUT ABOUT A FAILING NYS WORKERS' COMPENSATION SYSTEM



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EXECUTIVE SUMMARY

ATTENTION LEGISLATORS AND POLICYMAKERS:

Act now to reestablish the workers' compensation system's ability to meet injured workers' basic needs so that they may recover from job-related injuries and illnesses and return to work with dignity.

This report includes seven case studies from New Yorkers describing how they were injured on the job and the obstacles they have experienced getting diagnostic and medical treatment and compensation. Several of the cases are followed by comments from treating physicians and claimants' attorneys. These cases illustrate that the New York State workers' compensation system is fraught with systemic problems that are impeding the ability of injured workers to recover from their injuries and return to work. These cases illustrate the hardship and financial ruin that is often bestowed upon our state's seriously injured workers and their families.

These problems persist despite changes in the New York State's Workers' Compensation Law enacted in 1996 and 2007. The reforms were primarily designed to reduce employer costs by reducing benefits to workers with permanent partial disabilities, imposing a ten-year cap on benefits that could previously be paid for life. The reforms also dramatically increased the weekly maximum benefit, ultimately indexing it to two-thirds of the state's average weekly wage.

Although these changes resulted in a dramatic decline in employer premiums after 2007, the systemic problems faced by workers going through the New York's Workers' Compensation system have not been eliminated. As the interviews in this booklet demonstrate, the experience of many injured workers continues to be one of frustration, aggravation, delay and humiliation — a process that frequently results in inadequate medical care and compensation.

When the workers' compensation system was established in 1911, in the wake of the Triangle Shirtwaist Fire, New York State established the right of workers who are injured on the job to a no-fault system of medical treatment and wage replacement. In exchange workers gave up the right to sue their employers. This significant public policy advancement was a recognition that the tort system failed to serve the interests of injured workers, as most did not have resources to access legal representation to file lawsuits, and that cases often took years to wend their way through the courts. Meanwhile, injured workers and their families were forced into poverty.

Systemic problems are impeding the ability of injured workers to recover from their injuries and return to work.

The seven case studies in this report illustrate how the New York State workers' compensation system has abandoned its primary purpose of providing quick access to medical care and wage replacement for injured workers. Rather, insurance companies and even the State Insurance Fund (SIF) all too often focus their attention on challenging claims on every possible front including causality, degree of temporary and permanent impairment, and the necessity for medical diagnostic and treatment procedures. This is causing irreversible harm to the affected workers and their families.

Additionally, the significant goal of the workers' compensation system to serve as an incentive for employers to protect workers from injury and illness on the job has been subverted to the goal of cost containment in the name of improving the state's business climate. The current system rewards the insurance carriers and self insured groups financially when they stall, delay, and obstruct claims. There is a basic inequity and conflict of interest in allowing "for-profit" firms to administer basic medical care and wage replacement, when their primary purpose is to maximize profit by controlling losses.

The case studies in this report demonstrate how the changes to the system during the past two decades have essentially reestablished the conditions that gave rise to it. The people in these cases experienced major delays, often for years, in getting wage-replacement benefits and medical testing and treatment approved. Most seriously injured workers are forced to live on poverty-level incomes and are compensated by systems other than workers' compensation, including social security. As a result, workers who worked hard and played by the rules were denied their rights under the law. This reliance on social security shifts the cost of work injuries from employers, onto taxpayers and workers, who have no responsibility or control over hazardous workplace conditions.

It is time for policymakers to restore social and economic justice to the workers' compensation system by re-establishing adequate and timely medical care and wage replacement for injured workers. Following the case studies are a set of broad policy recommendations that address this urgent dilemma.

The trends documented in the cases are consistent with the findings of the ten scientific research studies that are referenced and excerpted on pages 43-46.

Summary of Key Findings and Recommendations

(See pages 37–41 for details)

KEY FINDING #1: Injured workers encounter unreasonable delays in obtaining diagnostic and medical treatment.

RECOMMENDATION 1.1: Collect data, supervise, and better regulate Independent Medical Examiners (IMEs) and the entities that coordinate Independent Medical Examinations.

RECOMMENDATION 1.2: Modify the Medical Treatment Guidelines.

RECOMMENDATION 1.3: Improve availability of medical care by removing barriers that are causing providers to leave or shun the system.

RECOMMENDATION 1.4: Codify that treatment provided by the state-supported occupational health clinic network will not be classified as IMEs.

KEY FINDING #2: Injured workers are not being provided with timely wage replacement benefits.

RECOMMENDATION 2.1: Prohibit unilateral compensation rate cuts by carriers without a judge's order.

RECOMMENDATION 2.2: Increase enforcement and penalties for employer/ carrier failure to make timely payments.

RECOMMENDATION 2.3: Index the minimum rate of compensation to 1/4 of the maximum.

KEY FINDING #3: Unnecessary litigation is increasing costs to the system and delaying the provision of benefits to injured workers.

RECOMMENDATION 3.1: Accept Social Security Administration determinations for disability and do not permit re-litigation of the issue in the workers' compensation system, absent good cause.

RECOMMENDATION 3.2: Adopt a statutory definition of voluntary withdrawal from the labor market/labor market attachment to replace the current punitive, unreasonable approach taken by the Workers' Compensation Board.

RECOMMENDATION 3.3: Prohibit insurers from cross-examining an injured worker or a treating physician unless documentary proof is submitted contradicting the worker’s claim or the doctor’s medical opinion.

KEY FINDING #4: Allowing for-profit carriers to administer benefits conflicts with the legislative goal of providing timely wage replacement and medical benefits to injured workers.

RECOMMENDATION 4: Evaluate the considerable cost savings and efficiency improvements that a dedicated state fund approach would provide.

GLOSSARY OF ACRONYMS

EOHC	Eastern New York Occupational and Environmental Health Center
FMLA	Family Medical Leave Act
IME	Independent Medical Examiner or Independent Medical Exam
MRI	Magnetic Resonance Imaging
MTG	Medical Treatment Guidelines
PT	Physical Therapy
SIF	New York State Insurance Fund
SSA	Social Security Administration
SSD	Social Security Disability
WCB	Workers’ Compensation Board
WC	Workers’ Compensation

CASE STUDIES

ANA HERNANDEZ

“One of the biggest problems in my case was the delay in getting approval for surgery. My condition got worse while I waited, and I was put on heavy medication for pain and discomfort. As a result, I became addicted to pain medication, which included morphine and valium.”



CASE: Ana Hernandez, 47 years old, certified nursing assistant

EMPLOYER: Lutheran Medical Center, Brooklyn, NY

BRIEF HISTORY: Worked as nursing assistant and as a result of patient-transferring tasks, developed chronic back pain due to bulging discs, one of which was pressing against her sciatic nerve.

CURRENT STATUS: Totally disabled, receiving workers’ compensation and Social Security Disability benefits

I developed chronic back pain while working as a certified nursing assistant (CNA), from patient lifting. I have been disabled from work for three years. I have four children and had been a stay-at-home mom. As the kids grew up, I wanted to get back to the workplace, so I signed up for Lutheran’s “Jet to Success” program. I completed the course with an A and my dream was coming true. They even published an article in the hospital’s annual report with my photo and story.

On the floor, we would see all types of patients. I would be assigned seven or eight patients at a time, and typically at least one would require manual transferring. The hospital had lifting equipment, but it was rarely used.

I began having pain in January of 2009. Initially I ignored it, as I figured it was part of doing a strenuous job. Then the pain became more persistent, so I sought medical attention. At first the pain only occurred at work and was worse at end of the day. Then it began affecting my left side and lower extremities. I went to a specialist who ran tests, including an MRI that revealed damage to lower discs. I found out that I had three bulging discs in my lower back that were compressing my nerves, causing numbness, pain, and sciatica.

My condition got worse while I waited to get approval for surgery. I was put on heavy medication for pain and discomfort. Because of the length of time it took to get approval, I became addicted to pain medication, which included

morphine and valium. I experienced severe constipation due to an intestinal blockage, which resulted in my being hospitalized for a week. My doctor told me my intestines were about to burst, and the pain medication was the most likely cause for blockage. After this medical crisis was resolved, I had to get one week of inpatient and seven weeks of outpatient addiction treatment. I no longer use narcotics for pain relief.

Another big issue raised by the State Insurance Fund was that there was no specific date of injury, but that is because the injury developed gradually, due to constant patient-transferring tasks.

Initially I did not file for workers' compensation and took a medical leave of absence. This was my first actual job, so I didn't know who was responsible for these medical bills. The Service Employees International Union/1199 union provided health insurance at first, but when the providers found it was a work-related injury they assigned it to workers' compensation.

I had the surgery in February of 2011. The final decision came through in March of 2012, which was when I first got any workers' compensation payments. It was a back-and-forth thing, a fighting thing. They just didn't want to pay it. They argued that my back injury was not related to work and that I didn't notify my employer in a timely fashion. It took three hearings and three years to get it approved. The first hearing was held one year and nine months after I went out. The insurance company argued at the appeal hearing that the claim should be denied because "moving, repositioning, and caring for patients are commonplace and relatively benign activities which fall far below the standard necessary for an accidental injury accruing over a period of time".

I was getting \$130 per week plus medical expenses from the workers' compensation system, and recently that was increased to \$170 per week due to the efforts of my attorney. Prior to this I was making about \$750 biweekly, working three days per week.

During this time I sought therapy for all the psychological impacts. I went to a counselor, using my own insurance. She knew a lot about treating anxiety and depression caused by pain and discomfort.

I also paid \$5,000 for chiropractic treatment, and that hasn't been reimbursed.

My life has changed dramatically, so I take it one day at a time. I have lots of restrictions, and this was a horrible experience. Sleeping is the worst thing. I will always have that discomfort and sleep better in the recliner.

My biggest frustration is if they would have paid for surgery right away, I would have recuperated faster and would not have gone through the trauma of intestinal blockage and addiction. I think I might have been able to return to work if they did the surgery sooner. My mind and hands are good, and there are other things I could be doing.

If they had paid for surgery right away, I would have recuperated faster.

Comments of Winston Kwa, MD, Occupational Medicine Physician, Mt. Sinai Center for Occupational & Environmental Medicine

Ana Hernandez's case was approved and accepted by the Workers' Compensation Board on three separate occasions, but due to the legal process, the carrier was able to appeal each and every time. This delayed any medical care that the patient could receive. It complicated her medical condition, since she was unable to get the appropriate medical care required to treat her. This increased the time that she was out of work and most likely led to increased cost in her medical care, since she had to get continued sessions of physical therapy and pain management while awaiting approval for surgery. Since the approval took over two years due to the appeals process, she developed other medical conditions related to the delay in treatment. These conditions required hospitalization and detox from pain medications.

I believe that if she had been able to get the appropriate care at the appropriate time, medical complications due to delayed treatment could have been avoided. This would have improved her quality of life and enabled her to return to the workplace sooner and become an active member of society again.

By limiting the complications and treating her in a timely manner, significant medical costs would have been saved. Also, the legal costs that were spent on three appeals over the span of two to three years could have been avoided.

Had Ana been able to get appropriate care at the appropriate time, medical complications could have been avoided.

Comments of Edgar N. Romano, Esq., Senior Partner, Pasternack Tilker Ziegler Walsh Stanton & Romano, LLP

Unfortunately, Ana's story and plight are too common. For 20 years I have been representing injured hospital workers, and for more than 80 years carriers have been denying their occupational back claims! Why? Usually it is not because they aren't liable. It is not because they truly doubt that the injuries are related to the constant lifting, pulling, and pushing these workers do day-in and day-out. It is because insurance companies don't care about injured workers but care about making money. Every dollar delayed to an injured worker is interest on the insurance carrier's investment. Every denied claim is an opportunity to frustrate the injured worker to the point where they give up their claim or are forced to pay the costs of treatment out of their own pocket. With every unnecessary denial there is opportunity to shift the cost to the claimant's union, private carrier, or the government (which means us, the taxpayers).

It is a horrible waiting game which Ana ultimately won, but at great cost to her health and well-being. Here the compensation insurance carrier was not successful in shutting her out of the system and avoiding its responsibility to pay her for three years. How many people can afford to live for years without

getting a check they are entitled to? How many doctors will continue to treat you when they don't get paid for years?

Ana has not only been irreparably damaged by her on-the-job injuries, but by the further physical and psychological injuries she developed as a result of the carrier's delay and manipulation of the system. Unfortunately the system rarely penalizes the carrier for delaying or denying these meritorious claims, and Ana will never be adequately compensated for her losses. Her wage-earning capacity has forever been diminished, and the insurance carrier will pay a pittance to her for the damages she received and the additional damages they have caused.

DELORIS LAKE

"They do not care if you live or die. I am in pain every day of my life. Sometimes I can't take a walk because it hurts so badly. If I sit long, it hurts because of my back. They won't approve the surgery."



CASE: Deloris Lake, 60 years old, fitting-room checker

EMPLOYER: Macy's Department Store, Queens, NY

BRIEF HISTORY: Injured right shoulder, hands, neck, knees, and herniated two discs in her back when she fell while working with clothing carts.

CURRENT STATUS: Totally disabled. Has not received any compensation for lost wages and has not been able to get approval for surgery and other treatments; she is dependent on family and friends to survive.

I worked as a fitting-room checker in the lingerie department, for Macy's in Queens. I was hurt in March 2003, when I became caught in big clothing rods that were left with merchandise on them. They were on a cart with wheels that was loaded with stuff people had tried on. There were three full carts in the sitting room. As I cleared clothes, I tried to remove the rods, and I got caught in them, causing me to fall down. My boss came and asked if I wanted help getting home. The next day everything hurt, including my chest, back, arms, legs, and hands, so I took a sick day.

The fall caused injury to my right shoulder, two hands, neck, knees, and caused herniated discs in my back. I scheduled an appointment three months later for surgery. But the surgery was cancelled because the workers' compensation insurance company refused to authorize it. I am supposed to have arthroscopic surgery on both knees, as well as surgery for carpal tunnel syndrome. I have a torn rotator cuff in my right shoulder and two herniated

discs in my back. I was referred by my doctor for PT because I couldn't walk. The insurance company denied the PT.

I have never received any workers' compensation benefits for lost wages. They said I wasn't really hurt. They said I was a liar, and that there is nothing wrong with me. But my doctor took an MRI and other tests. I have been waiting for more than three months for surgery approval.

I have had to rely on my family to feed me, and I am staying with my daughter. Some friends give me money. I am not getting SSD.

I used to be depressed about what I was going through, but I talked to a doctor at Mt. Sinai, and she helped me to not feel depressed anymore. I have a new doctor at Mt. Sinai, and workers' compensation is finally paying the medical bills.

They do not care if you live or die. I am in pain every day of my life. Sometimes I can't take a walk because it hurts so badly. If I sit long, it hurts because of my back, and they won't approve the back surgery.

DEBRA ALLEN

"My biggest frustration with the workers' compensation system is definitely lack of timely communications. I called my caseworker and left four voice mails to see if she received paperwork I sent her. I had no returned calls. I am trying to get better and get back to work, and I am frustrated that I have to deal with a lot less income. I am probably running short \$400 per month, which has forced me to turn to my mother for help. I fear that I will be down by thousands of dollars that I will have to pay back."



CASE: Debra Allen, 38 years old, nurse

EMPLOYER: Mohawk Valley Psychiatric Center, Utica, NY

BRIEF HISTORY: Assaulted by an adolescent psychiatric patient, April 2012, causing broken nose, concussion, cervical neck sprain/strain with spasms, and psychological trauma.

CURRENT STATUS: Recovering from multiple injuries and psychological trauma and hopes to return to work.

I was assaulted, punched in the face, causing my nose to be broken by an adolescent patient in the inpatient youth ward of the state-run psychiatric hospital where I work. The patient required manual restraint, at which time I was struck repeatedly in the left side of my head with her knee until I was able to restrain the patient.

I pressed charges immediately following the assault and was told by the responding police officer that my injury was not substantial enough to constitute pressing felony assault or any type of assault charge. Initially, the district attorney did not take the assault seriously. My Public Employee's Federation union representative helped me to get the charges increased to a felony.

I was diagnosed by a doctor at urgent care with head trauma (concussion), non-displaced nasal fracture, and cervical and neck sprain/strain with muscle spasms. I was given pain and muscle medications and instructed to see my personal physician in three to five days.

When I went to my doctor, I was experiencing severe headache, nausea, and vomiting. He treated me with pain and anti-nausea medications. When I returned, I reported that I was continuing to have headache, unresolved nausea, vomiting, loss of appetite, and that the pain medication had minimal effect. The doctor told me that my complaints were inconsistent with the assault I experienced, and he stated he didn't know what more he could do for me. He offered to send me to a pain-management clinic, and I declined, stating that I wanted to rule out complications before relying heavily on pain medications. He repeatedly asked me, "What exactly do you want me to do," and stated that I was putting him in a position to order "unnecessary medical tests" and that he would "try to get workers' compensation to approve a cat scan." He stated that I could stay out of work (two weeks after the incident) and continue to take the medications he prescribed. I told him I was not comfortable going back to work yet, due to the physical symptoms that were negatively affecting my ability to function at home, taking care of my kids, and sleeping.

This doctor refused to refer me to the concussion clinic as I requested, stating, "We do things differently, and if you feel you need to see them you will have to take care of it yourself."

I was also experiencing acute psychological trauma from the assault. I had increased anxiety, nightmares/terrors about my own young children at home assaulting me, trouble sleeping, increased incidence of acute anxiety attacks, and a generalized fear that I was unsafe both at work and in the community. These fears were reinforced by the feeling that the doctor I was seeing was minimizing and disregarding my complaints.

Fortunately, my union suggested I get a referral from a doctor to see a psychologist who accepts workers' compensation. Even with this help, when I called the counseling center they said they would mail me an application, that they were booking appointments several weeks out after processing applications, and would need to know before the appointment if it would be covered by workers' compensation.

Fortunately, I also received a referral from my union to the Central New York Occupational Health Clinic in Syracuse.

It was more than six weeks before I got any lost wages through workers' compensation, because my doctor did not send the required documentation in to the SIF, even though I called daily.

I finally got into the concussion clinic through the occupational clinic's efforts. I waited five weeks to get in. They focused on my vision, as I began having double vision after the assault. I was sent to an ophthalmologist, who fit me with sloped spheres to correct my vision. It was determined that the vision problem was a big factor in the headaches. They also diagnosed post-concussion syndrome.

I was extremely depressed for a couple of months. It was very difficult to raise my kids, who were eight and six years old at the time, and I was in tears every day.

On top of it all, I found out that my workplace, the psychiatric center, was shutting down much of its operations, which further added to my anxieties. Because I have a history of depression, the carrier tried to argue that my psychological symptoms were a pre-existing condition. Fortunately, the workers' compensation law judge established the psychological part of my claim.

My biggest frustration with the workers' compensation system is definitely lack of timely communications. I called my caseworker and left four voice mails to see if she received paperwork I sent her. I had no returned calls. I am trying to get better and get back to work, and I am frustrated that I have to deal with a lot less income. I am probably running short \$400 per month, which has forced me to turn to my mother for help. I fear that I will be down by thousands of dollars that I will have to pay back.

Comments of Michael Lax, MD, Medical Director, Central New York Occupational Health Clinical Center

Ms. Allen's case illustrates several common problems injured workers face after they are injured at work.

1. There is a need to continuously prove the severity of the injury. The doctors she saw, and the police and district attorney, viewed her injuries as non-serious, or, in the case of her own doctor, as "inconsistent" with the injury. The practical result of this is under-treatment and a failure to meet the patient's medical needs. Another result is the psychological stress it puts on the injured worker to always be considered a fraud or an exaggerator until proven otherwise.

2. There are long delays in treatment that result in the injury lasting longer and getting more severe.

As a result of the assault I had increased anxiety which was reinforced by the feeling that the doctor I was seeing was disregarding my complaints.

It was more than six weeks before I got lost wages because my doctor did not send the required documents.

3. The myth that injured workers have an easy ride on workers' compensation is false. The financial implications are often severe and sometimes devastating, as WC does not pay anything close to the injured worker's wage.

4. The failure of many physicians to either understand the requirements of the workers' compensation system, or to take the requirements seriously, results in further delays in treatment and income for the patient.

5. The unresponsiveness of the workers' compensation system to the needs of the injured worker is often problematic. A caseworker should be able to get back to the patient before four voice mails are left.

KARLYNE DRIMALAS

"After lengthy delays in getting treatment approval, my husband and I decided to pay for an injection out of our own pockets. It cost approximately \$1,000. When the insurance company found out, they called me on the phone and were upset with me. They said I shouldn't have done that because it is a workers' compensation injury. I said I was tired of waiting. They said the system is "you are supposed to wait." I said it has been three months and I am still in pain!! Then I said, "If I was Donald Trump, would I have to wait?"



CASE: Karlyne Drimalas, 51 years old, physical therapist

EMPLOYER: Visiting Nurse Service of Schenectady, NY

BRIEF HISTORY: Injured in a patient's home when emptying a commode. The handle on the commode broke as it was being taken out of the bathroom for emptying, and the sudden motion used in trying to prevent it from spilling caused disc herniations.

CURRENT STATUS: Established permanent partial disability after six years of failed diagnosis and treatment. Currently living on long-term disability, permanent partial disability (worker's compensation), and social security disability.

I was working at the Visiting Nurse Service (VNS) as a physical therapist and was in a patient's home when I was injured in 2005. The patient had a cast on, and had mental health and physical issues. She couldn't bear weight on the cast, and her doctor was concerned she would fracture a bone. She needed to practice transfers to and from the portable commode, which consisted of a portable chair with a removable bucket. The commode was full,

and she asked me to empty it. So I picked up the bucket, and the handle broke off as I was carrying it. In a split second I tried to prevent it from spilling on me and an oriental rug. I did a jerk and twist motion. I was in her bedroom, almost at the doorway, when it spilled all over. I slid a little bit. Almost immediately, I had severe lower-left back pain. I then cleaned up the mess and tried to get the commode back in functional order. I had severe pain as I went to my car, and I called my supervisor.

My supervisor put ice on my back and filled out forms and told me to see a doctor. The doctor prescribed anti-inflammatory medication and muscle relaxers and took me out of work. I thought that it was a sprain and tried to go back to work after three days. The doctor gave me a referral for PT, and I self-treated. I was working in pain and had trouble bending over patients' beds. I was treating a paraplegic at the time that had ALS (Lou Gehrig's Disease), and I couldn't do his range-of-motion treatments and transfers. Although there is no such thing as light duty at VNS, I informally transferred difficult cases such as this one to co-workers and tried to focus more on training patients rather than lifting. I had been working in the field for 20 years.

I kept self-treating the pain in my lower back and buttocks, hoping it would get better. My job required me to drive around and get in and out of the car, sometimes carrying equipment. I was going on vacation the second week in September to Cape Cod, and thought that resting my back on vacation would help. My husband agreed to drive so that I could lie down on the back seat. I brought ice packs and medications and took it easy. It got worse. While I was sitting in a chair, I stood up and all of a sudden experienced terribly sharp pain in my back that radiated down my left leg. It took my breath away.

I had tingling in my foot and all kinds of neurological symptoms. I couldn't sleep at night and could hardly walk. Because of what I do for a living, I suspected it was a disc.

When I came back from vacation, I went directly to personnel and told them I couldn't work and reported what happened. I saw my primary physician, and she ordered an MRI, which showed herniated discs and bulges. My doctor recommended I see an orthopedic surgeon. After waiting three months, I was given an epidural steroid injection that didn't relieve my symptoms.

After lengthy delays, I finally had a hearing to establish my case. The attorney for the insurance carrier said I was injured on vacation in Cape Cod, and the judge delayed his decision until he could hold another hearing to get my testimony. The carrier's IME declared that I only had a sprain, which he based on looking at the MRI report, and he only examined me upon my request.

I did not get any wage-replacement benefits and had to rely on short-term disability and vacation pay.

They said the system is “you are supposed to wait.”

After lengthy delays in getting treatment approval, my husband and I decided to pay for an injection out of our own pockets. It cost approximately \$1,000. When the insurance company found out, they called me on the phone and were upset with me. They said I shouldn’t have done that because it is a workers’ compensation injury. I said I was tired of waiting. They said the system is “you are supposed to wait.” I said it has been three months, and I am still in pain! I said, “If I was Donald Trump, would I have to wait?” The treatment was not effective. When I finally had the hearing, the judge ruled in my favor and ordered wage replacement and continued medical care, and I was reimbursed for the shot.

Fortunately, I was covered under my employer’s long-term disability policy, and I had private disability insurance.

I went to the Eastern New York Occupational and Environmental Health Center, where the doctor helped manage my case and referred me to an acupuncturist, prescribed pool therapy, and recommended that I see a pain-management doctor to be assessed for a spinal cord nerve stimulator. Nevertheless, I was declared permanently disabled in 2010 on a reserved decision. The judge reviewed the clinic’s treatment and came back and said the clinic did not provide medical care, but functioned as an IME.

As of December 2012 I began receiving permanent partial-disability payments of \$350 per week and continued medical care. The insurance company is trying to establish a Medicare set-aside and a Section 32 settlement to reduce their liability.

I had back surgery in 2008, but still have back pain and nerve pain in my leg and foot. I believe the delays in approval for treatment worsened my condition. The surgery enabled me to walk again, but did not relieve my back pain or nerve pain in my leg. Prior to the surgery, I could only walk about 500 feet because of the pain.

The system is flawed due to the constant delays. The battles with the insurance company over approval of payments for treatments and wage replacement, work search, and work-relatedness only function to cause more distress to the injured worker. I had to testify about searching for work a few times, even though it was documented that I was out looking for work, and I was also taking continuing education courses, as I needed 36 hours per year to keep my PT license active. I applied for manager jobs, but in this day and age a physical therapist must do hands-on work as well as manage. I also applied for jobs outside my field. As soon as employers know that you need some type of accommodation, or that you can’t lift anything over 20 pounds, you are unemployable in their eyes. They don’t want to take any perceived risks, and with the economy and competition for jobs today, they don’t have to.

Comments from Jean Marie McMahon, MD, Medical Director, Eastern New York Occupational and Environmental Health Center

I have been seeing Ms. Drimalas regularly since July 2007. During this period of time, I made recommendations regarding the medication regimen, referred her to an acupuncturist, and prescribed pool therapy. After the Workers’ Compensation Medical Treatment Guidelines went into effect on December 1, 2010, I filled out variance forms so that Karlyne could continue to access pool therapy, as well as social security disability forms, and responded to queries from her private disability insurance company regarding her ability to return to work.

On August 30, 2010, I determined that Karlyne had reached maximal medical improvement; indicating that her condition was permanent. On the basis of the Medical Impairment Guidelines of June 1996 that were still in effect at the time, I determined that she was permanently markedly (75 percent) disabled, based on her poor response to surgery. A poor response to surgery is clearly listed as one of the criteria for marked disability in the Guidelines.

I provided testimony at a WCB hearing regarding Karlyne’s degree of disability on December 3, 2010. The judge determined that I was not an “attending physician.” “Dr. McMahon does not prescribe medication ... Dr. McMahon has provided the claimant with prescriptions for pool therapy, but that is the extent of her minimal treatment of this patient.” Rather, the judge decided that I was an Independent Medical Examiner (IME). Since I had not filed my reports in compliance with the restrictive rules governing the submission of IME reports, my testimony and reports were precluded. The determination that I functioned as an IME was upheld on appeal.

Interestingly, on June 9, 2012, the same judge authorized the pool therapy that I had requested, as a treatment for this patient.

The problem, as I see it, is that the state’s Workers’ Compensation Law does not recognize that a team approach is required for the proper care of a patient with a complex chronic medical problem. Such a patient commonly needs the expertise of several medical disciplines, including their primary care provider, an orthopedist, a neurosurgeon, a pain-management specialist, a physiatrist, and a specialist in occupational medicine. As Karlyne’s specialist in occupational medicine, I was clearly a treating consultant. There is no such thing as “minimal treatment.” 12 NYCRR 300.2(b)(1) states: “Attending provider or attending practitioner means the provider or practitioner who has *primary* (italics added) responsibility for treating the claimant for the injury or illness for which such claimant is being examined.” Essentially, all other

The Workers’ Compensation Law does not recognize that a team approach is required for the proper care of a patient with a complex medical problem.

treating physicians are considered IMEs. Yet IMEs do not offer treatment. The law therefore does not accurately describe the role of other treating consultants involved in the patient's case and thereby ignores the valuable services offered by these consultants.

Comments from Alex C. Dell, Esq., of the law firm of Alex C. Dell, PLLC

One of the most disturbing parts of this claim involved the insurance carrier's repeated attempts to get the Workers' Compensation Board to suspend lost-time payments to Ms. Drimalas, upon baseless allegations that Ms. Drimalas was not looking for employment within her physical restrictions and limitations while she was considered partially rather than totally disabled from all forms of employment. Rather than invest in the services of a dedicated vocational rehabilitation professional who could have assisted Ms. Drimalas in a successful return to the workforce, the carrier instead paid its attorneys to attend multiple, unnecessary hearings on this issue, which amounted to nothing more than a feeble attempt to criticize Ms. Drimalas's valiant attempts to find alternative employment on her own. In the end, this was certainly not an effective use of the carrier's resources.

While Ms. Drimalas's claim was successfully resolved in the end, another troubling part of the claim involved the WCB's interpretation of Ms. Drimalas's relationship with the Occupational and Environmental Health Center of Eastern New York (OEHC), one of 11 regional health clinic centers established by the New York State Legislature in 1987. OEHC is an organization dedicated to the diagnosis, treatment, and prevention of occupational and environmental injuries and illnesses. Despite Ms. Drimalas's long-standing physician-patient relationship with Dr. Jean M. McMahon of OEHC, the Workers' Compensation Board incredibly ruled that Dr. McMahon's reports should not be considered in connection with her claim. Rather than treat Dr. McMahon as a treating physician, the WCB regarded Dr. McMahon as an IME consultant, whose reports did comply with a section of the Workers' Compensation Law governing medical consultants (see WCL Section 137), notwithstanding Dr. McMahon's evaluations of Ms. Drimalas spanning several years, which included working diagnoses, medication prescriptions, treatment plans, and referrals to specialty medical providers. The WCB's decision is in this regard at odds with, and significantly contradicts, the basis for which these statewide health clinical centers were established by the legislature, and needs to be re-evaluated by the Workers' Compensation Board; otherwise, the well-intended legislative purpose of these valuable health clinics will be lost. And, given the lack of medical providers

who are still willing to accept workers' compensation patients, the Workers' Compensation Board should not be deterring individuals from benefitting from the valuable medical services offered at these clinics.

A constant yet unnecessary battle also occurred when the carrier contended that Ms. Drimalas only possessed a mild (25 percent) disability per their medical consultant. Yet the same consultant, in the same report, restricted Ms. Drimalas to sedentary employment, which is generally consistent with a marked/severe disability (75 percent). Rather than concede that the restrictions were comparable to a marked/severe disability, which would have paid Ms. Drimalas the equivalent of 75 percent of two-thirds of her average weekly wage, which is what the WCB ultimately ruled, the carrier engaged in costly litigation, including wasting precious doctor time for testimony. These litigation expenses could have instead been applied toward paying for the medical evaluation/treatment which Ms. Drimalas required as a result of her occupational injury.

PHILLIP ROWE

"We didn't get anywhere against Walmart's lawyers. They offered to pay for the medical costs but then cut me off after I had the spine fusion. Medicaid paid for it at a cost of \$75,000. My co-pay was \$1,500. I now pay for medications out of pocket. I am as good as I am going to get."



CASE: Phillip Rowe, 54 years old, maintenance worker

EMPLOYER: Walmart, Schenectady, NY

BRIEF HISTORY: Injured his neck, arm, and back while moving sporting goods and furniture. Had spinal fusion and has developed cervical radiculopathy (nerves compressed in the neck). Was unable to establish workers' compensation claim.

CURRENT STATUS: Permanently disabled and living on SSD with the support of family.

After five co-workers were deported, I spent two months cleaning the entire store by myself. They used to have five people doing that job, and they would have me move furniture or sporting goods because they knew I would do the job. They gave me a \$50 gift certificate to take my kids out to eat. I believe I got injured lifting trampolines in sporting goods, when I was putting them on a shelf on a wall without any lifting equipment.

You have to meet the quota. I asked for help, but help didn't come. I worked there for ten years.

I was 46 years old at the time of my injury. I thought I pulled a muscle, but it turned out to be a pinched nerve in my spine. The pain was in my upper back on the right side, and my upper arm is in constant pain. I have been on Walmart's long-term disability, which pays me \$50 per month. I am also getting \$900.40 per month from Social Security Disability.

The insurance carrier wouldn't cover the surgery under workers' compensation, so my doctor put it on Medicaid. My doctor requested surgery for a year, and they kept promising to get back to him, and now I can't use my right arm. I hate being a burden to people, but rely on my 21-year-old son who lives with me.

We didn't get anywhere against Walmart's lawyers. They offered to pay for the medical costs but then cut me off after I had the spine fusion. Medicaid paid for it at the cost of \$75,000. My co-pay was \$1,500. I now pay for medications out of pocket. I am as good as I am going to get.

Initially, workers' compensation gave me everything and a month later took it all away. I personally feel they didn't treat me right. They told me I had full medical and then denied it for the spinal fusion and for my medications. I never got any payments for lost wages. At Walmart I was earning \$778 per week.

Walmart dragged their feet until I developed irreversible weakness in my upper extremity. I finally had the surgery, and Walmart refused to pay, claiming it was unrelated to my work.

At the workers' compensation hearing, the employer's attorney deposed the neurosurgeon who came to the case years after I was injured and didn't understand the relationship between my job and my condition. The neurosurgeon wouldn't say it was definitely work-related. I then began going regularly to the EOHC for treatment.

Currently, I am worried about losing my house. I bought it cheaply because it was a "fixer-upper" and in need of repairs to the roof, chimney, and front steps. Because of my condition, I can no longer do this work myself.

Comments from Jean Marie McMahon MD, Medical Director, Eastern New York Occupational and Environmental Health Center

I first saw Mr. Rowe on December 13, 2007, and he reported a 4 – 5-year history of neck pain, which had started to radiate down the right upper arm to the level of the elbow and had become associated with atrophy in the right arm and constant numbness in the right thumb. Imaging of the cervical spine had revealed a disc protrusion with compression of the right sixth cervical nerve root. These imaging findings were consistent with Mr. Rowe's

complaints and the findings on his physical examination. On September 5, 2006, a neurosurgeon had recommended an anterior cervical discectomy and fusion. On December 6, 2006, Mr. Rowe's neurologist had stated that surgery was the only way that Phillip was going to be able to regain strength and function in his arm. His neurologist repeated that opinion on June 7, 2007.

Additional tests in 2008 were consistent with the diagnosis of compression of the nerve root.

Mr. Rowe filed a workers' compensation claim, and his case for a work-related injury to the neck and upper back was established on June 17, 2008. By October of that year, both Phil's neurosurgeon and his physiatrist had requested a second neurosurgical opinion.

In November 2008, I tried to make an appointment for Phil to see a second neurosurgeon. His workers' compensation carrier verbally refused to authorize such a consultation, stating that his case was controverted. However, I believe that the issues in contention were the degree of causally related disability and voluntary withdrawal from the labor market¹ and *not* the need for medical treatment.

On April 8, 2009, the judge found that Phil was suffering from a marked (75 percent) to total (100 percent) degree of disability from his neck condition. She authorized a "second neurological evaluation." Her decision was appealed by the carrier on the issue of voluntary removal from the labor market. The authorization for "a second neurological evaluation" was not contested. Nonetheless, while the case was in appeal, I was unable to get authorization from the carrier. The neurosurgeon required written authorization from the carrier before he would see Phil.

Meanwhile, Phil's condition gradually worsened. On July 7, 2009, I wrote, "Unfortunately, by the time this process is all over, there might not be anything we can do for Phil because the condition has gone on for so long. I don't understand why we can't get medical care for a condition for which Phillip has an established case".

On September 18, 2009, more than five months after the judge's decision, the appeal WCB found that Phil was not entitled to disability payments because he had voluntarily removed himself from the labor market. "In all other respects, the decision remains in effect." This means that we should have been able to obtain the second neurosurgical opinion. On October 9, 2009, I requested written authorization from the carrier for a neurosurgical consultation. We never received this written authorization. In the meantime,

¹ The workers' compensation insurance carriers have been successful in denying injured workers benefits on the basis of arguing that they voluntarily removed themselves from the workforce when they have retired or stopped looking for work.

The issues in contention were the degree of causally related disability and voluntary withdrawal from the labor market and not the need for medical treatment.

Phil's pain had reached an unbearable level, and he had developed symptoms in his left arm indicating involvement of the nerve root.

Once Phil became eligible for Medicare on January 1, 2010, he had no problem getting an appointment with a neurosurgeon. Phil had surgery on July 23, 2010, paid for by Medicare. On July 22, 2011, a workers' compensation law judge determined that Phil's surgery was not causally related to his work!!!

Not surprisingly, surgical results have been poor. Since his workers' compensation carrier is not paying for medication, and Phil has no prescription coverage through Medicare, we struggle to control his pain with inexpensive prescription and over-the-counter medications. He still has difficulty washing his hair, bathing, and shaving, due to severe muscle weakness and atrophy. Likewise, he still cannot use a spoon with his right hand. He cannot shop for himself because he can't retrieve items from shelves above chest level. He can't push a cart, and he can't carry heavy items in his right hand. No further recovery is expected.

Comments from Alex C. Dell, Esq., of the law firm of Alex C. Dell, PLLC

Initially, the workers' compensation law judge determined that Mr. Rowe stopped working as a result of his occupational injuries and was entitled to lost-time awards. This determination was based on the judge observing Mr. Rowe and assessing his credible nature. Thereafter, upon the carrier's appeal, without ever personally assessing Mr. Rowe, the WCB summarily concluded that he had voluntarily left his employment and thus was not entitled to lost-time awards. This determination was based on the absence of evidence from Mr. Rowe that he had taken actions to find employment within his physical restrictions and limitations. The WCB's decision essentially forces Mr. Rowe to find employment when he has literally been told by multiple medical professionals, including at least one IME for the employer/carrier, that he cannot and should not work, and that he is permanently totally disabled. This type of decision-making is difficult to comprehend and certainly puts the injured worker at greater risk for further injury. Moreover, the fact that Mr. Rowe has been approved for social security disability benefits by the Social Security Administration means that he is disabled from substantial, gainful employment. The WCB should be required to consider this federal finding as presumptive evidence of an inability to work and entitlement to lost-time awards, rather than require Mr. Rowe to search for employment despite his doctor's directions to the contrary. Legislation to promulgate such presumption will benefit injured workers who simply cannot work or even find work, given their debilitating medical condition. Accepting the SSA's findings on disability

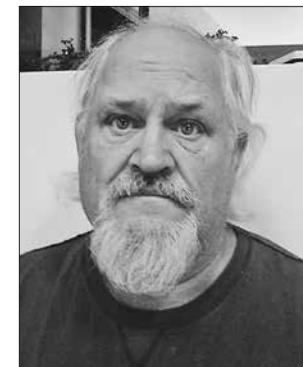
will cut employer/carrier costs by eliminating unnecessary and redundant medical exams and duplicative administrative procedures. The carriers should be limited to challenging claims on the question of labor market attachment only where there is a realistic medical ability to work.

We are continuing to work with Mr. Rowe to assist him in demonstrating to the WCB that he is attached to the labor market, and that he is entitled to lost-time awards, given the current decisions from the WCB, and notwithstanding his inability to work.

In terms of the causal relationship of the surgery performed, the doctor who performed the surgery was not involved in Mr. Rowe's initial diagnosis and treatment and only became involved years later when it was determined that there was a medical necessity for the surgery. Therefore, Dr. Jean McMahon was in a far better position to provide an opinion on the causal relationship of the surgery, given the time that she devoted to Mr. Rowe to obtain a detailed history on his occupational injuries. Consideration should be given to the objective findings of the expert occupational physicians who staff the valuable occupational health centers established by the New York State legislature. The occupational health centers were established in recognition of the unmet need for occupational medicine experts to diagnose, treat, and render opinions on causal relationship, which can be used to ensure that the treatment recommended has a causal connection to the individual's occupational injury.

ROBERT W. HUDSON

"The exposure at work has caused permanent disability. I am now being chastised by workers' compensation. They keep sending me to IMEs to prove my condition is not what my doctors are saying it is. I am being badgered. The procedures are flawed. My life as it was is ended now. I can never work again. I am tired of being screwed by all these people. They don't have to live with the constant worry, and coughing their brains out all night long, and worrying about internal injuries to my respiratory system."



CASE: Robert W. Hudson, 61 years old, building and grounds maintenance mechanic

EMPLOYER: Addison Central School District, Addison, NY

BRIEF HISTORY: Exposed to muriatic acid in 2009 while cleaning the school's swimming pool, causing permanent lung damage.

CURRENT STATUS: Permanently disabled and living on workers' compensation at a 66 percent rate and SSD.

The exposure at work has caused permanent disability. I am now being chastised by workers' compensation.

The director of facilities told us to clean the swimming pool as part of getting ready for major capital improvements. They brought in professional plumbers to change the drains. The pool needed to be cleaned and re-grouted, and it was going to cost \$22,000 to bring in a contractor to do it. Personally, I had never cleaned a pool before. I had been building rooms and offices and doing repairs and installing new tile and grout in bathrooms in the district and office rooms. For this pool cleaning, I was the person who applied the muriatic acid.

I provided my own full-face double-canister mask, and I brought two other masks that I shared with the two women cleaners I was working with. There were two guys as well, and they wore dust masks, raincoats, and heavy-duty rubber gloves provided by the district. The District provided no special ventilation.

The boss arranged for me to pick up 20 gallons of acid from Corning Building Company. The senior maintenance guy demonstrated cleaning a three-by-three foot area, and it looked like brand new tile again. Later I learned that this work was done in violation of the OSHA hazard-communication, respiratory, and personal protective-equipment standards. They had cleaned the pool with muriatic acid more than ten to 15 times previously in defiance of these safety and health requirements.

By 9:00 a.m. we had water hoses hooked up and were ready to work. We were given no directions about diluting, so we used it at full strength. After we got an area done, we hit it with a hose. By early afternoon I had already been overcome by the vapors a couple of times. I kept pushing myself. I was a company man, and I wanted to get the job done. My co-workers took a break, and I became overwhelmed by the vapors, and I crawled out of the pool and was on the ground for ten minutes. After about half an hour I was coughing, gasping for air. My ears, nose, eyes, and throat had a burning sensation like I was in a fire. I still have those sensations, just not as severe.

We were almost done. My co-workers told me they felt dizzy. I was hacking phlegm from my lungs. I went home, and I was spitting up blood and my eyes were on fire.

On Monday I came into work and told my boss that something was wrong. The pool had new stainless steel double doors that cost \$5,000 apiece, and they were pitted from the acid vapors. I carried 30 or 40 keys on the job and had placed them under my coveralls. When I retrieved them, all the finish on keys had been removed. The acid had gone right through my rain pants and coveralls.

We spent most of the week grouting the pool. By Thursday, I said to the boss, "I am sick," and I went to my family doctor. He referred me to an occupational health center. Within two minutes of arriving at the center, the material safety data sheet was faxed over. I had never seen it before!

The doctor's diagnosis was inhalation of toxic fumes. I went through many tests and began using inhalers. A week later I told the doctor I wanted to go back to work. But I didn't last but a couple of weeks, as I could no longer climb ladders and do the physical work required by the job.

They paid me sick and personal days for more than three months until I ran out of them. The occupational doctor sent in the paperwork to workers' compensation, and I had my first hearing in January, about four months after the incident. My first payment was about seven months after the incident. I received \$202.36 per week. I made about \$400 per week on the job.

The State Insurance Fund (SIF) sent me to an IME, who determined I was 50 percent disabled. My treating doctor determined I was 75 percent disabled. When I went to the hearing, the judge ruled I was 66 percent disabled and set the rate on that basis. This, despite the fact that I am deemed 100 percent disabled by my current treating doctor and the social security disability system.

The SIF refused to pay for my medication for the related anxiety and depression. Initially, my health insurance picked it up, and I was paying \$24 for each of three prescriptions. Then the workers' compensation judge ordered them to pay for it and raised my compensation by \$25 per week. I went a full year of paying co-pays for prescriptions.

The exposure at work has caused permanent disability. I am now being chastised by workers' compensation. They keep sending me to IMEs to prove my condition is not what my doctors are saying it is. I am being badgered. The procedures are flawed. My life as it was is ended now. I can never work again. I am tired of being screwed by all these people. They don't have to live with the constant worry, coughing their brains out all night long, and worrying about internal organ injuries to my respiratory system.

Currently I am receiving \$511 per month SSD, which is offset by the workers' comp payments of \$404.36 every two weeks, plus \$25 per week for depression and anxiety as determined to be causally related on September 26, 2012. There was no back pay for the three years I paid for that out of pocket.

Comments of Michael Lax, MD, Medical Director, Central New York Occupational Health Clinical Center

Mr. Hudson's case illustrates several issues with the WC process:

1. The severity of his illness is continuously being questioned, and his benefits reflect a much lower rate of payment than what he really deserves.

2. The psychological/emotional sequelae, in his case depression, which are almost to be expected in this type of illness, are frequently not included as part of the illness/injury. Even when they are, it is often difficult to find someone to treat them and to get medications paid for.

3. The financial consequences are severe as a result of the injury. He was not paid for seven months! Imagine trying to support a family or even an individual for that long without income.

4. This injury could have easily been prevented if proper right-to-know training had occurred and exposure controls been put in place. Instead, a man's whole life has been changed, as his ability to work has been destroyed.

CHARLES BROWN

"They have this law which is compensation for the worker, but I believe that money and wealth rule the most important parts of that law. I had the medical evidence, and I went with my attorney, who went over the facts, and the judge awarded me the money. Then they had 30 days to appeal, 30 days to reply. It seems they always wait until the 30th day to appeal. They schedule an IME, and it's weeks away."



CASE: Charles Brown, 51 years old, building maintenance engineer

EMPLOYER: Lord & Taylor Department Store, New York, NY

BRIEF HISTORY: Fell and experienced disabling injuries due to unsafe conditions in the work area where he was performing maintenance work.

CURRENT STATUS: Permanently disabled, has applied for social security disability. Has been awarded workers' compensation wage replacement and medical benefits, but that decision is being appealed by the carrier.

I was a member of the International Union of Operating Engineers, Local 30, doing building maintenance at Lord & Taylor on Fifth Avenue in Manhattan. I was on the job for 14 years. I am well aware of the hazards of the job, as most buildings in New York City contain asbestos, and our jobs require us to disturb asbestos-containing materials. I lost my dad to that at Macy's. He said if people in the stores knew about the asbestos, they would be alarmed. It was like it was snowing on the baby clothes. He had a hard time breathing for many years and died at age 66.

At Lord & Taylor I took care of heating, ventilation, and air conditioning systems; plumbing, pipefitting, sprinklers, refrigeration units; and I did cooling

tower maintenance. This real estate firm from Canada called Hudson Bay bought out Lord & Taylor in 2006. They cut staff across the board. They didn't replace people who left, and they cut the budget so we couldn't get supplies. The new bosses wanted things done that could never be done. Sometimes I'd be there for 17 hours. They tried to have us rescue people from elevators, which is the fire department's job. It was all about money with this company. They used threats to get things done and put pressure on us. Lots of people started getting hurt. A fellow I worked with was seriously hurt moving a cooling tower motor that weighed over 1,000 lbs. Instead of getting a crane, they had four guys with pipes try to lift it, and one guy was hurt instantly. These conditions were a danger to the public; for instance, the elevators were under-maintained.

I had gotten hurt twice. But the last one finished me off. Everything was a rush. In winter time, we would put glycol (antifreeze), in cooling coils to prevent freezing and corrosion. Instead of pumping it into the whole system with a tanker truck, they figured they could save money if they waited until the last moment and have us put it in manually. It was an early December 2010 morning, and my boss was in a panic. I was around 7:30 a.m., and the hallways were dark.

I had a 55-gallon drum of antifreeze on a barrel cart that I was wheeling down the seventh floor hallway to the mechanical room. I went through swinging doors, and as I went to put the barrel upright it pulled me forward, and that's all I remember. I hit the concrete floor so hard it knocked me out. Someone had stacked more than ten boxes of plastic coat hangers up against the mechanical room door and several of the boxes had split open, spilling plastic hangers all over the floor. It was poorly lit and I was rushing, so when I went through the swinging doors and pushed the barrel forward, I slipped on the hangers and hit the floor. As I stepped forward, my legs came out from under me and I landed on my left shoulder and hit my elbow and head. I had a bloody upper lip. It was a fire department violation to block the stairwell and pile the material up like that. Lots of rules were broken on that job. They do not call an ambulance unless you have a heart attack or break your back. That happened to a security guard. He fell through rotting steps and landed on a banister below. He broke his back.

The fall knocked the wind out of me. Another guy came over and asked, "Are you all right?" I had had surgery on my elbow a year earlier and I thought I had broken it again. Management called the insurance company, and I was placed in a cab and went to New York University Hospital where they did x-rays. They did an x-ray of my elbow, but did not x-ray my neck and spine, which became a big problem later on. After I saw my orthopedic doctor, I was given an MRI and x-ray that showed I had a torn labrum in my left shoulder.

I had a very hard time finding a neurosurgeon, as lots of doctors turned me away, saying that they don't accept workers' compensation cases.

The insurance company, Gallagher-Bassett, did everything to delay the shoulder surgery. I finally had the surgery a year and six months after the accident. During the delay I developed scar tissue, and a cyst formed. Things started to grow back together that needed to be cleaned out because they didn't belong. That wasn't my worst problem.

My main problem was that my spine was injured near the brain stem. I saw a neurosurgeon, as I was in intense pain and could barely talk. I had to be taken to the hospital several times and given intravenous drugs for pain. The doctor wanted to fuse four vertebrae and three discs and put in a metal plate. One of the bulging discs is pressing on my spinal cord.

For the first month I received payments of about \$600 per week. Then the insurance company cut me off, claiming that there was not enough medical evidence to continue paying me. I had a very hard time finding a neurosurgeon, as lots of doctors turned me away, saying that they don't accept workers' compensation cases. I had to travel two hours from home to find doctors who would treat me.

In the year and nine months since my injury, I have never been back on workers' compensation. I went through a lot. My wife and I had built a beautiful home, and we had to let it go. We had to sell all of our assets and vehicles and live on our savings. We finally were awarded back pay by a judge at a hearing, but it has been held up in appeal for seven months. My lawyer told me the average waiting time for appeal is six to eight months.

They have this law, which is compensation for the worker, but I believe that money and wealth rule the most important parts of that law. I had the medical evidence, and I went with my attorney, who went over the facts, and the judge awarded me the money. Then they had 30 days to appeal, 30 days to reply. It seems they always wait until the 30th day to appeal. They schedule an IME, and it's weeks away. My first time with the judge, he said, "Mr. Brown, we don't have much medical here." I said, "Judge, every time my doctors want to do a diagnostic or treatment procedure, we face delays."

Comments of Michael Lax, MD, Medical Director, Central New York Occupational Health Clinical Center

Mr. Brown's case illustrates several unfortunately too common aspects of the workers' compensation process.

1. The amount of time it has taken to resolve his case is extremely long and really unconscionable. The insurance carrier has seemingly endless resources to keep appealing on different issues. On what basis do they appeal? Much of the basis appears to be simply on principle, as opposed to any particular facts.

2. The patient had great difficulty finding a doctor who would accept workers' compensation. This is an increasingly difficult problem for patients

in our area. One reason doctors do not want to participate in workers' compensation is the reason Mr. Brown gives: the workers' compensation insurance carriers keep scheduling IMEs, delaying diagnosis and treatment. Most doctors want to practice good medicine, and workers' compensation often makes that very difficult to do. The consequences for the patient for such delays are frequently a worsening of the condition, making it more difficult to treat. Ironically, the short-term gain the insurance carriers realize by blocking treatment might result in higher long-term costs.

3. Though not related directly to workers' compensation, it should be noted that this accident was preventable. Workplace conditions worsened with the takeover of the company by a new owner. In order to cut costs, the employer cut staffing, which resulted in fewer staff having to work faster and cut corners. Safety suffered, and the patient was seriously injured. Unfortunately, there is no mechanism in workers' compensation that obliges the employer to take corrective action and prevent further injuries from occurring.

ADDITIONAL COMMENTARY FROM CLAIMANT ATTORNEYS

Comments from Vincent Rossillo, Esq., Managing Partner, Fine, Olin and Anderman, LLP

In reviewing the case histories, the two evident problems are the injured workers' inability to get both effective medical treatment and adequate monetary benefits in a timely manner. It can be argued that at no time in the 100-year history of the Workers' Compensation Law has the administration of the system been left to the insurance companies with so little oversight. In the name of efficiency, the WCB has ceded to the carriers its primary responsibility of administering claims to ensure that injured workers obtain benefits in a timely and proper fashion.

In a system that is adversarial by design, leaving the carriers to, in effect, adjudicate claims makes it very difficult for an injured worker to obtain justice. To the carrier, any delay or excuse not to pay is a victory. Every claim that is controverted or delayed represents profit to the carrier. While an adversarial system is not in itself a bad system, there must be a strong adjudicative process in place to make sure that the system is administered in a timely manner.

Over the years it has become more difficult to have a case even indexed by the WCB, let alone have a hearing. The WCB has created a number of procedures that have left key decision-making issues to lay personnel rather than judges and lawyers.

In the past, the WCB created a file upon receipt of an injured worker's claim and held a hearing. At that hearing, a judge would explain the law and the basic requirements to the injured worker. Now, the WCB will not even create a file until all of the evidence has been submitted. There have been numerous cases where both the injured worker and his/her doctor have submitted all their documents. The WCB, however, will not officially "assemble" a file until the employer and/or carrier have submitted their documents. Injured workers suffer medically and financially from this delay. The penalties imposed upon the carrier for causing this delay are relatively small and are not a deterrent.

These case histories further demonstrate that the system is dominated by one party that has virtually unlimited financial resources and the authority to accept or deny claims, with few limitations put into place. That party has a financial incentive to deny and delay claims. Time and money, which are allies of the carrier, are in short supply to the injured worker.

At no time in the 100-year history of the Workers' Compensation Law has the administration of the system been left to the insurance companies with so little oversight.

All of the case studies are examples of the power that the carriers have in this system. They can delay claims by denying them; they can deny surgery and monetary benefits until the WCB issues a decision; they can file appeals, knowing that they don't have to pay for anything while an appeal is pending.

In a system where carriers make money at the expense of injured workers' physical and financial health, it is more important than ever that the WCB put into place policies and procedures that not only protect injured workers but put their interests ahead of the carriers', as the law was intended to do.

Comments of Victor Fusco, Esq, Fusco, Brandenstein and Rada, PC

WORKERS' COMPENSATION PRACTICE, AN EXERCISE IN FUTILITY?

Over the past several years the practice of workers' compensation has become more and more an exercise in futility, as due process rights are whittled away daily by the WCB.

Advocates are spending more and more time trying to get treatments authorized. Every week, it seems we hear of a new set of rules concerning the submission of medical evidence, or the WCB promulgates a "new form."

Attorneys and doctors are wasting thousands of hours on "variance hearings." After many years, permanently disabled claimants are being told that they can no longer have the symptomatic care that had been awarded to them because the care "exceeds the treatment guidelines."

Doctors are required to take time out of their practice to testify to the necessity of certain treatments, and attorneys must prepare for depositions, which they are duty bound to handle but generally cannot be compensated for, since counsel fees are only payable as a lien on a monetary award to a claimant.

And while "variance hearings" seem to be the norm these days, examiners routinely refuse to schedule hearings on issues that cannot be informally resolved. The usual process to get a hearing is to file a written request, wait for nothing to happen, call the "customer service representative," be told there is no reason for a hearing, speak to an examiner, get nowhere and demand to speak to a supervisor, and then maybe you get a hearing.

Aging disabled seniors are forced to scramble for jobs they are no longer qualified to do, or physically capable of performing, in one of the worst job markets in U.S. history — one in which able-bodied people seldom find employment, and college grads are flipping burgers because the WCB has increasingly ruled that people who were classified with permanent disability many years after the fact have "voluntarily been removed from the labor market."

Claimants found medically and vocationally unable to engage in substantial gainful activity by the Social Security Administration are told they must make a bona fide job search or otherwise be precluded from receiving workers' compensation benefits on the basis of "voluntary withdrawal."

Carriers can appeal decisions on the flimsiest grounds and are seldom penalized. The fact that there is little to no financial disincentive for a carrier to file an appeal only emboldens them to do so.

We are now responding to an appeal, where the claimant's testimony of an accident was corroborated by his written statement, his self-filed C-3,

corroborative testimony by one of the employer witnesses, and consistent history in his doctors' reports, as well as the history in the carrier IME report. However, one co-employee testified he didn't see the accident and thought "he probably would have." The judge found that to be non-persuasive. The carrier, against this backdrop, has filed an appeal on the basis that this one employee's speculative testimony "probably would have" was more probative and reliable than everything else in the record. Meanwhile, with the appeal pending, so is any authorization for treatment. Without treatment the claimant can't return to work. With the limited protection of the Family and Medical Leave Act, a claimant can lose their position after 12 weeks as well as other benefits of employment, including medical insurance, and still will be unable to work.

The upshot of this system is that workers do not get the treatment they need, when they need it, and doctors are frustrated, with many dropping out of the system. Claimants are being thrown to the wayside, with no benefits, fewer quality doctors willing to take these cases, waiting months for hearings and appeals to be heard, if ever. Injured workers are forced to exist in the Catch-22 of the "voluntary removal" conundrum of being disabled and trying to find a job when there are none to be had. The WCB — bereft of any representation of labor or the worker advocate community — more and more puts the interests of the carriers and employers ahead of the need of injured workers.

KEY FINDINGS AND RECOMMENDATIONS

New York's workers' compensation system does not meet the needs for which it was established some 100 years ago. It was established as a historic compromise between employers and injured workers to avoid litigation and establish a no-fault system to provide injured workers with prompt medical treatment, adequate wage replacement and incentives for employers to eliminate job safety hazards. The testimonies of injured workers, doctors, and lawyers presented in this booklet are unanimous in agreeing that the current administration of the system does not meet these goals.

Over the last 25 years, as union density in the state of New York and throughout the country has declined, employers and the insurance industry have demanded changes which fundamentally undermine the basic presumption of the law — that workers' compensation was a safety net to meet the basic needs of workers and their families at a time when they are most vulnerable. The system has evolved into a complex bureaucratic tangle of delays and litigation. Ask any lawyer who has practiced in the system, and they will tell you, that benefits which were routinely granted to injured workers in the past are now contested and denied. The very presumption that the law was created to assist workers has been undercut.

Workers get a legal settlement; they do not get justice. Worse, as one attorney said, "The law is administered in a fashion that workers feel disrespected and abandoned."

The governor and legislature must work diligently with all stakeholders to address the workers' compensation policy failures that are devastating New York State's injured workers and their families.

The New York State Workers' Compensation Board website declares, "Today, the workers' compensation system guarantees both medical care and weekly cash benefits to people who are injured on the job. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the WCB. Employers pay for this insurance, and may not require the employee to contribute to the cost of compensation." Further down, it states, "Injured workers are getting benefits faster."

The above quote is no longer a valid statement of the operation of the New York State workers' compensation system. It is time to restore this promise by acting on the recommendations below.

New York's workers' compensation system does not meet the needs for which it was established some 100 years ago.

KEY FINDING #1: Injured workers encounter unreasonable delays in obtaining diagnostic and medical treatment.

The system continues to delay access to medical care for workers who are injured or who become ill on the job, due to delays caused by a cumbersome IME process and often frivolous challenges and appeals by insurance carriers that have resulted in a backlog to hearing schedules. The delays in approving diagnostic and treatment procedures frequently increase costs when there is a deterioration of the affected worker's health or medical complications. The delays are also causing medical providers to leave the system, due to lengthy periods of nonpayment for services rendered, and frustration with refusal to authorize accepted diagnostic and treatment procedures.

RECOMMENDATION 1.1: Collect data, supervise, and better regulate IMEs and IME entities.

Designating a doctor hired by the carrier or employer as an "Independent" medical examiner should be prohibited. Instead, such doctors should be clearly identified as "employer" or "carrier" medical examiners. Currently, injured workers are misled to believe that IME's are independent and/or impartial.

The current system of IMEs often interrupts the timely provision of medical care and wage-replacement benefits to injured workers. The WCB should collect data that identifies the IME company/provider and employer/carrier who regularly provide opinions solely for the purpose of denying the injured worker benefits and generating litigation. This would provide a basis to remove from the system those biased IMEs.

Carriers schedule IMEs to review whether the injury or illness is causally related to work, the degree of temporary impairment, and the appropriateness of diagnostic and treatment procedures. The IME does not engage in any treatment, but typically does a cursory examination, documentary review and interview of the patient. The IME findings often lead to a significant cut in wage-replacement benefits, as described below. It can also lead to major delays in obtaining approvals for diagnostic or treatment procedures. Delays can cause medical complications which ultimately cost more than the original treatment itself.

Currently, there are no requirements for carriers to have an evidentiary basis for ordering an IME. This has led to the routine use of IMEs. The current rules allow carriers to cut wage-replacement benefits unilaterally, based on the findings of an IME, until there is a hearing by a WCB judge. Once the judge establishes a wage-replacement rate, it cannot be reduced without a subsequent hearing.

The cost of frivolous IMEs is a significant financial waste in the system. The

fact that carriers use them routinely to try to reduce benefits and medical care begs for a regulatory solution.

When a serious injury occurs, it is common that a number of medical specialists may be involved, such as experts in orthopedic care, pain management, and psychology. However, it is common that carriers will deny treatment and reduce wage benefits based on opinions from IMEs who do not have accreditation in relevant areas of specialty.

RECOMMENDATION 1.2: Modify Implementation of the Medical Treatment Guidelines. The Medical Treatment Guidelines were adopted in an effort to increase access to needed treatment which was being routinely contested by insurance carriers. However, the implementation of the medical guidelines by the Workers' Compensation Board has resulted in uncertainty, limiting medical treatment by using arbitrary state-imposed rules and creating a litigation system that costs more than the cost of the treatment.

Delays also occur because many providers are unaware of the content of the guidelines or work in health care organizations that will not proceed without written approval from insurance carriers. The SIF, as well as other carriers, refuses to grant such approvals, as they are not required for the procedures that fall under the medical treatment guidelines. This has created a "Catch-22" for injured workers and their providers.

The WCB must educate doctors, insurance companies, and its own judges about the content of the guidelines. Although some workers have benefited from more rapid treatment, many injured workers have not received needed treatment in a timely manner. Some doctors disagree with the procedures outlined in the adopted medical guidelines. Although the guidelines are considered to be "evidenced-based," there remains disagreement about the treatment modalities. There is concern that imposition of the guidelines is resulting in doctors' leaving the workers' compensation system.

Additionally, the guidelines have limited the use of pain medication, physical therapy, and chiropractic treatment which have often been important modalities for palliative care of injured workers with serious injuries to the neck, back, shoulder, and torso. The WCB's decision to unilaterally implement this provision of the law retroactively, denying treatment to injured workers who had received palliative care for decades—treatment to which they believed they were entitled—has caused hardship as well as a sense of injustice among workers who settled their cases before the board imposed this ruling. While the WCB has recently modified its action to allow a limited amount of palliative care, the WCB's initial action has undercut its own credibility among injured workers and their advocates.

Injured workers encounter unreasonable delays in obtaining diagnostic and medical treatment.

Workers whose injury requires treatment which necessitates a deviation from the medical guidelines are required to get a variance from the WCB. The variance procedure has led to a severe bottling-up of the hearing schedule. The WCB reported that in its first year of implementing the guidelines, it has received 202,643 variance applications and another 28,901 applications for optional prior approval of treatment—almost a quarter-million requests to depart from the guidelines. The WCB has rejected almost 28 percent of the variance requests (about 50,000 applications) and more than half of the applications for prior approval (another 15,000 applications). The WCB has held almost 20,000 hearings on the remaining 165,000 applications and continues to schedule about 2,000 hearings per month on variance applications.²

It is imperative that this issue be rapidly resolved.

RECOMMENDATION 1.3: Improve availability of medical care by removing barriers that are causing providers to leave or shun the system.

Increase the provider fee schedule, reduce the paperwork, and prohibit arbitrary insurer partial payment or non-payment of bills to encourage doctors to enter, not leave, the system and to increase the options and quality of care for injured workers.

RECOMMENDATION 1.4: Codify that treatment provided by the state-supported occupational health clinic network will not be classified as IMEs.

The New York State legislature established the Occupational Health Clinic Network in 1987 in recognition of the significant impact that occupational diseases and injuries have on the state's workforce and employers. The network employs occupational physicians and other experts who are specially trained in the diagnosis, treatment, and prevention of work-related illness and injury. However, recently the WCB has made rulings that treatment provided by a doctor in a network clinic was an independent medical exam, thereby discounting their expertise to the detriment of injured-worker patients. Paradoxically, in this situation, the general skepticism of independent medical examiners actually works against the interests of injured workers seeking specialized care for what are often rare or complicated workplace accidents or illnesses.

² Workers' Compensation Alliance, Update on the Cost of MTGs, March 9, 2012.

KEY FINDING #2: Injured workers are not being provided with timely wage-replacement benefits.

The promise of the system to provide timely wage-replacement benefits is clearly not being met. The 2011 annual report from the WCB reported that more than 50 percent of claims took six months to more than a year to establish.

In all but the simplest claims, carriers delay making payments for a variety of reasons. For example, many carriers routinely challenge whether a claim is causally related to work, even when they have no evidence to support such a challenge. This denies injured workers and their families' wage-replacement benefits while waiting for a hearing.

RECOMMENDATION 2.1: Prohibit unilateral compensation rate cuts by carriers without a judge's order. Another common practice which reduces wage replacement benefits for injured workers is when the carrier employs an IME, and the IME determines the injured worker to be less disabled than their treating physician has determined. Under current regulations, the carrier can unilaterally cut benefits until there is a hearing in which a workers' compensation law judge orders benefit levels. Because of the delay in getting hearings scheduled, this can cause serious financial hardship for injured workers and their families.

RECOMMENDATION 2.2: Increase enforcement and penalties for employer/carrier failure to make timely payments.

New York is one of the worst states in the country in time lag from date of injury to date of first payment. The WCB should enforce and increase use of penalties for employer/carrier failure to make timely payments.³

RECOMMENDATION 2.3: Index the minimum rate of compensation to 1/4 of the maximum. The current benefit rates are driving many injured workers into poverty. The 2007 reform provided an increased maximum benefit to workers with temporary disabilities through the indexing of the maximum rate; however, this improvement did not help low-wage workers, who bear the brunt of occupational injury, according to U.S. Department of Labor statistics. Workers who make \$32,100 per year or less get no benefit from the increase and indexing of the maximum rate.

The WCB annual report for 2011 documents that 36.6 percent of claims had an average weekly wage that generated \$400 per week or less in benefits. Effective May 1, 2013, the minimum benefit was increased to \$150 per week for accidents.

³ Carol A. Telles and Ramona P. Tanabe, *Timeliness of Injury Reporting and First Indemnity Payment in New York: A Comparison with 14 States*, Workers' Compensation Research Institute, March 2008.

New York is one of the worst states in the country in time lag from date of injury to date of first payment.

KEY FINDING #3: Unnecessary litigation is increasing costs to the system and delaying the provision of benefits to injured workers.

RECOMMENDATION 3.1: Accept Social Security Administration determinations for disability and do not permit re-litigation of the issue in the workers' compensation system, absent good cause.

In the case studies, many of the workers applied for and were approved for SSD. However, the current workers' compensation law does not allow for acceptance of SSD determination for purposes of workers' compensation. Changing this legislatively could save significant costs, eliminate redundant exams, reduce unnecessary administrative costs, and provide for more timely determination of benefits for injured workers.

RECOMMENDATION 3.2: Adopt a statutory definition of voluntary withdrawal from the labor market/labor market attachment to replace the current punitive, unreasonable approach taken by the Workers' Compensation Board.

Currently, the following rules apply in the WCB-created doctrine of Attachment to the Labor Market (ATLM):

1. The duty of ATLM is for the life of the claimant;
2. Application of the doctrine is retrospective regardless of the PPD;
3. Frequency of the job search is whatever the WCB determines;
4. The Job market can be local, national or international;
5. The claimant is at risk if he or she overestimates or underestimates physical limitations;
6. Claimant is at risk if he or she overestimates or underestimates residual earning capacity;
7. Attachment to the labor market is not mitigated or abrogated by degree of disability, age, education, language skills or transferable skills; thus 70-year-olds with a 99% PPD must search for work.

These rules, which are not contained in New York State's Workers' Compensation Statute itself, but were created by the Workers' Compensation Board, are patently unfair to injured workers. The application of the "voluntary withdrawal from the labor market" defense to ongoing lost time claims should be limited legislatively. Currently, it is being used indiscriminately to take away weekly indemnity benefits from disabled workers.

Injured workers who are determined by their treating physicians, and IMEs, or the Social Security Administration to be totally disabled and unable to work should not be required to document a search for employment that is contrary to medical advice. Cutting injured workers off from their wage-replacement benefits in these instances adds insult to injury. Further,

carriers should not be allowed to raise the issue absent medical evidence that corroborates their contention.

RECOMMENDATION 3.3: Prohibit insurers from cross-examining an injured worker or a treating physician unless documentary proof is submitted contradicting the worker's claim or the doctor's medical opinion.

Allowing carriers to initiate hearings in an attempt to block treatments and cut benefits absent any evidence is a major source of delays in timely medical care and compensation to injured workers.

KEY FINDING #4: Allowing for-profit carriers to administer benefits is a conflict of interest with the legislative goal of providing timely wage-replacement and medical benefits to injured workers.

RECOMMENDATION 4: Evaluate the considerable cost savings and efficiency improvements that a dedicated state fund approach would provide.

Currently New York State has a competitive and not a dedicated state fund. However, it is clear that considerable savings would be generated by changing to a dedicated state fund. State funds began to emerge in the early 1900s, when employers feared that insurance companies might impose excessive premiums and receive unfair profits. The case studies in this report also document that it is clearly in the financial interest of carriers to delay and deny legitimate claims.

According to published research, both exclusive and competitive state funds consistently have lower overhead expenses compared to private carriers. Exclusive state funds also require no marketing, and consequently save additional costs. While state funds sometimes have higher losses, these losses are more than offset by lower expenses, better workplace injury-prevention efforts, more efficient use of technology, higher investment returns, and bigger dividends to employers. Moreover, state funds were found to have more stable reserves and contribute to states' economic development.

These rules, which are not contained in the New York State's Workers' Compensation Statute itself but were created by the WCB, are patently unfair to injured workers.

RELATED RESEARCH STUDIES

The trends documented in these case studies are consistent with the findings of the eight scientific research studies that are referenced below:

1. J. Paul Leigh, PhD, and James P. Marcin, MD, MPH, Workers' Compensation Benefits and Shifting Costs for Occupational Injury and Illness, *JOEM*, Volume 54, Number 4, April 2012.

“Total benefits in 2007 were estimated to be \$51.7 billion, with \$29.8 billion for medical benefits and \$21.9 billion for indemnity benefits. For medical costs not covered by workers' compensation, other (non-workers' compensation) insurance covered \$14.22 billion, Medicare covered \$7.16 billion, and Medicaid covered \$5.47 billion.”

“Conclusion: Incidence estimates of national benefits for workers' compensation were generated by combining existing published data. Costs were shifted to workers and their families, non-workers' compensation insurance carriers, and governments.”

2. National Academy of Social Insurance, *Adequacy of Earnings Replacement in Workers' Compensation*, Upjohn Institute for Employment Research, Kalamazoo, MI, 2004.

“Workers' compensation wage replacement in 16 states falls below the poverty level for a family of four. Only 11 states are above 120 percent of the poverty level, and only one jurisdiction is at more than 150 percent of the poverty level.”

“Workers' compensation covered roughly 27 percent of all costs. Taxpayers paid approximately 18 percent of these costs through contributions to Medicare, Medicaid, and Social Security.”

“Costs were borne by injured workers and their families, by all other workers through lower wages, by firms through lower profits, and by consumers through higher prices.”

3. Emily A. Spieler, JD, and John F. Burton Jr., LLB, PhD, Lack of Correspondence Between Work-Related Disability and Receipt of Workers' Compensation Benefits, *American Journal of Industrial Medicine*, Volume 55, Issue 6. Article first published online: 23 Jan 2012

“Many workers with disabilities caused by work do not receive workers' compensation benefits. The obstacles to compensation include increasingly restrictive rules for compensability in many state workers' compensation programs.”

4. Michael B. Lax, MD, and Frederica A. Manetti, Access to Medical Care for Individuals With Workers' Compensation Claims, *New Solutions*, Volume 11(4) 325-348, 2001.

"A number of barriers were identified by the survey including practices closed to new patients and practices closed specifically to patients with workers' compensation claims. Barriers also were found to be widespread among practices that did accept workers' compensation claims, primarily related to requiring a guarantee of payment prior to seeing the patient."

5. Michael B. Lax, MD, and Rosemary Klein, More than Meets the Eye: Social, Economic, and Emotional Impacts of Work-Related Injury and Illness, *New Solutions*, Volume 18(3) 343-360, 2008.

"The results showed almost two-thirds of respondents lost their health insurance after diagnosis with a work-related illness or injury, most for more than a year. Many reported that their treating physician did not want to become involved in workers' compensation, despite indicating a belief that the health condition was work-related. The financial impacts of a work-related diagnosis were particularly striking, with respondents reporting that they were burdened with both costs directly related to the medical care of their condition, and with coping with ongoing general expenses on a reduced income. Many respondents reported depleting savings, borrowing money, taking out retirement funds, and declaring bankruptcy in efforts to cope."

6. Leslie Boden and Emily A. Spieler, "The Relationship Between Workplace Injuries and Workers' Compensation Claims: The Importance of System Design," in R.A. Victor and L.L. Carrubba, eds., *Workers' Compensation: Where Have We Come From? Where Are We Going?* Cambridge, Massachusetts: Workers' Compensation Research Institute, 2010.

"At least some of the decline in reported injury rates and workers' compensation claims appears to be attributable to restrictions on benefit eligibility and increased barriers to claims approval that have been adopted in many states since 1990. If injured workers do not receive benefits, workers' compensation systems are not living up to their promise of providing injured workers with income replacement and coverage of medical costs."

7. Joseph LaDou, "Workers' Compensation in the United States: Cost Shifting and Inequities in a Dysfunctional System," *New Solutions*, Volume 20(3) 291-392, 2010.

"Workers' compensation is a far more significant expense to the U.S. economy than is commonly recognized. The total annual cost of the health

care and disability benefits in the U.S. is at least \$300 billion. The health care costs shifted by employers to Medicare/Medicaid and the disability costs shifted to the social security system far exceed the total costs of all the state workers' compensation programs. Most of the responsibility for compensating disabled workers now resides in the federal government, not in the state system. Federal funding of workers' compensation is at least four times that of state programs."

"The states' workers' compensation systems evade most of these costs, shifting them to individual workers, their families, private medical insurance, and taxpayers through social security, Medicare, and Medicaid. Industry responsibility for workers' compensation goes no further than is absolutely required by laws enforced by the states."

8. Proportion of Workers Who Were Work-Injured and Payment by Workers' Compensation Systems — 10 States," 2007, *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Weekly, Volume 59, No. 29, July 30, 2010.

"Among ten states collecting data in the 2007 Behavioral Risk Factor Surveillance System survey, the median proportion of workers who were work-injured during the preceding 12 months was 5.9 per 100 employed persons, and a median of 61 percent of self-reported work injuries had treatment paid by workers' compensation."

9. J Paul Leigh, PhD, *Numbers and Costs of Occupational Injury and Illness in Low-Wage Occupations*, Center for Poverty Research, and Center for Health Care Policy and Research, University of California–Davis, December 2012.

"Estimated costs for occupational injuries and illnesses in 65 low-wage jobs are \$39.1 billion in 2010—an amount that exceeds the costs of stroke in the U.S. In part, this large amount reflects the high percentage of the workforce (22.2 percent) in these 65 occupations and the fact that work exposures may occur at any time over, roughly, 40 hours per week and 50 weeks out of the year for most workers. Perhaps 25 percent of these costs are absorbed by workers compensation insurance systems, but the large remainder, 75 percent, are absorbed by workers and their families; other (non-workers compensation) private health insurance; and Medicare and Medicaid, i.e. taxpayers (Leigh, 2011)."

10. *Estimated Incidence of Self-Reported, Work-Injured Adults* and Proportion for Whom Treatment Was Paid By Workers' Compensation, By State, Behavioral Risk Factor Surveillance System, 10 states, 2007, Morbidity & Mortality Weekly Report, July 30, 2010*

STATE	NO. OF RESPONDENTS	WORK-INJURED RATE†		% INJURED WITH PAYMENT BY WORKERS' COMPENSATION¶	
		RATE	(95% CI§)	%	(95% CI)
KENTUCKY	2,552	4.0	(2.8–5.2)	77	(65–89)
MASSACHUSETTS	2,310	4.2	(3.1–5.4)	60	(45–75)
NEW JERSEY	1,730	4.3	(3.1–5.5)	64	(51–78)
CONNECTICUT	3,778	4.7	(3.7–5.6)	63	(53–74)
OREGON	2,425	5.9	(4.6–7.2)	62	(50–74)
TEXAS	4,643	5.9	(4.6–7.5)	47	(35–59)
WASHINGTON	7,348	6.0	(5.2–6.7)	61	(55–67)
MICHIGAN	1,482	6.3	(4.8–8.2)	56	(41–69)
CALIFORNIA	2,758	6.3	(5.1–7.4)	61	(55–66)
NEW YORK	3,173	6.9	(5.6–8.2)	50	(39–60)

* Respondents aged >18 years who were employed for wages at some time during the preceding 12 months and who responded to the work injury question. Work injuries were defined as those receiving medical advice or treatment.

† Data are weighted to be representative of the state population; rate per 100 employed persons.

§ Confidence interval.

¶ Respondents indicated that treatment was paid for by state or federal workers' compensation program, military insurance, or a pending workers' compensation payment decision; percentages are based on weighted data.

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