Technician Has Heart Attack on the Job



INCIDENT

Heart attacks can be covered by workers' compensation insurance depending on the circumstances. Witness and expert medical testimony swayed the court in this case.

Martan Kelly Jr. was a technician for Card Heating & Air Conditioning in Pennsylvania. One morning, he reported to work at a funeral home where the company was installing heating and air conditioning equipment. He told his foreman that he felt weak, tired and had a kink in his neck from sleeping poorly the night before. Kelly declined an offer to go home and was given a light-duty assignment of running thermostat wire.

Feeling better around noon, Kelly decided to run wire in the attic of the one-story building by climbing a 12-15-foot ladder. A short time later, employees heard moaning coming from the attic and found Kelly lying incoherent on the floor, bleeding from his head, face and leg.

Kelly was pronounced dead at a local hospital a short time later.

An autopsy revealed coronary artery and heart disease, three heart arteries significantly blocked (60-90%), and 90% stenosis of the left main descending coronary artery. The cause of death was a heart attack.

Kelly's widow filed a workers' compensation claim for survivors' benefits, claiming his heart attack occurred as a result of his employment. Card denied the claim, and the case went before a workers' comp judge (WCJ).

Kelly's widow testified he didn't have any health problems, didn't complain about chest pain, never saw a heart doctor and wasn't on any medications. She acknowledged her husband smoked a pack of cigarettes a day for the last 30 years.

Card's foreman also testified about how Kelly said he felt when he arrived for work the day he died. The foreman said he would not consider running wire to be physical labor, rather it was light duty work. A Card supervisor agreed running wire was a "pretty low strenuous job."

A board-certified cardiologist testified for Kelly's widow that Kelly's heart

attack occurred because he exerted himself by climbing the ladder that could have led to a plaque rupture and his heart attack. The doctor also said it was likely Kelly fell because of his bleeding when found by co-workers. A fall also could have caused a plaque rupture. The doctor acknowledged he couldn't be certain when the plaque ruptured and that Kelly had other risk factors, including smoking, a family history of coronary artery disease (his mother died of it at age 59) and untreated high cholesterol.

When he was cross-examined, the doctor said his statement that Kelly "likely fell and hit his head" "should probably be changed to 'potentially.'"

Card also had a doctor board certified in cardiovascular disease testify. The company's doctor didn't believe Kelly's heart attack was work-related. The company's doctor said Kelly's pre-existing coronary artery disease put him at a high risk for a sudden cardiac death. Since three of his arteries were so severely blocked, he was an imminent risk for a heart attack whether he was working or not.

The company doctor also said Kelly had been suffering from insufficient blood flow to the heart for 8 to 12 hours before coming to work. The doctor noted Kelly slept in a recliner chair the previous night because he wasn't able to lie flat in bed due to his cardiac symptoms. The doctor also said Kelly's duties the day he died were insufficient to cause the heart attack. Climbing the ladder wouldn't have elevated Kelly's heart rate enough to cause a cardiac event unless he had done it quickly or repeatedly and for more than nine minutes.

The WCJ ruled in favor of the company. The judge found the company doctor's testimony to be more credible and agreed with the foreman that the work Kelly was doing wasn't strenuous. The judge also noted Kelly's pre-existing blockages that put him at risk of an imminent heart attack with or without physical exertion.

Kelly's widow appealed, and the Pennsylvania Workers' Compensation Appeal Board affirmed the WCJ's ruling. She took her case to a state court

Not enough proof it was work-related

The burden is on the claimant (in this case Kelly's widow) to show that a fatal heart attack is work-related. Specifically, the claimant must show the heart attack:

- arose in the course of employment, and
- was related to employment.

Kelly's heart attack happened at work, so there's no question it arose in the course of employment. The question is whether it was related to employment.

If a worker's sudden cardiac death isn't obviously caused by work, a connection must be established by "unequivocal medical testimony."

Kelly's widow argued the Board erred because there wasn't proof, he was having symptoms 8 to 12 hours before the heart attack as the company doctor said.

Kelly's widow would not receive workers' comp survivor benefits for her husband's at-work heart attack.

NEED TO KNOW

Many people live sedentary lives. We spend most of our waking hours at work sitting behind a desk, behind the wheel, or behind a counter. Then we plop down on the couch and relax in front of the TV when we get home. Even those of us who have more active jobs likely don't get enough exercise. A lack of physical activity is hazardous to your overall health and wellness.

Workers who are depressed often feel tired, unmotivated and have difficulty concentrating. Depression can cause problems with decision-making abilities and an increase in errors and accidents. Workers with depression also miss work more often and experience a higher level of presenteeism, where a worker is present at work but less focused and productive than workers without depression.

Due to the stigma of mental illness, many people find it hard to talk about their depression and seek help for it. Getting help is important, because if left untreated, depression can lead to job loss, damaged relationships, substance abuse and suicide.

What's the danger?

Too little activity has been shown to increase the likelihood of:

- Heart attack and heart disease.
- Diabetes and obesity.
- Without enough exercise you lose muscle mass, strength and flexibility, and bone loss progresses faster in people who aren't active. These factors can lead to falls, broken bones and mobility issues.
- Lack of regular exercise has also been linked to an increased risk of dementia, mood swings and depression.
- Lastly, a sedentary existence can leave you with a weakened immune system and make you more susceptible to illnesses such as colds and the flu.

BUSINESS/REGULATION

The **Patient Protection and Affordable Care Act, Pub. L. 111-148**, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Pub. L. 111-152, was enacted on March 30, 2010 (these are collectively known as the "Affordable Care Act"). The **Affordable Care Act** reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

B. Wellness Exception to HIPAA Nondiscrimination Provisions

Prior to the enactment of the Affordable Care Act, titles I and IV of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191, added section 9802 of the Code, section 702 of ERISA, and section 2702 of the

PHS Act (HIPAA nondiscrimination and wellness provisions). These provisions generally prohibit group health plans and group health insurance issuers from discriminating against individual participants and beneficiaries in eligibility, benefits, or premiums based on a health factor. An exception to the general rule allows premium discounts or rebates or modification to otherwise applicable cost sharing (including copayments, deductibles, or coinsurance) in return for adherence to certain programs of health promotion and disease prevention.

The Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments [3]) published joint final regulations implementing the HIPAA nondiscrimination and wellness provisions on December 13, 2006 at 71 FR 75014 (the 2006 regulations). The 2006 regulations divided wellness programs into two general categories: Participatory wellness programs and health-contingent wellness programs. Under the 2006 regulations, participatory wellness programs are considered to comply with the HIPAA nondiscrimination requirements Start Printed Page 33159without having to satisfy any additional standards if participation in the program is made available to all similarly situated individuals, regardless of health status. Paragraph (d) of the 2006 regulations provided that, generally, distinctions among groups of similarly situated participants in a health plan must be based on bona fide employment-based classifications consistent with the employer's usual business practice. A plan may also distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse or dependent child) or based on the age of dependent children. Distinctions are not permitted to be based on any of the health factors listed in the 2006 regulations.

Under the 2006 regulations, plans and issuers with health-contingent wellness programs [6] were permitted to vary benefits (including cost-sharing mechanisms), premiums, or contributions based on whether an individual has met the standards of a wellness program that meets the requirements of paragraph (f)(2), which outlined five specific criteria.

C. Amendments Made by the Affordable Care Act

The Affordable Care Act (section 1201) amended the HIPAA nondiscrimination and wellness provisions of the PHS Act (but not of ERISA section 702 or Code section 9802). (Affordable Care Act section 1201 also moved those provisions from PHS Act section 2702 to PHS Act section 2705.) As amended by the Affordable Care Act, the nondiscrimination and wellness provisions of PHS Act section 2705 largely reflect the 2006 regulations (except as discussed later in this preamble), and extend the HIPAA nondiscrimination protections to the individual market.[7] The wellness program exception to the prohibition on discrimination under PHS Act section 2705 applies with respect to group health plans (and any health insurance coverage offered in connection with such plans), but does not apply to coverage in the individual market.

D. Proposed Regulations Implementing PHS Act Section 2705 and Amending the 2006 Regulations

On November 26, 2012, the Departments published proposed regulations at 77 FR 70620, to implement PHS Act section 2705 and amend the 2006 regulations regarding nondiscriminatory wellness programs in group health coverage. Like the 2006 regulations, the proposed regulations continued to divide wellness programs into participatory wellness programs and health-contingent wellness programs.

Examples of participatory wellness programs provided in the proposed regulations included a program that reimburses for all or part of the cost of membership in a fitness center; a diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes; and a program that provides a reward to employees for attending a monthly, no-cost health education seminar. Examples of health-contingent wellness programs in the proposed regulations included a program that imposes a premium surcharge based on tobacco use; and a program that uses a biometric screening or a health risk assessment to identify employees with specified medical conditions or risk factors (such as high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward to employees identified as within a normal or healthy range (or at low risk for certain medical conditions), while requiring employees who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, or complying with a health care provider's plan of care) to obtain the same reward.

The proposed regulations re-stated that participatory wellness programs are not required to meet the five requirements applicable to health-contingent wellness programs. The proposed regulations also outlined the conditions for health-contingent wellness programs, as follows:

1. The program must give eligible individuals an opportunity to qualify for the reward at least once per year.
2. The reward for a health-contingent wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed 30 percent of the total cost of employee-only coverage under the plan, or 50 percent to the extent the program is designed to prevent or reduce tobacco use.
3. The reward must be available to all similarly situated individuals. For this purpose, a reasonable alternative standard (or waiver of the otherwise applicable standard) must be made available to any individual for whom, during that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard (or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard).
4. The program must be reasonably designed to promote health or prevent disease. For this purpose, it must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease. The proposed regulations also stated that, to the extent a plan's initial standard for obtaining a reward (or a portion of a reward) is based on results of a measurement, test, or screening that is related to a health factor (such as a biometric examination or a health risk assessment), the plan is not reasonably designed unless it makes available to all individuals who do not meet the standard based on the measurement, test, or screening, a different, reasonable means of qualifying for the reward.
5. The plan must disclose in all plan materials describing the terms of the program the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard.

STATISTICS

5 lifestyle behaviors (physical inactivity, poor nutrition, smoking, alcohol use, and non-adherence to medications) and five chronic medical conditions (diabetes, heart disease, lung disease, mental illness, and cancer) drive 75% of all deaths worldwide.

More than 60% of survey respondents in a RAND report, reported that workplace wellness programs reduced their organizations' health care costs. Soeren Mattke et al., RAND Inc. Workplace Wellness Programs Study: Final Report (Santa Monica, CA: RAND Health, 2013).

Michael Roizen, M.D., chair of the Cleveland Clinic Wellness Institute, has determined there are **five behaviors that mitigate chronic disease:**

- Walking 30 minutes a day
- Eating healthy
- Not smoking
- Having a waist size that is less than half of your height
- Drinking alcohol only in moderation.
- If an individual engages in these five behaviors, they typically spend 33% to 50% less on health care costs compared with people who have health risks.

Multiple authors published an article in the Journal of Occupational and Environmental Medicine that asked the question, "Do Workplace Health Promotion (Wellness) Programs Work?" The authors concluded that programs using evidence-based strategies produced a ROI between $2 and $3.60. Employees adopted healthy habits, less time away from work, and lower medical and pharmacy costs.

PREVENTION

Get Moving!

- Research consistently shows that engaging in three days of physical activity per week, totaling 150 minutes or 50 minutes per session, produces health benefits.
- Brisk walking, running, bicycling, jumping rope, and swimming are all great examples of cardio exercises.
- Start with light or moderate aerobic exercise, for short periods of time (10 to 15 minutes) with sessions spread throughout the week to reduce your risk of injury and fatigue. Gradually build up to 50-minute sessions as your level of fitness improves.

Pump it up!

- Strength training, including lifting weights or resistance training, improves bone density and helps slow bone loss as you age.
- Weight training strengthens connective tissue, muscles and tendons. This decreases your risk of falls, sprains and strains.
- Strength training also helps prevent loss of muscle mass.
- Remember to start slowly to reduce the risk of injury and give your muscles time to rest and recover. Wait at least 48 hours before you train the same muscle group again.

Talk to your doctor before beginning a workout routine to make sure you are healthy enough for physical activity.

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