Testimony before the Senate Labor Committee
Workers' Compensation
May 15, 2024

Louis M. Dauerer, Esq.

NYS Senate Labor Committee
Hon. Jessica Ramos, Chair

I appreciate the honor of testifying at this committee's hearing regarding workers' compensation.

My name is Louis Dauerer, and I have been representing injured workers for nearly 30 years with the firm of Ouimette, Goldstein & Andrews, LLP. I am also a former president of the IWBA (Injured Workers' Bar Association) and a former co-chair of the NY WCA (New York Workers Compensation Alliance). The practice before the Workers' Compensation Board has changed quite a bit since I started. Due to time constraints, I will be focusing on issues that impact injured workers. Please don't construe the negative tenor of my testimony to mean that there is nothing good to say about the system.

As a young lawyer I learned two fundamental tenets: first, the workers compensation law is to be liberally construed to accomplish the humanitarian purpose of the act,[1] and second, "The Workmen's Compensation Law was framed to avoid technicalities and the requirements of precise pleading. . . ."[2] Unfortunately, over the last several decades we have witnessed an erosion of these principles.

Behind each WCB case # is an injured worker likely with a family dependent on their income. Please consider the gut-punch the injured worker feels when their doctor tells them, or they realize, that they can no longer return to their job – that their career, and to some extent, their life, as they knew it is over.

---

[1] In Re Petrie, 215 N.Y. 335, 109 N.E. 549, 550, (N.Y. 1915)
[2] Matter of Finkle v. Cushing Stone Co., Inc., 278 App. Div. 250, 252 (1951) citing (Matter of Kaplan v. Kaplan Knitting Mills, 248 N.Y. 10; Matter of Plouff v. Port Henry Light, Heat & Power Co., 225 A.D. 704, affd. 250 N.Y. 616).

Fundamentally, the WCL provides workers with a portion of the lost wages they will suffer and medical treatment they will require due to their injury.

In the brief time I have, I would like to address issues relating to medical treatment and the §35 hardship provision.

MEDICAL TREATMENT

In 2007 the legislature directed the Board in §13-a(5) to "develop a list of pre-authorized procedures" (beyond the $1000 limit) with the intention of expediting treatment to hasten the injured worker's return to work, because the longer someone is out of work, the less likely they are to return to work. Prior to the 2007 amendment, any treatment costing less than $1000 did not require prior authorization. In 2010 the Workers Compensation Board adopted the Medical Treatment Guidelines ("MTGs") along with pages and pages of rules and regulations which delay treatment by pre-denying[3] all treatment that is not contained within the guidelines even if it costs less than $1000.

One of the largest frustrations I see among my clients centers around the delays experienced in obtaining treatment and medication. Even with the new PAR portal[4], injured workers must wait months before getting a determination either from the MDO or a law judge. They want to get the treatment quickly to speed up their recovery in the hopes of returning to work, and those who cannot return to work wish to simply feel better.

Due to complexities of the system, many doctors no longer accept workers' compensation patients,[5] and due to the difficulties and delays, many providers and workers decide to bill

---

[3] This concept of pre-denied treatment was challenged in the courts, and in Matter of Kigin v. New York State Workers' Compensation Board, 24 NY3d 459 (2014) where, in a split 4-3 decision, the Court of Appeals concluded that it was proper for the Workers' Compensation Board to utilize the list of preauthorized procedures a.k.a. MTGs to predetermine that all excluded procedures are not medically necessary. It was argued that "list of pre-authorized procedures" should be a floor rather than a ceiling. Few doctors are willing to perform treatment listed in the guidelines without authorization for fear that the carrier will still deny the bills. The dissenting opinion in Kigin recognized that, now the injured worker "faces a previously unknown burden to rebut a presumption against payment for certain medical services" not listed in the guidelines.

[4] The PAR portal is web portal developed by the board to replace the previous system of forms used by doctors to request approval for treatment under the MTGs.

[5] In the Hudson Valley, on January 31, 2021, Crystal Run Healthcare in Orange, Rockland, and Sullivan Counties stopped treating workers' compensation patients leaving thousands of patients scrambling to find other providers.

privately, thereby shifting costs to private health carriers. The Board's decision to require out of state doctors to follow the MTGs and utilize the portal has resulted in the termination of care for many workers who have moved out of state, because they are unable to find doctors willing to participate in New York's workers' compensation system.

WCL §35 SAFETY NET

In 2007, WCL §35 was written as part of the reform legislation to create a "safety net" for the more severely injured workers impacted by the caps on PPD benefits. This section:

1. created a return-to-work task force;
2. preserve an injured workers' right to claim total industrial disability;
3. established a right for injured workers with a greater than 75% loss of wage earning capacity to apply for an "extreme hardship redetermination;"
4. directs the board to issue an annual safety net report.

Unfortunately, this provision, as interpreted by the Workers Compensation Board, has not accomplished the goal as set forth by the legislature.

The return-to-work task force made recommendations that were never adopted. New York's injured workers have no right following an injury to return to work light duty nor any job protection under the workers compensation law, thus creating the paradox where workers who take time off under the paid family leave act to care for a family member have job protection, but those who are forced out of work due to an on-the-job injury do not.

The Board's interpretation of § 35(3) "extreme hardship redetermination" has been so strict that, as far as we know, fewer than 30 applications for this have been approved since this provision was enacted. [The precise number of approvals should be contained in the Annual Safety-Net Report.] Applications under this provision likely began in 2018-19. In calculating this redetermination, the Board looks at all household income and has denied benefits in many cases even though the injured worker demonstrates that they cannot make

ends meet once their PPD benefits have expired.[6] I am compelled to ask: what good is a safety net that doesn't catch anybody?

Finally, the annual safety net reporting as required under subdivision 4 remains a mystery. For several years after this provision was enacted, the board published the safety net report on its website. Currently, neither the early nor recent annual safety net reports are visible anywhere on the board's website. This lack of transparency is troubling.

I ask the legislature to close the holes in the WCL §35 safety net, so that it benefits more of New York's injured workers.[7]

CONCLUSION

It's easy to point out problems or deficiencies in the system. Over the years the board has taken great strides with the adoption of the Electronic Case Folder, it's handling of the self-insureds crisis, as well as the use of virtual hearings during Covid. However, more can and should be done to help New Yorkers. I would like to see a greater focus on the injured worker. The grand bargain eliminated an employee's right to sue their employer in exchange for a system of lost wage benefits and treatment for their injuries. Over the last several decades, a system of rules, regulations, processes, and procedures have been put in place

---

[6] Decisions from the Board regarding this provision usually include language like this: "The board panel notes that, at least based on the C-35 and his testimony, the claimant does not appear to have many, if any, excess expenses. However, the mere fact that the claimant's income, absent his workers compensation benefits, would not exceed his expenses does not arise to the level of extreme hardship, as it is not unusual for someone on a fixed income to be in that position."

[7] S1798(Ramos)/ A294(Bronson) Amend §35 to define Hardship

which delay a worker's access to those benefits. The current focus on form over substance undermines the core mission of this statute to protect and adjudicate the rights of the parties. Finally, I ask that you please listen to the injured workers who are here today, and read the written testimonies submitted by those workers from around the state. They are the reason why we are here.

Respectfully submitted,

Louis M. Dauerer, Esq.
Ouimette, Goldstein & Andrews, LLP
88 Market St., PO Box 192
Poughkeepsie, NY 12602
(845) 454-9700

POST SCRIPT:

OTHER ISSUES OF CONCERN (beyond the time for oral testimony):

- Please fund the **NYS Occupational Health Clinics** they are a vital provider of treatment for New York's injured workers.
- **Workers' Compensation Law §32(a)** mandates that every carrier shall make a section 32 settlement demand within 2 years of the date of indexing or six months after classification with a permanent disability, but the WCB does not enforce this provision.
- **Workers' Compensation Law §137(3)(b)** reads, "Any practitioner performing the independent medical examinations shall be paid according to the fee schedule established pursuant to section thirteen of this chapter." The WCB does not enforce this provision and allows carriers to negotiate higher rates with their consulting physicians.
- **Workers' Compensation Law §169** was added in 2022 and reads, "Presumptive evidence. 1. The board shall accept the certifications of the Centers for Disease Control and Prevention World Trade Center Health Program as presumptive evidence of causation of certified illnesses pursuant to 42 USC 300mm for claims filed for conditions of impairment of health or death pursuant to a qualifying condition." The WCB has so narrowly interpreted this provision thereby rendering it meaningless. *Matter of Metropolitan Transportation AU*, WCB#G2930344 (August 21, 2023).

Notwithstanding the worker's WTC certification, the WCB still required the production of prima facie medical evidence of causal relationship.

- **Workers' Compensation Law §15(9)** created a fund for rehabilitating injured employees. Sadly, this has never been funded.
- The C-4.3 Doctor's Report of MMI/Permanent Impairment, does not contain a check-off box for Permanent Total Disability
- Medical providers don't have standing to object to decisions made by the WCB about the compensability of their bills.
- The WCB instituted a policy making commissioners responsible for writing their own dissents; thereby discouraging dissenting opinions that would trigger mandatory Full Board Review. Majority opinions are written by staff attorneys.
- Closed hearing points; hearing points not reopened since COVID.
- Elimination of the claimant's application for an advance on compensation C-21 disappeared from the WCB's website one day without explanation. WCB used to allow injured workers to apply for an advance against their future benefits. They no longer do that.
- No longer including Jefferson v. Bronx Psychiatric Center language in decisions to compel employers to restore an injured worker's accruals after the employer is reimbursed for the wages paid to the IW for lost time due to an injury.
- Understaffed WAMO (Waiver Agreement Management Office) resulting in huge delays in settling claims involving Special Funds.

- **Medical Witnesses:** The WCB is probably the only judicial forum in the world that prohibits an attorney from speaking with a medical provider before that doctor testifies on behalf of their patient. S8323 (Ramos) / A8957 (Reyes) would rectify this by permitting communication between an attorney and medical provider.

- **Diagnostic Testing Networks**: In Matter of Rivera v. North Central Bronx Hospital, 101 AD3d 1304 (2012) the appellate division upheld the board policy that if an injured worker failed to use the diagnostic testing network, the carrier would pay the non-network provider at the negotiated network rate. This simple rule which was in effect from 2012 to 2023 allowed injured workers to utilize pharmacies and testing facilities most convenient for them, and simultaneously allowed the carriers to limit their payments to the negotiated network rates. It was a win-win for everyone. Recently, the board adopted regulation 12 NYCRR §325-7.5(d)(4) (prohibiting payments to

out-of-network diagnostic testing providers)[8] thereby limiting injured workers to a small pool of diagnostic testing facilities causing significant delays in obtaining MRI's and other necessary testing. Adoption of these regulations serves only to line the pockets of the network providers while simultaneously limiting the workers' ability to obtain testing as requested by their medical provider. I urge the legislature to take steps to restore the injured workers' access to treatment. [9]

- **Hearings**: Unfortunately, the governor vetoed S5867 (Ramos)/ A6208 (Joyner) which would have given all parties the right to a hearing upon request to the board within 60 days of a request. Even though §20(1) states, ". . . Upon application of either party, [the board] shall order a hearing. . .", the board rarely schedules hearings when requested by the parties. The only instance where the board rapidly schedules hearings is upon a request by the carrier to reduce benefits pursuant to board rule § 300.23(b)(2) which requires a hearing be scheduled within 20 days upon the request. Unfortunately, there is no comparative rule to schedule a hearing when an injured worker seeks a reinstatement of benefits, increase in benefits, or authorization for medical treatment. Conversations with prior general counsel to the board revealed their position that §20 only provides a right to a hearing in controverted cases. Many years ago the board adopted a policy to try to reduce the number of "wasted" or "unnecessary" hearings. Unfortunately, this policy also serves to keep deserving cases off calendar thereby delaying access to adjudication. It's better that an "unnecessary" hearing be held than a "necessary" hearing be unscheduled.
- Not speaking English as an impediment to receiving benefits due to labor market attachment issues: A worker who does not speak English was denied benefits because he did not take any English classes. He was found not attached to the labor market even though he underwent a job assessment with ACCES-VR and was told that they could not help him. The judge stated at the hearing "Because of his physical restrictions, he is better suited to a sit-down job, but he has very little training for sit-

---

[8] The Board also adopted regulation §440.8(c) which similarly prohibits payments to non-network network pharmacies in contravention of the Rivera rule which allowed non-network pharmacies to be paid at the network rates.

[9] S6929 (Fernandez)/S6832-A (Lunsford) Workers' Access to Treatment

PROVISIONS:

1. Provide payments to non-network diagnostic testing providers at the carrier's negotiated network rate reinstating the rule that has existed since 2012 under the Rivera case.
2. Raise the prior authorization limit for treatment from $1,000 to $1,500;
3. Provide that the Workers' Compensation Board's list of pre-authorized procedures cannot be used as a basis to deny treatment not included on the pre-authorized list.

down jobs. And you – and there is limited English proficiency, which makes it more difficult. . . Pursuing other avenues means trying to fix or correct the problems that exist. If a lack of English proficiency is a detriment to searching for work, taking English classes would show a good-faith effort in trying to attach to the labor market."

- **Safety Valve:** In 2017 §15(5) was amended to create a "Safety Valve" it reads: "where the carrier or employer has provided compensation pursuant to subdivision 5 of this section [temporary partial] beyond 130 weeks from the date of accident or disablement, all subsequent weeks in which compensation was paid shall be considered to be benefit weeks for purposes of this section . . ." (emphasis added) The Board has interpreted this language to allow the carrier to begin taking credit against the PPD cap once 130 weeks has lapsed since the date of injury regardless of the amount of benefits paid thereby penalizing those who continue working after the injury, receive no lost wage benefits, and only begin losing time from work several years after the injury (eg. delay surgery for as long as possible). Once they pass 130 weeks the carrier may apply ongoing payments against the capped permanent partial disability award.

  However, once the 130 weeks has lapsed from the date of injury, the carrier only receives credit for the weeks in which they've paid the worker. So currently, payments made prior to the 130 weeks don't matter, but payments made after the 130 weeks do. The board has decided in several cases that a worker must produce a medical report and request a hearing to make a "no MMI" finding to avoid application of the carrier's credit rights. The board has further held that even though there was medical evidence of no MMI in the file, a failure to request a hearing on the issue was fatal and the provision would not apply.