Workers' Compensation
Seminar Short Version Outline

Notice to Readers

This outline/summary covers highlights of work injury claims under South Carolina Law.

The specific details of any claim or situation must be carefully collected and law applied. The information here is to at least let individuals gain insight as to what parts of a claim should be scrutinized and the potential problems/losses that may result if not investigated further only because of knowledge lacking as to options and benefits available under their particular circumstances.

Worker Compensation claim or something else

Worker Compensation laws are based on whatever the individual state legislatures decide to put in effect. In South Carolina private employers and state agencies that regularly employ 4 or more, part or full time employee, must pay for worker injury benefits as required by the state legislature. (Federal workers and Longshoreman are not under this.)

Except for Federal Workers and Longshoreman, workers hurt on the job, by law, injured workers are prohibited from filing suit against their employer for injuries suffered at work. The purpose or original intent of this, was to reduce conflict and dispute resolution in the workplace. In other words, if you are hurt while working for a private company or city/county/state agency you cannot have a jury trial, only a hearing by a Commissioner, to decide your benefits.

The judges of a worker compensation case are called "commissioners". They are selected by the Governor and reviewed by the SC State Senate. Qualifications for commissioners are minimal. They are not required to have any legal background and the current governor has promised to appoint only business and insurance people with no legal background.

Priority Concerns or **"What you don't know can hurt you!"**

I. Filing/Registering the claim

A. File a Form 50 with the Commission

1. Failure to file/register a claim within 2 years of accident/injury, may prohibit or bar the claim

2. 2 years runs differently for different injuries

a) occupational disease: 2 years from date worker is informed of a definitive diagnosis

b) repetitive trauma: Gradual onset of injury caused by cumulative effects of repetitive traumatic events; requires specific medical language opinion.

c) single event: 2 years from date of event/accident

II. Notice required to Employer of Accident **(How and when the employer must be told of the accident/injury)**

A. When? - Must be told to a supervising/mgmt company person (coworkers knowing "don't count") given immediately or as soon thereafter as is practical but not past 90 days. Repetitive trauma notice, time runs from when worker knew or should have known of work related condition.

B. If no timely notice to employer - employer and commission may deny all benefits. (Commissioner decides if notice was properly given)

C. Form of Notice to Employer

1. Not "fancy" ex. - supervisor(s) saw it happen
   or supervisor(s) was told
   or HR was told

2. Best notice is to have company fill out a S. C. Workers Compensation Commission Form 12-A to confirm accident/injury and do it promptly. If you don't have a witness that heard you tell the supervisor of the accident, then write company and keep copy of what you gave them.

   Example of what to write:

   "I know the law requires I tell the company of my injury at work or I'll possibly get in trouble, so, this is to let you know I was hurt on _____(date)_____ while doing ____describe____. Do you want me to see a doctor? My ____(body part)_____ was hurt." Please advise.

3. Never mail notice. Hand deliver it and note who you gave it to and when. Keep a copy for your records.

4. IMPORTANT: Even if you think you are "ok" and won't need medical treatment, always tell the employer just that or risk being denied later for lack of notice to employer, if you get worse instead of better.

III. Comp Rate

A. Has major affect on how much you are entitled to, in benefits.

B. Calculation methods for Determination of Correct Weekly Amount

a. Controlled by Section 42-1-40 S. C. Code of Laws, which provides four (4) basic methods to calculate average weekly wage, subject to maximum and minimum above.

1. Add previous gross pay for 52 weeks (prior to date of injury) and divide 52 to determine average weekly gross pay.

a. If more than 7 consecutive days missed during the year divided by remaining number of weeks.

1. When claimant worked less than 52 weeks prior to the injury, divide gross earning by number of weeks worked, if fair and just to both parties.

a. Ex: if claimant earned gross pay of $10,000 in 30 weeks, average weekly wage would be $333.33. ($10,000 divided by 30 wks = $333.33)

3. If length of employment is too short, casual or impractical to use above methods, compute based upon earnings of a "a person of the same grade and character employed in the same class of employment in the same locality or community." (Ex. Worker hurt 4th week on job so 52 weeks pay not available)

a. Known as "similar" or "like" employee;

b. Does not seem to require that this person be employed by the same employer.

4. Exceptional reasons clause: when all of the above would be unfair to either employer or employee, such other method may be used as will "most nearly approximate the amount which the injured employee would be earning were it not for the injury."

a. Booth v. Midland Trane Heating, 379 SE2d 730, 298, SC 251 (1989)

b. The Workers' Compensation Commission calculates the average weekly wage based upon the Employer filled out Form 20, which is required to be filed in all cases.

1. If Form 20 is incomplete or inadequate, Workers' Compensation Commission may require pay information of a similar employee's Form 20;

2. Either party may contest Commission's computation and dispute average weekly wage at the hearing before a commissioner.

c. If allowances are made in lieu of wages (eg: rent, meals, room & board, etc.), the value of these allowances are included in the average weekly wage, if they represent a "real and reasonable definite economic gain to the employee." See Bannister v. Shepherd, 191 SC 165, 4 SE2d 7 (1939)

d. The average weekly wage is determined as of the date of the injury and is usually not affected by pay increases after the injury date.

C. Example: Worker has 3 jobs but was accidentally injured only at job A.

Gross pay - no deductions
$300/wk Job A, 40 hrs/wk - accident occurred on this job
$300/wk Job B, 40 hrs/wk
$48/wk Job C, 6 hrs/wk
$648 total pay x .667 (2/3rds) = $432.21 wkly comp rate

If you determine weekly rate on Job A only ($300/wk) the rate would be (incorrectly) $300 x .667 (2/3rds) = $200.10

This example shows how important it is to include gross pay for all regular employment at the time of the injury.

If all of the jobs were "concurrent", weekly regular employments despite only being hurt at Job A , law considers the gross pay of all three employments to calculate the compensation weekly rate.

The employment, that the injury occurred at, fills out a form as to that job only. You must request all jobs be included **in the calculation** or it probably will be missed.

IV. Medical Benefits

A. Employer responsibility for medical referenced in 42-15-80 Code of Law Section requires medical be paid by the employer as reasonably necessary to benefit the worker. The employer, by law, chooses the medical provider, not the claimant/worker.
If a worker fails to reasonably cooperate with medical offered, all benefits may be terminated by the employer, until cooperation resumes. The statute wording refers to "unjustified" refusals to submit to medical treatment or receive no benefits. "Unjustified" is normally considered if a worker refuses therapy, office appt.. "Justified" usually includes any medical treatment that realistically could have a negative outcome (i.e. surgery, spinal shots, experimental treatment)

Be careful to document that it isn't the injured worker causing the problem with medical treatment. Document carefully if the carrier, the doctor, therapist is causing the problem?

B. What to do about "problem" doctors

1. Talking to the M.D.: If you are concerned that the doctor, at your appt, seems a bit "distant" or "standoffish" always ask the doctor if something is bothering him/her and that you hope they aren't thinking you are trying to "milk" the system because you sure didn't need this injury. I've found most people who nicely but clearly state this, looking the doctor in the eye, get a better relationship with the doctor. My experience has been that doctors aren't used to patients actually discussing the issues and when a patient does, they seem to take a more individual interest in that patient. Just be sincere, but direct and pleasant.

   If you find the doctor to have an abusive or otherwise inappropriate way of treating you consider requesting another opinion. The carrier may agree but if it doesn't you can file for a hearing to ask a commissioner (see below)

2. 42-17-30 is a code of SC laws section that allows a commissioner to override the employer/insurance carrier's choice of medical provider and require the carrier to pay for a commissioner chosen doctor if the commissioner thinks it is justified under the particular circumstances. The Commissioner doesn't have to do so by law.

C. "Body parts affected" by initial injury (Importance of documentation)
It is **very** important for the doctor to state specifically what body parts or conditions are affected by the initial injury. This includes "old" injuries or conditions made worse by the work accident. A doctor must **state** "his/her opinion **"to a reasonable degree of medical certainty, most probably"** or the

law says the body part or condition referenced as affected, is not resulting from the accident. If the doctor opinion says it "possibly" is connected...you lose.

Always let the doctor know of specific body parts or conditions that you wonder may be connected to the accident. Tell the doctor if you don't ask and he/she doesn't mention it in their notes the carrier will say later you never said anything to the doctor and otherwise bringing it up later, too much later, when in fact you told the doctor.

Example: Worker falls on the job and breaks one leg. While healing the broken leg, the other leg is worn out from overuse, to compensate for the broken one. If doctor states opinion that the other leg, not initially hurt, developed an injury in compensating for the bad leg, then both legs become covered by worker comp law for benefits.

D. FCEs (Functional Capacity Evaluations)

- Doctors usually request these but usually have no training or education about them.
- More than 55 different FCE methods, though no method is considered standard.
- FCEs are no more medically and scientifically reliable than polygraph tests, which are not admissible in evidence.
- Insurance Companies usually want an FCE.
- Rarely are therapists educated about FCEs in schools for therapists. FCEs are too often only used as income generators for therapy groups profits.
- You should always videorecord the entire FCE. Therapists may say they prohibit it but they won't and can't justify it for medical or scientific reasons. Some therapists simply don't "like" to be recorded but they often get upset about losing a fee in turning down the FCE. No video?...then its your word against the therapists about your performance.

E. **Entitlements to Future meds**

1. Ongoing maintenance (Dodge v. Bruccolli or 42-9-30 total spine or 42-9-10 total)
   If you prove you need ongoing medical maintenance (with a doctor opinion) it will normally be ordered. Be sure to have the statement from a doctor or you will lose.

2. Change/worsening of physical condition
If you level off and are as good as you will get (MMI) in the doctor's opinion and you don't settle out your case permanently, you usually have **1 year to try to prove** your condition physically substantially worsened and your claim should reopen. This usually requires an MRI or xray and the doctor opinion it worsened.

F. **Nurse Case Manager**
The insurance carriers sometimes hire these people to supervise your medical treatment. Be sure to never allow the nurse case manager to have private talks with your doctor without you being present. You have the right to exclude them from your exam.

G. **Medical releases**
Be very careful about signing those provided by an employer or insurance carrier. I have always found they include wording that waives worker privacy rights allowing the insurance carrier to have "private" talks about you without you knowing it or what is being told to the doctor about you.

You don't have to waive your being present but too often the carrier representatives either don't point out the "waiver" wording or "forget" to point it out. The law doesn't require the carrier to point the waiver wording out.

V. Settlement: What to look for and how to analyze

This is to assist you in analyzing whether:

- to accept an offer made by the other side (Insurance Carrier) or to reject it; and

- to either make a counter offer or settlement proposal from you and I, to the insurance carrier.

What you must always remember in considering settlement terms and options:

What is the judge/commissioner likely to award to you (or not award) if both sides don't agree on terms of settlement instead of "having the judge" decide the dispute for everyone.

This review will only address trying to come to a settlement regarding what a final award is thought to end up being to determine (by the commissioner) your rights and options under South Carolina Worker Compensation Law.

In many cases, an injured worker may have developed problems with additional body parts or systems that, at the time of the initial injury, were not affected. The new additional medical problems must be backed up with a medical opinion "tying in" or verifying the additional medical problems (in the written opinion of a doctor) probably (more likely than not) from the initial injury.

Examples that often come up are:

- one leg or knee/foot hurt in accident and worker overuses/relies on good leg causing a break down or injury to the "good leg".

- one or both legs initially hurt on job and walking oddly or "funny" causes the back or hips to have a medical problem.

- arthritis or diabetic condition is permanently made worse as a result of injury on the job, even if you had the conditions before the injury at work.

NOTE: All of these examples must be medically supported in writing by a doctor. Your opinion, no matter how believable you are, is not enough to prove the situation to meet the requirements of law.

Things to weigh or consider, especially how they will be, or might be, viewed by a commissioner, if a commissioner decides this for both sides:

1. How many body parts are injured/affected as a result of the job injury?

   If insurance company disagrees on just what is permanently hurt, can we prove they are wrong with a doctor? (Commissioners usually give more consideration to what the doctor says who has been treating you throughout the case.)

   a) Do doctor's notes talk about body parts affected, or not and why?

   b) Is it obvious the treating doctor missed something (other injuries)?

   c) Do we have or need to have another doctor review this for a 2nd opinion or not? (This cost usually ranges between $600.00 to $1,000.00, which I advance as an expense on your case, to be paid back out of any settlement or award is collected, if collected. These 2nd opinions are not justified in every situation/case. You and I have to discuss it and consider if it will help.)

d) Level of injury to each body part.

How disability is *supposed* to be considered and made by a judge/commissioner. They must consider:

- Only 1 body part permanently hurt?
- Then how much (%) permanent disability exists?

To determine, Commissioner is to review, usually:

- How serious the initial injury was.
- How long healing took until injury reached a plateau which means "this is the best it is going to get."
- What percent (amount) of permanent loss of use do you have to that body part?
- What impairment does doctor think you have for permanent injury?
- What can <u>you</u> specifically not do as well **or** not do at all as to the following:

<u>Non-Employment</u>	<u>Employment</u>
Home tasks (cleaning, cooking, etc.)	Job lifting requirements
Hobbies	Job standing, bending or other tasks affected
Sports	Employer kept you or did not
School	
Sexual relations	
Family obligations	

- **How much your "comp. rate" is or isn't.**

Your comp. rate is determined usually by taking a 2/3rds percent of your gross pay (before deductions) of the <u>average</u> of 52 weeks of gross pay of all jobs you worked at in the 52 weeks before the accident/injury. This is supposed to <u>include</u> pay from other employers on whose job you were not hurt.

Other exceptions to average of 52 weeks include basing comp. rate on recognition of pay estimate if you were hurt before you completed a year at job you were hurt at.

Should a recent "big raise" received just before the injury be considered.

Important: Make sure your comp. rate (weekly pay) is legitimately as high as it should be under law because it <u>controls</u> a lot of the value of what your benefits will or won't be.

<u>Short Review</u> - Commissioner looks at:

- Comp. rate
- Body part injured and permanent problems it appears you have
- Medications you need (or don't need) to take permanently
- How injury seriousness looks to Commissioner
- How long it took you to heal to as "good as you are going to be"
- How far you went in education and employment experience and whatever injury will affect your options. <u>Note:</u> Not supposed to consider this but <u>I'm</u> certain they do.
- Your age (they figure younger will usually have it easier than older injured person.)
- Your credibility in opinion of Commissioner
- The things at work or not at work you can't do now <u>or</u> can't do as well.

Commissioners then award an amount of permanent disability within the <u>maximum</u> of the number of weeks listed by the legislature for certain body parts.

Remember, if only <u>one</u> body part is <u>medically</u> proved to be affected, <u>no</u> award based on your actual earning capacity reduction in the work force is allowed. (I don't know why that is the law. Ask your legislator. It isn't that way in North Carolina.)

Multiple body parts affected?

Then you may receive (if you prove) an award of up to maximum benefits because you can no longer make the same income and you have either:

- A partial loss of earning ability
- A total loss of earning ability

The legislature passes laws that put maximum values on body parts injured/disabled. For example a thumb is worth no more that 65 weeks of your weekly compensation. Other examples: hand = 185 weeks; arm: 220 weeks; leg = 195 weeks, to name a few parts.

A commissioner is supposed to determine disability by considering:

- The doctor rating percentage loss
- Whether you are back at the same pay and job
- What physical permanent restrictions you were given by the doctor
- Other body parts affected by the primary injury (ex. back injury causes pain to legs or arms)
- How the permanent injury problems affect or don't affect daily activities at home or work
- Seriousness of the injury (ex. required surgery, multiple surgeries), time the injury took to heal up best it could
- Social Security offset language

  When you receive a lump sum award or settlement, Federal law provides that Social Security doesn't pay your monthly benefits until credited/offset. To illustrate this if you qualify for $1000/mo Social Security Disability payments and you receive $50,000 from Workers Comp lump sum award, Social Security won't pay you any disability benefits for 50 months, UNLESS you have the "special worded paragraph" to minimize the offset.

Below is an example of the wording

The settlement proceeds of $25,000.00 shall be allocated as follows: $8,333.33 as attorney's fees pursuant to a written contract between the claimant/employee and her attorney; $432.23 for costs pursuant to the same written contract; $16,234.44 in compromise settlement of disputed future lost earnings at the rate of $8.59 per week commencing August 1, 2011, and continuing thereafter for a period of 1,890.72 weeks (claimant/employee's remaining life expectancy per South Carolina Code Ann. §19-1-150). See Utica-Mohawk v. Orr, 227 D.V. 226, 87 S.E.2d 589 (1955); Sciarotta v. Bowen, 837 F.2d 135 (3d Cir. 1988); POMS §52001.555(c)(4).

. Clincher v. Form 16

If you do not settle or agree to conditions and disability money with the other side, do you have a reasonable belief you will get more benefits by having a commissioner decide?

The Short Summary of Choices includes the following three (3) choices:I. **1 year option** to

reopen claim if prove physical worsening of your injury Form 16 - Both sides work out an argument on what the permanent disability of **to reopen case** what specific percentages or any terms of medical treatment.

II. Decide rights at a Hearing - Both sides can reach an agreement on what the permanent disability percentage is and/or medical treatment if needed. A commissioner (judge) decides it after listening to sworn testimony from each side.

III. Give up 1 year Option to reopen claim if proof of physical worsening of your injury "Clincher" - usually a lump sum settlement to completely settle the claim and **Claim End** ends the employer/insurance carrier's obligation for this particular claim unless stated otherwise.

What is the "1 yr. option"?

Answer: If you can prove, usually with medical evidence (doctor's opinion), that your injury has "substantially physically worsened" you likely will be able to re-open your claim to receive more medical treatment and disability benefits. It usually takes more "proof" than your statement that it just hurts more. A doctor must (usually) be able to point out what physically has worsened since you last closed your case as a result of a hearing or Form 16.

Be sure to:

- Always take your time in reading any settlement documents to be satisfied in your mind that the papers reflect what the terms of settlement are supposed to be. If you have concerns that the papers are not reflective of what you thought the terms were to be, then do not sign until you receive adequate clarification.

- Read, approve and sign only if you think the documents are correct.

Note: Every case or claim is different. Never assume the papers are correct. Read carefully.

Considerations and Categories of settlement

1. "Clincher" Adkins agreement

"Clincher" is a slang term referencing settlement as in "clinching a deal."

The written details in the document control the specifics of the terms of any settlement.

Most "clincher" settlements agree to completely settle the claim forever by paying a lump sum to the worker and ending the worker's options for medical benefits or other compensation.

Some "clinchers" will settle on different terms, however, and agree to, for example:

- pay the worker a lump sum and pay certain specific types of medicals in the future or only previous insurance authorized medical bills.
- pay a lump sum and not require the employer to pay anything else (i.e. medicals).

2. **Form 16 settlements (Not a "clincher")**

Usually used when a worker is concerned about probability of having to "ask," petition to reopen the claim for need of treatment of a worsening of condition.

Form 16 only allows for a 1 year time period (from date of last payment of benefits) to reopen.

Every case is different and the terms of settlement must consider the following points and how relevant or important each is or is not in a particular claim.

The attorney and the client should decide together what to do specifically regarding terms of settlement or hearing prep.

3. Factors for review:

a. "Doubted and disputed" settlement option is used when both sides don't agree on anything, even that the worker was hurt on the job in the first place, but both sides are unsure how a commissioner/judge will decide the matter and want to settle to avoid a "bad" commissioner decision.

b. Medicare (social security) concerns: **Is a medical set aside account needed** for future medical of claimant or not? Will the assigned hearing commissioner likely award offset protection?

c. Personal decisions of the worker, such as how much the worker is willing to deal with the process or how little. Separate concerns from the claim (i.e. other family crisis).

d. Personality and background of the assigned commissioner (if one is yet assigned).

e. What are the permanent impairments (% loss of use) for each body part involved? What are the restrictions stated by the treating doctor?

f. Only one body part hurt, or more? (Loss of earning capacity can only be considered/awarded if claimant has more than one body part affected.)

4. **"The Bottom Line"**

If you thought the employer/insurance company was settling on specific points, then they should be in writing. If it is not in writing you should assume your settlement does not include those terms.

Examples:

- Does the carrier agree to pay all past authorized medical treatment?

-Also pay for part unauthorized treatment?

-medical savings account

-future ongoing medical payments, if needed, who pays for? (i.e. prescriptions, shots, surgery)

· MSAs (means: Medical Set Asides)

The Worker Compensation Commission can't order these but a carrier can agree to put a fund aside if the worker and Social Security Disability Agency (CMS) also agree. Carrier puts dollar estimate for lifetime medical aside in an account. Worker maintains it separate from all other funds; only used for the work injury. If Social Security Disability oks it and turns out it isn't enough, Social Security argues to cover the additional needed medical.

VI. Auto Accidents and Job Injuries

(How you can "wipe out" your work injury claim if you aren't careful)

If you are hurt on your job while in a car and you file suit or settle with the opposing driver beware..., if not properly done, you automatically wipe out (extinguish) any worker compensation claim you might have.

To avoid this problem, the worker must fill out and file two forms the Commission requires to allow both claims (auto accident against the driver and workers comp claim) to stay in effect. The law says you can't settle your case against the other driver without permission of the worker compensation carrier or you automatically end your worker compensation claim.

Example of problem:

Worker hires attorney for worker compensation claim only. Worker was hurt while driving a car to deliver car parts to another company store. Another driver/car runs a red light and hits worker.

Worker has 2 claims/cases: 1. Worker compensation claim with her employer for being hurt on job; 2. Auto accident trial case against other driver who ran through red light in opposing car. Worker settled with other driver's insurance but never told the worker comp attorney or insurance carrier for workers comp. By settling with the auto carrier and not getting ok from Worker Comp carrier, worker comp claim ends automatically. (So don't do this!)

How Disability is Determined

A Commissioner decides your
- a) disability award
- b) ongoing meds award

In deciding the % amount to award for permanent disability, the Commissioner considers:

- your age
- education level
- work experience
- impairment rating from the doctor
- how the permanent injury limits:
  - a) non work activities (home, hobbies, etc.)
  - b) work/employment options
- whether you can return to the same or a similar job/employment (total or partial loss of earning capacity
- the level of complexity of the injury
- your credibility/truthfulness in the opinion of the Commissioner

The commissioner comes up with a percent usually higher than the impairment % from the medical doctors. That is the big question and how much more %(1) has no formula and is often the "whim" of the personality of a particular commissioner.

Awards can be made in 2 ways:

1) wage loss (only if more than 2 body parts are affected)

OR

2) a percent of the total loss value that the S.C. Legislature listed
(Ex. total loss of a leg = 195 weeks)
Considering all info and the 7% med. loss an award might range from between 10% -11% disability of the leg to 15% of the leg.

I. Understanding the difference between Disability and Impairment

By Doctor	By Commissioner
Impairment loss	Disability decided only by Comm
of use of body part	Disability is:
or bodily system	Impairment and job loss, permanent restrictions other effects on life - no formula

II. Which type of Disability? Wage loss
or Physical loss of use of body

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