

2005 MWCEA Conference

Wednesday, September 21, 2005
9:30 – 10:15 a.m.



Recent Cases

Commissioner:
Employer:
Claimant:

Hon. Richard LaFata
Lance Montour, Esq.
Debora Fajer-Smith, Esq.

Section D

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Judicial Estoppel

Chaney Enterprises Limited Partnership v. Windsor, 158 Md. App. 1 (2004)

July 16, 2004

In Chaney Enterprises Limited Partnership v. Windsor, 158 Md. App. 1 (2004), the Court of Special Appeals upheld a decision of the Workers' Compensation Commission and summary judgment granted by the Circuit Court ruling that estoppel prevented a general employer's efforts to shift responsibility for compensation payments to a special employer.

The pertinent parties in this appeal are Chaney Enterprises Limited Partnership (Chaney), Redland Genstar (Genstar) and Bernard Windsor (Windsor). Chaney loaned Windsor to Genstar for the purpose of operating some of Genstar's equipment. Genstar paid Chaney for the services provided by Windsor. While working at Genstar, Windsor sustained injury. Chaney filed a First Report of Injury with the Commission. The First Report of Injury noted Windsor as an employee of Chaney, asserted right of subrogation, noted the accident occurred at Genstar while Windsor used Genstar equipment. Windsor filed an Employee's Claim solely naming Chaney as the employer. Chaney did not contest Windsor's claim, request a hearing, or file any issues. The Commission passed an initial Award of Compensation, which found Chaney to be Windsor's employer. Chaney did not appeal the Award of Compensation, but did pay benefits pursuant to the Award of Compensation and the law.

Three years after the accident, Windsor and Chaney's Insurer eventually filed a third-party action against Genstar for negligence. Five years after the accident, Chaney filed suit against Genstar alleging indemnification and breach of contract and seeking reimbursement of money paid to Windsor. Genstar filed for summary judgment, which resulted in a stay of Chaney's suit and Windsor's suit pending a determination by the Commission as to the status of the parties. Six years after the accident, Chaney impleaded Genstar and filed issues to obtain indemnification by asserting that Genstar was Windsor's special employer (at the hearing, Chaney also argued that Genstar was a co-employer of Windsor). Before the Commission, Genstar argued that Chaney was estopped from impleading them as a special employer and thus not entitled to indemnification. The Commission agreed with Genstar. Chaney appealed to the Circuit Court and again was found estopped. Chaney appealed to the Court of Special Appeals, but lost again.

Noting that Chaney accepted its status as a general employer of Windsor, the Court of Special Appeals reviewed the filings and lack of filings by Chaney to determine whether and to what extent the doctrine of estoppel applied (specifically judicial estoppel). Per the Court, the doctrine of judicial estoppel prevents a party from taking a factually incompatible position from a position taken in a prior judicial or administrative proceeding where the party had full knowledge of, or was chargeable with knowledge of, the facts and where another will be prejudiced by the party's action. Generally, the Court found that Chaney's attempt to implead Genstar as a special employer (or co-employer) was incompatible with its previous position. The Court, citing the difficulty in overlooking the six year delay by Chaney in asserting Genstar as a special employer, identified the specific circumstances leading to their determination. Pertinent in this regard was that: Chaney had not previously claimed Genstar as a special employer, despite full knowledge concerning fact underlying such an assertion; Chaney's First Report identified subrogation against Genstar, which the Court noted would not be available against any kind of an employer of Windsor; Chaney had failed to appeal the initial Award of Compensation finding it Windsor's employer; and Chaney never denied that the accident arose out of and in the course of Windsor's employment with Chaney.

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Continuing TT for Unrelated Medical Conditions

Moore v. Component Assembly Systems (Charter Oak), 158 Md. App. 388 (2004)
September 7, 2004

In Moore v. Component Assembly Systems, 158 Md. App. 388 (2004), the Court of Special Appeals offers guidance as to what to do when a claimant's treatment is interrupted for treatment of an unrelated medical condition. Are there circumstances when is a claimant's refusal to undergo treatment necessary to rectify his work injury is sufficiently reasonable so as to require continuing temporary total disability benefits?

Claimant Grover Moore was injured while working for Component Assembly Systems, injuring his foot and leg. Ultimately Mr. Moore needed surgery for the injury. In the meantime, however, claimant's high blood pressure had turned into coronary artery disease and he needed a stent implanted. Thereafter the cardiologist prescribed daily aspirin therapy. The foot surgeon, however, would not operate until the claimant could discontinue the aspirin for several days. This situation continued for over a year, during which time the cardiologist refused to authorize any break in the aspirin therapy. When the surgery was postponed for a second time, and postponed indefinitely, the insurer stopped paying temporary total benefits, as there was no foreseeable date when the necessary foot surgery was to be rescheduled.

The court found that benefits had to be paid throughout the period of delay prior to the surgery. The Court's view was that the delay in treatment was not unreasonable since the cardiologist refused to permit the claimant to discontinue aspirin therapy and the foot surgeon would not do the surgery while the claimant was taking aspirin. The Court reviews cases holding that a claimant cannot prolong his disability by refusing to accept medical treatment. They go on to analyze the situation in terms of determining whether the refusal to undergo the recommended treatment is objectively reasonable. If the refusal is objectively reasonable, the refusal does not sever the causal nexus between the employment, the injury and the temporary disability.

In this case, the Court found that Mr. Moore's refusal to undergo the necessary foot surgery was reasonable, given that the cardiologist would not allow him to cease the daily aspirin regimen. Once claimant was permitted to cease the aspirin regimen long enough to have the foot surgery, he did so, and the surgery was successful.

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Obligation of the UEF for Payments to Claimant, Penalties and Attorney's Fee

Uninsured Employers' Fund v. Danner, 158 Md. App. 502 (2004)
September 8, 2004

The Claimant was injured while working for an uninsured employer on February 16, 2001. The claim was filed on April 18, 2001 and came to hearing on June 6, 2002 at which time the Uninsured Employers' Fund (UEF) participated. At the hearing there were six issues raised, five of which were determined by the Order dated June 14, 2002, including the determination that the employer was uninsured, that the claim was compensable, and that temporary total disability was owed from the date of the accident to the present and continuing. The unresolved issue was whether the general contractor was a statutory employer. This issue was reserved at the request of the UEF.

The employer failed to pay on the Order within 30 days, and application was made to the UEF for payment of the Order. The UEF refused to pay because of the outstanding issue. This issue was dealt with at hearing on September 11, 2002 at which time the Commission determined that the general contractor was not a statutory employer. The UEF appealed this Order.

The UEF still did not pay on the June 14th Order. The Claimant raised issues for payment by the UEF, penalties and attorneys fees. By Order dated December 11, 2002, the Commission ordered the UEF to pay the June Order, and further assessed penalties of 40% and \$500 attorneys' fees. The UEF appealed this Order to the Circuit Court for Baltimore County, which granted the Claimant's motion for summary judgment and directed, by order, the UEF to pay the Claimant and affirmed the award of penalties and attorney's fees.

The issues on appeal were: 1. Does the UEF have to pay on an Order when there exist any outstanding issues; and 2. Can the Commission assess penalties and attorney's fees against the UEF.

In order to deal with the first issue, the Court of Special Appeals had to deal with the issue of when the UEF's obligation to pay an award arises. The UEF points to § 9-1002 (b) which states that the UEF does not have to pay until the uninsured employer is actually in default. The UEF then argued that the uninsured employer could not be in default until all issues in a case regarding either proper employer or statutory employers have been resolved. The UEF points to its appeal of the September 11th Order as staying its obligation to pay the June 14th Order, and the fact that it was not specifically named as a payor in that order. The Court determined that the UEF's obligation to pay was derivative from the uninsured employer, and that it ripened when the uninsured employer defaulted. Regardless of the collateral statutory employer issue, that the UEF reserved from the June 14th Order, the UEF was obligated to pay the compensation in the June 14th Order. The Court further discussed the "no stay" provision of § 9-741 as further support that the UEF must pay regardless of the collateral appeal. Since the uninsured employer could not stay the Order with an Appeal, the UEF could not either.

With respect to the second issue, the Court decided that the penalties statute, § 9-728 (b) did not apply to the fund since penalties only apply to the employer or insurer. However, the attorney's fees provision of § 9-734 does apply, but the UEF's conduct did not arise to the level that would allow the imposition of attorney's fees.

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That's My Story and I'm Sticking to it!

Abrams v. American Tennis, 160 Md. App. 213 (2004), (cert. denied)

December 9, 2004

Sir Walter Scott said it first: "Oh what a tangled web we weave, When first we practise to deceive!" Sir Walter was prescient – he must have made the comment anticipating Abrams v. American Tennis, 160 Md.App. 213 (2004), (cert. denied).

Claimant Carl Abrams was injured August 2, 1995. He filed a claim alleging he fell down the stairs at work and the claim was accepted. It later came out that he hadn't fallen down the steps; in fact he was knocked over by a truck driven by his boss. The boss had come to get him because he was late for work (and none too fit for work either); they got into an argument, claimant got out of the truck, and the boss started to drive off as the claimant reached in to get his jacket. Boss and another employee put claimant back in the truck and took him to the hospital. During the ride to the hospital the three of them cooked up the "fell down the stairs" story.

When the workers' compensation insurer, IWIF, found out that claimant hadn't fallen down the stairs, they filed to have the Commission reconsider the original award, which it did. The Commission nullified the original award (18 months after the fact) and ordered claimant to repay the benefits. Claimant appealed, and also filed a new claim. The Commission refused to hear the second claim, since the appeal of the first was pending, noting that it was really a duplicate claim, even though claimant had changed the description of the accident. Claimant appealed that as well and it was consolidated with the appeal on the first claim.

The Circuit Court for Baltimore County upheld the nullification of the award, and with respect to the second claim found that the claimant was going to work, so the incident fell under "going and coming" and therefore was not compensable (apparently not every ride in a company-owned vehicle is compensable). Claimant did not appeal that decision, but rather filed a tort suit against the employer and the boss, with yet another description of what had happened. This opinion is the second trip of the tort suit to the Court of Special Appeals.

On this second trip, the Court of Special Appeals upheld the Circuit Court's grant of summary judgment in favor of the employer based on judicial estoppel (which was essentially suggested by a previous CSA panel after the Circuit Court granted a motion for summary judgment based on election of remedies). The Court discusses judicial estoppel ("... precludes a party who ... secured a judgment in his or her favor from assuming a contrary position in another action simply because his or her interests have changed"), and when it applies, noting that it does apply to administrative proceedings. Mostly the opinion is a lengthy recitation of the "facts" and how they changed from claim to claim. Claimant argued judicial estoppel should not apply because the employer failed to show that claimant had prevailed below.

Quoting Middlebrook Tech, LLC v. Moore, 157 Md. App. 40, 849 A.2d 63 (2004), the Court reviews the three factors that "typically inform the decision whether to apply' the doctrine of judicial estoppel in a particular case: whether the party's later position is clearly inconsistent with its earlier position; whether the party succeeded in persuading the court in the earlier matter to accept its position, so that judicial acceptance of the contrary position in the later matter would create the perception that one of the courts had been misled; and whether the party seeking to assert the inconsistent position in the later matter would derive an unfair advantage, or would impose an unfair detriment on the other party, from being permitted to do so."

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In large measure the court found that judicial estoppel applied because claimant had not repaid any of the money as he was ordered to do by the Commission – so even though claimant had not prevailed, he had the benefit of having prevailed, to the tune of \$185,000! The suit against the supervisor was settled, and there is no mention of whether any of those funds were to be used to repay any of the \$185,000. This opinion was written by Judge Salmon and is actually rather amusing reading, except no doubt for IWIF, since they're still out \$185,000 on account of this fellow.

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Appeals – Presumption of Correctness & Burden of Proof

**Board of Education v. Spradlin, 161 Md. App. 178 (2005)
January 31, 2005**

In Board of Education v. Spradlin, 161 Md. App. 178 (2005), the Court of Special Appeals provides an exhaustive analysis of the substantive and procedural effect and meaning of a determination by the Workers' Compensation Commission when considered on appeal.

The Claimant was injured in an altercation with a co-worker while on the Employer's premises. The Claimant asserted that she was the subject of an unprovoked attack. The co-worker, a witness for the Employer, contended that the Claimant started the altercation when the Claimant used derogatory epithets and threw a frozen water bottle. Before the Commission, the Employer argued multiple theories, including that the Claimant was guilty of willful misconduct, that the incident did not arise out of her employment and that the Claimant was not in the course of her employment when the incident took place. Only the Claimant and her co-worker testified. The Commission found for the Employer, stating that the Claimant had not sustained an accidental personal injury arising out of and in the course of her employment. The Claimant appealed.

The appeal proceeded *de novo*, before a judge without a jury. During the appeal, two additional witnesses, also co-workers of the Claimant and her alleged assailant, were called as witnesses. The Claimant again asserted that she was the victim of an unprovoked attack by her co-worker. The Employer again argued that the Claimant was guilty of willful misconduct and that the incident did not arise out of her employment. On consideration of all of the evidence and arguments of counsel, the Circuit Court ruled that the Claimant sustained an accidental personal injury in the course of employment. The Employer appealed to the Court of Special Appeals.

In reviewing the determination made by the Circuit Court, the Court of Special Appeals determined that it would need to consider not only the substantive law applicable the involved compensability issues, but actually identify the procedural nature of Circuit Court appeals in general, as well as determine what decision of the Commission's had been appealed to the Circuit Court and how the presumption of correctness in LE 9-745(b) applies to that decision. Based on its review, the Court of Special Appeals affirmed the decision of the Circuit Court

The Court's analysis started with a review of the two methods for appeal from a Commission decision. The first is an appeal on the record, which the Court characterized as a routine administrative appeal. In this method, the Judge alone determines, pursuant to LE 9-745(c)&(e), whether the Commission justly considered all the facts, exceeded its power, or misconstrued the law and facts. The Judge must scrutinize the Commission's decision for legal error, including the question of evidentiary sufficiency, but must affirm absent the decision being clearly erroneous. The second method is what the Court termed an administrative appeal plus (essential trial *de novo*). It was the breadth of review given to this procedure that explained the length of the Court's opinion.

The Court's review of the administrative appeal plus was exhaustive, even noting that it is not explicitly stated in the Statute. The Court identified its origin in what is now codified as LE 9-745(d). The differences from the appeal on the record are that there is plenary fact-finding and no requirement of error in the Commission's fact-finding. Either party can request *de novo* fact-finding, even though this raises substantial procedural concerns that the Court quite wisely avoided trying to resolve.

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The Court noted that before there can be *de novo* review, the factual question on appeal must actually have been a factual question before the Commission (raising of a formal issue, or some evidence addressing the issue at the hearing would suffice). Once it is determined that an issue is subject to *de novo* review, it can be determined by either a Judge or a jury. In either case, the fact-finding determination is sustainable on further appellate review, unless clearly erroneous. The Court went even further to address what could be considered in the Circuit Court fact-finding process. Since the Circuit Court can consider more, less, and/or the same evidence considered by the Commission, it could include review of the Commission's record alone, the Commission's record with new arguments interposed, the same witnesses as before the Commission, and new witnesses not previously before the Commission, et cetera. When the proceeding is before a jury, the determination is on formal or specific issues, but not the ultimate verdict. This means that not every subordinate fact must be submitted to the jury. With a Judge as fact-finder, there is no need for formal or specific issues.

The description of the administrative appeal plus as "essentially" a trial *de novo* was compared to the true trial *de novo*, which puts all parties at their original starting point as if there was no prior determination. "Essentially" means that the Commission's decision has evidentiary and procedural significance. The Court noted that the decision is substantive evidence on the point it addresses and that is in dispute and when proceeding before a jury, the jury must be advised that it can give the decision the weight it deems proper. Procedurally, the decision may or may not serve to shift or satisfy the burdens of production and persuasion. Significantly, the Court noted that the party prevailing before the Commission is protected from determinations of summary judgment or directed verdict, even though summary judgment is fully available in workers' compensation appeals. As explained, the decision alone would meet any burden of production that is required of the party prevailing before the Commission. With regard to the burden of persuasion, the decision serves as a factual tiebreaker.

With the substantive and procedural basis provided, the Court of Special Appeals addressed the Employer's arguments one-by-one and rejected them. The Court found that the Claimant did not need to demonstrate that the incident arose out of her employment because LE 9-101(b)(2) provides that the willful act of a third-person, which includes a co-worker, only requires that the incident be in the course of employment (date, time, and place). The Employer argued that the Claimant was guilty of willful misconduct and that the Commission must have agreed, thus providing great import to a comment from the Judge that his mind was in equipoise as to the versions provided by the Claimant and her alleged assailant. Noting that reliance on provocative words, as a basis for a willful misconduct defense was probably misplaced, the Court noted the additional witnesses before the Judge were sufficient to support any finding that the Claimant was not guilty of willful misconduct. Further still, the Court concluded that the Employer had the burden of proof on the willful misconduct, as it is an affirmative defense, and thus the Claimant would have benefited from the procedural tiebreaker of the presumption of correctness.

As noted, the Employer argued that the Commission decided that the Claimant was guilty of willful misconduct because the claim was disallowed and that had been an argument advanced before the Commission. The Court rejected the Employer's attempt to rely on an allegedly implicit decision for the triggering effect of shifting the burdens of production and persuasion. The Court noted that there was not precedent for such an application and that the entire concept of an implicit decision pertains to a determination as to what issues are or are not subject to appeal proceedings. Further still, it was pointed out that the decision of the Commission could have many been based on other grounds and that even an implicit decision has to be one that was probably, not just possibly, decided. The Court clearly stated that not every decision made by the Commission is presumed correct, that it must be the "decision of the Commission" that is presumed correct. That term, a term of art, refers to the order that disposes of the case, not every subordinate, intermediate or subsumed issue.

Because the Circuit Court's decision that the Claimant met her burdens of production and persuasion and that decision was supported by the evidence, it was not clearly erroneous and the Court of Special Appeals affirmed the finding that the Claimant sustained an accidental personal injury in the course of her employment

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Appeals – Summary Judgment

**Kelly v. Baltimore County, 161 Md. App. 128 (2005)
January 31, 2005**

In Kelly v. Baltimore County, 161 Md. App. 128 (2005), the Court of Special Appeals addressed the question of whether summary judgment is available to an Employer when deciding an appeal from a decision of the Workers' Compensation Commission in favor of the Claimant on a complicated medical question.

The Claimant was injured in a motor vehicle accident and filed a claim for benefits, which was not contested by the Employer. The Commission found the claim compensable. Between the date of the accident and the initial Award of the Commission, the Claimant underwent surgery to his back. After the Commission's initial Award, the Employer raised issues contesting the causation of the back surgery. At the hearing before the Commission, the Claimant alleged his back surgery was the result of the motor vehicle accident aggravating a prior condition. The Employer argued that the surgery stemmed from the prior condition alone. The Employer's evidence consisted of an opinion from a medical expert that the surgery was solely causally related to the prior condition and certain of the Claimant's medical records that did not comment on the issue of causation and that noted surgery to the back was recommended before the accidental injury. The Claimant submitted medical records showing that although he had a prior condition that had improved prior to the accident, but was worse thereafter. The Claimant also testified to his condition, both as it was before and after the accident.

The Commission ruled for the Claimant finding the surgery related. The Employer appealed and requested a jury trial. The Employer filed for summary judgment relying on the Commission's record without additional evidence. The Employer argued that the Claimant did not have an expert medical opinion and the Commission must be reversed as a matter of law. The Claimant contended that the evidence before the Commission was sufficient and asserted that there was a genuine dispute as to the material fact as to causation of the surgery. The Claimant also argued that the Commission's decision was entitled to a presumption of correctness. After a hearing on the motion, the Circuit Court ruled for the Employer and reversed the Commission.

The Court of Special Appeals noted the methods for obtaining judicial review of a Commission decision, an appeal on the record and an essential trial *de novo*. The former being a determination of whether the Commission acted proper and that there was sufficient evidence for the finding. The latter requiring that the Commission's decision is presumed correct with the burden of proof on the issue falling to the appealing party. The Court noted that when the Claimant does not prevail, the burden of proof does not change. Conversely, when the Claimant does prevail, the burden of proofs of production and persuasion switch to the Employer. Implicitly, the Court found that because the Employer requested a jury trial that it had sought the essential trial *de novo*. The effect was to require the Employer to sustain the burden of proof.

The basis for the Employer's motion for summary judgment was that the causation issue was a complicated medical question requiring expert medical opinion. Because the Claimant did not have an explicit statement of causation before the Commission, the Employer reasoned that it was entitled to judgment as a matter of law. The Court of Special Appeals disagreed.

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The Court first set about identifying that the summary judgment procedure is available in workers' compensation appeals. Noting general rules for summary judgment, the Court stated that such determination is not appropriate where there is a genuine dispute of fact, or where the undisputed facts are susceptible of disputed inferences. Applying this standard, the Court held that summary judgment was wrongly granted by the Circuit Court because the evidence before the Commission was susceptible of disputed inferences. Reviewing the evidence, the Court noted that Claimant's testimony concerning the change in condition from before and after the accidental injury; the medical records showing the improved condition before the accidental injury; and the deterioration of the condition after the accidental injury. Because there were multiple inferences from that testimony, they showed have been construed against the Employer.

With regard to the requirement for expert medical opinion in complicated medical questions, the Court stated that it does not apply to the party that prevailed before the Commission because of the presumption of correctness. The Claimant, therefore, had no burden of proof and could have submitted no evidence at all. Summary judgment was inappropriate because the Claimant prevailed at the Commission, but also because the evidence at the Commission was sufficient by itself to create a genuine dispute as to a material factual inference. The Court also noted that the Claimant could have presented additional evidence at trial, including expert medical opinions on causation generated by a new medical examination.

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Policy Cancellations

Rockwood v. Uninsured Employers Fund, 385 Md. 99 (2005)

February 8, 2005

In Rockwood v. Uninsured Employers Fund, 385 Md. 99 (2005), the Maryland Court of Appeals addressed the correct procedures for cancellation of workers' compensation insurance policies. Insurers desiring to cancel policies for non-payment of premiums or other permissible reasons must adhere to the provisions of Md. Code Ann., Ins. §19-406, which are designed to provide actual notice of the cancellation to the employer.

The insurer herein, Rockwood, issued a workers' compensation insurance policy to the Carousel Hotel covering the period December 23, 1997 to December 23, 1998. On December 30, 1997, Rockwood mailed a notice to the Carousel and to its agent that the policy was being cancelled for non-payment of premium. The notice was mailed by certified mail as required, however the return receipt was marked "no evidence of delivery." In mid-February, Rockwood went to the Carousel to do a cancellation audit. On March 8, 1998, a Carousel employee was injured on the job. When Rockwood refused to pay, citing the cancellation, claimant filed against the Uninsured Employer's Fund (UEF). The Maryland Workers' Compensation Commission found Rockwood's attempted cancellation was invalid, and they were responsible for paying the claim. The Circuit Court for Worcester County granted the UEF's Motion for Summary Judgment; that ruling was upheld by both the Court of Special Appeals and now the Court of Appeals.

The Court's discussion and holding focus on the statute's contemplation of actual notice to the employer of the cancellation, in a fashion and at a time so as to allow the employer to obtain new insurance. In this case, although Rockwood complied with the statute by mailing the notice of cancellation by certified mail, the return receipt card clearly indicated that there was no evidence of delivery. The Court stated that mailing by certified mail creates a presumption of delivery, but it is a rebuttable presumption. In this case the presumption was rebutted by the return receipt card that indicated the item was not delivered.

There is also discussion in the opinion about the identity of the addressee. Ins. §19-406(a) allows the certified mail notice to be "addressed to the last known address of the employer." Ins. §19-406(b), however, goes on to state that "notice . . . may be given: (1) if the employer is a corporation, to an agent or officer of the corporation on whom legal process may be served; . . ." UEF took the position that this provision meant that the notice MUST be addressed to an officer on whom legal process could be served. However, the Court stated that the notice could be simply addressed to the employer, and as long as someone who is authorized to receive the mail signs for it, that is sufficient.

Once the presumption of receipt is rebutted, the insurer may present evidence that the notice was in fact actually received by the employer. In this instance, Rockwood pointed to their cancellation audit. However, the court found that the audit date was too late to succeed in canceling the insurance prior to the claimant's injury, since notice must be given at least thirty days prior to the date of cancellation, and the injury occurred prior to thirty days after the cancellation audit. (The Court also included an invitation to the legislature to address the issue of what happens when an insured employer is purposely evading receipt of notice under 19-406, but there is no indication that was the circumstance here.)

Judge Greene wrapped up the case succinctly in the last paragraph:
"In conclusion, we hold that § 19-406 (a) permits an insurer to choose whether to serve notice of cancellation of insurance by personal delivery or by certified mail. Service by certified mail, however, is not complete upon mailing. The statute contemplates actual delivery of notice. . . . The notice mailed in this case did not comply with the statutory requirements of actual delivery and, therefore, Rockwood's attempt to cancel Carousel's insurance failed."

N.B. Senate Bill 128, effective October 1, 2005, reduces the notice period for non-payment cancellations only to ten days.

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Permanency - Apportionment Required for 2 Distinct Claims

**Marshall v. UMMS, 161 Md. App. 379 (2005)
February 28, 2005**

In Marshall v. UMMS, 161 Md. App. 379 (2005), the Court of Special Appeals addressed the question of whether the Commission can issue a single award of compensation regarding permanent partial disability for two separate accidents, each with distinct injuries and occurring in different years. The Court of Special Appeals affirmed the Circuit Court's finding of summary judgment for the Employer and Insurer, finding that the Commission is bound to apportion permanency awards at the rates scheduled for the year each accidental injury occurred.

The Claimant injured both of her knees on May 21, 1999, after slipping and falling on a grape. She had arthroscopic surgery to the *right knee* as a result of the May 21, 1999, fall. The Claimant was involved in a second accident on April 10, 2001, and sustained injuries to her shoulders, ankles, lower back, and knees. As a result of the 2001 accident, she underwent surgeries to her *left knee* and *left elbow*. The Claimant was an employee of the University of Maryland Medical System Corp. on each date of accident.

On November 15, 2002 the Commission held a consolidated hearing on the Claimant's issues of permanent partial disability for each claim, and the Employer and Insurer's issues of causal connection and apportionment of disability. The Commission then issued a single award of compensation ruling, among other things, that the Claimant sustained a 25% impairment under "Other Cases" as a result of injury to the right leg (knee), back, left foot (ankle), left leg (knee), and left arm. The Commission further ordered compensation at the rate of \$223.00 payable weekly, beginning January 13, 2002, for a period of 125 weeks. The entire award of compensation was payable at the 2001 rate pursuant to LE § 9-629.

The Employer and Insurer's Motion for Rehearing, seeking apportionment of the 25% finding between the 1999 and 2001 accidents was denied. The Circuit Court for Baltimore County granted the Employer and Insurer's motion for summary judgment, and remanded the claims to the Commission for hearings to apportion the percentages of permanent injury between the two accidents. The Claimant appealed.

The Court of Special Appeals reviewed the three tier system of compensation for permanent injuries according to LE §§ 9-628 to 9-630. Based upon the statutory scheme of payment for permanent impairment according to the *calendar year* of accidental injury, the Court of Special Appeals found that the Commission erred in awarding permanent partial disability for the 1999 right knee injury at the 2001 rate of \$223.00/week. Furthermore, the Commission erred in combining the percentage of permanent injury for the 1999 right knee injury with the percentages of permanent injury for the 2001 left knee and left arm injuries under "Other Cases".

The Court of Special Appeals rejected the Claimant's argument that the Commission has discretion to order payment of both awards at the higher 2001 rate, stating that no legal authority was introduced to support such a contention.

Section D

Stay of WCC Award during Appeal (Revisited)

Gleneagles, Inc. v. Hanks, 385 Md. 492 (2005)
March 11, 2005

This was a collateral attack on an award for permanent partial disability to the claimant, and a denial of the employer's statute of limitations argument. The employer attempted to get an injunction to prevent it having to pay on the award until the appeal was resolved. The Claimant last received compensation on April 20, 1992. Timely permanency issues were filed, but because of various continuances, these issues never came to hearing. The Claimant filed new issues on September 19, 1996 requesting authorization for certain medical treatment, payment of medical expenses and requesting a determination as to causal connection of a new body part, but no compensation was requested in these issues. Because of various continuances, this hearing did not take place until June 5, 1997. On September 7, 1999, the Claimant requested a hearing on the previously filed issues of permanency. The SIF was subsequently impleaded and the claim finally came to hearing on May 7, 2003 at which time the statute of limitations was argued. The statute of limitations argument was denied and the claimant was awarded permanent partial disability to begin on April 28, 1992. This meant that the entire payment on the award by the employer was due and owing, less the attorney's fees, within the time that payment on the award was to commence.

Feeling aggrieved that the statute of limitations argument was denied and believing that it had a valid statute of limitations argument, the employer appealed the decision. Simultaneously, the employer filed a request for an injunction to stay the order, since, in many aspects, paying the award would render the appeal moot since the employer could not recover the money paid. A temporary restraining order was issued, but after argument on the permanent injunction, the Circuit Court denied the request finding that it did not have the power to stay the order of the Commission pending the appeal. It is from that Order that this appeal arises.

The Court of Special Appeals affirmed the judgment of the Circuit Court, agreeing that the "no stay" provision of LE § 9-741 applied. The Court of Appeals granted certiorari regarding this issue. In a four to three decision, the Court of Appeals affirmed the decision of the lower courts. The Court of Appeals affirmed a long line of cases enforcing the "no-stay" provision and rejected the employer's argument that an injunction is not a stay, and since it has more procedural safeguards it does not fall under the "no-stay" provisions.

A strong dissent was issued that would adopt Professor Larson's interpretation that "no-stay" provisions are susceptible to an injunction issued by a court with equitable powers so long as the employer can prove a likelihood to succeed on the merits and financial damage, essentially the elements necessary for an injunction to be issued.

Section D

Group Self-Insurance is Insurance

MMTA v. PCIGC, 386 Md. 88 (2005)

April 6, 2005

In MMTA v. PCIGC, 386 Md. 88 (2005), the Court of Appeals determined that the term insurer includes group self-insurance obtained for the purposes of workers' compensation.

In 1993, a number of trucking companies formed the Maryland Motor Truck Association Workers' Compensation Self-Insurance Group (MMTA) for the purpose of workers' compensation coverage. The MMTA obtained excess coverage from Reliance National Indemnity Company (Reliance) for claims exceeding \$150,000.00. During a period from February 1999 to June 2000, four claims exceeded \$150,000.00 and were submitted to Reliance for payment. Reliance was unable to pay and eventually declared insolvent. MMTA filed a claim with the Property & Casualty Insurance Guaranty Corp. (PCIGC) for the payments owed by the insolvent Reliance. PCIGC denied the claim by MMTA stating that it was not a covered claim, as a covered claim excluded amounts payable to an insurer. MMTA filed a declaratory judgment and breach of contract action against PCIGC. PCIGC filed for and was granted summary judgment by the Circuit. MMTA appealed to the Court of Special Appeals, but the Court of Appeals granted certiorari on its own initiative. The Circuit Court was affirmed.

The Court undertook a substantial review of Self-Insurance Groups, as permitted by LE 9-402(a) and INS 25-302, the MMTA's governing documents and general operation, the PCIGC and its function and the Self-Insurer's Guaranty Fund (SIGF). Noting that MMTA contended that it was not an insurer because: self-insurance is not insurance, it does not enter into insurance contracts and out-of-state authority agreed, the Court disagreed. Since the term insurer was a statutory term, the Court looked for a plain and unambiguous meaning. Not finding one, the Court refuted MMTA's position one point at a time.

First, the Court evaluated opposing foreign decisions on the question. Finding the determination from South Carolina (favoring PCIGC) more persuasive than one from Iowa (favoring MMTA), the Court noted that the Iowa case was not persuasive due to the specific requirements of Iowa law. This included the requirement that insurers (not self-insurance groups) must be licensed and regulations stating that self-insurance groups were not insurance companies, specifics found in Iowa law not existing in Maryland. Noting similarity between the Maryland law and South Carolina law on the statutory definition of an insurer, the Court followed the South Carolina analysis concerning the nature of the self-insurance agreement and the nature of risk transference and retained risk. Second, by applying the South Carolina analysis to the MMTA, the Court found that the self-insurance agreement used insurance specific terms and concepts, such as premium, insurance, excess insurance, underwriting guidelines, et cetera to determine that the self-insurance was a type of insurance contract. Finally, it was noted that like prime characteristics of insurance, self-insurance provided for risk transference and distribution among the members. The Court also rejected the notion that retained joint and several liability, which MMTA argued demonstrated a lack of risk transference, was dispositive by identifying the similarity that bore to the way that assessment mutual insurance companies provided insurance.

Accordingly, the Court of Appeals found that self-insurance groups for workers' compensation coverage fall within the definition of an insurer under INS 1-101(v) and thus the MMTA's claim against PCIGC was not a covered claim pursuant to INS 9-301(d)(2)(i).

Section D

Subsequent Injury Fund - When in Doubt, Implead the Fund

Darden v. Mass Transit Administration, CSA Nos. 0032 & 0033 (2005)

May 2, 2005

In Darden v. Mass Transit Administration, CSA Nos. 0032 & 0033 (2005) the Court of Special Appeals proclaimed, “[t]his case is a textbook example of what not to do.” The Court was called upon to unravel litigation involving two separate claims for permanent impairment involving distinct compensable accidents in 1994 and 1998, that had twice been taken up on appeal to the Circuit Court.

On January 18, 1994, the Claimant slipped and fell on ice, injuring the right side of his body, resulting in bilateral carpal tunnel surgery, right trigger thumb surgery, and right rotator cuff surgery. While employed by the same employer, on July 9, 1998, the Claimant injured his left knee and subsequently underwent left knee surgery. Both claims came before the Commission on April 1, 2002, on the Claimant’s issues of permanent impairment to the effected body parts for each case.

With respect to the January 18, 1994 case, the Commission awarded 55% under “Other Cases” industrial loss of use for injuries to his left shoulder, right shoulder, left upper arm, right upper arm, left thumb and right thumb, 12% of which was due to the pre-existing condition to the back, right knee, headaches, and pulmonary. The Commission specifically found that the Claimant was not permanently totally disabled. By separate Order for the July 9, 1998 case, the Commission found the Claimant sustained 15% loss of use of the left knee. The Commission also found the Subsequent Injury Fund (who was not represented at the hearing) was not liable with respect to the 1998 claim because the Claimant’s overall disability did not exceed 50% of the body as a whole.

The chain reaction of errors begins The Claimant filed *de novo* appeals of both decisions. However, the record reflects that the Claimant was only dissatisfied with the permanency award on the 1998 case. The two claims were consolidated on appeal and tried before a jury on March 3, 2003. Based upon what the Court of Special Appeals characterized as an ambiguous verdict sheet, the jury found the Claimant was permanently totally disabled *as a result of both accidents*, attributing 70% of his disability to the 1994 injuries, and 30% to the 1998 left knee injury. The jury also found 7% pre-existing, but the pre-existing was not likely to be a hindrance to the claimant’s employment. The cases were then remanded to the Commission for Orders consistent with the jury’s findings.

The second phase of errors on remand On June 17, 2003 the Commission issued two separate orders based upon the single verdict sheet of the jury. With respect to the 1994 case, the Commission ordered the Claimant permanently totally disabled as a result of the combination of the 1994 and 1998 injuries, 70% as a result of the 1994 injuries; 30% due to the 1998 left knee injury; and 7% due to pre-existing conditions. The Commission further stated the claimant was to be paid \$510.00 weekly beginning June 12, 2002 not to exceed the sum of \$178,478.00 allowed under “70% under Other Cases”, subject to a credit for monies paid under the Order dated April 17, 2002.

By separate Order dated June 17, 2003, with respect to the 1998 claim, the Commission found the Claimant was not permanently totally disabled, and increased the prior permanency award to the left knee from 15% to 30% loss of use. The Commission ordered payment for 90 weeks instead of 45 weeks at \$191.00 week.

The Claimant sought reconsideration and rehearing arguing that, pursuant to the verdict sheet, the increase from 15% to 30% as a result of the 1998 knee injury should have been to the body as a whole instead of the left knee. The Commission, rejecting the arguments of the parties, affirmed its June 17, 2003 Orders.

Section D

The final phase of errors The Claimant appealed the Commission's orders of June 17, 2003, to the Circuit Court, and the appeals were again consolidated. Relying upon *SIF v. Compton*, 28 Md. App. 526, 346 A.2d 478, affirmed in *Anchor Motor Freight, Inc. v. SIF*, 278 Md. 320, 363 A.2d 505 (1976), the Circuit Court denied the Claimant's motion for summary judgment on February 26, 2004, and affirmed the June 17, 2003 orders of the Commission.

The Court of Special Appeals offered some suggestions with respect to avoiding similar errors on appeal. First, whenever possible, litigate permanency claims timely and separately. Second, unless a party is dissatisfied with the decision, do not file an appeal. And third, do not consolidate unrelated cases on appeal.

Far more important than these suggestions, however, is the necessity to implead the Subsequent Injury Fund when the Claimant's pre-existing impairment from **any** injury, condition or disease could be rated at 125 weeks or more, and is likely to be an obstacle or hindrance to the Claimant's employment. It is of no significance whether the pre-existing impairments are work-related or non-work-related, or whether they were incurred while working for the same employer, different employer or no employer at all. While simply impleading the Subsequent Injury Fund is not necessarily sufficient to hold the Fund liable, it avoids results similar to this case by giving the Fund the opportunity to defend the claims in a timely manner.

For example, in this case, the Commission originally found 55% impairment under "Other Cases" as a result of the 1994 accident. Had that permanency claim been adjudicated in a timely manner, when the 1998 permanency claim was heard before the Commission, the finding of 55% pre-existing injury should have triggered one of the parties or the Commission to implead the Subsequent Injury Fund. Then, if the Commission found that the Claimant sustained 125 weeks or more permanent impairment as a result of the subsequent 1998 case, the Subsequent Injury Fund could be liable for the pre-existing impairment, subject to a credit for permanency paid under prior Orders.

However, the jury's findings in the 1994 and 1998 cases cannot stand. LE § 9-807(b)(1) and (2) provide that the Subsequent Injury Fund may be made a formal party to a case at any time, and that the Subsequent Injury Fund must be given a formal opportunity to defend against the claim. Therefore, based upon the fact that the Subsequent Injury Fund was not given the opportunity to defend either the 1994 or 1998 cases before the Commission, the Court of Special Appeals remanded the claims to the Commission for hearings with the Subsequent Injury Fund as a party.

Section D

Death Benefits - Offset for Firefighter's Dependents

Johnson v. Mayor and City Council of Baltimore City, CA No. 60 (2005)

Luster, Jr. v. Mayor and City Council of Baltimore City, CA No. 77 (2005)

May 12, 2005

In Johnson v. Mayor and City Council of Baltimore City, CA No. 60 (2005) and Luster, Jr. v. Mayor and City Council of Baltimore City, CA No. 77 (2005), the Court of Appeals addressed the question of whether dependents of deceased firefighters who died from occupational diseases covered under LE §9-503 are entitled, "...to collect the service pension benefits in addition to full workers' compensation benefits, or whether the workers' compensation death benefits must be reduced by the amount of service pension benefits the widows are currently receiving."

Mr. Johnson worked as a Baltimore City firefighter for thirty-two years and contracted colon cancer as a result of his employment. He died on March 11, 1994, and his wife, who was wholly dependent on her husband at the time of his death, began receiving \$603.90 per week from his service pension plan. Mr. Luster also worked as a Baltimore City firefighter and developed pancreatic cancer as a result of his employment. He died on August 8, 2000, and his wife, wholly dependent on her husband at the time of his death, began receiving \$294.83 per week from his service pension plan.

Each wife filed workers' compensation claims for death benefits. The Commission and the Circuit Court agreed that they could receive both workers' compensation and retirement benefits. The Court of Special Appeals disagreed and in Johnson's reported opinion and Luster's unreported opinion, the Court of Special Appeals found that the each widow's workers' compensation benefits must be reduced by the amount of service pension benefits received.

The Court of Appeals considered these cases as matters of strict statutory interpretation. § 9-610 is a general provision prohibiting the payment of dual benefits in workers' compensation cases. However, according to §9 - 503 (e), public safety employees are permitted to collect both workers' compensation and retirement benefits up to the amount of the employee's salary.

The issue here is whether the Legislature intended for *dependents* of deceased public safety employees to be eligible for dual benefits as well. The Claimants's position was that the offset provision of § 9-610 does not apply to them. They argued that they are covered under the exception created by § 9-503 (e) because their husbands were eligible for the dual benefits when they were alive, and to deny dual benefits to their dependents is to treat living firefighters differently from deceased firefighters. The Employer argued that because § 9-503 does not specifically mention dependents, the general offset provision of § 9-610 applies to the Claimants.

The Court of Appeals first observed that the statutes under consideration in this case are not ambiguous. § 9-503 (e) does not specifically mention dependents. As a result, simultaneous recovery of workers' compensation and service pension benefits are permitted only for firefighters (and other public safety employees) who are living but unable to work because of their occupational diseases. Therefore, the exception created by § 9-503 (e) does not survive upon the death of the employee, and their dependents are subject to the general offset provision of § 9-610.

In reaching its conclusion, the Court of Appeals rationalized that the Legislature did not intend to place the dependents of firefighters who die while saving people from a burning building (accidental injury) in a worse position than dependents of firefighters who die from cancer that they contracted while saving people from a burning building (occupational disease). Furthermore, "...the Legislature must be the body to remedy any [perceived] unfairness in the Workers' Compensation Act, should they consider it necessary."

Justice Battaglia's dissent took issue with the strict interpretation of the statute, and concluded that a liberal construction of § 9-503 (e) supports the benevolent purposes of the statute in affording dual benefits to firefighters and their dependents.