



1995

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Recommended Citation

Levasseur, Ronald J. (1995) "Commentary: Does the Workers' Compensation System of Maryland Favor the Injured Worker?: No," *University of Baltimore Law Forum*: Vol. 25 : No. 3 , Article 7.
Available at: <http://scholarworks.law.ubalt.edu/lf/vol25/iss3/7>

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OF MARYLAND FAVOR THE INJURED WORKER?

Ronald J. Levasseur

NO

The Maryland Workers' Compensation Act was designed to "provide compensation to injured workers in accordance with a statutory plan for work related disabilities." Unfortunately, a contest has developed between the various parties both at the Workers' Compensation Commission and in appeals in an effort to gain an advantage. The appellate courts of Maryland have long pronounced that uncertainties or conflicts regarding questions of construction of the Workers' Compensation Act should be resolved in favor of the claimant.¹ At first glance, it would appear that the claimant is given great advantage under the law. However, in the reality of representing injured workers before the Workers' Compensation Commission, what you see is not always what you get.

It is easy to point to excerpts of statutory language and isolated judicial decisions and conclude that the injured worker is the true beneficiary of our State's workers' compensation system. However, the vast majority of workers' compensation claims are resolved at the Commission level. At this stage, the employer or insurer, rather than the claimant, gains a great deal of control over the process of deciding workers' compensation claims, inevitably sacrificing the well-being of both the injured worker and the overall system.

There are four main areas where the law, not as it is written but as it is applied, serves to deter any true chance that the injured worker has to receive benefits commensurate with his disability, including an effective retraining and rehabilitation program that will enable him to re-enter the job market at a level reasonably

coordinate with his previous employment.

Vocational Rehabilitation

The vocational rehabilitation section of the Workers' Compensation Act is set forth in the Labor and Employment Article of the Annotated Code of Maryland.² The purpose of providing vocational rehabilitation to an injured worker is "to return the disabled covered employee to suitable gainful employment."³ Unfortunately, the interdependence between vocational rehabilitation providers and insurance companies is much too close, requiring vocational experts to rely upon insurance company representatives to approve or disapprove their recommendations.⁴

When the Workers' Compensation Commission finds that an injured worker is entitled to vocational rehabilitation, it refers that employee to a vocational rehabilitation provider. The employer or insurer must pay the expenses associated with the vocational rehabilitation of its covered employee.⁵ On its face, vocational rehabilitation looks to be a real boon to the claimant - an opportunity to develop his body and mind to obtain maximum employability. But appearances are deceiving under our workers' compensation system.

The fact that the employer or insurer controls the payment for rehabilitation services provided to the claimant essentially serves to shift the focus of the vocational rehabilitation provider from the injured worker to the employer/insurer. Natural economic self-interests make it obvious that the true client of vocational rehabilitation providers is the employer/insurer who

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al rehabilitation providers is the employer/insurer who pays the bills. This close relationship is further facilitated by the inescapable nature of the employer/insurer's involvement in the vocational rehabilitation system. Vocational rehabilitation providers rely upon employer/insurers to provide a steady stream of clients. This reliance is gradually transformed into subservience and, as "the customer is always right," the wishes of the employer/insurer take precedence over the best interests of the injured worker.

The law allows the employer/insurer to select and exert *de facto* control over the vocational rehabilitation provider and the rehabilitation program in general. Employer/insurers are economic entities primarily concerned with the bottom line and, as such, coerce vocational rehabilitation providers to follow the cheapest program possible. In an overwhelming majority of cases, this results in low cost "job searches" for the worker, frequently frustrating the intended vocational rehabilitation purpose. Too often, the worker is placed in situations where he is not comfortable and does not have the training needed to obtain a position that will compensate him anywhere near his previous salary.

The facts of the situation are thus: the employer/insurer has undue influence over the vocational rehabilitation provider. Rather than provide costly but effective skills retraining programs or educational opportunities, the least expensive means possible are utilized to get the worker a low-paying, low-skilled job. This aids the employer/insurer's goal of minimizing the cost of workers' compensation but does nothing to advance the desires of the claimant or the statutory intent of the system. As long as the law is interpreted as not requiring the independence of vocational rehabilitation providers, and input from both sides in vocational rehabilitation decisions is not solicited, the vocational rehabilitation component of the workers' compensation system will continue to be subtly wielded to the advantage of employers and insurers.

Permanent Partial Disability

On January 1, 1988, Maryland introduced a three-tier structure for the classification of permanently partially disabled workers. The law applies to incidents that occur after January 1, 1988 and creates a minor disability section.⁶ This section reduces the amount of awards for disabilities of less than 75 weeks duration to 33 1/3% of the average weekly wage.⁷ Awards of 75 weeks

remain unchanged at 66 2/3% of the average weekly wage.⁸ The tri-part disability system ties the level of benefits that the injured worker is eligible to receive to impairment ratings given by physicians. Usually, the employer/insurer and the claimant produce impairment ratings by different physicians. Obviously, each physician has some degree of allegiance to the best interests of the party who is the actual client, again out of normal economic self-interest.

The three-tier plan, designed to decrease the overall costs and delays inherent in administering the workers' compensation system, has resulted only in cutting costs for the employer/insurer. The added third tier, intended for less serious injuries, enables the employer/insurer to pay minimal benefits to the injured worker. How this adaption of workers' compensation law can be thought in any way to aid the cause of claimants is beyond the pale of common sense. The employer/insurer manipulates the system and contains costs by, explicitly or implicitly, directing physicians to place the impairment ratings within the lowest possible tier of benefits. An impairment rating which is only slightly less than that given by a claimant's treating physician can result in the denial of thousands of dollars in benefits to which the injured worker would otherwise be entitled.

While this aspect of the three-tier structure by itself is sufficiently contrary to the intent of the workers' compensation law, the repercussions to the system caused by the employer/insurer's use of the three-tier advantages is even more troubling. Stipulations have become increasingly difficult to negotiate due to the fact that the employer/insurer generally will not agree to any stipulation that would push benefit entitlements into a higher tier. As such, even minor discrepancies between physicians' impairment ratings are forced before the Commission for it to determine into which tier a claim should be placed. This, of course, clogs the system and creates longer waits for hearings in all categories, including temporary total disability payments, medical bill payments, and other areas to which the three-tier system is inapplicable.

A recent study by the National Council on Compensation Insurance (NCCI) reports that 61% of permanent partial disability claims involve contested impairment rating determinations.⁹ This same study noted that in Maryland, an injured worker waits a median of fifty days before receiving any workers' compensation payments, almost twice the median waiting period in twelve

other states reviewed by the NCCI. Further, 91% of workers' compensation claimants surveyed in the study found it necessary to retain counsel to assist them in receiving benefits. Worse, the expanding number of cases forced to be litigated on appeal to the circuit courts, with the attendant costs to the claimant, are not even factored into the study.¹⁰ It is foolhardy to suggest that these alarming numbers, in a system supposedly geared to assisting the injured worker quickly and efficiently, are not interrelated and that the three-tier system is not a root cause of the delays and difficulties.

It is the claimant who truly suffers under this burden. It is the injured worker's bills that are not paid, children's educations that are forced to suffer, and self-esteem that is left to flounder due to interminable delays. These are the true victims of a system that has gradually been transformed from a system which favored the injured worker at all stages into one which provides only statutory "lip service" to the injured worker while functionally serving as a "silent partner" of the employer/insurer.

Impairment Ratings and Medical Evidence

By law, the Commission has the power to regulate expenses for medical services rendered to claimants.¹¹ This regulatory power extends to the costs associated with the claimant obtaining medical evaluations for the purpose of determining impairment ratings and presenting medical evidence to verify his physical capabilities. The theory behind this extensive regulation is that the injured worker should be protected from having the great bulk of his compensation award eaten up by medical or legal expenses.

The rationale behind the regulation fades, however, in the arena of the employer/insurer's medical evaluation costs. The employer/insurer is free to engage multiple physicians and pay any fee required in seeking medical evaluations, since these expenses are not thought to directly diminish the amount of compensation that the injured worker may receive. While the impact of the employer/insurer's unlimited medical evaluation "war chest" on claimants' awards may not be direct, the incongruous results that it produces are substantial.

An injured worker is limited in both the number and the cost of physicians by whom he can be evaluated. Thus, in many cases, he is unable to obtain the best medical advice possible or to seek suggested, yet

costly, treatment in serious injury cases. The employer/insurer has no such hurdles in presenting medical evidence to the Commission regarding its view of the claimant's physical impairment and work capabilities. Imagine this inequity in other fields of law. It is difficult to fathom a system where one party in a dispute, whether it be contractual, domestic, product liability, etc., is capped by the fact finder and system administrator in the amount he can spend for expert evidence and opinions, while the other party is given carte blanche to buy as many expert opinions as possible in order to overwhelm the opponent, controlling the content of these opinions with an ample checkbook.

The role that medical evaluation and opinion play in the workers' compensation process cannot be underestimated. When the Commission determines the amount of benefits to which a claimant is entitled in a permanent partial disability case, it relies upon the impairment ratings offered by the claimant's physician and the physicians retained by the employer/insurer. Similarly, medical opinions as to causation, tenure and extent, medical improvement, and future work capabilities all weigh heavily on almost every Commission decision. The employer/insurer, by virtue of its unlimited access to medical diagnosis, has a precipitous advantage over the claimant when contesting any of these issues before the Commission. The Commission's adoption of one party's medical opinions can mean thousands of dollars in benefits to the injured worker. That the worker, the "beneficiary" of the workers' compensation system, should not be allowed to seek these opinions on an even basis seems fundamentally unfair and inconsistent with overall statutory intent.

Recently, the Maryland General Assembly attempted to place the employer/insurer and the claimant on more even ground when seeking medical evaluations and diagnosis. House Bill 370, proposed in 1994, would have expressly granted the Commission regulatory power over fees and charges for medical evaluations incurred by the employer/insurer. In the face of heavy industry opposition, HB 370 was unsuccessful, providing another example of why the Workers' Compensation Act has evolved into a tool of the employer/insurer rather than a safety net for the injured worker.

Failure to Timely Pay for Medical Bills and Services

By law, the employer/insurer is obligated to promptly pay medical bills and services required by an injured

worker.¹² The law also imposes penalties for non-payment of medical bills within a prescribed time if set forth in an Order of the Workers' Compensation Commission.¹³ However, a hearing must be held for the claimant to obtain such an Order. Non-payment causes physical as well as emotional harm to the injured worker. Health care providers often pursue payments directly from the injured worker, in some instances filing law suits against the worker while he awaits a hearing before the Workers' Compensation Commission attempting to obtain an Order.

A simple solution was offered before the 1994 General Assembly in House Bill 371. House Bill 371 would have set a specific time limit for either payment of medical bills or filing issues giving a reason for denial within 45 days. Unfortunately, HB 371 was also defeated in the Assembly after lobbying by insurance and business interests.

Conclusion

The employer/insurer has gained vast practical advantages over the injured worker when contesting workers' compensation claims. While the ostensible goal of the system is to provide workers with virtually "no fault" recovery on a rapid basis and return these casualties of industry to the job force in an efficient and productive manner, the unspoken goal has incrementally shifted to minimizing employer/insurer costs, regardless of the effect this may have on the claimant. The employer/insurers' financial superiority allows them to wield excessive influence over the medical and rehabilitation service providers so vital to the workers' compensation system. Their bargaining advantages force claimants, who wait inexcusably long periods to receive

just compensation, to either return to work when physically incapable, accept less benefits than to which they may be entitled, or face financial and personal ruin. The Workers' Compensation Act favors the injured worker in theory. It is the practice of workers' compensation that the employer/insurer has come to control.

ENDNOTES:

¹ See *Lisowsky v. White*, 177 Md. 377, 9 A.2d 599 (1939); *Bethlehem-Fairfield Shipyard Inc. v. Rosenthal*, 185 Md. 416, 45 A.2d 79 (1945); *Keene v. Insely*, 26 Md. App. 1, 337 A.2d 168 (1975); *Lovellette v. Mayor of Baltimore*, 297 Md. 271, 465 A.2d 1141 (1983).

² Md. Code Ann., Labor & Employment §§ 9-760-9-765 (1991).

³ § 9-673(a)(2)(ii).

⁴ See Ronald Levasseur, *Self-Interest Promotes Failure in the Rehabilitation Process*, (MTLA, Baltimore, MD) Oct. 1992.

⁵ Md. Code Ann., Labor and Employment § 9-674(a) (1991).

⁶ § 9-628.

⁷ § 9-628.

⁸ § 9-629.

⁹ Jane Bowling, *State Workers' Comp System Improving, But Delays Persist*, *The Daily Record*, Dec. 19, 1994, at 1.

¹⁰ *Id.* at 17.

¹¹ Md. Code Ann., Labor and Employment § 9-731 (1991).

¹² § 9-660.

¹³ § 9-728.

