

WORKERS COMPENSATION AVOIDING CLAIMS FOR PENALTY BENEFITS

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- I. Iowa Code §86.13 provides that a penalty benefit of up to 50% shall be awarded if a delay in commencement or termination of benefits occurs without reasonable or probable cause or excuse.
 - A. Imposition will be mandatory for any unexplained delay or denial.
 - B. This Section applies even when benefits have been paid, but at the wrong amount.
- II. Most Common Areas Where Claimant's Seek Penalty Benefits
 - A. Miscalculation of Rate: Employers and Insurers will be presumed to know what the Claimant's earnings were and be able to calculate the rate.
 - 1. Make sure to include customary work weeks. Deputies will frequently throw out low weeks of hours if they are deemed not to be reflective of an average week for the Claimant.
 - a. If the Claimant is a 40 hour per week employee and has one week of less, that week will generally be thrown out of the calculation.
 - b. If the Claimant works overtime, the overtime hours must be included, but are paid at the straight hourly rate, not time and a half.
 - c. Short holiday weeks are not customary and must be thrown out.
 - d. Bonuses. "Irregular bonuses" are not included in average weekly wage calculation. Varies in amount, dependent upon several conditions, not fixed in terms of entitlement or amount.
 - e. Mileage/Per diem: If payment is for reimbursement of an expense, it is not included in AWW. If claimant is paid by mileage driven, the mileage amount is included.
 - B. Delay or Denial of TTD/PPD Payments
 - 1. Must be paid weekly. If they are not, the Claimant can seek penalty for the weeks that are late. Payments must be in the mail no later than the last day of the period for which benefits are owed.

2. Send them to Claimant, not the employer. If mailed to employer, penalty will be awarded if they are not in the possession of claimant by the last day of the period for which benefits are due.
3. Defendants do have a reasonable opportunity to investigate claim. Get medical records promptly and obtain any medical opinions necessary on causation.

C. Failure to Obtain an Impairment Rating

1. On an accepted claim, when the Claimant is done treating (MMI), the Insurer must solicit an impairment rating from the physician.
2. Upon obtaining the impairment rating, make up any late PPD payments with interest, then start weekly benefits if any amount is still owing. The commencement date for PPD benefits is the RTW or MMI date, whichever comes first. Typically, this will be the RTW date. Communication with Employer is key.
3. If you disagree and do not start payments, get second opinion ASAP. Beware of the appearance of doctor shopping.

D. Underpayment of PPD and Industrial Disability

1. Payment for the Correct type of Injury: Body as a Whole vs. Scheduled Member. If you intend to assert that it is a scheduled member, pay it as such. If an arm injury goes in to the shoulder, it is a body as a whole. If the leg injury results in an altered gait, it may be body as a whole.

Although a doctor may rate as both a scheduled member and body as a whole, the weeks will likely be different. (Example: 10% leg equates to 22 weeks. Converted to a whole body impairment, it is 4%. Which equates to 20 weeks).

2. If the Underpayment becomes obvious in advance of trial, make up the underpayment with interest as soon as possible.

E. Investigation

1. Defendants have an affirmative duty to investigate the claim made by the Claimant.
2. Investigation must be timely.

III. Practical Ways to Avoid Penalty Benefits Under Iowa Law

- A. When a Claim arrives: Call the Employer and interview about the facts of the case. Interview all claimed witnesses and supervisors quickly. If they provide information favorable to your denial, get written statements. By the time the claim may be litigated, witnesses may have disappeared or forgotten. Written statements by witnesses are admissible in workers compensation cases.

Do not merely rely upon putting information in claim notes as this is protected work product. This information will not be produced and as a result, we cannot use it to deny the claim.

- B. Get the Wage Information for the last year (52 weeks) immediately, must include hours worked by each week. If claim is accepted, calculate the weekly rate using representative weeks and correct number of dependents. Do not include weeks which are low. Be able to explain why questionable weeks were included and why other weeks were excluded.
- C. If accepted, communicate the AWW and TTD/PPD rate to the Claimant with an explanation of how it was calculated. Explain which benefits are being paid and for how long, if known.
- D. If accepted, stay on top of medical treatment and get an impairment rating from the treating physician when the Claimant reaches MMI. Pay the impairment rating immediately or send for a second opinion immediately.

On accepted claims, the defendants have the right to communicate with the treating physicians. Use this right, if necessary, to resolve questions.

- E. If denied, communicate the denial and all of the reasons for denial immediately to the Claimant. Conclude by advising claimant that any additional information will be considered. Supreme Court has found that failure to communicate the reason for denial is not a basis for penalty, it helps show that defendants are acting reasonably.
- F. If denied, consider new evidence as it becomes available and re-evaluate the basis for your denial. If you continue to deny the claim, communicate it to the Claimant immediately.

IV. Denial of a Claim

- A. Never rest on a denial. Make sure the Claimant knows why you are denying a claim and make sure you have the evidence to support a denial before a Deputy.
- B. Get the medical opinions to support your claim. If relying on a pre-existing history of the problem, be prepared to defend against an aggravation claim.

V. Important Recent Penalty Decisions

Iowa Supreme Court

A. City of Madrid v. Blasnitz, 742 N.W.2d 77 (Iowa 2007).

A reasonable basis exists for denial of policy benefits if the insured's claim is fairly debatable either on a matter of fact or law. A claim is “fairly debatable” when it is open to dispute on any logical basis. Stated another way, if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.

The fact that the insurer's position is ultimately found to lack merit is not sufficient by itself to establish the first element of a bad faith claim. The focus is on the existence of a debatable issue, not on which party was correct.

In Blasnitz, the Iowa Supreme Court applied the following guidelines adopted from Bellville v. Farm Bureau Mut. Ins. Co., 702 N.W.2d 468 (Iowa 2005), to determine whether a claim is fairly debatable:

1. A claim is fairly debatable when it is open to dispute on any logical basis;
2. A debatable reason is an arguable reason, a reason that is open to dispute or question;
3. If reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable;
4. The fact that the insurer’s position is ultimately found to lack merit is not sufficient by itself to establish the first element of a bad faith claim;
5. The focus is on the existence of a debatable issue, not on which party was correct;
6. The issue is not whether the factfinder believes the evidence that [an insurer] believed when it denied the claim; the issue is whether the evidence existed;
7. A factfinder does not weight the conflicting evidence that was before the insurer; it decides whether evidence existed to justify denial of the claim;
8. The insurer is not required to view the evidence in the light most favorable to Plaintiff.

The Iowa Supreme Court granted further review. In Blasnitz, the Court detailed 12 different facts and circumstances which supported the insurer’s denial of the claim. The Court stated that “the fact that the commissioner was not convinced by the evidence supporting the insurer’s denial does not negate the existence of a genuine dispute with respect to whether the claimant’s January 2003 fall was the cause of her injury.” The Supreme Court ruled that as

a matter of law, the claim was fairly debatable and the claimant was not entitled to penalty benefits. As a result, the decision did not need to be remanded to the Commissioner

B. Thomas Millenkamp v. Millenkamp Cattle, Inc. and Allied Insurance.

In the underlying workers compensation decision, the claimant was kicked in the head by a cow and sustained a serious head injury. He later reported that while mushroom hunting, he fell, striking his head, necessitating an ER visit. The defendants denied the claim on the basis of two medical reports and the subsequent mushroom hunting incident. In the initial arbitration decision, the Deputy was highly critical of the medical opinions and believed that the fall was caused a blackout, or a manifestation of the work injury. However, the Deputy declined to award penalty benefits.

Following the decision, the defendants appealed to the Commissioner and did not pay the arbitration decision. The claimant filed a new petition for penalty benefits on the basis that defendants were unreasonable in failing to pay the benefits following the decision of compensability. The Deputy found that defendants had an ongoing duty to investigate the claim and that a finding by the Deputy that the claim was compensable triggered a duty to re-investigate and analyze their denial. As the defendants denial was solely based upon their own subjective belief that they stood a good chance of prevailing on appeal, the Deputy awarded penalty benefits in the amount of \$20,000. Since there was no new information, different than the evidence presented at hearing, the decision of compensability transformed the reasonableness of the denial. The Deputy acknowledged that defendants would be unable to recoup amounts paid if they were ultimately successful on appeal. However, since workers compensation laws are drafted in favor of the employee, the deputy found that consideration not to be persuasive.

The decision was affirmed by Commissioner Godfrey on appeal. The Commissioner's decision found that the underlying arbitration decision on compensability placed claimant on notice that their defense of the case was close to unreasonable. Furthermore, as determined by the Commissioner, the defendants did not re-evaluate whether it remained reasonable to continue to refuse to pay claimant for his disability. The Commissioner concluded that defendants "had no reasonable expectation" that the workers compensation commissioner would reverse the causation findings by the Deputy. As a result, "their continued refusal to commence some payment of indemnity benefits after [the arbitration decision], was unreasonable."

The practical effect of these decisions is that the insurer must engage in a meaningful review of their denial. Based upon this decision, if the defendant did not have a reasonable expectation that the Commissioner would reverse the decision, the arbitration decision needs to be paid while the appeal is pending. In particular, the Millenkamp, decision notes that decisions based upon the credibility of witnesses is within the province of the Deputy and is not usually overturned on appeal.

As a result, following an unfavorable arbitration decision two questions must be asked: (1) do we appeal the decision; and (2) if we appeal, do we have a reasonable chance of prevailing.

If not, the insurer needs to pay the arbitration decision pending appeal or file a Motion to Stay with the Agency. Otherwise, they will face a penalty on the entire accrued judgment.

This case is currently pending before the Iowa District Court on judicial review.

C. Cynthia Martin v. General Mills, File No. 5015640

Claimant sustained an injury to her left arm and alleged depression as a result of that compensable injury. She further alleged the depression left her permanently and totally disabled. The depression claim was denied, in part, because she suffered from and sought treatment for depression previous to the injury. The Deputy awarded permanent total disability benefits, but denied her claim for penalty benefits. On appeal to the Commissioner, claimant was awarded a 50% penalty. In so doing, the Commissioner wrote:

Indeed, they can only continue to properly defend against the claim so long as a duly diligent investigation continues to show a reasonable basis for denying the claim. In this case, contrary to that principle, defendants immediately took an adversarial stance as regards claimant's claim that her physical injury to her hand has substantially aggravated her depression. Defendants invested all their resources into defending and maintaining that stance. Defendants never attempted to inquire as to its correctness and they never altered from it.

Indeed, defendants disingenuously attempted to reframe the issue as whether claimant's depression was causally related to her employment. Such reframing was clearly done in an attempt to create a logical fallacy by raising the inference that claimant's claim was to be judged by the standards of a mental/mental injury. Both a reasonably competent claims adjuster adjusting in the state of Iowa or a workers' compensation attorney practicing in the state of Iowa clearly would have had notice from claimant's petition that she was claiming that her disabling depression was a non-scheduled member sequela of her left-hand injury. In other words, that she was claiming a physical/mental injury, which is not subject to the same legal causation standard of a mental/mental injury. Since a reasonably competent claims adjuster would be expected to have notice of this from the claimant's petition, the claims adjuster would have a duty to inquire further as to whether claimant's left hand injury could have brought about her claimed disabling depression.

Furthermore, defendants could not cast off their duty to investigate claimant's claim that her left arm injury was a substantial factor in bringing about her current level of disabling depression simply by stating that they were aware that claimant had at least one previous episode of [major depressive disorder](#). Reasonably competent claims adjusters that handle claims in the state of Iowa know that pre-existing conditions become compensable work injuries when the work injury or its sequela substantially aggravates the condition. In the original notice and petition, claimant alleged industrial disability, permanent total [disability] and odd lot as disputed issues. Each of these allegations raises an inference that the depression, on which claimant bases her claim for benefits differs substantially from the depressive symptoms she experienced during

her work years at General Mills. A reasonable claims adjuster would have investigated further in this regard. Herein, defendants did not do so.

In summary, defendants had a duty to investigate the question of whether the hand injury and its after-effects had materially and substantially aggravated claimant's earlier depression such that it was as debilitating as she claimed in her original notice and petition. Defendants wholly disregarded that duty. Instead, they utilized their resources stonewalling claimant's claim for benefits.

Penalty award was \$50,000.00.

This claim was recently reversed by the Iowa District Court for Polk County. In doing so, Judge Gamble determined that the Agency's decision was unreasonable, arbitrary and capricious. The defendants are not required to engage in a tit for tat, countering every medical opinion in favor of claimant with an opinion supporting defendants' denial. The ongoing duty to investigate is relevant with respect to the subjective element of whether defendants knew or should have known their denial was not fairly debatable. However, Judge Gamble found that Iowa Code §86.13 does not contain such a subjective element. As a result, the defendants had a duty to assert facts upon which the Deputy could reasonably find the claim was 'fairly debatable.' Meyers v. Holiday Express Corp., 557 N.W.2d 502, 505 (Iowa 1996). Judge Gamble reversed the decision to award penalty benefits. Both parties appealed the decision and the matter is now pending before the Iowa Supreme Court, with decision as to whether it will be assigned to the Court of Appeals pending.