Successfully Handling a Workers' Compensation Claim from Beginning to End

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Heather concentrates her practice in the areas of business and commercial litigation, products liability, premises liability, motor vehicle negligence, and workers' compensation. She is a diligent attorney, committed to providing the highest level of advocacy and representation for her clients. Heather practices with a comprehensive understanding of the law while balancing the necessary attentiveness to her clients' specific needs. She has presented seminars to various groups and clients on recent state reforms and the practical impact of these changes in law.

Heather graduated *magna cum laude* from North Carolina State University with a Bachelor of Arts degree in English and minors in Art & Design and Journalism, and was inducted into the Phi Eta Sigma Honors Fraternity. Heather received her Juris Doctor from the University of North Carolina School of Law.

While in law school, Heather was a staff writer and later served as Publication Editor of the *North Carolina Journal of Law & Technology*. Also during law school, Heather worked at the Capital Litigation/Federal Habeas Corpus Division of the North Carolina Attorney General's office. Heather co-founded an organization, Graduate2Graduate, which paired law school students with local high school students who were targeted as being academically at risk. She also volunteered to work on various pro bono projects and worked at the UNC Civil Litigation Clinic. Before law school, Heather worked as a communications intern at the North Carolina Arts Council and as a Medicare specialist at a pharmaceutical manufacturing company in Research Triangle Park.

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During law school, Elizabeth was a member of the Negotiation Team of the Holderness Moot Court Bench, and was also a member of the Broun National Trial Team. In addition, Elizabeth was a member and a Deputy Chair of the Graduate Honor Court. She also volunteered to work on various pro bono projects, completing over 100 hours of pro bono service, and worked in the Civil Litigation Clinic.

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This paper provides a general overview of how to handle a North Carolina workers' compensation claim. The goal of the paper is to assist in identifying important issues that may arise during the handling of a claim and to discuss the process a claim will go through at the Industrial Commission (I.C.). This paper should be used as an initial resource and does not cover every issue that may arise in a claim.

As a preliminary note, the North Carolina Workers' Compensation Act was significantly changed in 2011. The overall theme of this reform was a focus on returning claimants to work—in fact, the bill was entitled "An Act Protecting and Putting North Carolina Back to Work by Reforming the Workers' Compensation Act." Many of the reform provisions make it easier to get claimants back to work, and in some circumstances, actually mandates that employers and carriers provide vocational rehabilitation. The revised Act also allows for increased benefits for those employees who do return to work and strengthens the penalties, sanctions and consequences for employees who refuse to return. On June 24, 2011, the Governor signed this revised bill into law, so while most of the changes affect claims which arise on or after that date, several of the provisions impact all pending claims. These new changes are incorporated into this manual where appropriate, but for a fuller exposition on the details and the impact that they will have on your claims, we would recommend another Teague, Campbell, Dennis & Gorham paper, North Carolina Workers' Compensation Reform: An Insider's View, written by partner Bruce Hamilton, an instrumental player in the reform process.

A. A NEW CLAIM

1. Initial Investigation

When a claim is first reported, you are presented with the best opportunity to gather information about the accident and the employee. Recorded statements are very valuable because they can be used to impeach the employee later in the litigation. Ideally, the statement is taken at a time when the employee's memory of the events is the best. Later on, once counsel is retained, the employee's memory of the events, particularly whether an accident actually occurred, can change. A recorded statement will help address such changes. If an employee is represented, you need permission from his/her counsel to take the recorded statement.

Interviews or recorded statements of witnesses are also important because by the time the hearing is scheduled, witnesses may be gone. Statements will provide contact information as well as a witness' recollection of events. There have been times in hearings when co-employees will mention little known facts about the employee's story or hobbies. At that point, particularly if the case is already accepted, it can be too late to use the information to defend the case.

What to ask in a recorded statement or interview depends on the case. In all cases, employees should be asked about prior claims, accidents and past medical treatment received for the injured body part(s). If the claim is an accident claim, nail down the specifics of how it occurred; find out how what the employee was doing differed from the regular way employee performed the job on a daily basis. In an occupational disease claim, get a job history, including job descriptions and employer names; also ask about hobbies. Obtaining a medical release in all claims will be helpful, as well an index check.

2. Form 18 Information

The Form 18 is the Employee's Notice of Accident. It is to be completed by the employee, or counsel, and filed with the I.C. Employees technically have 30 days from the date of accident (or date of knowledge about an occupational disease) to file the Form 18 or otherwise provide the proper written notice to the employer. Failure to do so, however, will be excused under some conditions. The employee has two years from the date of injury to file notice of the claim with the IC. The filing of the Form 18 starts the clock for the 30 days to admit or deny the claim. Whenever you start paying indemnity benefits, a form needs to be filed, either Form 60 or Form 63.

3. Form 19 Information

The I.C. Form 19 is the appropriate form for the employer to use whenever an employee has developed an occupational disease or has been involved in a work-related accident. It should be completed as soon as the accident or occupational disease is reported to the employer. The Form 19 contains self-explanatory blanks for information

associated with the employee; the job title, supervisor, and wages; the reporting of the accident; and other identifying information. When a Form 19 is completed and sent to the I.C., a copy must be sent to the employee, along with a blank Form 18, for the employee to complete.

When completing a Form 19, it is helpful to complete as much information as possible up front, rather than trying to fill in the blanks months or years later. Forms 19 often contain telling information which can raise red flags in the claim. For example, the date of the notice (did employee wait a long time to report), time employed (is this a new employee) and description of accident (is it consistent with medical records or other reports).It is very important to include a detailed description of the body parts the employee is alleging to be affected by the injury or disease; if the description is too broad, an employer may face exposure for unrelated conditions. For example, if an employee slips and falls at work, scratching her right knee, the employer should include all that information in the injury description. A description of simply "slip and fall" may seem clear at the time of the accident, but if, several months or years later, the employee claims to have injured her back, head, or hip as a result of the slip and fall, the employer or carrier will have trouble denying that they received notice of that condition when the description is too broad.

Similarly, the top right side of the Form 19 **must** be completed in its entirety. In recent months, the I.C. has been sanctioning employers with fines for failing to complete basic claims information such as carrier code, I.C. file number, and employer code. That information can be found on the I.C. website, at http://www.comp.state.nc.us or by calling the I.C. Statistics Section at (919) 807-2506.

4. Whether To Accept or Deny a Case

Under N.C.G.S. § 97-18 the employer has 30 days from receipt of notice from the I.C. that a Form 18 has been filed to promptly investigate each injury and to file a Form 60 (accepting the claim), Form 61 (denying the claim) or Form 63 (payment without prejudice). The failure to file one of these forms may result in the imposition of sanctions. The I.C. can grant extensions to the 30-day time period if needed. When a Form 63 is used and benefits are paid without prejudice, the employer has 90 days from the employer's actual notice of the injury to notify the IC that it is denying compensability. The Form 63 must indicate if indemnity and medical benefits are being paid. Any denial after a Form 63 has been filed must be very detailed, because the employer could be limited to these defenses.

a. Was there an accident?

There are many issues to consider in deciding whether to accept or deny a claim. Whether there was an injury by accident is a good place to start. An accident is an interruption of the regular work routine and the introduction of unusual circumstances, such as a slip, trip or fall or other unusual activity, likely to result in unexpected consequences. Determining if there was an interruption of the regular work routine is very fact specific and the definition of the "regular work routine" can be quite narrow. For example, in *Legette v. Scotland Memorial Hospital*, 181 N.C. App. 437, 640 S.E.2d 744 (2007), the Court found that an accident occurred when a nurse had to reposition a patient by herself. The evidence showed that she had repositioned patients before but that she usually did it with another nurse.

Back claims and hernia claims are compensable if the employee can establish an injury by accident or a specific traumatic incident. A specific traumatic incident does not require an incident. The employee can be doing their normal job when the injury occurs, but there generally does have to be some event associated with the injury like lifting, bending, twisting, etc. For occupational disease claims, the employee must demonstrate that (a) the employee was exposed to an increased risk of developing or contracting the disease, as compared to the general public, and (b) the conditions of employment were significant contributing factors.

b. Did the accident arise out of/in the course of employment?

In order to be compensable under the North Carolina Workers' Compensation Act, an injury must arise out of and in the course of employment. *Barham v. Food World, Inc.*, 300 N.C. 329, 332, 266 S.E.2d 676, 678 (1980). In general, the term "in the course of" refers to the time, place, and circumstances under which an accident occurs. An accident arising "in the course of" the employment is one which occurs while the employee is doing "what a man so employed may reasonably do within a time during which he is employed and at a place where he may reasonably be during that time to do that thing or one which occurs in the course of the employment and as the result of a risk

involved in the employment, or incident to it, or to conditions under which it is required to be performed." *Hildebrand v. McDowell Furniture Co.*, 212 N.C. 100, 109, 193 S.E. 294, 301 (1937).

The term "arising out of employment" must have its origin in the employment. *Gallimore v. Marilyn's Shoes*, 292 N.C. 399, 402, 233 S.E.2d 529, 531-32 (1977). There must be some causal relation between the employment and the injury. *Bass v. Mecklenburg Co.*, 258 N.C. 226, 231, 128 S.E.2d 570, 574 (1962). An injury arises out of the employment when it comes from the work the employee is to do, or out of the service he/she is to perform, or as a natural result of one of the risk of the employment; the injury must bring from the employment or have its origin therein. *Williams v. Hydro Print, Inc.*, 65 N.C. App. 1, 7, 308 S.E.2d 478, 482 (1983). Our Supreme Court has stated that where any reasonable relationship to the employment exists, or employment is a contributory cause, the Court is justified in upholding the award as "arising out of employment." *Allred v. Allred-Gardner, Inc.*, 253 N.C. 554, 557, 117 S.E.2d 476, 479 (1960).

The following categories of cases involve special rules pertaining to the notions of "arising out of" and "in the course of employment." These categories include "the coming and going rule," break time injuries, assaults, horseplay and athletic/social events.

1) The "Coming and Going Rule"

In general, injuries sustained by an employee going to or from work are not ordinarily compensable under workers' compensation principles. This general rule is known as the "coming and going rule." However, there are 5 noted exceptions to the "coming and going rule." These 5 exceptions, discussed in the case of *Hollin v. Johnston County Council on Aging*, 181 N.C. App. 77, 639 S.E.2d 88 (2007), are as follows:

1. **Special errand exception** - the employee is engaged in a special errand, mission, or duty;
2. **Traveling salesman exception** - the employee is making a journey to perform a service on behalf of his/her employer and has no definite time and place of employment;
3. **Contractual duty exception** - the employer has either contractually provided the employee's transportation or pays an allowance to cover its cost;
4. **Personal vehicle exception** - the employee is required to use his/her personal vehicle while at work as a condition of employment; and
5. **Premises exception** - the employee is traveling to or heading from work but is on the employer's premises when the accident occurs. In order for the premises exception to apply, the employer must own, maintain, provide, control or exercise dominion over the premises.

Examples - Premises Exception

Deseth v. LensCrafters, 160 N.C. App. 180, 585 S.E.2d 264 (2003): Sharing maintenance costs for parking with other mall tenants does not rise to the level of "maintenance" for employer to exercise control under the premises exception.

Jennings v. Backyard Burgers, 123 N.C. App. 129, 472 S.E.2d 205 (1996): Employer instructed employees to park in a parking lot behind the building next door. The lot was accessible only by using a steep stairway. Employer did not own, control, or maintain the stairway or parking lot. Employee's claim from falling down the steps of the stairway was not compensable.

Glassco v. Belk-Tyler, 69 N.C. App. 237, 316 S.E.2d 334 (1984): The North Carolina Court of Appeals found that the employer did not control the premises even though the employer enforced the landlord's parking condition against employees.

Maurer v. Salem Co., 266 N.C. 381, 146 S.E.2d 432 (1966): Employee's claim was compensable when he was pushing an inoperable car in the employer-owned parking lot at the end of the day.

Arp v. Parkdale Mills, 356 N.C. 657, 576 S.E.2d 326 (2003): A worker used employer's back parking lot. The back lot had a chain link gate (6 feet high) with an additional 1.5 foot barbed wire. On the date of his accident, the gate was locked and plaintiff could not squeeze through the gate. He therefore climbed over the gate. He slipped and fell, breaking his leg. The Deputy Commissioner, the Full Commission, and the North Carolina Court of Appeals found the claim to be compensable. However, the North Carolina Supreme Court, adopting the dissent of Judge Tyson from the Court of Appeals' opinion, held that the premises rule will not apply when a plaintiff is injured by getting into places where he has no right to go. Judge Tyson stated that scaling a 7.5 foot tall locked chain link and barbed wire gate is an unreasonable activity when the employer provided a safe and secure exit.

2) Break Time Injuries

An employee is injured in the course of employment when the injury occurs under circumstances in which the employee is engaged in an activity which he is authorized to undertake and which is calculated to further, directly or indirectly, the employer's business. In tending to personal physical needs, an employee is indirectly benefiting the employer. Thus the course of employment continues when the employee goes to a wash room, takes a smoke break or takes a break to partake of refreshment. *Harless v. Flynn*, 1 N.C. App. 448, 162 S.E.2d 47 (1968).

Examples

Lewis v. Orkand Corp., 147 N.C. App. 742, 556 S.E.2d 685 (2001): Plaintiff was going to the cafeteria during one of her allowed 15 minute breaks. The cafeteria was within the employer's place of business. Plaintiff had to pass by a security area on the way to the cafeteria. While passing the security area, she attempted to catch a falling table, sustaining multiple injuries. The Deputy Commissioner and Full Commission found the case compensable. The Court of Appeals affirmed, holding that plaintiff was obtaining refreshment during a scheduled break in a manner approved by the employer. The Court also noted that plaintiff was trying to benefit the employer by attempting to catch the table.

Forsythe v. INCO, 95 N.C. App. 742, 384 S.E.2d 30 (1989): Plaintiff choked on a peanut butter sandwich she brought from home. Employer required employees to remain on premises during lunch and breaks. Plaintiff died as a result of the choking. The Court of Appeals held that the plaintiff's death did not arise out of her employment.

Watkins v. City of Wilmington, 290 N.C. 276, 225 S.E.2d 577 (1976): The firefighter plaintiff worked 24 hour shifts. After working a 24 hour shift, he would have the next day off. While working a 24 hour shift, the plaintiff would sleep and eat at the fire station. When off duty, he would report for emergencies in his personal car. One day while on shift during lunch, plaintiff cleaned the oil cap on his personal vehicle by setting it on fire. An explosion ensued, and plaintiff was burned. The fire chief said that firefighters were allowed to make minor repairs on their personal automobiles. It was well known to plaintiff's superiors that firefighters made such repairs to their personal automobiles. The Deputy Commissioner, Full Commission and Court of Appeals found that the accident was compensable. The Supreme Court agreed that the injury arose out of employment. It was noted that firefighters made minor repairs to their law enforcement/emergency vehicles during their lunch hour, the practice was well known by superiors, and the repairs were to an appreciable extent a benefit to the Fire Department since the employees used the cars off duty to report to an emergency.

3) Assaults

Workplace assaults by one co-worker against another are compensable when the assault is "directly connected with" or "rooted in" the employment. Conversely, an employee's injuries do not arise from the employment and are not compensable where the assault was not related to the employment, regardless of whether the assault was committed by a co-worker or a third party.

Examples - Attack by Co-workers

Pittman v. Twin City Laundry & Cleaners, 61 N.C. App. 468, 300 S.E.2d 899 (1983): Plaintiff was an assistant manager of employer's entire laundry operation. It was not unusual for plaintiff to work at the Trade Street plant. Plaintiff, the Trade Street plant manager, and another Trade Street employee, Whitted, were at the Trade Street cleaners waiting for the dryer to complete its cycle. The plant manager and Whitted got in an argument as to whether the plant manager had fired Whitted 2 weeks earlier. Whitted kicked the plant manager in the mouth and fatally shot plaintiff. The Court of Appeals found that the shooting arose out of employment. Plaintiff's employment

was the cause of the accident because he would not have been exposed to an equal risk of injury outside of his employment.

Hauser v. Advance Plastiform, 133 N.C. App. 378, 514 S.E.2d 545 (1999): Employer laid off several employees, including Mann. Plaintiff was instructed to prepare and distribute a memo regarding unemployment benefits to those laid off. Mann did not receive the memo but the other employees had. Mann was eventually informed to discuss unemployment with the plaintiff. Plaintiff told another employee that she was meeting Mann for lunch and that she was carrying him a piece of paper. The I.C. found as a fact that there was overwhelming evidence that the piece of paper that plaintiff was taking to Mann was the memo explaining the unemployment benefits. Plaintiff was kidnapped and murdered by Mann. The Court of Appeals held that the nature of plaintiff's employment, rather than some personal relationship, created the risk of her attack. Thus, plaintiff's death arose out of and in the course of her employment and was compensable.

Sisk v. Tar Heel Capital Corp., 166 N.C. App. 631, 603 S.E.2d 564 (2004): Plaintiff was sexually harassed by her manager. The Court of Appeals held that the claim was not compensable. If the motive surrounding the assault is personal in nature and unrelated to the employment, the claim is not compensable. Sexual harassment is a risk the public is generally exposed to.

Examples - Attack by a Third Person

Dildy v. MBW Investment, Inc., 152 N.C. App. 65, 566 S.E.2d 759 (2002): Plaintiff was a cashier at a gas station. Prior the incident in question, plaintiff's ex-boyfriend constantly threatened plaintiff and caused plaintiff psychological distress. Plaintiff never told her co-workers or supervisors about her relationship with her ex-boyfriend. On the day in question, the ex-boyfriend entered the store while plaintiff was working and threw a six pack of beer at her face. After he left, plaintiff asked the store supervisor to call the police because she was scared that the ex-boyfriend would come back and kill her. The supervisor asked plaintiff to continue working. He did not call the police and he told plaintiff that the ex-boyfriend would not be back. Twenty minutes after his first visit to the store, the ex-boyfriend returned and shot plaintiff in the right hand and leg. The Court of Appeals upheld the denial of benefits. I stated that an injury is not compensable when it is inflicted in an assault upon an employee by an outsider as a result of a personal relationship between them, and the attack was not created by and not reasonably related to the employment. For an assault by an outsider to be compensable, the assault must have had such a connection with the employment that it can be logically found that the nature of the employment created the risk of the attack.

D'Aquisto v. Mission St. Joseph's Health System, 171 N.C. App. 216, 614 S.E.2d 583 (2005): Plaintiff, a cancer analyst, left her office on the first floor to go to the morgue on the second floor. She was carrying paperwork to the morgue to confirm the causes of death of several patients. While waiting for the elevator, a man wearing scrubs assaulted her. Plaintiff testified that she did not know her attacker. The Deputy Commissioner and the Full Commission found the claim compensable. The Court of Appeals upheld the award of benefits. The Court found that (i) the employment was a contributing cause of the injury - plaintiff's job duties included her having to leave her office and walk to the morgue; and (ii) a contributing proximate cause of the injury was a risk inherent or incidental to the employment, to which the employee would not have been equally exposed apart from the employment - plaintiff's job duties took her to an area of the hospital where there were few other people around. Plaintiff was at an increased risk of being exposed to an assailant not by virtue of her job as a cancer analyst, but rather because of where her job duties took her, including the morgue and other such places with few, if any, people in her vicinity.

4) Horseplay

In general, claims involving horseplay are compensable. The workers' compensation system accepts that people who work together will goof around and sometimes people will get hurt.

Examples - Horseplay

Bare v. Wayne Poultry Co., 70 N.C. App. 88, 318 S.E.2d 534 (1984): Plaintiff worked as a chicken deboner on an assembly line. While working on the assembly line, plaintiff playfully cut the strings on a co-worker's apron. The co-worker retaliated and tried to cut plaintiff's apron, but instead cut plaintiff's thigh. The I.C. found that it was a common practice of employees to play around with the knives. The injury occurred during the course of employment and arose from plaintiff's employment.

5) Athletic/Social Events

The general rule involving athletic/social events is: where, as a matter of goodwill, an employer at his own expense provides an occasion for recreation or an outing for his employees and invites them to participate, but does not require them to do so, and an employee is injured while engaged in the activities, such injury does not arise out of the employment.

Examples - Athletic/Social Events

Perry v. American Bakeries Co., 262 N.C. 272, 136 S.E.2d 643 (1964): employer required plaintiff to attend a sales meeting at a hotel. The employer paid all of the plaintiff's expenses. The meeting was not going to start until Monday, but the employer asked everyone to be there on Sunday for a social event. After the social event, plaintiff went to dinner and later returned to the hotel pool to go swimming. While diving, he fractured a cervical vertebra. The North Carolina Supreme Court held that plaintiff's activity of swimming was not a function or duty of his employment, was not calculated to further directly or indirectly his employer's business to an appreciable degree, and was authorized only for the optional pleasure and recreation of plaintiff while off duty during his stay at the hotel. The injury did not arise out of the employment and was not compensable.

Chilton v. Bowman Gray School of Medicine, 45 N.C. App. 13, 262 S.E.2d 347 (1980): The Radiology Department of the hospital organized and paid for a picnic for members of the faculty and new residents to become acquainted. Employees felt no direct pressure to attend, but felt that they should go to the picnic. During a volleyball game at the picnic, plaintiff broke his ankle.

The Court of Appeals listed factors from Larson's *Worker's Compensation Law* treatise to consider in determining whether an injury occurring at an employer-sponsored recreational activity is compensable. Those factors include: (i) did the employer in fact sponsor the event; (ii) to what extent was attendance voluntary; (iii) was there some degree of encouragement to attend evidenced by such factors as taking a record of attendance, paying for the time spent or requiring the employee to work if he did not attend, or maintaining a known custom of attending; (iv) did the employer finance the occasion to a substantial extent; (v) did the employees regard it as an employment benefit to which they were entitled as of right; and (vi) did the employer benefit from the event, not merely in a vague way through better morale and goodwill, but through such tangible advantages as having an opportunity to make speeches and awards.

After consideration of the factors cited in the Larson treatise, the Court of Appeals found the injury not to be compensable. The Court of Appeals held that it was not clear that the Radiology Department sponsored the picnic; the event seemed to be a self-perpetuating one that occurred each year more because of tradition than from any initiative taken by the Department heads; attendance was voluntary; no record of attendance was taken; the participants were not paid for the time spent, nor was any employee required to work at the medical school if he did not attend; the picnic was not an event that employees regarded as being a benefit to which he was entitled as a matter of right; and the Radiology Department did not utilize the picnic as an opportunity to give a "pep" talk or grant awards.

Martin v. Mars Mfg. Co., 58 N.C. App. 577, 293 S.E.2d 816 (1982): The employer sponsored a Christmas party for its employees. All employees were encouraged to attend, but attendance was voluntary. At the party, the plant manager made a speech praising employees. Plaintiff twisted her ankle while dancing. The Court of Appeals applied the *Chilton* factors and found the claim compensable. The Court found that the event was clearly employer-sponsored (factor i); employees were encouraged to attend, by being paid for the time spent and plaintiff had attended all but one of these annual events in her 7 years of employment with employer, thus maintaining a known custom of attending (factor iii); the employer paid all the expenses for the event (factor iv); and the employer benefited from the event through such tangible advantages as having an opportunity to make speeches and present awards (factor vi).

Frost v. Salter Path Fire & Rescue, 361 N.C. 181, 639 S.E.2d 429 (2007): Employer arranged a fun day at an amusement park for fire and rescue squad volunteers which was paid for by community donations. Participation was voluntary, but attendance was encouraged. Plaintiff was injured in a go-cart accident at the fun day. The Supreme Court followed *Perry* and found that the injury did not arise out of the employment. The fun day was purely voluntary and plaintiff's operation of the go-cart was not a function of her duties or responsibilities. In so holding,

the Court noted that while the *Chilton* factors "made several helpful guideposts in this inquiry, this Court has never recognized these factors as controlling and we decline to do so here."

c. Pre-existing Conditions

A claim may still be compensable despite the existence of a pre-existing condition. If an injury materially aggravates or accelerates a pre-existing condition, and causes disability, it is compensable. If you are in a situation where an employee has many pre-existing problems but was able to perform the job for an extended period of time and then is out of work due to the new injury, the claim is probably compensable.

5. How to Deny a Claim

If the decision is made to deny the claim, a Form 61 needs to be completed. The Form 61 specifically states that the employer/insurance carrier must provide a detailed statement of the grounds for denying the compensability of the claim where payments have previously been made under the Payment Without Prejudice option (Form 63/N.C.G.S. § 97-18(d)). In addition, N.C.G.S. § 97-18 requires a detailed statement of the grounds upon which the right to compensation is denied in any case. If the employer or carrier, in good faith, is without sufficient information to admit or deny, it is acceptable to deny the case but make sure to detail your efforts to investigate the claim. For example, if the employee has not provided you with some information that you have requested, put that in the Form 61.

When completing the Form 61, it is a good idea to indicate that you are reserving the right to allege other grounds of which you are currently unaware as further investigation and discovery may provide additional defenses. The Form 61 and/or letter of denial needs to be sent to the employee,his/her attorney, if any, all known health care providers who have submitted bills and provided medical records, and the Commission.

One under-utilized basis for denial is a good practice pointer to mention here. As part of the 2011 reform provisions, a denial is valid if there is a willful misrepresentation by a new employee regarding his or her physical condition or abilities. If the employee had a past injury and that employee later injures the body part which was not disclosed as a pre-existing problem that misrepresentation is a valid reason to deny the claim. For claims arising on or after June 24, 2011, the Act bars an injured employee from receiving compensation if the employer is able to establish that (1) the employee "knowingly and willfully made a false representation as to his physical condition" in his employment application or while undergoing a post-offer medical examination; (2) the employer relied on that misrepresentation and the reliance was a substantial factor in the decision to hire the employee; and (3) the injury for which a claim is subsequently made is causally connected to the employee's misrepresentation. Admittedly, these are not common occurrences, but if a review of prior medical records indicates a pre-existing problem with the same body part that has been newly injured, it is worth asking the employer if there may be a viable defense on this issue. A word of caution: employers need to be very careful about the manner in which they inquire about pre-existing conditions or past injuries.

6. How to Accept a Claim

The Form 60 is the form that is used to formally accept a claim. Whether a Form 60 is necessary when only medical benefits are being paid ("a med-only claim") is the subject of some debate. As of August 1, 2008, the I.C. has designated the Form 63 as the proper form for accepting a medical-only claim.

When completing the Form 60, be very specific when completing the portion of the form that asks for a description of the injury by accident or occupational disease. List the specific body parts (*i.e.*, which hand, leg), including areas of the back (cervical, lumbar, low back, neck) and the type of injury.

Claims used to be accepted on a Form 21. The Form 21 carries with it a presumption of ongoing disability, while the Form 60 does not. Under *Perez v. American Airlines/AMR Corp.*, 174 N.C. App. 128, 620 S.E.2d 288 (2005), a Form 60 can carry the presumption that future medical treatment is related, but is still the better way to accept a claim.

B. PAYMENT OF COMPENSATION

1. Indemnity Benefits

All indemnity payments are late when they are not paid within 14 days of becoming due. A 10% late payment penalty may be assessed for late payments.

a. Temporary Total Disability (TTD)

Once a claim has been accepted, if an employee is out of work as a result of the injury, s/he is entitled to receive weekly benefits, temporary total disability (TTD), at his/her compensation rate, which is 2/3 of their average weekly wage. There is a seven day waiting period before TTD benefits should start. Once the employee is out of work seven days, TTD benefits should begin. If the employee is out of work 21 days, the seven day waiting period should also be paid.

A major change in the law occurred with the 2011 reforms. There is now a 500 week cap (in most cases) for the payment of TTD benefits on claims arising on or after June 24, 2011. (For claims that arise prior to that date, there is no cap on TTD benefits.) In order to receive TTD benefits, an employee needs to prove, by a preponderance of the evidence, that s/he is unable to earn the same wages that s/he had earned before the injury, either in the same or other employment. If the claimant proves this, or the defendants agree to this pursuant to a Form 60, then the claimant would be entitled to TTD benefits up to a maximum (in most cases) of 500 weeks from the first date of disability. (the first day they were unable to work.)

There is a provision for those workers who are seriously hurt and have a total loss of wage earning capacity to obtain benefits beyond the cap, but a hearing has to be requested and evidence presented in that regard. An employee can not file a request for hearing on this issue until 450 weeks have passed. Also, if an employee qualifies for benefits beyond the 500 weeks, then the employer will be entitled to a 100% credit for Social Security retirement benefits received by the claimant. This credit applies only to TTD benefits received past 500 weeks and does not apply to Social Security disability benefits.

There are certain cases which allow for automatic permanent and total disability benefits -- catastrophic cases where a claimant actually loses two or more limbs - meaning that these employees are entitled to lifetime benefits without regard to whether they return to work or not. Three other categories create a rebuttable presumption of permanent and total disability benefits. These include spinal injury involving severe paralysis of both arms, both legs or the trunk, severe brain or closed head injury as evidenced by severe and permanent motor disturbances communication disturbances, etc., and second or third degree burns to 33% or more of the total body surface. Under these three sections, if the employer can prove that the claimant is capable of suitable employment, then permanent and total disability benefits would not be due and payable. There is no credit for Social Security retirement benefits for catastrophic injuries that fall under this Section.

b. Temporary Partial Disability/Wage Loss (TPD)

If an employee is still working, but is earning less money as a result of the injury, either due to decreased hours or a move to a lower paying position, s/he is entitled to receive 2/3 of the difference between the average weekly wage s/he was earning at the time of the accident and his/her current wage. For claims arising before June 24, 2011, the employee is entitled to receive these payments for up to 300 weeks from the date of accident. It does not matter when the employee started missing work. The 300 weeks start running on the day of the accident. In other words, for example, if an employee is out of work for 200 weeks and is paid TTD and then returns to a light duty job or a job that pays less, s/he will be able to receive 2/3 of the difference for another 100 weeks.

For claims arising on or after June 24, 2011, an employee who returns to work for lower wages can collect TPD benefits for up to 500 weeks from the date of disability (which will not necessarily be the same as the date of accident.) For example, if a person returns to work following an injury, works for a time, is later taken out of work and then returns at a lower wage, the 500 weeks will start running on the date the employee was first unable to work following the injury.

Note that the 500 week cap for TTD and TPD means 500 weeks of payments, regardless of the type. In other words, if the claimant receives TTD benefits, those weeks of benefits are deducted from the 500 weeks if TPD comes into play. Also, weeks where there is a return to work following a period of disability count against the 500 weeks.

c. Permanent Partial Disability (PPD)

Permanent partial disability (PPD) is payable under N.C.G.S. § 97-31 based on the rating assigned by the physician to the particular body part. N.C.G.S. § 97-31 contains the schedule for all of the different parts. For example, if a person receives a 10% rating to the back, s/he is entitled to 30 weeks of benefits (300 weeks (set by § 97-31 for a back) x 10%=30 weeks.) Payment for the rating, if the claim is not being settled through a clincher, is made on a Form 26A.

If a rating is assigned and never paid, the two year statute of limitations on change of condition does not begin to run. Also, if a rating is not assigned but should have been, the statute does not begin to run. For claims arising on or after June 24, 2011, employers are entitled to a credit if the claimant received TTD or TPD benefits and then subsequently decides to take the rating/PPD benefits under N.C.G.S. § 97-31. There is some debate as to whether this credit is available for claims arising prior to June 24, 2011 although TEAGUE CAMPBELL takes the position that it is available.

d. Bodily Disfigurement/Scarring/Loss of Organ

Bodily disfigurement awards are limited to $10,000. Awards for facial or head disfigurement and permanent injury to an organ or part of the body are limited to $20,000. Employees cannot receive both PPD and disfigurement for the same body part.

e. Calculation of Average Weekly Wage

The average weekly wage is calculated using the Form 22. The employee's wages for the 52 weeks before the accident are used to calculate the average weekly wage. The Form 22 has specific instructions on the back for completion. If an employee missed a week or more of consecutive days, that time needs to be deducted from the 52 week period. If an employee worked less than 52 weeks before the accident, you may need to get another employee's wage information to calculate the average weekly wage. The other employee needs to be employed in a similar position with that same employer.

2. Medical Benefits

Under the Workers' Compensation Act, employees are entitled to have the medical treatment they undergo, paid for by the employer. Defendants have the right to direct medical care in all workers' compensation claims. That said, an employee does have the right to request a second opinion evaluation. The procedure requires the employee to first contact the defendants and make a request in writing for an Independent Medical Evaluation (IME). The defendants then have 14 days to try and work out some agreement on the request for an IME. If the parties cannot reach an agreement on the IME, then the employee can file a motion with the Industrial Commission seeking authorization for a second opinion evaluation. The second opinion evaluation can be on any issue in the case, work restrictions, medical treatment options, surgical options, etc.

An employee does have the right to select his or her own medical care subject to the approval of the Industrial Commission, but there is a high standard on the Commission's ability to actually transfer care away from one doctor, as opposed to allowing the IME discussed above. In order for the Industrial Commission to order a change in treating physician, the employee must prove by a preponderance of the evidence that the change is reasonably necessary to effect a cure, provide relief, or lessen the period of disability. When deciding whether to grant an employee's request to change treatment or healthcare provider, the Commission may disregard or give less weight to the opinion of a healthcare provider from whom the employee sought treatment before the employee first requested authorization in writing from the employer, carrier or Commission.

After the approved physician finds that the employee is at maximum medical improvement (MMI) and assigns a rating, the employee is allowed to seek a second opinion from another doctor as to the amount of the rating. If a plaintiff does request a second opinion on the rating and the rating physician goes beyond the rating to discuss other issues, then the I.C. must either disregard or give less weight to the opinions of that second opinion physician on the issues outside the scope of the rating.

Defendants have an absolute right to compel an IME in any case, even one that is denied. This means that employers get to pick the IME physician and are allowed to engage in direct communications with the IME physician. If the IME physician physically examines the employee, the employer must produce a copy of the IME report within 10 business days of receipt along with copies of all documentation and written communications sent to the IME physician. If the employee refuses to attend an IME, then defendants can file a Form 24 Application and ask to terminate benefits.

a. Travel

Employees are entitled to payment for mileage to and from medical appointments only if the medical appointments result in travel that is **20 miles** or more round trip. A Form 25T is the form that an employee must complete to receive reimbursement for mileage. Make sure that the employee has signed the form certifying that the mileage has been incurred. It never hurts to check MapQuest or another service to confirm the mileage is accurate. Employees are also entitled to reimbursement for lodging and meal expenses when it is medically necessary for them to stay overnight.

Trips to the pharmacy for prescriptions are not reimbursable unless they are medically necessary. N.C.G.S. 97-25 requires medication and supplies to be purchased on visits to medical providers.

C. MEDICARE REPORTING REQUIREMENTS

While the MSA (Medicare Set Aside) process is focused on ensuring that Medicare is the payer of last resort for any **future** medical expenses which may be related to a workers' compensation injury, as of December 29, 2007, the federal government implemented new legislation called the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "MMSEA"), which is designed to ensure recovery of conditional payments made by Medicare for a claimant's injury related care received **from the date of injury to the date of settlement.** As a result of the enactment of the MMSEA, risk managers, defense attorneys, employees and their attorneys will need to alter their approach to the claims handling and settlement process. New procedures which are designed to protect Medicare's interests in recovering these conditional payments should be implemented to avoid incurring substantial monetary penalties. These procedures need to be followed at the outset of a claim.

As of January 1, 2011, the MMSEA requires insurers to do two things. They are:

a) Determine whether a claimant is currently entitled to Medicare benefits; and
b) If the claimant is entitled to benefits, report certain information to Medicare **at the time of the settlement, judgment, award or payment.**

The first question then becomes, "How do I determine if the claimant is entitled to benefits?" Fortunately, the answer is fairly simple. The Centers for Medicare and Medicaid Services (CMS), has set up a query access system for insurance carriers, (responsible reporting entities or RREs) to determine a claimant's Medicare entitlement status. In order to do this, a Risk Manager can log into the query access system (using the insurer's ID number, which is assigned when the carrier registers with CMS), and provide the following data:

a) Claimant's Medicare health insurance claim number
b) The first letter of claimant's first name
c) The first six letters of claimant's last name
d) Claimant's date of birth
e) Claimant's gender

After this information is submitted to the query access system, within 14 days, CMS will respond with a "yes" or "no," regarding whether the claimant is currently entitled to Medicare. If the answer to the entitlement question is "yes", then the carrier is subsequently required to report certain information, at certain times, during the life of the

case.

However, workers' compensation claims, that meet **all** of the following criteria, are excluded from the reporting requirement, through December 31, 2011:

a) Medical-only claims
b) When the lost time for the worker is less than 7 days
c) When all payments have been made directly to the medical provider
d) Total payments do not exceed $750

("Reporting Obligations for Settling Insurers Where Medicare is a Secondary Payer", Garretson and von Saucken August 27, 2009)

1. When to Report to CMS

In the event that a "yes" answer is returned by the query system and the claim does not meet the criteria set out above, the question then becomes "**When** should I report to CMS, and **what** information is required for reporting purposes?"

As to **when** a report needs to be made to CMS, the RRE is required to report certain information **at the time of settlement, judgment, award or payment.** A settlement, judgment, award or payment can be any of the following:

a) RREs must report when there has been a settlement, judgment, award or other payment (even when a case has not settled, but an initial payment for medical expenses has been made based on an RRE accepting such responsibility). One time payments for settlements, judgments or awards **are reportable.**

b) If an RRE has accepted ongoing responsibility for medical payments, only two events must be reported:

    1) an initial record to reflect the acceptance of such responsibility; and
    2) a second (and final) report reflecting the termination of that responsibility.

The RRE need not report every occasion the payment is made.

c) RREs must report settlements, judgments, awards, or other payments regardless of an admission of or denial of, or determination of liability.
d) The reporting obligation does not have to allocate between damages for indemnity and medical expenses.
e) There is no age threshold for reporting purposes.
f) If there is no settlement, judgment, award or other payment and the file is ready to be closed, there is no reporting requirement. ("Reporting Obligations for Settling Insurers Where Medicare is a Secondary Payer", Garretson and von Saucken August 27, 2009)

2. What to Report to CMS

As to what information should be reported to CMS, currently, the RRE will be responsible for information in the following areas, which are referred to by CMS as "data points;"

a) Injured Party Data
b) Claimant Data
c) Primary Plan Data
d) Policy Holder Data
e) Injured Party/Claimant Attorney Data
f) Incident Data
g) Resolution Data

3. Penalties

The MMSEA contains significant penalties for noncompliance. Specifically, CMS is authorized to fine an RRE $1,000 **per day, per beneficiary,** for non-compliance. Therefore, it is critically important that risk managers identify when it is appropriate to report to CMS.

4. Risk Handling Tips

Compliance with the MMSEA can be achieved by starting early in the process. Risk Managers should submit information to the query access system at the outset of the claim in order to determine if the claimant is entitled to Medicare benefits. Thereafter, in compensable claims, it is important to submit queries on a quarterly basis in order to determine if the claimant's Medicare entitlement status changes. If, at any point, a "yes" response is received, the Risk Manager must be vigilant about submitting additional information required by Medicare **at the time of settlement, judgment, award or payment,** which may include the initial payment of medical or indemnity payments to a claimant.

D. CESSATION OF WEEKLY BENEFITS

1. Return to Work

When an employee is able to return to work but is under restrictions, then a Form 28T must be filed with the Commission. This type of return to work is known as a trial return to work. On No. 4 on the Form, you indicate the date employee is returning to work and then indicate whether s/he is returning at the same wages s/he was earning at the time of the accident or at lower wages. If the wages are lower, write the word "varies" in the blank requesting the new rate.

If an employee returns to work under restrictions and a Form 28T is filed, in order to have benefits reinstated, the employee's treating physician has to complete the Form 28U. Any of the approved physicians who have treated employee can sign this form. Benefits do not have to be reinstated until the Form 28U is completed.

If an employee returns to work without restrictions, a Form 28 must be filed with the IC. If the employee becomes completely disabled again after that return to work and benefits are reinstated, a Form 62 should be filed with the Commission to document that benefits have been reinstated.

2. Getting an Employee Back to Work

During a case, there may come a time when the employer has a position for the employee or a voc case manager has found a position within the employee's restrictions. If a voc case manager is involved, s/he should follow The North Carolina I.C. Rules for Utilization of Rehabilitation Professionals in Workers' Compensation Claims and obtain approval of the job from the treating physician. If there is no case manager, the Commission has formulated questions that can be sent directly to the treating physician, with a copy of the job description attached. The letter must be copied to the employee or the employee's attorney.

Employers are entitled to communicate job offers directly to the employee, but need to copy the claimant's attorney with such communication. If you have a position approved by the physician and the employee does not appear for it, you can then file a Form 24 with the Commission seeking to terminate the payment of weekly benefits. The Form 24 has specific instructions on it for service of the document and **it is to be sent to the employee even when s/he is represented by counsel** as well as the employee's attorney. The Form 24 will be set for a telephonic hearing with one of the Special Deputy Commissioners. If the Form 24 is not granted, you can appeal the decision by filing a Form 33 Request for Hearing. That appeal must be filed within 15 days.

Frequently, when you are attempting to bring someone back to work, you will hear objections that the position that the employee is being offered is not a real position or "make work." A full discussion of this issue is best reserved for another paper but, generally, an employer cannot make up a position for an employee after s/he reaches maximum medical improvement (MMI) - any job offer post MMI to the employee has to be an actual position with the company. For claims arising on or after June 24, 2011, if an employee is not at maximum medical improvement, it is acceptable for the employer to create a job for the employee as part of the rehabilitation process, so long as the authorized treating physician feels that it would be rehabilitative for the claimant. If the employee refuses to

present for work after such an offer is made, you have good grounds to file a Form 24 Application. For claim that were filed before June 24, 2011, the offered position has to be an actual position.

If the employer does not have a job available for the employee, the burden falls on the employer/carrier to try and find the employee another job. Usually, this is when vocational rehabilitation gets assigned to the file. This is also a good time to talk about resolving the case by a clincher agreement. After the employee reaches MMI, the requirements of showing that a suitable position exists in the marketplace increase. At that point, employment is considered suitable if the employee is capable of performing the job, taking into account their preexisting and injury-related physical and mental limitations, vocational skills, education, and experience and is located within 50 miles radius of the employee's residence at the time of the injury or the employee's current residence if the employee had a legitimate reason for relocation. For all claims arising on or after June 24, 2011, wages have been removed from the definition of "suitable employment." Therefore, if an employer or carrier finds employment for the claimant paying less than the employee's pre-injury average weekly wage, then pay will not be a basis to refuse the employment and it should not be a basis for denial of a Form 24 Application. There is no requirement that the post-MMI job offer even include any specific likelihood that the claimant will advance to their pre-injury average weekly wage. However, the statute does allow a claimant to request vocational rehabilitation services if they are paid less than 75% of their pre-injury average weekly wage, so it is in the employer's best interest to maximize the claimant's post-injury average weekly wage so that TPD exposure can be reduced and potential costs of engaging in vocational rehabilitation services can be avoided.

3. Reinstatement of Compensation

Whenever the employee's right to compensation has been admitted, or liability has already been established, the employee may move for reinstatement of compensation pursuant to a Form 23 Application to Reinstate Payment of Disability Compensation or a Form 33 Request for Hearing. The form must: (1) contain the reasons for the proposed reinstatement of compensation, (2) be supported by available documentation, and (3) inform you of your right to contest the application by filing an objection in writing with the I.C. within 14 days.

If you contest the employee's right to reinstatement, the I.C. must conduct an informal hearing by telephone with the parties or their counsel within 25 days. Just as with a Form 24 Application, each side will be provided an opportunity to state a position and to submit documentary evidence at the informal hearing. If either party objects to conducting the hearing by telephone, the I.C. may elect to conduct the hearing in person. The employee may also waive his or her right to an informal hearing in order to proceed immediately to the formal hearing.

If the employee's application is approved or not contested, then compensation shall be reinstated immediately and continue until further order of the Commission. If the application is granted, you can appeal the decision by filing a Form 33 Request for Hearing.

E. MOTIONS PRACTICE

1. In General

If an employee has filed a Motion with the I.C., the employer and/or carrier will have 10 days to respond to that Motion. On the whole, most Motions are directed to the Executive Secretary of the I.C., currently Meredith Henderson. Motion and Responses do not need to be a formal document - a simple letter or e-mail is fine. The Executive Secretary's office will sometimes notify the defendants that a Motion has been received and that they have 10 days to respond but often do not. Defendants should receive a copy of any Motion that is filed.

Extensions, especially if consented to by opposing counsel, are usually granted. Any decision rendered by the I.C. in response to a Motion is an Administrative Decision that can be appealed by the filing of a Form 33. An Administrative Decision must be appealed in 15 days of the date of the decision. Medical Motions, however, have their individual considerations.

2. Expedited, Emergency, and Other Medical Motions

Senate Bill 174 became law on July 18, 2013, when it was signed by Governor Pat McCrory. Enacted as Section 4 to Session Law 2013-294, Senate Bill 174 formally created a new protocol for the I.C. to follow with respect to the filing and handling of expedited, emergency, and other medical Motions. The I.C. will be taking the necessary steps to

review the new statutory process and the existing Rule 609A Medical Motions and Emergency Medical Motions. If the existing Rule 609A conflicts with Section 4 of Session Law 2013-294, the I.C. will provide notification of any process to repeal Rule 609A.

Effective August 1, 2013, in compliance with N.C.G.S. § 92-25(f), expedited, emergency, and other medical Motions shall now be filed with the Office of the Chief Deputy Commissioner. The non-moving party has the right to contest the Motion. All Motions and Responses must be submitted simultaneously by electronic mail to the Commission at medicalmotions.ic.nc.gov, to the opposing party, and to the opposing party's attorney. Once a medical Motion has been submitted, the I.C. will conduct an informal telephonic conference to determine if the Motion warrants an expedited or emergency hearing.

a. Non-Expedited or Non-Emergency Medical Motions

If the Motion is found not to warrant an expedited or emergency hearing, then the Motion will be decided administratively within 60 days of the date that the Motion was filed.

b. Expedited Medical Motions

If the I.C. determines that a medical Motion should be expedited, each party will be afforded an opportunity to state its position and to submit documentary evidence at an informal telephonic hearing. The expedited medical Motion must contain documentation and support of the request, including the most relevant medical records, a representation that informal means of resolving the issue have been attempted in good faith, and the position of the opposing party, if known. The I.C. will then determine whether deposition testimony of medical and other experts is necessary, and, if so, it will order that the testimony be taken within 35 days of the date that the Motion was filed. The I.C. has authority to reduce or enlarge this time frame for good cause shown. All deposition transcripts must be expedited and paid for by defendants and submitted electronically to the I.C. within 40 days of the date the Motion is filed. After its receipt of the deposition transcripts, the I.C. will render a decision within five days.

c. Emergency Medical Motions

If the I.C. determines that a Medical Motion is an emergency, it must make a determination on the Motion within five days of its receipt. All Motions requesting emergency medical relief must contain: (1) an explanation of the medical diagnosis and treatment recommendation of the healthcare provider that requires emergency attention; (2) a specific statement detailing the time-sensitive nature of the request, including relevant dates and the potential for adverse consequences to the employee if the recommended treatment is not provided emergently; (3) an explanation of opinions known and in the possession of the employee of additional medical or other relevant experts, independent medical examiners, and second opinion examiners; (4) documentation known and in the possession of the employee in support of the request, including relevant medical records; and (5) a representation that informal means of resolving the issue have been attempted.

d. Orders Appealed to the Deputy Commissioner Section

When Notice of Appeal from an Order filed by the Executive Secretary's Office or from a Form 33 is filed, with the only issue being a Medical Motion, the processing of the appeal through the Dockets Department will be expedited, and under normal circumstances, the Motion or the Form 33 bypasses mediation, unless the parties indicate a desire to mediate. The appeal is docketed before one of the two designated Deputy Commissioners, five days from the date of appeal. A telephonic Pre-Trial Conference will be held immediately to clarify the issues, to encourage the parties to consent to a "paper" review of the contested issues (parties submitting the medical records and opinion letters via e-mail), to fashion the medical evidence to be presented if there is to be a hearing, and to explore settlement possibilities. The Deputy Commissioner will then file an Automatic Stay Order electronically signed by the administrative officer from the Executive Secretary's Office. If the Deputy Commissioner determines that the case needs to go to a full evidentiary hearing, then the Deputy Commissioner will refer the case to mediation. If depositions are necessary, then only a brief time will be allowed. The taking of lay testimony will be discouraged. Any such lay witnesses will either come to Raleigh, or the designated Deputy Commissioner may request another Deputy Commissioner hearing cases near the witness's location to gather such testimony and then refer it back to the designated Deputy Commissioner. A transcript will be immediately ordered by the designated Deputy Commissioner, initially at the defendants' expense. The preparation of the transcript is be expedited.

Deputy Commissioners are authorized to: a) deny requests for independent medical examinations, unless there is a valid need for this evaluation; b) deny requests for depositions; and c) where the parties are granted the opportunity to depose medical providers, impose time limits on the scheduling and the taking of depositions, as well as the delivery of transcripts. Contentions and briefs should be limited in length, and are to be filed, at most, within five days (5) after the record is closed. The Deputy Commissioner will issue an Order, at most, within five days after receipt of contentions and briefs. The overall process at this level should be approximately 30 days from the Notice of Appeal of an order filed by the Executive Secretary's Office or filing of a Form 33.

It is highly recommended that once an appeal has been filed by a party from an Administrative Order, that the parties evaluate their case and determine what if any medical dispositions are needed and go ahead and get those depositions scheduled because the Deputy hearing the case will normally require that the record close within 30 days of the Notice of Appeal. This deadline can sometimes be next to impossible to meet given the doctors' schedules, but it is better to have the first available date that the doctor can do a deposition ready to tell the Deputy during the Pre-Trial Conference call.

c. Orders Appealed to the Full Commission

An appeal of the designated Deputy Commissioner's Order will be acknowledged by the Dockets Department within three days by sending either the Represented Party Order or the *Pro Se* Order under the name of the Chair of the Panel. The Docket Department will then set the appeal before the earliest Full Commission panel that will allow time for briefing. Represented parties will be ordered to agree to an abbreviated schedule if they are given an opportunity to file briefs. When the plaintiff is *pro se,* the panel chair will telephone the parties to schedule filings within five (5) days of the Docket Department acknowledgement. In either case, the panel chair will determine if oral arguments are to be by telephone, in person, or waived. The Full Commission panel will file an Order within five (5) days after the designated hearing date, or sooner if the situation permits. The overall process at this level should be approximately 30 to 45 days from the Notice of Appeal.

F. THE HEARING PROCESS

When a party wants to take a case to hearing, that party files a Form 33 Request for Hearing. This form is normally filed by the employee and it states the issues to be heard, and (hopefully) it specifically enumerates what benefits employee is seeking. Once a Form 33 is filed, the other side has 45 days to file a Form 33R Response to Request for Hearing. Both the Form 33 and Form 33R should be sent to the Docket Director at the I.C.

1. The Mediation

Once a Form 33 is filed, the case is referred to mandatory mediation unless the employee is without counsel (pro se.) The parties have 55 days from the filing of the Form 33 to select a mediator and 120 days to schedule and complete the mediation. It is fairly easy to obtain an extension of time to complete the mediation. More often than not, a file requires a significant amount of discovery and investigation before it is ready for mediation, so extensions often are requested and granted. Requests for extensions of time to complete mediations are sent to the assistant assigned to the Dispute Resolution Coordinator (currently Deputy Commissioner John Schafer).

There are two ways a mediator is assigned to case - s/he is either designated or appointed. A mediator is **appointed** when the parties miss the deadline to pick a mediator and the I.C. appoints a mediator for the parties from the approved list. A mediator is **designated** when the parties agree on a mediator, and file a Designation of Mediator Form with the Dispute Resolution Coordinator at the I.C. It is always best to have a say in who will mediate the case. If the 55 days is close to running, an extension of time to choose the mediator can be requested from the Dispute Resolution Coordinator. If the I.C. appoints a mediator and the parties agree to use a different one, they can substitute mediators with approval of the I.C., but there will usually be a $100 fee payable to the Commission as well as payment of the administrative fee to the original mediator.

Mediation can be a good discovery tool, and even if discovery responses are outstanding or additional investigation may be necessary, you can learn a lot at the mediation. You can get a better understanding of the other side's position and get a look at the employee.

The I.C.'s Rules require that the employee be present at the mediation and that a representative for the employer and/or an agent for the insurer be present as well. If there is a "suitable employment" issue, the rules require the attendance of an employer representative. As a practical matter, the defense counsel can write opposing counsel and request that his or her client be allowed to attend by telephone, and normally, that is in fact what happens. If you are appearing by telephone, make sure that you are available by telephone throughout the mediation for as long as the mediation lasts. This includes staying at your desk or being able to be reached while at lunch or after business hours.

There are a few cases where mediation would not be helpful, and accordingly, a party can file a Motion with the Dispute Resolution Coordinator to dispense with mediation.

2. The Hearing

If the parties reach an impasse at mediation or a Motion to Dispense with Mediation is granted, the case will be placed on a hearing docket. The time between the impasse and when the case will show up on a hearing docket varies; however, it is usually within 60 to 90 days. The I.C. now posts, on their web site, cases that will be placed on a hearing docket for the next available month, usually two months out. The I.C. requests that attorneys check the list and let the Commission know if a case is not ready for hearing. If the parties do not let the Commission know, the case will be placed on the hearing docket, and it will be extremely difficult to get it removed or continued.

Once a case is placed on the hearing docket, the parties will normally have to submit a Pre-Trial Agreement the third Thursday of the month prior to the hearing to the Deputy Commissioner who is hearing the case. The parties can request that they be allowed to submit the Pre-Trial Agreement on the date of the hearing. The person requesting the hearing has the burden of drafting the Pre-Trial and sending it to the other side for revisions and additions. However, if the party responsible for preparing the Pre-Trial does not do so, the other party is supposed to draft their portion of the Pre-Trial and send it to the Deputy Commissioner.

The typical Pre-Trial has stipulations, issues to be addressed, witnesses and doctors to be deposed after the hearing, list of exhibits and estimated length of the hearing.

Once a case is on a hearing docket, or after the hearing, all correspondence and motions should be sent to that Deputy Commissioner. The hearing will take place in the county where the injury occurred. At the hearing, lay witnesses will testify, but all medical depositions will take place after the hearing. The parties will have either 60 or 90 days to complete these depositions. In the normal injury by accident case the parties are given 60 days to complete depositions, and in an occupational disease case the parties are given 90 days to complete depositions.

After the hearing and medical depositions have been completed, the parties will normally have 30 days from the close of the record to submit briefs and/or a proposed Opinion and Award. Deputies have 180 days to file their Opinion and Award; however, most decisions are filed well within the 180-day deadline.

G. THE APPELLATE PROCESS

1. Appeals to the Full Commission

If a party does not win before the Deputy Commissioner, they can appeal to the Full Commission. The Full Commission consists of seven Commissioners and they sit in groups of three. A party has 15 days from receipt of an Opinion and Award to appeal from that decision. The notice of appeal should be sent to the Docket Director at the Commission. Thereafter, the Commission will acknowledge the Appeal and will eventually produce a transcript of the hearing.

Once the appealing party (appellant) receives the transcript, they have 25 days to submit a brief and Form 44. The other party has 25 days from receipt of appellant's brief to submit their brief. The parties can stipulate to a one time 30-day extension if the matter has not been calendared for hearing. If the appellant does not submit a brief, than

the appellee has 25 days from the date he or she would have received the appellant's brief had it been written. Appealing parties must file a Form 44 identifying their grounds for review.

The case will then be placed on a hearing calendar, hopefully within 90 days, and oral arguments will be held in Raleigh at the Dobbs Building before three of the six Commissioners.

2. Appeals to the Court of Appeals

If a party is dissatisfied with a decision from the Full Commission, they can appeal to the Court of Appeals. The deadline for filing an appeal to the Court of Appeals is 30 days from the date of an award of the I.C. or 30 days after receipt of notice to be sent by registered or certified mail of such award. N.C.G.S. § 97-86. The notice of appeal is filed with the I.C., and the appeal is thereafter governed by the Rules of Appellate Procedure.

Although the Full Commission may make a complete review of all evidence of record and make findings of fact which are completely contrary to those made by a deputy commissioner, the review by the Court of Appeals on factual issues is limited to a determination of whether there is competent evidence in the record to support the findings of fact made by the I.C. If there is any competent evidence in the record to support the findings made by the I.C., those findings will be upheld on appeal. The Court of Appeals may also review all questions of law, and therefore may consider whether the Commission properly applied the relevant law to the findings of fact.

3. Appeals to the Supreme Court

Appeals to the Supreme Court are governed by Rules 14 and 15 of the Rules of Appellate Procedure. When there is a dissent in the Court of Appeals, the losing party has an automatic right of appeal to the Supreme Court. In cases where there is no dissent, the Supreme Court has to agree to review the case (discretionary review.) Rule 15 sets out the requirements for a discretionary review by the Supreme Court. An appeal under Rule 14 based upon a dissent in the Court of Appeals requires filing of a notice of appeal with the clerk of the Court of Appeals and the clerk of the Supreme Court within 15 days after the mandate of the Court of Appeals has been issued by the I.C. must also be served with the notice of appeal. Unless otherwise specified in the Opinion of the Court of Appeals, the mandate is deemed to be issued twenty days after the written Opinion of the Court has been filed with the clerk. The Record on Appeal filed in the Court of Appeals constitutes the Record on Appeal for review by the Supreme Court.

H. SETTLEMENT AGREEMENTS

Once an employee has been found to be at maximum medical improvement and a rating has been assigned by the physician (on a Form 25R) it is time to resolve the case.

1. Form 26A Information

The Form 26A is typically used in situations when an employee has returned to work and wants to be paid for any rating received. N.C.G.S. §97-31 sets out the schedule of injury and assigns a certain number of weeks to each body part. If payment for a rating is made on a Form 26A, the employee can continue to receive medical treatment as long as one year of time does not pass between appointments. The employee also has two years from the last payment of indemnity compensation to allege a change of condition and seek indemnity benefits.

The Form 26A has to be submitted to the I.C. along all medical and vocational records are submitted. **The employee must sign both sides of the form.**

The I.C. carefully scrutinizes Form 26A Agreements and will expect to see that every form documenting employee's time out of work, and return to work is in the file. Sometimes, the Commission will refer Form 26A cases to an evidentiary hearing on the issue of whether employee will need future medical treatment. Once a Form 26A is approved and paid, a Form 28B should be filed with the Commission.

Prior to the creation of the Form 26A on August 1, 2008, a Form 21 was used to pay ratings. Clients were always cautioned that Form 21 agreements should be entered into carefully because, once approved by the Commission, they may entitle the employee to a "presumption" of disability. Whether the same is true for Form 26A Agreements remains to be seen but the creation of a presumption of disability should be considered particularly when an employee is not back to work.

2. Clincher/Compromise Settlement Agreement

A clincher or compromise settlement agreement can completely resolve a claim. Sometimes parties will use clinchers to settle portions of the claim but usually it is used to entirely close out a claim. The clincher details the history of the claim, the medical treatment and the agreement the parties have reached as to settlement. It also has to be submitted to the I.C. for approval. If the claim has not been assigned to a hearing docket, the clincher is submitted to the Executive Secretary's office. If the case is on a hearing docket, the clincher should go to the Deputy assigned to the case. If the case is at the Full Commission, there is usually a Commissioner designated to receive the clinchers.

An important clarification from the 2011 reform effort is that parties are not prevented from settling an employment claim or other issues at the same time as a workers' compensation settlement. Workers' compensation settlements still need to be separate from the employment settlement or any other settlements, but before this portion of the law was amended, there was some question as to whether employment claims could be settled at all during the pendency of a workers' compensation case.

Like the Form 26A Agreements, the I.C. will scrutinize any settlement agreement involving an employee not represented by counsel. If the employee has received a rating, the payment made to settle the case must be at least 10% more than what the employee would receive under N.C.G.S. § 97-31 for that rating.

Once a clincher has been approved, payment of the settlement proceeds must be made in **24 days** from receipt of the Order of Approval or will be subject to a 10% penalty unless the delay was beyond the carrier's control. A Form 28C must be filed with the Commission once a clincher has been approved and paid.

a. Medicare Set Asides

In certain situations, Medicare's interests may need to be considered when negotiating a final settlement of a claim.

i) **Triggers** - Settlements which MUST consider Medicare's interests:

a) **Claimant is already on Medicare - <u>regardless</u> of the amount of the settlement.**

OR

b) **The settlement amount exceeds $250,000 AND there is a "reasonable expectation" that the claimant will be enrolled in Medicare within 30 months of the settlement date.**

"Reasonable expectation" is:
- Claimant has applied for Social Security Disability; or
- Claimant is appealing an adverse decision on an SSD application; or
- Claimant is 62 years and 6 months old.

If Medicare's interests must be considered, this usually means a portion of the workers' compensation settlement will need to be set aside to cover future medical expenses that would otherwise be paid by Medicare.

ii) **If the claim meets the triggers described above:**

a) **Find out whether Medicare has already made payments for the condition or injury. If so, make sure that all Medicare liens are satisfied at the time of the settlement.**

b) **If the settlement involves future medical expenses, a Medicare set-aside allocation (MSA) will most likely need to be made.**

In determining the allocation, it is advisable to confer with a vendor which has expertise in the area of projecting future medical expenses which may be covered by Medicare. Also, the likelihood of CMS approval of the allocation is greater if one of these firms is involved. Simply having a Life Care Plan prepared is not sufficient because it does not

take into account what expenses are covered under Medicare. All defenses to a claim should be communicated to the vendor, because it could alter the amount of the set aside.

The allocation can either be self-administered by the claimant or can be placed in an account to be administered by a third party administrator. An annuity can be used to fund the MSA.

c) Decide whether the agreement will be submitted for CMS approval.

The Centers for Medicare & Medicaid Services (CMS) has asserted a right to review any agreement containing these triggers but the statute does not mandate that the agreements be submitted to CMS. The benefit to receiving CMS approval, however, is that it is **the only way to guarantee that Medicare's interests have been reasonably considered and that Medicare will not contest the MSA at a later date. CMS will not review a settlement to give its approval if the settlement is for less than $25,000.00 in any case and if the settlement is for less than $250,000.00, unless the claimant is a current Medicare beneficiary.**

d) Not every case requires that money actually be set aside.

If you can show that settlement is only for past medical expenses, there is no evidence that parties are maximizing the lost wage part of a settlement to the detriment of Medicare and the treating doctor concludes in writing that to a reasonable degree of medical certainty the claimant will no longer require any Medicare-covered treatments for the workers' compensation injury, no set aside may be required.

If you decide to seek CMS approval, note that the Atlanta CMS office is taking approximately 4 months to review Agreements. Therefore, try to negotiate some way for indemnity and medical benefits to be paid against the settlement proceeds during the approval process.

iii) Consequences for not considering Medicare's interests:

Although even experts agree that the statute is difficult to interpret, it appears that CMS could pursue recovery from a workers' compensation insurer, a self-insured employer, or anyone that has received a portion of a third party payment, directly or indirectly. This includes medical providers, as well as claimants and their attorneys. Therefore, in a situation where a **claimant's attorney tries to avoid making an allocation** when it is appropriate according to the guidelines, remind them that they are also at risk of being pursued by Medicare for recovery of its payments.

iv) CMS' position on attempts to avoid MSA

a) Waiver - The position of CMS is that simply stating in the agreement that the claimant agrees not to seek Medicare benefits for this injury/condition in the future is not a proper means of considering Medicare's interests.

b) Denial of Liability - The position of CMS is that it is not acceptable to simply compromise and settle a disputed claim with an express denial of liability without taking Medicare's interests into consideration if the agreement contains one of the triggers. Even in a denied claim, a MSA may need to be made. A wholesale denial is not enough.

v) Some additional rules of thumb:

- **If claimant is on Medicare but the settlement amount is relatively low** an issue may arise as to whether you will submit the agreement for CMS approval which requires added time and expense. This is sometimes a tough decision. Although you MUST consider Medicare's interests, CMS approval is not mandated but is the only way to have full protection against a later action by Medicare for recovery. Also consider factors about how indemnity and medical benefits will be paid during approval process, which could take 9 months.

- If the settlement if for less than $25,000.00, CMS will not review the agreement to give its approval, but an MSA might still be required.
- If there is a very strong defense for denying the case, this should be well documented in the clincher and might provide a basis for not submitting to CMS for approval or reducing or eliminating the amount of any MSA if it is submitted for approval.
- **If the settlement amount is over $250,000 but the "reasonable expectation" trigger is not there,** still take a serious look at Medicare set-aside issues. For greater protection, consider adding language to the agreement stating the reasons why it is not necessary for Medicare's interests to be considered in that particular claim, and possibly add set-aside language in case CMS does look at the clincher.
- **If the claimant is not on Medicare and the settlement amount is less than $250K** (basically every other settlement agreement), consider adding language to the agreement stating the reasons why it is not necessary for Medicare's interests to be considered in that particular claim (Patel Memo). Although some claimant's attorneys may want to include a set-aside allocation, do not agree to hold the file open for submission to CMS for approval. If claimant's counsel wants to submit agreement for CMS approval, get I.C. approval and insist that claimant's counsel take care of the CMS submission so our file can be closed.

vi) Issues to consider during settlement negotiations

If the agreement will be submitted to CMS for approval, MAKE SURE the following issues are adequately decided at the time of claim settlement:

- **Does the Medicare Set-Aside allocation come out of the total settlement proceeds or it is in addition to the settlement proceeds?** Some carriers insist that the parties reach settlement on all issues except the MSA and the carrier will pay the MSA after CMS approval.
- **Will CMS approval be sought before or after I.C. approval of the clincher?** Since IC approval will be required before indemnity compensation can cease, it might be wise to seek IC approval first. However, if CMS increases the allocation, the agreement will need to be amended for re-consideration by the IC and issues need to be worked out about who bears the risk for the increased allocation.
- **If CMS requires a higher allocation than what was recommended or what the parties agreed to, who will be responsible for the additional allocation funds?** Will defendants add to the allocation, will it come out of plaintiff's portion of the settlement proceeds or will each party contribute equally?
- **How will indemnity compensation and/or medical compensation be paid while approval is pending?** Will compensation be subtracted from settlement proceeds or will defendants continue to pay as if claim is open until approval is granted? One option for cutting off indemnity after IC approval but while CMS approval is pending is to simply pay claimant a portion of the lump sum settlement but reserve the balance until approval is granted. That way, the claimant has money during the approval process but the parties are protected in a situation where the allocation is increased by CMS. Continuation of medical expenses is a more difficult issue and some creative solutions may need to be explored by the parties.

I. MISCELLANEOUS

1. Third Party Claims

If an employee is injured in the course of employment due to the actionable negligence of a third party, then the employee can seek recovery against that third party. In that case, under N.C. Gen. Stat. § 97-10.2, the employer/carrier would be entitled to a lien against any recovery ultimately obtained by the employee. In practical terms, however, the employer rarely recovers its full lien in such cases, because that same statute allows a civil judge to eliminate the lien if s/he believes that the recovery obtained by the employee against the third party is not sufficient to compensate the employee. N.C. Gen. Stat. § 97-10.2(j). The employer and insurer also have the right to pursue a claim against that third party, even if the employee does not do so but they can only exercise that right beginning one year after the accident occurred up until 60 days prior to the running of the statute of limitations on the third party claim. It is a good idea to try and reach some type of agreement on how the lien issue is going to be handled at the time a claim is clinchered.

2. Use of Private Investigators/Surveillance

Private investigators often provide wonderful evidence which is very valuable at a mediated settlement conference or hearing to prove defenses. Employers tend to use private investigators mainly for purposes of surveillance, to determine whether the employee is working or whether the employee is truly as physically disabled as s/he claims to be. Photos or video of an employee either working for money or performing yard work, washing a car, or shopping can be helpful and even can win a case in certain situations. However, private investigators are capable of performing a wide array of helpful functions. For example, investigators can take in-person recorded statements from the injured employee and witnesses; can perform criminal and civil background checks; run motor vehicle histories to determine where the employee has owned vehicles; perform background checks in those other states; interview neighbors and friends to determine an employee's history of making false claims or medical history; and determine an employee's education and work history.

One important fact to tell all investigators before hiring them is that they are not permitted to speak to the employee under any circumstances if the employee is represented by an attorney. For purposes of the North Carolina Revised Rules of Professional Conduct, the investigator is considered to be an agent of the employer. Therefore, just as the employer is not permitted to talk to the employee about his workers' compensation claim if the employee is represented by counsel, neither is the investigator. The I.C. often excludes otherwise valuable evidence if it is found that the evidence was obtained improperly, by communicating directly with a represented employee. Don't waste good time and money by sending out an investigator without those specific instructions.

3. Contact with Physicians/Obtaining Medical Records and Information

There are always questions about how much contact a claims examiner can have with the treating physician. Recognizing the need to facilitate the exchange of information, the legislature revised N.C.G.S. § 97-25.6 in 2011 to make it easier for defendants to obtain medical documentation and communicate with medical providers, while attempting to balance the claimant's right to some privacy for unrelated matters and preventing the improper disclosure of prejudicial information to the claimant's treating physician. In general, the information requested must be related to the employee's particular injury or disease, reasonably related to the injury or disease, or related to an assessment of the employee's ability to return to work as a result of the injury or disease. The overall process breaks down as follows:

First, the employer/carrier may request medical records directly from the healthcare provider. In a compensable case, where the employer and carrier are paying benefits, authorization from the employee is not necessary to obtain medical records. In a denied case, the employer and carrier must give contemporaneous notice to the employee when they are requesting these records. It is a good practice for employers and carriers to obtain medical records releases when possible, but, if they are unable to obtain one, or there is a delay in obtaining it, they are not precluded from requesting medical records from various medical providers. If the employer/carrier does not get the information they needed through a simple records request, the employer or carrier may write the healthcare provider with contemporaneous notice to the employee, or their attorney, and ask questions that are relevant to a longer list of issues than those that are covered by the Medical Status Questionnaire (see below for a link to this form). Employers and carriers can still use the Medical Status Questionnaire if they want to, but are no longer limited to it. In addition, the employer or carrier needs to provide a copy of any response to the employee within 10 business days of receipt by the employer.

Finally, if the employer or carrier cannot secure information by requesting medical records or sending a letter to the medical provider, then the employer or carrier can schedule a telephone conference with the doctor so long as the employee is allowed to participate in the conversation. If an employer or carrier wants to talk to a doctor, they must give the employee prior notice of the purpose of the intended oral communication and an opportunity for the employee to participate in the communication. The employer or carrier is required to provide the employee with a summary of the communication with the healthcare provider within 10 business days of any oral communication in which the employee did not participate.

In short, requesting medical records is fairly open, writing the doctor and requesting information is fairly easy, but talking to the doctor is somewhat more difficult.

In addition to the communication provisions outlined above, the employer or carrier will also be allowed to provide additional information to the healthcare provider that is not contained in the medical records (i.e., surveillance, prior medical records of which the doctor may not be aware, etc.). However, the employer or carrier must provide a copy of the communication and additional information/documentation to the employee or counsel 10 business days in advance of the transmittal to the doctor. The employee will then have a right to object and file a motion to prohibit the communication. If either party acts unreasonably by initiating or objecting to the communication, that party can be sanctioned. This deals with the normal situation where there is a surveillance report, medical records or some other information that is relevant to a doctor's evaluation and treatment of a claimant, but the doctor may not be aware of it or have access to that information. Under the prior rules, defendants were basically prohibited from providing that information to the healthcare provider. Under the new rules, defendants will be able to get that information to the doctor, but have to give prior notice to the other side. This new provisions apply to all claims, not just those that occur on or after June 24, 2011.

Lastly, an employer or carrier may still request medical records, bills and other non-substantive information, such as claimant's attendance at an evaluation, etc., by phone without notifying the employee. Employers and carriers need to be careful that any oral communication done in this way is limited to this non-substantive information. In most cases, it is understood that this communication will be with the physician's staff as opposed to the actual physician.

As noted above, the Commission has developed a set of questions, which can be found on the Commission's website, www.comp.state.nc.us/ncichome.htm that employers can use to communicate with an employee's treating physician. This Questionnaire is very limited in its scope and will probably not be used very often given the provisions that allow written communication, when copied to employee or counsel, with the physician.

4. Death Claims

If the employee dies as a result of an accident, within six years of the accident or occupational disease, or within two years of a final determination of disability, death benefits and burial/funeral expenses are payable. For claims arising on or after June 24, 2011, death benefits are paid for 500 weeks (400 weeks for claims arising before June 24, 2011) unless the employee's spouse is disabled or there are children under the age of the age of 18 years. Funeral expenses are paid up to $10,000 ($4,000 for claims arising before June 24, 2011.) If there are children under the age of 18, they receive benefits until they reach 18 or for the 500 weeks (400 weeks for claims arising prior to June 24, 2011), whichever is greater. If an employee does not have a spouse or children, then benefits are paid to the next of kin, with parents being the first in line. Benefits to next of kin are paid in a lump sum after being reduced to present value. N.C.G.S. § 97-40.

When an employee dies, the employer/carrier must make certain that all people who are entitled to receive benefits are identified. While death benefits can be paid on a Form 30, in order to fully protect their interests, an employer/carrier may want to have a dependency hearing and obtain an Opinion and Award from the I.C. that identifies the beneficiaries. In all death cases, the I.C. will want to see the employee's birth certificate and the employee's death certificate. Other documents that may be submitted are: a marriage license, birth certificates of any of the employee's children and tax returns. Even with a request for a dependency hearing, evidence can be submitted by Affidavit and Stipulation.