INTRODUCTION

PURPOSE

The workers’ compensation laws are complex, and vary a great deal from state to state. While it is difficult to maintain a command of the ever-changing laws in the fifty states, ALFA International Workers’ Compensation Practice Group has designed this Compendium to provide, in an easy to use format, a thorough overview of the workers’ compensation laws in each of the individual state jurisdictions in the United States, as well as selected others of potential interest.

GOALS

Employers at one time tended to view expense related to workers’ compensation as an aspect of “the cost of doing business” over which they had little or no control. Accordingly, the typical approach was to simply purchase the least expensive “first dollar” insurance policy available. Similarly, many insurers were apt to pay claims. As costs have continued to skyrocket, however, there has been an increasing awareness among employers of workers’ compensation, and a need for more sophisticated ways to limit exposure and costs.

The clear trend has been for companies to retain more of their risk, either by pure self-insurance or a “fronted” or retrospectively related (“retro”) approach. Employers have accordingly gained more control over the claim process. By exercising this control in an informed manner, many employers have been able to dramatically reduce the overall “bottom line” of related costs. Insurers have similarly become increasingly more sophisticated and aggressive in defending claims and reducing costs.

HOW TO USE THIS TEXT

We developed a questionnaire intended to cover, in an organized sequence, a broad range of topics and aspects of workers’ compensation law typically encountered. ALFA Member Law firms then prepared individual responses for each jurisdiction covered. It is suggested that the reader review and become familiar with the master questionnaire. Then, for any particular topic, the reader need only to turn to the same question in any individual response to obtain information on the issue in that jurisdiction.

In editing individual responses to the questionnaire, we have attempted to provide consistency in format and accuracy in content while maintaining the individual styles of the participating firms. The information and opinions remain those of the reporting firms. We have also generally attempted to make the responses technically correct (e.g. citations in accordance with “The Blue Book”), but have made some modifications in the interest of making the text more “user friendly.”
This text is the result of a tremendous amount of research, time and effort, and is intended to serve as a valuable source of information. It is not, however, intended to offer legal advice or counsel. Each claim must be analyzed based upon its particular facts and merits. If you wish to discuss any particular claim or issue, or require further assistance, feel free to call upon the ALFA law firm attorneys listed for each jurisdiction, to take advantage of their expertise. We welcome your comments and questions.

FIFTEENTH EDITION

The response to the first fourteen editions of this work has been gratifying, both in terms of volumes in use and the appreciative feedback from the readers. We have produced the fifteenth edition primarily to update the ever-changing workers’ compensation laws.

ACKNOWLEDGMENTS

Sincere thanks to the entire participating ALFA Member Law firms for donating their time and expertise. We also wish to thank our fellow partners for allowing us to devote so many of the firm’s resources to this project, as well as, ALFA Workers’ Compensation Steering Committee and ALFA staff, especially Aria Trombley Wolf, for their tireless efforts on behalf of this project.

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1. Citation for the state's workers' compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

All employees, other than domestic servants, farm laborers, casual employees, and those employed by employers of less than five employees, are covered. Also, licensed real estate agents operating under licensed brokers and product demonstrators are not considered employees. Ala. Code §25-5-50 (1975).

3. Identify and describe any "statutory employer" provision.

There is no such provision. An "employer" is defined as "[e]very person who employs another to perform a service for hire and pays wages directly to the person." Ala. Code §25-5-1 (4).

4. What types of injuries are covered and what is the standard of proof for each:

   A. Traumatic or "single occurrence" claims.

   Compensation is paid to an employee for injuries caused by an accident arising out of and in the course of the employment, without regard to any question of negligence. Ala. Code §25-5-51. The employee must prove his or her claim by a preponderance of evidence. Ala. Code §25-5-81(c). Even carpal tunnel, if the result of a one-time accident, can be shown by a preponderance of the evidence, rather than clear and convincing evidence. Ex parte USX Corp., 881 So.2d 437 (Ala. 2003).\(^1\)

   B. Occupational disease (including respiratory and repetitive use).

   Diseases arising out of and in the course of employment and due to hazards in excess of those ordinarily incident to employment in general are compensable. The disease must be caused by a hazard peculiar to the occupation and result directly from exposure, over a period of time, to the normal working conditions of the occupation. Ala. Code §25-5-51.

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\(^1\) But see, Millry Mill Co. v. Manuel, 999 So.2d 508 (Ala.Civ.App. Mar 07, 2008) (indicating that the appropriate standard for gradual deterioration or cumulative stress carpal tunnel syndrome cases is clear and convincing evidence)
110. The employee must prove his or her claim by a preponderance of evidence, except claims involving gradual deterioration or cumulative physical stress disorders which must be proven by clear and convincing evidence. Ala. Code §25-5-81(c); *Williams v. Union Yarn Mills, Inc.*, 709 So.2d 71 (Ala. Civ. App. 1998).

5. **What, if any, injuries or claims are excluded?**


6. **What psychiatric claims or treatments are compensable?**

The term "injury" does not include a mental disorder or injury that has neither been produced nor proximately caused by some physical injury to the body. Ala. Code §25-5-1(9) (1992 Supp.). Attempts to recover compensation benefits for “occupational stress disorder” as an occupational disease have been denied by the Alabama Court of Appeals when there is no physical injury. *Herchenhahn v. Amoco Chemical Co.*, 688 So.2d 847 (Ala. Civ. App. 1997).

However, if an employee’s mental disorder originates from both physical and emotional factors, it is compensable. See, *Ex Parte Vongsouvah*, 795 So.2d 625 (Ala. 2000).

7. **What are the applicable statutes of limitations?**

The statute of limitations for accident and occupational disease cases is two years from the date of the accident or two years from the date of last payment of compensation (not medical) benefits. Ala. Code §§25-5-80, 25-5-117 (1992 Supp.). (Note the latter is the occupational disease statute and time runs from the date of last exposure.)

For “cumulative trauma injuries,” the two year statute of limitations runs two years from the date of the last exposure (i.e. carpal tunnel syndrome). *Dun & Bradstreet Corp. v. Jones*, 678 So.2d 181 (Ala.Civ.App.1996).

For death claims, the statute is two years from the date of death, but in no event may a claim be filed if the death occurs more than three years from the date of the accident. Ala. Code §25-5-80 (1992 Supp.).

8. **What are the reporting and notice requirements for those alleging an injury?**

Although the statute requires written notice, case authority allows actual notice to suffice.

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2 Likewise, injuries caused by the willful misconduct of the employee, including refusal or failure to use safety devices provided by the employer, or by accident due to intoxication or illegal drug use are also excluded. Ala. Code §25-5-51 (1992 Supp.).
Notice must be within five days or the employee loses the right to benefits until actual notice is received. If notice is not provided within 90 days, there is an absolute bar to compensation. Ala. Code §25-5-78 (1992 Supp.).

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.


B. Willful misconduct, "horseplay," etc.


The employer bears the burden of proof for establishing misconduct. Ala Code §25-5-36.

C. Injuries involving drugs and/or alcohol.

Under the Act an employer is not required to pay compensation for an injury or death caused by willful misconduct. Ala. Code §25-5-51. (The provision specifically addresses intoxication from alcohol and illegal drugs). The employer, however, must prove that the impairment (from drugs or alcohol) was the cause of the injury. Ross v. Ellard Construction Co., Inc., 686 So.2d 1190 (Ala. 1996).

10. What, if any, penalties or remedies are available in claims involving fraud?

Case law has established that an employee may have a claim against his or her employer for fraudulent misrepresentations that relate to a workers' compensation claim. The Alabama Supreme Court has held that if such a claim is supported by "clear and convincing proof," a claim for fraud will not be barred by the exclusivity provision of the Act. Lowman v. Piedmont Executive Shirt Mfg. Co., 547 So.2d 90 (Ala. 1989). Legislation effective August 1, 1992 makes it a felony for an employee to make a false or fraudulent material statement or misrepresentation for the purpose of obtaining workers' compensation benefits.
11. Is there any defense for falsification of employment records regarding medical history?

Ala. Code §25-5-51 allows such a defense. For an employer to successfully defend a claim on that basis it must prove (1) that the employee knowingly and willingly made a false representation about his condition; (2) that the employer relied upon the false representation and his reliance is a substantial factor in the hiring of the employee; and (3) that there is a causal connection between the false representation and the injury. *B.E. & K v. Weaver*, 801 So. 2d 12 (Ala. Civ. App. 2000). Additionally, to deny compensation based upon misrepresentations regarding physical or medical history at the time an employer makes an unconditional offer of employment the employer must provide a written warning in bold type print stating, ”Misrepresentations as to preexisting physical or mental conditions may void your workers' compensation benefits”. Ala. Code § 25-5-51 (1992).

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Although there are no direct cases on point, the groundwork is laid for arguments that employer sponsored social activities can give rise to compensable events. The Alabama Supreme Court set forth the following standards in considering whether an employee can recover for an injury sustained while attending a party given by his employer: (1) whether the activity is customary; (2) whether the employer subsidized or encouraged the activity; (3) the extent to which the employer directs the activity; (4) the presence of pressure or compulsion upon the employee to attend and participate; or (5) whether the employer expects to receive a benefit from the employee’s participation in the activity. *Anderson v. Custom Caterers, Inc.*, 185 So.2d 383 (Ala. 1966); *Board of Managers of the City of Birmingham Retirement and Relief System v. Elliott*, 532 So. 2d 1019 (Ala. Civ. App. 1988); compare *St. Paul Insurance Co. v. Harris*, 758 F. 2d 1450 (11th Cir. 1985).

Ironically, no good deed goes unpunished. When an employer gave his employee a Christmas ham, the injury she suffered when picking up the ham was compensable. *Moesch v. Baldwin County Electric Membership Corporation*, 479 So.2d 1271 (Ala. 1985).

13. Are injuries by co-employees compensable?

An employer will usually have liability for an injury to an employee if it is the result of an action by a co-employee (for limited exceptions involving personal ill will see section 14). However, the injured employee may also pursue a claim against a co-employee who “intentionally” causes the injury. Ala. Code § 25-5-11 (1992 Supp.). One scenario, which has produced considerable litigation, occurs where the co-employee removes a safety guard. Ala. Code §25-5-11 (1992 Supp.); *see also, Moore v. Reeves*, 589 So.2d 173 (Ala. 1991).
14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?

"Injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of reasons personal to him or her and not directed against him or her as an employee or because of his or her employment." Ala. Code §25-5-1(9) (1992 Supp.). However, if circumstances of the assault arise out of the employment, the assault is compensable. Beverly v. Ruths Chris Steak House, 682 So.2d 1360 (Ala. Civ. App. 1996).

**BENEFITS**

15. What criterion is used for calculating the average weekly wage?

A 52 week wage history is used to calculate the average weekly wage. If that information is unavailable, the employer may substitute a 52 week wage statement of a "similarly situated" employee. Ala. Code §25-5-57 (1992 Supp.). Average weekly wage should include the employer-paid portion of health, life, and disability insurance premiums unless the same continue to be made available to the employee during compensable lost time. Ala. Code §25-5-1(6).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

The rate is two-thirds of the average weekly wage, subject to certain maximum and minimum amounts. The Alabama legislature publishes new maximums and minimums every July 1st. For injuries occurring between July 1, 2013 and July 1, 2014, the maximum is $788.00 per week and the minimum is $217.00 per week. If at the time of injury the employee received average weekly earnings of less than the minimum, then he or she shall receive the full amount of the average weekly earnings per week. Ala. Code §25-5-57(a)(1).

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

Unless good cause can be demonstrated, any installment of compensation must be paid within 30 days after it becomes due or a 15% penalty shall be paid in addition to the installment. Ala. Code §25-5-59(b).

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out 21 days before recovering benefits for the first 3 days)?

Compensation is not payable for the first three days of disability. However, if the employee is out longer than 21 days, compensation is payable for the first three days. Ala. Code §25-5-59.
19. **What is the standard/procedure for terminating temporary benefits?**


20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

The number of temporary total disability weeks is credited towards the calculation of a "body as a whole" permanent partial disability award. However, no credit is received for temporary total disability weeks paid in the calculation of the number of weeks due for a scheduled member injury. Injuries to the back, shoulder, head, etc. are not deemed scheduled injuries, and calculation of benefits due depends upon loss of ability to earn. Ala. Code §25-5-57(a)(3) (1992 Supp.).

21. **What disfigurement benefits are available and how are they calculated?**

Case authority requires that the disfigurement result in a loss of “employability” before permanent compensation may be awarded. *Flowers Speciality Foods of Montgomery, Inc. v. Glenn*, 718 So.2d 1137 (Ala. Civ. App. 1998). The applicable code section is §25-5-57(a)(3)(a.)(34.). The loss can not exceed 100 weeks.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

   **A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

The maximum number of weeks for each scheduled member are as follows:

<table>
<thead>
<tr>
<th>Bodily Parts</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>thumb</td>
<td>62</td>
</tr>
<tr>
<td>first (index) finger</td>
<td>43</td>
</tr>
<tr>
<td>second finger</td>
<td>31</td>
</tr>
<tr>
<td>third finger</td>
<td>22</td>
</tr>
<tr>
<td>fourth finger</td>
<td>16</td>
</tr>
<tr>
<td>first phalange of thumb or finger</td>
<td>½ thumb or finger</td>
</tr>
<tr>
<td>two or more phalanges</td>
<td>entire thumb or finger (but if more than one finger involved maximum is the amount for a hand)</td>
</tr>
<tr>
<td>great toe</td>
<td>32</td>
</tr>
</tbody>
</table>
toes other than great toe &emsp; 11
first phalange of any toe &emsp; ½ toe
two or more phalanges &emsp; entire toe
Hand (includes amputation
   between elbow and wrist) &emsp; 170
arm &emsp; 222
foot (includes amputation
   between knee and ankle) &emsp; 139
leg &emsp; 200
eye &emsp; 124
complete and permanent
hearing loss:
both ears &emsp; 163
one ear &emsp; 53
eye and a leg &emsp; 350
eye and an arm &emsp; 350
eye and a hand &emsp; 325
eye and a foot &emsp; 300
two arms (other than
at shoulder) &emsp; 400
two hands &emsp; 400
two legs &emsp; 400
two feet &emsp; 400
One arm and the other hand &emsp; 400
one hand and one foot &emsp; 400
one leg and the other foot &emsp; 400
one hand and one leg &emsp; 400
one arm and one foot &emsp; 400
one arm and one leg &emsp; 400

These numbers are not off-set by the number of weeks of temporary total disability benefits due. Weekly rates are calculated based upon two-thirds of the average weekly wage. The max compensation payable for permanent partial disability shall be no more than the lesser of $220.00 per week or 100% of the average weekly wage. Ala. Code §§25-5-57(3) and 25-5-68(b) (1992 Supp.).

B. Number of weeks for "whole person" and standard for recovery.

Up to 300 weeks are available for permanent partial disability (less than 100% disability). The compensation shall be 66 2/3 percent of the difference between the average weekly earnings of the worker at the time of the injury and the average weekly earnings he or she is able to earn in his or her partially disabled condition, subject to the maximum weekly compensation. If a permanent partial disability follows a period of temporary total disability resulting from the same injury, the number of weeks of the temporary total disability shall be deducted from the number of weeks payable for the permanent partial disability. Ala. Code §25-5-57(a)(3)g (1992 Supp.).
Under amendments made to the Act in 1992, if an employee returns to work making a wage equal to or greater than his pre-injury wage, the employee shall not be entitled to compensation based on vocational disability. Instead, the Court will award the employee compensation based on a physical impairment rating. Ala. Code §25-5-57(a)(3)(i). Under the provision, if the employee should lose his job within 300 weeks of the injury (except for specified reasons) he can petition the Court within 2 years thereof to reconsider his permanent partial disability rating.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

The employee is required to accept vocational retraining if requested by the employer. The employer is required to provide vocational retraining if suggested in writing by the treating physician and a vocational specialist. Ala. Code §25-5-77(c) (1992 Supp.).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Calculation of benefits is based upon two-thirds of the average weekly earnings, subject to maximum and minimum amounts. For injuries occurring between July 1, 2015 and July 1, 2016, the maximum rate is $832.00. The minimum rate during the same time period is $229.00, unless the average weekly wage is less than the minimum, which would require use of the average weekly wage.

25. **How are death benefits calculated, including the minimum and maximum rates?**

   A. **Funeral expenses.**

   The burial allowance is $3,000.00. Ala. Code §25-5-67 (1992 Supp.).

   B. **Dependency claims.**

   If there are no dependents, the estate is entitled to a one time $7,500.00 lump sum payment. Ala. Code §25-5-60(1)g (1992 Supp.). If there is one dependent, benefits are payable to that dependent based upon 50% of the employee's average weekly wage. If there are two or more dependents, benefits are payable at two-thirds of the average weekly earnings (subject to maximum and minimum tables) for the period of dependency up to 500 weeks. Ala. Code §25-5-60(1) (1992 Supp.).

26. **What are the criteria for establishing a "second injury" fund recovery?**

   Alabama no longer has a Second Injury Trust Fund.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**
A claim may not be re-opened because of a worsened condition if settlement has been approved by a judge. A Trial Judge can not reserve the issue of extent of disability in his decree. *Ex parte Kimberly-Clark Corporation*, 779 So.2d 178 (Ala. 2000). Settlements may be set aside for fraud, undue influence, or coercion, provided application is made therefor within six months of the settlement. Ala. Code §25-5-56 (1992 Supp.). An employer may petition a judge to set aside an award of permanent total disability if, as the result of physical or vocational rehabilitation, or otherwise, the employee is able to obtain gainful employment. Ala. Code §25-5-57(a)(4)h (1992 Supp.).

Under the return to work provision, Ala. Code § 25-5-57(a)(3)(i), if the employee has settled his claim based on a physical impairment, and then loses his job (except for certain specified reasons) he or she can then petition the court within two years thereof for reconsideration of his or her permanent partial disability rating (within 300 weeks from the injury).

### 28. What situation would place responsibility on the employer to pay an employee's attorney’s fees?

The statute precludes a plaintiff’s attorney’s fee without approval of the judge. Ala. Code § 25-5-90. Attorney’s fees, by statute, come out of the amount awarded to the employee. The attorney’s fee is limited to 15% of the compensation award. The attorney’s fees can be awarded in a lump sum but the amount is deducted from the employee’s benefits and calculated in accordance with Ala. Code § 25-5-83. *Ex parte St. Regis Corp*, 535 So.2d 160 (Ala. 1988).


### EXCLUSIVITY/TORT IMMUNITY

#### 29. Is the compensation remedy exclusive?

##### A. Scope of immunity.

The exclusive remedy provision is statutory. Ala. Code §25-5-53 (1992 Supp.). One interesting recent case from the Court of Civil Appeals held that when an employee was involved in an altercation with a co-worker at the time she was fired, the employee’s exclusive remedy is under the Workers’ Compensation Act. *Cook v. AFC Enterprises, Inc.*, 826 So.2d 174 (Ala. Civ. App. 2002). However, there are exceptions.

##### B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

The exclusive remedy provision may not protect the employer/insurer from the following claims: (1) intentional fraud, *Lowman v. Piedmont Executive Shirt Manufacturing Co.*,

30. **Are there any penalties against the employer for unsafe working conditions?**

Statutory duty to provide a safe workplace is imposed upon the one who has control or custody of the employment or place of employment. Ala. Code § 25-1-1(a) (1975); *Procter & Gamble Co. v. Staples*, 551 So. 2d 949 (Ala. 1989). Claims against employers for failing to provide a safe workplace should be barred by the exclusivity provision of the Workers' Compensation Act. Under rare circumstances, co-employees may be subject to direct action for willful and intentional violation of a specific written safety rule. Ala. Code §25-5-11(c)(4) (1992 Supp.). The state is required to assist an employer in developing a safety program. Ala. Code §25-5-15.1(c)(4) (1992 Supp.).

31. **What is the penalty, if any, for an injured minor?**

If the minor was employed in violation of law, the penalty is compensation of twice the ordinary amount. Ala. Code §25-5-34 (1992 Supp.).

32. **What is the potential exposure for "bad faith" claims handling?**

There is no cause of action for "bad faith" handling of claims. *Farley v. CNA Insurance Co.*, 576 So.2d 158 (Ala. 1991). Where the employer/insurer has some ulterior motive for denying benefits, however, a cause of action for "outrageous conduct" might exist. In the past the Alabama Supreme Court has affirmed a jury verdict for outrageous conduct arising out of the workers' compensation environment. *Continental Casualty Ins. Co. v. McDonald*, 567 So.2d 1208 (Ala. 1990) (insurer held liable for intentional infliction of emotional distress for purposefully withholding benefits in an attempt to coerce acceptance of a small lump sum settlement). See also *Travelers Indemnity Co. of Illinois v. Griner*, 809 So.2d 808 (Ala. 2001);

33. **What is the exposure for terminating an employee who has been injured?**

Termination because of the claim may entitle the employee to a jury trial with compensatory and punitive damages. Ala. Code §25-5-11.1. Case law from the Alabama Supreme Court has clarified the *prima facie* case in retaliatory discharge cases and held that there are five prongs to a *prima facie* case including:

(1) Proof of an employment relationship;
(2) An on-the-job injury;
(3) Notice to the employer of the on-the-job injury;
(4) Subsequent termination of the employment; and
(5) Proof of a causal relationship between the workers’ compensation claim and the subsequent discharge.


**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

   Yes. Cases must be brought through the procedures under Ala. Code §25-5-11 (1992 Supp.).

35. **Can co-employees be sued for work-related injuries?**

   Co-employees may be subject to claims for willful conduct (requires intent to injure) and removal of a safety guard. Ala. Code § 25-5-11. *See also Moore v. Reeves*, 589 So.2d 173 (Ala. 1991).

36. **Is subrogation available?**


**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

   An employee can make claims for medical benefits even if a claim was not filed within the typical two-year statute of limitations period. *Ex Parte Tuscaloosa County*, 522 So.2d 782 (Ala. 1988). Under the 1992 amendments, all undisputed medical bills must be paid within 25 working days of receipt of claims or a 10% penalty can be imposed. Ala. Code §25-5-77(h) (Supp. 1992).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

   Alabama adjudicates workers' compensation claims in the state judicial system applicable to all civil and criminal actions. Medical information and records may therefore be obtained by ordinary discovery methods. Alternatively, a statutory provision allows
either party to obtain the employee's medical records without notice to opposing party. Ala. Code §25-5-77(b). Medical records can be introduced at trial without a deposition using a statutory procedure for authenticating the records. Ala. Code §25-5-81(f)(4).

39. **What is the rule on (a) Claimant’s choice of a physician; and (b) Employer’s right to second opinion and/or Independent Medical Examination?**

   **A. Claimant’s choice of a physician.**

   The employer has the right to select the initial treating physician. If the employee is dissatisfied with the initial treating physician selected by the employer and if further treatment is required, the employee can select a physician from a panel or list of four physicians selected by the employer. Ala. Code §25-5-77(a).

   **B. Employer’s right to second opinion and/or Independent Medical Examination.**

   The employee must submit to examination by the employer’s physician at all reasonable times. The employee has the right to have his or her own doctor present at the examination. Ala. Code §25-5-77(b).

   The Court may also appoint a neutral physician to examine the employee who will report his findings to the Court. Ala. Code §25-5-77(b).

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**


41. **Which prosthetic devices are covered, and for how long?**


42. **Are vehicle and/or home modifications covered as medical expenses?**

   There are few cases on point, but the general thought is that such expenses will be covered if they are deemed reasonable and necessary. *See Continental Casualty Ins. Co. v. McDonald*, 567 So. 2d 1208 (Ala. 1990). The statute does not require employers to purchase vehicles such as a specially retrofitted van. *Ex Parte City of Guntersville*, 728 So.2d 611 (Ala. 1998). (declining to address the issue of whether an employer would be required to modify a vehicle for an injured employee).
43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**


44. **What, if any, provisions or requirements are there for "managed care"?**

None.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

A petition for determination of a disputed claim may be filed by either party in the circuit which would have had jurisdiction over the parties in a tort claim. Typically, this is the county where the accident occurred or the county where the employee lives if the employer does business in that county. Ala. Code § 25-5-81.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

An Ombudsman may be used by either party, but both parties must agree to utilization of the ombudsman unless the Court orders the parties to mediate. Ombudsmen do not create a record and serve only to mediate claims. Ala. Code §25-5-290 *et seq.* (1992 Supp.). This mediation option offers significant opportunity for reduction of legal expenses.

B. **Trial court.**

Alabama provides for initial adjudication of workers' compensation disputes by circuit court judges. These are the same judges that preside over typical civil and criminal matters. Standard rules of evidence and procedure apply in workers' compensation cases, except for levels of proof required (either preponderance of evidence or clear and convincing proof, the latter for repetitive motion claims) and a provision allowing medical records to be introduced without the testimony of the treating physician. Ala. Code §25-5-81 (f)(4) (1992 Supp.).

C. **Appellate.**

Appeal is to the Alabama Court of Civil Appeals. Writ of Certiorari to the Alabama Supreme Court may be sought after an appellant loses at the Court of Civil Appeals. There is no presumption of correctness at the Court of Civil Appeals but decisions may
not be reversed if the trial court’s decision is supported by substantial evidence. Ala. Code §25-5-81(e) (1992 Supp.).

47. **What are the requirements for stipulations or settlements?**


48. **Are full and final settlements with closed medicals available?**

Full and final settlements are available. The 1992 amendments specifically entitle parties to settle matters involving medical payments and rehabilitation. A trial court must still determine that the settlement is in the best interest of the employee. Ala. Code §25-5-56 (1992 Supp.).

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Settlements can be approved by the Circuit Court or by an Ombudsman in a Benefits Review Conference.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

There is no current state fund. There is an assigned risk pool administered by the National Council of Compensation Insurance (NCCI). There are a number of active group funds.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

An applicant must have a net worth of $5.0 million and a current ratio of 1.0 or better. The employer must provide audited or certified financial reports for the prior three years of operation. There must be a positive net income history as shown on the audit and financial statements. The employer must provide a copy of the company’s annual report, or statement of assets and liabilities to the Department at the close of each fiscal year, as evidence of continued financial ability to self-insure its liability under said Law. There is a $500 application fee.

B. **For groups or "pools" of private entities.**

Such groups are allowed. Contact the Department of Industrial Relations for a copy of
52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

There are no cases on point. Under the statute, the term employee specifically includes aliens, although there is no reference to whether these workers are employed legally or not. In all likelihood, these workers would be covered under the Act since it recognizes aliens and the Act allows double recovery for minors who are not legally employed. Ala. Code §25-5-1. However, please recall that the Act does not cover domestic servants, farm laborers, casual employees, and those employed by employers of less than five employees. Ala. Code §25-5-50 (1975).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No specific state requirements that must be satisfied are known. Generally, under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical bills for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee agrees to close out medical benefits and meets the following criteria:

- the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC '1395)

55. How are subrogation liens of Medicaid and health insurers treated under workers’
compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. ' 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. ' 1396k(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). Therefore, your current practice of obtaining medical records could proceed under state law.

In Alabama to obtain medical records through subpoena one must file a notice of intent fifteen days before the subpoena can be issued. This notice may be sufficient to provide notice to the patient that Protected Health Information is being sought. Ala. Civ. Proc. R. 45.

57. **What are the provisions for “Independent Contractors”?”**

Alabama courts have established that the general test to ascertain whether a worker is an employee or an independent contractor for workers compensation purposes is: whether the person to whom the worker provides services has reserved the right to control the manner in which those services are performed. *Gordon v. West Weaver Baptist Church*, 777 So.2d 734 (Ala. Civ. App. 2000). Alabama courts have stated that an employment relationship may be inferred from four basic factors: (1) direct evidence which demonstrates a right or exercise of control, (2) the method by which the individual receives payment for his or her services, (3) whether equipment is furnished or not, and (4) whether the individual has the right to terminate. *Hooker Const., Inc. v. Walker*, 825 So.2d 838 (Ala. Civ.App. 2001).

The language that used to be in 25-5-50(h) was deleted as of August 1, 2008. This language provided employers engaged in the business of residential construction the option of option out of workers’ compensation provisions. 25-5-50(a) now states that:

(a) This article and Article 2 of this chapter shall not be construed or held to apply to…an employer who regularly employs less than five employees in any one business, other than the business of constructing or assisting on-site in the construction of new single-family, detached residential
dwellings

Essentially, an employer who regularly employs less than five employees in the business of constructing or assisting on-site in the construction of single-family, detached residential dwellings no longer has an option to opt for exemption from coverage as of August 1, 2008.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific provisions. However, under case law such workers may be either classified as loaned workers or joint employees depending upon the facts of the case.

When a general employer loans an employee to a special employer, the special employer becomes an employer only if: (1) the employee has made a contract of hire, express or implied, with the special employer; (2) the work being done is essentially that of the special employer; and (3) the special employer has the right to control the details of the work. Alabama courts recognize that if the above three conditions are met, the special employer may become liable for compensation in the event of a work-related injury. *Rast Const., Inc. v. Peters*, 689 So.2d 781 (Ala. 1996); *Ex parte Stewart*, 518 So.2d 118 (Ala. 1987).

Whereas, joint employment occurs most commonly when an employee’s services are leased or sold to another employer by the employee’s original employer and the original employer retains some control over the work performed. Some examples of joint employment are: (1) a truck driver leased to a common carrier by a trucking company, and (2) an employee of a labor broker who is assigned to work for a special employer. *Craig v. Decatur Petroleum Haulers*, Inc, 340 So.2d 1127 (Ala. Civ. App. 1976); *Rhodes v. Alabama Power Co.*, 599 So. 2d 27 (Ala. 1992). In a joint employment relationship, both employers become liable for compensation. The allocation of liability for joint employers has been specifically addressed in Ala. Code § 25-5-76 which appears to provide for apportionment of compensation awards between joint employers based on each employer’s contribution to the employee’s wages, unless the employers have contractually agreed otherwise. However, the statute has never been construed. Case law has only shown courts finding joint employers jointly and severally liable for compensation. *Domino’s Pizza, Inc. v. Casey*, 611 So. 2d 377 (Ala. Civ. App. 1992); *Street v. North Alabama Conf. For United Methodist Church*, 753 So. 2d 1169 (Ala. Civ. App. 1999).

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Ala. Code § 25-5-1(4) states, “In no event shall a common carrier by motor vehicle operating pursuant to a certificate of public convenience and necessity be deemed the “employer” of a leased-operator or owner-operator of a motor vehicle or vehicles under
contract to the common carrier.” Thus, where common carriers enter into contracts with owners of motor vehicles for the use of those vehicles, the common carrier is not the employer of the leased-operator or owner-operator. Alaplex Transp., Inc. v. Rossen, 836 So.2d 901 (Ala. Civ. App. 2002) (driver injured while operating a truck leased by a common carrier from an owner-operator could not recover benefits under the Act from the common carrier because the legislature "chose ... to maintain the immunity afforded under the Act to common carriers in one particular situation, i.e., where common carriers have entered into contracts with owners of motor vehicles for the use of those vehicles" (emphasis added)). Compare Liberty Mutual Insurance Co. v. D & G Trucking, Inc., 966 So.2d 266 (Ala. Civ. App. 2006).

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized Best Practices plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.
1. Citation for the state's workers' compensation statute.

AS §23.30.005, et. seq.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

An employee is a person employed by the State or its political subdivision or a person employing one or more persons in connection with a business or industry coming within the scope of the chapter and carried on in Alaska. Executive officers and sole proprietors may opt out. Part-time babysitters, cleaning persons, harvest and similar transient help, contract entertainers, statutorily-defined taxi cab drivers and statutorily defined commercial fishermen are also not employees. AS §§23.30.395(12), (13); AS §23.30.230.

3. Identify and describe any "statutory employer" provision.

If the employer is a subcontractor, the principal contractor is liable for and shall secure the payment of compensation to the employees of the subcontractor unless the subcontractor secures the payment. This is referred to as the "contractor under" provision. AS §23.30.045(a).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

All accidental injuries or death arising out of and in the course of employment are covered, if the injury or disability would not have occurred but for the employment, and reasonable persons would conclude that the employment is a substantial factor in the injury or disability. Substantial factor means that reasonable persons would consider it to be significant and attach responsibility to it. Once a preliminary link is established between the employment and the injury or disability, there is a rebuttable presumption of compensability of the claim, and the employer must introduce substantial evidence to rebut that presumption. Once that has been introduced, the employee must prove his or her case by a preponderance of the evidence. The factual decisions of the Alaska Workers' Compensation Board are reviewed on a substantial evidence basis. "Injury" includes breakage or damage to eyeglasses, hearing aids, dentures, or any prosthetic devices which function as part of the body and also includes an injury caused by the willful act of a third person directed against an employee because of the employment. AS §23.30.395(17); Osborne Const. Co. v. Jordan, 904 P.2d 386 (Alaska 1995).

B. Occupational disease (including respiratory and repetitive use).

Occupational diseases or infections which arise naturally out of the employment or unavoidably result from an accidental injury are subject to the same proof requirements referred to above. If a disease is caused by conditions of the employment and these
conditions carry with them a risk of incurring the disease greater than that which prevails in employment and living conditions in general, then it is an occupational disease within the scope of the Act. AS §23.30.395(17).

5. **What, if any, injuries or claims are excluded?**

A compensable injury does not include mental injury caused by mental stress unless it is established that the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment and the work stress was the predominant cause of the mental injury. Furthermore, a mental injury is measured by actual events and is not considered to arise out of and in the course of the employment if it results from a disciplinary action, work evaluation, layoff, demotion, termination, job transfer or similar action taken in good faith by the employer. Also, injuries caused by an employee's willful intent to injure or kill any person, or caused by the intoxication of the employee, are not compensable. AS §23.30.395(17); §23.30.235.

6. **What psychiatric claims or treatments are compensable?**

See answer 5.

7. **What are the applicable statutes of limitations?**

The right to compensation is barred unless a claim is filed within two years after the employee has knowledge of the nature of the disability and its causal relationship to the employment. The maximum time for filing a claim, other than those involving an occupational disease, is four years from the date of injury. The right to compensation for death is barred unless a claim is filed within one year after the death. However, if compensation payment has been made without an award, a claim may be filed within two years of the last payment of compensation. AS §§23.30.180, 23.30.185, 23.30.190, 23.30.215. In cases involving latent defects causing compensable disability, an injured employee has a right to file a claim, as determined by the Board, time limits notwithstanding. AS §23.30.105(a).

Failure to file a claim within the prescribed limitations period is not a bar to compensation unless objection to the failure is made at the first hearing of the claim in which all parties of interest are given reasonable notice and opportunity to be heard. AS §23.30.105(b). The limitation periods are stayed during any period a person is mentally incompetent or a minor and no guardian or other authorized representative has been appointed. AS §23.30.105(c). Once a guardian or other representative is appointed the statute of limitations are applicable. In the case of a minor, if a guardian is appointed before the person becomes of age, the limitation period is applicable from the date the minor comes of age. AS §23.30.105(c).

If an employer brings a suit at law or in admiralty to recover damages with respect to injury or death, and that recovery is denied on the ground that the person was an employee and that the defendant is an employer within the meaning of the Worker’s Compensation Statute and the employer has secured compensation to the employee under this statute, the limitation period of the Worker’s Compensation statute begins to run only from the date of termination of any such suit. AS §23.30.105(d).

8. **What are the reporting and notice requirements for those alleging an injury?**
Notice of an injury or death must be given to the Board and to the employer within thirty days after the date of injury or death. Failure to give notice does not bar a claim if the employer, an agent of the employer in charge of the business in the place where the injury occurred, or the insurance carrier had knowledge of the injury or death, and the Board determines the employer or carrier has not been prejudiced by failure to give notice. In addition the Board may excuse the failure on the ground that for some satisfactory reason notice could not be given. A defense based upon failure to provide timely notice is waived unless it is raised before the Board at the first hearing of a claim for compensation in respect to the injury or death. AS §23.30.100(a) and (d).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

   A claim is barred if the injury is the result of the employee's willful intent to injure or kill himself or herself. AS §23.30.235; *Walt's Sheet Metal v. Debler*, 826 P.2d 333 (Alaska 1992).

   B. **Willful misconduct, "horseplay," etc.**

   See answer 9A.

   C. **Injuries involving drugs and/or alcohol.**

   A claim is barred if the injury was caused by the intoxication or being under the influence of drugs, unless the drugs were prescribed by the employee's physician. AS §23.30.235.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    There are criminal penalties for theft by deception for any person who willfully makes a false or misleading statement to obtain, or deny, workers' compensation benefits. AS §23.30.250.

11. **Is there any defense for falsification of employment records regarding medical history?**

    Yes. An employee who knowingly makes a false statement as to his or her physical condition on an employment or pre-employment questionnaire may not receive workers' compensation benefits if: (1) the employer relied upon the false representation; (2) this was a substantial factor in the hiring; and (3) there is a causal connection between the false representation and the injury. AS §23.30.022.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

    If the employee's work is at a remote site, the answer is clearly yes. If the employee's work is not at a remote site, then the answer is maybe, depending upon whether the recreational or other non-work activities are of a substantial benefit to the employer or if the injury occurred at an employer-sanctioned or employer-provided facility. This is a fact-specific question. *LeSuer-Johnson v. Rollins Burdick Hunter of Alaska*, 808 P.2d 266 (Alaska 1991); *Anderson v. Employer's Liability Assurance Corp.*, 498 P.2d 288 (Alaska 1972).
13. **Are injuries by co-employees compensable?**

Yes. AS §§23.30.015(a); 23.30.055.

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**

The liability of an employer for medical treatment is not affected by the fact that the employee was injured through the fault or negligence of a third party not in the same employee, unless the employee provides the employer with notice of election to sue the third party or a suit has been brought against the third party without giving notice to the employer. In addition, the employer has a cause of action against the third party to recover any amount paid by the employer for the medical treatment. The employee need not elect whether to receive compensation or to recover damages from the third party. Acceptance of Worker’s Compensation operates as an assignment to the employer of all rights of the person entitled to the compensation to recover damages from the third person unless the employee commences an action against the third person within one year after the compensation award. An employer under an assignment may either institute proceedings for recovery of damages or may compromise with any liable third person. The amounts recovered by an employer under assignment are subject to statutorily prescribed distribution. AS §§23.30.015 and 23.30.050.

Injuries which arise out of and in the course of employment, i.e., of which the employment is a substantial factor and but for the employment would not have occurred, are compensable. In Alaska, “work relatedness” and compensability are presumed. AS 23.30.120. The employee will prevail on such claims, unless the employer can introduce substantial evidence to rebut the presumption by establishing another, non-work, cause for the injury, or effectively ruling out all probabilities that the injury is work-related. Therefore, "irate paramour" injuries may or may not be work-related and compensable.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage or, in Alaska, the spendable weekly wage, is the employee's gross weekly earnings minus payroll tax deductions. Gross weekly earnings are calculated under AS §23.30.220, which provides for different payment formulas (e.g. an employee paid weekly would receive gross weekly earnings, while an employee paid monthly would receive monthly earnings multiplied by 12, then divided by 52).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The maximum compensation rate is 120% of the average weekly wage, as calculated by the Commissioner applicable on the date of injury of the employee. A Commissioner shall determine the average weekly rate by December 1, of each year, by dividing the average annual wage in Alaska for the preceding calendar year by 52. The resulting figure is the average weekly wage in Alaska applicable for the period beginning January 1, and ending December 31, of the following calendar year. The Alaska average weekly wage and minimum/maximum compensation rates for each calendar year are published in a bulletin generated by the Alaska Worker’s Compensation Division. The maximum
average weekly wage for the period from January 1 through December 31, 2008 is $782.68. Therefore, the maximum compensation rate (120% percent of the AAWW) is $939.00. The minimum compensation rate (22% of the maximum compensation rate) is $207.00. The Alaska Workers’ Compensation Division publishes compensation rate tables based on these formulas. These tables are then referenced throughout the statute. AS §§23.30.175, 23.30.185.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Payment must be made within 14 days after knowledge of the injury or death. AS §23.30.155.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out _____ days before recovering benefits for the first _____ days)?**

The employee must be out more than 28 days before receiving benefits for the first 3 days. AS §23.30.150.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary benefits may not be paid past the date of medical stability, which is the date after which further objectively measurable improvement is not reasonably expected to result from additional medical care. Medical stability is presumed in the absence of objectively measurable improvement for a period of 45 days. AS §§23.30.185, 23.30.395(21). In addition, a claimant, per AS §23.30.187, does not have a right to receive temporary total or permanent total disability benefits during any week in which unemployment compensation benefits have also been collected. However, per Alyeska Pipeline Serv. Co. v. DeShong, 77 P.3d 1227, 1228 (Alaska 2003): “Receipt of unemployment benefits does not absolutely bar temporary total disability benefits if the unemployment benefits are paid back.”

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No.

21. **What disfigurement benefits are available and how are they calculated?**

None are available.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled member/parts, and the standard for recovery?**

Permanent partial disability benefits are no longer paid according to a schedule. See answer 22B.

B. **Number of weeks for "whole person" and standard for recovery.**
Permanent partial impairment is paid on the basis of multiplication of $177,000 by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment is the percentage of impairment to the particular body part or function converted to the percentage of impairment of the whole person as provided under the American Medical Association Guides to the Evaluation of Permanent Impairment. Furthermore, the ratings must be reduced by a permanent impairment that exists before the compensable injury. AS §23.30.190.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

There are extensive requirements. If an employee suffers a compensable injury that may permanently preclude a return to the occupation at the time of the injury, the employee may request an eligibility evaluation for re-employment benefits. This must be done within 90 days after the notice of injury unless it is determined that there is an unusual and extenuating circumstance that prevents a timely request. Thereafter, a rehabilitation specialist retained by the administrator performs an eligibility evaluation. The administrator then decides whether the employee is eligible, and this decision may be appealed. An employee is eligible for re-employment benefits upon a written request and by having an employee predict that he or she will have permanent physical capacities that are less than the physical demands of the employee's job at the time of the injury or any other jobs that the employee has held or received training for within the ten years prior. Benefits include the preparation of a rehabilitation plan, which may not extend past two years from the date of its approval, and the cost shall not exceed $10,000. AS §23.30.041.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

The minimum and maximum rates are the same as for any other type of disability. Permanent total disability is determined on a case-by-case basis, but loss of both hands, both arms, both feet, both legs, both eyes, or any two of them, in the absence of conclusive proof to the contrary, constitutes permanent total disability. Alaska utilizes a concept of disability that rests upon loss of earning capacity rather than medical impairment. AS §23.30.180.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Reasonable and necessary funeral expenses up to $5,000.00 are covered. AS §23.30.215.

B. **Dependency claims.**

1) **Death Benefits for fatalities prior to January 1, 2007.**

If there is a surviving spouse or children, then percentages of the spendable weekly wages of the deceased are paid as follows: 80 percent for the spouse with no children; 50 percent for a spouse with one child and 40 percent for the child; 30 percent for the spouse with two or more children and 70 percent divided among the children; 100 percent for an only child with no spouse; if there is no spouse or children, then for the support of father, mother, grandchildren, brothers or sisters if dependent, 42 percent of the
spendable weekly wage of all such beneficiaries, not to exceed $20,000 in the aggregate. There are minimums of $25 per week to a child or $50 for children and $75 for a spouse, and the maximum is as stated elsewhere. AS §23.30.215.

2) Payment for fatalities on or after January 1, 2007.

Death benefits payable to a surviving spouse with one child are fixed at:

(a) If the employee’s compensation rate in the tables is $801.00 or above, the payments are fixed at $500.00 per week for the surviving spouse and $400.00 a week for the surviving child.

(b) If the employee’s compensable rate in the tables is $800.00 or below, the surviving spouse is entitled to the employee’s compensation rate divided by .8 x .5. The surviving child’s compensation rate is equal to the employee’s compensation rate divided by .8 x .4.

Death benefits payable to a surviving spouse with two or more surviving children are paid as follows:

(a) If the employee’s compensation rate in the tables is $721.00 or above, the payments are fixed at $270.00 per week for the surviving spouse, and $631.00 per week for the surviving children.

(b) If the employee’s compensation rate in the tables is $720.00 or below, the surviving spouse is entitled to compensation at the employee’s compensation rate divided by .8 x .3. The surviving children’s compensation is the total of the employee’s compensation rate divided by .8 x .7.

(c) The total weekly amount of compensation may not be less than $75.00 for a surviving spouse, or less than $50.00 for surviving multiple children.

Death benefits in cases with only one child and no surviving spouse, or two or more surviving children and no surviving spouse are paid as follows:

(a) If the employee’s compensation rate in the tables is $721.00 or above, the payments are fixed at: $901.00 per week for the only surviving child, or $901.00 per week divided equally among multiple surviving children.

(b) If the employee’s compensation rate in the tables is $720.00 or below, are sole surviving child is entitled to the employee’s compensation rate divided by .8. Multiple surviving children are entitled to the employee’s compensation rate divided by .8, equally divided among the children.

(c) The total weekly amount of compensation may not be less than $25.00 to a child or less than $50.00 for children.
If the surviving spouse remarries, the surviving spouse is entitled to be paid a lump sum amount equal to the compensation to which the surviving spouse would otherwise be entitled in the two years commencing on the date of remarriage, as full and final settlement of all sums due.


26. What are the criteria for establishing a "second injury" fund recovery?

If an employee has a permanent physical impairment from any cause and incurs a subsequent disability arising out of the employment, resulting in compensation for a disability that is substantially greater by reason of the combined effects of the two injuries than would have resulted from the subsequent injury alone, the employer/insurer must first pay all the disability, but is reimbursed from the Second Injury Fund for all payments made after 104 weeks. The employer must establish by written records that it had knowledge of the permanent physical impairment before the subsequent injury and that the employee was hired or retained with that knowledge. Also, permanent physical impairment means any one of 27 specifically listed conditions or any other condition which would support a disability rating of 200 weeks or more. AS §23.30.205.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The Board may, before one year after the date of the last payment of benefits, or before one year after the rejection of a claim, review a compensation case, on the ground of a change of conditions, or because of a mistake in a determination of fact. AS §23.30.130.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

In Alaska, generally every circumstance will suffice. If the employer either controverts or resists payment, then it is liable for the employee's attorneys fees. AS §23.30.145.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The compensation remedy is exclusive and in place of all other liability of the employer and any fellow employee, unless the employer fails to secure payment of compensation as required. AS §23.30.055.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

The exclusivity provision does not bar an intentional tort claim. There can be no contractual waiver, but contractual indemnity is not precluded. Furthermore, a common law damage action by an illegally employed child is not barred. AS §23.30.055; Bell Helicopter Textron, Inc. v. U.S., 967 F.2d 307 (9th Cir. 1992); Whitney-Fidalgo Seafoods, Inc. v. Beukers, 554 P.2d 250 (Alaska 1976).
30. Are there any penalties against the employer for unsafe working conditions?

Yes, State and Federal OSHA have jurisdiction over the employer under their statutes and regulations, and the exclusive remedy provision has no effect on them.

31. What is the penalty, if any, for an injured minor?

This depends upon the nature of the employment. If the minor is illegally employed, then there is no exclusivity, and an ordinary tort suit is permitted. Furthermore, such a minor could also obtain enforcement of various fines through OSHA. See also answer 29B.

32. What is the potential exposure for "bad faith" claims handling?

The Workers' Compensation Board can fine or impose a penalty upon an employer who controverts a claim in bad faith. To date, however, there have been no reported opinions of viable lawsuits against an employer/insurer claiming bad faith in the handling of a workers' compensation claim. It is thus unclear what, if any, liability they would have. AS §23.30.155.

33. What is the exposure for terminating an employee who has been injured?

An employee may not be terminated for having a workers' compensation claim. Terminating an employee because he or she is no longer physically fit to do the job, because of an injury, simply establishes the employee's permanent disability. AS §23.30.247.

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. AS §23.30.015.

35. Can co-employees be sued for work-related injuries?

No. AS §23.30.055.

36. Is subrogation available?

Yes, unless the employee sues first. If the employee does not sue, then the employer/insurer may sue a third party. AS §23.30.015.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Medical bills must be paid within 14 days, or a 25% penalty is assessed. AS §§23.30.095, 23.30.155.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?
Medical reports are required to be filed with the Board by the parties upon receipt. No payment of the provider is required unless the provider files reports with the Board. No payment is required if the employee fails to execute a medical or other records authorization. Upon written request, an employee must provide written authority to the employer or carrier to obtain medical and rehabilitation information relative to the employee’s injury, although the employee does have the right to file a petition for protective order with the division. AS § 23.30.107, AS §§23.30.095(c), (h); 8 AAC §45.095.

39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.

The employee may choose a physician, and may change physicians once if written notice is given. The employee may not change more than once without permission from the employer. AS §23.30.095.

B. Employer’s right to second opinion and/or Independent Medical Examination.

The employer has the right to an IME. AS 23.30.095(e). The Alaska Workers’ Compensation Board has the right to order an SIME (second IME) at the employer’s expense. AS 23.30.095(k).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The employer is to pay medical care for two years from the date of injury but the Board may extend that time. Medical care is broadly defined to include physicians' fees, nurses' charges, hospital services, hospital supplies, medical and prosthetic devices, physical rehabilitation, and transportation charges. "Physician" includes medical doctors, surgeons, chiropractors, osteopaths, dentists and optometrists. AS §23.30.095.

41. Which prosthetic devices are covered, and for how long?

Such prosthetic devices as may be reasonably required, and which arise out of or are necessitated by an injury, are covered. These include, but are not limited to, eyeglasses, hearing aids, dentures, and other such devices and appliances, and the repair or replacement of such devices necessitated by ordinary wear and tear. They are covered for the same time period as other medical care. AS §23.30.095.

42. Are vehicle and/or home modifications covered as medical expenses?

This is a fact-specific question. The Act neither precludes nor requires such coverage.

43. Is there a medical fee guide or schedule or other provisions for cost containment?

There is no cost containment guideline, but there are maximum treatment frequency guidelines, and each medical care provider must submit a treatment plan. AS §23.30.095.

44. What, if any, provisions or requirements are there for "managed care"?
PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

The employer either controverts a claim, in whole or in part, or petitions the Board for a determination of certain allegations. AS §23.30.155.

46. What is the method of claim adjudication?

A. Administrative level.

The initial adjudication of claims is before an administrative body, the Alaska Workers' Compensation Board. It is composed of a state employee which is the hearing chairperson, and two private citizens appointed by the governor, representing labor and management, respectively. AS §§23.30.005, 23.30.105, 23.30.110. The standard of proof in claims at this level is that of a “preponderance of the evidence” as provided in Denuppiis v. Unocal Corp., 63 P.3d 272 (Alaska 2003).

B. Trial court.

The state trial court hears the first level of appeal from the Alaska Workers' Compensation Board. AS §23.30.125.

C. Appellate.

There is a second level of appeal from state superior court or trial court to the state supreme court. AS §23.30.125.

47. What are the requirements for stipulations or settlements?

Stipulations and settlements must be approved by the Alaska Workers' Compensation Board to be effective. There are certain technical requirements that the Board has imposed for the approval of stipulated settlements, specifically that they be found to be in the best interest of the employee. AS §23.30.12.

48. Are full and final settlements with closed medicals available?

Yes, but they are not favored by the Board. See AS §23.30.012 and corresponding regulations.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. AS §23.30.012.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?
An employer is required either to insure its liability under the Act with an insurer or association authorized to do business in the state or be an approved self-insurer. Private insurance is available, and for those who cannot obtain it there is an assigned risk pool. AS §23.30.025.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   There are extensive regulations dealing with self-insurance. The Workers' Compensation Board may allow self-insurance if the employer provides satisfactory proof that it has the financial ability to meet its obligations, has available claims facilities within the state, has been in business in Alaska for at least five years, has a safety/loss control program, has at least 100 employees in Alaska or in another state or states, and has a net worth of at least $5,000,000. One or more of these can be waived if appropriate. Proof of financial ability requires review of audited financial statements for about 18 different types of information. AS §23.30.090; Alaska Admin. Code tit. 8, §46.010, et seq.

   **B. For groups or "pools" of private entities.**

Joint ventures can be approved if each member of the venture qualifies. The requirements for members of such groups are essentially the same as for those seeking individual self-insured status. See answer 51A.

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

   This has not been decided in Alaska. However, an illegally employed minor can, if he wishes, avoid the exclusive remedy provisions of the Act and sue for damages or use the Act’s benefits. *Whitney Fidalgo Seafoods v. Home Ins. Co.*, 447 F. Supp. 393 (D. Alaska 1978).

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Neither the Alaska Workers Compensation Board nor the Alaska Supreme Court have specifically addressed this issue. However, coverage has been found to exist in unexplained situations and unprovoked attacks on employees by drunks and lunatics. See e.g. *Fireman's Fund Am. Ins. Companies v. Gomes* 544 P.2d 1013 (Alaska 1976). Therefore, it is likely Alaska would find a terrorist attack to be a “neutral assault” such as attacks by lunatics, drunks, small children, and “other irresponsibles.” See 1 A. Larson, *The Law of Workmen’s Compensation*, § 8.03, at 8-58 (2001). See also *Temple v. Denali Princess Lodge*, 21 P.3d 813, 822 (Alaska 2001)(holding the positional risk doctrine, which provides compensation for injuries that “would not have occurred but for the fact that the conditions and obligations of employment placed the claimant in the position where he was injured,” did not apply where the origin of assault was private and personal and the employer did not facilitate the assault.) Therefore it is likely Alaska would hold coverage applies. See also, Answer 14.
54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Alaska statutes and regulations do not specifically address Medicare/Medicaid trusts, liens, subrogation rights, or the Secondary Payer Act. However, pursuant to 8 AAC 45.040(c) ‘any person who may have a right to relief . . . should be joined as a party.” The Alaska Supreme Court has interpreted this provision to authorize the Worker’s Compensation Board to join a health insurance provider having a right to relief as an equitable subrogee of the health care providers it has paid, unless the insurer explicitly waives its subrogation right. Sherrod v. Municipality of Anchorage, 803 P.2d 874 (1990). Therefore, the Board and or the Alaska Supreme Court could also determine Medicare falls under the purview of 8 AAC 45.40.040(c), and the parties should address this issue prior to settlement.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

See Answer 54.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPPA)?

45 C.F.R. 164.512 (l) (HIPAA) excludes protected health information as authorized by and to the extent necessary to comply with the laws relating to workers’ compensation or other similar programs. Pursuant to Alaska Statute, upon written request, an employee must provided written authority to the employer, carrier, rehabilitation specialists, or reemployment benefits administrator to obtain medical and rehabilitation information relative to the employee’s injuries. The request to the employee for written authority must include notice of the employee’s right to file a petition for a protective order with the division, and must be served either by certified mail to the employee’s address on the notice of injury, or by hand delivery. AS §23.30.107. Medical or rehabilitation records contained in an employee’s file, maintained by the division, or held by the board are not public records subject to public inspection and copying. AS §23.30.107(b). Reemployment Benefits Administrators, the Division of Workers’ Compensation, the Department of Labor and Work Force Development, and the Workers’ Compensation Board may, without the employee’s consent, release medical or rehabilitation records in an employee’s file to a physician providing medical services under AS §23.30.095(k) or §23.30.110(g), a party to a claim filed by the employee, or a governmental agency. The division may not assemble or provide information respecting individual records for commercial purposes that are outside the scope of the Alaska Workers’ Compensation Act. AS §23.30.107.
What are the provisions for “Independent Contractors”?

Compensation or benefits are payable for disability or death with a need for medical treatment for employees only, if the disability or death of the employee or the employee’s needs for medical treatment arose out of and in the course of employment. AS §23.30.010(a). The Board will determine whether a person is an “employee” based on the “relative-nature-of-the-work test. The test includes a six part determination of whether the work:

1) is a separate calling or business; if the person performing the services has the right to hire or terminate others to assist in the performance of the service for which the person was hired, there is a inference that the person is not an employee; if the employer

   (a) has the right to exercise control of the manner and means to accomplish the desired results, there is a strong inference of employee statute;

   (b) and the person performing the services have the right to terminate the relationship at will, without cause, there is a strong inference of employee status;

   (c) has the right to extensive supervision of the work then there is a strong inference of employee status;

   (d) provides the tools, instruments, and facilities to accomplish the work and they are of substantial value, there is an inference of employee status; if the tools, instruments, and facilities to accomplish the work are not significant, no inference is created regarding the employment status;

   (e) pays for the work on an hourly or piece rate wage rather than by the job, there is an inference of employment status; and

   (f) and a person performing the services entered into either a written or oral contract, the employment status the parties believed they were creating in the contract will be given deference; however, the contract will be construed in view of the circumstances under which it was made and the conduct of the parties while the job is being performed;

2) is a regular part of the employer’s business or service; if it is a regular part of the employer’s business, there is an inference of employee status;

3) can be expected to carry its own accident burden; this element is more important than 4-6; if the person performing the services is unlikely to be able to meet the costs of an industrial accident out of the payment for the services there is a strong inference of employee status;

4) involves little or no skill or experience; if so there is an inference of employee status;

5) is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job; if the work amounts to hiring of continuous services, there is an inference of employee status;
6) is intermediate, as opposed to continuous; if the work is intermediate there is a weak inference of no employee status.

Factor 1 is the most important factor and is independent with factor 2. At a minimum, either factor 1 or factor 2 must be resolved in favor of employee status for the board to find a person is an employee. 8 ACC 45.890.

See also answer 59.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

No.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Yes. An individual who drives a taxi cab and 1) is compensation for taxi cab services exclusively by customers of the service, 2) whose written contractual arrangements of owners of taxi cab vehicles, taxi cab permits, or radio dispatch services are based upon flat contractual rates and not based on a percentage share of the individual’s receipts from customers, and 3) whose written contract with owners of taxi cab vehicles, taxi cab permits, or radio dispatch services specifically provides that the contract places no restrictions on hours worked by the individual, or on areas in which the individual may work except to comply with local ordinances, is not covered by the Alaska Workers’ Compensation Act, unless the hours worked by the individual or the areas in which the individual may work are restricted except to comply with local ordinances. AS §23.30.230(7).
1. Citation for the state’s workers’ compensation statute.

Arizona Revised Statutes (hereafter A.R.S.) Annotated §§ 23-901, et seq.
Note: Arizona’s Employer Liability Law for hazardous occupations is excluded from the herein analysis.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

With the exception of certain specifically exempted persons, essentially every person in the service of the state, any political subdivision thereof, or any person, (including an alien, or minor legally or illegally permitted to work for hire) in the service of any employer subject to the workers’ compensation provisions, is considered to be an employee. Any person employed as a casual employee or not in the usual course of a trade is not considered an employee. Independent contractors are not employees. A.R.S. § 23-901. Recent amendment to the statute clarified that working members of limited liability companies and working shareholders of corporations are covered employees if they hold/own less than 50% beneficial/membership interest in the LLC/corporation. Working members/shareholders holding/owning more than 50% may be covered employees on written acceptance, by endorsement, or an application for coverage at the discretion of the insurance carrier for the LLC/corporation. A.R.S. §23-901(q),(r),(s),(t).

3. Identify and describe any “statutory employer” provision.

When an employer procures a contractor to perform work which is part of the employer’s business and the employer retains supervision or control over the work, the contractor and those employed by the contractor are considered employees of the original employer. A.R.S. § 23-902.
4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims

Injuries suffered by an accident arising out of and in the course of one’s employment are covered. A.R.S. § 23-1021. An injury occurs when there is some objective physical damage, a systematic aggravation of a pre-existing problem, or one that has occurred over a period of time. With the exception of certain presumptions, the employee must prove the elements of the claim by a preponderance of the evidence.

There are special statutory provisions related to heart and mental injuries, hernias, AIDS, Hepatitis C, Methicillin-resistant staphylococcus aureus, spinal meningitis, and tuberculosis. A.R.S. §§ 23-1043 through 23-1043.04.

B. Occupational disease (including respiratory and repetitive use).

Any disease which is an expected consequence in a particular industry and which may occur as the result of exposure over an indefinite period of time can be classified as an occupational disease. Several statutory factors determine whether the disease is sufficiently related to the occupation and employment. Existence of an occupational disease requires proof by a preponderance of the evidence. There are specific provisions which, subject to stated requirements, may create a presumption of occupational disease for firefighters and peace officers. A.R.S. § 23-901.01.

5. What, if any, injuries or claims are excluded?

Claims which the employee cannot prove by a preponderance of the evidence are excluded. A.R.S. § 23-1021(A). Also, purposely self-inflicted injuries, injuries caused by the willful misconduct of an employer or employee, or those caused or continued by an unreasonable refusal to follow competent surgical treatment or medical assistance are excluded. A.R.S. §§ 23-901.04, 23-1021, 23-1022 (A), 23-1027.

6. What psychiatric claims or treatments are compensable?

Where there is physical trauma resulting in mental injury, the employee must prove that a work-related injury was a substantial cause of the mental injury. Where a mental stimulus causes a mental injury, the employee must prove the mental injury arose from an unusual, unexpected or extraordinary work-related event. A third situation that is covered is where there is a mental stimulus resulting in a physical injury (i.e., an ulcer). A.R.S. § 23-1043.01(B).

7. What are the applicable statutes of limitations?

A claim must be filed within 1 year after the injury becomes manifest or the employee knows or should know that there is a compensable injury. The statute of limitations can be waived
by failure to raise it in a timely manner. The statute may be tolled where: (1) the employee is insane, incompetent or incapacitated when the injury occurs; (2) an employer/insured pays compensation; or (3) the employee justifiably relies on a material representation by the employer/insurer. A.R.S. § 23-1061(A)(B).

A claim for temporary partial disability benefits must be filed (1) within two years after an employee knew or should have known that the carrier, self-insured employer or special fund denied or improperly paid compensation, or (2) within two years after the date on which an award for benefits encompassing the entitlement period becomes final. No accrual date exists prior to the 2008 enactment date of this limitation. A.R.S. § 23-1061 (J).

8. **What are the reporting and notice requirements for those alleging an injury?**

There is no specified period of time; an employee must “forthwith” report an accident/injury to the employer. A.R.S. § 23-908 (E). The employee must not delay receiving treatment or prejudice the employer’s ability to investigate the incident. After notifying the employer, the employee must file a claim with the Industrial Commission. A.R.S. § 23-1061(A).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury**

      Any injury which is purposely self-inflicted is excluded, but this defense is narrowly construed to preclude recovery only when the act and consequences are intended. A.R.S. § 23-1021.

   B. **Willful misconduct, “horseplay,” etc.**

      The employer must prove that the employee’s act was a substantial deviation from authorized activities (i.e., was outside the course and scope of employment). Courts examine the extent and seriousness of the deviation, the extent to which the deviation has become accepted, and the extent to which the nature of the employment may be expected to include such activity. *Jaimes v. Industrial Commission*, 163 Ariz. 307, 787 P.2d 1103 (Ariz. App. 1990).

   C. **Injuries Involving Drugs and/or alcohol**


10. **What, if any, penalties or remedies are available in claims involving fraud?**

    Any person committing fraud to obtain a benefit for him/herself or another is guilty of a class 6 felony, and an employee convicted of this offense loses all right to compensation. A.R.S. §
11. **Is there any defense for falsification of employment records regarding medical history?**

   Only for claims for occupational disease, where compensation may be denied for willful self-exposure, including a failure by the employee to truthfully answer an inquiry by the employer as to previous injuries, disabilities, or other health matters. A.R.S. § 23-901.04.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

   An injury is usually deemed to be in the course of employment if it takes place on the employer’s premises. However, if the activity takes place off the premises, several factors are considered, including: (1) when the activity takes place; (2) whether participation is compelled; (3) whether the employer sponsors the activity; and (4) whether the employer benefits from the employee’s participation. A.R.S. § 23-1021.

13. **Are injuries by co-employees compensable?**

   Yes, if the injury is caused by a co-employee acting within the scope of his/her employment, the compensation remedy is exclusive. But if the injury is the result of the co-employee’s willful misconduct or the co-employee was far removed from the scope of employment at the time of the injury, the employee may elect to accept worker’s compensation coverage or to sue the co-employee. A.R.S. § 23-1022.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. “irate paramour” claims)?**

   Yes, as long as the injury arises from an accident during the course of employment. A.R.S. §§ 23-1021-1024.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

   Wages are calculated on a monthly basis using the employee’s average monthly wage at the time of the injury. Typically, the reference for establishing average monthly wage is the employee’s wages for the previous thirty days. If the employee did not work thirty continuous days prior to injury or death, the employee’s partial wages shall be compared with those of comparable workers. If the employee is working under contract, the guaranteed wage set in the contract shall be paid, but no less than wages paid to employees not under contract for similar work. A.R.S. § 23-1041. A special calculus is applied for covered
working members of limited liability companies owning over 50% membership interest in an LLC, and covered working shareholders of corporations owning over 50% beneficial interest in a corporation. A.R.S. §23-901(r),(t).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

For temporary total disability, 66 and 2/3 percent of the employee’s average monthly wage (plus $25 a month for dependents). A.R.S. § 23-1045. For temporary partial disability, 66 and 2/3 percent of the difference between the average monthly wage and the wage he/she is able to earn thereafter. A.R.S. § 23-1044. There is no minimum, but there is a maximum of $3000 for employees injured from/after December 31, 2007 but before January 1, 2009 and a maximum of $3600 for employees injured from/after December 31, 2008 but before January 1, 2010. A.R.S. §23-1041(D)(6) and (7). The Industrial Commission now meets each year and adopts an adjusted maximum rate to reflect the annual percentage increase in the Arizona mean wage published by the Arizona Department of Economic Security using Bureau of Labor statistics occupational statistics data coded for all occupations for the prior calendar year. The commission shall not decrease the rate or increase the rate more than 5% from the prior year. A.R.S. § 23-1041 (E).

17. **How long does the employee/insurer have to begin temporary benefits from the date disability begins?**

21 days after notification by the Industrial Commission to the carrier of the filing of a claim except where the right to compensation is denied. A.R.S. § 23-1062(B).

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

An employee must be out 15 days before receiving benefits for the first 7 days. A.R.S. § 23-1062(B).

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary disability benefits are terminated when the employee is able to return to suitable work and is cleared to do so by the attending physician.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

21. **What disfigurement benefits are available and how are they calculated?**

Facial disfigurement is compensable when scarring causes an observable marring or impairment to the natural appearance of the employee. While a reduction in earning capacity need not be demonstrated, it may be considered. The commission may base the compensation paid upon what it believes just given the proof submitted. A.R.S. §§ 23-1044(B)(22), 23-1047.

22. **How are the permanent partial disability benefits calculated, including the minimum and maximum rates?**

These are allowed to the extent an employee suffers a loss of earning capacity. For certain enumerated disabilities the employee is entitled to 55% of his/her average monthly wage. A.R.S. § 23-1044(B). For those not enumerated, the employee is entitled to receive compensation equal to 55% of the difference between the pre-injury average monthly wage and the current wage. A.R.S. § 23-1044(C). There is no minimum, but there is a maximum of $3000 for employees injured from/after December 31, 2007 but before January 1, 2009 and a maximum of $3600 for employees injured from/after December 31, 2008 but before January 1, 2010. A.R.S. § 23-1041(D)(6) and (7). The Industrial Commission now meets each year and adopts an adjusted maximum rate to reflect the annual percentage increase in the Arizona mean wage published by the Arizona Department of Economic Security using Bureau of Labor statistics occupational statistics data coded for all occupations for the prior calendar year. The commission shall not decrease the rate or increase the rate more than 5% from the prior year. A.R.S. § 23-1041 (E).

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

The schedule ranges from 1 ¼ months for loss of the first phalanx of any toe to 60 months for permanent and complete loss of hearing in both ears. There is a conclusive presumption that scheduled injuries result in the loss of earning capacity. Awards may be commuted to a lump sum of up to $25,000 for scheduled injuries with or without the consent of the carrier liable for the commutation. A.R.S. §§ 23-1044(B), 23-1067(A).

B. **Number of weeks for “whole person” and standard for recovery?**

All other injuries are determined by earning capacity. Any such injuries may be commuted to a lump sum of $150,000 for requests made from and after June 30, 1987 with the consent of the carrier liable to pay the claim. Recovery is determined by the ability to return to suitable employment at the pre-injury earning capacity level. A.R.S. § 23-1067 (B).
23. **Are there any requirements/benefits for vocation rehabilitation, and what is the standard for recovery?**

Such benefits are not required, but the Industrial Commission has a fund which may cover such services. The cost is borne entirely by the Commission, and cease when the employee is able to engage in suitable employment. A.R.S. § 23-1065.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

An employee suffering from a total loss of earning capacity is entitled to 66 and 2/3 percent of the average monthly wage, determined as described in (16.) above. A.R.S. §§ 23-1045, 23-1041(D)(5).

25. **How are death benefits calculated, including the minimum and maximum rates:**

   **A. Funeral Expenses**


   **B. Dependency claims**

   The surviving spouse is entitled to a monthly benefit of 66 and 2/3 percent of the average monthly wage of the deceased and a lump sum payment of two years’ wages if he/she remarries. If the surviving spouse has children, the monthly benefit is 35% of the average monthly wage of the deceased and upon remarriage the lump sum payment, while the surviving children receive 31 and 2/3 percent of the average monthly wage to be divided among the children equally. If no spouse survives, a single surviving child receives 66 2/3% of the average monthly wage but if there is more than one child then the 66 and 2/3 percent limit is divided among the surviving children. A.R.S. § 23-1046 (A)(2) and (3).

   If there is no surviving spouse or child, a surviving dependent parent receives 25% plus 15% if both are dependent. A.R.S. § 23-1046(A)(4). Dependent brothers or sisters may recover if there are no surviving dependent parents (25% for one, 35% for more than one). However, surviving parents or siblings must prove they were wholly dependent on the employee for support at the time of the employee’s death. A.R.S. § 23-1046(A)(5)(a)(b).

26. **What is the criteria for establishing a “second injury” fund recovery?**

The Special Fund may reimburse the employer/insurer in an amount equal to one-half of yearly permanent disability benefits, when an employee sustains a scheduled injury that becomes unscheduled because of a previous work-related scheduled injury. Also, the same benefit is available where the employee suffered from a 10% or more nonindustrial physical impairment that constituted a hindrance to employment, so long as the pre-existing
27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Re-opening is permitted, and there is no statute of limitations. To re-open a claim, the employee must file a petition to re-open and generally must submit medical evidence which establishes to a reasonable medical probability that the industrial injury caused or contributed to a new, additional or previously undiscovered condition. In other words, the industrial injury must be a producing cause of the condition for which re-opening is sought. A claim shall not be re-opened if compensation was previously denied by Notice of Claim Status filing or determination by the commission and the notice or determination was allowed to become final and no exception applies under A.R.S. § 23-947 excusing a late filing to request a hearing. A claim shall not be re-opened because of increase subjective pain if the pain is not accompanied by a change in objective physical findings. A claim shall not be re-opened solely for additional diagnostic or investigative tests, but reasonable tests, if shown to be causally related to the injury, will be charged to the employer. The employer has 21 days after the petition is filed to accept or deny the petition. A.R.S. §§ 23-1061(H) and (I).

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

While regulations suggest that attorney’s fees and costs may be awarded as a sanction, it is not clear if the Industrial Commission has authority to order such penalties. Sanctions and attorneys’ fees may also be awarded against the employer/insurer or counsel on appeal if the claim is found to be frivolous. Such fees are rarely awarded.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

**A. Scope of Immunity**

So long as the employee has not elected to forego worker’s compensation coverage before the injury, worker’s compensation is the exclusive remedy. The immunity is only to the employer and co-employees, not third parties. A.R.S.§ 23-1022. The employer may be deemed to have waived the exclusive remedy if it does not purchase worker’s compensation insurance or furnish to the Industrial Commission of Arizona satisfactory proof of financial ability to pay compensation directly or through a pool approved by the Commission. A.R.S. § 23-907, A.R.S. § 23-961, A.R.S. § 23-962. In such instance, the employee may accept compensation paid through a special fund, which payments are charged against the employer, or the employee may file a civil suit against the employer, in which suit the employer is prohibited from asserting the defenses of assumption of the risk and contributory negligence. In such action, proof of the injury constitutes prima facie evidence of negligence and the
employer bears the burden to show freedom from negligence resulting in the injury. A.R.S. § 23-907. Either choice, however, is exclusive. If the employee accepts worker’s compensation benefits, the employee cannot file a civil suit.

B. Exceptions (intentional acts, contractual waiver, “dual capacity”, etc.)

As noted above, the employee can waive worker’s compensation coverage. Also, the employee can be deemed to be an independent contractor or fall into the class of persons for whom coverage does not exist by statute. One exception to the exclusivity provision is for willful or intentional injuries by the employer or a co-employee. However, this exception has very rarely been found. The dual capacity doctrine has been mentioned by the Arizona courts, but never favorably applied on behalf of an employee. A.R.S. §§ 23-901, 23-1022, 23-1023.

30. Are there any penalties against the employer for unsafe working conditions?

No. However, see the Arizona Occupational Health and Safety Act of 1972 for information regarding an employer’s duty to furnish a safe working environment for employees.

31. What is the penalty, if any, for an injured minor?

None. However see A.R.S. § 23-905(B) concerning minors who work at an age and an occupation not legally permitted. In that event, the injured minor may receive additional compensation in an amount equal to fifty percent of the compensation the injured minor would otherwise receive pursuant to the statute. If an insurance carrier is required to pay additional compensation pursuant to the statute, the insurance carrier shall be subrogated and entitled to recover any such amounts paid from the employer.

32. What is the potential exposure for “bad faith” or claims handling?

When the employer/insurer fails to give notice of the claim status as required, it can be required to pay benefits immediately from the date it was notified of the claim. Furthermore, an employee may be entitled to interest at the legal rate when his or her compensation payments are not timely made as required. The employer/insurer may also be found to have engaged in bad faith or unfair claim processing practices and this determination is made exclusively by the Industrial Commission. When an infraction has been determined, the employee may be awarded a penalty of 25% of the benefit amount or $500, whichever is greater. If the employee is found to have a history of such practices, the Commission may impose a civil penalty of up to $1000 for each violation payable to the Commission’s Special Fund.

The standard for bad faith is when the employer/insurer: (1) institutes a proceeding or defense that is not well grounded in fact or law; (2) unreasonably delays payment of benefits or authorization for medical benefits; (3) unreasonably underpays benefits; (4) unreasonably terminates benefits; (5) intentionally misleads an employee as to benefits or remedies
available; or (6) unreasonably interferes with or obstructs the employee’s right to choose attending physicians. The standard for an unfair claim is when an employer/insurer: (1) unreasonably issues a notice of claim status without adequately supporting information; (2) fails to acknowledge and act reasonably and promptly upon communication from the Commission, the employee or employee’s attorney; (3) directly advises the employee not to consult with or obtain the services of an attorney; or (4) communicates directly with an employee represented by an attorney for an improper purpose. There are also potential criminal sanctions for any of several acts of the employer/insurer. A.R.S. §§ 23-930 and 23-932. While the bad faith remedy for the claim of injury is exclusive to the worker’s compensation system, Arizona recognizes a civil cause of action for bad faith and breach of conduct for injuries which are separate and distinct from the original injury and can only be attributed to the employer’s or its insurance carrier’s bad faith. Examples of such actions are for mental distress, Franks v. United States Fidelity & Guaranty Co., 149 Ariz. 291, 295, 718 P.2d 193, 197 (1984) and for breach of a contract to pay the difference between benefits awarded by the Industrial Commission and the contracted salary of an employee. Stoecker v. Brush Wellman, Inc. 194 Ariz. 448, 984 P.2d 534 (1999). Punitive damages are available in a bad faith civil action.

33. **What is the exposure for terminating an employee who has been injured?**

None.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes, however, any recovery in tort may be required to be used to satisfy medical liens associated with the worker’s compensation coverage. A.R.S. § 23-1023.

35. **Can co-employees be sued for work-related activities?**

No, they are immune from liability as long as the employee did not forego worker’s compensation coverage and as long as the co-employee did not commit willful misconduct. A.R.S. § 23-1022. Also, while Arizona’s statute of limitations for personal injury tort actions is two years, A.R.S. § 12-542, a third-party action is controlled by the employee for only the first year. If suit is not filed within one year, control of the third-party claim reverts to the worker’s compensation carrier to recover damages at its discretion. However, the employee can request and obtain a reassignment of the claim from the carrier in the second year to pursue a third party claim. A.R.S. § 23-1023.

36. **Is subrogation available?**

Yes, in the form of granting the payor of compensation a lien on a third party recovery to the extent of all compensation and medical benefits rendered, and a credit which acts like a

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The Industrial Commission’s Rules of Procedure exempt the employee for any responsibility for amounts due the medical provider, including disputed amounts. To the extent an employee could be subject to liability for a medical bill, such as a pharmacy bill, there is no specified time period in which this charge must be paid, but the employer/insurer can be found to have acted in bad faith for “unreasonably delaying” payment of benefits. Benefits must be paid promptly. A.R.S. § 23-930.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

Hospital records or authorization obtained by any physician or surgeon are not considered a privileged communication if such information is requested by an interested party for a proper understanding of the case and a determination of the rights involved. Medical information unrelated to the pending industrial claim remains privileged. A.R.S. § 23-908(D).

39. **What is the rule on choice (a) claimant’s choice of physician; (b) employer’s right to a second opinion and/or Independent Medical Examination?**

   A. **Claimant’s choice of physician.**

This depends on whether the employer has elected to provide medical services directly to its employees, subject to the Industrial Commission’s approval. If the employer provides such services, then the employee must accept the services unless the employee can demonstrate that their health, life or recovery is endangered or impaired by those services. The employee must then make application to the Industrial Commission to change doctors. If the employer does not provide such services, the employee is free to choose a physician. Furthermore, the employee can change physicians upon written permission of the attending physician, employer/insurer, or Industrial Commission. A.R.S. §§ 23-1070, 23-1071(B).

   B. **Employer’s right to a second opinion and/or Independent Medical Examination.**

An employer is entitled to have an employee, who may be eligible for benefits for worker’s compensation, submit him or herself to an independent medical examination upon request of the Industrial Commission, state compensation fund, employer/insurer. If an employee refuses to submit to the examination, his or her right to compensation will be suspended until the examination is made. A.R.S. § 23-1026.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy,**
The employee is entitled to coverage for medical services reasonably required as a result of the injury. Reasonable necessity of care is a medical question. Furthermore, services may provided by physicians or other licensed practitioners of the healing arts, which has been construed to include chiropractors and even spiritual healers if certain requirements are met. *Capital Foundry v. Industrial Commission*, 117 Ariz. 37, 570 P.2d 808 (Ariz. App. 1977), A.R.S. § 23-1062(A).

41. **What prosthetic devices are covered, and for how long?**

   Any prosthetic device reasonably required as a result of the injury is covered, without a time limit. A.R.S. § 23-1062(A).

42. **Are vehicle and/or home modifications covered as medical expenses?**


43. **Is there a medical guide or schedule, or other provisions for cost containment?**

   Yes, the Industrial Commission has set a fee schedule, reviewed annually, limiting fees which may be charged by physicians treating industrial injuries. A.R.S. § 23-908(B).

44. **What, if any, provisions or requirements are there for “managed care”?**

   None.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

   When notice is first submitted, the employer/insurer may deny a claim by stating it is disputed. The employer or its insurance carrier has 21 days to accept or deny a claim from the day it is filed. If the employer or carrier files no response within 21 days, the claim is deemed accepted. If the claim is denied, the employee may invoke the hearing procedures administered by the Industrial Commission. Likewise, if the claim is accepted and the employee contests the employer/insurer’s determination and award, the hearing procedures may be invoked. The employer/insurer does not need to formally contest claims, since it makes the initial award determinations. A.R.S. § 23-1061.

46. **What is the method of claim adjudication?**
A. Administrative level.

The employee/insurer first makes a benefit determination and, if the employee disagrees, he or she may contest this determination before the Industrial Commission. Administrative law judges from the Industrial Commission conduct evidentiary hearings concerning contested cases, subject to general principles of justice and due process. Formal rules of evidence and procedure need not be strictly followed. Discovery, such as interrogatories, depositions and independent medical examinations, is permitted. A.R.S. §§ 23-941 et seq.

B. Trial court

Contested worker’s compensation cases are appealed to the Court of Appeals. The Industrial Commission therefore serves as the trial court. A.R.S. § 23-951.

C. Appellate

Judicial review is obtained by a Petition for Special Action to the Court of Appeals. The action of the Court of Appeals may be further appealed by a Petition for Review to the Arizona Supreme Court. Safeway Stores v. Industrial Commission, 152 Ariz. 42, 730 P.2d 219 (Ariz. 1986); Procedures Manual, Industrial Commission of Arizona.

47. What are the requirements for stipulations or settlements?

Arizona recognizes compromise and settlement agreements. There must be a genuine dispute as to compensation, the applicant must read and understand the terms of the compromise and settlement agreement, and there must not be any coercion, duress, fraud, misrepresentations or undisclosed additional agreements used in achieving the settlement. A.R.S.§23-941.01, Safeway Stores v. Industrial Commission, 152 Ariz. 42, 730 P.2d 219 (Ariz. 1986); Procedures Manual, Industrial Commission of Arizona.

48. Are full and final settlements with closed medicals available?

Yes, such a settlement may provide for finality or issue preclusion and may be enforceable to prevent the employee from seeking additional medical costs for that condition in the future. The agreement must be explicit as to the issue involving compensability or causal relationship of a particular medical condition, otherwise future medical benefits may be awarded in a subsequent re-opening of the claim. Procedures Manual, Industrial Commission of Arizona. See A.R.S. § 23-941.01 for specific requirements for approval of a full and final settlement.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, they must be submitted to the Industrial Commission and approved by an administrative law judge as under question 46. If the judge rejects the agreement, the parties may appeal to the Court of Appeals. A.R.S.§23-941.01, Procedures Manual, Industrial Commission of
Arizona.

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required; and what is available (e.g. private carriers, state Fund, assigned risk pool, etc.)?

The employer must provide worker’s compensation coverage either through insurance or by meeting the requirements for self-insurance. Several private insurers provide worker’s compensation coverage. Note that a multi-state employer may be required to provide worker’s compensation coverage in Arizona if its employees may be found there. A.R.S. § 23-961.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

An employer seeking to be self-insured must provide to the Industrial Commission satisfactory proof of financial ability to pay compensation. The Industrial Commission may require a deposit or other security from the employer in any amount fixed by the Commission, but not less than $100,000. Self-insured employers, like insurers, must annually pay to the treasurer for the benefit of the administrative fund a 3% amount, of at least $250, of what would have been paid had the employee been fully insured. A.R.S. § 23-961.

B. For groups or “pools” or private entities.

Two or more employers, each of whom are engaged in similar industries, may enter into contracts to establish a workers' compensation pool to provide for the payment and administration of workers' compensation claims pursuant to the statute. The members of the pool must elect a board of trustees and each member employer must have been in business for at least five consecutive years before entering into the pool. The total amount of gross premiums paid by pool members in the year preceding execution of the contract must equal at least $750,000. A.R.S. § 23-961.01. (A) Worker’s compensation pools established pursuant to this statute are exempt from taxation under title 43-101 et. seq. A.R.S. § 23-961.01(C)

52. Are ‘illegal aliens’ entitled to benefits of workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of ‘employee’?”

No Arizona or Federal court has considered this issue as it applies to A.R.S. § 23-901(6)(b), which does include “aliens... legally or illegally permitted to work for hire.” However, N.L.R.B. v. Kolka allows ‘illegal aliens’ to vote in union elections despite the exclusion under the Immigration Control Act. 170 F.3d 937 (9th Cir. 1999). It should be noted that
Arizona voters passed Proposition 200 which denies “illegal aliens” the right to some state sponsored benefits. An attorney general opinion limited the scope of the act to several distinct programs. 2004 Az.Op.Atty.Gen. No. I04-010. At this time, no court opinion excludes payment to “illegal aliens” and the Industrial Commission continues to award benefits to “illegal aliens.”

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA regulations provide an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). Therefore, the standard practice of obtaining medical records could proceed under state law.
57. **What are the provisions for “Independent Contractors”?**

A.R.S. § 23-902(c) defines Independent Contractors and excludes them from coverage. The definition is one who “while so engaged is independent of that business in the execution of the work and not subject to the rule or control of the business for which the work is done, but is engaged only in the performance of a definite job or piece of work, and is subordinate to that business only in effecting a result in accordance with that business design.” A.R.S. § 23-902(d) provides a basis for which a business that uses the services of an Independent Contractor may prove the existence of an Independent Contractor relationship, prescribing a written agreement with several specific terms of engagement. A.R.S. § 23-902(f) provides that said agreement may be found null and void if the agreement is obtained through deception, coercion or duress.

No other statutory provision exists, though case law further defines “control” and has created the “right to control” doctrine to further define whether a worker is an Independent Contractor. The Courts give several indicia of control, none of which are conclusive and must be considered on a case by case basis, applying a totality of the circumstances test. Arizona Worker’s Compensation Handbook, § 2.2.2.3.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There is no specific identification of “Independent Contractors,” but Arizona recently added provisions for professional employer organizations. Under A.R.S. § 23-901.08, a person engaged in the business of providing professional employer services is subject to the worker's compensation laws whether the person uses the description professional employer organization, staff leasing company, employee leasing company, or any other similar name. Under A.R.S. § 23-901.08, as long as the professional employer organization’s agreement with a client remains in force, it shall be regarded as a co-employer, along with the client of the organization. As such, both shall be entitled to the protection of the exclusive remedy of worker's compensation. See A.R.S. § 23-901.08(c). However, under A.R.S. § 23-562(a)(5), an agreement between a professional employer organization and the client can specify one party to be responsible for purchasing worker's compensation insurance on behalf of both. Unless the agreement specifically provides otherwise, the client remains solely responsible for control of the work of covered employees. A.R.S. § 23-570.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

No.

61. **Are there any state specific requirements which must be satisfied in light of the**
obligation of the parties to protect Medicare’s interests when setting the right to medical treatment benefits under a claim?

No.

62: Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Arizona law permits the usage of medical marijuana. A.R.S. § 36-2801 et. seq. The workers compensation laws don’t themselves speak to usage of medical marijuana, though the medical marijuana law does in part address workplace use. An employer is not required to allow ingestion of medical marijuana in the workplace or for any employee to work “under the influence” of marijuana, except that a registered qualifying patient shall not be considered “under the influence” solely because of the presence of metabolites or components of marijuana that appear in insufficient concentration to cause impairment. Employees can be disciplined for ingesting marijuana in the workplace or working “under the influence”. A.R.S. § 36-2814. In terms of worker’s compensation law, the effect of impairment should otherwise be the same for medical marijuana as for other drugs.

63: Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No, N/A.
1. **Citation for the state’s workers’ compensation statute.**

   Arkansas Code Annotated § 11-9-101 et seq.


**SCOPE OF COMPENSABILITY**

2. **Who are covered “employees” for purposes of workers’ compensation?**

   “Employee” means any person, including a minor, whether lawfully or unlawfully employed under any contract of hire, written or oral, express or implied, but excluding agricultural farm laborers, State employees, one whose employment is casual and not in the course of a trade, business, profession, or occupation of the employer. The Act excludes persons who perform work while incarcerated. The Act also provides that sole proprietors and partners are employees unless they file written notice with the Commission opting out. Any reference to a deceased employee also includes the legal representative, descendants, and other persons to whom compensation may be payable. Ark. Code Ann. § 11-9-102.

3. **Identify and describe any “statutory employer” provision.**

   When a subcontractor fails to secure workers’ compensation insurance, the prime contractor is liable for compensation to the subcontractor’s employees. Any contractor or its insurer who becomes liable for the payment of compensation for an employee of a subcontractor may recover from the subcontractor for liability so incurred. A claim for recovery constitutes a lien against all money due to or to become due the subcontractor by the prime contractor.
There is no coverage for sole proprietors or partners when there is an election for non-coverage. Neither the prime contractor nor its insurer is liable for injuries to the sole proprietor or partner. The prime contractor is still, however, liable for injuries to employees of the sole proprietor or partner. Ark. Code Ann. § 11-9-402.

4. **What types of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or Single occurrence claims.**


      An injury is accidental only if it is caused by a specific incident and is identifiable by time and place of occurrence. There are exceptions for: (1) injuries caused by rapid repetitive motion; (2) carpal tunnel syndrome; (3) gradually occurring back injuries; and (4) gradual hearing loss. With regard to such exceptions, however, the injury must be proved by a preponderance of the evidence and the work must be shown to be the major cause of the disability or need for treatment.

      In addition to these exceptions, there are three separate statutes which define the requirements for certain types of compensable injuries: mental injury or illness (§ 11-9-113); cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular injury illness or death (§ 11-9-114); hernia (§ 11-9-523).

   B. **Occupational disease (including respiratory and repetitive use).**

      Occupational disease is any disease that results in disability or death and arises out of and in the course of the employment, or naturally follows or unavoidably results from a compensable injury. The disease must be due to the nature of an employment in which the hazards of the disease actually exist, are characteristic thereof, peculiar to the employment and actually incurred in the employment. Ark. Code Ann. § 11-9-601(g). No compensation is payable for any ordinary disease of life to which the general public is exposed. A causal connection between the employment and the occupational disease must be established by a preponderance of the evidence. Ark. Code Ann. § 11-9-601(e). The employer in whose employment the employee was last injuriously exposed is liable for all benefits. Ark. Code Ann. § 11-9-601(f). There is a separate statute covering silicosis and asbestosis. See Ark. Code Ann. § 11-9-602.

5. **What, if any, injuries or claims are excluded?**

The Arkansas Act defines certain types of excluded injuries: unprovoked assaults, horseplay (except “innocent victims”), certain recreational and social injuries, injuries which occur at a time when “actual employment services are not being performed,” and injuries substantially occasioned by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician’s orders. Ark. Code Ann. § 11-9-102(4)(B).

6. **What psychiatric claims or treatments are compensable?**

Prior to July 1, 1993, all psychiatric claims were compensable so long as there was a causal connection between the injury and the employment. The employee also had to prove that the stress was greater than the day-to-day stress experienced by all employees. *McClain v. Texaco, Inc.*, 29 Ark. App. 218, 780 S.W.2d 34 (1989). All treatments were compensable if reasonable and necessary. Ark. Code Ann. § 11-9-508. *See* answer 5 regarding stress claims.

For conditions arising after July 1, 1993, mental injuries or illness are not compensable unless the condition is caused by physical injury to the employee’s body. However, the physical injury limitations do not apply to a victim of crime or violence. Ark. Code Ann. § 11-9-113(a)(1). Moreover, no mental injury or illness is compensable unless diagnosed by a licensed psychiatrist or psychologist, using a diagnosis consistent with the current issue of the Diagnostic and Statistical Manual of Mental Disorders. Ark. Code Ann. § 11-9-113(a)(2). There is also a twenty-six week limitation on disability benefits associated with psychological injuries. Finally, there is a one year limitation on death benefits resulting from a mental injury. Ark. Code Ann. § 11-9-113.

7. **What are the applicable statutes of limitations?**

Compensation for disability for an injury, other than an occupational disease or infection, is barred unless a claim is filed with the Commission within two years from the injury. If, during the two year period following the filing of the claim, the employee receives no weekly benefits or medical treatment from the injury, the claim is barred. Ark. Code Ann. § 11-9-702(a)(1).

A claim for an injury which is either an occupational disease or occupational infection is barred unless filed within two years from the date of the last injurious exposure. Ark. Code Ann. § 11-9-702(a)(2). A claim for silicosis or asbestosis must be filed within one year after disablement, and the disablement must occur within three years from the last injurious exposure. Ark. Code Ann. § 11-9-702(a)(2)(B). A claim for a disease or condition caused by an exposure to x-rays, radioactive substances, or ionizing radiation, must be filed within two years from the date the condition is made known to an employee following an examination and diagnosis by a doctor. Ark. Code Ann. § 11-9-702(a)(2)(C). Act 796, effective July 1, 1993, defines “date of injury” as the date an injury is caused by an accident.

A claim for compensation on account of death is barred unless filed within two years of the death. Ark. Code Ann. § 11-9-702(a)(3). If within six months after the filing of a claim, and no hearing has been requested, the claim will [upon motion] be dismissed without prejudice until the refiling of the claim within limitations. Ark. Code Ann. § 11-
9-702(a)(4). A claim for additional compensation is barred unless filed within one year from the last payment of compensation or two years from the date of the injury, whichever is later. Ark. Code Ann. § 11-9-702(b).

8. **What are the reporting and notice requirements for those alleging an injury?**

An employer is not responsible for a claim until the employee reports the injury to a person or at a place specified by the employer, on a form prescribed by the Commission, unless the employee is rendered unable to do so by the injury. Ark. Code Ann. § 11-9-701(a)(1). The foregoing does not apply when an employee requires emergency medical treatment outside of the employer’s normal business hours. In that event, however, the employee must report the injury on the employer’s next regular business day. Ark. Code Ann. § 11-9-701(a)(3).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

      A claim is barred if the injury or death was substantially occasioned by willful intention of the employee to bring about the injury or death. Ark. Code Ann. § 11-9-401(a)(2).

   B. **Willful misconduct, “horseplay,” etc.**

      An injury resulting from horseplay or willful misconduct is not compensable if the employer had no prior knowledge of the conduct, unless the injury is sustained by an innocent party. *Southern Cotton Oil Division v. Childress*, 237 Ark. 909, 377 S.W.2d 167 (1964). See also Ark. Code Ann. § 11-9-102(4)(B)(i).

   C. **Injuries involving drugs and/or alcohol.**

      A claim is barred if the injury or death was substantially occasioned by the employee’s intoxication. Ark. Code Ann. § 11-9-102(4)(B)(iv).

      Also, the use of prescription drugs in contravention of a physician’s orders may bar a claim. The law also now shifts the burden of proof. If testing reveals the presence of a drug, there is a rebuttable presumption that it caused the injury. Finally, the employee is deemed to have impliedly consented to reasonable and responsible testing for drugs and alcohol. One caveat: The relatively new state law permitting medical marijuana will complicate the intoxication defense. Stay tuned.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    Any person or entity who willfully and knowingly makes any false statement or representation for the purpose of obtaining benefits or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim or payment or obtaining or avoiding workers’ compensation coverage, is guilty of a Class D felony. The Act also provides for the establishment within the Arkansas Insurance Department of a workers’
compensation fraud investigation unit. That unit has been given broad powers to investigate and, where appropriate, to refer for prosecution. Ark. Code Ann. § 11-9-106.

11. Is there any defense for falsification of employment records regarding medical history?

No compensation will be paid if the employee, at the time of entering into the employment, falsely represented in writing not having previously been disabled, laid off or compensated for an injury. Ark. Code Ann. § 11-9-601(b). False representation of a physical condition in procuring employment will preclude benefits if it is shown that: (1) the employee knowingly and willfully made a false representation as to the condition; (2) the employer relied upon the representation; (3) the reliance was a substantial factor in the hiring decision; and (4) there was a causal connection between the concealed condition and the new injury. *Shippers Transport of Georgia and Travelers Ins. Co. v. Stepp*, 265 Ark. 365, 578 S.W.2d 232 (1979). See answer 10.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Injuries suffered by an employee while watching, participating in, or going to or coming from recreational activities sponsored in whole or in part by employer are generally not compensable, but there are exceptions where employees are required to participate, there is regular participation or participation incidental to the employment, or recreational facilities are maintained by an employer for its own interest and not merely because of altruistic motives. Ark. Code Ann. § 81-13-1 et seq.; *Woodmansee v. Frank Lyon Co.*, 223 Ark. 222, 265 S.W.2d 521 (1954). Recreational or social activities do not provide the basis for a claimed compensable injury when the activities are determined to be primarily for the “employee’s personal pleasure”. Ark. Code Ann. § 11-9-102(4)(B)(ii).

13. Are injuries by co-employees compensable?

Yes, if they arise out of and in the course of the employment.

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?


**BENEFITS**

15. What criterion is used for calculating the average weekly wage?

State average weekly wage is determined by the director of the Department of Labor. Compensation is computed on the average weekly wage earned at the time of the accident and in no case on less than a full time workweek. Ark. Code Ann. § 11-9-518.
Per diem payments for truckers must be included in calculating their average weekly wage. See *Eckhardt v. Willis Shaw*, 62 Ark. App. 224, 970 S.W.2d 316 (1998).

Where the employee was working on a piece basis, the wage is determined by dividing the earnings by the number of hours required to earn the wages, up to 52 weeks preceding the accident, and by multiplying this wage by the number of hours in a full time work week. Ark. Code Ann. § 11-9-518(a)(2). Overtime earnings are added by dividing the overtime earnings by the number of weeks worked in the same employment, up to 52 weeks before the accident. Ark. Code § 11-9-518(b).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Compensation for temporary/lost time must not exceed two-thirds of the employee’s average weekly wage, up to a statutory maximum. Ark. Code Ann. § 11-9-501(b). The minimum is $20.00 per week. *Id.* Also, the benefit rates are rounded to the nearest whole dollar, effective January 1, 1994. *Id.* The maximum rate for temporary/lost time benefits changes each year, along with the state average weekly wage. Ark. Code Ann. § 11-9-501. For maximum and minimum rates in recent years, see below:

**Total Disability (TTD and PTD)**

- As of 1/1/20  $711 (max) and $20 (min)
- As of 1/1/19  $695 (max) and $20 (min)
- As of 1/1/18  $673 (max) and $20 (min)
- As of 1/1/17  $661 (max) and $20 (min)
- As of 1/1/16  $646 (max) and $20 (min)
- As of 1/1/15  $629 (max) and $20 (min)
- As of 1/1/14  $617 (max) and $20 (min)
- As of 1/1/13  $602 (max) and $20 (min)
- As of 1/1/12  $584 (max) and $20 (min)
- As of 1/1/11  $575 (max) and $20 (min)
- As of 1/1/10  $562 (max) and $20 (min)

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The first installment becomes due on the fifteenth day after notice to the employer, and all compensation then accrued must be paid. Subsequent compensation must be paid every two (2) weeks unless the Commission directs otherwise. § 11-9-802(a). For failure to pay benefits, including willful and intentional failure to pay benefits, see Ark. Code Ann. § 11-9-802(b),(c),(e).
18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

Compensation is not allowed for the first seven days, excluding the day of injury. If a disability extends beyond that period, compensation commences with the ninth day of disability. If a disability extends for a period of two weeks, compensation is allowed beginning the first day of disability, excluding the day of injury. Ark. Code Ann. § 11-9-501(a).

19. **What is the standard/procedure for terminating temporary benefits?**

Benefits continue until the healing period ends, when the employee is as far restored as the permanent character of the injury will permit. *Mountain Valley Superette, Inc. v. Bottorff*, 4 Ark. App. 251, 629 S.W.2d 320 (1982). Within 30 days after the final payment of compensation, the employer/insurer must send to the Commission a notice, on the prescribed form. This Form (AR-4) must state that the final payment has been made, the total amount of compensation paid, the employee’s name and any other person to whom compensation has been paid, and the date of injury or death. Ark. Code Ann. § 11-9-810(b)(l). If payments are suspended, the employer/insurer must notify the Commission on a prescribed form (AR-4). Ark. Code Ann. § 11-9-810.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No.

21. **What disfigurement benefits are available and how are they calculated?**

Compensation for serious and permanent facial or head disfigurement may be awarded up to $3,500.00. No award for disfigurement can be entered until 12 months after the injury. Ark. Code Ann. § 11-9-524.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

The permanent partial disability rate (PPD) shall, in most instances, not exceed seventy-five (75%) of the employee’s total disability rate. Ark. Code Ann. § 11-9-501(d). There are different calculations – narrowing the gap between PPD and TTD – when the total disability rate is less than $205.35 per week. For maximum and minimum rates in recent years, see below:

**Partial Disability (PPD)**

- As of 1/1/20 $533 (max) and $20 (min)
- As of 1/1/19 $521 (max) and $20 (min)
- As of 1/1/18 $505 (max) and $20 (min)
- As of 1/1/17 $496 (max) and $20 (min)
- As of 1/1/16 $485 (max) and $20 (min)
As of 1/1/15 $472 (max) and $20 (min)
As of 1/1/14 $463 (max) and $20 (min)
As of 1/1/13 $452 (max) and $20 (min)
As of 1/1/12 $438 (max) and $20 (min)
As of 1/1/11 $431 (max) and $20 (min)
As of 1/1/10 $422 (max) and $20 (min)

A. How many weeks are available for the scheduled member/parts, and the standard for recovery?

Arm amputated at the elbow, or between the elbow and shoulder.................................244 weeks
Arm amputated between the elbow and wrist.................................................183 weeks
Leg amputated at the knee or between knee and the hip..................................................184 weeks
Leg amputated between the knee and the ankle..................................................131 weeks
Hand amputated.........................................................................................183 weeks
Thumb amputated..................................................................................73 weeks
First finger amputated..................................................................................43 weeks
Second finger amputated..................................................................................37 weeks
Third finger amputated..................................................................................24 weeks
Fourth finger amputated....................................................................................19 weeks
Foot amputated..............................................................................................131 weeks
Great toe amputated......................................................................................32 weeks
Toe other than great toe amputated........................................................................11 weeks
Eye enucleated, in which there was useful vision...........................................105 weeks
Loss of hearing of one ear.............................................................................42 weeks
Loss of hearing of both ears.........................................................................158 weeks
Loss of one testicle.....................................................................................53 weeks
Loss of both testicles................................................................................158 weeks


Compensation for amputation of a first phalange is one-half (1/2) of the compensation for the amputation of the entire digit. Compensation for amputation of more than one phalange of a digit is the same as for the loss of entire digit. Ark. Code Ann. § 11-9-521(b).

Compensation for amputation or loss of use of two or more digits or one or more phalanges or two or more digits of a hand or foot may be proportioned to the total loss of use of the hand or the foot occasioned thereby but must not exceed the compensation for the total loss of a hand or foot. Ark. Code Ann. § 11-9-521(d). Compensation for the total loss of use of a member is the same as for amputation of the member. Compensation for permanent partial loss or loss of use of a member is the same as for the proportionate loss or loss of use of a member. Ark. Code Ann. § 11-9-521(e)-(f).
Compensation for the permanent loss of 80 percent or more of the vision of the eye is the same as for the loss of an eye. In all cases of permanent loss of vision, the use of corrective lenses may be taken into consideration in evaluating the extent of the loss of vision. Ark. Code Ann. § 11-9-521(c). There is no impairment when vision can be corrected by eyeglasses. *See Barnard v. B&M Construction*, 52 Ark. App. 61, 915 S.W.2d 296 (1996).

Amputations or permanent total loss of use of a member are to be paid at the total disability rate. Ark. Code Ann. § 11-9-501(d)(2)(B).

The Act provides an impairment rating guide which is included in Commission Rule 34. It outlines criteria for acceptable impairment ratings. Impairment rating must be made using the *AMA Guide to the Evaluation of Permanent Impairment, 4th Edition*.

**B. Number of weeks for “whole person” and standard for recovery.**


**23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**


The Act incorporates a strong return to work incentive. Under Section 505(a)(1), an employer who refuses without reasonable cause to return an injured employee to suitable employment, where such is available, will be ordered to pay the difference between benefits received and the employee’s average weekly wage for up to one year.

**24. How are permanent total disability benefits calculated, including the minimum and maximum rates?**

An employee receives, during permanent total disability, two-thirds of the average weekly wage, subject to the maximum rates for total disability (*see* answer 16). In the absence of clear and convincing proof to the contrary, the loss of both hands, both arms, both legs, both eyes, or any two thereof constitutes permanent total disability. In all other cases, permanent total disability is determined in accordance with the facts. Ark. Code Ann. § 11-9-519.

The Act provides for the reduction of payments in certain situations where the employee is paid benefits from public or privately funded retirement pension plans, but there is no reduction for payments made pursuant to the employee’s contributions to such a plan. There is no benefit offset for Social Security retirement benefits. *Golden v. Westark Community College*, 333 Ark. 41, 969 S.W.2d 154 (1998).

Ark. Code Ann. § 11-9-502 provides for a Death and Permanent Disability Trust Fund that covers losses associated with death and permanent disability after the employer and insurer have paid beyond a certain threshold. For injuries occurring on or after January 1, 2008, the employer or its carrier shall pay weekly benefits for death or permanent total disability “not to exceed three hundred twenty-five (325) times the maximum total disability rate” in effect at the time of the injury. Thus, the maximum exposure for permanent disability changes from year to year.

25. **How are death benefits calculated, including the minimum and maximum rates?**

   **A. Funeral expenses.**

   The employer pays the actual funeral expenses, up to $6,000. Ark. Code Ann. § 11-9-527(a).

   **B. Dependency claims.**

   Death benefits must not exceed two-thirds of the employee’s average weekly wage. The weekly minimum is $20.00. Ark. Code Ann. § 11-9-501(a). The maximum rate changes each year.

   Compensation for death is paid to those who were wholly and actually dependent upon the deceased employee in the following percentage of the employee’s average weekly wage and in the following order of preference: (1) to the spouse if there is no child, 35 percent and the compensation is paid until death or remarriage; but, the surviving spouse must establish some dependence upon the deceased employee before becoming entitled to benefits; (2) to the spouse if there is a child, the compensation payable under subdivision one of this section and 15 percent on account of each child; (3) to one child if there is no spouse, 50 percent; (4) to more than one child if there is no spouse, 15 percent to each child, and in addition thereto, 35 percent to the children as a class to be divided equally; (5) to the parents, 25 percent each; and (6) to brothers, sisters, grandchildren and grandparents, 15 percent each. Ark. Code Ann. § 11-9-527.

26. **What are the criteria for establishing a “second injury” fund recovery?**

27. **What are the provisions for reopening a claim for worsening of condition, including applicable limitations periods?**

The Commission may review any compensation order, award or decision on the ground of a change of physical condition or proof of an assignment of an erroneous wage rate. Ark. Code Ann. § 11-9-713 (a) and *United States Fid. & Guar. Co. v. Brewer*, 52 Ark. App. 214, 916 S.W.2d 773 (1996). Aging and its effects are not considered in determining whether there has been such a change.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

When the Commission finds that a claim has been controverted, in whole or in part, it will direct that fees for legal services be paid directly to the employee’s attorney as follows: ½ by the employer/insurer in addition to compensation awarded and ½ by the employee or dependent. Attorney fees are allowed only on the amount of compensation (indemnity) controverted and awarded and may not exceed 25% of the indemnity benefits awarded. Ark. Code Ann. § 11-9-715. There is no attorney’s fee on medical benefits whether or not controverted.

If an employee prevails on appeal, his or her attorney is entitled to additional fees at the full Commission and appellate court levels; the additional fee to be paid equally by the employer/insurer and by the employee or dependents. *Id.*

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**


B. **Exceptions (intentional acts, contractual waiver, “dual capacity”, etc.).**

Where the employer is uninsured, the employee may elect to claim workers’ compensation benefits or to sue in tort. Ark. Code Ann. § 11-9-105(b)(1). Also, where the acts of the employer which result in injury to the employee are deemed willful and intentional, the employer loses exclusive remedy protection. Ark. Code Ann. § 11-9-105; *Sontag v. Orbit Value Co.*, 283 Ark. 191, 672 S.W.2d 50 (1984).

In *Stapleton v. MD. Limbaugh Constr. Co.*, 333 Ark. 381, 969 S.W.2d 648 (1998), the Arkansas Supreme Court ruled that the prime contractor is not the “statutory employer” of the injured worker where the subcontractor paid workers’ compensation benefits to the injured employee. In such situations there is no real or quasi-employment relationship between the prime contractor and the injured employee. Hence, the injured worker may recover tort damages against the prime contractor.
Finally, where it is determined that an employee’s injuries are not covered by the workers’ compensation act, the circuit court has jurisdiction to hear a tort claim against the employer. In *Automated Conveyor Systems v. Hill*, 362 Ark. 215, 208 S.W.3d 136 (2005), the Arkansas Supreme Court ruled that circuit court had jurisdiction to consider a negligence action against the employer where it has previously been determined that the injured worker’s injuries were not of a type covered by the Workers’ Compensation Act. Jurisdiction to determine jurisdiction, however, rests solely with the Workers’ Compensation Commission. *Nucor Corp. v. Rhine*, 366 Ark. 550, 237 S.W.3d 52 (2006).

30. **Are there any penalties against the employer for unsafe working conditions?**

Prior law made additional compensation available to employees who established by clear and convincing evidence that an injury or death was caused in substantial part by the failure of an employer to comply with any Arkansas statute or official regulation pertaining to employee health or safety. That changed in 1993. Enhancement of benefits is no longer available to employees in such circumstances, however penalties may be assessed. Safety violations may trigger various provisions under Ark. Code Ann. § 11-9-409, which pertain to the Health and Safety Division. The Act provides for the establishment of a Workers’ Health and Safety Division, to, among other things, make designations of “extra-hazardous employers”. Such designations require formulation of remedial plans, inspections, etc. The Act also provides for formal accident prevention services. Ark. Code Ann. § 11-9-409.

31. **What is the penalty, if any, for an injured minor?**

Where an injury or death is sustained by a minor employed in violation of federal or state statutes pertaining to the minimum age for their employment, compensation or death benefits are doubled. However, the penalty does not apply when the minor misrepresents his or her age, in writing, to the employer. Ark. Code Ann. § 11-9-504.

32. **What is the potential exposure for “bad faith” claims handling?**

Willful discrimination with regard to hiring or tenure, or any term or condition of work on account of pursuing a compensation claim may result in a Class D felony with a fine up to $10,000. The same penalties are imposed on employers who obstruct or impede the filing of a claim for benefits. Ark. Code Ann. § 11-9-107.

33. **What is the exposure for terminating an employee who has been injured?**

See answer 32. It should be noted that under § 107 the penalty is not paid to the claimant, but rather to the Special Funds Division. Hence, there is little incentive for the claimant to pursue § 107 benefits.

An Arkansas Court of Appeals decision changed this. The Court of Appeals, in *Nestle, USA, Inc. v. Drone*, 2009 Ark. App. 311, 307 S.W.3d 54 (2009) determined that an employee, injured in the course of employment, may under certain circumstances receive enhanced disability benefits for up to one year under Ark. Code Ann. § 11-9-505(a). To receive such enhanced benefits, the claimant must prove that: (1) he or she sustained a
compensable injury, (2) suitable employment which is within his physical and mental limitations was available, (3) the employer refused to return the employee to work, and (4) the employer’s refusal was without reasonable cause.

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?


35. Can co-employees be sued for work-related injuries?


36. Is subrogation available?

Yes and no. An action at law can be commenced by an employee or the employer/insurer to recover damages against a responsible third party. If the action is initiated by the employee, the employer can intervene and assert a statutory lien. See Ark. Code Ann. § 11-9-410. However, in recent years, efforts by the employer/carrier to recover § 410 liens have been an exercise in futility. This is because of the impact of the “made whole” doctrine. In Franklin v. HealthSource of Arkansas, 343 Ark. 163 (1997), the Arkansas Supreme Court ruled that a health insurance carrier could not recover in a civil action until the injured plaintiff has been made whole. This decision rendered nugatory a contract between the injured party and his health carrier. This “made whole” requirement was extended to workers’ compensation liens by General Accident Insurance Company v. Jaynes, 343 Ark. 143 (2000). Hence, until the injured party is made whole, respondents will not be able to recover under the § 410 lien. Therefore, as a practical matter unless respondents can persuade claimant to waive the made whole defense, respondents will not be able to participate in a third party recovery.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Medical bills must be paid within 30 days of receipt. Willful failure to comply may result in a penalty of up to 36%. Ark. Code Ann. § 11-9-802(d)(e). Bills may, however, be audited and, when appropriate, reduced in line with the Commission Medical Cost Containment Program. (Commission Rule 099.30)

38. What, if any mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Medical records are obtained pursuant to a signed release. If the provider does not release records pursuant to a valid release, either party may ask the Commission to issue a subpoena. Commission Rule 099.30 also contains provisions pertaining to the release of medical records.
39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Evaluation?**


The claimant has an absolute right once during the claim to petition for a change in treating physician. Ark. Code Ann. § 11-9-514. Though the Commission tends to honor the claimant’s request for a specific treating physician, the ultimate decision is made by the Commission (Cost Containment Division). The Commission has found that the “one-time” change of treating physicians has not occurred until the Commission enters an order changing the physician. Where the claimant simply requests a new physician and the employer agrees, the Commission does not recognize that as the one-time change. A word to the wise: be certain that a change order is entered by the Commission.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**


41. **Which prosthetic devices are covered, and for how long?**

All prosthetic devices deemed reasonable and necessary are covered. Ark. Code Ann. § 11-9-508.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Vehicle and/or home modifications are covered as medical expenses if they are reasonable and necessary.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. The medical fee guide is Commission Rule 30.

44. **What, if any, provisions or requirements are there for “managed care”?**

Pursuant to Ark. Code Ann. § 11-9-508, the Workers’ Compensation Commission adopted Commission Rule 33. It provides for the establishment of a managed care program. Initially, the managed care program was to become mandatory in 1997, but it did not. Due to a number of challenges, managed care in Arkansas remains voluntary. Ark. Code Ann. § 11-9-530. Details concerning the purpose, rules, administration, certification, etc., are provided in Commission Rule 33.
**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Each employer desiring to controvert the right to compensation must file, on or before the fifteenth day following notice of the alleged injury or death, a statement on a form prescribed by the Commission [Form AR-2] asserting that the right to compensation is controverted, the grounds therefor, the names of the employee, employer, and insurer, if any, and the date and place of the alleged injury or death. Failure to file a statement of controversion does not preclude any defense to a claim subsequently filed, nor will the filing of the statement of controversion preclude additional defenses to those contained in it. Ark. Code Ann. § 11-9-803.

46. **What is the method of claim adjudication?**

   A. **Administrative level.**

   An administrative law judge presides over a hearing.

   B. **Trial court.**

   A party can appeal the administrative law judge’s decision to the Arkansas Workers’ Compensation Commission. This is a *de novo* review on the record. The standard of review is preponderance of the evidence.

   C. **Appellate.**

   An appeal from the Commission’s opinion is heard by the Arkansas Court of Appeals. This is an appeal of right. An appeal from the Arkansas Court of Appeals may be taken to the Arkansas Supreme Court upon a grant of a writ of certiorari. The much higher substantial evidence standard applies.

47. **What are the requirements for stipulations or settlements?**

Upon petition filed by the employer or carrier and the injured employee requesting a final settlement, the Workers’ Compensation Commission shall hear the petition, take testimony, make any investigation, and determine whether the proposal is in the best interest of the claimant. This is termed a “joint petition” procedure. If approved, the settlement is final as to all workers’ compensation rights, including future medical. Ark. Code Ann. § 11-9-805; Commission Rule 099.19.

48. **Are full and final settlements with closed medicals available?**

Yes. The Commission is not permitted to approve settlements with open medicals.
49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. A workers’ compensation claim cannot be settled in Arkansas without approval by the Commission. Informal settlements are not binding.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Every employer must secure compensation for disability or death from injury arising out of and in the course of employment. Ark. Code Ann. § 11-9-401(a)(1). Private insurers and an assigned risk pool are available.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

Each employer desiring to become an individual self-insurer, as contemplated by Ark. Code Ann. § 11-9-404, must make application to the Commission for such privilege on a prescribed form, at least sixty days prior to the desired effective date. The application must contain answers to all questions propounded and must be under oath. (Commission Rule 099.05)

Before considering the application, the Commission will require a current financial statement showing a net worth of not less than $250,000.00, a current ratio of more than one-to-one, and a working capital of an amount establishing financial strength and liquidity of the business to promptly pay normal claims. The requirement for a more than one-to-one ratio may be waived for a public utility or in those instances where generally recognized accounting principles peculiar to a particular industry make the requirement unreasonable. In any event, the net worth must be no less than three times the annual loss fund, or in the event that aggregate excess insurance is not maintained, at least three times the self-insurer’s annual standard premium. Financial statements dated six months or more prior to the date of application may be required to be accompanied by an affidavit stating that there has been no material lessening of net worth or significant deterioration of current ratio since the statement.

The Commission, as a condition to granting self-insured status, may require the employer to deposit either an indemnity bond or securities. The conditions of the surety include authorization to the Commission, in case of default, to sell any securities sufficient to pay awards or to bring suit on the bonds to procure prompt payment of compensation.

B. **For groups or “pools” or private entities.**

The Commission, under such rules and regulations as it may prescribe, may permit two or more employers engaged in a common type of business activity or pursuit to enter into agreements to pool their liabilities under the Act for the purposes of qualifying as self-insurers, and each member of such group is classified as a self-insurer.
In order to qualify as a group self-insurer, the group must furnish to or satisfy the Commission as to the following: (1) an application accompanied by an indemnity agreement jointly and severally binding each member to comply with the Act and an individual application by each member; (2) a current, audited financial statement of each member showing a combined net worth of all members of not less than $1,000,000.00, a combined ratio of current assets to current liabilities of not less than one-to-one, and working capital of an amount establishing financial ability and liquidity sufficient to promptly pay normal claims; (3) that the group deposits and maintains with the Commission acceptable securities or has posted a surety bond issued by a corporate surety authorized to do business in Arkansas, in an amount determined by the Commission, but not less than $200,000.00; (4) that there are ample facilities and competent personnel of good character within the group, or through an approved service organization, for the group to service its own program with respect to underwriting matters, claims and adjusting, industrial safety engineering, accounting, and financial management; (5) that the group maintains acceptable excess insurance; and (6) that such financial statements, payroll records, accident experience, and compensation reports and such other reports and statements are filed at such time and in such manner as the Commission may require. Ark. Code Ann. § 11-9-404.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Given the other compensability requirements, illegal aliens are covered in Arkansas.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No. The CMS Guidelines control in Arkansas.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for
medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

As for health insurers, liens would typically be covered by the contract of insurance. However, in dealing with workers’ compensation the Arkansas Supreme Court has determined that the “made whole” doctrine applies. *Franklin v. Healthsource of Arkansas*, 328 Ark. 163, 942 S.W. 2d 837 (1997). Thus, the insurer receives nothing on its lien until and unless it is determined that the claimant has been made whole.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(1)]

57. **What are the provisions for “Independent Contractors”?**

By definition, an Independent Contractor is not an employee, and therefore not covered under the Arkansas Workers’ Compensation Law. The Courts in Arkansas have considered this issue on many occasions. In reaching a determination as to whether a particular claimant is, or is not, an independent contractor, the Courts have designated a number of factors that can be considered. In *Franklin v. Arkansas Craft, Inc.*, 5 Ark. App. 264, 635 S.W.2d 286 (1982), the following factors were listed as those that may be considered: 1. The right to control the means and method by which the work is done; 2. The right to terminate the employment without liability; 3. The method of payment, whether by time, job, piece, or other unit of measurement; 4. The furnishing, or the obligation to furnish, the necessary tools, equipment, and materials; 5. Whether the person employed is engaged in a distinct occupation or business; 6. The skill required to do a particular occupation; 7. Whether the employer is in business; 8. Whether the work is an integral part of the regular business of the employer; and 9. The length of time for which the person is employed. In considering those factors the Courts and the Commission give greatest weight to the amount of control an employer has exercised (or has the right to exercise) over the claimant. This is sometimes referred to as the “relative nature of the work” test. *See Silvicraft, Inc. v. Lambert*, 10 Ark. App. 28, 661 S.W.2d 403 (1983).

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

Arkansas Code Ann. § 23-92-401, et. seq. provides for the licensing and operation of professional employer organizations. A licensed professional employer organization shall be deemed an employer of the covered employee and shall perform the following employer responsibilities in conformity with all applicable federal and state laws and regulations to: “Be entitled and to entitle the client, together as joint employers to the exclusive remedy under § 11-9-105, under both the workers’ compensation and
59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

There are no special provisions for owner/operators or delivery drivers. The ordinary factors listed at number 57 are applied. However, the Arkansas Workers’ Compensation Commission has examined this question in the case of *Arlie Stark v. Lee Transportation Co.* AWCC Claim Nos. E507889 & E505795, June 26, 1997. In that case, owner/operators were held not to be employees and therefore not entitled to workers’ compensation benefits. Such cases are highly fact specific.

The Arkansas Code was amended to include Ark. Code Ann. § 11-9-412 which pertains to owner-operators (and their drivers). When specific requirements of the statute are followed, the owner-operators are deemed to be independent contractors (not employees) for workers’ compensation purposes. However, to take advantage of this 2013 change in Arkansas law, motor carriers must provide owner-operators the option to purchase workers’ compensation coverage through the motor carrier. Note that this option must be provided to the owner-operator in the parties’ written contract.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

No.
62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation Law?**

Yes, Arkansas permits medical marijuana due to the passage of a medical marijuana amendment to the Arkansas Constitution approved by the voters in November 2016. Act 593, among other acts, modified the amendment to allow employers to have and enforce substance abuse and drug free workplace programs that are compliant with state or federal law. Additionally, employers are free to prohibit employees a) from being under the influence of medical marijuana while at work or during work hours (although a positive drug test alone is not sufficient to show impairment), b) from possessing medical marijuana while at work or during work hours, and c) from holding safety-sensitive jobs if they are current users of medical marijuana.

The Arkansas Workers’ Compensation Commission is examining its Drug Free Workplace regulations with regard to the implementation of the medical marijuana amendment; no determination has been made yet whether there will be any rule or regulation modifications issued.

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

No.

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1. Citation for the state's workers' compensation statutes.

California Labor Code Division 1, Chapter 1 and Chapter 5; Division 3, Chapters 1 and 2; Division 4 through Division 4.7.

**SCOPE OF COMPENSABILITY**

2. Who are covered "employees" for purposes of workers' compensation?

   a. An "employee" means every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed. Cal. Lab. Code §3351. A person who renders service to another, other than as an independent contractor, is presumed to be an employee. Id. §3357.

   b. The term "employee" includes: (1) aliens and minors; (2) all elected and appointed paid public officers; (3) all officers and members of boards of directors of quasi-public or private corporations while rendering actual service for the corporations for pay; (4) persons employed by the owner or occupant of a residential dwelling whose duties are incidental to the ownership, maintenance, or use of the dwelling, including the care and supervision of children, or whose duties are personal and not in the course of the trade, business, profession, or occupation of the owner or occupant; (5) persons incarcerated in a state penal or correction facility while engaged in assigned work or work performed under a contract; (6) working members of a partnership or limited liability company receiving wages irrespective of profits from the partnership or limited liability company. Id. §3351.

   c. Persons generally excluded from employee status include: (1) any domestic employee whose employment by the employer to be held liable, during the 90 calendar days immediately preceding the date of injury, for injuries as described in Section 5411, or during the 90 calendar days immediately preceding the date of the last employment in an occupation
exposing the employee to the hazards of the disease or injury, for diseases or injuries as described in Section 5412, comes within either of the following descriptions:
(1) The employment was, or was contracted to be, for less than 52 hours;
(2) The employment was, or was contracted to be, for wages of not more than one hundred dollars ($100); (3) persons performing services in return for aid or sustenance only, received from any religious, charitable, or relief organization; (4) persons participating in, or officiating for, amateur sporting events (including intercollegiate or interscholastic sports events); and (5) any person performing voluntary services at or for a non-profit recreational camp or as a ski patroller, who receives no compensation for those services other than meals, lodging, and transportation. \textit{Id.} §3352.

d. In addition, the employee of a joint venture is an employee of each individual member of the joint venture. \textit{Horney v. Guy F. Atkinson Co.}, 190 Cal. Rptr. 18, 22-23 (Ct. App.1983). However, an employee of one party in a joint venture is not as a matter of law an employee of the joint venture itself or the other joint venturers. \textit{Rogness v. English Moss Joint Venturers}, 239 Cal. Rptr. 387, 388-89 (Ct. App. 1987).

e. Independent contractors are not employees for purposes of workers’ compensation. However, a worker’s status as independent contractor is a matter of law and not controlled by the intention of the hirer or the worker or the contracts between them. The WCAB retains jurisdiction to determine if a worker is properly classified as an employee or independent contractor. There is a rebuttable presumption that a worker performing services for which a license is required or is performing services for a person who is required to obtain such a license is an employee rather than an independent contractor. Cal. Lab. Code §2750.5. The test to determine the degree of control that distinguishes an employment relationship from an independent contractor relationship is set out in Cal. Lab. Code 2750.3 (effective January 1, 2020). In summary, a person paid for labor or services “shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates that the person is free from the control and direction of the hiring entity in connection with the performance of the work, the person performs work that is outside the usual course of the hiring entity’s business, and the person is customarily engaged in an independently established trade, occupation, or business.”

3. \textbf{Identify and describe any "statutory employer" provision.}

For purposes of the Act, the term “employer” is defined as (a) the state and every state agency, (b) each county, city, district, public or quasi-public corporation, and public agency, (c) every person (including a public service corporation) that has a natural person in service, and (d) a deceased employer’s legal representative. Cal. Lab. Code §3300.

California has long recognized that the employer-employee relationship exists for purposes of awarding compensation whenever the employer retains the right to direct how the work shall be done as well as the result to be accomplished. \textit{State Comp. Ins. Fund v. Indus.}
Accident Comm'n, 116 P.2d 173, 175 (Cal. Ct. App. 1941). Specifically, the determinative factor is whether the purported employer has the right to control rather than the amount of control exercised. Id. The right to exercise complete or authoritative control rather than mere suggestion concerning details must be shown. Id.

"An employer may secure the payment of compensation on employees provided to it by agreement by another employer by entering into a valid and enforceable agreement with that other employer under which the other employer agrees to obtain, and has, in fact obtained workers' compensation coverage for those employees." Cal. Lab. Code §3602(d)(1).

Effective January 1, 2020 California passed AB 5 which created Cal. Lab. Code §2750.5. The statute purports to statutorily embody the tests for control that had been judicially described by the California Supreme Court in Dynamex Operations West, Inc. v. Superior Court of Los Angeles, (2018) 4 Cal.5th 903. To distinguish an employment relationship from an independent contractor relationship, Cal. Lab. Code 2750.3 provides that, with several exceptions, a person paid for labor or services “shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates that the person is free from the control and direction of the hiring entity in connection with the performance of the work, the person performs work that is outside the usual course of the hiring entity’s business, and the person is customarily engaged in an independently established trade, occupation, or business.” As there are multiple exceptions, each case must be closely compared to the statute.

4. What types of injuries are covered and what is the standard of proof for each:

The Act compensates for injuries arising out of and in the course of employment (“AOE/COE”). Id. §3600(a); see also id. §3208. For an injury to arise out of the employment, it must occur by reason of a condition incident to the employment. Id. §3600(a). That is, the employment and the injury must be linked in some causal fashion. Id. However, such connection need not be the sole cause of the injury; it is sufficient if the employment is a contributory cause of the injury. Maher v. Workers' Comp. Appeals Bd., 190 Cal. Rptr. 904, 906 (1983). “Where the injury occurs on the employer's premises, while the employee is in the course of the employment, the injury arises out of the employment unless the connection is so remote from the employment that it is not an incident of it.” Madin v. Indus. Accident Comm’n, 292 P.2d 892, 895 (Cal. 1956) (en banc).

The test for the "arising out of" element has been gradually liberalized. Witkin, 2 Summary of California Law, Workers' Compensation §221 (9th ed.). The requirement is satisfied where the employee's work brings him or her into a position of danger at the time and place of the injury. The risk need not be foreseeable or peculiar to the employment. Emp't. Mut. Liab. Ins. Co. v. Indus. Accident Comm’n, 263 P.2d 4, 6 (Cal. 1953) (en banc); Indus. Indem. Co. v. Indus. Accident Comm’n, 214 P.2d 41, 47-48 (Cal. Ct. App. 1950).

The employee has the burden of proof by a preponderance of the evidence that there is a
causal relationship between work and disability. Cal. Lab. Code §3202.5; see also McAllister v. Workmen's Comp. Appeals Bd., 71 Cal. Rptr. 697, 702 (1968) (en banc). However, Section 3200, et seq. (the “Act”) “shall be liberally construed” to extend “benefits for the protection of persons injured in the course of their employment.” Cal. Lab. Code §3202.

When an employee's death takes place at work, in the absence of any evidence of what caused the death, most courts will infer that the death arose out of the employment, since the occurrence of the death at the place of employment at least indicates that the employment brought the employee within the range of harm, and the cause of harm, being unknown, is not personal. See Clemmons v. Workmen's Comp. Appeals Bd., 68 Cal. Rptr. 804, 806 (Ct. App. 1968). Also, when the death removes the only witness who could prove causal connection, fairness suggests some softening of the rule requiring the claimant to provide affirmative proof. Id.

In most cases, the employee's burden to show causation must be sustained with medical evidence. See Lundberg v. Workmen's Comp. Appeals Bd., 71 Cal. Rptr. 684, 686 (1968) (en banc); Peter Kiewit Sons v. Indus. Accident Comm'n, 44 Cal. Rptr. 813, 817-18 (Ct. App. 1965). Supporting testimony of a single physician may be sufficient, even if it conflicts with the testimony of several others. Allied Comp. Ins. Co. v. Indus. Accident Comm'n, 17 Cal. Rptr. 817, 821 (1961) (en banc); Mkt. Basket v. Workers' Comp. Appeals Bd., 149 Cal. Rptr. 872, 876 (Ct. App. 1978).

This obligation to prove causation also requires that there be a proximate cause between the employment and the injury. Proximate cause is a legal hurdle present in both negligence suits and workers’ compensation. However, in South Coast Framing, Inc. v. WCAB, Jovelyn Clark, (2015) 61 Cal.4th 291, the California Supreme Court makes clear that the height of that hurdle is far greater outside of workers’ compensation. The court writes that “[I]n the workers’ compensation system, the industrial injury need only be a contributing cause to the disability.”

There is but one cause of action for each injury coming within the provisions of this division – all claims brought for medical expense, disability payments, death benefits, burial expense, liens, or any other matter arising out of such injury may, in the discretion of the appeals board, be joined in the same proceeding at any time. Cal. Lab. Code §5303.

All questions of fact and law regarding either specific injuries or cumulative injuries, or both, shall be separately determined with respect to each such injury, including, but not limited to, the apportionment between such injuries of liability for disability benefits, the cost of medical treatment, and any death benefit. Id. §3208.2. No injury, whether specific or cumulative, shall merge into or form part of another injury. Id. §5303.

A statutory presumption of industrial causation applies to certain law enforcement and firefighting personnel with specified conditions, including hernia, heart trouble, cancer,
pneumonia, meningitis, tuberculosis, Lyme disease, and back problems, if the condition developed or manifested itself during the employment period. \textit{Id.} §§3212-3213.2. The presumption applies to all hospital, surgical, and medical treatment, disability benefits, and death benefits. \textit{Zipton v. Workers' Comp. Appeals Bd.}, 267 Cal. Rptr. 431, 432 n. 1, 436-37 (Ct. App. 1990). In order to be entitled to the presumption, the employee must show that the condition exists and that it developed or manifested itself during the period in which the employee worked for the public agency. \textit{Smith v. Workers' Comp. Appeals Bd.}, 260 Cal. Rptr. 327, 329 (Ct. App. 1989).

No workers' compensation claim shall be denied because the employee's injury or death was related to the employee's race, religious creed, color, national origin, age, gender, marital status, sex, sexual orientation, or genetic characteristics (i.e., violent acts perpetrated against an employee because of an immutable characteristic). Cal. Lab. Code §3600(c).

\textbf{A. Specific and cumulative trauma claims.}

A “compensable injury” is one that causes disability or a need for medical treatment. \textit{Livitsanos v. Superior Court}, 828 P.2d 1195, 1201 (Cal. 1992). Compensable injuries may be emotional or physical. \textit{Id.; see also} Cal. Lab. Code §3208.3 (establishing the threshold of compensability for psychiatric injuries).

"Injury" includes any injury or disease arising out of the employment, including injuries to artificial members, dentures, hearing aids, eyeglasses and medical braces. Cal. Lab. Code §3208. The injury may be either "specific," occurring as the result of one incident or exposure, or may be "cumulative," occurring as repetitive mentally or physically traumatic activities extending over a period of time. \textit{Id.} §3208.1. A compensable injury may arise out of a combination of both specific insult and cumulative trauma. The number and nature of the injuries suffered are questions of fact for the workers' compensation appeals board to determine. In \textit{Western Growers Ins. Co. v. Workers' Comp. Appeals Bd.}, 20 Cal. Rptr. 2d 26, 32 (Ct. App. 1993), the court of appeal explained that "under section 3208.1, an injury causing a need for medical treatment is compensable even in the absence of disability. In this case Austin had a compensable injury from 1985 onward. Although he had two periods of disability, i.e., the inability to work, those two periods of disability were connected by a continuous need for medical treatment all caused by a single work-related cumulative injury, stress-induced depression."

The California Supreme Court addressed the question of how to determine the date of injury in \textit{Fruehauf Corp. v. Workmen's Comp. Appeals Board}, 68 Cal. Rptr. 164 (1968). "For the purposes of discussion, we observe that compensable injuries under the workmen's (sic) compensation law generally fall into four categories: (1) specific injuries incurred as the result of one incident or exposure in the employment, the effects of which are immediately realized or realizable; (2) industrial injuries suffered as the result of a specific incident or exposure but which have latent effects; (3) continuous cumulative traumatic injuries, such as that involved here, suffered as the result of a number of minor strains over a period of time;
(4) cumulative injuries, such as silicosis, resulting from continuous exposure to harmful substances.” *Id.* at 167. The definition of cumulative trauma includes contagious and infectious diseases, and diseases that are products or aggravations of discogenic diseases. *See Chavez v. Workmen's Comp. Appeals Board*, 106 Cal. Rptr. 853, 859 (Ct. App. 1973).

**B. Occupational disease (including respiratory and repetitive use).**

Although "occupational disease" is not specifically defined by the Labor Code, “any injury or disease arising out of the employment” qualifies as an injury. Cal. Lab. Code §3208. California has long recognized that an occupational disease is the cumulative effect that results from continually absorbing small quantities of a deleterious substance from the environment of the employment ultimately results in manifest pathology. *Associated Indem. Corp. v. IAC*, 12 P.2d 1075, 1076 (Cal. Ct. App. 1932), disapproved of on other grounds by *Colonial Inc. Co. v. Indus. Accident Comm’n*, 172 P.2d 884, 888 (Cal. 1946) (*en banc*).

However, the cause of action for the occupational disease does not arise until the employee knows of the effect of the exposure. For example, silicosis is not an “injury” until the employee knows, or by due care and diligence is presumed to know, that he has an occupational disease which has progressed to the extent that he is so disabled that the efficiency of his work is appreciably affected thereby, and such injury may not arise until after the employment proximately causing it has ceased. *Bonner v. Indus. Accident Comm’n*, 140 P.2d 1000, 1003 (Cal. 1943) (rehearing granted).

Exposure to infectious disease in the work environment can also result in compensable injury. "For example, recovery was available for kerato-conjunctivitis, an infectious eye disease, contracted during a workplace epidemic; poliomyelitis from contact with patients in a hospital; dermatitis from cinnamon exposure; and HIV from exposure to the HIV virus." 1-4 CA Law of Employee Injuries & Workers’ Comp. §4.71.

**5. What, if any, injuries or claims are excluded?**

Injuries caused by the employee's intoxication, either by alcohol or the unlawful use of a controlled substance, are not covered. Cal. Lab. Code §3600(a)(4). In addition, the Act excludes intentionally self-inflicted injuries, suicide, injuries arising out of an altercation in which the employee is the initial aggressor, injuries caused by commission of felonious acts for which the employee has been convicted, and injuries from voluntary participation in any off-duty recreational, social or athletic activity not constituting part of the work-related duties, except where the activity is reasonably expected of the employee. *Id.* §3600(a)(5)-(9).

Claims filed after involuntary termination of the employment for injuries occurring prior to termination are barred, if the employer was unaware of the injury, the employee's medical records do not contain evidence of the injury prior to termination, or the date of injury as that is defined for cumulative traumas is subsequent to the date of notice of termination or layoff.
Id. §3600(a)(10). The date of injury for a cumulative trauma is the first date of disability and knowledge or "in the exercise of reasonable diligence [when the employee] should have known that such disability was caused by his present or prior employment." Id. §5412.

Claims for psychiatric injury filed post termination are subject to a higher threshold of compensability. See State Comp. Ins. Fund v. Workers' Comp. Appeals Bd., 139 Cal. Rptr. 3d 215, 218-19 (Ct. App. 2012); see discussion infra at paragraph 6.

6. What psychiatric claims or treatments are compensable?

A psychiatric injury may be compensable if it is a mental disorder arising out of the actual events of the employment which causes disability or need for medical treatment. Cal. Lab. Code §3208.3. For injuries on or after July 16, 1993, an employee must demonstrate by a preponderance of the evidence that actual events of employment are predominant as to all causes combined of the psychiatric injury. Id. §3208.3(b)(1). This means that the work related cause of the injury must be greater than 50 percent of the entire set of causal factors. Dep’t of Corr. v. Workers’ Comp. Appeals Bd., 90 Cal. Rptr. 2d 716, 720 (Ct. App. 1999).

In determining all the causes of the injury, no compensation is payable if the psychiatric injury was substantially caused by a lawful, nondiscriminatory, good faith personnel action. Cal. Lab. Code §3208.3(h). The burden of proof rests with the party asserting the good faith personnel action. Id.

Two conditions must be satisfied before an allegation can qualify for an award of workers’ compensation benefits for a psychiatric injury. Pac. Gas & Elec. Co. v. Workers’ Comp. Appeals Bd., 8 Cal. Rptr. 3d 467, 472 (Ct. App. 2004). First, the factor must be an “event” (i.e., it must be something that takes place in the employment relationship). Id. Second, the event must be “of employment” (i.e., it must arise out of an employee’s working relationship with his or her employer). Id. The Legislature's intent to limit claims for psychiatric benefits due to their proliferation and their potential for fraud and abuse “should be considered when determining whether an award for benefits is warranted.” Id. at 473. Thus, “any interpretation of the section 3208.3 that would lead to more or broader claims should be examined closely to avoid violating express legislative intent.” Id. (citing Dyna-Med, Inc. v. Fair Emp’t. Hous. Comm’n, 241 Cal. Rptr. 67, 70 (1987)).

In cases where the injury resulted from a violent act, the employee only has to show by a preponderance of the evidence that actual events of employment were a substantial cause of the injury. Cal. Lab. Code §3208.3(b)(2). The term “substantial” means at least 35 to 40 percent of the causation from all sources combined. Id. §3208.3(b)(3); Sonoma State Univ. v. Workers' Comp. Appeals Bd., 48 Cal. Rptr. 3d 330, 332-34 (Ct. App. 2006).

A psychiatric injury is only compensable if the employee has been employed by that employer for at least six months. Cal. Lab. Code §3208.3(d). However, the 6 month qualification does not apply if the injury is caused by a sudden and extraordinary employment condition. Id. There remains tension over the meaning of "sudden and
extraordinary" in this context. The Court of Appeal sustained a WCAB determination that an injury was "sudden and extraordinary for a lumber loader who lost several fingers while arranging wood on a conveyor belt and caught his hand in the chain attached to a saw mechanism. Redwood Empire Sawmill v. Workers' Comp. Appeals Bd., 78 Cal. Comp. Cases 498 (Cal. App. 1st Dist. 2013). Yet, the Court of Appeal reversed the WCAB and denied compensation for the psychiatric consequences of serious injuries suffered by an avocado picker/high tree worker who fell from a 24' ladder approximately two months after being hired. State Comp'n Ins. Fund v. Workers' Comp. Appeals Bd., 139 Cal. Rptr. 3d 215, 221 (Ct. App. 2012).

Claims for psychiatric injury filed after termination of the employment for injuries alleged to have occurred prior to termination are barred unless the employee proves by a preponderance of the evidence that one or more of the following conditions exist: sudden and extraordinary events of employment were the cause of the injury; the employer has notice of the psychiatric injury prior to the notice of termination; the employee's medical records prior to the notice of termination contain evidence of treatment; a finding of sexual or racial harassment by any trier of fact; or, the date of injury in the case of a cumulative trauma is after the date of termination or layoff. Cal. Lab. Code §3208.3(e).

For dates of injury on or after January 1, 2013, no permanent disability benefits are payable for psychiatric disorders, sleep dysfunction or sexual dysfunction that "arise out of a compensable physical injury." Cal. Lab. Code §4660.1(c)(1). The exceptions to this limitation include being a victim of a violent act, or being the victim of a catastrophic injury such as loss of a limb, severe burn, or paralysis. Id. at (c)(2)(A) - (B). However, making the "determination of whether an injury is catastrophic under section 4660.1(c)(2)(B) focuses on the nature of the injury and is a fact-driven inquiry." Wilson v. State Of California Cal Fire, (Cal.W.C.A.B. May 10, 2019) 84 Cal. Comp. Cases 393. The WCAB en banc held that psychiatric permanent disability was payable when "evidence in [the] record reflected that claimant’s industrial injury was serious and life-threatening, including that claimant was intubated and remained in hospital for approximately two weeks, physical injury caused permanent impairment to multiple body parts, and claimant was unable to return to work as a firefighter because of industrial injury." Id.

7. What are the applicable statutes of limitations?

The California Labor Code provides that a claim for specific or cumulative trauma must be filed within 1 year from the last of any of the following events: (1) date of injury; (2) date of the last indemnity payment; or (3) date of the last furnishing of any medical benefit. Cal. Lab. Code §5405. In practice the operation of the statute is complicated by the definition of date of injury. "The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability there from and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment." Id. §5412. The California Supreme Court has determined that a claimant cannot be imputed to have knowledge of industrial causation until the
information is conveyed by a physician. "It would be unreasonable to hold that although an employee who has suffered an injury resulting from several minor traumas is deemed not to be injured for the purposes of the statute of limitations until the minor traumas result in disability, once the injury has ripened into disability he is required to know immediately that such disability was caused by his employment." Fruehauf Corp. v. Workmen's Comp. Appeals Bd., 68 Cal. Rptr. 164, 169 (1968) (en banc).

New & Further Disability Benefits: Once the WCAB issues an order, it has continuing jurisdiction to amend that order within 5 years from the date of injury. Cal. Lab. Code §5804. A petition for new and further permanent disability may be filed within 5 years of the date of injury, regardless of the date of the award. Id §5410. However, the jurisdiction of the WCAB to enforce its awards of future medical care extends for the life of the injured worker. Id. §5803; see Barnes vs. Workers’ Comp. Appeals Bd., 97 Cal. Rptr. 2d 638, 644 (2000). The Board’s jurisdiction to consider granting additional benefits after an award, does not extend the 104 week within 5 years limitation on receiving temporary disability benefits imposed by Labor Code §4656. County of San Diego v. WCAB, Kyle Pike, 21 Cal.App. 5th 1 (2018).

Subsequent Injuries Benefits: Five years from the date of injury if during that period the employee knows, or can reasonably be deemed to know, that there is a substantial likelihood that he or she will be entitled to subsequent injury benefits. Subsequent Injuries Fund v. Workers’ Comp. Appeals Bd., 465 P.2d 28, 33 (Cal. 1970).

Death Benefit or Burial Expense: One year from the date of death where death occurs within one year from the date of injury; or one year from the last furnishing of benefits when the death occurs more than one year from the date of injury; or one year from the date of death, where death occurs more than one year after the date of injury and benefits have been furnished. Cal. Lab. Code §5406. No proceedings may be commenced more than one year after the date of death, nor more than 240 weeks from the date of injury. Id.

Serious and Willful Misconduct of Employer: Twelve months from the date of injury. Id. §5407. This period cannot be extended by payment of compensation, agreement, or the filing of application for compensation benefits. Id.

Serious and Willful Misconduct of Employee: Twelve months from the date of injury, but there is no time limit if employee has commenced proceedings for serious and willful employer misconduct. Id. §5407.5.

Vocational Rehabilitation: The vocational rehabilitation statutes, Labor Code sections 4635 to 4647, were repealed in 2003. Thus, the WCAB has no jurisdiction to award benefits regardless of the date of injury or to enforce an award of vocational rehabilitation benefits that was not final by January 1, 2009, when California Labor Code section 139.5 was repealed. Beverly Hilton Hotel v. Workers' Comp. Appeals Bd., 99 Cal. Rptr. 3d 50, 54-57 (Ct. App. 2009).
Supplemental Job Displacement Voucher: Concurrently with the elimination of vocational rehabilitation the legislature created the Supplemental Job Displacement Voucher (SJDV) to provide reimbursement for some educational expenses and supplies in the event an employer does not offer an injured worker the opportunity of returning to work. For injuries after January 1, 2013, the voucher expires 2 years after the date it is furnished or five years after the date of injury, whichever is later. Cal. Lab. Code §4658.7(f).

Change of Prior Award: Five years from date of injury to file petition to rescind, alter, or amend prior award. Cal. Lab. Code §5804; see also Barnes v. Workers’ Comp. Appeals Bd., 97 Cal. Rptr. 2d 638, 644 (2000).


8. **What are the reporting and notice requirements for those alleging an injury?**

Written notice signed by the employee must be served upon the employer within thirty days after the injury. *Id.* §5400. An employer’s knowledge of the injury, however, obtained from any source (e.g., managing agent, superintendent, foreman, or other person in authority) or the employer's knowledge of assertion of a claim of injury sufficient to afford the employer opportunity to investigate, is equivalent of service required by the statute. *Id.* §5402.

If a claim for benefits asserted under section 5402 is denied by the employer within 90 days of receiving a Notice of Claim, an Application for Adjudication of Claim must be filed within the applicable statute of limitations. *Id.* §5404; see *supra* question 7 for the applicable statutes of limitations.

9. **Describe available defenses based on employee conduct:**

"Employee misconduct, whether negligent, willful, or even criminal, does not necessarily preclude recovery under workers’ compensation law. In the absence of an applicable statutory defense, such misconduct will bar recovery only when it constitutes a deviation from the scope of employment. [Citations.] In determining whether particular misconduct takes an employee outside the scope of his employment, 'A distinction must be made between an unauthorized departure from the course of employment and the performance of a duty in an unauthorized manner. Injury occurring during the course of the former conduct is not compensable. The latter conduct, while it may constitute serious and willful misconduct by the employee [citation], does not take the employee outside the course of his employment. [Citations.]'" *Westbrooks v. Workers’ Comp. Appeals Bd.*, 252 Cal. Rptr. 26, 27-28 (Ct. App. 1998).

A. **Self-inflicted injury.**
An employee who intentionally injures himself or herself is not entitled to workers' compensation benefits. Cal. Lab. Code §3600(a)(5)-(6). However, the distinction between what is intentional in contrast to volitional but impulsive will affect the determination of compensability. "Employees who merely act rashly or impulsively neither expect nor intend to necessarily hurt themselves nor are their resulting work-related injuries automatically noncompensable.” Smith v. Workers’ Comp. Appeals Bd., 94 Cal. Rptr. 2d 186, 193 (Ct. App. 2000).

B. Willful misconduct, "horseplay," etc.

Serious and willful misconduct reduces compensation by one-half, except when the injury results in death, or the injury results in permanent disability of at least 70%, or the injury is caused by an employer's safety violation, or when the employee is under age 16. Cal. Lab. Code §4551. "The employee's transgression of rules, instructions, or established custom, as the case may be, is wholly within the sphere of the employment. It may constitute serious and willful misconduct of the employee, but it does not take him out of the course of his employment." Williams v. Workers' Comp. Appeals Bd., 116 Cal. Rptr. 607, 609 (Ct. App. 1974).

Furthermore, injuries suffered by an employee who was a willing participant in “horseplay” are not compensable, unless the employer knowingly condoned the activity. See Hodges v. Workers' Comp. Appeals Bd., 147 Cal. Rptr. 546, 552-53 (1978).

C. Initial Physical Aggressor

Injuries arising out of an altercation in which the injured employee is the initial physical aggressor are not compensable. Cal. Lab. Code §3600(a)(7).

D. Injuries involving drugs and/or alcohol.

Injuries caused by intoxication (alcohol or controlled substance) are not compensable. Id. §3600(a)(4). However, only if the intoxication is proved to be a substantial cause of the injury will this bar apply. "Published California court decisions do not fully explain what kind of causation is required to prove the defense of intoxication. However, the results reached in the cases indicate that the courts interpret the statutes as requiring that intoxication must be shown to be a proximate cause or substantial factor in causing injury, but not necessarily the sole cause." Smith v. Ed Smith Welding, 176 Cal. Rptr. 843, 848 (Ct. App. 1981).

E. Suicide.

Death caused by the willful and deliberate actions of the employee is not compensable. Cal. Lab. Code §3600(a)(6). However, the California Supreme Court has determined that a suicide resulting from an uncontrollable impulse generated by an industrial injury is
compensable, "Recovery is proper if it is shown that without the injury there would have been no suicide." *Ballard v. Workers' Comp. Appeals Bd.*, 92 Cal. Rptr. 1, 4 (1971) (*en banc*).

**F. Criminal Conduct**

Injuries arising out of the employee's commission of a felony for which the employee is convicted are not compensable. Cal. Lab. Code §3600(a)(8).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

An employee may be subject to fines and imprisonment for knowingly making a fraudulent oral or written material statement for the purpose of obtaining, or discouraging a party from obtaining, workers' compensation benefits. Cal. Ins. Code §1871.4(a); Cal. Lab. Code §3820(b). Any person convicted of such violation is ineligible to receive benefits and restitution will be ordered. Cal. Ins. Code §§1871.4(b), 1871.5. Labor Code section 3820(d) provides for a penalty of not less than $4,000 nor more than $10,000 for violations. However, the benefits that the employee is disqualified from receiving or may be obligated to reimburse are only those benefits "directly stemming from the fraud." *Farmers Ins. Group of Companies/Truck Ins. Exchange v. Workers' Comp. Appeals Board (Sanchez)*, 128 Cal. Rptr. 2d 353, (Ct. App. 2002).

For injuries occurring on and after January 1, 2005, an illegal alien who is not able to return to his or her usual and customary occupation, modified, or alternative work with an employer is not permitted to receive a 15% increase in permanent disability benefits under Labor Code section 4658(d) because of his or her illegal alien status. *Farmer Brothers Coffee v. Workers' Comp. Appeals Bd.*., 35 Cal. Rptr. 3d 23  (Ct. App. 2005). [The 15% increase or decrease dependent on the injured workers’ employment status is eliminated for all dates of injury on or after January 1, 2013. Cal. Lab. Code §4660.1]

A party, including health care professionals and attorneys, may be subject to fines and imprisonment for the use of third parties to engage in fraudulent activities. Cal. Ins. Code §1871.7; Cal. Bus. & Prof. Code §§2273, 6152, 6153. A health care provider presenting a false claim for treatment may be subject to fines and imprisonment. Cal. Penal Code §550(b). A physician may not refer an injured worker to a diagnostic or treatment facility in which the physician or the physician’s immediate family has a financial interest. Cal. Lab. Code §139.3(a). An insurance claims adjuster's solicitation or acceptance of anything of value to refer or settle a claim may be subject to fines and imprisonment. *Id.* §3219(a)(2). Offering or accepting any benefit for referring patients or clients for workers' compensation services or benefits may be subject to fines and imprisonment. *Id.* §§3215, 3218.

Civil penalties of up to $25,000.00 may be imposed for willful misclassification of a worker as an independent contractor. Cal. Lab. Code §226.8. Additionally, a person who receives a fee for advising an employer to treat a worker as an independent contractor to avoid
employee status “shall be jointly and severally liable with the employer if the individual is found not to be an independent contractor.” Cal. Lab. Code §2753. This penalty does not apply to practicing attorneys.

11. Is there any defense for an employee’s falsification of employment records regarding medical history?

Falsification intended as part of a fraudulent attempt to gain workers' compensation benefits is subject to the penalties described in paragraph 10, supra.

12. Are injuries sustained during recreational activities paid for, or supported by, the employer compensable?

Generally, injuries arising from "voluntary participation" in off-duty recreational, social, or athletic activities are not compensable. Id. §3600(a)(9). The narrow exception is where the activities are "a reasonable expectancy of," or "are expressly or impliedly required by," the employment. Id.; Ezzy v. Workers’ Comp. Appeals Bd., 194 Cal. Rptr. 90, 92 (Ct. App. 1983).

13. Are injuries caused by co-employees compensable?

Yes, if the injury arises out of and in the course of employment, regardless of negligence. Cal. Lab. Code §3600(a). An exception to this general rule is where the injury arises out of an altercation in which the claimant-employee is the initial physical aggressor. Id. §3600(a)(7).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?

The employee must show a causal connection between the employment and the injury-producing event and must further demonstrate that the risk of harm was somehow limited to the place of employment. See, e.g., Rogers v. Workers' Comp. Appeals Bd., 218 Cal. Rptr. 662, 665 (Ct. App. 1985); W. Airlines v. Workers’ Comp. Appeals Bd., 202 Cal. Rptr. 74, 75 (Ct. App. 1984).

However, if the assailant's identity or motive is not purely personal, then the risk is said to be neutral and the injuries sustained from the assault are compensable. The WCAB en banc wrote, "Injuries occurring because of a neutral risk in the course of one's employment have been held to arise out of the employment and are thus compensable." Ephraim v. Certified Sandblasting Co., 33 Cal. Comp. Cases 599, 604 (1968).

BENEFITS

15. What criterion is used for calculating the average weekly wage?
Where employment is for 30 or more hours per week, and for five or more days per week, the average weekly wage ("AWW") is the number of working days multiplied by the daily earnings at the time of the injury. Cal. Lab. Code §4453(c)(1). When the employee is working for more than one employer, AWW is the aggregate of the earnings from all employers computed in terms of one week. Id. §4453(c)(2). If earnings are at an irregular rate, AWW is the average AWW as may conveniently be taken to determine an average weekly rate of pay. Id. §4453(c)(3).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Temporary Total Disability indemnity is two-thirds of the AWW during the period of such disability, subject to statutory minimum and maximum rates. Id. §§4453, 4653-4654. The benefit is payable during the period of such disability. Id. §4654. However, such payment is reduced by the sum of unemployment compensation benefits and extended duration benefits received by the employee during the period of disability. Id.

For injuries on or after January 1, 2006, the maximum AWW is the greater of $1,260 or 1.5 times the state average weekly wage. Id. §4451(a)(10). From January 1, 2007, the minimum and maximum AWW are increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year." Id.

For injuries on or after April 19, 2004, temporary total disability benefits shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of payments. Cal. Lab. Code §4656 (c)(1). After January 1, 2008, the duration of payment may occur within a period of 5 years from the date of injury. Id. §(c)(2).

The 104 week limit for Temporary Total Disability payments is extended to 240 weeks under 9 exceptions, including *inter alia* acute and chronic hepatitis B and C, amputations, severe burns, HIV, high-velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis and chronic lung disease. Id. ¶(c)(3).

In cases of Temporary Partial Disability the weekly loss in wages consists of the difference between the average weekly earnings and the weekly amount which the injured worker will "probably be able to earn during the disability." Id. §4657.

17. **How long does the employer/insurer have to begin temporary disability benefits from the date disability begins?**

The first payment of temporary disability must be made no later than 14 days after knowledge of the injury and disability, unless liability for the injury has already been denied. Id. §4650(a). The claims administrator must provide notice to the employee of the amount of disability benefits, how it was calculated, and the duration/schedule of payment. Cal.
Code Regs. tit. 8, §9812(a)(1). Subsequent temporary total disability payments are made every two weeks following the first payment on the day designated with the first payment. Cal. Lab. Code §4650(c). If payments are not made on time, they are automatically increased by 10%. Id. §4650.

18. What is the "waiting" period for temporary disability benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?

No temporary disability benefits are recoverable for the first 3 days of an employee’s temporary disability period. Id. §4652. However, this three-day rule does not apply if the temporary disability period continues for more than 14 days, the injury requires hospitalization, or the disability results from a violent criminal act against certain state employees. Id. §§4652, 4650.5. For purposes of calculating the waiting period, the day of the injury shall be included unless the employee was paid full wages for that day. Id. §4652.

19. What is the standard/procedure for terminating temporary disability benefits?

Temporary disability is payable until the benefits are statutorily exhausted, the employee is medically released to return to work or reaches Maximum Medical Improvement. Huston v. Workers' Comp. Appeals Bd., 157 Cal. Rptr. 355, 362 (Ct. App. 1979).

Where there is an award of continuing temporary disability issued by the Workers’ Compensation Appeals Board, the employer must file a petition to terminate temporary disability before terminating benefits. Cal. Lab. Code §4651.1; Cal. Code Regs. tit. 8, §10462. There is a rebuttable presumption that the employee’s temporary disability continues for at least one week following the filing of such a petition unless the employee has returned to work before the petition was filed. Cal. Lab. Code §4651.1.

20. Is the amount of temporary total disability paid to the employee credited toward the amount entitled for permanent disability?

No; an injured employee is entitled to compensation for any permanent disability sustained by her/him in addition to any payment received by such injured employee for temporary disability. Id. §4661.

21. What disfigurement benefits are available and how are they calculated?

Workers' compensation permanent disability benefits are intended to reflect an employee's diminished earning capacity. Id. §4660(b)(2). There is no separate disfigurement benefit. Disfigurement is taken into account when determining the percentage of permanent disability. See id. §4660(a).

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?
A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

The number of weeks paid for permanent disability are derived from a range propounded by the legislature. *Id.* §4658. The number of weeks awarded for each body part is determined by converting the whole person impairment from the AMA Guides for Evaluating Permanent Disability, Fifth Edition, to a permanent disability percentage utilizing the Schedule for Rating Permanent Disabilities compiled by the administrative director of the Division of Workers' Compensation. *Id.* §§4660-4660.1. The ultimate permanent disability rating is based on various factors modifying the AMA whole person impairment, including the employee’s occupation, and the employee’s age at the time of injury. *See id.* §4660(a). For injuries occurring on or after January 1, 2013, the schedule omits modification for loss of future earning capacity. *Id.* §4660.1. The modification for future earning capacity was in place only beginning January 1, 2005 and was removed as a part of the reform act of 2012 known as SB 863.

When the final permanent disability rating is calculated, it is applied to the tables set forth in Labor Code section 4658. For example, a 25% permanent disability for a 2005 injury to any body part provides 100.75 weeks of benefits at a maximum of $220 per week for a total of $22,165.00. The same disability in 2013 results in an award of 100.75 weeks of benefits paid at a maximum of $230 per week for a total of $23,172.50. When the final permanent disability rating is 70% or greater, but less than 100%, then the employee receives a life pension at the end of the payment of the full rate weeks of benefits. *Id.* §4659. The life pension rate is 1.5 percent of the average weekly earnings (with statutory maximums unique to this purpose), for each 1 percent of disability in excess of 60 percent. *Id.* For example, a 75% disability for a 2005 injury of an employee earning $300 per week will qualify for a life pension of $57.98 per week. The same disability and earnings for an injury occurring in 2013 qualifies for a life pension of $67.50 per week. As of January 2014, all calculations and payment of permanent partial disability is made at $290 per week.

B. **Number of weeks for "whole person" and standard for recovery.**

For injuries occurring on or after January 1, 2005, permanent disability is no longer based on the employee’s capacity to compete in the open labor market. *Id.* §4660, et seq. Instead the disability is based on a percentage of whole body impairment as provided in the fifth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (“AMA Guides”) and diminished future earning capacity. *Id.* The AMA Guides also apply to claims arising before January 1, 2005 when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by section 4061 to the employee. *Id.* §4660(d).

Compensation for total permanent disability (100%) is paid at the temporary total disability
rate set at the date of injury for the remaining life of the employee. *Id.* §4659(b). For injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or total permanent disability indemnity shall have that payment increased annually commencing on January 1, 2004. *Id.* §4659(c). The method of determining the extent of disability is discussed at paragraph 22.A., *supra*.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

For injuries occurring before January 1, 2004, employees were entitled to vocational rehabilitation. *See id.* §5405.5 (repealed 2003).

As of January 1, 2004, the statute providing vocational rehabilitation was repealed as to all dates of injury. Thus, no “vocational rehabilitation” exists for any date of injury. Instead, for injuries on or after January 1, 2004, the employee may be entitled to supplemental job displacement benefits in the form of nontransferable voucher for educational training, tuition, books, career counseling, and/or skill enhancement at certain state approved institutions if the employee does not return to work within sixty days after the termination of temporary disability benefits. *Id.* §§ 4658.5(a), 4658.6, 4658.7. The value of the voucher was tied to the extent of permanent disability for injuries occurring between January 1, 2004 and December 31, 2012. For injuries occurring thereafter the value of the voucher is $6,000, regardless of the extent of disability. *Id.* §4658.7(d). For injuries after January 1, 2013, the voucher expires 2 years after the date it is furnished or five years after the date of injury, whichever is later. Cal. Lab. Code §4658.7(f).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

An employee who is permanently totally disabled (100%) receives weekly indemnity for the remainder of his or her life at the temporary total disability rate established on the date of injury. *Id.* §§4453, 4658, 4659(b). For injuries occurring on or after January 1, 2003, indemnity paid for total permanent disability is increased annually on January 1 of the year following the start of the benefit by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. *Id.* § 4659(c); see also *Baker v. Workers' Comp. Appeals Bd.*, 129 Cal. Rptr. 3d 133, 138-39 (2011).

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

The statutory maximum burial expense is $2,000 for death resulting from injuries occurring on or before December 31, 1990, $5,000 for death resulting from injuries occurring from January 1, 1991 through December 31, 2012, and up to $10,000 for dates of injury on or after January 1, 2013. Cal. Lab. Code §4701.
B. Dependency claims.

In order to qualify as a dependent, a person must in good faith be a member of the family, or be the deceased worker’s spouse, child, grandchild, parent, father-in-law, mother-in-law, sibling, uncle or aunt, brother-in-law or sister-in-law, nephew or niece. *Id.* §3503.

Children under 18 years of age, or over that age but physically or mentally incapacitated from earning, are conclusively presumed to be wholly dependent for support upon the deceased employee-parent with whom the child is living at the time of the injury or for whose maintenance the parent was legally liable at the time of injury. *Id.* §3501(a). A spouse is presumed to be totally dependent if the surviving spouse earned $30,000.00 or less in the 12 months preceding the death. *Id.* §3501(b). In all other cases, questions of entire or partial dependency and questions as to who are dependents and the extent of their dependency are determined in accordance with the facts as they exist at the time of the injury to the employee. *Id.* §3502.

The maximum amounts for total dependency benefits vary depending upon the date of injury, and number of dependents. *Id.* §4702. For injuries occurring on or after January 1, 2006, the maximum amounts in cases of total dependency are as follows: $290,000 for two total dependents and regardless of the number of partial dependents; not more than $290,000 for one total and one or more partial dependents; $250,000 for one total dependent and no partial dependents; $250,000 for no total dependents and one or more partial dependents; and $320,000 for three or more total dependents regardless of the number of partial dependents. *Id.* §4702; but see *Six Flags, Inc. v. Workers’ Comp. Appeals Bd.*, 51 Cal. Rptr. 3d 377, 382-83 (2006) (holding section 4702(a)(6)(B) unconstitutional, which provides benefits for a deceased employee's estate).

In the case of one or more totally dependent minor children, payment of death benefits shall continue until the youngest child attains age 18, or until the death of a child physically or mentally incapacitated from earning. Cal. Lab. Code §4703.5 (a). Under certain circumstances, a child of a law enforcement officer can receive death benefits until age 19. See id. §4703.5(b)(1).

26. What are the criteria for establishing a "second injury" fund recovery?

The requirements for recovering from the Subsequent Injuries Benefits Trust Fund are: (1) the employee had a pre-existing permanent disability; (2) the employee receives a subsequent industrial injury which results in permanent partial disability; (3) the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone; (4) the combined effect of the subsequent injury and the previous disability or impairment is a permanent disability equal to 70 percent or more of the total disability; and (5) either (a) the previous disability affected a hand, arm, foot, leg, or eye, and the disability resulting from the subsequent injury affects the opposite member, and
such latter disability is equal to 5 percent or more of the total, or (b) the permanent disability resulting from the subsequent industrial injury is 35 percent or more of the total. *Id.* §4751; see also *Subsequent Injuries Fund v. Indus. Accident Comm’n*, 366 P.2d 496 (Cal. 1961).

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

A petition to re-open must state specific facts to establish good cause for re-opening. Cal. Code Regs. tit. 8, §10455 (“Workers’ Compensation Appeals Board – Rules and Practice Procedure”). To re-open a claim, the employee must have received compensation benefits from the employer/insurer, either voluntarily or pursuant to a Board award. *Standard Rectifier Corp. v. Workmen's Comp. Appeals Bd.*, 54 Cal. Rptr. 100, 102-03 (1966); see also Cal. Lab. Code §5410.

The WCAB has continuing jurisdiction to reopen its awards for new and further disability within five years after the date of injury. Cal. Lab. Code §5410. The date of injury for occupational diseases or cumulative injuries is that date upon which the employee first suffered disability and either knew or by the exercise of reasonable diligence should have known that the disability was caused by employment. *Id.* §5412.

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

The most common instance arises when the employer/insurer deposes an employee or any person claiming benefits as a dependent. *Id.* §5710(b)(4). The employer is obligated to pay the reasonable applicant’s attorneys’ fees for attending the deposition.

In certain circumstances where the employer has caused the employee to obtain legal services, the employer may be ordered to pay the reasonable value of those services. The employer may be required to pay a reasonable fee for the services of an employee's attorney when: (1) a petition for writ is filed without reasonable basis, *id.* §5801; (2) the employer is uninsured, *id.* §4555; or (3) defendant files an unsuccessful petition to reduce permanent disability indemnity. *Id.* §5410.1. Additionally, if the employer files a Declaration of Readiness when applicant is unrepresented, the employer is liable for any attorney’s fees incurred by the employee in connection with the Declaration of Readiness. *Id.* §4064(c).

The workers' compensation appeals board is empowered to assess "reasonable expenses, including attorney's fees and costs" as a result of bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay. *Id.* §5813. Further, when payment of compensation has been unreasonably delayed or refused subsequent to an award, the appeals board "shall, in addition to increasing the order, decision or award pursuant to Section 5814, award reasonable attorneys' fees' incurred in enforcing the payment of compensation." *Id.* §5814.5.
EXCLUSIVITY/TORT IMMUNITY

29. **Is the compensation remedy exclusive?**

   **A. Scope of immunity.**

   Workers' compensation is the employee's sole remedy for injuries arising out of and occurring in the course of employment so long as the employer has secured the payment of compensation. *See id.* §3600.

   **B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

   There are statutory exceptions to exclusivity when: (1) the employee's injury or death is proximately caused by a willful physical assault by the employer; (2) the employee's injury is aggravated by the employer's fraudulent concealment of the existence of an injury and its connection with the employment; (3) the employee's injury or death is proximately caused by a defective product manufactured by the employer and sold, leased, or otherwise transferred for valuable consideration to an independent third person, and the product is thereafter provided for the employee's use by a third person; or (4) the employee's injury or death is proximately caused by the employer's removal of, or failure to install, a point-of-operation guard on a power press, and the removal or failure to install is specifically authorized by the employer under conditions known by the employer to create a probability of serious injury or death. *Id.* §§3602(b), 4558. These exceptions were put into place to supplant the judicially created concept of “dual capacity” as that doctrine was described by the California Supreme Court in *Duprey v. Shane* (1952) 39 Cal.2d 781.

   A cause of action may be concurrently maintained before the appeals board, for violation of Cal. Lab. Code §132a (discriminatory retaliation for making a claim), and at law, for violation of the Fair Employment and Housing Act proscriptions against discrimination against people with a disability as set forth in Cal. Gov't. Code §12940 et. seq. *City of Moorpark v. Superior Court*, 959 P.2d 752 (Cal. 1998).

30. **Are there any penalties against the employer for unsafe working conditions?**

   Every California employer is obligated to provide a safe place to work and is subject to the provisions of the California Occupation Safety and Health Act, Cal. Lab. Code §6300 *et. seq.* The Division's duties and powers under the Act extend to administering and enforcing all laws and lawful standards and orders or special orders, including imposing fines and penalties. *Bendix Forest Prods. Corp. v. Div. of Occupational Safety & Health*, 600 P.2d 1339, 1342 (Cal. 1979).

   The employee may also claim that the employer's failure to provide a safe place to work constituted serious and willful misconduct as defined by Labor Code section 4553. *Abron v. Worker's Comp. Appeals Board*, 109 Cal. Rptr. 778, 781-82 (1973). To do so, the employee
must establish that the employer: (1) knew of the dangerous condition; (2) knew that the probable consequences of its continuance would involve serious injury to an employee; and (3) deliberately failed to take corrective action. Johns-Manville Sales Corp. v. Worker's Comp. Appeals Bd., 158 Cal. Rptr. 463, 468 (Ct. App. 1979).

If an employee establishes serious and willful misconduct, the amount of compensation otherwise recoverable by an employee may be increased by 50%, together with costs and expenses not to exceed $250. Cal. Lab. Code §4553. The increase applies to every benefit payment, including medical treatment costs. Ferguson v. Workers' Comp. Appeals Bd., 39 Cal. Rptr. 2d 806, 810-11 (Ct. App. 1995).

31. What is the penalty, if any, for an injured minor?

If an employer has illegally employed a minor who is under 16 years of age, the employer will be liable for an additional 50% of the amount of compensation awarded to the employee. Cal. Lab. Code §4557. This additional compensation may not exceed the maximum amount outlined in Labor Code section 4553 for additional compensation recoverable as a result of the employer’s serious and willful misconduct. Id.

An additional "penalty" involving a minor awards an employee under the age of 18, whose incapacity is permanent, the average weekly earnings that he or she would ordinarily be able to earn at the age of 18, in the occupation at the time of the injury, or in any occupation to which he or she would reasonably have been promoted had the injury not occurred. Id. §4455.

32. What is the potential exposure for "bad faith" claims handling?

No civil action for "bad faith" actions based on an insurer's delay or unreasonable refusal to settle a claim, or to pay an award, are permitted. These are barred by the exclusive remedy doctrine. Id. §3602; Cervantes v. Great Am. Ins. Co., 189 Cal. Rptr. 761, 764 (Ct. App. 1983).

The Act does not bar employee suits against an insurer for its conduct outside of the normal investigation and processing of claims. Unruh v. Truck Ins. Exch., 498 P.2d 1063, 1073 (Cal. 1972) (superseded by statute on other grounds). The facts to be considered include: (1) whether the conduct was "socially objectionable" as opposed to what would reasonably be expected; (2) whether the injuries caused were separate and distinct from an otherwise compensable claim; and (3) whether an independent action is necessary to adequately deter harm. Cont'l Cas. Co. v. Superior Court, 235 Cal. Rptr. 260, 262 (Ct. App. 1987). If a separate tort action is allowed, there may be an offset against any award. Young v. Libbey-Owens Ford Co., 214 Cal. Rptr. 400, 405 (Ct. App. 1985).

Persons other than “employers” or “insurers,” including the independent administrator of a permissibly self-insured employer, are not protected by exclusivity. Cal. Lab. Code §3850(b); Marsh & McLennan, Inc. v. Superior Court (Silvestri), 774 P.2d 762, 764 (Cal.
1989). For example, in Unruh, an investigator employed by the insurer was subject to a civil suit as a third party. Unruh, 498 P.2d at 1069-70.

The Workers' Compensation Act provides a 25% penalty not to exceed $10,000 against employers for unreasonable delay or refusal to pay a claim. Cal. Lab. Code §5814(a). This penalty may be avoided, if within 90 days of discovery of violation of section 5814 and before the employee gives notice of a claim of penalty, the employer pays the amount unreasonably delayed or refused plus a 10% self-imposed penalty. Id. §5814(b).

33. **What is the exposure for terminating an employee who has been injured?**

Any employer who discriminatorily discharges, threatens to discharge an employee who has filed a claim or made known an intention to do so, or has received an award, is guilty of a misdemeanor. Id. §132a(1). Additionally, the employee is entitled to reinstatement and reimbursement for lost wages and all awarded workers' compensation benefits are increased by one-half, not to exceed $10,000. Id. Costs and expenses will also be awarded, not to exceed $250. Id. The same misdemeanor charges apply to any insurer who advises or directs their insured to discharge an employee, or threatens an insured that their policy will be canceled or premiums raised. Id. §132a(2).

Labor Code §132a does not provide the exclusive remedy for the wrongfully terminated employee. A cause of action may be concurrently maintained at law based on the Fair Employment and Housing Act proscriptions against discrimination against people with a disability as set forth in Cal. Gov't. Code §12940 et. seq., City of Moorpark v. Superior Court 959 P.2d 752 (Cal. 1998).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes; however, an employee who brings an action against a third party must provide a copy of the complaint to the employer by personal service or certified mail. Cal. Lab. Code §§3852, 3853.

35. **Can co-employees be sued for work-related injuries?**

Only in limited circumstances. An employee can recover civil damages from a co-employee if: (1) the injury was proximately caused by the co-employee's willful and unprompted physical act of aggression or intoxication; or (2) the co-employee, when causing the injury, was not acting within the scope of his or her employment. Id. §§3600, 3601(a).

36. **Is subrogation available?**

Yes. An employer or workers' compensation insurance carrier who pays benefits, or is
obliged to pay benefits, may bring an action against a third person, and may recover, in addition to the total amount of compensation benefits, any damages including salary, wage, pension or other emolument paid to the employee or his or her dependents. *Id.* §3852.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The reasonable cost of necessary medical treatment provided or authorized by the primary treatment physician and submitted with all required documentation must be paid within 45-working days after receipt of an itemization of medical services provided. *Id.* §4603.2(b)(1). If not paid within this time limit, the bill must be increased by 15% with interest retroactive to the date of submission of the proper bill unless the employer properly contests the expenses. *Id.* An exception to this rule is electronic receipt of itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted per section 5307.1. *Id.* §4603.4(d). The employer must pay these bills within 15-working days after electronic receipt of the billing. *Id.* If the billing is contested, denied or incomplete, payment is to be made in accordance with section 4603.2. *Id.* Where the only dispute over payment arises from disagreement over the amount properly charged, the parties must utilize the Independent Bill Review process provided at Labor Code §4603.6.

Medical-legal expenses that are incurred in accordance with the limiting provisions of the Labor Code must be paid within 60 days after receipt by the employer of the billing and report. *Id.* §4622; *see also* *id.* §4620(a) (defining “medical-legal expense”). If not paid within this time limit, the rate of service must be increased by 10% with interest retroactive to the date of the submission of the proper bill unless the employer properly contests the expenses. *Id.* §4622.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

After the filing of an application for adjudication, a party or lien claimant may request another party to serve copies of medical reports. Cal. Code Regs., tit. 8 §10608. The party receiving the request must serve the reports within six days of the request and must serve a copy of any subsequently received reports within six days of receipt of the report. *Id.* The obligation to serve all medical reports and medical legal reports applies during the continuing jurisdiction of the Appeals Board. *Id.* at §10615. Medical records may be obtained under WCAB subpoena and the workers' compensation judge may issue a discovery order to compel discovery. Cal. Lab. Code §4055.2.

39. **What is the rule on (a) Claimant’s choice of physician; and (b) Employer’s right to a second opinion?**
A. Employer’s initial control over treatment.

Absent advance written predesignation of the employee's personal physician, who agrees to be predesignated, the employer controls and directs medical treatment for the first 30 days from the date of the report of injury. Id. §4600(c). However, during the period of employer control of medical treatment, the employee may request a one-time change of physician and the employer must provide the alternative physician, acupuncturist or chiropractor within five working days from the date of the request. Id. § 4601. After 30 days from the date the injury is reported, the employee may be treated by a physician or facility of his or her choice unless the employer has established a Medical Provider Network (MPN). Id. §4600(c).

B. Medical Provider Network.

As of January 1, 2005, an insurer or self-insured employer may establish or modify a medical provider network. Id. §4616. The network must include enough physicians treating nonoccupational injuries and physicians treating occupational injuries to provide treatment in a timely manner. Id. §4616. The goal is to have at least 25% of the physicians primarily engaged in the treatment of nonoccupational injuries. Cal. Code Regs. tit. 8, §9767.3(d)(8).

After the first visit with a physician from the medical provider network, the employee may select a physician of his or her choice from within the network. Cal. Lab. Code §4616.3(b). If the employee disputes the diagnosis or treatment of treating physician, the employee may seek the opinion of a second or third physician in the medical provider network. Id. §4616.3(c).

When an employee disputes the diagnosis or treatment, the employee must notify the employer, either orally or in writing that he or she disputes the treating physician’s opinion and requests a second opinion, make an appointment within 60 days from a physician in the medical provider network and inform the employer of the appointment date. Cal. Code Regs. tit. 8, §9767.7(b). The employer must provide a regional area listing of network providers to the employee, provide a copy of records to the second opinion physician prior to the appointment and to the employee on request and notify the second opinion physician in writing that he or she has been selected and the nature of the dispute with a copy to the employee. Id. The same process is used if the employee disagrees with the diagnosis or treatment of the second opinion physician and seeks the opinion of a third physician within the medical provider network. Id §9767.7(d).

If, after the third physician’s opinion, the treatment or diagnosis remains disputed, the employee may request an independent medical review. Cal. Lab. Code §4616.4(b). The independent medical reviewer shall issue a written report to the administrative director indicating whether the disputed diagnostic service or treatment was consistent with the medical treatment utilization schedule (MTUS) established in Labor Code section 5307.27 or the American College of Occupational and Environmental Medicine’s Occupational Medicine (ACOEM) Practice Guidelines. Id. If deemed consistent with Labor Code section
5307.27 or the ACOEM guidelines, the employee may seek the disputed diagnostic service or treatment from a physician from within or outside the medical provider network. Id. §4616.4(i). The parties may appeal the decision by filing a petition with the Workers’ Compensation Appeals Board and serving a copy on the Administrative Director, within 20 days after receipt of the decision. Cal. Code Regs. tit. 8, §9768.16(b).

C. Employee’s right to receive treatment outside of the Medical Provider Network.

An employee is not limited to obtain treatment with a provider within the Medical Provider Network if the employee notified his or her employer in writing prior to the date of injury that he or she predesignates a personal physician to provide treatment for an industrial injury and the doctor agrees to the predesignation. Cal. Lab. Code §4600(d). The personal physician must be the employee’s regular physician and surgeon, licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code; must be the employee’s primary care physician who has previously directed the medical treatment of the employee and who retains the employee’s records; and must agree to be pre-designated. Id. If the employee is treating with a physician within the employer’s established MPN and the physician's contract with the MPN terminates, the employee may request completion of treatment by a terminated provider if the employee, at the time of the contract’s termination, was receiving services from that provider for one of the following conditions: (1) an acute condition; (2) a serious chronic condition; (3) a terminal illness; or (4) performance of a surgery or other procedure authorized by the employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract’s termination date. Id. §4616.2(d)(3).

An employee who is being treated outside of the medical provider network for an occupational injury that occurred prior to coverage of the network must be provided completion of treatment under the four circumstances identified above as set forth in Labor Code section 4616.2(d). Cal. Code Regs. tit. 8, §9767.9(e).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

An employee is entitled to all necessary medical, surgical, chiropractic and hospital treatment reasonably required to cure or relieve the effects of the injury. Cal. Lab. Code §4600. This specifically includes nursing, medicines, medical and surgical supplies, crutches, and apparatus, including prosthetic devices includes but is not limited to services and supplies by physical therapists, chiropractic practitioners, and acupuncturists, as licensed by California state law and within the scope of their practice as defined by law. Id. §3209.5. The definition of physician includes physicians and surgeons holding an M.D. or D.O. degree, optometrists, dentists, podiatrists, chiropractic practitioners, and certain licensed psychologists. Id. §3209.3. Treatment by marriage, family and child counselors and clinical social workers is covered if
the employee is referred by a licensed physician or surgeon, with the employer's approval. *Id.* §3209.8. The services and supplies by licensed physical therapists are also included. *Id.* §3209.5. Any other form of therapy, treatment, or healing practice agreed upon voluntarily, in writing, by the employee and the employer is covered. *Id.* §3209.7.

Whether treating within the MPN or outside, for injuries occurring on and after January 1, 2004, an employee is entitled to no more than 24 chiropractic, 24 physical therapy and 24 occupational therapy visits per industrial injury. *Id.* §4604.5(c)(1). That limit is waived for postsurgical physical medicine or rehabilitation provided in accordance with the postsurgical treatment utilization schedule. *Id.* §4604.5(c)(3).

The determination of the necessity of a particular medical treatment is based on the medical treatment utilization guidelines (MTUS) promulgated by the Administrative Director. The guidelines are "presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury." *Id.* §4604.5(a).

Employers are required to establish a utilization review process in compliance with Labor Code section 4610. *Id.* §4610(b). The utilization review process must be consistent with the medical treatment utilization guidelines promulgated by the Administrative Director. *Id.* §4610.

For injuries occurring on or after January 1, 2013 and for all utilization review decisions communicated after July 1, 2013, an employee who disagrees with the utilization review decision that denies, modifies or delays a treatment recommendation, may request an independent medical review ("IMR"). *Id.* §4610.05(d). The utilization review decision may only be reviewed by independent medical review. *Id.* §4610.5(e). The decisions of the IMR are deemed to be the determination of the administrative director and are binding on the parties. *Id.* §4610.6(g). "The determination of the administrative director is presumed to be correct and may be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal: (1) The administrative director acted without or in excess of the administrative director's powers. (2) The determination of the administrative director was procured by fraud. (3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5; (4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability. (5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion." *Id.* §4601.6(h)(1)-(5). Further, "In no event shall a workers' compensation administrative law judge, the appeals board or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization." *Id.* §4610.6(i).
41. Which prosthetic devices are covered, and for how long?

Covered prosthetic devices include crutches and apparatus, including artificial members, which are reasonably required to cure or relieve the effects of the injury. *Id.* §4600. An "artificial member" has been defined as a substitute for a natural part, organ, limb or separable part of the body. *Cal. Cas. Indem. Exch. v. Indus. Accident Comm’n*, 90 P.2d 289, 289 (Cal. 1939). Although "apparatus" has not been specifically defined, eyeglasses would be considered an apparatus if provided to relieve the effects of an injury to the eye. *Id.* at 290-91. Thus, it would appear that any apparatus which would help rehabilitate or cure the employee is covered. Injuries to artificial members are covered like any other injury. *Cal. Lab. Code* §3208.

42. Are vehicle and/or home modifications covered as medical expenses?

Such modifications may be compensable if they are reasonable and necessary as part of medical recovery or treatment for the industrial injury. *Id.* §4600; see, e.g., *Smyers v. Workers’ Comp. Appeals Bd.*, 203 Cal. Rptr. 521, 524 (Ct. App. 1984) ("The test then is whether [expenditures] are medically necessary and reasonable. If the claimant can produce evidence to answer this question in the affirmative, then the expenses . . . are recoverable as a ‘medical treatment’ under section 4600.").

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Labor Code section 5307.1(a)(1) mandates implementation of a medical treatment fee schedule that is periodically revised. "Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems." In 2012 the fee schedule for physician services was to be revised "based on the resource-based relative value scale for physician services and nonphysician practitioner services" *Cal. Lab. Code* §5307.1(a)(2)(A). As part of the revision the code establishes that "maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012." *Id.*

Notwithstanding the existence of the fee schedule, an employer or insurer may contract with a medical provider for reimbursement rates different from those prescribed. *Id.* at §5307.1(h).

Prior to the 2012 changes to Cal. Lab. Code §5307.1, a medical provider was permitted to charge fees in excess of the schedule when the fee: (1) was reasonable; (2) did not exceed the provider's usual fee; and (3) was accompanied by itemization and explanation. *Id.* §5307.1; see also *Gould v. Workers’ Comp. Appeals Board*, 6 Cal. Rptr. 2d 228, 232 (Ct. App. 1992).

44. What, if any, provisions or requirements are there for "managed care"?
"On or after January 1, 2005, an insurer, employer, or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees." Cal. Lab. Code §4616. Administrative director approval of an application to establish a medical provider network (MPN) requires, among other requirements, that "the number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner." Id. §4616(a)(1). "Every medical provider network shall establish and follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services and facilities, and costs." Id. at (b)(2). "Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment." Id. at (c). "All treatment provided shall be provided in accordance with the medical treatment utilization schedule." Id. at (e). Commencing January 1, 2014, the MPN must provide a "medical access assistant" to "help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary." Id. at (a)(5).

Contracting With Health Care Organizations

Notwithstanding Labor Code section 4600, any workers' compensation insurer or self-insured entity may contract with two or more health care organizations that are certified pursuant to Labor Code section 4600.5 for health care services to be rendered to injured employees. Id. §4600.3(a)(1). The employer must give the employee an affirmative choice at the time of employment and at least annually thereafter in order to designate a health care organization or personal physician. Id. By designating a personal physician or chiropractor prior to injury, employees may opt out of treatment programs offered by such contracting facilities. Id. Any employee, who does not affirmatively choose between the health care organization provided by the employer and designation of a personal physician, will be permitted to choose only between the health care organizations contracting with the employer. Id. At least one of the health care organizations with whom the employer or insurer contracts must be compensated on a fee-for-service basis. Id. §4600.5(e).

Labor Code section 4600.3 has specific provisions regarding contracted for health services based on the status of the employee; whether the employee is receiving health care coverage for nonoccupational injuries and whether the employee is eligible to receive health care coverage for nonoccupational injuries. The employee's status and whether the employee designated a personal physician prior to injury will determine how much time the employee has to notify the employer that the employee wishes to receive treatment from someone other than the health care organizations with whom the employer has contracted. See id. §4600.3(c).

Collective Bargaining

Any employer required to bargain with an exclusive or certified bargaining agent representing employees, must obtain a bargained for agreement from the bargaining agent or
must have bargained to impasse before the employer can contract with particular health care
organizations and limit employee choice. *Id.* §4600.3(b).

**PRACTICE/PROCEDURE**

**45. What is the procedure for contesting all or part of a claim?**

An employer is obligated to make a decision on the compensability of all or part of a claim within 90 days of receipt of a claim form (form DWC 1) filed in accordance with Labor Code section 5401. "If liability is not rejected within 90 days after the date the claim form is filed, the injury shall be presumed compensable. The presumption is rebuttable only by evidence discovered subsequent to the 90 day period." *Id.* §5402(b).

Although an answer to an application for adjudication is not required, in the absence of a claim form it is the appropriate method for a defendant to deny liability and raise issues with or defenses to the claim, and must be made within 10 days after service of the application. *Id.* §5505; *Argonaut Ins. Exch. v. Indus. Accident Comm.*, 260 P.2d 817, 822 (Cal. Ct. App. 1953). A general denial will not suffice, and the form must conform to California Code of Regulations title 8, section 10484. Cal. Code Regs. tit. 8, §10484. A copy of the answer must be served on all parties. *Id.*. Failure to file an answer is not an admission of facts alleged in the application and no default is permitted. Cal. Lab. Code §5506; *Peak v. Indus. Accident Comm.*, 187 P.2d 905, 909 (Cal. Ct. App. 1947). Affirmative defenses, however, are deemed waived if not set up by a responsive pleading. Cal. Code Regs. tit. 8, §10484.

Once a claim is denied in accordance with Labor Code section 5402, the employee must file an application for adjudication of claim within the applicable statute of limitations. It is the filing of the application that establishes the jurisdiction of the appeals board and commence proceedings for the collection of benefits. Cal. Lab. Code §5500.

**46. What is the method of claim adjudication?**

**A. Administrative level.**

The Workers’ Compensation Appeals Board has exclusive jurisdiction over claims for compensation and related issues. *Id.* §§5300(a), 5301. The Workers’ Compensation Appeals Board consists of 7 members appointed by the Governor with the advice and consent of the Senate. Five of the members shall be experienced attorneys at law. The remaining two need not be attorneys. *Id.* §§111-112.

The adjudication of many medical treatment issues is carved out of the trial jurisdiction of the Workers’ Compensation Appeals Board for injuries on or after January 1, 2013. Disputes about whether a prescribed treatment is necessary are first subject to Utilization Review by a “licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician’s
practice…” Cal. Lab. Code §4610. The review must comply with statutory obligations governing the organization of the review process and the time permitted for each step of the process. \textit{Id.} at (c) – (i).

Review of the utilization review decision is limited to Independent Medical Review (IMR) as it is described at Cal. Lab. Code §4610.5. The reviewer is an entity contracting with the State of California to provide opinions “limited to the medical necessity of the disputed medical treatment.” Cal. Lab. Code §4610.6. The decision of the IMR is legally deemed to be the determination of the administrative director and shall be binding on all parties. The determination is subject to only limited review by the courts of appeal and not subject to the jurisdiction of the WCAB, except in limited circumstances. \textit{Id.} at (g) and (h).

\textbf{B. Trial court.}

Workers' Compensation Appeals Board acts as the trial court. \textit{Id.} §§5300, 5301. It directs that trials are held before a workers' compensation administrative law judge or itself. \textit{Id.} §§5309-5310.

A mandatory settlement conference shall be conducted at least 10, but no more than 30 days after the filing of the Declaration of Readiness to Proceed. \textit{Id.} §5502(d)(1). However, many offices do not meet this statutory goal. If the dispute is not resolved, a trial shall be held not more than 75 days after the declaration of readiness to proceed was filed. \textit{Id.}

After trial, the workers' compensation administrative law judge "shall, within 30 days after the case is submitted, make and file findings upon all facts involved in the controversy and an award, order, or decision stating the determination as to the rights of the parties." \textit{Id.} §5313.

A person aggrieved by a final order, decision or award of a workers' compensation administrative law judge or the appeals board may petition to the appeals board for reconsideration within the time limits set by law. \textit{Id.} §5900. A petition for reconsideration from a decision of the workers' compensation judge must be filed within 20 days of service. \textit{Id.} §5903.

\textbf{C. Appellate.}

Any person aggrieved by a decision of the Workers' Compensation Appeals Board may apply to the District Court of Appeal for the appellate district in which he or she resides, or to the Supreme Court of California, for a writ of review. \textit{Id.} §5950. On appeal, the court reviews for errors of law. \textit{Id.} An application for writ of review must be made within 45 days after a petition for reconsideration is denied. \textit{Id.} Alternatively, if a petition is granted or reconsideration is had on the appeals board's own motion, the writ of review must be made within 45 days after the filing of the order, decision, or award following reconsideration. \textit{Id.}
47. What are the requirements for stipulations or settlements?

The parties may submit an issue or issues for a decision on a stipulation of facts. *Id.* §5702; Cal. Code Regs. tit. 8, §10496; see *Sacramento v. Workers’ Comp. Appeals Bd.*, 92 Cal. Rptr. 2d 290, 292-93 (Ct. App. 2000). The Board may: (1) make its finding and award based upon the stipulation; (2) schedule a hearing and take further testimony; or (3) make further investigation necessary for it to determine the matter in controversy. Cal. Lab. Code §5702.

Any employee or dependent may compromise and release any claim. *Id.* §5000. A Compromise and Release (“C&R”) will be accepted by the appeals board and entered as an award. *Id.* §5002. A compromise and release must be set out using a form promulgated by the administrative director. Cal. Code Regs. tit. 8, §§10205.2, 10874. For a release or compromise to be valid, it must be in writing and signed by both parties. Cal. Lab. Code §5003. The signature of the employee or other beneficiary must be attested by two disinterested witnesses or acknowledged before a notary public. *Id.* It must be approved by the workers’ compensation judge. *Id.* §5001. "Agreements that provide for the payment of less than the full amount of compensation due or to become due and undertake to release the employer from all future liability will be approved only where it appears that a reasonable doubt exists as to the rights of the parties or that approval is in the best interest of the parties." Cal. Code Regs., tit. 8, §10870.

The C&R must specify: (1) the date of the accident; (2) the average weekly wage; (3) the nature of the disability, whether total or partial, permanent or temporary; (4) the amount paid, or due and unpaid, up to the date of the release or agreement or death, and the amount of the payment or benefits thereafter; (5) the length of time such payment or benefit is to continue; and (6) in the event a claim of lien has been filed, the number of days and the amount of temporary disability which should be allowed to the lien claimant. Cal. Lab. Code §5003.

48. Are full and final settlements with closed medicals available?

Yes. Nothing in the statute impinges upon the right of the parties to compromise a claim for future medical treatment. *Id.* §§5000-5001.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, stipulations and settlements must be approved by the California Workers' Compensation Appeals Board. *Id.* §5001. The Board must inquire into the adequacy of all compromise and release agreements, unless it makes a finding that there is a good faith issue which, if resolved against the employee, would defeat the right to recover benefits. *Id.* §5001; see also Cal. Code Regs. tit. 8, §§10870, 10882.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. What insurance is required; and what is available (e.g. private carriers, state fund,
assigned risk pool, etc.)?

Every employer is required to secure the payment of benefits, either by insurance or by qualifying as a self-insurer. Cal. Lab. Code §3700. Private insurance, certified self-insurance for private or public employers, group self-insurance, and pooling arrangements under joint exercise of powers agreements for public employers only, are available. Id.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

The requirements for self-insurance are the same for all private entities (individual, groups or "pools"). See id. Each must secure from the Director of Industrial Relations a certificate of consent to self-insure. Id. Such a certificate will be issued only upon the employer's furnishing satisfactory proof that it is able to self-insure and to pay any compensation benefits that may become due. Id.

Employers seeking to self-insure must apply with the State of California, Office of Self Insurance Plans. (“SIP”). In order to qualify, applicant must demonstrate: (1) $5 million shareholders equity, (2) Average net profits of $500,000 per year for the last five years, and (3) produce certified, independently audited financial statements. State of California Department of Industrial Relations, Self-Insurance Plans – Requirements for Becoming Self Insured (Aug. 29, 2013), http://www.dir.ca.gov/osip/apprequirements.htm.

If the state approves an application, the self-insured entity must still file an annual report to SIP which describes: (1) Claims paid in indemnity and medical, (2) Future Liability on open claims, (3) Average number of employees and total wages for each adjusting location, and (4) A list of all open indemnity claims. Id.

B. For groups or "pools" of private entities.

See supra answer 51A.

52. Are "illegal aliens" entitled to benefits of workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of "employee"?

The Immigration Reform and Control Act makes it unlawful to knowingly hire or continue to employ an alien and does not provide for or prohibit state compensation for injured workers. 8 U.S.C. §1324(a). As such, Congress has not occupied the field of workers’ compensation. Farmers Bros. Coffee v. Workers’ Comp. Appeals Bd., 35 Cal. Rptr. 3d 23, 28 (Ct. App. 2005). Thus, an alien’s eligibility for benefits under California’s workers’ compensation laws is not preempted by the federal statute. Id. Illegal aliens are specifically included in the

However, an undocumented worker might not be entitled to the full panoply of benefits offered through the workers’ compensation system. For example, job reinstatement remedy prohibited by federal law cannot be ordered. Id. §1171.5. For injuries occurring on and after January 1, 2005, an illegal alien who is not able to return to his or her usual and customary occupation, modified, or alternative work with an employer may not receive a 15% increase in permanent disability benefits under Labor Code section 4658(d), because of his or her illegal alien status. Farmer Bros. Coffee v. Workers’ Comp. Appeals Bd., 35 Cal. Rptr. 3d 23 (Ct. App. 2005).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles for compensability applicable to injuries committed by other third parties. See supra answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Although the Act does not set out requirements that must be satisfied, the following excerpt comes from Judge Alan Eskesazi, California Civil Practice: Workers’ Compensation §6:25 (2007):

Settlement by Compromise and Release can be delayed or even made virtually impossible in certain cases because of the Federal Government's current rules involving what is normally referred to as a Workers' Compensation Medicare Set-Aside (WCMSA), normally referred to as a "Medicare Set-Aside" or a "MSA Trust".

The interests of Medicare must be considered in all Compromise and Release agreements in which the injured worker is either receiving Medicare benefits or is likely to receive them. For injured workers already receiving Medicare benefits, Medicare will only require a WCMSA where the total settlement amount is greater than $25,000.00. In cases where the injured worker is not yet receiving Medicare benefits, Medicare will require a WCMSA only when the injured worker has a reasonable expectation of becoming Medicare eligible within 30 months of the date of settlement, and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life of the injured worker is expected to be greater than $250,000.00. This will normally be true if the injured worker is already receiving Social Security Disability Indemnity (SSDI) or where the injured worker is between 62 1/2 and 65 years old.
The Set-Aside procedure essentially requires a specified breakdown of how much consideration was included in the settlement for future medical care because Medicare will not pay for treatment that should be covered by the workers' compensation insurer. In effect, Medicare will assert a "credit" against the settlement based upon the anticipated or estimated cost of future medical care for the industrial injury. If Medicare accepts the proposed estimated "set-aside" amount, the Applicant must spend the entire amount on treatment for the industrial injury before Medicare will cover the cost of additional treatment for that injury. The amount to be "set-aside" must be based on actual medical evidence, and the parties normally use a professional service for doing this type of work-up and computing an ostensibly appropriate figure.

Judge Eskenazi also provides the following California practice tip:

Since, from the applicant's perspective, one of the basic advantages of settlement by Compromise and Release is that he or she will be receiving a "lump sum" payment, one which is significantly higher than the amount of permanent disability alone, the "set aside" may, in the mind of Applicant, defeat the entire purpose of the Compromise and Release since it will be deducted from the settlement amount. However, if the amount set aside is small enough compared to the total amount of the Compromise and Release, the applicant may still be receptive to this procedure. Of course, the procedure does involve additional time and effort, generally entailing a delay of at least six months which would not otherwise take place.

The WCMSA can be either professionally administered or administered by the injured worker.

Since the amount required to be "set-aside" will reduce the Applicant's net recovery, many practitioners will have the insurance company retain a professional WCMSA service to put together a tentative WCMSA amount in advance so that Applicant and counsel will have an idea as to the amount that they may want to demand for a Compromise and Release. This should avoid further unnecessary delay at the time of final settlement negotiations.

The issue of a WCMSA only comes into play when the Applicant is settling his or her right to further medical care. Obviously, Stipulations with Request for Award will not trigger Medicare involvement. The parties may also want to consider a Compromise and Release with open medical. \textit{Id.}

Under Medicare regulations, Medicare is a secondary payer to the payment of workers' compensation by a workers' compensation carrier or self-insured employer. 42 C.F.R.
§411.46. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. *Id.*

CMS defines individuals with a “reasonable expectation” of Medicare enrollment within 30 months as including, but not limited to, an individual who: (1) has applied for SSDI benefits; (2) has been denied SSDI benefits but anticipates appealing that decision; (3) is in the process of appealing and/or refiling for SSDI benefits; (4) is at least 62 and six months old; or (5) has end stage renal disease (ESRD) but does not yet qualify for Medicare based on ESRD. Memorandum to All Regional Administrators from Director, Center for Medicare Management, Medicare Secondary Payer-Workers’ Compensation (WC) Additional Frequently Asked Questions (April 21, 2003), http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Memorandums/Downloads/April-21-2003-Memorandum.pdf.

If the employee meets the criteria for Medicare qualification, Medicare must be notified in the event of a settlement of the workers' compensation future medical benefits. *See* 42 C.F.R. §§404, 411. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, it may require a Medicare set aside trust (MSA) for large settlements, or it may require merely a custodial self-administered trust account. *See* 42 C.F.R. §§404, 411.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include the following provisions in their plan for medical assistance: (1) the individual will assign to the State any rights to payment for medical care from any third party; and (2) the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. *Id.* §1396k(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-64, establishes Federal protections for the privacy of protected health information (PHI). The law expressly allows “covered entities” including employers and insurers to use or disclose PHI to the extent necessary to comply with the law. 45 C.F.R. §164.512(a).

The disclosure of PHI by covered entities is limited to the “minimum necessary to accomplish the intended purpose of the use, disclosure, or request.” *Id.* §164.502(b).
A number of exceptions to this requirement, enumerated in 45 C.F.R. §164.502(b)(2), include: (1) disclosures to a health care provider; (2) disclosures or uses made pursuant to an individual’s authorization; (3) disclosure or uses that are required by law as described by 45 C.F.R. section 164.512(a).

California also legislatively imposes confidentiality of medical information in its Confidentiality Of Medical Information Act, Cal. Civil Code §56 et seq. “[P]ersons receiving health care services have a right to expect that the confidentiality of individual identifiable medical information derived by health service providers be reasonably preserved. It is the intention of the Legislature in enacting this act, to provide for the confidentiality of individually identifiable medical information, while permitting certain reasonable and limited uses of that information.”

The claim administrator "is prohibited from disclosing or causing to be disclosed to an employer, any medical information" as it is defined in the California Civil Code. Cal. Lab. Code §3762(c). The two exceptions to this general rule are (1) "the diagnosis of the mental or physical condition" for which benefits are claimed or (2) information "that is necessary for the employer to have in order for the employer to modify the employee's work duties." Id. at (c)(1)-(2).

In 2018 California passed AB 375, The California Consumer Privacy Act of 2018. First effective January 1, 2020, the bill imposes new obligations on a business “that collects consumers’ personal information . . . and determines the purposes and means of the processing of consumers’ personal information, that does business in the State of California, and that satisfies one or more of the following thresholds:

(A) Has annual gross revenues in excess of twenty-five million dollars ($25,000,000)…
(B) Alone or in combination, annually buys, receives for the business’ commercial purposes, sells, or shares for commercial purposes, alone or in combination, the personal information of 50,000 or more consumers, households, or devices.
(C) Derives 50 percent or more of its annual revenues from selling consumers’ personal information. A covered business must, among other duties, “delete any personal information about the consumer which the business has collected from the consumer.” There are several exceptions, including “[T]o enable solely internal uses that are reasonably aligned with the expectations of the consumer based on the consumer’s relationship with the business.”

While the impact of this legislation on workers’ compensation administration has yet to be tested, California insurance carriers and administrators must be attentive to their responsibilities under the act.

57. **What are the provisions for “Independent Contractors”?**

Independent contractors are generally excluded under the Act. Id. §3357. An “independent contractor” is a person who renders service for a specified recompense for a specified result, under the control of a principal as to the result of the work only, and not as to the means by which the result is accomplished. Id. §3353. Section 2750.5 creates a rebuttable presumption that an unlicensed contractor is an employee rather than an independent

An employer and an independent contractor may jointly elect to come under the Act. Cal. Lab. Code §4150. The employer elects by either taking out workers’ compensation insurance or by filing a statement of acceptance of the Act with the Administrative Director. Id. §4151. The independent contractor is then deemed to have elected unless he or she gives notice of rejection. Id. §4154.

The burden of proof rests upon the employer to establish that an injured person claiming to be an employee was an independent contractor or otherwise excluded from the protection of this division where there is proof that the injured person was at the time of his or her injury actually performing service for the alleged employer. Id. §5705; see S.G. Borello & Sons, Inc. v. Dep’t of Indus. Relations, 256 Cal. Rptr. 543, 547-50 (Cal. 1989).

Effective January 1, 2020 California passed AB 5 which created Cal. Lab. Code §2750.5. The statute purports to statutorily embody the tests for control that had been judicially described by the California Supreme Court in Dynamex Operations West, Inc. v. Superior Court of Los Angeles, (2018) 4 Cal.5th 903. To distinguish an employment relationship from an independent contractor relationship, Cal. Lab. Code 2750.3 provides that, with several exceptions, a person paid for labor or services “shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates that the person is free from the control and direction of the hiring entity in connection with the performance of the work, the person performs work that is outside the usual course of the hiring entity’s business, and the person is customarily engaged in an independently established trade, occupation, or business.” As there are multiple exceptions, each case must be closely compared to the statute.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

An employer who contracts with another employer to provide employees may procure coverage by "entering into a valid and enforceable agreement with that other employer under which the other employer agrees to obtain, and has, in fact, obtained workers' compensation coverage for those employees." Cal. Lab. Code §3602(d)(1). For the two employers to be covered the obligated employer must in fact obtain the coverage and it must remain in effect for the duration of the employment. Id.
After January 1, 2013, a certificate to self-insure may not be issued to any employer, regardless of name or form of organization, which the director determines to be in the business of providing employees to other employers. Cal. Lab. Code §3701.9.

In *Santa Cruz Poultry, Inc. v. Superior Court*, 194 Cal. App. 3d 575 (Ct. App. 1987) however, an employee referred by a temporary employment agency for a one-day job assignment brought a negligence action against the employer to whom the employee was temporarily assigned. The employee claimed damages for industrial injuries and the employee’s insurer claimed a lien for workers’ compensation benefits paid to employee. *Id.* at 579-80. The trial court denied the temporary employer's motion for summary judgment made on grounds of exclusivity of the employee's workers' compensation remedy. *Id.* at 579. The appellate court held that the trial court erred in denying the employer's motion for summary judgment because the employer controlled the result of the temporary employee's work and the means by which it was accomplished. *Id.* at 583. As such, the temporary employer was immune from a negligence action and the employee’s exclusive remedy was workers’ compensation. *Id.* at 583-84.

Under AB5, effective January 1, 2020, “a person providing labor or services for remuneration shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates” certain conditions are satisfied. However, if a business provides services to clients through a referral agency, “the determination whether the service provider is an employee of the referral agency shall be governed by *Borello*, if the referral agency demonstrates that all of the following criteria are satisfied:
(A) The service provider is free from the control and direction of the referral agency in connection with the performance of the work for the client, both as a matter of contract and in fact.
(B) If the work for the client is performed in a jurisdiction that requires the service provider to have a business license or business tax registration, the service provider has the required business license or business tax registration.
(C) If the work for the client requires the service provider to hold a state contractor’s license pursuant to Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code, the service provider has the required contractor’s license.
(D) The service provider delivers services to the client under service provider’s name, rather than under the name of the referral agency.
(E) The service provider provides its own tools and supplies to perform the services.
(F) The service provider is customarily engaged in an independently established business of the same nature as that involved in the work performed for the client.
(G) The service provider maintains a clientele without any restrictions from the referral agency and the service provider is free to seek work elsewhere, including through a competing agency.
(H) The service provider sets its own hours and terms of work and is free to accept or reject clients and contracts.
(I) The service provider sets its own rates for services performed, without deduction by the referral agency.
(J) The service provider is not penalized in any form for rejecting clients or contracts.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

There are no specific provisions for independent contractors who own or operate their own vehicles for driving or delivery of people or property. The threshold question, however, in determining whether an independent contractor falls under the Act is the injured person’s status.

To determine status, courts place greatest emphasis on whether the hirer had the right to control the detailed manner and means by which the work was to be performed. Millsap v. Federal Express Corp., 277 Cal. Rptr. 807, 811 (Ct. App. 1991). If control may be exercised only as to the result of the work and not the means by which it is accomplished, an independent contractor relationship is established. Id. at 811. In Millsap, the court found that a package delivery driver was the delivery company's independent contractor where the driver used his own car, furnished his own gas and oil and liability insurance, assumed the costs of necessary car repairs, was paid on a “per route” basis and received no employee benefits, and the company did not withhold taxes from his paychecks or instruct driver how to make deliveries or how to drive his car. Id. at 811. Once an injured person is found to be an independent contractor, he or she is generally exempted from the Act. Cal. Lab. Code §3357; see also supra answer 57. Although determining status is ordinarily a question of fact, it is a question of law when all the facts lead to only one inference. Torres v. Reardon, 5 Cal. Rptr. 2d 52, 56 (Ct. App. 1992).

Under AB5, effective January 1, 2020, “[f]or work performed after January 1, 2020, any business entity that provides construction trucking services to a licensed contractor utilizing more than one truck shall be deemed the employer for all drivers of those trucks.
(C) For purposes of this paragraph, “construction trucking services” mean hauling and trucking services provided in the construction industry pursuant to a contract with a licensed contractor utilizing vehicles that require a commercial driver’s license to operate or have a gross vehicle weight rating of 26,001 or more pounds.
(D) This paragraph shall only apply to work performed before January 1, 2022.
(E) Nothing in this paragraph prohibits an individual who owns their truck from working as an employee of a trucking company and utilizing that truck in the scope of that employment. An individual employee providing their own truck for use by an employer trucking company shall be reimbursed by the trucking company for the reasonable expense incurred for the use of the employee owned truck.
60. **What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefit costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing exposure is a strong and individualized “Best Practices” plan. The best plan of action for an employer incorporates knowledge of the business field, the workers’ compensation coverage elected by the employer, the employment environment and history of industrial injuries for the employer and in the industry, among many others.

The ALFA affiliated counsel who compiled this State specific compendium offers an expert, experienced and business-friendly resource for review of an existing “Best Practices Plan” or to help write one individualized for a particular business. No one is able to predict when the need for workers’ compensation expertise will arise, so ALFA counsels that each business make it a priority to review its plan with the ALFA workers’ compensation attorney listed below.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

The Act does not set out requirements that must be satisfied. However, the obligation of the WCAB to evaluate the reasonableness of a settlement tangentially requires protection of Medicare’s secondary payor status.

The WCAB must appraise every settlement of future medical care to ensure that it is in the best interest of the parties. Cal. Code Regs. tit. 8, §10870. In making this appraisal the WCAB must determine that in light of the issues the future medical needs of the applicant are adequately provided. When the parties determine that the settlement requires CMS approval and obtain a Medicare Set-Aside analysis, the WCAB will review the MSA to determine if the overall settlement is adequate.

For more information, see Question 54 above.

62. **Does California permit medical marijuana and what are the restrictions for use and for work activity in Workers’ Compensation law?**

California’s Compassionate Use Act of 1996 amended Section 11362.5 of the Health and Safety Code to exempt marijuana use for medical purposes from certain California criminal statutes. (see also Health & Saf. C. §11362.83). However, possession, transportation and use of marijuana remains a crime under federal law.

Therefore, employers may fire or refuse to hire individuals who use marijuana or test positive for marijuana use, even when the use was recommended by a physician to alleviate a
disability: “The FEHA does not require employers to accommodate the use of illegal drugs.”


California requires that industrially injured workers’ receive all reasonable and necessary medical treatment for relief of pain and to cure the illness or injury. What is deemed to be necessary is determined through utilization review protocols that apply the California Medical Treatment Utilization Schedule. For the most part that schedule does not deem marijuana to be an appropriate treatment for pain. “In total, 11 states have approved the use of medical marijuana for the treatment of chronic pain, but there are no quality controlled clinical data with cannabinoids.”

63. **Does California permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Effective January 1, 2018, California passed Proposition 64, the “Control, Regulate and Tax Adult Use of Marijuana Act,” which permits recreational use of marijuana for those over 21. Health & Saf. Code §11362.45(f).

Additionally, Cal. Lab. Code §§432.7 and 432.8 prohibit employers or prospective employers from requiring disclosure of conviction for the possession of marijuana occurring more than 2 years in the past.

Nevertheless, injury solely due to intoxication, whether induced through alcohol or other drugs, bar the collection of workers’ compensation benefits. Cal. Lab. Code §3600(a)(4) (and, see question 5. above). Further, an employer is permitted to test for drugs, including marijuana, following a serious workplace accident, provided it is done without discriminatory intent.

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1. Citation for the state's workers' compensation statute.

The Colorado Workers’ Compensation Act is proscribed by Colorado Revised Statutes § 8-40-101, et seq., (hereinafter, “the Act”).

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Every person in the service of any person, association of persons, firm, or private corporation, under any contract of hire, express or implied, including aliens and also including minors, whether lawfully or unlawfully employed constitute employees under the Colorado Workers’ Compensation Act. C.R.S. § 8-40-202(1)(b). Additionally, any person who performs services for pay for another is a covered employee, unless such individual is free from control and direction in the performance of service and such individual is customarily engaged in an independent trade or occupation related to the service performed. C.R.S. § 8-40-202(2)(a).

Volunteer firefighters, volunteer rescue teams or groups, volunteer disaster teams, volunteer ambulance teams or groups, and volunteer search teams are deemed employees during the actual performance of their duties, and during drills, practice, and training necessary and proper for the performance of their duties. C.R.S. § 8-40-202(1)(a)(I)(A). In addition, volunteer police officers may constitute employees under the Act. City of Florence v. Pepper, 145 P.3d 654, 660 (Colo. 2006).

Persons confined to city or county jail or any department of corrections facility with certain exceptions, persons who volunteer time and services for a ski area operator or for a ski area sponsored program or activity, and persons working as drivers under a lease agreement with a common carrier or contract carrier are not considered “employees.” C.R.S. § 8-40-301(3)-(5). Under certain circumstances, persons who provide host home services, as part of residential services and support, will not be considered employees. C.R.S. 8-40-301(7).

3. Identify and describe any "statutory employer" provision.
Every person, association of persons, firm, and private corporation that has one or more persons engaged in the same business or employment in service under contract of hire, express or implied, is a statutory employer. C.R.S. § 8-40-203(b). The state, and every county, city, drainage and school district and all other taxing districts, all public institutions, and administrative boards, therein without regard to the number of persons engaged in the same business or employment, also constitute statutory employers under the Act. C.R.S. § 8-40-203(a).

Employers engaged in any business by contracting out part or all of their work are deemed to be employers of subcontractors and the subcontractors’ employees, and such employers are liable for workers’ compensation benefits. C.R.S. § 8-41-401(1)(a). However, the buyer of goods is not liable as a statutory employer when a lessee, sub-lessee, contractor, or sub-contractor, or their employee who is delivering goods to the buyer, is injured while not on the buyer’s premises. Id. However, where the employer hires the subcontractor to perform work on real property that it owns, the employer is entitled to recover the cost of workers’ compensation insurance from the subcontractor and may withhold and deduct the insurance costs from the contract price. C.R.S. § 8-41-402(1). Additionally, an owner of real property who contracts out work for the improvement to real property is deemed to be the employer of all subcontractors and their employees, unless the work is completed on qualified residential property, in which event the owner is excepted from the definition of employer. Id.

Additionally, if a contractor, subcontractor, or person undertaking work on real property, is also an employer in the doing of such work, and possesses workers’ compensation insurance, the contractor, subcontractor, or person or employees thereof do not have rights of contribution or action against the owner of the real property. C.R.S. § 8-41-402(2).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.


All physical injuries may be deemed compensable under the Act. Mental impairment injuries are also compensable, but certain restrictions apply. C.R.S. § 8-41-301(2)(a). A claim for mental impairment must be supported by the testimony of a licensed physician or psychologist and must be precipitated by a psychologically traumatic event that is generally outside an employee's usual experience and would evoke significant symptoms of distress in an employee in similar circumstances. Id. Disabilities from heart attacks are covered, but the employee must demonstrate by competent evidence that the heart
attack was caused by an “unusual exertion” arising out of and within the course of employment. C.R.S. § 8-41-302(2).

B. Occupational disease (including respiratory and repetitive use).

Under the Act, an occupational disease means “a disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.” C.R.S. § 8-40-201(14).

Traumatic or "single occurrence" claims and occupational diseases fall within the same definition of "injury" and are equally compensable, assuming the employee meets the burden of proving that the trauma or occupational disease arose out of occurred through the course of the employment. Generally, “where employment conditions act upon a claimant's individual allergy, hypersensitivity, or pre-existing weakness so as to disable him, he has a compensable occupational disease[.]” Denver v. Hansen, 650 P.2d 1319, 1321 (Colo. App. 1982).

In the event there is more than one employer of an employee who has contracted an occupational disease, the employer in whose employ the employee was last injuriously exposed to the hazards of the disease, and suffered a substantial permanent aggravation thereof, is alone liable without right to contribution from any prior employer. C.R.S. § 8-41-304(1). However, apportionment of benefits may be available where there is proof of nonoccupational exposure or causation. Anderson v. Brinkhoff, 859 P.2d 819, 825 (Colo. 1993).

5. What, if any, injuries or claims are excluded?

Excluded claims include all mental disability claims based, in whole or in part, on facts and circumstances common to all fields of employment, heart attacks caused by anything other than unusual exertion within the course of the employment, and occupational diseases caused by hazards to which the employee was equally exposed outside of the employment.

6. What psychiatric claims or treatments are compensable?

Mental impairment claims are limited to recognized permanent psychological disabilities resulting from accidental injuries without physical injury. A claim for mental impairment is compensable if: (1) the claim arises primarily from the occupation and place of employment and in the course of employment; (2) the mental impairment is, in and of itself, either sufficient to render the employee temporarily or permanently disabled from pursuing the occupation from which the claim arose or require medical treatment; (3) the claim is supported by the testimony of a licensed physician or psychologist; (4) the mental impairment involves no physical injury and arises from a psychologically
traumatic event that is generally outside an employee's usual experience and would evoke significant symptoms of distress in an employee in similar circumstances; and (5) the claim does not arise from a disciplinary action, work evaluation, job transfer, lay-off, demotion, or similar action taken in good faith by the employer. C.R.S. § 8-41-301(2)(a).

7. **What are the applicable statutes of limitations?**

The employee must file a claim for compensation with the Division of Workers' Compensation within two years after the injury or death. C.R.S. § 8-43-103(2). However, this limitation does not apply to any employee to whom compensation has been paid, or who establishes to the satisfaction of the Division within three years of the injury that a reasonable excuse existed and the employer was not prejudiced by the delay. *Id.* The provision of medical benefits does not constitute payment of benefits or compensation for the purposes of the statute of limitations. *Id.*

This limitation does not apply to disabilities resulting from certain toxic exposures. Where the disability results from exposure to radioactive materials, substances, or machines or fissionable materials, or any type of malignancy caused thereby, or from poisoning by uranium, or from asbestos, silicosis, or anthracosis, the right to compensation is barred five (5) years after commencement of the disability unless a worker’s claim for compensation is filed with the Division. C.R.S. § 8-43-103(3).

8. **What are the reporting and notice requirements for those alleging an injury?**

The employee must give written notice to the employer within four working days of the occurrence of the accident or injury. C.R.S. § 8-43-102(1)(a). In the event of an occupational disease, the employee must provide the employer with written notice within 30 days after the first distinct manifestation of the disease. C.R.S. § 8-43-102(2).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

   Intentionally self-inflicted injuries are not compensable. C.R.S. § 8-41-301(1)(c).

   B. **Willful misconduct, "horseplay," etc.**

   Generally, an injury sustained while engaging in horseplay that is unrelated to an employee’s duties is not compensable. However, where horseplay has become a regular incident of employment and is sufficiently related to the circumstances under which the employee normally performs his or her duties, injuries resulting from such horseplay may be compensable. *Lori’s Family Dining, Inc. v. Indus. Claim Appeals Office*, 907 P.2d 715, 718 (Colo. 1995).

   If an employee incurs an injury as a result of horseplay, and is not himself or herself a
participant in such horseplay, the injury is deemed compensable. *Indus. Comm'n of Colo. v. Emp'yrs Cas. Co.*, 318 P.2d 216, 218 (Colo. 1957).

C. Injuries involving drugs and/or alcohol.

Disability payments for non-medical benefits, otherwise payable to an injured worker, are reduced by 50% for injuries that result from the presence of non-medically prescribed controlled substances in an employee’s system. The employer is responsible for preserving a duplicate sample from any test conducted which determines the presence of drugs or alcohol, and the sample must be made available to the worker for purposes of a second test to be conducted at the workers’ expense. C.R.S. § 8-42-112.5; see also *Stohl v. Blue Mountain Ranch Boys Camp*, W.C. No. 4-516-764 (February 25, 2005); affirmed 2005 Colo. App. LEXIS 2155 (Colo. App. Dec. 29, 2005).

10. What, if any, penalties or remedies are available in claims involving fraud?

The Act provides for two remedies in cases involving fraud. First, an employer/insurer may take a credit or an offset of previously paid benefits or payments against any further benefits due when the employee obtains benefits through fraud. The fraud must either be admitted, or a civil judgment or criminal conviction entered against the employee. C.R.S. § 8-43-304(2). Additionally, anyone who willfully makes a false statement or representation material to a claim to obtain any order, benefit, award, compensation or other payment under the Act commits a class 5 felony and will be punished as provided by the criminal statutes, and forfeits all right to compensation if convicted of the offense. C.R.S. § 8-43-402.

11. Is there any defense for falsification of employment records regarding medical history?

Compensation benefits are reduced by 50% if an injured employee willfully misleads the employer regarding the employee’s physical ability to perform the job, and the employee is subsequently injured on the job as a result of the misleading physical ability. C.R.S. § 8-42-112(1)(d).

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Injuries sustained by an employee while engaging in a recreational activity when the employee is relieved of and is not performing any duties of employment are not compensable. C.R.S. § 8-40-301(1)(a). Injuries incurred during off-duty exercise or other non-work activities are compensable only if the activity is an incident of employment. The five factors to be considered are whether: (1) the injury occurred during working hours; (2) the injury occurred on the employer's premises; (3) the employer initiated the employee's activity; (4) the employer exerted any control over the activity; and (5) the employer stood to benefit from the employee's activity. The court gives the most weight to factors one and two. *Price v. Indus. Claim Appeals Office*, 919

13. **Are injuries by co-employees compensable?**

Yes, injuries by co-employees are compensable if the injuries arise out of and in the course of employment. If the injury arises out of a tort claim based on a co-employee assault, the Court has developed a test to determine if the injuries arise out of employment for purposes of the Workers’ Compensation Act. Under the test, willful assaults by co-employees are divided into three categories: (1) those assaults that have an inherent connection with the employment; (2) those assaults that are inherently private; and (3) those assaults that are neutral. *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). Both the first and third categories of assaults arise out of the employment for the purposes of the Act. Only the second category of assaults, inherently private assaults, do not arise out of employment and thus are not covered by the Act. See *Horodyskyj v. Karamian*, 32 P.3d 470, 477 (Colo. 2001). “Ordinary” sexual assaults have been determined to fall into the second category, those assaults that are inherently private,” and thus, are not compensable under the Colorado Workers’ Compensation Act. *Id.*

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**


**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Average weekly wage is determined by the monthly, weekly, daily, or hourly wage earned by the employee at the time of the injury. If the employee is paid by the month, the average weekly wage is determined by multiplying the monthly salary by twelve and dividing by fifty-two. If paid by the week, that wage is deemed to be the average weekly wage. If paid per diem, the daily wage is to be multiplied by the number of days and fractions of days in a week that the employee was working at the time of the injury. When paid by the hour, the average weekly wage is calculated by multiplying the hourly rate by the number of hours in a day during which the employee was working or would have worked if the injury had not occurred; the daily wage is then multiplied by the number of days in a week the employee was working. C.R.S. § 8-42-102(2).

The value of certain fringe benefits specifically enumerated in the statute, e.g., *inter alia*, health insurance plan, board and lodging, are also to be included in calculating average weekly wage. C.R.S. § 8-40-201(19). However, the administrative law judge may disregard the product yielded by these equations if the wages computed are not a fair
representation of the earnings at the time of the injury. C.R.S. § 8-42-102(3). For example, an employee hasn’t worker for the employer for a sufficient period of time or the employee has been ill.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

C.R.S. §§ 8-42-105, 8-42-106 govern the payment of temporary disability benefits. Under the Colorado Workers’ Compensation Act, two types of temporary disability benefits are available to injured workers: temporary total disability benefits and temporary partial disability benefits.

Temporary total disability benefits are payable to the injured worker where he or she incurs total wage loss as a result of the injury, and are paid at the rate of two-thirds of the employee's average weekly wage. C.R.S. § 8-42-105(1).

If the injured worker continues to work after his or her injury, but is earning less than before his or her industrial injury, and his or her average weekly wage is consequently decreased, temporary partial disability benefits are payable at the rate of two-thirds of the wages lost due to the injury. C.R.S. § 8-42-106(1).

There is no minimum amount of benefits. The maximum weekly temporary benefits for injuries occurring after July 1, 2019 is $1,022.56, which is determined by calculating 91% of the state average weekly wage. The state average weekly wage and the maximum TTD rate are re-determined every July 1st by the Director of the Division of Workers’ Compensation. C.R.S. § 8-47-106.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The first installment of compensation shall be paid on the same date that liability for the claim is admitted by the insurance carrier or self-insured employer, unless the claim is denied. C.R.S. § 8-42-105(2)(a).

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out ___ days before recovering benefits for the first ___ days)?**

If the period of disability does not last longer than 3 days from the day the employee leaves work as a result of the injury, then the employee is not entitled to temporary total disability benefits. If the employee is off work as a result of the injury for more than two weeks, temporary disability benefits are recoverable from the first day the injured employee left work as a result of the accident or injury. C.R.S. § 8-42-103(1)(a)-(b).

19. **What is the standard/procedure for terminating temporary benefits?**

For injuries arising on or after July 1, 1991, temporary benefits may be suspended or
terminated unilaterally by the employer under one of the following five circumstances: (1) the employee has reached maximum medical improvement (MMI) and the employer's final admission of liability takes a position on the issue of permanency; (2) the primary treating physician reports that the employee is able to return to regular employment; (3) the employee has returned to work, verified by the employer, and the employer reports the employee's earnings; (4) the employer sends the employee a certified letter offering employment within work restrictions and a statement from an authorized treating physician that the employment offered is within those restrictions; or (5) the employee fails to appear at a rescheduled medical appointment after being warned by the employer, through a certified letter, that temporary benefits will be suspended for a failure to appear, and the treating physician confirms the failure to appear. Only the first offer of modified employment by a temporary help contracting firm need be in writing. Workers' Compensation Rules of Procedure (“WCRP”) 6-1(A)(1-5).

If the employer/insurer seeks to suspend for any other reason, it must submit a written petition to suspend, stating the factual background and the legal principle that warrants the suspension or termination. A hearing is scheduled if the employee submits a timely objection. WCRP 6-4.

However, in the event that the employee is responsible for his or her termination of employment, his or her resulting wage loss is not attributable to the industrial injury, and no temporary total disability benefits are owed. C.R.S. § 8-42-105(4).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

An insurance carrier is entitled to credit against permanent disability benefits for any temporary disability benefits paid beyond the date of maximum medical improvement, except where vocational rehabilitation is offered. WCRP 5-6(D); C.R.S. § 8-42-105(1).

Additionally, for injuries occurring after July 1, 2019, an employee may not receive more than $94,330.19 from combined temporary disability and permanent partial disability payments if the employee has a medical impairment rating of 25% whole person impairment or less. C.R.S. § 8-42-107.5. If the impairment rating is greater than 25%, the ceiling for combined temporary disability and permanent disability benefits is $188,658.00 for injuries occurring after July 1, 2019. C.R.S. § 8-42-107.5.

21. **What disfigurement benefits are available and how are they calculated?**

An employee who is seriously, permanently disfigured “about the head, face, or parts of the body normally exposed to public view,” may receive benefits up to $4,000.00, at the discretion of the Director of the Division of Workers’ Compensation. C.R.S. § 8-42-108(1).

An employee who sustains: 1) extensive facial scars or burn scars, 2) extensive body scars or burn scars, or 3) stumps due to loss or parial loss of limbs may receive up to
22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

Permanent partial disability benefits, referred to under the Act as "medical impairment benefits," are calculated differently depending on whether the injury is to a part of the body which is classified by the statute as a "scheduled injury," or a part of the body not so classified. In the event that the injury is incurred to a part of the body that is not statutorily scheduled, permanent partial disability benefits will be paid based upon a whole person calculation. C.R.S. § 8-42-107(8)(d).

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

From July 1, 2019 to June 30, 2020, scheduled injuries, in which a member of the body has been permanently impaired, are paid out at the scheduled rate of $320.90 per week. The scheduled rate is determined by the Director of the Division of Workers’ Compensation, and changes every July 1st. C.R.S. § 8-42-107(6)(b). The statute sets forth the number of weeks of compensation to be awarded for each scheduled injury. C.R.S. § 8-42-107(2).

For example, the statute awards 208 weeks of compensation for the loss of an arm at the shoulder. The total award for such a loss would be calculated by multiplying the number of weeks (208) by the scheduled rate, which differs depending upon the year in which the injury was incurred. If an injured worker incurred an injury subsequent to July 1, 2019, the applicable scheduled rate is $320.90. Thus, 208 weeks is multiplied the amount to be paid by the week ($320.90), which yields a product of $66,747.20

Assuming, hypothetically, the employee has only a 10% permanent impairment of the arm, the award would be determined by multiplying $66,747.20 by 10%, rendering an award of $6,674.72. ($320.90 x 208 x .10 = $6,674.72).

B. Number of weeks for "whole person" and standard for recovery.

Benefits for all permanent injuries not classified as "scheduled injuries" are determined by a formula, which factors in the employee's age, whole body impairment rating, and temporary total disability rate. For example, assume a 40-year-old employee suffers a lower back injury and has a whole person medical impairment rating of 10%. Assume, furthermore, that the same employee has an average weekly wage of $300. The statute requires that the award be determined by multiplying the impairment rating (10%) by the age factor (1.40, according to the statute) by the temporary disability rate (2/3 of the $300 average weekly wage, or $200), by 400 weeks. In this example, .10 x 1.40 x $200 x 400 produces an award of $11,200.00 for the 40-year-old employee with the 10% whole person impairment rating. The applicable age factors are set forth in the statute. C.R.S. §
23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Vocational rehabilitation is offered at the discretion of the employer/insurer. An employee who refuses an offer of vocational rehabilitation is not eligible for an award of permanent total disability benefits, if the employee is capable of rehabilitation. C.R.S. § 8-42-111(3).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are paid to the employee at the rate of two-thirds of his or her average weekly wage, not to exceed the maximum temporary total disability rate, for the employee’s life. C.R.S. § 8-42-111. The maximum temporary disability rate is determined on a yearly basis by the Director of the Division of Workers’ Compensation.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

The employer/insurer must pay in one lump sum, within 30 days of the death, up to $7,000.00 for reasonable funeral and burial expenses. C.R.S. § 8-42-123. If the employee leaves no dependents, no funeral or burial expenses are payable under the Act. *Id.*

B. **Dependency claims.**

Death benefits are paid to the dependent spouse for life, or until remarriage, in an amount equal to two thirds of the deceased employee's average weekly wage. C.R.S. § 8-42-114; C.R.S. § 8-42-120. At the time of remarriage, a two-year lump sum is paid to the spouse, if there are no dependent children. If there are dependent children, the benefits to the spouse terminate upon remarriage and survive to the other dependents. Benefits to dependent children are payable until they reach the age of eighteen. C.R.S. § 8-42-120. Benefits may be apportioned among the dependents in a manner determined to be just and equitable by the Division of Workers' Compensation. C.R.S. § 8-42-121. The maximum rate for death benefits to dependents is 91% of the state average weekly wage, which is the same as the current maximum for temporary total disability, $1,022.56. C.R.S. §§ 8-42-114, 8-42-120. The minimum rate is 25% of the applicable maximum per week.

26. **What are the criteria for establishing a "second injury" fund recovery?**

Colorado previously established a Subsequent Injury Fund. C.R.S. § 8-46-101. However, the Subsequent Injury Fund has been abolished for injuries occurring after July
1, 1993 or for occupational diseases occurring after April 1, 1994. C.R.S. § 8-46-104. For injuries sustained prior to July 1, 1993, a recovery may be had against the Subsequent Injury Fund where an employee has sustained a previous industrial disability, and, in a subsequent work-related injury, sustains additional permanent disability, which, in combination with the first injury, renders the employee permanently and totally disabled. In such a case, the employer of the last injury causing permanent disability is responsible only for the portion of disability attributable to that injury. C.R.S. § 8-46-101. The Subsequent Injury Fund is liable for the remainder. Id.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A claim may be re-opened at any time within six years of the injury on the grounds of fraud, overpayment, error, mistake, or change in condition, unless the employee has entered into a settlement in which he or she has waived the right to re-open; however, a settlement may be reopened at any time on the ground of fraud or mutual mistake of material fact. C.R.S. § 8-43-303(1). At any time within two years after the payment of the last temporary or permanent disability benefit, the Division may re-open the claim for fraud, overpayment, error, mistake, or change of condition, unless the employee has entered into a settlement in which he or she has waived the right to re-open. C.R.S. § 8-43-303(2)(a).

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

An employer may be obligated to pay an employee’s attorney fees where the employer files a frivolous appeal, or attempts to set for hearing an issue not ripe for adjudication. C.R.S. § 8-43-211(3).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Where an employer constitutes a statutory employer under the Act, the employer is immune from civil liability for damages resulting from the employee’s industrial injury. C.R.S. §§ 8-41-401, 8-41-402. In cases in which a tortfeasor would be considered an employee’s “statutory employer” under the Colorado Workers’ Compensation Act, the employer is immune from civil liability, even if the employee has already received workers’ compensation benefits from his actual employer. See Finlay v. Storage Tech. Corp., 764 P.2d 62, 63 (Colo. 1988).

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

There are no statutory exceptions to the exclusivity of the workers’ compensation
remedy. Even in situations where an injury is the result of an intentional assault by a co-worker, a finding that the injury arose out of the employment is not precluded. Rather, assaults upon employees are generally divided into three categories: (1) those that have some inherent connection with the employment, as where the assault results from the "enforced contacts" required by the conditions of the employment; (2) those that are inherently private disputes imported into the employment; and (3) those that are neither, and may therefore be termed "neutral." Unless the assault arises from a private or personal dispute, injuries resulting from an assault are compensable. *Triad Painting Co. v. Blair*, 812 P.2d 638, 642 (Colo. 1991). Accordingly, intentional acts against an employee that are personal to the employee, such as sexual harassment, have been held to be outside the scope of employment. *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991).

30. **Are there any penalties against the employer for unsafe working conditions?**

No.

31. **What is the penalty, if any, for an injured minor?**

No penalties against employers are specifically provided for under the Act for injuries sustained by minor employees. Under the Act, a minor is a person under the age of twenty-one years. *Torres v. Canam Indus.*, 942 P.2d 1384, 1385-86 (Colo. App. 1997). Benefits are payable to minors for temporary as well as permanent disability. For temporary disability, the minor’s benefits are payable the same as an adult, two thirds of the minor’s average weekly wage. In the instance of a whole person permanent disability, benefits are paid at the maximum permanent partial disability rate at the time the employee is placed at maximum medical improvement. C.R.S. § 8-42-102(4).

32. **What is the potential exposure for "bad faith" claims handling?**

An employer or insurer who violates any provision of the Workers' Compensation Act, or who refuses to comply with any lawful order, "shall be punished" by a fine of not more than $1,000 per day. Each day of noncompliance constitutes a separate offense. C.R.S. § 8-43-304(1).

An employer or insurer who willfully refuses to cooperate with claims management efforts of the Division is subject to the penalty provisions of C.R.S. § 8-43-304 and to the denial or vacation of a hearing date. C.R.S. § 8-43-218(3); *Vaughan v. McMinn*, 945 P.2d 404, 410 (Colo. 1997).

recommendation of the Division will suspend or revoke the license or authority of such
carrier to do a compensation business in the state. C.R.S. § 8-44-106.

33. What is the exposure for terminating an employee who has been injured?

An employee discharged for filing a workers' compensation claim may pursue a cause of
action in District Court for retaliatory or wrongful discharge. Lathrop v. Entenmann's,

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. See C.R.S. § 8-41-203. An employee who is entitled to compensation under the
Colorado Workers’ Compensation Act, and is injured or killed by the negligence or
wrong of another not in the same employ, may pursue a remedy against that person “to
recover any damages in excess of the compensation available” under the Act. C.R.S. § 8-
41-203(1)(a).

However, the insurance carrier’s payment of benefits to the injured worker “operate[s] as
an assignment of the cause of action against such other person to…the insurance carrier
liable for the payment of such compensation.” C.R.S. § 8-41-203(1)(b). In the event the
insurance carrier recovers an amount in excess of the amount paid in compensation to the
injured employee, the carrier is subrogated to the rights of the injured employee against
the third party causing injury. Id.

35. Can co-employees be sued for work-related injuries?

Generally, no. However, an employee can sue a co-employee for intentional acts that are

36. Is subrogation available?

Yes. See C.R.S. § 8-41-203(1)(c).

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late
payment?

Yes. The time limit for an insurance carrier’s payment of medical bills is 30 days
subsequent to the receipt of the bill by the insurer. WCRP 16-11(A)(2). A violation may
subject an employer to penalties of up to $1,000 per day. C.R.S. § 8-43-304.

38. What, if any, mechanisms are available to compel the production of medical
information (reports and/or authorization) at the administrative level?
There are several Rules of Procedure mandating the exchange of medical records. When the Final Admission is predicated upon medical reports, such reports must accompany the Admission. WCRP 5-5(A). Medical, hospital, physician and vocational reports, and records of the employer must be provided to the opposing party at least 20 days prior to a formal hearing. C.R.S. § 8-43-210. With regard to authorizations, the employee or any other person must execute and return any request for release of medical information within 15 days from the date of mailing. WCRP 5-4(C).

39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

**A. Claimant’s choice of physician.**

Effective April 1, 2015, Colorado law changed regarding choice of physician. C.R.S. § 8-43-404(5)(a) provides how an authorized treating physician is chosen. A list of at least four physicians or four corporate medical providers or two physician and two corporate medical provider, where available, must be provided to the injured worker and then the injured worker selects the physician that will attend to him. C.R.S. § 8-43-404(5)(a)(I)(A). At least one of the designated providers shall be at a distinct locations without common ownership. *Id.* If there are not two providers without common ownership within 30 miles of each other, the employer may designate two providers at the same location or with shared ownership interests. *Id.* If a physician is not selected at the time of the injury, the employee has the right to select a physician or a chiropractor. *Id.*

An employee may obtain a one-time change in the designated authorized treating physician when:

1) Notice is provided within ninety days after the date of the injury but before the injured workers reaches maximum medical improvement;

2) The notice is in writing and submitted on a form designated by the Director of Workers’ Compensation;

3) The notice is directed to the insurance carrier and to the initial authorized treating physician;

4) The new physician is on the employer’s designated list;

5) The transfer of medical care does not pose a threat to the injured employee.

*See* C.R.S. § 8-43-404(5)(a)(III)(A)-(E).

In addition to the one-time change of physician and upon written request to the insurance carrier, an injured worker may get written permission to have a personal physician treat
him. C.R.S. § 8-43-404(5)(a)(VI). The request is deemed granted, unless the insurance carrier or employer objections to the request within 20 days. Id. If the employer timely objects, the employee may nonetheless petition the Division of Workers’ Compensation for an order authorizing a change in physicians. Id.

B. Employer’s right to second opinion and/or Independent Medical Examination.

The employer has a right to request the employee to submit to a reasonable number of Independent Medical Examinations upon written request. C.R.S. § 8-43-502(5). The employee has the right to have a physician of his or her own choosing present at the independent medical examination. Id.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The employer and insurer are responsible for providing all reasonable and necessary medical care to cure and relieve the effects of the injury. C.R.S. § 8-42-101(1)(a).

41. Which prosthetic devices are covered, and for how long?

All prosthetic devices are covered, if the expense is reasonable and necessary and the device is needed to relieve the employee of the effect of the injuries. The employer must furnish a prosthetic device, and any necessary replacements, if reasonably required to improve the function of the part of the body affected by the injury. C.R.S. § 8-42-101(1)(b).

42. Are vehicle and/or home modifications covered as medical expenses?

Yes, so long as the modifications are reasonable and necessary to cure and relieve the effects of the injury. Modifications designed strictly to enhance the quality of the employee's living environment are not covered. See, e.g., Deets v. Multimedia Audio Visual, W.C. No. 4-327-591 (March 18, 2005).

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. The Division of Workers' Compensation establishes a fee schedule fixing the fees for which all medical and rehabilitation expenses shall be compensated. The schedules are revised on or before July 1st of each year by the Division. C.R.S. § 8-42-101(3)(a)(I); WCRP 18.

44. What, if any, provisions or requirements are there for "managed care"?

"Managed care" is the provision of medical care through an organization that is defined by the statute as a health maintenance organization, or through a network of medical providers accredited to practice workers' compensation medicine. The employer and
insurer are required to offer managed care or medical case management in the areas of major cities and towns, and to offer medical case management throughout the state. C.R.S. § 8-42-101(3.6)(p).

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

The employer and insurer are responsible for filing a First Report of Injury with the Division of Workers' Compensation within 10 days after they knew, or should have known, of an injury to an employee, assuming the employee is disabled for more than three shifts or three calendar days, irrespective of whether liability is admitted or contested. C.R.S. § 8-43-101(1). Thereafter, the employer must submit a position statement with the Division of Workers' Compensation, either admitting to the claim or denying the claim, within 20 days of filing the First Report of Injury. WCRP 5-2 (C).

If the employee submits a claim, the employer and insurer must admit or contest liability within 20 days of receiving notice of the claim. C.R.S. §8-43-203(1)(a). If the claim is contested, the employee may request an expedited hearing on the issue of compensability and medical benefits only if it is requested within 45 days of the date of mailing of the notice to contest. Id. Other issues may be contested and determined at a hearing, even where compensability is not a contested issue.

An employee may request a hearing on compensability only but litigate other issues, e.g., average weekly wage, change of physician, etc. at any time as those issues become ripe for adjudication.

46. What is the method of claim adjudication?

A. Administrative level.


B. Trial court.

The Industrial Claims Appeals Office, commonly referred to as ICAO, presides over appeals of orders entered by the administrative law judge. C.R.S. § 8-43-301.

C. Appellate.

The parties may further appeal the case to the Colorado Court of Appeals and the Colorado Supreme Court. C.R.S. §§ 8-43-307, 8-43-313.
47. **What are the requirements for stipulations or settlements?**

The parties are free to enter into stipulations and settlements regarding claims for compensation, benefits, penalties, and interest. C.R.S. § 8-43-204. The settlement must be in writing and signed by representatives of the insurer and employer, and signed and sworn to by the injured employee. C.R.S. § 8-43-204(2)-(3). However, settlements must be approved by the Division of Workers' Compensation, and *pro se* settlements are strictly scrutinized. C.R.S. § 8-43-204(3); WCRP 9-9.

48. **Are full and final settlements with closed medicals available?**

Yes. C.R.S. § 8-43-204(1).

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. C.R.S. § 8-43-204(3).

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Employers may become self-insured, participate in an insurance pool, subscribe to the state fund (Pinnacol Assurance), or elect to seek coverage from a private insurer or stock or mutual corporation. If an employer secures coverage with a stock or mutual corporation, it must file a notice with the Division of Workers' Compensation providing the name of insurer and insured, as well as other pertinent information. C.R.S. § 8-44-101.

51. **What are the provisions/requirements for self-insurance?**

**A. For individual entities.**

If the employer elects to be self-insured, it must apply for a permit from the Division of Workers' Compensation and provide, on a form prescribed by the Division, all information that is required. C.R.S. §§ 8-44-101(1)(c), 8-44-205.

**B. For groups or "pools" of private entities.**

If the employer elects to participate in a self-insurance pool, a proposal of the plan providing information on claims handling, reinsurance, administration, etc. must first be submitted to and approved by the Division. C.R.S. §§ 8-44-101, 8-44-205.

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they**
cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?


53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There is no provision under the Colorado Workers’ Compensation Act that would explicitly preclude terrorist acts from coverage.

54. Are there any state specific requirements, which must be satisfied in light of the obligation of parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

There is no provision in the Colorado Workers’ Compensation Act that provides any state specific requirements, which must be satisfied under Medicare.

However, under Medicare regulations (42 C.F.R. § 411.20), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare beneficiary and the total settlement amount is greater than $25,000; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 C.F.R. 411.46; 42 USC §1395y).

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.
Medicare is requiring Medicare set-aside trusts to be established for settlements in which the employee is likely to be qualified for or is receiving Medicare and faces significant medical costs related to the employee’s industrial injury in the future. If the trust is not established, Medicare reserves the right to file a claim in the future against all parties involved in the settlement, including the lawyers representing both parties, and the insurance company.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

Medicaid and health insurers have a right to file a claim in civil court against any parties involved in a workers’ compensation matter for medical bills which should have been covered under a workers’ compensation case.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. §§ 160-164 and 65 Fed. Reg. 82462, went into effect on April 14, 2003. The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. § 164.512(l)]. Therefore, your current practice of obtaining medical records could proceed under state law.

HIPAA will apply to workers’ compensation cases. Therefore, all parties need to be careful in dealing with medical records in worker’s compensation matters.

57. **What are the provisions for “Independent Contractors”?**

C.R.S. § 8-40-202(2)(b)(II) provides nine criteria for determining whether a worker is an independent contractor or an employee. In order to prove independence, it must be shown that the individual for whom services are performed does not:

A. Require the individual to work exclusively for the person for whom services are performed; except that the individual may choose to work exclusively for such person for a finite period to time specified in the document;
B. Establish a quality standard for the individual; except that the person may provide plans and specifications regarding the work but cannot oversee the actual work or instruct the individual as to how the work will be performed;

C. Pay a salary or at an hourly rate instead of at a fixed or contract rate;

D. Terminate the work of the service provider during the contract period unless such service provider violates the terms of the contract or fails to produce a result that meets the specification of the contract;

E. Provide more than minimal training for the individual;

F. Provide tools or benefits to the individual; except that materials and equipment may be supplied;

G. Dictate the time of performance; except that a completion schedule and a range of negotiated and mutually agreeable work hours may be established;

H. Pay the service provider personally instead of making checks payable to the trade or business name of such service provider; and

I. Combine the business operations of the person for whom service is provided in anyway with the business operations of the service provider instead of maintaining all such operations separately and distinctly.

However, it is not necessary to satisfy all nine criteria because evidence of one factor is not conclusive evidence that an individual is an employee instead of an independent contractor. Nelson v. Indus. Claim Appeals Office, 981 P.2d 210, 212 (Colo. App. 1998).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organization/temporary service companies/leasing companies?

No. C.R.S. § 8-41-401.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Yes. C.R.S. § 8-40-301(5)-(6) states that a person who is working as a driver under a lease agreement with a common carrier or contract carrier is not considered an employee. However, any person working as a driver with a common carrier shall be eligible for workers’ compensation through Pinnacol Assurance or similar insurance carrier that provides coverage under workers’ compensation or a private insurance policy with
similar coverage.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. Financial exposure to workers’ compensation is an expensive and complex challenge for all businesses. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

61. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Colorado law permits the use of medical marijuana. Colorado employers retain the right, however, to terminate an employee for use of medical marijuana. In Coats vs. Dish Network, 350 P.3d 849 (Colo. 2015), the plaintiff was terminated for use of medical marijuana to treat his chronic condition. The Colorado Supreme Court ruled a claimant can be terminated for use of medical marijuana despite its legalization under Colorado law as it remains illegal under federal law. However, the Colorado legislature introduced a bill in early January 2020, which would prohibit employers for firing workers for participating in activities off the clock that are otherwise illegal under federal law. House Bill 1089.

Respondent insurance carriers are not liable for reimbursement of medical marijuana. “No governmental, private, or any other health insurance provider shall be required to be liable for any claim for reimbursement for the medical use of marijuana.” Colo. Const. art. XVIII, § 14(10)(a).

62. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Colorado permits the recreational use of marijuana. Colorado employers retain the right, however, to terminate an employee for use of marijuana, even if it is after-hours and off premises. The only requirement is that a standing enforced policy forbidding marijuana use be in place. Coats vs. Dish Network, 350 P.3d 849 (Colo. 2015). However, the Colorado legislature introduced a bill in early January 2020, which would prohibit employers for firing workers for participating in activities off the clock that are otherwise illegal under federal law. House Bill 1089. If this bill is enacted as a law, it would prevent employers from firing workers for engaging in marijuana use outside of work. This bill would still allow employers to terminate employees for marijuana use at work.

If a claimant’s use of recreational marijuana results in a work injury, a respondent can assert an intoxication defense or a safety rule violation defense. If successful, these defenses entitle a respondent to a 50% reduction in all indemnity benefits owed. Additionally, if a claimant returns to work following injury performing some kind of light duty, they can be terminated if they are subsequently found to have consumed marijuana
in violation of a standing employment policy. This is called a “termination for cause defense.” If a claimant is found to be terminated for cause, temporary indemnity benefits can be modified or terminated.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Douglas J. Kotarek, Esquire
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Tel: (303) 628-3300
1. Citation for the state workers' compensation statute.

Connecticut General Statutes Sections 31-275 through 31-355a (Chapter 568).

**SCOPE OF COMPENSABILITY**

2. Who are covered "employees" or “workers” for purposes of workers' compensation?

An "employee" is any person who has entered into or works under any contract of service or apprenticeship with an employer, whether such contact contemplated performance of duties within or without the state. C.G.S. §31-275(9).

A sole proprietor or business partner may elect to be covered under the Act. An independent contractor is not a covered employee, see Thompson v. Twiss. 90 Conn. 444 (1916), nor is a so-called "casual employee" (someone hired on a casual basis who is "employed otherwise than for purposes of the employer's trade or business"), C.G.S. §31-275(9)(B)(ii).

In determining whether the owner of a single-member liability company is an “employee” within the meaning of the Act, the test to be applied is “whether the member performed services for the company and was subject to the hazards of the company’s business.” Gould v. City of Stamford, 331 Conn. 289 (2019).

3. Identify and describe any "statutory employer" provision.

C.G.S. §31-275(10) defines an employer as any person, corporation, limited liability company, firm, partnership, voluntary association, joint stock association, the state and any public corporation within the state using the services of one or more employees for pay. Connecticut has a "principal employer" statute (C.G.S. §31-291) which, in practice, applies generally to construction site injuries. A so-called “principal employer” (usually a general contractor) can be liable for injuries to subcontractors or their employees if four criteria are met: (1) there must be a "principal employer" relationship between the employer and the contractor whereby the contractor was hired to perform work for the principal employer; (2) the contractor must have been hired to perform work which is "a
part or process in the trade or business of such principal employer,” i.e., work that is ordinarily or appropriately performed by the principal employer's own employees in furtherance of its business (e.g., a general contractor hiring a carpentry subcontractor); (3) the injury must occur on or about premises under the control of the principal employer; and (4) the employee's own employer must not have workers' compensation coverage as required by statute. The principal employer is not entitled to the exclusive remedy defense unless it has actually paid compensation benefits.

4. **What types of injuries are covered and what is the standard of proof for each:**

A. **Accidental Injuries, C.G.S. § 31-275(16)(A).**

An accidental injury is one “which may be definitely located as to the time when and the place where the accident occurred…” C.G.S. § 31-275(16)(A). The one year notice period begins to run on the date of accident. The standard of proof upon an employee is that, to a reasonable degree of medical probability, the injury arose out of and in the course of the employment.

B. **Repetitive Trauma, C.G.S. § 31-275(16)(A).**

A repetitive trauma injury is caused by repetitive acts and stresses of the employment. Notice of claim regarded as timely if filed within one year from the last trauma (or micro trauma) that produced the incapacity. The standard of proof is the same as that for single occurrence claims.

C. **Occupational Disease, C.G.S. § 31-275(15).**

An occupational disease “includes any disease peculiar to the occupation in which the employee was engaged and due to causes in excess of the ordinary hazards of employment as such…” C.G.S. § 31-275(15). Occupational diseases such as asbestosis and symptoms caused by exposure to work place chemicals are covered. The standard of proof is the same as that for single occurrence claims. Notice of claim is regarded as timely if filed within three years of being diagnosed with an occupational disease and informed of its relation to work exposures.

D. **Mental Stress Injury, C.G.S. § 31-275(16)(B).**

A mental or emotional injury is no longer a covered injury unless such impairment arises from a physical injury or occupational disease. However, the employer may now have exposure for damages in a civil action for a purely mental or emotional injury because the workers’ compensation remedy no longer exists. Karanda v. Pratt & Whitney Aircraft, 1999 WL 329703 (Conn. Super.)

A new law took effect on July 1, 2019 to allow police officers, municipal constables, parole officers, and firefighters, both paid and volunteer, to receive limited workers’ compensation benefits for PTSD. To be eligible for benefits the diagnosis must be made by a board certified mental health professional, psychiatrist, or psychologist who has experience in the diagnosis and treatment of PTSD. Eligibility is triggered by a “qualifying event” in which the claimant, in the line of duty: (1) views a deceased minor; (2) witnesses the death of a person or an incident involving the death of a person; (3) witnesses an injury to a person who subsequently dies before or upon admission at a
hospital as a result of the injury and not as a result of another intervening cause; (4) has physical contact with or treats an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of another intervening cause; (5) carries an injured person who subsequently dies before or upon admission to a hospital as a result of the injury and not as a result of another intervening cause; (6) witnesses a traumatic physical injury that results in the loss of a vital body part or a vital body function that results in permanent disfigurement of the victim. In order to receive benefits, a claimant must show that the qualifying event is a substantial factor in causing the PTSD.

5. **What, if any, injuries or claims are excluded?**

The following “personal injuries” or injuries” are excluded: (1) an injury which result from voluntary participation in any activity the major purpose of which is social or recreational, including but not limited to athletic events, parties and picnics whether or not the employer pays some or all of the cost of such activity; (2) a mental or emotional impairment unless such impairment arises from a physical injury or occupational disease. *Biasetti v. City of Stamford*, 250 Conn. 65 (1999); or (3) a mental or emotional impairment which results from a personnel action including, but not limited to, a transfer, promotion, demotion or termination. C.G.S. § 31-275(16)(B).

6. **What psychiatric claims or treatments are compensable?**

Psychological claims are compensable only if the claimed psychiatric or emotional problem arises from a compensable physical injury or occupational disease. C.G.S. §31-275(16)(B).

7. **What are the applicable statutes of limitations?**

There is a one-year limitations period for traumatic, single event. Regarding an occupational disease claim, the Supreme Court case of *Ricigliano v. Ideal Forging Corp.*, 280 Conn. 723 (2006), the Court ruled that the limitations period does not commence until the claimant learns that there is a causal connection between his disease and employment. This typically occurs when a physician diagnoses a condition and advises the claimant of its causal relation to employment.

For death cases, the applicable statute of limitations is two years from the date of accident or onset of symptoms of the occupational disease, or one year from date of death, whichever is later. C.G.S. §31-294c.

8. **What are the reporting and notice requirements for those alleging an injury?**

"Notice of Injury" must be given to an employer "immediately," but failure to do so will not affect benefits unless prejudice is shown. The burden is on the employer to show prejudice.
Written "Notice of Claim," also referred to as a Form 30C, must be given to an employer within the time period outlined in answer 7, describing the date and place of the accident and a layperson's description of the injury, and providing the name and address of the employee and the person in whose interest is claimed. Notice must be served personally or by registered or certified mail. The notice requirement is excused if, within the statutory period: (1) an informal hearing held within the applicable time period; (2) a hearing is requested or scheduled; or (3) a voluntary agreement between the parties is signed and submitted to the commissioner for approval; (3) medical care is provided by the employer. C.G.S. §31-294.

For survivor’s benefits under C.G.S Section 31-306, the Commission has introduced a new form called a Form 30D which is now used to place the employer on notice of claim for these benefits. Recent Connecticut Supreme Court caselaw has concluded that there is no statute of limitations on the filing of the Form 30D if the underlying claim was filed timely. See McCullough v. Swan Engraving, Inc., 320 Conn. 299 (2016).

9. **Describe available defenses based on employee's conduct:**

   A. **Self-inflicted injury.**

   Suicides or self-inflicted injuries are generally not compensable, unless they result from a mental condition arising from the employment. See Wilder v. Russell Library Co., 107 Conn. 56 (1927).

   B. **Willful misconduct, "horseplay," etc.**

   Injuries caused by the willful and serious misconduct of the employee are not compensable. C.G.S. §31-284 (a). If such conduct is condoned by the employer, it can be found compensable. Injury caused to an innocent bystander as a result of misconduct or horseplay is covered. Mascika v. Connecticut Tool & Engineering Co., 109 Conn. 473 (1929).

   C. **Injuries involving drugs and/or alcohol.**

   An injury caused by the employee's intoxication is not compensable. Conn. Gen. Stat §31-284 (a). Moreover, "in the case of an accidental injury, a disability or death due to the use of alcohol or narcotic drugs shall not be construed to be a compensable injury." Conn. Gen. Stat §31-275(1)(c).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    An employer is guilty of a Class D Felony if it fraudulently deceives any insurer by
providing false or misleading information regarding employees, for the purpose of obtaining a lower premium. C.G.S. §31-288.

An employee (or anyone assisting an employee) who makes a fraudulent claim is guilty of a Class C Felony if the value of the benefits received or claimed is less than $2,000. If the value exceeds $2,000, it is considered a Class B Felony. Additionally, any such person is liable for treble damages in a civil action for damages. C.G.S. §31-290c. But, a claimant does not have an affirmative duty to disclose all potentially relevant evidence to an opposing party before entering into a stipulated agreement. Estate of Josephine Secola v. State of Connecticut, 1703 CRB-S-93-4 (January 31, 1995).

11.  **Is there any defense for falsification of employment records regarding medical history?**

There is no specific statutory defense for such actions.

12.  **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

   No. Recreational or non-work injuries occurring after July 1, 1993, are not compensable. C.G.S. §31-275(16)(B). However, if the employee can prove that his/her participation in the recreational activity was expected and incidental to employment, s/he may be able to establish compensability. Thomas v. City of Bridgeport, 6206 CRB-3-17-1 (July 30, 2018);

13.  **Are injuries by co-employees compensable?**

   An assault by a co-employee is generally not compensable, unless the assault was in some way incidental to the employment (rather than strictly personal), or if the existence of employee fighting was known to the employer. See Stulginski v. Waterbury Rolling Mills Co., 124 Conn. 355 (1938).

14.  **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., "irate paramour" claims)?**

   No.

**BENEFITS**

15.  **What criterion is used for calculating the average weekly wage?**
The "average weekly wage" is calculated by averaging the weekly gross wages for the 52-week period immediately preceding the week in which an accidental injury occurred. C.G.S. §31-310. In the case of an employee claiming an occupational disease or an injury from repetitive trauma, the week of injury is deemed to be the week the employee became totally or partially incapacitated. C.G.S. §31-310c.

16. How is the rate of temporary/lost time benefits calculated, including minimum and maximum rates?

The maximum weekly compensation rate is determined as of October 1st of each calendar year and is 100% of the average weekly earnings of all employees in the State, as determined by the State Labor Commissioner. Conn. Gen. Stat §31-309(a). "No employee entitled to compensation ... shall receive less than 20% of the maximum weekly compensation rate, as provided in §31-309, provided the minimum payment shall not exceed 75% of the employee's average weekly wage." Conn. Gen. Stat §31-307(a).

Subject to the foregoing maximum and minimum rates, temporary total disability benefits are 75% of the average weekly wage, reduced by various deductions for federal taxes. Conn. Gen. Stat §31-3-7(a). It is an extremely complicated formula (the result of an October 1991 statutory amendment). As a practical matter, compensation rates are generally not mechanically calculated, but instead require the employer/insurer to obtain a "weekly benefit table" published annually by the Workers' Compensation Commission.

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

Benefits not paid within 35 days of Written Notice of Claim are deemed "unduly delayed," unless a Notice to Contest is timely filed. C.G.S. §31-300. In matters where compensability has been established either by way of a commissioner's award or a voluntary agreement, payment due under the award or the agreement must commence on or before the twentieth day following the award or agreement. Payments not made within that 20-day period are subject to a 20% penalty. C.G.S. §31-303. If an employer pays benefits within 28 days of receiving notice of a claim, it can make such payments on a without prejudice basis for up to one year before determining whether it will contest the compensability of the claim.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out days before recovering benefits for the first days)?

Compensation is not owed until the employee has been out of work for more than three days of work. If the incapacity continues for a period of more than three days but less than seven days, compensation shall begin at the expiration of the first three days of total or partial incapacity. If the incapacity continues for a period of seven days or beyond, compensation shall begin from the date of the injury. C.G.S. §31-295(a).
19. What is the standard/procedure for terminating temporary benefits?

Respondents must file a Form 36 to terminate temporary benefits. The Form 36 is a written petition filed by the Employer/Respondent to reduce or terminate benefits in accordance with C.G.S. § 31-296. In order to terminate benefits, the Form 36 must be approved by the commissioner.

Generally, the Form 36 will be approved by the commissioner as of the date the form is received in the commissioner’s office unless contested by the employee within fifteen (15) days. Some commissioners automatically schedule hearings in response to a Form 36 filed in cases where claimant is pro se. If the Form 36 is contested by the claimant or his or her counsel, an informal hearing will be scheduled as quickly as possible by the Commissioner to discuss the proposed termination or reduction of medical or indemnity benefits.

If an employee objects to the Form 36, weekly benefits must continue pending the scheduling of an informal hearing. A respondent which fails to follow this procedure is exposed to monetary penalties at the discretion of the commissioner, which may include attorney’s fees and costs. Although the Act generally requires a Form 36 to be approved, standard practice in the Connecticut forum does involve one exception to these requirements, i.e., if a claimant has returned to full duty work and is already collecting wages, respondents generally will discontinue benefits before a Form 36 is approved.

If the basis for the reduction in benefits is a medical opinion of a treating physician or respondents’ medical examiner (RME), a supporting medical report must be attached to the Form 36 to provide the basis for the termination of benefits.

It should also be noted that the Connecticut Supreme Court has held the temporary total benefits may not be discontinued because of the employee’s incarceration for a crime, because the Act clearly requires the payment and contains no express exception for incarceration Laliberte v. United Security, Inc., 261 Conn. 181 (2002).

In order to receive temporary partial benefits (typically based on light duty restrictions) an injured worker must be ready, willing, and able to work. Consequently, injured workers that are incarcerated, terminated for cause, or who voluntarily resign from employment are not eligible to receive temporary partial disability benefits.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No, unless a Commissioner retroactively approves a Form 36 that sought to convert the claimant to permanent partial disability status while the claimant was collecting total disability benefits.

21. What disfigurement benefits are available and how are they calculated?

A commissioner may award up to 208 weeks of benefits for any "permanent, significant disfigurement or permanent significant scar on the face, head or neck or any other area of
the body which handicaps the employee in obtaining or continuing to work." C.G.S. §31-308(c). In addition, “[t]hose who do not obtain an award for scarring within two (2) years of the date of injury, but not earlier than one (1) year from the date of injury, will not be entitled to this benefit” C.G.S.§ 31-308(c). The calculation and scope of scarring awards rests within the discretion of the Trial Commissioner.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

Benefits for permanent partial disability, known as a "specific disability award," are based on three factors: (1) the employee's weekly compensation rate; (2) the portion of the body injured; and (3) the percentage of disability to that portion of the body as a result of the injury, as found by the commissioner or agreed upon by the parties. Connecticut has a schedule under which the complete loss of use of a particular portion of the body is assigned a specific number of weeks of compensation. C.G.S. §31-308(b).

The statute contains a schedule of compensation for specified body parts:

**SCHEDULED INJURIES**

- Loss of the master arm at or above the elbow 208 Weeks
- Loss of the other arm at or above the elbow 194 Weeks
- Loss of the master hand at or above the wrist 168 Weeks
- Loss of the other hand at or above the wrist 155 Weeks
- Loss of one leg at or above the knee 155 Weeks
- Loss of one foot at or above the ankle 125 Weeks
- Complete and permanent loss of hearing in both ears 104 Weeks
- Complete and permanent loss of hearing in one ear 35 Weeks
- Complete and permanent loss of sight in one eye 157 Weeks
The reduction in one eye to one-tenth or less of normal vision 157 Weeks

Complete and permanent loss of thumb on the master hand 63 Weeks

Thumb on the other hand 54 Weeks

Complete and permanent loss of first finger 36 Weeks

Complete and permanent loss of second finger 29 Weeks

Third Finger 21 Weeks

Fourth Finger 17 Weeks

Great Toe 28 Weeks

Any other toe 9 Weeks

Loss of the use of back max. 374 Weeks

The following guideline for additional “non-scheduled” injuries has been developed by the Compensation Commissioners:

Heart 520 Weeks
Liver 347 Weeks
Lung 117 Weeks
Cervical Spine 117 Weeks
Kidney 117 Weeks
Rib Cage (bilateral) 69 Weeks
Nose (sense and respiratory function) 35 Weeks
Jaw (mastication) 35 Weeks
Testis 35 Weeks
Mammary 35 Weeks
Penis (within discretion of Commissioner) 35 to 104 Weeks
Senses (smell, taste) 17 Weeks
Spleen (in addition to scar) 13 Weeks
Tooth 1 Week
Speech 163 Weeks
Pancreas 416 Weeks
Carotid Artery 520 Weeks
Brain 520 Weeks
Coccyx (actual removal) 35 Weeks
Stomach 260 Weeks
Bladder 233 Weeks
Gall Bladder 13 Weeks
Loss of drainage- duct of eye:
   Corrected 17 Weeks
   Uncorrected 33 Weeks

B. Number of weeks for "whole person" and standard for recovery.

Connecticut does not recognize a permanent partial disability rating for the "whole person."

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Vocational rehabilitation benefits are available to workers who suffer from a permanent impairment which substantially disables them or a significant period of time from performing the workers most recent or customary type of work. C.G.S. Section 31-283a. An employee may receive support for basic living expenses if they are not entitled to other enumerated benefits.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total disability benefits are calculated in the same manner as temporary total disability benefits. See answer 16. Certain injuries which are presumed to result in
permanent total disability are listed in the statute. C.G.S. §31-307(c).

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Four thousand dollars ($4,000) shall be paid for burial expenses in any case where the employee died on or after 1988. C.G.S. §31-306(a)(i).

B. **Dependency claims.**

A qualified dependent, such as a surviving spouse, receives the same weekly benefit as provided for temporary total or permanent total disability benefits. See answer 16. Special rules apply for allocating this benefit if there is a surviving spouse as well as dependent children who are not the offspring of the surviving spouse. C.G.S. §31-306.

26. **What are the criteria for establishing a "second injury" fund recovery?**

Transfer of claims to the Second Injury Fund for injuries after June 30, 1995 was eliminated by Public Act 95-277, §3. Public Act 96-242, §§1 and 2 imposed a “drop dead” transfer date of July 1, 1999 for all pending cases. While the Second Injury Fund is no longer acting in its former capacity, it still exists to administer non-insurance claims pursuant to § 31-355(b), and reimburse respondents in cases involving concurrent employment pursuant to § 31-310.

27. **What are the conditions for re-opening a claim for worsening of condition, including applicable limitations periods?**

The commissioners may modify both awards and voluntary agreements whenever it appears "that the incapacity of an injured employee has increased, decreased or ceased, or that the measure of the dependency on account of which the compensation is paid has changed, or that changed conditions of fact have arisen which necessitate a change of such agreement or award in order to properly carry out the spirit [of the Act]." C.G.S. § 31-315. There is no statute of limitations applicable to such requests for modifications. No modification is allowed if the employee has agreed to, and the commissioner has approved, a final settlement known as a "full and final stipulation," with the exception that the claimant can request a modification in order to prevent a reduction in Social Security benefits. In such situations, even when the full and final stipulation is modified, it cannot be done so in a manner that requires employers to pay benefits beyond the settlement payment.

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**
Such fees may be awarded if: (1) through fault or neglect, there is an unreasonable delay in paying benefits where no Notice to Contest is filed (thirty-five days is presumed to be "unreasonable"); or (2) the commissioner finds, after a hearing, that the employer/insurer has unreasonably contested liability. C.G.S. §31-300. If a claimant sustains a relapse of his or her injury, he or she may be entitled to a relapse rate for the calculation of benefits pursuant to C.G.S. §31-307b. The claimant has the ability to choose a compensation rate in effect at the original time of injury or at the time of relapse, whichever higher.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The compensation remedy is generally exclusive. C.G.S. §31-284.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

i. Independent Legal Relationship

The employer-employee relationship does not bar a claim brought by a party against the employer where the employer has agreed to provide indemnification to the entity sued by the employee. Ferryman v. Groton, 212 Conn. 138 (1999).

ii. Statutory Exceptions

An employee can sue a fellow employee for an injury caused by negligence if the action is based on the fellow employee’s negligence in the operation of a motor vehicle. C.G.S. § 31-293a.

iii. Intentional/Reckless Misconduct

The Connecticut Supreme Court has carved out an exception to the exclusive remedy provisions of the Connecticut Workers’ Compensation Act by allowing causes of action against employers for certain workplace injuries involving allegation of intentional or near certain injuries. Suarez v. Dumont Industries, 242 Conn. 255 (1997).

a. Intended tort theory – employer must have intended both the act itself and injuries, which are consequences of the act.

b. Substantial certainty theory – employer must have intended the act and have known that injury was substantially certain to occur from the act.

iv. Bad Faith Claim Against Insurer

The exclusivity provision of the Workers’ Compensation Act bars a cause of

30. Are there any penalties against the employer for unsafe working conditions?

If an employee is injured due to the employer's violation of any state or federal OSHA regulation for which the employer has previously been cited but has not corrected, the employee shall receive weekly compensation equal to 100% of such employee's average weekly earnings. C.G.S. §31-307(b).

31. What is the penalty, if any, for an injured minor?

There is no specific penalty for an injured minor, although the commissioner has certain discretion with respect to establishing the rate of compensation. "For the purpose of determining the amount of compensation to be paid in the case of a minor under the age of 18 years who has sustained an injury entitling him to compensation for total or partial incapacity for a period of 52 or more weeks, or to specific indemnity for any injury ..., the commissioner may add 50% to his average weekly wage, except in the case of a minor under 16 years of age, in which case the commissioner may add 100% to his average weekly wage." C.G.S. §31-310.

32. What is the potential exposure for "bad faith" claims handling?

Attorneys' fees can be awarded by the commissioner if it is determined that an employer/insurer has unreasonably delayed payments or unreasonably contested liability. C.G.S. § 31-300. Civil actions for "bad faith" are barred by exclusivity unless there is egregious behavior by the claims handler that results in the insurer no longer acting on behalf of the insured.

33. What is the exposure for terminating an employee who has been injured?

An employer cannot discharge, or cause to be discharged, or in any manner discriminate against any employee because the employee has filed a claim for workers’ compensation benefits or otherwise exercised the rights afforded to him pursuant to the provision of the Act. C.G.S. §31-290a.

An aggrieved employee may,

A. Bring a civil action in the superior court for reinstatement, payment of back wages and re-establishment of employee benefits. The court may also award punitive damages.

B. File a complaint with the chairman of the Commission. The Trial Commissioner may award reinstatement, payment of back wages and re-establishment of employee benefits. Any appeal proceeds directly to the Appellate Court.
THIRD PARTY CLAIMS

34. Can third parties be sued by the employee?

Yes.

35. Can co-employees be sued for work-related injuries?

Yes, but only if the injury was caused intentionally or was the result of the negligent operation of a motor vehicle (there is extensive litigation over the meaning of "motor vehicle").

36. Is subrogation available?

Yes. C.G.S. §31-293, which authorizes an injured employee to maintain an action at law against any third party which may be liable for the injury, also creates a right in the employer to recover from the third party any amounts paid as compensation for the injury. Enquist v. General Datacom, 218 Conn. 19 (1991). If an employee initiates a third-party action against the tortfeasor, s/he is statutorily entitled to keep keeps one-third of the net proceeds of the settlement, regardless of the amount of the employer’s lien. Although an employer is entitled to a moratorium against future benefits, the amount of that moratorium does not include the one-third portion paid to the employee. Callahan v. Car Parts International, LLC., 329 Conn. 564 (2019). The lien reduction is only applicable in those cases where the employee brings the third-party action; an employer can avoid the reduction by bringing the action itself.

If the employer, insurance company or Second Injury Fund does not intervene, a lien letter will protect the right of the two-thirds reimbursement of the workers’ compensation lien.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Theoretically, the provisions outlined in answer 17 may be applicable to medical payments. As a practical matter, this issue does not arise often since payments are made directly to the medical provider.
38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

All medical reports concerning any injury of an employee sustained in the course of employment must be furnished to the employer. C.G.S. 31-294f. Although there is no statutory requirement that an employee produce an authorization, in practice they are routinely provided. If necessary, a party can seek an order from the commissioner for an authorization. Attorneys may also subpoena medical records from providers.

39. **What is the rule on (a) Claimant's choice of physician; (b) Employer's right to second opinion and/or Independent Medical Examination?**

**A. Claimant's choice of physician.**

The claimant is permitted to select the physician. Conn. Gen Stat. § 31-294d. However, an employee may be limited to a list of providers who participate in the employers' Medical Care Plan. The employee may refuse the medical and surgical aid or hospital and nursing service provided by the employer and obtain the same at their own expense. § 31-294e.

**B. Employer's right to second opinion and/or Independent Medical Examination.**

Pursuant to C.G.S. § 31-294f, the employer is entitled to an Independent Medical Examination, also known as a respondents’ medical examination (RME). A respondents’ medical examination is used to obtain a second opinion on issues such as medical causation, diagnosis, need for surgery and extent of disability. A credible physician will carry more weight with the commissioner than a physician who has a reputation of being used exclusively by claimants. If there is a dispute in opinion between the treating physician and respondents’ medical examiner the commissioner has the discretion to order a commissioner’s examination. Although not binding, in practice this third opinion serves as a de facto “tie breaker”.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Virtually every type of care is compensable, including chiropractic care, physical therapy, podiatry, dentistry, psychiatry, and naturopathy, as long as it is deemed to be "reasonable or necessary." C.G.S. §31-294d. In addition, palliative treatment such as acupuncture and massage have been held, in certain instances, to be reasonable and necessary treatment. See Zalutko v. Danbury Hospital, Case No. 4299 CRB-7-00-4. Palliative care that allows an injured worker to maintain a work capacity is given the same level of credibility as curative medical treatment.
41. Which prosthetic devices are covered, and for how long?

All prosthetic devices are covered, and an employer is responsible for providing, maintaining, and replacing those devices throughout the employee's life. C.G.S. §31-294d. Generally, glasses only need to be replaced if they were damaged as part of a compensable injury.

42. Are vehicles and/or home modifications covered as medical expenses?

Although not specifically authorized by statute, such modifications are generally reimbursable when prescribed by a physician.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. The commission is required to publish annually a fee schedule setting the fees payable for services rendered by an approved medical provider. Payment of the established fee by the employer/insurer shall constitute full payment to the practitioner. The practitioner may not recover any additional amount from the employee. C.G.S. §31-280(b)(11)(B). A fee schedule for hospital and ambulatory surgical centers was created pursuant to Connecticut Public Act 14-167.

44. What, if any provisions or requirements are there for "managed care?"

Employers with an approved managed care plan must provide employees with a listing of all physicians and pharmacies that will provide medical services and pharmaceutical services at which the employer or insurer is obligated to make direct payment. (§31-279(c)).

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

**Form 43 – Notice to Contest**

The employer/respondent is given a period of twenty-eight (28) days during which it may contest liability following receipt of a Form 30C Notice of Claim for compensation, or its equivalent. However, an employer who commences payment to the claimant before the expiration of the twenty-eight (28) day period has up to one (1) year after such notice to contest compensability. This process is intended to encourage payment to the employee pending investigation of a claim while preserving an employer’s defenses to a non-compensable event.

It is imperative that both employers, and insurance providers and/or third party administrators be aware of this twenty-eight (28) day deadline if a disclaimer is
necessary in order not to prejudice a claim. In the absence of a timely disclaimer a claimant will file a Motion to Preclude seeking to bar the employer from asserting defenses to compensability.

The employer and its insurance carrier should therefore be aggressive in its preliminary investigation so it can determine whether a denial is appropriate. Any payments issued during this investigation must be made on a “without prejudice” basis. The following considerations apply:

A. The reasons for denial set forth on the Form 43 must be specific and not overly vague or general. “Alleged injury did not arise out of or in the course of employment” has been held sufficient for purposes of an initial denial.

B. If the respondent fails to file a proper disclaimer or issue payments without prejudice within the twenty-eight day time period, the respondent will be precluded from contesting compensability.

C. The Form 43 should be filed by certified mail or hand delivered to the employee and the Commission. C.G.S. § 31-321. A Form 43 cannot be filed with the commission via fax. Woodbury-Correa v. Reflexite Corp., 190 Conn. App. 623 (2019).

D. Defense counsel and claim handlers must be certain that the Form 43 is sent to the person claiming compensation. For example, if a death claim is pursued the disclaimer should be sent to the representative of the estate of the person who has died as well as any dependents who may have filed a written notice of claim for compensation.

46. What is the method of claim adjudication?

A. Administrative level.

A commissioner is the "fact finder" at so-called "Formal Hearings" and enters a "Finding and Award" or a “Finding and Dismissal” following a bench trial. Within ten days from receiving meaningful notice of the commissioner's decision, either party may file an appeal to the Compensation Review Board. C.G.S. §31-301. Conaci v. Hartford Hospital, 36 Conn. App. 298 (1984). Three members of the Compensation Review Board, which is comprised of the Chairman of the Workers’ Compensation Commissioner and all of the state workers' compensation commissioners, then hear the appeal. C.G.S. §31-301 (b).

B. Trial court.

The trial courts do not hear workers' compensation appeals in Connecticut.

C. Appellate.

Any appeal from the Compensation Review Board must be filed within 20 days of the
rendering of a decision. Such appeals are heard by the Connecticut Appellate Court. Any further appeal to the Connecticut Supreme Court may be made only by certification, and not as a matter of right.

47. **What are the requirements for stipulations or settlements?**

Under Connecticut law, there is no mandate that claims be settled or closed. Moreover, unlike some states, a claim under the Connecticut Act remains “open” for the life of the claimant or until the claim is settled. The claimant, however, continues to have the burden to prove that any ongoing claims relate back to the original work-related injuries. The parties may, however, elect to enter into a full and final settlement of the pending claims. Settlements are not final until they are approved by a commissioner at a stipulation approval hearing.

A full and final settlement closes the workers’ compensation case entirely. This settlement takes the form of a written document, a “stipulation”, which must be approved at a hearing by a commissioner. Once a stipulation is approved by a commissioner the claimant will no longer be able to pursue benefits, either medical or indemnity, for the injury which was the subject of the stipulation. Parties can also enter into “stipulation to date” agreements, whereby all issues up to the date of the document’s approval are resolved. The claimant then retains the right to pursue future benefits and the respondents reserve the right to contest the same.

Commissioners will, however, refuse approval of settlement where, in their judgment, the best interests of the claimant are not met. The commissioner will examine all the facts carefully before approving a stipulation because of the serious consequences of entering into a stipulation. The factors considered by the trial commissioner include:

A. Whether there are any past due lost wages or permanent partial benefits owed;
B. Whether there are any outstanding medical bills relating to the compensable injury;
C. Present and future medical needs including the possibility of surgery;
D. Whether the claimant is currently employed;
E. Whether the claimant currently has health insurance benefits;
F. Collateral claims such as social security/Medicare, pension offsets, disability claims;
G. Anticipated future exposure to the respondent for both medical and indemnity benefits;
H. Life expectancy of the claimant and/or spouse; and,
I. Whether the proposed settlement amount adequately reflects the future exposure of the claim.
The commissioner will discuss the settlement with the claimant to assure that the claimant fully understands the stipulation and its effect. Once the settlement is approved, the respondent has twenty (20) days in which to pay the stipulation. C.G.S. 31-303.

An original stipulation along with at least four (4) signed copies should be sent to claimant’s counsel, who will have the claimant sign the documents and make arrangements for approval. Most district offices will schedule stipulation approval hearings on an expedited basis. The claimant and his/her counsel must attend the stipulation approval hearing so that the commissioner can ensure the meaning and effect of settlement are understood by the claimant. Respondents should be present in cases involving pro se claimants to ensure accuracy of the agreement and to explain the settlement to the commissioner.

Claims administrators should contact defense counsel for additional information on settlement procedure in Connecticut, especially for cases involving out of state claimants, multiple parties (employers and/or insurers), multiple injuries, and recovery of workers’ compensation liens in third party actions. It should also be noted that in certain cases the underlying claim can be left open, but contested issues can be resolved through the present date and compromised by agreement, under what is called a “stipulation-to-date.”

In order to properly evaluate future exposure in a workers’ compensation case, thus valuing a claim for settlement, the following factors should be considered:

A. Type of injury;
B. Amount of benefits received to date;
C. Amount of future benefits owed;
D. Amount of future treatment and type of treatment;
E. Recommended or anticipated future treatment;
F. Age of the claimant;
G. Age of dependents;
H. Whether respondent’s medical expert (IME) supports causal relationship;
I. Is the claimant currently working for the same employer?
J. If working for a new employer, what is the likelihood of new and/or intervening injury?

48. Are full and final settlements with closed medicsals available?

Yes.
49. **Must stipulations and/or settlements be approved by the state administrative body?**

All stipulations and/or settlements must be submitted in writing to, and approved by, the Workers' Compensation Commissioner. C.G.S. §31-296.

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**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

All workers' compensation policies sold in Connecticut must provide for complete coverage of all benefits allowable under the Act. Deductibles on such policies are not permitted. Insurance is available through private insurers, and there is an assigned risk pool administered by the State Insurance Department for the benefit of those employers who cannot obtain coverage through commercial insurers. Collective bargaining agreements can provide injured workers with rights above and beyond those available under the Act, but cannot diminish or eliminate such rights.

51. **What are the provisions/requirements for self-insurance?**

**A. For individual entities.**

An employer which does not insure the liability imposed by the Act may be authorized to act as a self-insurer by either securing a Certificate of Solvency from the Board of Compensation Commissioners or by filing with the Insurance Commissioner, in a form acceptable to the commissioner, security guaranteeing the performance of the obligations of the Act. To provide coverage against catastrophic loss from one accident, a self-insurer must purchase excess coverage from an insurer licensed by the Insurance Commissioner to write workers' compensation insurance. The assessments made by the state treasurer for the expenses of the operation of the Second Injury Fund and the Workers' Compensation Commission must be paid in full by the self-insured entity.

**B. For groups or "pools" of private entities.**

Employers who wish to insure their liabilities collectively as a mutual association must submit a plan to the Insurance Commissioner for approval. The association is subject to the jurisdiction of the Insurance Commissioner, as are other insurers. A mutual association must apply for a Certificate of Solvency, obtain excess coverage, and pay all assessments made by the state treasurer, like an individual self-insurer. A mutual association must be comprised of employers in the same industry which employ persons...
who perform comparable work. The group members must agree to provide for the joint and several liabilities of the group, and the other members' obligations.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

The Connecticut Workers' Compensation Act does not expressly include "illegal aliens" within the definition of "employee." However, the Connecticut Supreme Court has ruled that a claim for a work-related injury by an "illegal alien" is within the jurisdictional confines of the Connecticut Workers' Compensation Act. Dowling v. Slotnick, et al, 244 Conn. 781 (1998). Illegal aliens are permitted to collect total disability and permanent partial disability benefits. There remains a question of whether they are eligible for temporary partial disability benefits or post-specific benefits, although the general practice is to assume they are ineligible for those benefits based on the prerequisite of being “ready, willing, and able” to work in order to receive the same.

53. Are terrorist acts or injuries covered or excluded under workers' compensation law?

In Parsons v. United Technologies Corp., et al, 243 Conn. 66 (1997), the Court recognized a clear and defined public policy requiring an employer to provide a reasonably safe work place to its employees. In this regard the Court noted that the relevant inquiry is whether the employer directed the employee to work in a place or condition that posed an objectively substantial risk of death, disease, or serious bodily injury to the employee. Thus, if an employee could prove that a terroristic threat negated the employer’s ability to provide a safe work place, any resulting injury could arguably be covered under the Workers’ Compensation Act.

54. How are workers' compensation settlements affected by Medicare trusts and liens?

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

A. the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or

B. there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.
If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC 1395)

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

There is no Connecticut case law with regard to Medicare trusts. C.G.S. Section 38a-470 provides that "any insurer or medical service corporation, health care center, or employee welfare benefit plan" that has furnished benefits to any person suffering an injury or an illness covered by the workers' compensation act has a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner.

55. How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

Connecticut law provides that "any insurer or medical service corporation, health care center, or employee welfare benefit plan" that has furnished benefits to any person suffering an injury or an illness covered by the workers' compensation act has a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner.

56. What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(1)]

Under Connecticut General Statute Section 31-128f, no individually identifiable information contained in the personnel file or medical records of any employee shall be
disclosed by an employer to any entity not affiliated with the employer in the absence of the employees' express written consent.

57. **What are the provisions for “Independent Contractors”?**


The test to be applied by the trial commissioner is set forth in *Malchik v. Division of Criminal Justice*, 266 Conn. 728 (2003). “[T]here is no dispute about the ultimate test [for deciding whether a worker is an employee under the Workers’ Compensation Act]. It is the right of general control of the means and methods used by the person whose status is involved.” *Malchik*, Id., 743.

In *Dupree v. Masters*, 1791 CRB-7-93-7 (April 25, 1995), *aff’d*, 39 Conn. App. 929 (1995)(per curiam) it was found that when the nature of the work could have been performed as either an independent contractor or as an employee, the decisive factor is the claimant’s tax filings.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific provisions. The issue is factual for the commissioner to decide.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

As stated above, there are no specific provisions. If there is any question as to the right of control issue, then the commissioner will rely on the claimant’s tax filing status and tax records. Independent Contractors are not covered by the Workers’ Compensation Act, but often the question of whether an injured party is an employee or independent contractor is one that must be litigated.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.
The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Matthew Necci, Esquire  
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Claudia D. Heyman, Esquire  
heyman@halloransage.com  
Tel: (203) 227-2855
1. Citation for the state's workers' compensation statute.

   Delaware Code Annotated Title 19, §§ 2301-2397.

SCOPe OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

   "Employee" includes every person in service of any corporation, association, firm or person under any contract of hire or performing services for a valuable consideration. 19 Del. C. § 2301(10).

   The following are specifically excluded from the definition of "employee": (1) the spouse and minor children of a farm employer if they are not named in an endorsement to the farm employer's contract of insurance; (2) any person whose employment is casual and not in the regular course of the trade, business, profession or occupation of the employer and; (3) any person to whom articles or materials are furnished or repaired, or adopted for sale in the employee's own home, or on the premises not under the control or management of the employer. 19 Del. C. § 2301(10).

3. Identify and describe any "statutory employer" provision.

   A contractor or subcontractor shall be deemed to be an employer. 19 Del. C. § 2311(a)(1). Additionally, lessees transporting passengers for hire in motor vehicles leased pursuant to written leases shall be deemed to be employers. 19 Del. C. § 2311(b)(2).

   A common law inquiry may also be made to determine whether the employee of the putative subcontractor was indeed that subcontractor's employee or whether his or her day to day activities were directed by the general contractor.
4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

Personal injuries rising out of and in the course of employment are compensable. 19 Del. C. § 2301(16). “Injury” and “personal injury” are defined as “violence to the physical structure of the body, such disease or infection as naturally results directly therefrom when reasonably treated.” 19 Del. C. § 2301(16).

The Delaware Supreme Court outlined four scenarios where a Claimant is entitled to an award. They are as follows:

1. He proves that "the injury happened at a fixed time and place and was attributable to a clearly traceable incident of . . . [his] employment", Gray's Hatchery & Poultry Farms v. Stevens, Del.Super., 45 Del. 191, 81 A.2d 322, 324 (1950); Faline v. Guido and Francis DeAscanis & Sons, Del.Supr., 56 Del. 202, 192 A.2d 921, 924 (1963);

2. He proves that "unusual exertion" in the course of his employment aggravated a pre-existing physical weakness, Milowicki v. Post and Paddock, Inc., Del.Supr., 260 A.2d 430, 432 (1969); Faline v. Guido and Francis DeAscanis & Sons, supra 192 A.2d at 924;

3. He proves that he sustained a "compensable occupational disease" as defined in § 2301(4), cf. Air Mod Corporation v. Newton, Del.Supr., 59 Del. 148, 215 A.2d 434, 441 (1965);

4. He proves that his work has had a cumulative detrimental effect on his physical condition, General Motors Corporation v. McNemar, Del.Supr., 57 Del. 511, 202 A.2d 803, 806 (1964).

Duvall v. Charles Connell Roofing, 564 A.2d 1132, 1135 (Del. 1989). Additionally, the employee must present a medical opinion to a reasonable degree of medical probability regarding the cause and nature of the injury alleged.

However, in the aforementioned case the Supreme Court of Delaware modified the "unusual exertion" provision. The Court stated that the appropriate principal to follow is the "usual exertion" rule, which provides that irrespective of previous condition, an injury is compensable if the ordinary stress and strain of employment is a substantial cause of the injury. Duvall v. Charles Connell Roofing, 564 A.2d 1132, 1136 (Del. 1989).

See also Day & Zimmerman Sec. v. Simmons, 965 A.2d 652, 657 (Del. 2008) (pre-existing disease does not disqualify a claim for workers' compensation if the employment aggravated or in combination with the infirmity produced the disability for the employer takes the employee as he finds him).
B. Occupational disease (including respiratory and repetitive use).

Compensable occupational diseases include all occupational diseases arising out of and in the course of the employment only when the exposure has occurred during the employment. 19 Del. C. § 2301(4). The employee must show the working conditions produced the disease as a natural incident of the occupation in such a manner as to attach to that occupation a hazard distinct from and greater than the hazard attending employment in general. Anderson v. General Motors Corp., 442 A.2d 1359 (Del. 1982). See also, Rhodes v. Diamond State Port Corp., 2 A.3d 75 (Del. 2010); Walker v. State, 2009 Del. Super. LEXIS 180 (Del. Super. Ct. May 18, 2009); Diamond Fuel Oil v. John S. O’Neal, 734 A.2d 1060 (Del. 1999).

Ionizing radiation injuries are compensable if they result from the employment. A compensable ionizing injury radiation injury is any harmful change in the human organism including damage to or loss of a prosthetic appliance arising out of and in the course of employment and caused by exposure to ionizing radiation which renders the party disabled. 19 Del. C. § 2301(3).

5. What, if any, injuries or claims are excluded?

1. An employee who refuses reasonable surgical, medical and hospital services, medicines or supplies tendered by the employer shall forfeit their right to compensation for any injury or increase in incapacity is shown to have resulted from such refusal. 19 Del. C. § 2353(a).

2. Injuries as a result of the employee’s own intoxication. 19 Del. C. § 2353(b).

3. Injuries as a result of the employee’s own deliberate or reckless indifference to danger. 19 Del. C. § 2353(b).

4. Injuries due to the employee’s own willful intention to bring about the injury or death of the employee or of another. 19 Del. C. § 2353(b).

5. Injuries as a result of the employee’s willful failure or refusal to use a reasonable safety appliance provided for the employee or to perform a duty required by statute. 19 Del. C. § 2353(b).

6. If an employee refuses suitable employment, the employee forfeits any right to compensation for the period of such refusal, unless the Board finds the refusal was justified. 19 Del. C. § 2353(c).

7. If an employee is receiving benefits or claims to be eligible for benefits, whether partial or total disability, those benefits may be suspended by agreement or order of the Board, where an employee is incarcerated. 19 Del. C. § 2353(d).

Personal injury is excluded from the coverage of the Workmen's Compensation Act.
where the injury was caused by the act of another employee whose act was "willful," and whose act was directed against the injured employee "by reasons personal to such employee and not directed against him as an employee or because of his employment." Ward v. General Motors Corp., 431 A.2d 1277, 1279 (Del. Super. 1981).

Rose v. Cadillac Fairview Shopping Center Properties (Delaware) Inc., Del. Super., 668 A.2d 782 (1995) (finding that the exclusivity provision of workers' compensation law barred a personal injury suit brought against the employer by an employee who was raped, because the injury arose out of and in the course of employee's work), aff'd sub nom. Rose v. Sears, Roebuck & Co., 676 A.2d 906, Del. Supr., Veasey, C.J. (1996). Because the Act does not contain any provision excluding sexual harassment claims, an employee cannot maintain a common law action against her employer for personal injury caused by the on-job sexual harassment by co-employees. Konstantopoulos v. Westvaco Corp., 690 A.2d 936, 939 (Del. 1996). See also Postell v. Eggers, 2008 Del. Super. LEXIS 17, 2008 WL 134830 (Del. Super.) (In order to be exempted, the wrongful acts must be completely unrelated to the conditions existing in, or created by the workplace).

6. What psychiatric claims or treatments are compensable?

All claims resulting from the original work-related injury, as defined in 19 Del. C. § 2301(15), are covered. An injured worker can recover for the full effect of an injury, including psychological or neurotic disorders. Rice’s Bakery v. Adkins, 269 A.2d 215 (Del. 1970). In addition, a psychological or mental injury which is substantially caused by the gradual and cumulative stress and strain of employment is also compensable. Duvall v. Charles Connell Roofing, 564 A.2d 1132 (Del. 1989). Note: The term “substantial cause” has no application to causation relating to specific and identifiable accidents. See Reese v. Home Budget Center, 619 A.2d 907 (Del. 1992) (it is unnecessary to quantify causation where there is no dispute that a specific accident contributed to the condition, which would not have occurred without the accident).

A mental injury can be compensable even if (1) there was no prior physical trauma, (2) the injury was the result of gradual stimuli rather than a sudden shock, and (3) the job-related stress causing the injury was not unusual. An employee must establish by objective proof his/her working conditions were actually stressful, and were a substantial cause of the disabling injury. See State v. Cephas, 637 A.2d 20 (Del. 1994) (the objective causal nexus test does not require proof that a reasonable or average person would have been affected by the job-related stress).

7. What are the applicable statutes of limitations?

Unless the employer has actual knowledge of the occurrence of the injury or unless the employee, or someone on the employee's behalf, or some of the dependents, or someone on their behalf, gives notice thereof to the employer within 90 days after the accident, no compensation shall be due until such notice is given or knowledge obtained. 19 Del. C. § 2341. In cases of personal injury or death, all claims for compensation are barred unless, within two years after the accident, the parties have agreed upon the compensation due,
or, one or more of the interested parties have filed a claim within two years after the accident with the Industrial Accident Board. 19 Del. C. § 2361(a).

Concerning occupation diseases, unless the employer during the continuance of the employment has actual knowledge that the employee has contracted a compensable occupational disease or unless the employee, or someone in the employee's behalf, or some of the employee's dependents, or someone on their behalf, gives the employer written notice or claim that the employee has contracted one of the compensable occupational diseases, which notice to be effective shall be given within a period of 6 months after the date on which the employee first acquired such knowledge that the disability was, could have been caused or had resulted from the employee's employment, no compensation shall be payable on account of the death or disability by occupational disease of such employee. 19 Del. C. § 2342. Claims for compensation for compensable occupational disease or for an ionizing radiation injury are barred unless a petition is filed in duplicate with the Department within one year after the date on which the employee first acquired such knowledge the disability was or could have been caused by the employment. 19 Del. C. § 2361(d).

Where payments of compensation have been made pursuant to an agreement or an award of the Board, the statute of limitations does not expire until five years from the time of the making of the last payment for which a proper receipt has been filed with the Department. 19 Del. C. § 2361(b). Note: Payment of a medical bill may extend the statute of limitations. See New Castle County v. Goodman, 461 A.2d 1012 (Del. 1983) (where the employer or its carrier made a payment under a feeling of compulsion, there was an agreement within the meaning of § 2361(b)); Tenaglia-Evans v. St. Francis Hosp., 2006 Del. LEXIS 648 (2006) (Simple payment of expenses is not enough; there must be a finding of "compulsion" on the part of the employer or its insurance carrier to pay the expenses). The Court in Rash v. State (DHHCI), 2007 Del. Super. LEXIS 286 (Del. Super. Ct. Sept. 28, 2007) explained that where the issue of compensability was not previously litigated, and it appears that the State voluntarily agreed to pay for claimant's surgery based on inaccurate information it had at the time the surgery was approved, the State is not liable for the disfigurement that is associated with the surgery.

8. **What are the reporting and notice requirements for those alleging an injury?**

Unless the employer has actual knowledge of the injury or unless the employee, or someone on his or her behalf, or dependents, or someone on their behalf, gives notice thereof to the employer within 90 days after the accident, no compensation is due until such notice is given or knowledge is obtained. 19 Del. C. § 2341.

Unless the employer during the continuance of the employment has actual knowledge that the employee contracted a compensable occupational disease, the employee, someone on the employee’s behalf, the employee’s dependents or someone on their behalf must give the employer written notice or claim that the employee has contracted one of the compensable occupational diseases within a period of 6 months of when the employee first knew that the disability was, could have been caused or had resulted from
the employee’s employment. If notice is not provided, no compensation shall be payable on account of the death or disability by the occupational disease. 19 Del. C. § 2342.

9. **Describe available defenses based on employee conduct:**

a. Refusal of services - Injuries or any increase in the employee’s incapacity which results from the employee’s refusal of reasonable surgical, medical, and hospital services, medicines and supplies are not compensable. 19 Del. C. § 2353(a).

b. Refusal of employment - If an employee refuses employment procured for the employee and suitable to the employee’s capacity, the employee shall not be entitled to compensation during the period of such refusal. 19 Del. C. § 2353(c).

c. Self-inflicted injury - Intentionally self-inflicted injuries are not compensable. 19 Del. C. § 2353(b).

d. Willful misconduct, "horseplay," etc. - Injuries caused by the employee's deliberate or reckless indifference to danger, or willful refusal to use a reasonable safety appliance or to perform a duty required by statute, are not compensable. 19 Del. C. § 2353(b).

e. Injuries involving drugs and/or alcohol - Injuries which result from the employee's intoxication are not compensable. 19 Del. C. § 2353(b). However, the employer must prove by a preponderance of the evidence both the accident and the injuries were caused by the intoxication.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Neither the workers' compensation statute nor the rules for the Industrial Accident Board provide any penalties or remedies for claims involving fraud. The Industrial Accident Board, however, will deny claims based on fraud. In *Air Mod Corporation v. Newton*, 59 Del. 148, 215 A.2d 434 (Del. 1965) the Delaware Supreme Court held:

An employee forfeits his right to benefits . . . if, in applying for employment, the employee (1) knowingly and willfully made a false representation as to his physical condition; and (2) the employer relied upon the false representation and such reliance was a substantial factor in the hiring; and (3) there was a causal connection between the false representation and the injury.

Additionally, the Fraud Prevention Bureau of the Delaware Insurance Department will be notified by the Department or Board if either has reason to believe that any person is committing or has committed an act of insurance fraud.

Under 11 Del. C. § 913(a)(1), “[a] person is guilty of insurance fraud when, with the
intent to injure, defraud or deceive any insurer the person...presents or causes to be presented to any insurer, any written or oral statement...as part of, or in support of, a claim for payment or other benefits pursuant to an insurance policy, knowing that such statement contains false, incomplete or misleading information concerning any fact of thing material to such claim.” Further, the legislature enacted the Delaware Insurance Fraud Prevention Act. 18 Del. C. § 2401 et. seq. The Fraud Protection Act establishes the Insurance Fraud Prevention Bureau which has the authority to conduct independent investigations where fraud has been committed. The commissioner may impose an administrative penalty of not more than $10,000 for each act of insurance fraud which violates the Fraud Prevention Act.

11. **Is there any defense for falsification of employment records regarding medical history?**

Yes. The employer must show through medical testimony that there was a causal nexus between an allegedly misrepresented or undisclosed prior physical condition and the subsequent injury. Mountaire of Delmarva, Inc. v. Glacken, 487 A.2d 1137, 1141 (Del. 1984). See also Air Mod Corporation v. Newton, 59 Del. 148, 215 A.2d 434 (Del. 1965) (there was a causal connection between the misrepresented physical condition and the plaintiff’s present physical condition); General Motors Corp. v. Cresto, 265 A.2d 42 (Del. Super. Ct. 1970) (there was no causal connection between the misrepresented disability of the back and the present injury to the elbow).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Each case is determined on a case by case basis and according to the specific facts. As a general rule, for an injury to be compensable, it must be “caused in a time and place where it would be reasonable for the employee to be under the circumstances” and “there must be a reasonable causal connection between the injuries and the employment.” Rose v. Cadillac Fairview Shopping Center, 668 A.2d 782 (Del. Super. 1995), aff’d, Rose v. Sears, 676 A.2d 906 (Del. 1996).

There are three factors to be examined in determining whether an injury that occurred during a non-sponsored recreational activity was within the scope of the individual’s employment: (1) it occurs on the premises during lunch or a recreation period as a regular incident of employment; (2) the employer brings the activity within the orbit of the employment by expressly or impliedly requiring participation, or by making the activity part of the services of an employee and; (3) the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life. State v. Dalton, 878 A.2d 451 (Del. 2005) citing 2 Larson, Workers’ Compensation Law, ch. 22 (LEXIS Publishing 2001) § 22.01. See Bedwell v. Brandywine Carpet Cleaners, 684 A.2d 302 (Del. Super. 1996) (where a carpet cleaner was compensated for injuries sustained after a slip and fall in the parking lot of a fast food restaurant where claimant had stopped to eat lunch while traveling from one work site to another).
13. **Are injuries by co-employees compensable?**

Yes, to the extent the injury (or death) of the employee was caused in whole or part by "the want of ordinary or reasonable care of or by the negligence of a fellow employee."

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

No. An injury must arise out of and in the course of the employment contract to be compensable.

15. **What criterion is used for calculating the average weekly wage?**

Under § 2302 (a), "average weekly wage" means the weekly wage earned by the employee at the time of the employee's injury at the job in which the employee was injured, including overtime pay, gratuities and regularly paid bonuses (other than an employer's gratuity or holiday bonuses) but excluding all fringe or other in-kind employment benefits. The term "average weekly wage" shall include the reasonable value of board, rent, housing or lodging received from the employer, which shall be fixed and determined from the facts in each particular case.

Under §2302 (b), AWW is determined by computing the total wages paid to the employee during the 26 weeks immediately preceding the date of injury and dividing by 26, provided that:

(1) If the employee worked less than 26 weeks, but at least 13 weeks, in the employment in which the employee was injured, the average weekly wage shall be based upon the total wage earned by the employee in the employment in which the employee was injured, divided by the total number of weeks actually worked in that employment;

(2) If an employee sustains a compensable injury before completing that employee's first 13 weeks, the average weekly wage shall be calculated as follows:

a. If the contract was based on hours worked, by determining the number of hours for each week contracted for by the employee multiplied by the employee's hourly rate;

b. If the contract was based on a weekly wage, by determining the weekly salary contracted for by the employee; or

c. If the contract was based on a monthly salary, by multiplying the monthly salary by 12 and dividing that figure by 52; and
d. If the hourly rate of earnings of the employee cannot be ascertained, or if the pay has not been designated for the work required, the average weekly wage, for the purpose of calculating compensation, shall be taken to be the average weekly wage for similar services performed by other employees in like employment for the past 26 weeks.

19 Del. C. §2302 (b). The weekly compensation allowed shall not exceed the maximum or be less than the minimum provided by law. 19 Del. C. §2302 (b)(3). Note: Gratuites received from the employer or others are not included in the definition of wages.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

For all injuries resulting in total disability after July 1, 1975, the benefits to be paid during the period of total disability are 66⅔% of the employee's wages, not to exceed 66⅔% of the state average wage as announced by the Secretary of the Department of Labor for the last calendar year for which a determination of the state wage has been made, nor be less than 22 2/9% of the state wage. If, at the time of the injury, the employee receives wages of less than 22 2/9% of the state wage, then the employee receives the full amount of such wages per week. 19 Del. C. § 2324.

Effective July 1, 2017, the maximum weekly workers’ compensation rate is $686.99 The minimum weekly workers’ compensation rate is $229.00.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employer has fifteen days after receipt of knowledge of a work-related injury to accept or deny a claim. 19 Del. C. § 2362(a). If the parties reach a written agreement as to the compensation due the claimant, payment must start within 14 days of the agreement. 19 Del. C. § 2362(c). An employer/insurance carrier has no more than 14 days after an award by the Board becomes final and binding to make payment. 19 Del. C. § 2362(d). Note: For all payments of total or partial disability, it shall be printed above the endorsement on the reverse side of the check “Your acceptance of this check for total or partial disability is a representation by you that you are legally entitled to such payment and a false representation is punishable under federal and state laws.” 19 Del. C. § 2344(b)(2).

Following a demand, the employer has 30 days from the date of settlement fixing compensation or the date of a Board order requiring the employer to pay. Huffman v. C.C. Oliphant & Sons, Inc., 432 A.2d 1207 (Del. 1981) (the remedy for recovery of unpaid wages under 19 Del. C. § 2357 is also available for the recovery of wrongfully withheld workers’ compensation benefits). Under 19 Del. C. § 2357 and the Huffman case, an employer can be liable for liquidated damages if it is in default for thirty days after demand for payment of an amount due under the Worker's Compensation law.
Specifically, 19 Del. C. § 2357 provides: "If default is made by the employer for 30 days after demand in the payment of any amount due under this chapter, the amount may be recovered in the same manner as claims for wages are collectible." See Kelley v. ILC Dover, Inc., 787 A.2d 751, 2001 Del. Super. LEXIS 125 (Del. Super. Ct. 2001) ("wages" in Section 1113(a) must be construed to include claims based on unpaid workers' compensation benefits due after proper demand therefor has been made.).

A demand letter cannot in and of itself create a default in payment where one has not yet occurred. See Ramirez v. Murdick, 2007 Del. Super. LEXIS 344, 2007 WL 4171117 (Del. Super.) aff’d 948 A.2d 395, 2008 Del. LEXIS 202 (Del. 2008); Delmarva Warehouses, Inc. v. Yoder, 2001 Del. LEXIS 453, 2001 WL 1329691 (Del. Supr.) (holding that it would amount to an unreasonable elevation of form over substance to require the employee to reassert his demand in order to trigger the employer's obligation to pay the award); Ramirez v. Murdick, 948 A.2d 395, 399 (Del. 2008) (because the default was for less than thirty days from the date the amount was due, the remedies under 19 Del. C. § 2357 do not apply).

Importantly, absent the predicate of a proper demand, the employee has no Huffman claim. The Court in Shortridge v. Del. Hospice, 984 A.2d 124 (Del. 2009) noted that there is no magic language that has been blessed by the courts as to what constitutes a proper Huffman demand. However, between counsel whose expertise is in the field of industrial accident compensation, correspondence which sets forth the amount owed, proof of the amount owed, and a request to be paid would be construed as a demand.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?

If there is lost time which extends beyond three days due to the injury, temporary benefits become payable starting with the fourth day lost. The employee must be out seven days or more, including the day of the injury, to recover benefits for the first three days. However, if the permanent injury relates to vision or hearing loss, surgical, medical and hospital services, medicines and supplies, or funeral benefits, payment shall be made from the first day of injury. 19 Del. C. § 2321.

19. What is the standard/procedure for terminating temporary benefits?

An employer wishing to terminate benefits must file a Petition For Review of Compensation ("Petition to Terminate") with the Industrial Accident Board. The petition to terminate will not be accepted by the Department unless it is accompanied by proof that a copy has been served by registered mail upon the other party to the agreement or award. On the application of any party in interest, the Board may at any time, but not oftener than once in 6 months, review any agreement or award. 19 Del. C. § 2347. Absent agreement of the parties, benefits cannot be terminated except upon order of the Board following a hearing. 19 Del. C. § 2347. See Huffman v. C.C. Oliphant & Sons, Inc., 432 A.2d 1207 (Del. 1981). Note: Although the right by Claimant to receive total disability benefits continues after the petition to terminate is filed, the benefits are paid by

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No. The two rights of recovery are independent of each other. 19 Del. C. § 2324 (temporary total disability) and § 2325 (partial disability).

21. What disfigurement benefits are available and how are they calculated?

The Board may award compensation for "serious and permanent disfigurement to any part of the human body up to 150 weeks, provided that such disfigurement is visible and offensive when the body is clothed normally . . ." Such compensation is paid at the rate of 66⅔% of the employee's average weekly wage, and where the injury causes both disfigurement and loss of use to the same part of the body, compensation shall be the higher of the amount of compensation due for disfigurement or the amount of compensation due for loss of use plus 20% for disfigurement. 19 Del. C. § 2326(f).

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

For all permanent injuries to scheduled members, compensation is paid at the rate of 66⅔% of wages pursuant to the schedule and regardless of the earning power of the employee after the injury. 19 Del. C. § 2326(a)-(e).

Schedule:

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand</td>
<td>220</td>
</tr>
<tr>
<td>Arm</td>
<td>250</td>
</tr>
<tr>
<td>Foot</td>
<td>160</td>
</tr>
<tr>
<td>Leg</td>
<td>250</td>
</tr>
<tr>
<td>Thumb</td>
<td>75</td>
</tr>
<tr>
<td>Index finger</td>
<td>50</td>
</tr>
<tr>
<td>Middle finger</td>
<td>40</td>
</tr>
<tr>
<td>Ring finger</td>
<td>30</td>
</tr>
<tr>
<td>Little finger</td>
<td>20</td>
</tr>
<tr>
<td>Great toe</td>
<td>40</td>
</tr>
<tr>
<td>Other toes</td>
<td>15</td>
</tr>
<tr>
<td>Loss of hearing:</td>
<td></td>
</tr>
<tr>
<td>One ear</td>
<td>75</td>
</tr>
</tbody>
</table>
Both ears 175
Loss of vision:
One eye 200

There are also unscheduled losses payable up to three hundred weeks. 19 Del. C. § 2326(g). As a general rule, permanency is calculated as the product of three factors: (1) the percentage of loss of the body part affected; (2) 66⅔% of wages; and (3) the number of weeks reflected in the schedule for the particular body part. P = (% of loss of body part)(66⅔%)(no. of weeks). 19 Del. C. § 2326.

Compensation benefits are paid at 66⅔% of the employee's average weekly wage, not to exceed two-thirds of the state average weekly wage nor be less than 22-2/9% of the state average weekly wage. If, at the time of injury, the employee's average weekly wage is less than 22-2/9% of the state average weekly wage, then compensation paid the full amount of his/her weekly wage. 19 Del. C. § 2326(h).

B. Number of weeks for "whole person" and standard for recovery.

Not applicable.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

The Board may require an employee to participate in vocational rehabilitation services by any public or private agency, upon motion by the employer, after making a finding that such services constitute the tender of reasonable medical services. Refusal to accept rehabilitation services pursuant to order of the Board shall result in a loss of compensation for each week of the period of refusal.. Reasonable expenses, including board, lodging and travel when necessary because of the situs of the rehabilitation agency, must be paid by the employer. 19 Del. C. § 2353(a).

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Total disability is a disability that prevents an employee from obtaining employment commensurate with his or her qualifications and training. See Keith v. Dover City Cab Co., 427 A.2d 896 (Del. Super. 1981) (total disability is not equated with utter helplessness, but rather is where an employee is unable to perform any services other than those which are so limited in quality, dependability or quantity that a reasonable stable market for them does not exist).

Permanent total disability benefits are paid at two-thirds of the employee's average weekly wage, not to exceed 66⅔% of the state average weekly wage as announced by the Secretary of the Department of Labor, nor be less than 22 2/9% of the state average weekly wage. If the employee receives wages less than 22 2/9%, the employee receives his or her full wages. Benefits continue for the duration of the total disability. 19 Del. C.
How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

The employer must pay reasonable burial expenses up to $3,500.00. 19 Del. C. § 2331.

B. Dependency claims.

Death benefits are calculated as a percentage of the decedent's wages (not to exceed the state average weekly wage for the most recent calendar year for which such information has been published) and are adjusted according to the status and dependency condition of the beneficiary. See 19 Del. C. § 2330. Section 2330 sets out the beneficiary matrix with corresponding benefits. However, where a child is entitled to death benefits, that child may receive such benefits "until . . . the age of 18 years, or if enrolled as a full-time student . . ., until such child ceases to be so enrolled or reaches the age of 25 years, and in the case of a widow or widower entitled to compensation . . . the compensation shall continue . . . until the widow or widower dies or remarries." 19 Del. C. § 2330(b). See also 19 Del. C. § 2330(c)(relating to extended benefits for minor siblings of the deceased during the period of their education or as a consequence of a mental or physical handicap).

What are the criteria for establishing a "second injury" fund recovery?

When a subsequent permanent injury in connection with a previous permanent injury results in total disability, as defined in 19 Del. C. § 2326, the employee is paid compensation from a special fund known as the "Workers' Compensation Fund." 19 Del. C. § 2327(a). Where an employee who has previously sustained a permanent injury suffers a subsequent permanent injury, the Board apportions liability. The employer for whom the employee was working at the time of the subsequent injury need only pay the amount of compensation as would be due for the subsequent injury alone. 19 Del. C. § 2327. No petition of an employer or its insurance carrier for reimbursement from the Workers’ Compensation Fund will be accepted by the Department unless the employer or its insurance carrier first notifies the Deputy Attorney General assigned to the Board, by certified mail, of its intention to seek reimbursement from the Fund, and thereafter supplies the Department with proof of compliance when its petition is filed. Board Rule 24.

19 Del. C. § 2327 applies only to employers insured by insurance carriers. The Workers’ Compensation Improvement Act of 1997 revoked the right for reimbursement by self-insureds.

What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?
A petition to determine additional compensation must be filed with the Department within five years from the time of the making of the last payment for which a proper receipt has been filed with the Department. 19 Del. C. § 2361(b).

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

A reasonable attorney’s fee is not to exceed 30 percent of the award or 10 times the average weekly wage in Delaware at the time of the award, whichever is smaller. 19 Del. C. § 2320(10)(a). The reasonable attorney’s fee shall be allowed by the Board to any employee awarded compensation and taxed as costs against a party. Any fee awarded to any employee under 19 Del. C. § 2320(10)(a) shall be applied to offset the fees that would otherwise be charged to the employee by the employee’s attorney under the fee agreement.

However, if an offer to settle an issue pending before the Board is communicated to the claimant in writing at least 30 days prior to the trial date established by the Board and the offer is equal to or greater than the amount ultimately awarded by the Board on that issue, the attorney’s fee will not be taxed as costs against the employer. 19 Del. C. § 2320(10)(b). *See Clements v. Diamond State Port Corp.*, 831 A.2d 870 (Del. 2003).

Board Rule 23 sets forth the requirements for the filing of an Affidavit Regarding Attorney’s Fees.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**

Workers' compensation is the exclusive remedy for an employee who sustains an industrial injury. 19 Del. C. § 2304. The exclusivity provision only applies between the employer and the employee, and third party suits are permitted. *See Konstantopolous v. Westvaco Corp.*, 690 A.2d 936 (Del. 1996), *cert. denied*, 522 U.S. 1128, 119 S. Ct. 1079, 140 L. Ed. 2d 137 (1998) (an employee’s recovery against an employer for personal injuries sustained arising out of and during the course of employment is limited to those remedies under the Delaware Workers’ Compensation Act, even if those personal injuries are the result of sexual harassment).

Injured employees cannot generally bring third party claims against co-employees because co-employees are generally considered to be "in the same employ" under § 2363(a), and, thus, fall within the definition of "employer" under § 2304. *See Grabowski v. Mangler*, 938 A.2d 637, 2007 Del. LEXIS 301 (Del. 2007) aff’d 956 A.2d 1217, 2008 Del. LEXIS 408 (Del. 2008). As explained by the Court in *Groves v. Marvel*:

"person in the same employ" means a person employed by the same employer and acting in the course of his employment at the time of the
injury to the co-employee ... It is clear, therefore, that to have been acting in the course of his employment, . . . the defendant need not have been engaged in a regular duty or function of his own employment at the time of injury to the plaintiff. [The co-employee is immune from liability] if the act complained of was one which the defendant might reasonably do, or be expected to do, within a time during which he was employed and at a place where he could reasonably be during that time--even through outside his regular duties ....

213 A.2d 853, 855 (Del. 1965). The Court in Lovett v. Chenney, 2007 Del. Super. LEXIS 110, 7-8 (Del. Super. Ct. Apr. 19, 2007) noted that an exception to § 2304 does exist when a claimant is injured by a co-worker's conduct, but in that case, the claimant must establish the co-worker's specific, intentional conduct, and a deliberate intent to cause the injury.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).


Under Delaware law, derivative claims are barred under the workers' compensation statute because the exclusivity provision extinguishes the predicate claim. See Deuley v. DynCorp International, Inc., 8 A.3d 1156, 2010 Del. LEXIS 623, 31 I.E.R. Cas. (BNA) 1849 (Del. 2010) (a wrongful death action is derivative and wholly dependent on whether the decedent had a right to bring a claim during his lifetime and are subject to the same infirmities as would have existed in a suit by the deceased if still alive).

30. Are there any penalties against the employer for unsafe working conditions?

No, not under the workers' compensation statute.

31. What is the penalty, if any, for an injured minor?

None under the Act. The minor employee, however, even if employed illegally, is not thereby barred from receiving workers' compensation benefits. 19 Del. C. § 2315.

32. What is the potential exposure for "bad faith" claims handling?

Employees may sue workers' compensation insurers for breach of the implied covenant of good faith and fair dealing as third-party beneficiaries of contracts of insurance between employers and insurers. Pierce v. International Ins. Co. of Illinois, 671 A.2d 1361 (Del. 1996).
An insurer who neglects or refuses to pay, such delay being avoidable or due to negligence, is fined not less than $500 nor more than $2,500, which is payable to the Workers’ Compensation Fund. 19 Del. C. § 2362.

33. **What is the exposure for terminating an employee who has been injured?**

None under the Act. However, there may be other remedies under federal law if the employee is disabled.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. See 19 Del. C. § 2363.

35. **Can co-employees be sued for work-related injuries?**

Co-employees cannot be sued for injuries arising from their negligence. They can, however, be sued for willful acts directed against a co-employee for personal reasons. 19 Del. C. § 2301(19).

36. **Is subrogation available?**

Yes. See 19 Del. C. §§ 2363(c)-(e). The employer/insurer is responsible for its pro-rata share of litigation costs expended. Keeler v. Harford Mut. Ins. Co., 672 A.2d 1012 (Del. 1996), overruling Cannon v. Container Corp. of America, 282 A.2d 614 (Del. 1971). The Court noted in Roadway Express v. Folk, 817 A.2d 772, 776 (Del. 2003), that the trial court may use its discretion to deviate from a pro rata apportionment to account for the employer's or its insurance company's attorneys' fees if the court believes a reduction is necessary to achieve an equitable result. See Arthur Lawson, The Law of Workmen's Compensation, § 117.02 (2001) ("[U]nder a statute …that has been construed to permit apportionment of the claimant's attorneys' fees, the services provided by the carrier's attorney may be taken into account in adjusting the amount of fees to be borne by the carrier and the employee.").

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

An employee's request for reimbursement for nonpreauthorized care medical expenses must be paid within 30 days after presentation to the insurer, as long as the claim contains substantially all the required data elements necessary to adjudicate the invoice, unless the invoice is contested in good faith. 19 Del. C. § 2322F(h). Fines, of not less than $1,000.00, nor more than $5,000.00, may be assessed for failure to pay medical expenses
properly due. 19 Del. C. § 2322F(g). Unpaid invoices incur interest at a rate of 1% per month payable to the provider. 19 Del. C. § 2322F(h). See also 19 Del. C. § 2346 (hearing to settle disputes between medical provider and person charged with duty to pay such provider).

19 Del. C. § 2322F(d) provides that treatments, evaluations and therapy provided by a certified health care provider shall be paid within 30 days of receipt of the health care provider's bill or invoice together with records or notes as provided in this section, unless compliance with the health care payment system or practice guidelines adopted pursuant to § 2322B or § 2322C is contested, in good faith, to the utilization review system set forth in subsection (j) of this section. If employer is denying payment for health care services provided pursuant to this chapter, whether in whole or in part, the denial shall be accompanied with written explanation of reason for denial. 19 Del. C. § 2322F(e).

However, it must be noted that under §2322(h):

An employer or insurance carrier may pay any health care invoice or indemnity benefit without prejudice to the employer's or insurance carrier's right to contest the compensability of the underlying claim or the appropriateness of future payments of health care or indemnity benefits. In order for any provision or payment of health care services to constitute a payment without prejudice, the employer or insurance carrier shall provide to the health care provider and the employee a clear and concise explanation of the payment, including the specific expenses that are being paid, the date on which such charges are paid, and the following statement, which shall be conspicuously displayed on the explanation in at least 14 point type:

This claim is IN DISPUTE and payment is being made without prejudice to the Employer's right to dispute the compensability of the workers' compensation claim generally or the Employer's obligation to pay this bill in particular.

Further, partial payment of the uncontested portion of a partially contested health care invoice shall be considered a payment without prejudice to the right to contest the unpaid portion of a health care invoice, provided the above notice requirements are met. 19 Del. C. §2322(h)(1).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Prior to an employee filing a Petition with the Department, an employer has the right to request that the employee provide an executed authorization. The employee has no duty to provide medical reports. However, if the employee fails to provide an executed authorization, the employer can deny the claim on the basis it is prevented from properly investigating the claim.
After an employee files a petition with the Department, an employer has the right to serve a Request for Production upon the employee or employee's counsel. The employee must provide a written response within fifteen days. The response must contain the requested items including medical records or it must advise where the records can be obtained. Additionally, the employee must provide a medical authorization. If the employee fails to provide a response or an authorization, the employer may file a motion with the Department compelling the production of the requested information. Moreover, any party may request the Industrial Accident Board to issue subpoenas for medical or other records. See, Board Rule 11.

39. **What is the rule on choice (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Examination?**

**A. Claimant’s choice of physician.**

An employee who alleges an industrial injury has the right to select a physician, surgeon, dentist, optometrist or chiropractor. Notice of intention to employ such medical aid must be given to the employer/insurer, or to the Board. Notice that medical aid was employed must be given within 30 days thereafter to the employer/insurer in writing. If the alleged injury is subsequently held to be compensable, the employer is liable for the reasonable cost of the services of any provider utilized by the employee if proper notice of the treatment was given to the employer/insurer. 19 Del. C. § 2323.

Certification is required for a health care provider to provide treatment to an employee, without the requirement that the health care provider first pre-authorize each health care procedure, office visit or health care service to be provided to the employee with the employer if self-insured, or the employer's insurance carrier. 19 Del. C. §2322D(a)(1). A health care provider shall be certified only upon meeting the following minimum certification requirements:

1. Have a current license to practice, as applicable;

2. Meet other general certification requirements for the specific provider type;

3. Possess a current and valid Drug Enforcement Agency ("DEA") registration, unless not required by the provider's discipline and scope of practice;

4. Have no previous involuntary termination from participation in Medicare, Medicaid or the Delaware workers' compensation system. Any such involuntary termination shall be considered to be inconsistent with certification;

5. Have no felony convictions in any jurisdiction, under a federal-controlled substance act or for an act involving dishonesty, fraud or misrepresentation. A felony conviction in any jurisdiction under a federal-controlled substance act or for an act involving dishonesty, fraud or misrepresentation shall be considered to
be inconsistent with certification;

6. Provide proof of adequate, current professional malpractice and liability insurance.

In addition to the above, the health care provider to be certified must agree to the terms and conditions set forth on the Health Care Provider Application for Certification, as follows:

1. Comply with Delaware workers' compensation laws and rules;

2. Maintain acceptable malpractice coverage;

3. Complete state-approved continuing education courses in workers' compensation every two (2) years from the date of the health care provider's initial certification. A listing of continuing education courses in workers' compensation care approved by the State of Delaware, Department of Labor, Office of Workers' Compensation, will be posted on the Office of Workers' Compensation website. To maintain certification, every two (2) years from the initial date of certification the health care provider must provide written notification to the Office of Workers' Compensation of compliance with the continuing education course requirement noted above, setting forth the name of the course(s) completed and the date of completion;

4. Practice in a best-practices environment, complying with practice guidelines and Utilization Review Accreditation Council ("URAC") utilization review determinations;

5. Agree to bill only for services and items performed or provided, and medically necessary, cost-effective and related to the claim or allowed condition;

6. Agree to inform an employee of his or her liability for payment of non-covered services prior to delivery;

7. Accept reimbursement for and not unbundle charges into separate procedure codes when a single procedure code is more appropriate;

8. Agree not to balance bill any employee or employer. Employees shall not be required to contribute a co-payment or meet any deductibles;

9. Agree to have knowledge of all statements authorized under the certified health care provider's signature and to be responsible for the content of all bills submitted pursuant to the provisions of 19 Del. C. §2322B, C, E, F;

10. Agree to provide written notification to the Department of Labor, Office of Workers' Compensation, State of Delaware, of any relevant changes to the
requirements set forth in the Certification Form within thirty (30) days of the health care provider's knowledge or receipt of notice of any and all such change(s).

19 Del. C. §2322D (a)(2). Any health care provider may provide services during one office visit, or other single instance of treatment, without first having obtained prior authorization from the employer if self-insured, or the employer's insurance carrier, and receive reimbursement for reasonable and necessary services directly related to the employee's injury or condition at the health care provider's usual and customary fee, or the maximum allowable fee pursuant to the workers' compensation health care payment system adopted pursuant to 19 Del. C. §2322D (B), whichever is less. The provisions of §2322D are limited to the occasion of the employee's first contact with any health care provider for treatment of the injury, and further limited to instances when the health care provider believes in good faith, after inquiry, that the injury or occupational disease was suffered in the course of the employee's employment.

B. An employer’s right to a second opinion and/or independent medical examination.

Following an injury and during the period of disability, the employee shall submit for an examination at a reasonable and place by a physician legally authorized to practice upon reasonable request by an employer or order by the Board. If the employee requests, he/she shall be entitled to have a physician of the employee’s own selection, to be paid for by the employee, present to participate in the examination. 19 Del. C. § 2343(a). Note: This evaluation is not to be referred to as an “Independent Medical Examination.”

The refusal of the employee to submit to the examination or the employee's obstruction of such examination shall deprive the employee of the right to compensation during the continuance of such refusal or obstruction and the period of such refusal or obstruction shall be deducted from the period during which compensation would otherwise be payable. 19 Del. C. § 2343(b).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The standard is whether the charges are reasonable, necessary, and causally related. If medical charges are disputed, “any interested party” may request a hearing before the Board in regard to the dispute. 19 Del. C. § 2346.

41. Which prosthetic devices are covered, and for how long?

During the period of disability, the employer must furnish reasonable surgical, medical, dental, optometric, chiropractic and hospital services, medicine and supplies, including repairing damage to or replacing false dentures, false eyes or eyeglasses and providing hearing aids, as and when needed, unless the employee refuses to allow them to be furnished by the employer. 19 Del. C. § 2322(a). In addition, an employee is entitled to
mileage reimbursement in an amount equal to the state specified mileage allowance rate for travel to obtain said devices. 19 Del. C. § 2322(g).

42. Are vehicle and/or home modifications covered as medical expenses?

Industrial Accident Board decisions generally permit vehicle and/or home modifications in catastrophic cases.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. The intent of the health care payment system developed pursuant to Delaware's Workers' Compensation Act ("Act") is to establish a system that eliminates outlier charges and streamlines payments by creating a presumption of acceptability of charges implemented through a transparent process, involving relevant interested parties, that prospectively responds to the cost of maintaining a health care practice, eliminating cost shifting among health care service categories, and avoiding institutionalization of upward rate creep. 19 Del. C. §2322B(1).

Carriers pay the lesser of the rate established by the State payment schedule, or the actual charge. The maximum allowable payment for health care treatment and procedures covered under the Workers' Compensation Act shall be 200% of the Federal Medicare schedule price for that procedure, with the exception of 250% for radiology services and 300% for surgical services. 19 Del. C. §2322B(3)(b)(6).

44. What, if any, provisions or requirements are there for "managed care"?

"Any employee who alleges an industrial injury shall have the right to employ a physician, surgeon, dentist, optometrist or chiropractor of the employee's own choosing." 19 Del. C. § 2323.

Employees must give notice of their intent to obtain medical aid. If the employee gives notice, the employer "is liable for the reasonable cost of the services of any physician, surgeon, [etc.] whose employment was utilized by the employee." Id.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

No formal pleading or formal answer shall be required of any party to any action before the Board. Board Rule 6(A). However, each person making a written request for a hearing must file with the Department on forms approved by the Department a statement giving substantially the information requested on the forms. Board Rule 6(A).

If the employer and employee (or in the case of any employee’s death the employee’s dependents) fail to reach agreement in regard to compensation, either party may notify the Department of the facts and the Department shall schedule a hearing. 19 Del. C. §
What is the method of claim adjudication?

A. Administrative level.

The adjudication of a claim begins with a hearing before the Industrial Accident Board. The Board consists of ten members appointed by the governor and confirmed by the state senate for a term of six years. 19 Del. C. § 2301A(a). Two members of the Board constitute a quorum for hearings conducted under Title 19. 19 Del. C. § 2301A(c).

The parties may also agree to the adjudication of a claim by a hearing officer. Hearing officers are appointed by the Secretary of Labor for a term of five years. 19 Del. C. §2301B(b).

B. Trial Court.

An employer may petition the Department for a rehearing. Board Rule 21 provides: applications for (1) further hearing in a proceeding after the closing of testimony and before final submission on oral argument or brief, or for (2) reopening a proceeding after final submission and before decision, or for (3) rehearing, or reargument after decision, must be made by petition within 10 days after the date of such closing of testimony, final submission, or decision, as the case may be.

An employer, may, in the alternative, file an appeal on the record with the Superior Court within 30 days of the Board's decision. The court reviews the decision of the Board to determine whether there was substantial evidence to support the Board's decision or whether there was an error of law. 19 Del. C. §§ 2349, 2350.

C. Appellate.

An appeal may then be taken to the State Supreme Court.

What are the requirements for stipulations or settlements?

They must be approved by the Industrial Accident Board.

Pursuant to § 2358(a), following application of either party and notice to the other party, the compensation may be commuted by the Board at its present value when discounted at 5% interest, with annual rests, disregarding, except in commuting payments due under § 2324 of this title, the probability of the beneficiary's death. The commutation may be allowed if it appears that it will be for the best interest of the employee or the dependents of the deceased employee, or that it will avoid undue expense or hardship to either party, or that such employee or dependent has removed or is about to remove from the United States or that the employer has sold or otherwise disposed of the whole or the greater part of the injured employee's or the dependents of a deceased employee's business or assets.
Important, it shall not be allowed for the purpose of enabling the injured employee or the dependents of a deceased employee to satisfy a debt created before the accident, other than a mortgage upon the injured employee's or the dependents of a deceased employee's or their home or household furniture.

48. Are full and final settlements with closed medicals available?

Rarely. Medicals must ordinarily stay open as a condition of approval of any commutation of benefits.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Coverage is available through private insurers or assigned risk pools. In addition, self-insurance is permitted.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Every employer to whom this chapter applies shall insure and keep insured the employer's liability for compensation in some corporation, association or organization approved by the Department and authorized to transact the business of workers' compensation insurance in this State or shall furnish to the Department satisfactory proof of the employer's financial ability to pay directly the compensation, in the amount and manner and when due, as provided in this chapter. 19 Del. C. § 2372 (a).

B. For groups or "pools" of private entities.

Under 19 Del. C. § 2376 there is a provision for the creation of mutual insurance companies (pooling of risks by two or more companies) to satisfy the requirements of §2372. The groups are subject to such reasonable conditions and restrictions as may be fixed by the Department.

52. Are “illegal aliens” entitled to benefits of Worker’s Compensation in light of The Immigration Reform and Control Act of 1986, which indicates they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Immigration status is not an outright bar to receipt of benefits. While there are no
Delaware Statutes that are directly on point, the Delaware Superior Court has addressed this issue and stated the following:

This Court must and can reasonably assume the General Assembly is aware of the myriad issues swirling around illegal immigrants. From that, too, the Court can deduce, the Legislature's silence, especially in 2006 when the amendment to § 2353 was passed, could readily mean it chose not to add an exclusion due to deportation/exclusion to the list of disqualifications or reasons for suspension of benefits. Del. Valley Field Servs. v. Ramirez, 2012 Del. Super. LEXIS 622 (Del. Super. Ct. 2012).

The Supreme Court has also dealt with immigration status as a factor in determining job availability and whether an injured worker is considered “displaced” under the meaning of the Act. See, Campos v. Daisy Construction Co., 107 A.3d 570 (Del. 2014); Roos Foods v. Guardado, 152 A.3d 114 (Del. 2016).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There are no known statutory provisions or Superior Court cases addressing this issue.

54. Are there any state specific requirements which must be satisfied in light of the obligations of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC§1395).

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?
The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

As a general rule, in cases where an employee is injured within the course of his employment by a third party, the employee is permitted to recover worker’s compensation benefits from his employer, and also pursue a personal injury action against the tortfeasor. See 19 Del. C. § 2363. However, any recovery by an employee in such action “shall first reimburse the employer or its workers’ compensation insurance carrier for any amount paid or payable under the Workers’ Compensation Act...”, and any balance shall be paid to the employee. 19 Del. C. § 2363(e). The statute prevents a double recovery by the employee, and permits the employer or its insurer to recoup its compensation payments.

Insurers providing benefits under an employee’s own motor vehicle policy are subrogated to the rights of the employee for whom benefits are paid under the worker’s compensation law. See 21 Del. C. §2118(f).

An employer’s worker’s compensation carrier cannot assert a priority lien for payments made to the employee by the employer’s own underinsured motorist insurer. See 18 Del. C. § 3902, and 19 Del. C. § 2363.

The state public assistance subrogation statute is codified at 31 Del. C. § 522. “In any claim for benefits by a recipient who receives medical care under [Title 31], where the recipient has a cause of action against any other person, the Department of Health and Social Services [is] subrogated against (substituted for) the recipient to the extent of any payment made by the Department of Health and Social Services on behalf of the recipient receiving medical care, resulting from the occurrence which constituted the basis for the action against the other person.” Id.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

At the present time, HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers.

As a general rule, an employee’s medical records, which may contain facts of a personal nature, are within the ambit of privacy protection. *Petition of Greenwood Trust Co.*, C.A. No. 98M–03-007-WTQ, 1999 WL 167792, Quillen, J. (Del. Super. March 3, 1999). In
addition, Delaware courts have adopted a testimonial privilege recognizing the confidentiality of the physician-patient relationship, and medical records are included in this privilege. Del. Rule of Evidence 503. The General Assembly also recognizes physicians have a professional duty to maintain patient confidences. “[W]illful violation of the confidential relations and communications of a patient” constitutes unprofessional conduct by a medical doctor or surgeon under Delaware law. 24 Del. C. § 1731(b)(12).

However, under the Worker’s Compensation Act, no fact communicated to, or otherwise learned, by a physician or surgeon who has attended or examined the employee, or who has been present at any examination is privileged in any hearings under the Act, or in any other action at law. 19 Del. C. § 2343(c).

The employer can request, or the Board can order, the employee to submit to a medical examination by a physician at a reasonable time and place, and as often as reasonably necessary. 19 Del. C. § 2343(a). The Board can also order the examining physician to testify before the Board. 19 Del. C. § 2320(7). The Board has broad statutory authority to examine physicians as witnesses, take medical evidence, and require the production of medical documentation. 19 Del. C. § 2320(4); Board Rule 11.

On appeal, the Superior Court can also appoint 1 or more impartial physicians to examine the injuries of the employee. 19 Del. C. § 2351(a).

57. **What are the provisions for “Independent Contractors”?**


The Restatement (Second) of Agency states that the following non-exclusive "matters of fact" are to be considered in deciding whether the actual tortfeasor is a servant or an independent contractor:

(a) the extent of control, which, by the agreement, the master may exercise over the details of the work;

(b) whether or not the one employed is engaged in a distinct occupation or business;
(c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;

(d) the skill required in the particular occupation;

(e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;

(f) the length of time for which the person is employed;

(g) the method of payment, whether by the time or by the job;

(h) whether or not the work is a part of the regular business of the employer;

(i) whether or not the parties believe they are creating the relation of master and servant; and

(j) whether the principal is or is not in business.

Restat. 2nd of Agency 220 (2).

There is a strong inference that an individual is the servant of the owner if the work is done upon the premises of the employer with his machinery and it is agreed that the general rules for the regulation of the conduct of employees will be obeyed by the individual. This inference is not necessarily rebutted by the fact that the individual is paid by the amount of work performed or by the fact that he supplies in part his own tools or even his assistants. If, however, the rules are made only for the general policing of the premises, as where a number of separate groups of workmen are employed in erecting a building, mere conformity to such regulations does not indicate that the workmen are servants of the person making the rules. See Falconi v. Coombs & Coombs, Inc., 902 A.2d 1094 (Del. 2006)

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

The general rule is that an employee, with his consent, may be loaned by his general employer to another to perform specific services, and that, in the course of and for the purpose of performing such services, he may become the employee of the specific employer rather than the employee of the general employer. As such, a loaned employee may become the specific employer's employee, while at the same time remaining the employee of employer who loaned his/her services. Restatement of Agency 2d § 227.
The borrowed servant doctrine is recognized in Delaware and was outlined in Richardson v. John T. Hardy & Sons, Inc.:

Whether or not a loaned employee becomes the employee of the one whose immediate purpose he serves is always a question of fact, and depends upon whether or not his relationship to the specific employer has the usual elements of the employer-employee status. Fundamentally, it is not important whether or not he remains the employee of the general employer as to matters generally. What is important to determine is, with respect to the alleged negligent act in question, whether or not he was acting in the business of and under the direction of the general or the specific employer. This is almost always determined by which employer has the right to control and direct his activities in the performance of the act allegedly causing the injury, and whose work is being performed.

54 Del. 567, 182 A.2d 901, 4 Storey 567 (Del. 1962).

As held by the Court in Volair Contrs., Inc. v. AmQuip Corp., 829 A.2d 130, 134 (Del. 2003):

The common law borrowed servant doctrine focuses on the relationship between an employer and an employee. The general rule is that an employee, with his consent, may be loaned by his general employer to another to perform specific services, and that, in the course of and for the purpose of performing such services, he may become the employee of the specific employer rather than the employee of the general employer. Accordingly, a loaned employee may become the specific employer's employee while at the same time remaining, generally speaking, the employee of him who loans his services.

Whether or not a loaned employee becomes the employee of the one to whom he/she is loaned depends upon whether or not his relationship to the specific employer has the usual elements of the employer-employee status. Specifically, it must be determined whether or not he was acting in the business of and under the direction of the general or the specific employer. Restatement of Agency 2d, § 227, comment a; 35 Am. Jur., Master and Servant, § 541. The existence of an employer-employee relationship is an issue of law. Porter v. Pathfinder Servs., 683 A.2d 40, 42 (Del. 1996). The test is who hired the worker, had the power to discharge him, paid his wages, and was in control of the worker's activities while he was working. Barnard V. State, Del. Super., 642 A.2d 808 (1992), aff'd, Del. Supr., 637 A.2d 829 (1994); Lester C. Newton Trucking Co. v. Neal, Del. Supr., 58 Del. 55, 204 A.2d 393 (1964). See Richardson v. John T. Hardy & Sons, Inc., 54 Del. 567, 571, 182 A.2d 901, 903 (Del. 1962) (“This is almost always determined by which employer has the right to control and direct his activities in the performance of the act allegedly causing the injury, and whose work is being performed.”). The greatest weight is given to the issue of control. Barnard, 642 A.2d at 815; White v. Gulf Oil, Del. Supr., 406 A.2d 48 (1979).
59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Under Lester C. Newton Trucking Co. v. Neal, 204 A.2d 393, 395 (Del. Supr. 1964), the four-prong test in determining employer-employee status is: (1) who hired the employee; (2) who may discharge the employee; (3) who pays the employee's wages; (4) who has the power to control the conduct of the employee when he is performing the particular job in question. In distinguishing between an employee and an independent contractor, there are four factors to be considered in showing the right of control: (1) direct evidence of right or exercise of control, (2) method of payment; (3) furnishing equipment; (4) right to fire. 1C A. Larson, Workmen's Compensation Law §44.00 (1982). See Patterson v. Blue Hen Lines, Inc., 1986 Del. Super. LEXIS 1060 (1986) (ICC regulations standing alone are insufficient to turn owner-operators into employees).

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No, other than the generally-applicable requirements of the Medicare Secondary Payer Act described in Question 54, above. However, closed medical commutations are rarely available and must be approved by the Industrial Accident Board.

62. Does your state permit medical marijuana and what are the restrictions for use and
for work activity in your state Workers’ Compensation law?

Delaware has an operational medical marijuana program. Patient’s participation in the program requires a diagnosis of one or more listed conditions and certification by a physician with whom the patient has a bona fide relationship. 16 Del. C. § 4903A. Patients are issued registration cards upon approval and may purchase and possess up to 6 ounces of marijuana products per month. Notably, this includes smokeable marijuana. 16 Del. C. § 4902A(9) and 16 Del. C. § 4701(27). All marijuana must be purchased from a state-approved dispensary. See, 16 Del. C. § 4901A, et seq.

The laws specifically exempts insurers from having to pay for medical marijuana treatment. 16 Del. C. § 4907A(a). Employers are allowed to prohibit and discipline employees for on the job medical marijuana use. 16 Del. C. § 4907A(b).

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Recreational use of marijuana remains illegal in Delaware. There is a current effort at legalization in the legislature but, the process is still ongoing.
1. Citation for Florida’s workers’ compensation statute.

The Florida Workers’ Compensation Act is set forth in Chapter 440, Florida Statutes. In 2003, the Florida legislature enacted substantial reforms of the Florida Workers’ Compensation Act, many of which became effective on October 1, 2003, with other changes taking effect on January 1, 2004. Please note that the law discussed herein is applicable to the current Workers’ Compensation Act and, therefore, may not apply to dates of accident prior to October 1, 2003.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

An "employee" is defined as any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment under any appointment or contract for hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, aliens and minors. Fla. Stat. §440.02(15)(a) (2006).

The term "employee" also includes the following:

(1) any person who is an officer of a corporation and who performs services for remuneration for such corporation within this state, whether or not such services are continuous;

(2) a sole proprietor or a partner who is not engaged in the construction industry, devotes full time to the proprietorship or partnership, and elects to be included in the definition of employee by filing notice thereof, as provided in Section 440.05, Florida Statutes;

(3) all persons who are being paid by a construction contractor as a subcontractor, unless the subcontractor has validly elected an exemption as permitted by this chapter, or has otherwise secured the payment of compensation coverage as a subcontractor, consistent with Section 440.10, Florida Statutes, for work performed by, or as a, subcontractor;

(4) an independent contractor working or performing services in the construction industry; and
(5) a sole proprietor who engages in the construction industry and a partner or partnership that is engaged in the construction industry.


The term "employee" does not include the following categories of workers:

(1) an independent contractor who is not engaged in the construction industry;

(2) a real estate licensee, if that person agrees, in writing, to perform for remuneration solely by way of commission;

(3) bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment;

(4) an owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish motor vehicle equipment as identified in the written contract and the principal costs incidental to the performance of the contract, including, but not limited to, fuel and repairs, provided a motor carrier's advance of costs to the owner-operator when a written contract evidences the owner-operator's obligation to reimburse such advance shall be treated as the owner-operator furnishing such cost and the owner-operator is not paid by the hour or on some other time-measured basis;

(5) a person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer;

(6) a volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity (a person who does not receive monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee);

(7) an officer of a corporation who elects to be exempt from Chapter 440;

(8) an officer of a corporation engaged in the construction industry who elects to be exempt from Chapter 440;

(9) an exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided that a written contract is entered into prior to commencement of such activity which reflects that an employee/employer relationship does not exist;
(10) a taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues;

(11) a person who performs services as a sports official for an entity sponsoring an interscholastic sports event or for a public entity or private, nonprofit organization that sponsors an amateur sports event; and


In 2010, the First DCA looked at the owner-operator exception. They held the exception only applies if the owner-operator pays all costs associated with the operation of the vehicle. Reynolds v. CSR Rinker Transport, 31 So. 3d 268 (Fla. 1st DCA 2010). In Reynolds, the employer paid for the insurance that covered the owner’s equipment. The court held that, based on the plain language of the statute, because not all of the expenses were paid for by the owner, the exception did not apply.

3. Identify and describe any "statutory employer" provision. What is the definition of "employer" under the Act?

According to Section 440.02(16), Florida Statutes (2006), the Florida Workers’ Compensation Act defines "employer" as the state and all political subdivisions thereof, all public and quasi-public corporations therein, every person carrying on any employment, and the legal representative of a deceased person or the receiver or trustees of any person. Fla. Stat. §440.02(16)(a) (2006). The term "employer" also includes employment agencies, employee leasing companies, and similar agents who provide employees to other persons. Id. If the employer is a corporation, parties in actual control of the corporation, including, but not limited to, the president, officers who exercise broad corporate powers, directors, and all shareholders who directly or indirectly own a controlling interest in the corporation, are considered the employer for the purposes of Sections 440.105, 440.106, and 440.107, Florida Statutes.

A homeowner shall not be considered the employer of persons hired by the homeowner to carry out construction on the homeowner's own premises if those premises are not intended for immediate lease, sale, or resale. Fla. Stat. §440.02(16)(b) (2006).

4. What type of injuries are covered and what is the applicable standard of proof for each?

A. Traumatic or "single occurrence" claims.

A carrier must provide benefits to a worker who has sustained an injury by accident arising out of and occurring within the course of employment. The Act defines "injury" as personal injury or death by accident arising out of and in the normal course and scope
of employment, and such diseases or infection as naturally or unavoidably result from such injury. Fla. Stat. §440.02(19) (2006). The term "accident" is defined under the Act to mean only an unexpected or unusual event or result that happens suddenly. Fla. Stat. §440.02(1) (2006).

The injury, its occupational cause, and any resulting manifestations or disability shall be established within a reasonable degree of medical certainty and based on objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries. Fla. Stat. §440.09(1) (2003). The term "major contributing cause" has been defined as the cause which is more than 50% responsible for the injury as compared to all other causes combined for which treatment or benefits are sought. Id. Major contributing cause must be demonstrated by medical evidence only. Id. Pain and subjective complaints alone, without objective relevant medical findings, are not compensable. Id. "Objective relevant medical findings" are those findings which correlate to the subjective complaints of the employee and are confirmed by physical examination findings and diagnostic testing. Id.

B. Occupational diseases (including respiratory and repetitive use).

Pursuant to Section 440.151, Florida Statutes, an "occupational disease" is defined as a disease which is due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process or employment, and to exclude all ordinary diseases of life to which the general public is exposed, unless the incidence is substantially higher in the particular trade, occupation, process, or employment than for the general public. Fla. Stat. §440.151(2) (2003). In addition, "occupational disease" means only a disease for which there are epidemiological studies showing that exposure to the specific substance involved, at the levels to which the employee was exposed, may cause the precise disease sustained by the employee. Id.

The statute essentially requires that the following six factors be shown in order to find an occupational disease compensable: (1) a condition peculiar to the occupation causes the disease; (2) the employee contracts the disease during employment in the occupation; (3) the occupation presents a particular hazard of the disease; (4) incidence of ordinary diseases of life is substantially higher in the occupation than in the public; (5) the nature of employment was the major contributing cause of the disease; and (6) there are epidemiological studies showing that exposure to the substance involved, at the levels at which the employee was exposed, may cause the precise disease sustained by the employee.

For accidents occurring prior to October 1, 2003, in order to prove an occupational disease, an employee was only required to show the following: (1) the disease must actually be caused by employment conditions that are characteristic of, and peculiar to, a particular occupation; (2) the disease must be actually contracted during employment in the particular occupation; (3) the occupation must present a particular hazard of the disease occurring so as to distinguish that occupation from usual occupations, or the incidence of the disease must be substantially higher in the occupation than in usual
occupations; and (4) if the disease is an ordinary disease of life, the incidence of such a
disease must be substantially higher in the particular occupation than in the general
public. Hamilton v. Stamas Yachts, 496 So. 2d 230 (Fla. 1st DCA 1986); King Motor
Company v. Pollack, 409 So. 2d 160 (Fla. 1st DCA 1982); Lake v. Irwin Yacht &
Marine Corp., 398 So. 2d 902 (Fla. 1st DCA 1981).

Effective October 1, 2003, the Act provides that an occupational disease is not
compensable unless the nature of employment where the disease was contracted is the
contributing cause must be shown by medical evidence only, as demonstrated by physical
examination findings and diagnostic testing. Id. Major contributing cause is statutorily
defined as the cause which is more than 50% responsible for the injury as compared to all
other causes combined.

An occupational disease differs from an exposure injury. Although these two doctrines
occasionally overlap and exposure to repeated trauma could possibly also be an
occupational disease, these two concepts are not identical. Exposure and repetitive
trauma are compensable only if the injured employee can show all of the following: (1)
prolonged exposure; (2) the cumulative effect of which is injury or aggravation of a pre-
existing condition; (3) that he has been subjected to a hazard greater than that to which
the general public is exposed; and (4) for a pre-existing condition to be compensable, it
must be exacerbated by some non-routine, job-related physical exertion or by some form
of physical trauma. Festa v. Teleflex, Inc., 382 So. 2d 122 (Fla. 1st DCA 1980);
University of Florida v. Massie, 602 So. 2d 516 (Fla. 1992).

5. **What, if any, injuries or claims are excluded?**

Compensation is not payable for injuries primarily caused by intoxication of the
employee under the influence of drugs, barbiturates or other stimulants not prescribed by
a physician or by the willful intention of the employee to injure or kill himself, herself, or
another. Fla. Stat. §440.09(3) (2003). In addition, an employee is not entitled to
compensation or benefits under the Act if any Judge of Compensation Claims,
Administrative Law Judge, court, or jury convened in Florida determines that the
employee has knowingly and intentionally engaged in any of the acts described in
Section 440.105, Florida Statutes (pertaining to fraudulent acts), or any criminal act for
Providing a false social security number for the purpose of obtaining benefits falls under
this section and bars the employee from compensation, even if they are an "illegal alien"
entitled to benefits. See Arreola v. Administrative Concepts, 17 So. 3d 792 (Fla. 1st DCA
2009).

The Act also excludes the following injuries: (1) those arising from recreational and
social activities, unless such activities are expressly required by the employer and
produce a substantial, direct benefit to the employer beyond improvement in the
employee’s health and morale that is common to all kinds of recreation and social life;
(2) those suffered while going to, or coming from work, whether or not the employer
provided such transportation if such means of transportation was available for the exclusive personal use by the employee, unless the employee was engaged in a special errand or mission for the employer; (3) those sustained while deviating from the course of employment, including leaving the employer’s premises, unless such deviation is expressly approved by the employer, or unless such deviation or act is in response to an emergency and designed to save life or property; and (4) those caused by a subsequent intervening accident arising from an outside agency which are the direct and natural consequence of the original injury, unless suffered while traveling to or from a health care provider for the purpose of receiving remedial treatment for a compensable injury. Fla. Stat. §440.092 (1)-(3), (5) (2001). However, an employee that is required to travel in connection with his or her employment, who suffers an injury while traveling, is eligible for workers’ compensation benefits under the Act only if the injury arises out of and in the course and scope of employment while he or she is actively engaged in the duties of employment. Fla. Stat. §440.092(4) (2001). Note that the Florida courts have historically applied this section liberally in favor of awarding benefits to "traveling employees."

Any subsequent injuries the employee suffers as a result of an original injury are not compensable unless the original injury is the major contributing cause of this subsequent injury. Fla. Stat. §440.091(1)(a) (2003). If an injury arising out of employment combines with a pre-existing disease or condition to cause or prolong disability or the need for treatment, compensation and/or benefits are only payable as long as the injury arising out of employment is and remains more than 50% responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Fla. Stat. §440.091(b) (2003).

6. What psychiatric claims or treatments are compensable?

A mental or nervous injury due to stress, fright or excitement only is not an injury by accident arising out of the employment. Fla. Stat. §440.093(1) (2003). In order for benefits to be payable for mental or nervous injuries, an accompanying "physical injury" requiring medical treatment, must also be present. Id. A mere touching cannot suffice as the physical injury necessary to make a mental or nervous injury compensable. However, the fact that the physical injury is relatively minor will not necessarily bar compensation for such an injury. City of Holmes Beach v. Grace, 598 So. 2d 71 (Fla. 1992).

Mental or nervous injuries occurring as a manifestation of a compensable injury must be demonstrated by clear and convincing evidence by a psychiatrist. Fla. Stat. §440.093(2) (2003). The compensable physical injury must be, and remain, the major contributing cause of the mental or nervous condition. Id. In addition, compensation and medical treatment are not due and owing for depression resulting from the employee being out of work or losing employment opportunities, resulting from a pre-existing mental, emotional or psychological condition, or due to pain or other subjective complaints which cannot be substantiated by objective medical findings. Id.
For accidents occurring after October 1, 2003, temporary total disability benefits are not payable for disability caused by a compensable mental injury for more than six months after the claimant reaches maximum medical improvement for the physical injury. Fla. Stat. §440.093(3) (2003).

7. What are the applicable statutes of limitations?

The right to any benefits, medical or indemnity, under the Act is time barred unless a claim is filed within two years after the date on which the employee knew or should have known that the injury or death arose out of work performed in the course and scope of employment. Fla. Stat. §440.19(1) (1997). Payment of any medical or indemnity benefits shall toll the limitations period for one year from the date of such payment. Fla. Stat. §440.19(2) (1997).

The filing of a Petition for Benefits tolls the statute of limitations unless said petition fails to meet the specificity requirements in Section 440.192, Florida Statutes. Fla. Stat. §440.19(3) (1997). The employer/carrier must raise the statute of limitations defense in its initial responsive pleading or the defense is waived. Fla. Stat. §440.19(4) (1997). Any claim asserted via a Petition for Benefits, even a claim for just attorney’s fees and costs, will toll the statute of limitations. Longley v. Miami-Dade County School Board, 82 So. 3d 1098 (Fla. 1st DCA 2012); Black v. Tomoka State Park, 106 So.3d 973 (Fla. 1st DCA 2013).

8. What are the reporting and notice requirements for those alleging an injury?

An employee suffering an injury arising out of his or her employment must advise his or her employer of said injury within 30 days after the date, or the initial manifestation, of the injury. Fla. Stat. §440.185(1) (2004).

The 30 day notice requirement may be excused if the employer had actual knowledge of the injury or if the cause of the injury could not be identified without a medical opinion and the employer was advised within 30 days after the medical opinion was obtained. Fla. Stat. §440.185(1)(a)-(b) (2004). The requirement may also be waived if the employer failed to notify its employees of their rights to workers' compensation benefits. Fla. Stat. §440.185(1)(c) (2004). Finally, "exceptional circumstances," outside the scope of the previously described exceptions, may also justify a failure to timely report an injury. Fla. Stat. §440.185(1)(d) (2004).

Within 7 days after actual knowledge of an employee’s injury or death, the employer shall report said injury or death to its carrier. Fla. Stat. §440.185(2) (2004). If an injury results in death, the employer is also required to notify the Department of Financial Services, by telephone or telegraph, within 24 hours. Fla. Admin. Code r. 69L-56.401.
9. **Describe available defenses available based on an employee’s conduct:**

**A. Self-inflicted injury.**

These claims are generally barred. Fla. Stat. §440.09(3) (2003). However, the Act requires a willful intent to injure oneself (or another) in order to bar a claim. Fla. Stat. §440.09(3) (2003). An injury is deemed to be intentional and willful if the employee’s actions are committed with premeditation and deliberation and the employee reasonably expected that his acts would cause injury to himself or another. 391st Bomb Group v. Robbins, 654 So. 2d 1200 (Fla. 1st DCA 1995); see also Restoration Technology v. Reyes, 936 So. 2d 1187 (Fla. 1st DCA 2006).

**B. Willful misconduct, "horseplay" etc.**

The defense of "horseplay" focuses on the concept of deviation from employment. The classification of horseplay as a substantial deviation precluding compensability depends on: (1) the extent and seriousness of the deviation; (2) the completeness of the deviation (whether it involved an abandonment of employment duties); (3) the extent to which similar conduct had either been forbidden or had become an accepted or tolerated practice; and (4) the extent to which such horseplay may have been expected or reasonably foreseeable in the employment. Times Publishing Co. v. Walters, 382 So. 2d 720 (Fla. 1st DCA 1980). In addition, when horseplay occurs during a lull at work, this is a factor of substantial importance, since the deviation does not involve the abandonment of any work duties and may actually be an expected consequence of a waiting period. Id. To render an injury not compensable, a deviation must amount to a wholesale abandonment of the employee’s work. Boyd v. Florida Mattress Factory, Inc., 128 So. 2d 881 (Fla. 1961).

**C. Injuries or occupational diseases involving drugs and/or alcohol.**

Injuries caused primarily by intoxication or drugs, barbiturates or other stimulants not prescribed by a physician are barred. Fla. Stat. §440.09(3) (2003). If, at the time of injury, the employee has a blood alcohol level of 0.08 or more grams per 100 milliliters of blood, pursuant to Section 316.193, Florida Statutes, or a positive confirmation of a drug, it is presumed that the injury was occasioned primarily by the intoxication of, or by the influence of, the drug upon the employee. Fla. Stat. §440.09(7)(b) (2003). If the employee refuses to submit to a drug test, it is presumed that the injury was caused primarily by the influence of drugs, absent clear and convincing evidence to the contrary. Fla. Stat. §440.09(7)(c) (2003).

**D. Aggressor Doctrine / Fight Cases.**

Injuries resulting from fights at work are possibly compensable, depending upon the connection between the fight and the employment. However, the "aggressor" in a physical confrontation is generally denied compensation. The "aggressor" is the
individual who first made an assault upon another person with the intention to injure or kill. Florida Forest and Park Service v. Strickland, 18 So. 2d 251 (Fla. 1944).

10. What, if any, penalties or remedies are available in claims involving fraud?

Pursuant to Section 440.09(4), Florida Statutes (2003), an employee forfeits his right to workers’ compensation benefits if it is determined by a Judge of Compensation Claims, Administrative Law Judge, court or jury that the employee knowingly or intentionally engaged in any of the acts described in Section 440.105, Florida Statutes, for the purpose of securing workers’ compensation benefits. Section 440.105, Florida Statutes, describes the prohibited activities and includes such things as knowingly making false, fraudulent or misleading statements. In order to establish the fraud defense, it must be shown not only that the employee violated Section 440.105, but that the violation was done for the purpose of securing workers’ compensation benefits. Matrix Employee Leasing v. Hernandez, 975 So. 2d 1217 (Fla. 1st DCA 2008).

The statute imposes an affirmative obligation on all parties to send a report of, or information pertaining to, any suspected fraudulent activity to the Division of Insurance Fraud, Bureau of Workers’ Compensation Fraud. Fla. Stat. §440.105(1)(a) (2003). In absence of fraud or bad faith, an individual is not subject to civil suit for slander or defamation for the reporting of fraudulent activities pursuant to Section 440.105(1)(b), Florida Statutes. However, a person who knowingly and falsely reports workers’ compensation fraud or who retaliates against a person making such a report commits a third degree felony. Fla. Stat. §440.105(1) (2003).

11. Is there any defense for falsification of employment records regarding medical history?

Section 440.15(5)(a), Florida Statutes (2012) codifies this defense which is more commonly known as the "Martin v. Carpenter defense," having been first established by the case of Martin Co. v. Carpenter, 132 So. 2d 400 (Fla. 1961). A false representation as to one’s physical condition or health made by an employee in procuring employment will preclude workers’ compensation benefits for an otherwise compensable injury if the following requirements are met: (1) there is evidence of a causal relationship between the injury and the false representation; (2) there is knowledge by the employee that the representation is false; (3) there is reliance by the employer on the false representation; and (4) said reliance results in consequent damage to the employer. Id.

Of note, if an employee does not answer questions on an application or medical questionnaire, those omissions are not deemed to be representations or misrepresentations. An employer has an obligation to obtain answers to the questions and exercise some diligence in investigating a misrepresentation or omission. If the employer does not do so, the employer cannot claim reliance on said omissions regarding same. Landers v. Medical Personnel Pool, 647 So. 2d 173 (Fla. 1st DCA 1994).
12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

The Act provides that recreational or social activities are not compensable unless such activities are expressly required by the employer and produce a substantial, direct benefit to the employer beyond the improvement in employee health and morale that is common to all kinds of recreation and social life. Fla. Stat. §440.092(1) (2001).

13. Are injuries by co-employees compensable?

Injuries by co-employees are compensable if they arise out of and in the course of employment. To preclude compensability there must be a complete deviation from the job duties. Boyd v. Florida Mattress Factory, Inc., 128 So.2d 881 (Fla. 1961). The deviation from the job duties must be a wholesale abandonment and more than momentary fooling around by co-employees. Dunlevy v. Seminole County Dep’t of Public Safety, 792 So.2d 592 (Fla. 1st DCA 2001).

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

Acts by third parties unrelated to work but committed on the employer’s premises are generally not compensable so long as the work place is merely the fortuitous site of the personal assault, the altercation is purely private in origin, and the employment does not otherwise impact on the altercation, even if the employee is not the aggressor. However, if the employment is a contributing factor, the injury could be compensable. Carnegie v. Pan American Linen, 476 So. 2d 311 (Fla. 1st DCA 1985).

Benefits

15. What criterion is used for calculating the average weekly wage?

If the employee has worked in the employment in which he or she was working on the date of accident, whether for the same or another employer, during substantially the whole of 13 weeks immediately preceding the accident, his or her average weekly wage will be 1/13 of the total wages earned during the 13 weeks. Fla. Stat. §440.14(1)(a) (2004). The 13 weeks to be used in calculating the average weekly wage are the 13 calendar weeks before the accident, excluding the week during which the accident occurred. Id. "Substantially the whole of 13 weeks" is defined as at least 75% of the employee’s total customary hours of employment within such period considered as a whole. Id. Please note that for accident dates occurring on or before September 30, 2003, the 13 week period used to determine the average weekly wage was the consecutive period of 91 days prior to the injury and the term "substantially the whole of 13 weeks" was defined as at least 90% of the total customary full time hours of employment within that time period. Fla. Stat. §440.14(1)(a) (1997).
If an employee did not work during substantially the whole of the 13 weeks prior to the date of accident, the average weekly wage is calculated pursuant to the earnings of a similar employee in the same employment who has worked substantially the whole of such 13 weeks. Fla. Stat. §440.14(1)(b) (2004). A similar employee is considered as one who does the same type of work as the injured worker, works in the same place and preferably on the same crew as the injured worker, receives pay at the same rate as the injured worker, and works substantially the same hours as the injured worker. Coleman v. Burnup & Sims, Inc., 95 So. 2d 895 (Fla. 1957); Hilton v. Coral Springs Honda, 572 So. 2d 7 (Fla. 1st DCA 1990). If there is no similar employee available, the average weekly wage is based upon either the contract rate of pay or the injured worker’s actual earnings. Fla. Stat. §440.14(1)(d) (2004).

Outside or concurrent employment is included in the calculation of the average weekly wage so long as the wages earned in such employment are reported for tax purposes and the employee was subject to workers’ compensation coverage and benefits at the concurrent employment. Fla. Stat. §440.02(28) (2004); Fla. Stat. §440.14 (2004); and Vegas v. Globe Sec., 627 So. 2d 76 (Fla. 1st DCA 1993).

The average weekly wage is calculated from wages earned and reported for federal income tax purposes on the job where the employee was injured and any other concurrent employment where the employee is covered by workers’ compensation coverage. Fla. Stat. §440.02(28) (2004). Of note, a claimant’s unreported income to the I.R.S. did not constitute "wages" for the purpose of calculating the claimant’s AWW under the Act. Fast Tract Framing, Inc. v. Caraballo, 994 So. 2d 355 (Fla. 1st DCA 2008).

Also included in the average weekly wage is the reasonable value of housing, if provided by the employer and such housing is the permanent and year-round residence of the employee, gratuities to the extent reported to the employer in writing as taxable income, and employer contributions for health insurance for the employee and his or her dependents. Vegas v. Globe Sec., 627 So. 2d 76 (Fla. 1st DCA 1993). However, if employer contributions for housing or health insurance are continued after the time of injury, the contributions are not considered "wages" for the purpose of calculating average weekly wage. Id.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Temporary total disability benefits are paid at a rate of 66 2/3 percent of the employee’s average weekly wage, not to exceed the maximum amount or time limits for the year in which the accident occurred. Fla. Stat. §440.15(2)(a) (2012). The minimum rate is $20.00, unless an employee's wages are less than $20.00, in which case the employee’s full weekly wages are paid. Fla. Stat. §440.12(2) (2012). Effective January 1, 2020, the maximum compensation rate is $971.00 per week. (A list of the maximum and minimum compensation rates by year can be found at http://www.myfloridacfo.com/division/wc/insurer/bma_rates.htm.) For accident dates
occurring on or after January 1, 1994, the maximum period of temporary disability benefits payable is arguably 104 weeks. Fla. Stat. §440.15(2) (2012).  

An employee who has suffered a catastrophic work-related injury (defined as the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparatic, or has lost the sight of both eyes) shall be paid temporary total disability benefits at the rate of 80% of his or her average weekly wage. Fla. Stat. §440.15(2)(b) (2012). This increased compensation must not exceed a period of 6 months from the date of accident. Id. In addition, these benefits are not due and owing if the employee is eligible for, entitled to, or collecting permanent total disability benefits. Id.

Temporary partial disability benefits are paid at the rate of 80% of the difference between 80% of the employee’s average weekly wage and the salary, wages, and other remuneration the employee is able to earn post-injury, as compared weekly. Fla. Stat. §440.15(4)(a) (2012). Weekly temporary partial disability benefits may not exceed an amount equal to 66 2/3 percent of the employee’s average weekly wage at the time of the accident and are also subject to the maximum compensation rate set forth above. Id.

17. How long does the employer/carrier have to begin temporary benefits from the date disability begins?

The employer/carrier must issue the first installment of compensation to the employee "no later than the 14th calendar day after the employer receives notice of the injury or death, when disability is immediate and continuous for 8 calendar days or more after the injury." Fla. Stat. §440.20(2) (2013). If the first 7 days of disability are not consecutive, the first installment of compensation is due on the 6th day after the first 8 calendar days of disability. Id.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ____ days before recovering benefits for the first ____ days)?

No compensation is allowed for the first 7 days of disability. Fla. Stat. §440.12(1) (2012). The employee must be out of work due to his or her disability for more than 21 days before he or she can recover compensation for the first 7 days of disability. Id. For example, if an employee is out of work due to his injury for 3 days, he receives no compensation for same. If he is out of work for 16 days, he can collect compensation benefits only for the 8th through the 16th day, a total of 9 days. Finally, if the employee is out of work for 22 days, compensation is due for the entire period of time that he was out of work (from the date of accident through the 22nd day).

1 The Florida Supreme Court in Westphal v. City of St. Petersburg, 194 So.3d 311 (Fla. 2016) declared the statutory limitation unconstitutional and in turn revived the portion of the statute prior to the 1994 amendments, which provided for temporary indemnity benefits up to 260 weeks.
19. What is the standard/procedure for terminating temporary benefits? When are temporary benefits most often terminated?

Any time that an employee’s compensation benefits are suspended or changed, a carrier must file a Notice of Action/Change (Form DWC-4) with the Division, stating the reasons for the suspension or change of benefits.

Temporary total disability benefits are most frequently suspended when an employee is released to return to work or is placed at maximum medical improvement by his or her treating physician.

Even if the employee is assigned work restrictions by his or her treating physician, if he or she is able to return to work within said restrictions, temporary compensation benefits may also be suspended, so long as the employee continues to earn 80% or more of his or her average weekly wage. Fla. Stat. §440.15(4) (2012). In addition, if an employee is terminated from post-injury employment based on the employee’s own misconduct, temporary partial disability benefits are not payable and may be suspended. Fla. Stat. §440.15(4)(e) (2004). Further, if an employee refuses suitable employment that is offered to him, temporary compensation benefits are not payable and may be suspended during the continuance of such refusal unless a Judge of Compensation Claims determines that such refusal is justifiable. Fla. Stat. §440.15(6) (2012).

Temporary disability benefits can also be suspended if the carrier has paid out the maximum weeks of benefits. Temporary disability benefits, whether for total or partial disability, shall not be paid for a period of more than 104 weeks. Fla. Stat. §440.15(2)(a) (2012).²

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

In Florida, workers assigned a permanent impairment rating for their work related injuries are entitled to impairment benefits. An employee's entitlement to impairment benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier. Fla. Stat. §440.15(3)(c) (2012). Therefore, an employee’s temporary disability benefits may be credited toward the employee’s impairment benefits when the employee continues to receive temporary disability benefits after being placed at maximum medical improvement.

21. What disfigurement benefits are available and how are they calculated?

All permanent impairment benefits are calculated in the same manner, whether for disfigurement or other permanent disabilities. The method of calculation of impairment benefits under the Act is set forth in the paragraph below.

22. How are permanent partial disability/impairment benefits calculated, including the minimum and maximum rates?

² As noted above, this statutory limitation has been deemed unconstitutional and the time period has been increased to 260 weeks, in regards to TTD benefits. See Westphal v. City of St. Petersburg, 194 So.3d 311 (Fla. 2016).
All impairment benefits are based on the impairment ratings set forth in the Florida Impairment Guidelines, and the amount of benefits an employee is entitled to is based on the impairment rating assigned by the employee’s treating physician. Impairment ratings must be based on objective abnormalities. Fla. Stat. §440.15(3) (2012).

Impairment benefits are paid biweekly at a rate of 75% of the employee’s average weekly temporary total disability benefits, not to exceed the maximum weekly benefit. However, such benefits shall be reduced by 50% for each week in which the employee has earned income equal to or in excess of the employee’s average weekly wage. Fla. Stat. §440.15(3)(c) (2012). If the employee makes less than the average weekly wage, there does not have to be a causal connection between the injury and the reduced earnings; the employer is required to pay at the 75% rate. See Seminole County Government v. Baumgardner, 28 So. 3d 145 (Fla. 1st DCA 2010).

The employee is paid two weeks of impairment benefits for each percentage point of impairment from 1% up to and including 10%. Fla. Stat. §440.15(3)(g)1. (2012). For each percentage point of impairment from 11% up to and including 15%, the employee receives 3 weeks of benefits. Fla. Stat. §440.15(3)(g)2. (2013). For each percentage point of impairment from 16% up to and including 20%, the employee receives 4 weeks of benefits. Fla. Stat. §440.15(3)(g)3. (2012). Finally, for each percentage of impairment from 21% or higher, the employee is paid 6 weeks of benefits. Fla. Stat. §440.15(3)(g)4. (2012).

Please note that for accidents occurring between January 1, 1994 through September 30, 2003, impairment benefits are calculated in a different manner. For these accident dates, the weekly impairment benefit is an amount equal to 50% of the employee’s average weekly temporary total disability benefit, not to exceed the maximum benefit. Fla. Stat. §440.15(3)(a) (2002). In addition, an injured worker is entitled to 3 weeks of impairment benefits for each percentage point of impairment. Id.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

The carrier may require the employee to undergo a reemployment assessment as it considers appropriate. Fla. Stat. §440.491(4)(a) (2011). However, the carrier is encouraged to obtain a reemployment assessment if it determines that the employee has a risk of remaining unemployed or if the case involves a catastrophic or serious injury. Id. The carrier shall authorize only a qualified rehabilitation provider to provide the reemployment assessment. Fla. Stat. §440.491(4)(b) (2011). The rehabilitation provider shall conduct its assessment and issue a report to the carrier, the employee, and the Department of Education within 30 days after the time such assessment is complete. Id. If the rehabilitation provider recommends that the employee receive medical care coordination or reemployment services, the carrier shall advise the employee of the recommendation and determine whether the employee wishes to receive such services. Fla. Stat. §440.491(4)(c) (2011). The employee shall have 15 days after the date of receipt of the recommendation in which to agree to accept such services. Id. If the employee chooses to receive these services, the carrier may refer the employee to a rehabilitation provider for such coordination and services within 15 days of receipt of the assessment report or notice of the employee’s election, whichever is later. Id.

Once the carrier has assigned a case to a qualified rehabilitation provider for medical care coordination or reemployment services, the provider shall develop a reemployment plan and submit the plan to the carrier and the employee for approval. Fla. Stat. §440.491(5)(a) (2011). If the rehabilitation provider concludes that training and education are necessary to return the employee to suitable gainful employment, or if the employee has not returned to suitable gainful employment within 180 days after referral for reemployment services or receives $2,500.00 in reemployment services, whichever comes first, the carrier must discontinue reemployment services and refer the employee to the Department of Education for a vocational evaluation. Fla. Stat. §440.491(5)(b) (2011).

Upon referral of an injured employee by the carrier or upon request of the employee, the Department of Education shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation and, if appropriate, approve training and education or other vocational services for the employee. Fla. Stat. §440.491(6)(a) (2011). If the Department of Education, Division of
Workers’ Compensation, approves retraining for an injured employee, the carrier must pay temporary total disability benefits to the employee for 26 weeks. Fla. Stat. §440.491(6)(b) (2011). This period can be extended for an additional 26 weeks if such extended period of time is determined to be necessary and proper by a Judge of Compensation Claims. Id. Of note, an employee is not entitled to these benefits beyond the 104 week temporary benefit limitation set forth in Section 440.15(2), Florida Statutes. However, an employee that refuses to accept training or education that is recommended by the vocational evaluator and considered necessary by the Department will forfeit any additional training and education benefits and any payment for lost wages under this section. Fla. Stat. §440.491(6)(b) (2011). Id. For dates of accident prior to October 1, 2003, rehabilitation temporary total disability benefits under Section 440.491, Florida Statutes, were payable in addition to the 104 weeks of temporary benefit entitlement. See Bober v. Bush Air Conditioning, 826 So. 2d 487 (Fla. 1st DCA 2002).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

**Under what circumstances are permanent total disability benefits due and owing?**

Permanent total benefits are calculated at 66 2/3 percent of the employee’s average weekly wage during the term of total disability. Fla. Stat. §440.15(1)(a) (2012). No permanent total disability benefits shall be payable if the employee is engaged in, or is physically capable of engaging in, at least sedentary employment. Id.

An injured employee is presumed to be permanently and totally disabled if any of the following conditions are present: (1) a spinal cord injury involving severe paralysis of an arm, leg, or the trunk; (2) amputation of an arm, hand, foot or leg involving the effective loss of use of that appendage; (3) severe brain or closed head injury as evidenced by severe motor or sensory disturbance, severe communication disturbances, severe complex integrated disturbances of cerebral function, severe episodic neurological disorders, or other severe brain and closed head injury conditions at least as severe in nature as the prior listed conditions; (4) second degree or third degree burns of 25% or more of the total body surface or third degree burns of 5% or more to the face and hands; and (5) total or industrial blindness. Fla. Stat. §440.15(1)(b) (2012). This presumption can be overcome if the employer/carrier can show that the employee is physically capable of engaging in at least sedentary employment within a 50 mile radius of the employee’s residence. Id. In all other cases, in order to obtain permanent total disability benefits, an employee must establish that he or she is not able to engage in at least sedentary employment within a 50 mile radius of the employee’s residence due to his or her physical limitation. Id.

Entitlement to permanent total disability benefits ceases when an employee reaches age 75, unless the employee is not eligible for Social Security benefits because the employee’s compensable condition has prevented the employee from working sufficient quarters to be eligible for such benefits. Id. If the employee is injured on or after the age of 70, benefits are payable for permanent and total disability for no more than a period of 5 years following determination of entitlement to same. Id. Of note, prior to the 2003 amendments, a permanently and totally disabled employee was entitled to permanent total disability benefits for life. Fla. Stat. §440.15(1) (1997).

The employee also receives supplemental compensation benefits equal to 3% of the weekly compensation rate, multiplied by the number of calendar years since the date of injury. Fla. Stat. §440.15(1)(f) (2012). Please note that, prior to the 2003 amendments, these supplemental benefits were payable at a rate of 5% per annum. Fla. Stat. §440.15(1)(f) (1997).

The weekly compensation payable and the supplemental benefits payable, when combined, may not exceed the maximum weekly compensation rate in effect at the time of payment. Id. Supplemental benefits shall not be paid or payable after the employee attains the age 62, regardless of whether the employee has applied for, or is eligible to apply for, Social Security disability or Social Security retirement benefits, unless the employee is not eligible for Social Security benefits because the employee’s compensable injury prevented him from working sufficient quarters to be eligible for such benefits. Id.

25. **How are death benefits calculated, including the minimum and maximum rates?**
A. Funeral expenses.

Actual funeral expenses up to $7,500.00 are payable. Fla. Stat. §440.16(1)(a) (2004).

B. Dependency claims.

Dependency benefits are payable to spouses, children, parents, brothers, sisters, and grandchildren, if the individual received substantial and regular support from the deceased. A child must be under the age of 18 (unless the child is a student and then dependency ends at age 22) and includes a posthumous child, a child legally adopted prior to the employee’s injury, a step-child, and an acknowledged illegitimate child. Benefits are payable on a scheduled basis depending on the dependent status of the beneficiary at a rate of two-thirds of the employee’s average weekly wage, not to exceed $150,000.00. Fla. Stat. §440.16 (2004).

26. What is the criteria for establishing a "second injury" fund recovery?

Florida’s second injury fund is known as the Special Disability Trust Fund. However, entitlement to any potential recovery from the Special Disability Trust Fund was repealed prospectively by the Florida Legislature with the January, 1998 amendments to Chapter 440.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

Claims for modification of orders must be made within 2 years after the date of the last payment of compensation pursuant to any order or within 2 years after the date copies of an order rejecting a claim are mailed. A claim for modification can only be made if there is a change in the employee’s condition or when there is a mistake in the judge’s determination of the facts. Fla. Stat. §440.28 (1994).

28. What situation would place responsibility on the employer to pay an employee’s attorney fees? How are such fees calculated?

Normally, an employee is responsible for the payment of his or her own attorney’s fees. However, there are several exceptions to this rule. An employer/carrier may become responsible for the payment of a reasonable attorney’s fee if a) the claimant successfully asserts a claim for medical benefits only and the claimant has not filed or is not entitled to file a claim for disability, permanent impairment, wage-loss, or death benefits arising from the same accident; b) if the employer/carrier denies that an accident occurred and the claimant prevails on the issue of compensability; c) if the employer/carrier files a response to a petition for benefits denying benefits and the claimant hires an attorney who successfully obtains the benefits requested; or d) if the claimant prevails in a proceeding to enforce or modify an order. Fla. Stat. §440.34 (2009). Effective July 1, 2002, an attorney’s fee does not attach until 30 days after the employer/carrier receives a petition for benefits, regardless of the date the benefits were originally requested. Therefore, as long as the employer/carrier provides the benefits requested in a petition within 30 days, it will not become responsible for the payment of attorney’s fees. Fla. Stat. §440.34(3) (2009).

If there is no pending petition for benefits and an employer/carrier takes the deposition of the claimant, the employer/carrier will be responsible for a reasonable fee for the claimant’s attorney’s preparation for, and attendance of, the deposition. Fla. Stat. §440.30 (1991).

The law allowing for the entitlement to an attorney’s fee has not changed significantly since 1994. However, in October of 2003, the legislature provided significant changes to this section affecting the amount of attorney’s fees allowed. Pursuant to these amendments, a claimant’s attorney is entitled to recover a fee for only the benefits he or she has secured on behalf of the claimant. The fee is based on a statutory fee schedule (the statutory fee schedule has since been questioned by the Florida Supreme Court as noted below), with one exception, and must be approved by the Judge of Compensation Claims. Fla. Stat. §440.34(1), (2) (2009). The exception to this rule applies when the case involves a petition for medical benefits only. In such a case, the Judge of Compensation Claims may award, as an alternative to
the scheduled fee, an attorney’s fee not to exceed $1,500.00 based on a maximum hourly rate of $150.00 per hour. Such an alternative fee may only be awarded once per accident. Fla. Stat. §440.34(7) (2009).

In April of 2016, the Florida Supreme Court addressed the issue of the calculation of attorney’s fees under Section 440.34 in Castellanos v. Next Door Co., 192 So.3d 431 (Fla. 2016). In Castellanos, the Florida Supreme Court found the mandatory fee schedule in § 440.34, which creates an irrebuttable presumption that precludes any consideration of whether the fee award is reasonable to compensate the attorney, unconstitutional under both the Florida and United States Constitutions as a violation of due process. In doing so, the Court revived the immediate predecessor statute, which was addressed in Murray v. Mariner Health, 994 So.2d 1051 (Fla. 2008). Id. at 448. With Murray as a guide, courts must now allow a claimant to present evidence to show that application of the statutory fee schedule will result in an unreasonable fee. Id. at 448-49. In Murray, the Court explained that as § 440.34 does not define a "reasonable fee", same is to be determined based on the factors set forth in Lee Engineering & Construction Co. v. Fellows, 209 So. 2d 454, 458 (Fla. 1968) which include the following: (1) the time and labor required; (2) the novelty and difficulty of the questions involved in the case; (3) the skilled required to properly conduct the case; (4) whether acceptance of the case will preclude the attorney from appearing in other cases; (5) the customary charge for similar services; and (6) the amount involved in controversy.

An additional change made in 2003 involves offers to settle. If the employer/carrier offers to settle the issues raised in a petition for benefits, the Judge of Compensation Claims can only award the claimant’s attorney a fee based on the benefits secured in excess of the benefits referenced in the offer to settle. Such offer must be made in writing to the claimant’s attorney at least 30 days prior to the hearing date. Fla. Stat. §440.34(2) (2009).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The workers’ compensation liability of an employer is exclusive and replaces all other liability of such employer to any third party tortfeasor and to the employee, legal representative thereof, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such employer at law or in admiralty on account of such injury or death. Fla. Stat. §440.11 (2003).

Effective October 1, 2003, the legislature amended the Act to extend immunity to subcontractors from suits brought by the employees of the general contractor or by employees of another subcontractor. Such immunity applies only if the general contractor provided workers’ compensation insurance on behalf of the subcontractor or the subcontractor purchased its own workers’ compensation insurance and the injury was not the result of the subcontractor’s gross negligence. Fla. Stat. §440.10(1)(e) (2004).

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

There are exceptions to the employer's immunity for independent intentional torts and for failure to secure workers’ compensation insurance. Fla. Stat. §440.11(1) (2003). Prior to October 1, 2003, an employee was found to have met the burden of showing that the employer’s actions constituted an intentional tort if objective evidence established that the injury was substantially certain to occur. See R.L. Haines Const., LLC v. Santamaria, 161 So.3d 528 (Fla. 5th DCA 2014). However, effective October 1, 2003, the legislature amended the Act to provide that the employee has the burden of proving by clear and convincing evidence that (1) the employer intended to injure the employee; or (2) that the employer engaged in conduct that the employer knew, based on prior similar accidents or an explicit warning specifically identifying a known danger, was virtually certain to result in injury or death to the employee, and the employee was not aware of the risk because the danger was not apparent and the employer concealed or misrepresented the danger. Fla. Stat. §440.11(1)(b) (2003). This is a much stricter standard
and the law now requires the employee to prove that the employer intended to cause an injury either by action or inaction. If intent cannot be shown, the employee can only establish an intentional tort by showing that the employer knew that an injury was virtually certain to occur, but deliberately concealed or misled the employee about the danger.

30. **Are there any penalties against the employer for unsafe working conditions?**


31. **What is the penalty, if any, for an injured minor?**

There is no "penalty" for an injured minor unless he or she was employed in violation of Florida's Child Labor laws. In such a case, the employer will be responsible for additional compensation as determined by the Judge of Compensation Claims. However, the total compensation payable cannot exceed double the amount otherwise payable. The increased amount is payable by the employer alone. Fla. Stat. §440.54 (1991).

32. **What is the potential exposure for "bad faith" claims handling?**

For accidents occurring prior to October 1, 1989, an employer/carrier owed attorney’s fees if it was determined that the employer or carrier handled the claim in bad faith and such bad faith caused an economic loss to the injured employee. However, Florida no longer provides a separate cause of action for bad faith claims handling in workers’ compensation cases. That being said, the Supreme Court of Florida has held that adjusters and carriers are not completely immune from independent tort actions when their conduct rises to the level of an intentional tort. The court recognized that a statutory bad faith cause of action is not available in workers’ compensation cases. However, the court found that carriers could be held liable for the intentional infliction of emotional distress if the adjuster’s conduct goes beyond simple bad faith and rises to the level of intentional conduct that is outrageous. See Aguilera v. Inservices, Inc., 905 So. 2d 84 (Fla. 2005).

33. **What is the exposure for terminating an employee who has been injured?**

An employer may not discharge, threaten to discharge, intimidate or coerce an employee for filing a valid claim for compensation or for attempting to claim compensation. Fla. Stat. §440.205 (1991). Violation of this section creates a third party civil cause of action for wrongful termination.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. An employee has the sole right to sue third parties within the first 12 months after the industrial accident. During the second year, both the employee and the employer have the right to sue a third party tortfeasor directly. However, if the carrier provides 30 days notice to the employee of its intent to bring suit, the employee is barred from bringing its own separate action. If the employer fails to file suit during the second year, the right of action reverts solely to the employee. The employee continues to have the sole right to bring suit until the applicable statute of limitations expires. Fla. Stat. §440.39(4)(a), (b) (1997).

35. **Can co-employees be sued for work-related injuries?**
Generally, employees enjoy the same immunity as the employer as long as the employee is acting in furtherance of the employer’s business and the employee is entitled to receive workers’ compensation benefits. However, there are several exceptions to this rule. Immunity does not apply if the co-worker’s actions constitute willful and wanton disregard, unprovoked physical aggression, or gross negligence. Further, immunity does not apply to employees of the same employer if the employee is assigned primarily to unrelated works. Unfortunately, what is considered an “unrelated work” has yet to be defined and such a determination is made on a case by case basis. Fla. Stat. §440.11(1) (2003).

36. Is subrogation available?

Yes. An insurer is subrogated to the rights of the employee and his or her dependents against third party tortfeasors to the extent of the amount of compensation and medical benefits paid or to be paid. The insurer may file in the third party suit a notice of payment of compensation and medical benefits to the employee. This notice constitutes a lien upon any judgment or settlement recovered to the extent that the court may determine to be its pro rata share for compensation and medical benefits paid or to be paid. The subrogation right does not apply to payment of vocational benefits, attorney’s fees or miscellaneous claims expenses such as investigation or the use of experts. Fla. Stat. §440.39(2),(3)(a) (1997). See also Employer’s Casualty Insurance Company v. Manfredo, 542 So. 2d 1365 (Fla. 3rd DCA 1989), aff’d, 560 So. 2d 1162 (Fla. 1990).

MEDICALS

37. Is there a time limit for medical bills to be paid and are penalties available for late payment?

For medical services provided after January 1, 2004, all medical, hospital, pharmacy or dental bills properly submitted by the provider, except for bills that are disallowed or denied by the carrier, must be paid within 45 calendar days after the carrier’s receipt of the bill. Penalties are imposed for late payments that fall below a minimum of 95% timely performance standard. For late payments that fall below the 95% timely performance standard, a $25.00 per bill penalty is assessed. For late payments that fall below the 90% timely performance standard, a $50.00 per bill penalty is assessed. Fla. Stat. §440.20(6)(b) (2011). Providers must enforce the payment of unpaid medical bills. Claimants do not have standing to seek payment of same. See J.D.B. Brother’s v. Miranda, 25 So. 3d 1271 (Fla. 1st DCA 2010).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Subject to certain limitations, a physician is required to provide medical records, reports and information regarding an injured employee upon a reasonable request from the employer, the carrier, an authorized qualified rehabilitation provider, or the attorney for the employer/carrier as long as the records are relevant to the particular injury or illness for which compensation is sought. In addition, the physician is required to discuss the employee’s medical condition upon a reasonable request. The release of medical information does not require authorization from the injured employee. If the health care provider willfully refuses to provide medical records or to discuss the employee’s medical condition after a reasonable request is made, the health care provider is subject to one or more penalties as prescribed by the statute. Such penalties may include an order barring the provider from payment, deauthorization of care, denial of payment for care rendered in the future, decertification of the health care provider as an expert medical advisor, and/or a fine not to exceed $5,000.00. Fla. Stat. §440.13(4)(c), (8)(b) (2008).

Effective January 1, 1994, the insurer must respond to a written request for authorization within 3 business days or it will be deemed to have consented to the medical necessity for such treatment. Fla. Stat. §440.13(3)(d) (1994). Effective October 1, 2003, the legislature amended this section to provide that the time limitation to respond to a request for authorization only applies to referrals from an authorized health care provider. Unfortunately, it is unclear from the language of the statute what requests for authorization this section applies to. However, the applicable case law suggests that this section only applies to referrals from an authorized physician to another physician. See Walmart Stores, Inc. v. Mann, 690 So. 2d 649
A claim for specialist consultations, surgery, physiotherapeutic or occupational therapy procedures, x-rays, or special diagnostic laboratory tests that cost more than $1,000.00 will not be valid and reimbursable unless services have been expressly authorized by the carrier, or unless the carrier has failed to respond to a written request for authorization within 10 days, or unless emergency care is required. Fla. Stat. §440.13(3)(I) (2008).

Case law has held that an employer/carrier is estopped from arguing that a referral to a specialist was not reasonable or medically necessary when the employer/carrier failed to respond to written requests by the claimant’s authorized treating physician for such referral during the three or ten day deadlines set forth in Sections 440.13(3)(d) and (i). Elmer v. Southland Corp., 5 So.3d 754 (Fla. 1\textsuperscript{st} DCA 2009).

In addition, the case of Butler v. Bay Center, 947 So. 2d 570 (Fla. 1\textsuperscript{st} DCA 2006), establishes that Section 440.13 prescribes the procedure for authorizing medical providers and, therefore, any changes to this statute apply retroactively and regardless of the date of the claimant’s accident.

39. What is the rule on (a) the claimant’s choice of physician; and (b) the employer’s right to a second opinion?

A. Choice of Physician.

Prior to the October 1, 2003 legislative changes, the extent of an employee’s right to the choice of physician was controlled by whether or not managed care applied. Under a managed care arrangement, an employee was entitled to one change to another medical provider within the same specialty and network. Fla. Stat. §440.134(10)(c)(1994). For claims outside of managed care, the employee was entitled to one change of physician during the course of treatment for any one accident. Under the old law, upon written request from the employee for a change in physician, the carrier had the obligation to provide the employee with a list of at least 3 physicians from which the employee could choose. Fla. Stat. §440.13(2)(f) (2001).

Effective October 1, 2003, the legislature repealed the provision requiring that a managed care plan provide for a one time change in physician and provided that the procedures for allowing for a change in physician under a managed care plan are the same as those applicable in non-managed care situations. Pursuant to these amendments, the law provides that, upon the written request of the employee, the carrier shall provide the employee the opportunity for one change of physician within 5 days after the receipt of the written request, and the alternate physician may not be professionally affiliated with the previous physician. If the carrier fails to provide an alternate physician within 5 days, the employee is free to select the physician and such physician shall be considered authorized. Fla. Stat. §440.13(2)(f) (2008). Pursuant to Butler v. Bay Center, 947 So. 2d 570 (Fla. 1\textsuperscript{st} DCA 2006), the current procedures for providing a one time change of physician would apply retroactively to any and all dates of accident and not simply those subsequent to October 1, 2003. The 5 day period to provide an alternate physician refers to 5 calendar days and not 5 business days. Hinzman v. Winter Haven Facility Operations, Inc., 109 So.3d 256 (Fla. 1\textsuperscript{st} DCA 2013).

B. Second Opinions.

Prior to the October 1, 2003 amendments, an employee was entitled to one second opinion in the same specialty and within the network for claims falling under managed care. Fla. Stat. §440.134(6)(c)(9) (1994). However, effective October 1, 2003, the legislature repealed this section and a managed care plan is no longer required to contain a provision allowing for a second opinion. Further, there is no statutory provision allowing for a second opinion in a non-managed care situation. However, the First DCA has held that a claimant may be entitled to a second opinion at the expense of the employer/carrier if the claimant
can show that same is reasonable and medically necessary. See Lombardi v. Southern Wine & Spirits, 890 So. 2d 1128 (Fla. 1st DCA 2004).

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employer/carrier must provide treatment that is reasonable and medically necessary. Fla. Stat. §440.13(2)(a) (2008). Treatment is considered to be medically necessary if it is used to identify or treat an illness or injury, is appropriate to the employee’s diagnosis and status of recovery, and is consistent with the location of the service, the level of care provided, and applicable practice parameters. Fla. Stat. §440.13(1)(k) (2008). Effective October 1, 2003, an employee is entitled to chiropractic care for a maximum of 24 treatments or 12 weeks from the date of first chiropractic treatment. Fla. Stat. §440.13(2)(a) (2008).

41. **Which prosthetic devices are covered, and for how long?**

An employee is entitled to all medically necessary prosthetic devices. Fla. Stat. §440.13(2)(a) (2008). Prior to December 31, 1993, there was no statute of limitations on the right to remedial treatment related to the insertion or attachment of a prosthetic device. Fla. Stat. §440.19(1)(b). However, effective January 1, 1994, the legislature repealed this section and prosthetic devices are now subject to the same statute of limitations as all other medical treatment.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Home modifications may be covered as long as they are considered reasonable and medically necessary. If the claimant’s current home cannot be modified, the employer/carrier may be required to provide a modified home. However, the employer/carrier will only be responsible for the difference between the cost of the claimant’s current home and the cost of a fully equipped home. See Ramada Inn South Airport v. Lamoureux, 565 So. 2d 376 (Fla. 1st DCA 1990). Similarly, vehicle modifications may also be covered if same are considered to be reasonable and medically necessary.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes.

44. **What, if any, provisions or requirements are there for "managed care"?**

Beginning January 1, 1997, an employer/carrier was required to provide all medically necessary medical treatment through a managed care arrangement. Fla. Stat. §440.134 (1997). In order to utilize a managed care arrangement, the employer/carrier was required to file a completed application with the agency, along with a payment of a $1,000.00 application fee, and the agency had to be satisfied that the applicant had the ability to provide quality of care consistent with the prevailing professional standards of care. Fla. Stat. §440.134(2)(b) (2003). Effective October 1, 2001, employer/carriers were no longer required to provide medical treatment through a managed care arrangement. However, managed care could continue to be provided on a voluntary basis. Fla. Stat. §440.134(2)(a) (2001). This law remains unchanged with the 2003 amendments, and the criteria governing managed care arrangements are set forth in Section 440.134, Florida Statutes (2011).

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

If the employer/carrier initially chooses to controvert all or a portion of a claim, it must file a Notice of Denial within 14 days after receiving the first report of injury. If a petition for benefits is filed, the employer/carrier has 14 days in which it must either pay the requested benefits (without prejudice to its right to deny within 120 days of receipt of the petition), or file a Notice of Denial with the Division. A carrier that fails to respond to a petition for benefits within 14 days by either filing a Notice of Denial or
providing the benefits requested is considered to have denied the requested benefits. Fla. Stat. §440.192(8) (2011).

If the employer/carrier initially accepts the claim as compensable and provides benefits, but later decides to deny the claim, it must admit or deny compensability within 120 days after the initial provision of compensation or benefits. This is more commonly referred to as the "pay and investigate" provision. The initial provision of compensation or benefits means the first installment of compensation or benefits to be paid by the carrier pursuant to Florida Statutes, Section 440.20(2), or pursuant to a petition for benefits. Fla. Stat. §440.20(4) (2011). An employer/carrier that does not deny compensability within 120 days is deemed to have accepted the accident (but not necessarily all injuries or treatment claimed) as compensable, unless it can establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation within the 120 day period. Fla. Stat. §440.192(8) (2011); see also Checkers Restaurant v. Wiethoff, 925 So. 2d 348 (Fla. 1st DCA 2006).

46. **What is the method of claim adjudication?**

   **A. Mediation and trial court.**

   A mediation conference must be held within 130 days after a Petition for Benefits is filed. Fla. Stat. §440.25(1) (2011). The parties are given at least 60 days to conduct discovery and a final hearing must be held and concluded within 90 days after the mediation. The final hearing shall be held within 210 days after receipt of the Petition for Benefits in the county where the injury occurred. Fla. Stat. §440.25 (2011). The adjudicators of all workers’ compensation claims in Florida are Judges of Compensation Claims.

   **B. Appeals.**

   Decisions of the Judges of Compensation Claims can be appealed by either party to the First District Court of Appeals in Tallahassee, Florida, by filing a Notice of Appeal within 30 days of the date copies of the order are mailed to the parties. Fla. R. App. P. 9.180(b)(3) (1997). Benefits that are specifically appealed may be withheld pending the outcome of the appeal. All other benefits ordered to be paid, but not appealed, must be paid as ordered. Fla. R. App. P. 9180(d). Decisions of the First District Court of Appeals are appealed to the Supreme Court of Florida as provided by the Appellate Rules of Procedure.

47. **What are the requirements for stipulations or settlements?**

   If a claimant is unrepresented, the parties can enter into a lump sum settlement of all benefits if the claimant has reached maximum medical improvement or if the employer/carrier has filed a Notice of Denial within 120 days after the employer receives notice of the injury. Fla. Stat. §440.20(11) (2011). Settlements reached under Sections 440.20(11)(a) and (b) must be approved by a Judge of Compensation Claims, who must find that the settlement is in the best interests of the claimant.

   When a claimant is represented by counsel, he or she may waive all rights to any and all benefits under Chapter 440, Florida Statutes, by entering into a settlement agreement releasing the employer and the carrier from liability for workers' compensation benefits in exchange for a lump sum payment to the claimant. This type of settlement does not require that the claimant have reached maximum medical improvement and only requires approval by the Judge of Compensation Claims as to the amount of the attorney's fees paid to the claimant's attorney and as to whether the settlement provides for appropriate recovery of any child support arrearage. Neither the employer nor the carrier is responsible for any attorney's fees relating to the settlement and/or release of claims. Fla. Stat. §440.20(11)(c) (2011).

   Effective October 1, 2001, the Judge of Compensation Claims must consider whether a settlement provides for appropriate recovery of any child support arrearage. This applies to all settlements regardless of whether or not the claimant is represented by an attorney. Fla. Stat. §440.20(11)(d) (2011).

48. **Are full and final settlements with closed medical available?**
49. **Must stipulations and/or settlements be approved by the state administrative body?**

Settlements where the claimant is unrepresented must be approved by the Judge of Compensation Claims. Fla. Stat. §440.20(11)(a)(b) (2011). However, settlements where the claimant is represented by an attorney only require approval from the Judge of Compensation Claims as to the amount of attorney’s fees and child support being paid. Fla. Stat. §440.20(11)(c) (2011). The proceeds from a settlement must be paid within 14 days after the Judge of Compensation Claims mails the order approving the attorney’s fees. Fla. Stat. §440.20(11)(c) (2011).

### RISK FINANCE FOR WORKER'S COMPENSATION

50. **When is workers’ compensation insurance required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

All private employers not in the construction industry with more than 4 employees must secure workers compensation coverage. Fla. Stat. §440.02(17)(b) (2006). Non-construction employers with less than 4 employees may voluntarily come under the Florida Workers’ Compensation Act by securing coverage. However, they are not required to. Employers in the construction industry are required to carry workers’ compensation coverage regardless of how many employees they have. Fla. Stat. §440.02(17)(b) (2006). Employers can secure workers’ compensation coverage by either buying an insurance policy directly or through an association or by qualifying as a self-insurer. Fla. Stat. §440.38 (2004).

51. **What are the provisions/requirements of self-insurance?**

Employers within the scope of Section 440.38(6) are deemed to be self-insured unless they elect to procure and maintain a policy of insurance. All other individual employers shall qualify for self-insurance under Section 440.38(1)(b), and must have and maintain a minimum net worth of $1,000,000.00, have at least 3 years of financial statements or summaries in the name of the applicant, provide a copy of the Amended Articles of Incorporation if the name of the business has changed in the last 3 years, and have the financial strength to ensure the payment of current and estimated future compensation claims when due, as determined through review of their financial statement or summary by the division. Fla. Admin. Code R. 69L-5.102 (2006). All self-insurers must join the Florida Self-Insurers Guaranty Association which takes over the handling of an employee’s claim if the self-insured employer becomes insolvent. Fla. Stat. §440.385 (2011).

52. **Are "illegal aliens" entitled to workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within definition of "employee"?**

Florida’s definition of "employee" includes aliens. Fla. Stat. §440.02(15)(a) (2006). The First District Court of Appeals has held that the statutory definition of "employee" includes illegal aliens and that same are not precluded from receiving workers’ compensation benefits. See Cenvill Development Corp. v. Candelo, 478 So. 2d 1168 (Fla. 1st DCA 1985); Safeharbor Employer Services I, Inc. v. Cinto, 860 So. 2d 984 (Fla. 1st DCA 2003). However, effective October 1, 2003, the Act was amended to provide that providing false information about a person’s identity in order to obtain employment constitutes a felony. Fla. Stat. §440.105(2) (2010). The First District Court of Appeals analyzed this section in conjunction with Section 440.09(4), which states that an employee is not entitled to compensation under the act if a Judge of Compensation Claims determines that the employee has knowingly and intentionally engaged in any of the acts described in Section 440.105 or any criminal act for the purpose of securing workers’ compensation benefits. Matrix Employee Leasing v. Hernandez, 975 So. 2d 1217 (Fla. 1st DCA 2008). In Hernandez, the claimant, who presented false identification for obtaining employment, was not precluded from obtaining workers’ compensation benefits because, although he was in clear violation of Section 440.105, he did not do so for the purpose of securing workers’ compensation benefits.
Of note, the First DCA has held that a claimant’s unreported income to the I.R.S. did not constitute "wages" for the purpose of calculating the claimant’s AWW under the Act. Fast Tract Framing, Inc. v. Caraballo, 994 So. 2d 355 (Fla. 1st DCA 2008). In Caraballo, the claimant received cash payments from an employer, which were not reported to the I.R.S., while also receiving Social Security Disability benefits. "Wages" as defined by Section 440.02(28), Florida Statutes, includes "wages earned and reported for federal income tax purposes" and, therefore, any earnings not reported to the I.R.S. would not fall within the definition of "wages" for the purpose of determining AWW under Section 440.14, Florida Statutes. Although the Caraballo case did not specifically involve an illegal alien, Judge Padavano dissented from the majority’s opinion, stating that he feared the decision may encourage employers to hire undocumented aliens and compensate them with unreported cash payments, thereby avoiding the provision of compensation for workplace injuries. Judge Padavano also indicates that the majority’s interpretation of the term "wages" is at odds with the statutory definition of the term "employee" which includes undocumented aliens. He stated, "[a] worker who is unlawfully employed would be qualified to receive benefits, but he could succeed in obtaining benefits only if he were to report the existence of his unlawful employment to the government. The worker would be covered only in a theoretical sense. As a practical matter, the employer would never have to pay." Id. at 359. Despite Judge Padavano’s opinion on dissent, the majority’s decision remains the binding authority on this issue. See Centimark Corp. v. Gonzalez, 10 So. 3d 644 (Fla. 1st DCA 2009). The First DCA addressed this issue again in a case where they distinguished Fast Tract and Gonzalez. The claimant, although undocumented, filed forms with the IRS disclosing his wages. The employer argued he did not properly comply with the tax code and, therefore, did not meet the reporting requirements of the statute. The court disagreed, finding that the employee was entitled to benefits because reported his income. See Rene Stone Work Corp. v. Gonzalez, 25 So. 3d 1272 (Fla. 1st DCA 2010).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles applicable to injuries by other third parties. There is no specific exclusion for injuries as a result of terrorist acts.

54. Are there state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

There are no state specific requirements under the Workers’ Compensation Act with regard to the parties’ obligation to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act. However, under the Medicare regulations, Medicare is the secondary payer concerning the payment of workers’ compensation by an employer/carrier. 45 C.F.R. Part 411.1, et seq. The obligation to pay medical benefits for a compensable condition cannot be shifted to Medicare. Therefore, Medicare’s interests must be taken into account in all lump sum settlements, regardless of whether the employee is a Medicare recipient. Further, any settlement in which Medicare is an issue must account for any claim Medicare may have for medical bills it has already paid as "conditional payments" in its role as "secondary payer." 42 U.S.C. §1395y. In addition, while Medicare’s interest must be considered in all settlements, Medicare approval of a Medicare set aside trust must only be obtained if the settlement amount exceeds $25,000.00 and, at the time of the settlement, the employee meets the following criteria:

(1) the employee has already qualified to receive Medicare benefits; or

(2) there is a reasonable expectation that the employee will become qualified for Medicare within 30 months of the settlement and the settlement amount is greater than $250,000.00.

Medicare has several options and sanctions for not taking its interests into consideration, including pursuing the employee, the employer/carrier and the attorneys for benefits that it is required to pay in the future, plus double damages and interest.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?
The Federal Medicaid statute requires states to include in its plan for medical assistance provisions (1) that the individual will assign to the state any rights to payment for medical care from any third party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The state is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

In Florida, Medicaid is to be considered the payer of last resort. Should Medicaid make payments that are later determined to be covered under workers’ compensation, Medicaid is entitled to a full recovery of any benefits paid on behalf of the Medicaid recipient. Fla. Stat. §409.910 (2010).

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512. Therefore, it is permissible under Florida law to obtain medical records in relation to workers’ compensation claims. In addition, Florida law provides that there shall be reasonable access to medical information by all parties in a workers’ compensation case. An employee who reports a work related injury waives any physician-patient privilege with respect to any condition or complaint reasonably related to the condition for which the claimant is seeking compensation. Fla. Stat. §440.13(4)(c) (2008). Therefore, employers, carriers and their representatives (including attorneys) have the statutory right to meet with the employee’s authorized treating physicians and discuss the employee’s compensable conditions without notice to, or the presence of, the employee and/or his attorney.

However, an exception to the above applies for medical records dealing with a claimant’s HIV testing or treatment. The law prohibits disclosure of HIV or AIDS tests or results without written authorization from the claimant or an order from the Judge of Compensation Claims. Fla. Stat. §381.004 (2008).

57. What are the provisions for "Independent Contractors"?

In general, independent contractors, except those in the construction industry, are not employees and, therefore, an independent contractor not in the construction industry is not eligible for benefits from the hiring entity. On the other hand, independent contractors in the construction industry are considered to be employees of the hiring entity and are eligible for benefits. This rule essentially means that there is no such person as an “independent contractor” in the construction industry. Fla. Stat. §440.02(15)(c)3. (2006).

Prior to January 1, 2004, the law provided that independent contractors were not considered "employees" under the Act if they met all of the following conditions:

(1) maintains a separate business with its own work facility, truck, equipment, materials or similar accommodations;

(2) holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to do so;

(3) does, or agrees to do, specific services or work for specific amounts of money and controls the means of doing the services;

(4) incurs the principal expenses related to the services;

(5) is responsible for the satisfactory completion of work or services and is or could be held liable for failure to complete same;
(6) receives compensation for work or services done for a commission or on a per-job or competitive bid basis and not on any other basis;

(7) may realize a profit or suffer a loss concerning the work or services;

(8) has continuing or recurring business liabilities or obligations; and

(9) the success or failure of the independent contractor’s business depends on the relationship of the business receipts to expenditures.


Effective January 1, 2004, an individual is considered an independent contractor if at least four of the following criteria are met:

(1) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

(2) The independent contractor holds or has applied for a federal employer identification number, unless the individual is a sole proprietor who is not required to obtain same;

(3) The independent contractor receives compensation for services rendered or work performed and such compensation is paid to a business rather than an individual;

(4) The independent contractor holds one or more bank accounts in the name of the business entity for the purposes of paying business expenses or other expenses related to services rendered or work performed for compensation;

(5) The independent contractor performs work or is available to perform work for any entity in addition to or besides the employer at his own election without the necessity of completing an employment application or process; or

(6) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement unless such agreement expressly states that an employment relationship exists.

Fla. Stat. §440.02(15)(d)1.a. (2006). If four of these criteria do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

(1) the independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work;

(2) the independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform;

(3) the independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform;

(4) the independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis;

(5) the independent contractor may realize a profit or suffer a loss in connection with performing work or services;

(6) the independent contractor has continuing or recurring business liabilities or obligations;
(7) The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.

Fla. Stat. §440.02(15)(d)1.b. (2006). An individual claiming to be an independent contractor has the burden of providing that he or she is an independent contractor. Fla. Stat. §440.02(15)(d)1.c. (2006).

58. Are there any specific provisions for "Independent Contractors" pertaining to professional employment organizations/temporary service companies/leasing companies?

There are no provisions specifically addressing "independent contractors" with regard to professional employment organizations/temporary service companies/leasing companies. However, the Act provides that, when an employer leases its workers from an employee leasing company, the leased workers are considered borrowed employees of the employer. The actual employer/client company is responsible for providing the workers' compensation coverage if the leasing company does not do so. Fla. Stat. §440.11(2) (2003). In addition, statutory immunity extends to employers who lease their workers from employee leasing companies and the fact that the leasing company may provide the workers' compensation coverage does not alter the actual employer’s immunity status. Id. The First DCA looked into this issue in Crum Services v. Lopez, 975 So. 2d 1184 (Fla. 1st DCA 2008). In Lopez, the leasing company was responsible for providing payroll services and workers’ compensation benefits for the employees it leased to the contractor. However, the roofing worker in Lopez was hired directly by the contractor and never filled out any employment forms for the contractor or leasing company. Therefore, he was found to have no employer/employee relationship with leasing company. Because the leasing company was only required to provide workers’ compensation coverage for those individuals with whom it had an employer/employee relationship, it was not required to provide workers’ compensation benefits to the worker. In addition, the leasing company was not a contractor under the statutory employee provision of the Act and, therefore, could not be the statutory employer of the roofing worker hired by the contractor.

59. Are there any specific provisions for "Independent Contractors" pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Individuals are considered "independent contractors" only if they meet the provisions listed above. However, the Act sets forth specific provisions as to whether owner-operators of trucks or other vehicles for the delivery of people or property are considered "employees" and are covered under the Act.

Pursuant to Section 440.02(15)(d)4. (2006), the term "employee" under the Act does not include an owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish motor vehicle equipment as identified in the written contract and the principal costs incidental to the performance of the contract including, but not limited to, fuel and repairs, provided a motor carrier’s advance of costs to the owner-operator when a written contract evidences the owner-operator’s obligation to reimburse such advance shall be treated as the owner-operator furnishing such cost and the owner-operator is not paid by the hour or on some other time-measured basis. Fla. Stat. §440.02(15)(d)4. (2006). Therefore, the owner-operator is excluded from receiving workers’ compensation benefits if the owner-operator transports property under a written contract with the motor carrier that contains all of the above provisions.

The term "employee" also does not include a taxicab, limousine, or other passenger vehicle-for-hire driver who operates the vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues. Fla. Stat. §440.02(15)(d)10. (2006).

60. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?
There are no state specific requirements under the Workers’ Compensation Act with regard to the parties’ obligation to satisfy Medicare’s interests when settling the right to medical treatment benefits. 3

61. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Florida passed the Medical Marijuana Initiative (Amendment 2), Art. X §28, Fla. Const., on November 8, 2016, effective January 3, 2017. Section 381.986, Fla. Sta., Medical Use of Marijuana became effective on June 23, 2017. Under section 381.986 provides stringent requirements before medical marijuana is prescribed to a patient, such as: being diagnosed with one of the enumerated medical conditions within the statute, and being evaluated by a qualified physician or medical director who is eligible to prescribe medical marijuana.

Under Florida Worker’s Compensation law, recently a Judge of Compensation Claims has ruled that without complying with the requirements of section 381.986, a claimant is not entitled to medical marijuana as a benefit. The court has not commented on work and activity restrictions, as the issue has not yet been presented to the court. Greenfield v. City of Tallahassee & Tallahassee Police Dept., Tallahassee District Office, Judge John J. Lazzara, OJCC No. 12-025601JJL (Dec. 6, 2017).

62. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

The State of Florida does not permit the recreational use of marijuana.

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3 As stated in the Answer to Question 54, Medicare is the secondary payer, and as such, the obligation to pay medical benefits cannot be shifted to Medicare. Medicare’s interests, therefore, must be taken into account in all lump sum settlements, regardless of whether the claimant receives Medicare. Medicare approval of a Medicare set aside trust must only be obtained if the settlement amount exceeds $25,000.00. See answer to Question 54 for more information regarding this.
1. **Citation for the state's workers' compensation statute.**


**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers' compensation?**

   Covered employees are generally those who are hired to work for employers with three (3) or more full or part-time employees. Officers of corporations may elect to be exempt from coverage by providing written notice to the insurer or, if there is no insurer, to the State Board of Workers’ Compensation. O.C.G.A. § 34-9-2.1. Specifically, if the employer’s business is incorporated, the corporation is considered to be the employer and all active officers are considered to be employees of the business. As many as five officers may waive coverage on themselves. However, by waiving coverage on themselves, the officers do not exempt themselves from being counted in the "three or more employees" rule, unless the exemptions reduce the employee count to zero. O.C.G.A. § 34-9-2.1(a)(3); Hitchcock v. Jack Wiggins, Inc., 249 Ga. App. 845, 848, 549 S.E.2d 806 (2001). In contrast, sole proprietors and partners in partnerships are considered to be *employers*, not employees. Therefore, these people are not counted in the “three or more employee computation.” However, they can elect to be covered as an
employee by advising the business’s insurance carrier. O.C.G.A. § 34-9-2.2.

An "employee" is broadly defined as any person under the employ of another, under any contract of hire or apprenticeship, written or implied, except for a person whose employment is not in the usual course of the trade, business, occupation, or profession of the employer. O.C.G.A. § 34-9-1. The fact that an employee is not paid for services rendered does not, in and of itself, prohibit that person from being an employee. If the employer retains the right to control the time, manner, and method of performing the work and receives valuable services from the worker, the worker can still be an employee. Housing Auth., City of Cartersville v. Jackson, 226 Ga. App. 182, 183-84, 486 S.E.2d 54 (1997); MCG Health, Inc. v. Nelson, 270 Ga. App. 409, 413, 606 S.E.2d 576 (2004).

The exclusions from coverage under the Act are codified in O.C.G.A. § 34-9-2. Generally, the following categories of employment are excluded from coverage: (i) rail common carriers engaged in interstate or intrastate commerce (O.C.G.A. § 34-9-2(a)(2)-(3)); (ii) farm laborers (which term has been given a very broad interpretation; see Glen Oak's Turf, Inc. v. Butler, 191 Ga. App. 840, 383 S.E.2d 203 (1989)); (iii) domestic servants: (iv) licensed real estate salespeople or associate brokers; and (v) independent contractors who fall under the statutory definition of O.C.G.A. § 34-9-2(c). Employees and their employers can voluntarily accept the provisions of the Act, despite any statutory exemption. Farm laborers are allowed to do so by a specific statute. O.C.G.A. § 34-9-2.3.

3. Identify and describe any "statutory employer" provision.

O.C.G.A. § 34-9-8. Generally, the issue arises in the context of construction contractors. If the immediate employer does not regularly have three employees, then the claim may be presented to the intermediate or principal contractor. The intermediate or principal contractor also must meet the numerical qualification. Bradshaw v. Glass, 252 Ga. 429, 431, 314 S.E.2d 233 (1984); G & M Quality Builders, Inc. v. Dennison, 256 Ga. 617, 618, 351 S.E.2d 622 (1987).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

In order for a claim to be compensable it must be an "accident arising out of and in the course of employment." O.C.G.A. § 34-9-1(4). Almost any physical injury is considered covered if it occurs: (i) within the period of employment; (ii) at a place where the employee reasonably may be in the performance of duties; and (iii) while the employee is fulfilling the duties or engaged in an activity incidental thereto. Coleman v. Columns Props., Inc., 266 Ga. 310, 311, 467 S.E.2d 328 (1996).

B. Super added injuries.
"Super-added injuries," subsequent injuries that are caused by the worker's compensation injury, are compensable as part of the total disability calculation. City of Buford v. Thomas, 179 Ga. App. 769, 774, 347 S.E.2d 713 (1986). See also Noles v. Aragon Mills, 116 Ga. App. 560, 158 S.E.2d 261 (1967); Clark v. Liberty Mut. Ins. Co., 108 Ga. App. 806, 807, 134 S.E.2d 534 (1963); Fieldcrest Mills, Inc. v. Richard, 141 Ga. App. 702, 703, 234 S.E.2d 345 (1977) (each discussing super-added injuries resulting "in consequence of" or "as a consequence of" the initial injury). The Georgia Court of Appeals has held that “[a]n employee sustains a compensable superadded injury when, as a result of a work-related disability to one part of the body, the employee suffers a disabling injury to another part of the body.” Lowndes County Bd. of Comm’rs v. Connell, 305 Ga. App. 844, 850 (2), 701 S.E.2d 227 (2010); Baugh-Carroll v. Hosp. Auth. of Randolph County, 248 Ga. App. 591, 595 (2), 545 S.E.2d 690 (2001). For example, in Baugh-Carroll, a former nurse had sought compensation for "unbearable pain" in her second knee, which was determined by the Board of Workers’ Compensation to have been "at least aggravated, if not caused, by her original on-the-job accident and injury to her first knee years before. On appeal, the Georgia Court of Appeals held that the evidence supported the Board’s finding that the nurse had suffered a compensable super-added injury. Baugh-Carroll, 248 Ga. App. at 595, 545 S.E. 2d at 694. See also W. Point Pepperell, Inc. v. Baggett, 139 Ga. App. 813, 229 S.E.2d 666 (1976) (affirmed award of the Board of Workers’ Compensation which included compensation for the superadded injury of the development of acute schizophrenia resulting from the claimant’s original, work-related physical injury).

C. Occupational disease (including respiratory and repetitive use).

The occupational disease statute was drastically changed, both substantively and procedurally, in 1987. For claims arising after that date the law is less technical and requires proof of the following essential elements: (1) a direct causal connection between the conditions under which the work is performed and the disease; (2) the disease followed as a natural incident of exposure by reason of the employment; (3) the disease is not of a character to which the employee may have had substantial exposure outside of the employment; (4) the disease is not an ordinary disease of life to which the general public is exposed; and (5) the disease must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence. O.C.G.A. § 34-9-280(2).

Such a claim must be made within one year after the employee knew or in the exercise of reasonable diligence should have known of both the disablement and its relationship to the employment. O.C.G.A. § 34-9-281(b)(2). The claim will also be barred if it is not filed within seven years from the date of the last injurious exposure. Id. Georgia statutory law specifically provides that an employee with asbestosis or mesothelioma related to exposure to asbestos, however, must file any claim for disablement within one year from the date of first disablement after diagnosis of such disease. Id. In any event, in cases of death where the cause of action was not barred during the employee's life, the claim must be filed within one year of the date of death. Id. Additionally, in order to be a compensable injury under the Workers’ Compensation Act, the disease must arise out
of and in the course of the employment; it must be contracted while the employee is so engaged; and it must result from a hazard characteristic of the employment in excess of the hazards of such disease attendant to employment in general. O.C.G.A. § 34-9-281(b)(1).

D. **Aggravation of pre-existing injury.**

An aggravation of a pre-existing injury is also compensable but only so long as the aggravation continues to be the cause of the claimant’s disability. O.C.G.A. § 34-9-1(4).

5. **What, if any, injuries or claims are excluded?**

Several situations can remove an injury from the covered "arising out of" category, such as the following:

A. **Deviation from the employee’s regular job at time of injury.**

“[W]here the employee steps aside from his employer's business to do some act of his own, not connected with his employer's business, the relationship of employer and employee, or master and servant, is, as to that act, completely suspended, and an accident occurring at that time, resulting in injury to the employee, does not arise out of the employment within the meaning of the Workmen's Compensation Act.” S. Ga. Timber Co. v. Petty, 218 Ga. App. 497, 498, 462 S.E.2d 176 (1995); Stokes v. Coweta County Bd. of Ed., 313 Ga. App. 505, 509, fn. 5 (2012). In Petty, for example, the Georgia Court of Appeals held that where an employee was abducted at knifepoint, her resultant injury did not arise out of the course of her employment for workers' compensation purposes because the employee's abduction occurred a substantial distance away from any place she would have been on the business of her employer, the deviation was to conduct personal business, and she had not yet resumed her duties to her employer at the time she was attacked. Petty, 218 Ga. App. at 498-99.

B. **Practical jokes and “horseplay.”**


C. **Willful misconduct, attempts to injure others, or willful failure to use safety appliance or perform duty required by statute.**

Any injury or death is not compensable if it results from the employee's willful misconduct, including intentionally self-inflicted injury, or growing out of his or her
attempt to injure another, or from a willful failure or refusal to use a safety appliance or to perform some duty required by statute. O.C.G.A. § 34-9-17(a). An employee’s commission of a criminal act generally is considered “willful misconduct.” See Roy v. Norman, 261 Ga. 303, 304, 404 S.E.2d 117 (1991); Aetna Life Ins. Co. v. Carroll, 169 Ga. 333, 343, 150 S.E. 208 (1929). Specifically, the Georgia Supreme Court has defined “willful misconduct” as “conduct of a criminal or quasicriminal nature, the intentional doing of something, either with the knowledge that it is likely to result in serious injury, or with the wanton and reckless disregard of its probable consequences.” Roy, 261 Ga. at 304. By contrast, mere negligence, gross negligence, “inadvertent, unconscious, or involuntary violations” of statutes, instructions, orders, rules, or ordinances, and even the commission of hazardous acts with respect to which the resultant danger is obvious, do not constitute willful misconduct or willful failure to perform a duty required by statute. Id.; Carroll, 169 Ga. at 333-34. Similarly, traffic violations such as excessive speeding generally are not considered to amount to “willful misconduct.” See Ga. Dep’t of Pub. Safety v. Collins, 140 Ga. App. 884, 886, 232 S.E.2d 160 (1977). But see Young v. Am. Ins. Co., 110 Ga. App. 269, 270, 138 S.E.2d 385 (1964) (holding that employee’s act of driving approximately 100 miles per hour after being asked by a coworker to slow down constituted willful misconduct).

D. Accidents occurring while employee is traveling to or from work.


However, this rule does not apply, and an injury will be deemed to have arisen from the course and scope of employment, under the following circumstances: (i) where the employer furnishes transportation to the employee; (ii) where the employee is doing some act permitted or required by the employer and beneficial to the employer while en route to and from work; (iii) where the employee is going to and from parking facilities provided by the employer (often called the “parking lot” exception); (iv) where an employee is “on call” and furnishes or is reimbursed for his transportation costs; (v) where the employee is engaged in a “special task” for the employer; or (vi) where the employee is required to travel as part of his employment. Collie, 272 Ga. App. at 580 (1); Harrison v. Winn Dixie Stores, Inc., 247 Ga. App. 6, 7-8, 542 S.E.2d 142 (2000); Corbin, 117 Ga. App. at 823; Employer’s Liab. Assurance Corp. v. Pruitt, 63 Ga. App. 149, 10 S.E.2d 275 (1940) (discussing scope of employment with regard to a “traveling” employee).

The “parking lot” exception does not apply, and workers’ compensation benefits have been held to be unavailable, with respect to injuries sustained going to or from, or while an employee is on, any parking lot not owned, controlled, or maintained by the employer.

E. Accidents occurring during “lunch breaks” or other breaks from work.

An injury is compensable where it arises from an accident occurring while an employee is on a scheduled lunch break (or other scheduled break) and is not involved in any activity in furtherance of the employer’s business, as long as the worker is free to leave the employer's premises during lunch break. Ocean Accident & Guar. Corp. v. Farr, 180 Ga. 266, 178 S.E. 728 (1935). See also Coe v. Carroll & Carroll, Inc., 308 Ga. App. 777, 783 (2), 709 S.E.2d 324 (2011). But see Edwards v. State, 173 Ga. App. 87, 325 S.E.2d 437 (1984) (holding that claimant was acting within scope of employment when she fell while picking up lunch for her supervisor). By contrast, "if an employer . . . operates a cafeteria on its premises, in the immediate vicinity of the work, at which its employees are, expressly or by fair implication, invited to eat, and they accept the invitation by using the facilities provided, the relation of master and servant is not temporarily suspended during the noon hour of such employees." Holman v. Am. Auto Ins. Co., 201 Ga. 454, 459, 39 S.E.2d 850 (1946).

The general rule in this regard is that “where a scheduled rest break or lunch break is provided to employees during which the employee is free to use the time as he chooses, making it personal to him, an injury occurring during the break period arises out of an individual pursuit and not out of his employment and is not compensable.” ATC Healthcare Serv., Inc. v. Adams, 263 Ga. App. 792, 793, 589 S.E.2d 346 (2003); Home Indem. Co. v. Swindle, 146 Ga. App. 520, 520, 246 S.E.2d 507 (1978); Wilkie v. Travelers Ins. Co., 124 Ga. App. 714, 715, 185 S.E.2d 783 (1971). But see Rockwell v. Lockheed Martin Corp., 248 Ga. App. 73, 73, 545 S.E.2d 121 (2001) (“Where the employee is still on her employer's premises in the act of egressing those premises, even if on break, then the Workers' Compensation Act does apply.”). By contrast, "if the employee sustains an injury while conducting the employer's business or following job-related instructions during the ‘break,’ the injury is compensable” as a work-related injury. Swindle, 146 Ga. App. at 520; Wilkie, 124 Ga. App. at 715. See also Employer’s Mut. Ins. Co. v. Carlan, 104 Ga. App. 170, 121 S.E.2d 316 (1961).


F. Idiopathic injuries.

To be compensable, there must be a causal connection between the employment and the injury and the injury must be the rational consequence of some hazard connected to the
employment.  Harris v. Peach County Bd. of Comm’rs, 296 Ga. App. 225, 227, 674 S.E.2d 36 (2009); Davis v. Houston Gen. Ins. Co., 141 Ga. App. 385, 233 S.E.2d 479 (1977). Thus, even where an injury occurs at the employee’s place of employment, the injury will not be compensable for workers’ compensation purposes if it “can not fairly be traced to the employment as a contributing proximate cause and [it] comes from a hazard to which the workman would have been equally exposed apart from the employment.” Harris, 296 Ga. App. at 227; Davis, 141 Ga. App. at 386.

Hernias, however, are treated differently under Georgia workers’ compensation law. See O.C.G.A. § 34-9-266. For a hernia to be deemed a compensable injury, the burden generally is on the employee to definitely prove that the hernia: (i) resulted from an injury; (ii) appeared suddenly; (iii) was accompanied by pain; (iv) immediately followed an accident; and (v) was not pre-existing. Id.

Similarly, heart disease, heart attack, failure or occlusion of any coronary blood vessel, stroke, or thrombosis will only be deemed compensable for workers’ compensation purposes where it is shown “by a preponderance of competent and credible evidence, which shall include medical evidence,” that such injury or condition is attributable to the performance of the employee’s usual work or employment. O.C.G.A. § 34-9-1(4).

6. What psychiatric claims or treatments are compensable?

Under Georgia workers’ compensation law, psychological injury is compensable, if two conditions are satisfied: (i) the psychological injury arises out of an accident in which a compensable physical injury was sustained; and (ii) while the physical injury need not be the precipitating cause of the psychological condition or problems, at a minimum, the physical injury must contribute to the continuation of the psychological trauma. DeKalb County Bd. of Educ. v. Singleton, 294 Ga. App. 96, 100, 668 S.E.2d 767 (2008); Abernathy v. City of Albany, 269 Ga. 88, 88-89, 495 S.E.2d 13 (1998). See also The Coca-Cola Co. v. Parker, 297 Ga. App. 481, 677 S.E.2d 361 (2009). While non-trauma induced illnesses or injuries are not generally compensable, long-term, stress-type claims may be compensable as “occupational disease.” See O.C.G.A. § 34-9-280.

7. What are the applicable statutes of limitations?

A claim is barred unless filed within one year after the injury, or within one year after the last medical treatment provided by the employer, unless payment of weekly benefits has been made, in which case the claim may be filed within one year after the date of the last remedial treatment or within two years after the date of the last payment of weekly benefits. O.C.G.A. § 34-9-82(a). In death cases, any claim must be filed within one year after death. O.C.G.A. § 34-9-82(b). Any statute of limitation defense must be raised at the first hearing or else will be deemed to have been waived. Board Rule 82. See also Section 27 below. Additionally, there is a four-year statute for permanent partial disability benefits. O.C.G.A. § 34-9-104(b).

8. What are the reporting and notice requirements for those alleging an injury?
Notice must be given within 30 days after an accident. O.C.G.A. § 34-9-80. Exceptions to this requirement exist where: (i) the employee is prevented from giving notice by reason of physical or mental incapacity, or by reason of fraud or deceit by the employer; (ii) the employer, agent, representative, or supervisor knew of the accident; or (iii) there is a reasonable excuse made to the satisfaction of the Board, and the employer was not prejudiced by the lack of notice. See Id. The employee does not need to give notice of a claim; notice of an injury alleged to have occurred at work is sufficient. Jones v. Fieldcrest Mills, Inc., 162 Ga. App. 848 (1982). Notice has been deemed insufficient where the employee merely reported that he was returning to work after a heart attack, when no symptoms of the heart attack were apparent at work and where he did not give any indication to his employer that he would seek benefits for the same. Schwartz v. Greenbaum, 138 Ga. App. 695 (1976).

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

Self-inflicted injuries are not compensable. O.C.G.A. § 34-9-17(a). See also Section 5.C. above.

B. Willful misconduct, "horseplay," etc.

Injuries arising out of willful misconduct, assaults, or willful failure to use a safety appliance or perform a duty required by statute are not compensable under workers’ compensation. O.C.G.A. § 34-9-17(a). See also Section 5.C. above.

C. Injuries involving drugs and/or alcohol.

No compensation is allowable under Georgia’s Workers’ Compensation Act for injury or death due to alcohol intoxication or being under the influence of marijuana or a controlled substance, except where the substance was prescribed for the employee and taken by the employee in accordance with the prescription. O.C.G.A. § 34-9-17(b). There arises a rebuttable presumption that an accident was caused by an employee’s consumption of alcohol and/or drugs where: (i) the amount of alcohol in an employee's blood within three (3) hours of the time of the accident exceeds .08 grams (per liter); (ii) any amount of marijuana or controlled substance is in the employee's blood within eight (8) hours of the time of the accident; or (iii) the employee refuses to submit to a reliable scientific test to determine the presence of alcohol or a controlled substance in the employee’s blood, urine, breath or other bodily substance. O.C.G.A. § 34-9-17(b). Drug addiction or disabilities resulting therefrom are compensable only when the addiction or disability results from the use of medication provided by the treating physician for the original work injury. O.C.G.A. § 34-9-1(4).

10. What, if any, penalties or remedies are available in claims involving fraud?
Attorney’s fees and reasonable litigation expenses may be assessed against a party if it is
determined that the proceedings have been brought, prosecuted, or defended in whole or
in part without reasonable grounds. O.C.G.A. § 34-9-108(b)(1), (b)(4). The “reasonable
litigation expenses” that may be recovered are limited to witness fees and mileage,
reasonable expert witness fees, reasonable deposition transcript costs, and the cost of the

In addition, the Board has the authority to assess a civil penalty between $1,000.00 and
$10,000.00 in the event it determines that anyone has intentionally made a false or
misleading statement to obtain or to attempt to deny benefits. O.C.G.A. §§ 34-9-18(b),
34-9-19. A civil penalty of between $500.00 and $5,000.00 also may be assessed against
any employer who fails to carry insurance or to file proper insurance forms with the
Board, and the fraud unit even may seek criminal prosecution in such instances.
O.C.G.A. §§ 34-9-18(c), 34-9-121, 34-9-126(a).

In the event that an employer fails to comply with any provision regarding the “Method
of Payment” under O.C.G.A. § 34-9-221, absent reasonable grounds for such failure, if a
claimant thereafter retains an attorney to enforce his rights and subsequently prevails on
such claim, the Board may determine and assess against the employer the reasonable
quantum meruit fees of the attorney, as well as the costs of the proceedings. O.C.G.A. §
34-9-108(b)(2).

Regarding fraud by misrepresentation of a physical condition in an application for
employment, see Section 11 below.

11. Is there any defense for falsification of employment records regarding medical
history?

Fraud by misrepresentation of physical condition by an employee in an application for
employment can serve as a complete defense to a subsequent workers' compensation
111 (1989). The conditions which must be met in such instance are: (i) the employee
knowingly and willfully made a false representation as to his physical condition; (ii) the
employer relied upon the employee’s false representation and this reliance was a
substantial factor in hiring the employee; and (iii) there was a causal connection between
the employee’s false representation and his injury. Caldwell, 267 Ga. at 613. There is
some authority suggesting that such misrepresentations may be actionable even if oral,
(1992). Moreover, no compensation is payable for an occupational disease if the
employee falsely represents in writing to the employer that he or she has not been
previously disabled, laid-off, or compensated in damages or otherwise because of such

Note, however, that the sufficiency of this defense is in question now that the Subsequent
Injury Trust Fund no longer exists.
12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

“Recreational or social activities are within the course of employment, and thus subject to the Workers' Compensation Act, if (i) they occur on work premises during a lunch or recreation period as a regular incident of employment, or (ii) employee participation is required, either expressly or by implication, or (iii) the employer derives a substantial benefit from the event beyond the improvement in employee health and morale that is common to all kinds of recreational or social activities.” Pizza Hut of Am., Inc. v. Hood, 198 Ga. App. 112, 112 (1), 400 S.E.2d 657 (1990); Crowe v. Home Indem. Co., 145 Ga. App. 873, 245 S.E.2d. 75 (1978). See also City Council of Augusta v. Nevils, 149 Ga. App. 688, 689, 255 S.E.2d 140 (1979), citing 1A Larson, Law of Workmen’s Compensation, 5-101, 5-106, § 22.24 (1979 Rev.) (listing four variables which are “useful” in making the determination of whether an employee’s injury while participating in a company-related athletic team is compensable under workers’ compensation).

13. Are injuries by co-employees compensable?

Yes, unless the injury is the result of a willful act for personal reasons. O.C.G.A. §§ 34-9-1, 34-9-17.

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., "irate paramour" claims)?

Generally not. O.C.G.A. § 34-9-1. However, the Georgia Court of Appeals has adopted the “positional risk” theory, which states that if the employment is such as to place the employee in the locale of the peril, then the injury is compensable, even if any other person would have been injured irrespective of employment. See Chaparral Boats, Inc. v. Heath, 269 Ga. App. 339, 342 (1), 606 S.E.2d 567 (2004); Nat’l Fire Ins. Co. v. Edwards, 152 Ga. App. 566, 567 (1), 263 S.E.2d 455 (1979). But see Collie Concessions, Inc. v. Bruce, 272 Ga. App. 578, 584-85, 612 S.E.2d 900 (2005) (rejecting applicability of the “positional risk” doctrine under the peculiar facts of that case).

BENEFITS

15. What criterion is used for calculating the average weekly wage?

As long as the employee in question worked in the same employment for “substantially the whole” of the thirteen (13) weeks immediately preceding the injury, then his average weekly wage is calculated as one-thirteenth (1/13) of the total wages the employee earned during that 13-week period. O.C.G.A. § 34-9-260(1). If the employee was not employed in such capacity for substantially the whole of the previous 13-week period, then the amount of wages of a similarly situated employee during that time period is used. O.C.G.A. § 34-9-260(2). Finally, if neither of the above methods can be “reasonably and fairly” applied to the subject employee, then the full-time weekly wage of the employee
16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The temporary total disability rate is determined on the basis of two-thirds of the employee's average weekly wage, not to exceed $500.00 nor to be less than $50.00 per week. However, when the weekly wage is below $50.00, the employer should pay a weekly benefit equal to the average weekly wage. O.C.G.A. § 34-9-261.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Payment is due on the twenty-first (21st) day after the employer has knowledge of the injury or death, and thereafter on a weekly basis. O.C.G.A. § 34-9-221(b). Payments are considered made when mailed. Id.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out _____ days before recovering benefits for the first _____ days)?**

The employee must be out of work twenty-one (21) consecutive days before recovering benefits for the first seven (7) days of incapacity. O.C.G.A. § 34-9-220.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary benefits are suspended by filing a Form WC2. Benefits may be unilaterally suspended in certain situations such as normal duty work release by the treating physician. If the employee has not returned to work, ten (10) days’ advance notice is required, and benefits must be paid during this period. There are other restrictions, and where the employee's release to return to work is accompanied by restrictions, a hearing and an order of the Board are required except in cases where there has been a statutory "offer of suitable employment" pursuant to O.C.G.A. § 34-9-240. If an employee attempts the new job for fifteen (15) days and is unable to physically perform the new duties, temporary total benefits must be reinstated immediately. Interlocutory orders pending a hearing are available on proper motion.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No. However, an employee is not entitled to benefits for temporary total disability or temporary partial disability at the same time he or she is receiving benefits for permanent partial disability. *But see Cedartown Nursing Home v. Dunn*, 174 Ga. App. 720, 330 S.E.2d 905 (1985) (holding simultaneous payment authorized for separate injuries).

21. **What disfigurement benefits are available and how are they calculated?**
22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

According to O.C.G.A. § 34-9-263(c), for a permanent partial disability claim, the employer must pay weekly income benefits equal to two-thirds (2/3) of the employee's average weekly wage for the number of weeks determined by the percentage of bodily loss or loss of use times the maximum weeks as follows:

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm</td>
<td>225</td>
</tr>
<tr>
<td>Leg</td>
<td>225</td>
</tr>
<tr>
<td>Hand</td>
<td>160</td>
</tr>
<tr>
<td>Foot</td>
<td>135</td>
</tr>
<tr>
<td>Thumb</td>
<td>60</td>
</tr>
<tr>
<td>Index Finger</td>
<td>40</td>
</tr>
<tr>
<td>Middle Finger</td>
<td>35</td>
</tr>
<tr>
<td>Ring Finger</td>
<td>30</td>
</tr>
<tr>
<td>Little Finger</td>
<td>25</td>
</tr>
<tr>
<td>Great Toe</td>
<td>30</td>
</tr>
<tr>
<td>Any other toe</td>
<td>20</td>
</tr>
<tr>
<td>Loss of Hearing, Traumatic:</td>
<td></td>
</tr>
<tr>
<td>One Ear</td>
<td>75</td>
</tr>
<tr>
<td>Both Ears</td>
<td>150</td>
</tr>
<tr>
<td>Loss of Vision (one eye):</td>
<td>150</td>
</tr>
<tr>
<td>Body as a Whole</td>
<td>300</td>
</tr>
</tbody>
</table>

B. Number of weeks for "whole person" and standard for recovery.

There is a 400-week maximum for total disability claims, unless the claim is catastrophic, in which case the weekly benefit shall be paid until the employee undergoes a “change in condition for the better.” O.C.G.A. § 34-9-261. See also O.C.G.A. § 34-9-200.1(g) (defining “catastrophic injury”); O.C.G.A. § 34-9-104(a)(1) (defining “change in condition”).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

No, except for those injuries designated as “catastrophic,” with respect to which vocational rehabilitation is mandatory. O.C.G.A. § 34-9-200.1. There are very detailed rules governing rehabilitation, which rules should be carefully scrutinized in such cases.
and which can be found in O.C.G.A. § 34-9-200.1.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total disability benefits are paid at two-thirds (2/3) of the employee's average weekly wage, not to exceed $500.00 per week nor to be less than $50.00 per week, and shall continue for a period not to exceed 400 weeks from the date of injury. O.C.G.A. § 34-9-261. In the instance of a “catastrophic injury,” the weekly benefit shall be paid until the employee undergoes a “change in condition for the better.” O.C.G.A. § 34-9-261. See also O.C.G.A. § 34-9-200.1(g) (defining “catastrophic injury”); O.C.G.A. § 34-9-104(a)(1) (defining “change in condition”). The average weekly wage is determined as set forth in Section 15 above.

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

Reasonable expenses of the employee’s last sickness and burial are compensable up to $7,500.00. O.C.G.A. § 34-9-265(b)(1). If the employee has no dependents, this is the sole death benefit compensation available. Id.

B. Dependency claims.

Those wholly dependent upon the decedent are entitled to regular weekly benefits computed in accordance with O.C.G.A. § 34-9-261 for “total incapacity” for up to 400 weeks from the date of injury. O.C.G.A. § 34-9-265(b)(2). If the employee leaves dependents who are only partially dependent on his or her earnings for their support at the time of the injury, the weekly compensation for these dependents shall be in the same proportion to the compensation for persons wholly dependent as the average amount contributed weekly by the deceased to the partial dependents bears to the deceased employee’s average weekly wages at the time of the injury. O.C.G.A. § 34-9-265(b)(3). These benefits are payable only during dependency. O.C.G.A. § 34-9-265(c). There is a conclusive presumption of total dependency for a spouse and any minor children, as well as non-minor children who are physically or mentally incapable of earning a livelihood or are full-time students under the age of 22. O.C.G.A. § 34-9-13(b). Where one of the presumptions is not applicable, the facts at the time of the accident are taken into consideration. However, any dependency must have existed for a period of three or more months prior to the injury. O.C.G.A. § 34-9-13(d).

Likewise, partial dependency is determined based upon the facts at the time of the accident, but if there is one or more persons wholly dependent, then no benefits for partial dependency are due. Dependency can be terminated by remarriage, death, or emancipation (age 18), unless physically or mentally incapacitated. Meretricious relationships can also terminate dependency. O.C.G.A. § 34-9-13(e).
There is a 20% statutory penalty, up to $20,000.00, applicable to death resulting from an injury proximately caused by the intentional act of the employer, if the employer had actual knowledge that the intended act was certain to cause the injury and knowingly disregarded this certainty of injury. O.C.G.A. § 34-9-265(e). Flagrant disregard of workplace safety regulations could subject an employer to this penalty.

Compensation to a surviving spouse, when there is no other dependent for one year or less after the death of the employee, is limited to $150,000.00. O.C.G.A. § 34-9-265(d).

26. **What are the criteria for establishing a "second injury" fund recovery?**

The Subsequent Injury Trust Fund was established for injuries occurring on or after July 1, 1977. O.C.G.A. § 34-9-352. This is a reimbursement mechanism for the employer/insurer. There are three requirements: (i) the employee had a pre-existing permanent impairment; (ii) the employer had knowledge of the impairment; and (iii) merger of a subsequent injury with the pre-existing permanent impairment. O.C.G.A. § 34-9-363.1.

Since this statutory scheme is a reimbursement mechanism, the employer/insurer must pay all compensation and medical expenses. Notice to the Fund must be given not later than 78 calendar weeks following an injury or the payment of an amount equivalent to 78 weeks of income or death benefits, whichever occurs last. O.C.G.A. § 34-9-362. The second injury fund will not accept claims for injuries after June, 30, 2006. O.C.G.A. § 34-9-368.

The Fund has been terminated with regard to self-insured employers or insurers for subsequent injuries for which a claim is made occurring after June 30, 2006. Claims made prior to this date that qualify for reimbursement will still be reimbursed. O.C.G.A. § 34-9-368.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

The time for the filing of a claim for a change in condition is generally two (2) years from the last payment of income benefits, though this period may be tolled if there are any benefits outstanding which have not been paid. O.C.G.A. § 34-9-104(b).

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

There are two such situations, both based upon unreasonable behavior: (i) where a proceeding is brought, prosecuted, or defended without reasonable grounds; or (ii) where some provision of O.C.G.A. § 34-9-221 has not been observed, without reasonable grounds, and the employee engages the services of an attorney who successfully enforces the employee's rights. O.C.G.A. § 34-9-108. Employers should make certain that any attorney's fee problems have been resolved by a stipulation filed with the Board. In Don
Mac Golf Shaping Co. v. Register, 185 Ga. App. 159, 363 S.E.2d 583 (1987), the employer was required to pay attorney's fees to the fired former attorney for the employee. See also Yates v. Hall, 189 Ga. App. 885, 887, 377 S.E.2d 887 (1989).

NOTE: An award of attorneys’ fees for an employer’s failure to observe any of the ministerial functions within O.C.G.A. § 34-9-221 are now based solely on quantum meruit. O.C.G.A. § 34-9-108(b)(2). Thus, employees’ attorneys are no longer routinely permitted to recover contingent fees in this type of assessment.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.


B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).


30. Are there any penalties against the employer for unsafe working conditions?

No. Moreover, nothing in Georgia’s Workers’ Compensation Act works to enhance the remedies available to the employee. See Reid v. Lummus Cotton Gin Co., 58 Ga. App. 184, 197 S.E. 904 (1938). Also, the WCA does not function in a similar fashion to OSHA, for instance. However, the WCA does not exempt an employer from any penalty which may otherwise be imposed for failure or neglecting to perform any statutory duty. O.C.G.A. § 34-9-9.
31. **What is the penalty, if any, for an injured minor?**

None.

32. **What is the potential exposure for "bad faith" claims handling?**

Such potential exposure would be limited in this context to possible attorney's fees, penalties and litigation expenses related to unreasonable behavior. There are various administrative penalties which may be assessed for late filings and the like, and civil fines may be imposed for flagrant violations of Board rules. O.C.G.A. § 34-9-108.

33. **What is the exposure for terminating an employee who has been injured?**

None. Georgia follows the general rule that employment relationships are terminable at will by either the employer or the employee, absent a controlling agreement specifying the terms of the employment. O.C.G.A. § 34-7-1; Balmer v. Elan Corp., 278 Ga. 227, 228, 599 S.E.2d 158 (2004). However, a terminated employee with an existing injury may successfully pursue a change in condition claim if he or she can show that the employment related injury prevents him or her from obtaining suitable alternative employment.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes, the injured employee can sue third parties responsible for the employee’s injuries. See O.C.G.A. § 34-9-11(a) (third-party tort-feasors are not protected by the exclusivity provision of the Workers’ Compensation Act). Moreover, the employer or its insurer also can bring civil suits against third parties, or, alternatively, can intervene in any suit brought by an injured employee against third parties, but only to the extent of the workers' compensation lien. See Section 36 below.

35. **Can co-employees be sued for work-related injuries?**


36. **Is subrogation available?**

Yes, under limited circumstances. O.C.G.A. § 34-9-11.1(b). If an employee fails to bring an action within one year after the injury, the employer or the employer’s insurer may file suit to enforce the employee's claim. O.C.G.A. § 34-9-11.1(c). The employer or the employer’s insurer may recover only if the employee has been “fully and completely compensated” for all economic and non-economic losses incurred as a result of the injury. O.C.G.A. § 34-9-11.1(b). There is no bright-line test for the full compensation standard, and this is the primary area of litigation and reported decisions. The
employer/insurer has the right to intervene to protect the lien, and, indeed, it has been held that the failure to do so may constitute a waiver of the right to collect on the lien against a recovery by the employee because the employer/insurer has no way to prove that the employee recovered more than what was required to fully compensate him for his economic and non-economic losses. See Canal Ins. Co. v Liberty Mut. Ins. Co., 256 Ga. App. 866, 570 S.E.2d 60 (2002).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Yes. Medical bills typically must be paid within 30 days from the date of receipt of the charge, and penalties are available for late payment. O.C.G.A. §§ 34-9-203(c)(1), (3). However, payment of mileage expenses must occur within 15 days, rather than 30 days. O.C.G.A. § 34-9-203(c)(1), (2). Board Rule 203 governs the payment of medical expenses. Medical expenses are limited to the usual and customary charges as found by the Board pursuant to O.C.G.A. § 34-9-205, and in accordance with the fee schedule adopted by the Board. The employer and the provider may seek relief by using a peer review system for contested charges. Board Rule 203 was changed, effective July 1, 2007, to provide that any challenge by a medical provider to the amount of payment for goods, services, or expenses must be submitted to the payor within 120 days of payment, and that failure by a medical provider to challenge the amount of payment of such goods, services or expenses within the 120 day time limit constitutes a waiver of additional payment. Board Rule 203(b)(2). A provider whose bill is reduced by the Board may not seek additional payment from the employee. See also Board Rule 203(c)(7).

Georgia law provides that penalties for late payment of medical bills shall be added to such charges and shall be paid to the medical provider at the same time as and in addition to the charges claimed for the health care goods or services. O.C.G.A. § 34-9-203(c)(3). Any payment of charges made between 30 and 60 days after the due date shall be assessed a penalty of ten percent of the charges. Id. Any payment of charges made between 60 and 90 days after the due date shall be assessed a penalty of 20 percent of the charges. Id. Payment of any charges more than 90 days after the due date, in addition to the 20 percent add-on penalty, shall include interest on that combined sum at a rate of twelve percent per annum from the 91st day after the due date until full payment is made. Id.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or authorization) at the administrative level?**

The parties to a claim are required to exchange copies of medical records that are intended to be used in evidence prior to the hearing. There is no physician-patient privilege in Georgia, and the expectation of confidentiality (even as to psychiatric records, which are privileged at common law) is waived to the extent that physical condition is placed into issue by filing a claim. O.C.G.A. § 34-9-207. The State Board
of Workers’ Compensation is empowered to compel third parties to release medical records, but since these providers are usually looking to the litigation to pay their bills, and because they often charge high reproduction costs, this is rarely a problem.

Georgia law explicitly provides that where an employee refuses to provide a signed release for medical information as required by O.C.G.A. § 34-9-207, and the Board finds that such refusal was not justified under that statute, the employee will not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim. O.C.G.A. § 34-9-207(c).

39. What is the rule on (a) Claimant's choice of a physician; (b) Employer's right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.

The employee is limited to a selection from a panel of at least six physicians or associations selected and maintained by the employer. In the absence of such a panel, the employee may select any physician or medical provider. Board Rule 201(c). The physician or medical provider so selected by the employee becomes the authorized treating physician. The employee thereafter may make one change from that physician to another physician without approval of the employer and without an order of the Board. Any further change of physician or treatment, however, must be made in accordance with O.C.G.A. § 34-9-200 and Board Rule 200. Care should be exercised in referral situations so as not to lose control over the medical providers. Any referral by an authorized treating physician will result in coverage for the medical expenses incurred as a result of such referral, unless the employer properly and promptly contests such referral. See O.C.G.A. § 34-9-201; Board Rule 201(b).

B. Employer’s right to a second opinion and/or Independent Medical Examination.

The employer/insurer has a right, upon proper notice and payment of travel expenses, to a second opinion or independent medical examination (IME) with the doctor of the employer/insurer’s choice. O.C.G.A. § 34-9-202(a). Under certain circumstances and with certain limitations, the employee also may be entitled to a one-time IME at the employer’s expense. O.C.G.A. § 34-9-202(e). Medical examinations authorized under O.C.G.A. § 34-9-202 expressly include psychiatric and psychological examinations. O.C.G.A. §§ 34-9-202(a), (c).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

For all injuries occurring on or before June 30, 2012 and for injuries considered catastrophic (pursuant to O.C.G.A. § 34-9-200.1) after July 1, 2013, a covered employee is entitled to medical, surgical, hospital care, and other treatment, items, and services, as prescribed by a licensed physician. O.C.G.A. § 34-9-200(a). The employee is also
entitled to whatever medical and surgical supplies, artificial members, and prosthetic
devices and aids damaged or destroyed in a compensable accident, which in the judgment
of the Board are reasonably required and appear likely to effect a cure, give relief, or
restore the employee to suitable employment. Id.

The employer’s liability for expenses relating to medical, surgical, hospital service, or
other treatment required, when ordered by the board, is expressly limited to “such
charges as prevail in the State of Georgia for similar treatment of injured persons of a like
standard of living when such treatment is paid for by the injured persons.” O.C.G.A. §
34-9-203(a). Medical expenses are limited to the usual and customary charges as found
by the Board. See O.C.G.A. § 34-9-205; Board Rule 203. In addition to the fees of
physicians and charges of hospitals, the Board also has authority as to charges for
prescription drugs and other items and services. Medical expenses, in addition to those
owed the treating physician, can include: (i) reasonable costs of attendant care, directed
or ordered by the treating physician during travel or convalescence; (ii) reasonable costs
of travel between home and the place of examination or treatment or physical therapy, or
the pharmacy (paid at a rate of 40 cents per mile, subject to change based upon changes
in fuel costs, per Board Rule 203(e)); (iii) physical therapy prescribed by the treating
physician; (iv) hospital charges, if hospitalized at the direction of the treating physician,
or an emergency; and (v) prosthetic devices. See Board Rule 203; O.C.G.A. § 34-9-
200(a). Chiropractic care is a required element of care under the conformed panel and
managed care models. See Board Rules 201, 208. An employee must submit a claim for
mileage expenses within one year of the date of incurring those expenses or is deemed to
have waived his or her right to collect such charges from the employer or its workers’

41. **Which prosthetic devices are covered, and for how long?**

Medical and surgical supplies, artificial members, and prosthetic devices and aids
damaged or destroyed in a compensable accident and which are prescribed by the
authorized treating physician could be covered for life if, in the judgment of the State
Board, they are reasonably required to effect a cure, give relief, or restore the employee
to suitable employment, assuming there is no settlement of this aspect of the claim.
O.C.G.A. § 34-9-200(a).

42. **Are vehicle and/or home modifications covered as medical expenses?**

Such modifications can be covered as medical expenses, if they are shown to be
reasonably required to affect a cure, give relief, or restore the employee to suitable
employment. These expenses are often part of a rehabilitation program. The Board is
empowered to order such modifications in catastrophic cases. See Board Rule
200.1(a)(5)(ii) (“An Independent Living Plan encompasses those items and services,
including housing and transportation, which are reasonable and necessary for a
catastrophically injured employee to return to the least restrictive lifestyle possible.”).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**
Yes, the Board is required to annually publish a list, by geographical location, of the usual, customary, and reasonable charges for all medical services provided. O.C.G.A. § 34-9-205. Challenges by medical providers of the amount of payments received from the payor must be made within 120 days of payment. Failure to meet the 120 day deadline will result in a waiver of additional payment for medical goods, services, or expenses. Board Rule 203(b)(2).

44. **What, if any, provisions or requirements are there for "managed care"?**

An employer may provide employees with controlled access to medical care by posting a list of at least six medical providers ("Posted Panel"). In 1994, the legislature also introduced the concept of a "Conformed Panel of Physicians." O.C.G.A. § 34-9-201. The Conformed Panel, an interim step between the posted panel and true managed care, must contain at least ten physicians of various specified types. An employer may also provide authorized care through a managed care organization, which must be certified by the Board according to very detailed and specific requirements, and which must provide a specified broad range of services and providers. *See* O.C.G.A. § 34-9-201(b)(3); Board Rule 208(a)(1)(E).

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

A claim is contested by filing a Notice to Controvert, either as part of the Employer's First Report of Injury (Form WC-1), or as a separate Notice to Controvert (Form WC-3). The filing is governed by one of three standards, which are dependent on the time of filing. To controvert a claim from the start, a Form WC-1 (complete Section C) or a Form WC-3 must be filed within 21 days of the employer's knowledge of the injury or death. *See* O.C.G.A. § 34-9-221; Board Rules 61, 221. If the employer decides to controvert a claim after the initial 21 days, but prior to expiration of 60 days from the due date of the first benefits, then the employer should file two forms—a Form WC-3 Notice to Controvert and a Form WC-2 Notice of Payment or Suspension of Benefits. The last standard governs controverting a claim after the expiration of 81 days from first notice. Here, Forms WC-2 and WC-3 are required, and the claim may only then be contested upon a change in condition or newly discovered evidence; both types of contests have been the subject of many published court opinions. An employer must be careful to pay all payments due, including any statutory penalty for late payments, if it wants to preserve its right to contest a claim at a later date, although failure to make such payments will not prevent the employer from contesting a claim based on a change in condition. *See* *Fallin v. Merritt Maint. & Welding, Inc.*, 283 Ga. App. 485 (2007).

46. **What is the method of claim adjudication?**

A. **Trial court.**

B. Appellate.

There are three levels of appellate review available:

(1) Review by the Appellate Division of the State Board of Workers’ Compensation. The appellate panel is composed of members of the Board serving as appellate ALJs. O.C.G.A. § 34-9-47. Any party may review. The application for review must be made to the appellate division within 20 days of notice of the award of the administrative law judge in the trial division. The standard of review is whether the award is supported by a preponderance of competent and credible evidence contained within the record. O.C.G.A. § 34-9-103.

(2) Review by the Superior Court. Review is also available in the superior court of the county in which the injury occurred, or, if the injury occurred outside the state, to the superior court of the county in which the original hearing was held. O.C.G.A. § 34-9-105(b). The superior court is not empowered to substitute its judgment for the judgment of either the ALJ or the full Board, and can set aside the Board’s decision only upon a showing that (i) the Board acted outside its powers, (ii) the decision was procured by fraud, (iii) the facts found by the Board do not support the decision, (iv) the competent evidence in the record was insufficient to support the Board’s decision, or (v) the decision was contrary to law. O.C.G.A. § 34-9-105(c). The standard of review outlined above has been interpreted consistently as meaning that the findings of fact of the ALJ or those of the Board are conclusive and binding on the superior court if supported by any evidence in the record. See Ray Bell Constr. Co. v. King, 281 Ga. 853, 854, 642 S.E.2d 841, 843 (2007); St. Joseph’s Hosp. v. Ward, 300 Ga. App. 845, 846, 686 S.E.2d 443, 444 (2009).

(3) Discretionary appeals to the Court of Appeals or Georgia Supreme Court. Such appeals must be submitted in the form of an application for certiorari, which is seldom granted. See O.C.G.A. § 34-9-105(e).

47. What are the requirements for stipulations or settlements?

All stipulations and settlements must be submitted for approval to the Board in the form of a "Stipulation and Agreement." There are two forms: a compromise stipulation and a no-liability stipulation. A compromise stipulation sets forth opposing contentions of the parties, the fact that a settlement has been reached, and the terms of the settlement. It is
submitted when there is a bona fide dispute as to the facts, the determination of which will materially affect the right of the employee or dependent to recover compensation or the amount of compensation which would be recovered or under circumstances when there is a dispute as to the applicability of the Act. Once compensation in any form (including medical benefits) is paid, then this is the only manner by which a claim may be settled. O.C.G.A. § 34-9-15; Board Rule 15. In addition, where a case is being settled with a claimant who is represented by an attorney, and where that attorney is seeking payment for his or her expenses out of the settlement, the attorney must certify that the expenses comply with Rule 1.8(e) of the Georgia Rules of Professional Responsibility and Board Rule 108. Board Rule 15(e).

"No liability" stipulations have been sanctioned by the courts. See Lavender v. Zurich Ins. Co., 110 Ga. App. 196, 138 S.E.2d 118 (1964). These involve the submission of an agreement between the parties that no compensation is owed and the simultaneous execution of a Covenant Not to Sue. Once approved, an order is issued by the Board finding, as a matter of fact and law, that no compensation is owed. Payment is then made pursuant to the terms of the covenant.

48. Are full and final settlements with closed medicals available?
Yes.

49. Must stipulations and/or settlements be approved by the state administrative body?
Yes. See Section 47.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

All employers subject to the Act must insure the payment of compensation. See O.C.G.A. §§ 34-9-120, 34-9-121. By law, unless otherwise ordered or permitted by the Board, insurance must be secured from a “corporation, association, or organization licensed by law to transact the business of workers' compensation insurance in this state or from some mutual insurance association formed by a group of employers so licensed; or such employer shall furnish the board with satisfactory proof of his financial ability to pay the compensation directly in the amount and manner and when due.” O.C.G.A. §§ 34-9-121(a). Thus, insurance is available through private insurers, trade associations, professional associations, and group self-insurance funds.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

To qualify, application must be made to the Board, and security must be made by way of

B. For groups or "pools" of private entities.

Detailed requirements are codified for group self-insurance funds. See O.C.G.A. §§ 34-9-150, et seq. Such funds are also subject to regulation by the Georgia Insurance Department.

52. Are "illegal aliens" entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?


53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There do not appear to have been any terrorist act cases in Georgia to date, but the laws relating to third party criminal acts likely would guide such cases. In that regard, the fact that an injury is the result of a willful or criminal act committed by a third party does not prevent recovery, as long as the injury arises out of the employment. Zamora v. Coffee Gen. Hosp., 162 Ga. App. 82, 84, 290 S.E.2d 192 (1982); Hartford Accident & Indem. Co. v. Cox, 101 Ga. App. 789, 115 S.E.2d 452 (1960). An exception exists where the third party’s actions are directed against the employee for personal reasons, in which case there can be no recovery. See Employers Ins. Co. v. Wright, 108 Ga. App. 380, 381, 133 S.E.2d 39, 40 (1963); Pinkerton Nat’l Detective Agency v. Walker, 30 Ga. App. 91, 94, 117 S.E.2d 281, 283 (1923). Further, O.C.G.A. § 34-9-17(a) provides that there is no compensation for injury or death due to an employee’s willful misconduct, including intentional self-inflicted injuries. See Section 5.C. above. “Willful” is defined as a premeditated, obstinate, or intentional act. Armour & Co. v. Little, 83 Ga. App. 762, 766, 64 S.E 2d 707, 710 (1951).

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Yes. These issues are controlled by federal law. Practitioners must account for both Medicare and Medicaid liens in effecting settlement. See 42 U.S.C. §§ 1395, et seq. (Medicare); 42 U.S.C. §§ 1396, et seq. (Medicaid). 42 U.S.C. § 1395y(b)(2)(B)(i), part of the complex Medicare statute, specifically states that repayment is required and is
“conditioned on reimbursement.”

Under Medicare regulations, Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer; the obligation to pay medicals for a compensable condition cannot be shifted to Medicare. See 42 C.F.R. § 411.46. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria: (i) the employee is already a Medicare enrollee, and the settlement amount is greater than $25,000; or (ii) there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets these criteria, Medicare must be notified in the event of a settlement. Upon review of the file, if Medicare concludes that the settlement does not meet its criteria, it may require a Medicare set-aside trust for large settlements or a custodial self-administered trust account. See 42 C.F.R. § 411; 42 U.S.C. § 1395.

Under revised Board Rule 15(d), if a stipulated settlement agreement provides for a Medicare Set-Aside Arrangement (MSA), the stipulated settlement agreement must contain a provision as to the actual cost or projected cost of the MSA.

Medicare enforcement varies by geographical region. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The federal Medicaid statute requires states to include in their plan for medical assistance provisions both (i) that the individual will assign to the state any rights to payment for medical care from any third party, and (ii) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. See 42 U.S.C. §§ 1396k(a). The state is authorized to retain an amount as necessary to reimburse it (and the federal government, as appropriate) for medical assistance payments and to pay the remainder to the individual. See 42 U.S.C. § 1396k(b).

Pursuant to O.C.G.A. § 34-9-206, any party to a claim, including a group insurance carrier or health care provider, who covered the cost of medical treatment to an injured claimant may give notice to the Board, “at any time during the pendency of the claim,” that such party has a right to payments. In addition, with regard to Medicaid, one must look to both federal and state law, since Medicaid is a cooperative program. The requirements for obtaining Medicaid funds are set forth in 42 U.S.C. § 1396, whereas O.C.G.A. § 49-4-149 addresses the authority of the governing body to collect the funds by filing a lien within one year from the date of the last item of treatment. This lien must be filed in the county where the recipient lives and in Fulton County. O.C.G.A. § 49-4-149(b). The practitioner should check for all types of liens.
56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

Georgia does not recognize a physician-patient privilege. See *Nat’l Stop Smoking Clinic-Atlanta, Inc. v. Dean*, 190 Ga. App. 289, 289, 378 S.E.2d 901, 902 (1989). However, communications between a patient and psychiatrist or licensed psychologist are recognized as an enforceable privilege. O.C.G.A. § 43-39-16. As noted in Section 38 above, any such privilege is waived to the extent the claimant places his or her physical or mental condition in issue. See O.C.G.A. § 34-9-207.

The 1996 Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. §§ 164 et seq., contains numerous provisions intended to protect insureds. One provision seeks to prevent discrimination and to protect insured privacy rights, but an exception exists for workers’ compensation claims so as to allow for collection of medical records related to the injury by employers and insurers. 45 C.F.R. § 164.512(l). Regarding ex parte communications between a treating physician and an employer, HIPAA does not preempt Georgia law allowing such communications “because HIPAA exempts from its requirements disclosures made in accordance with state workers’ compensation laws.” *Arby’s Rest. Group, Inc. v. McRae*, 292 Ga. 243, 245–46 (2012). However, parties requesting ex parte communications with treating physicians must “set parameters consistent with privacy protections afforded under state and federal law.” Id. at 247.

57. **What are the provisions for “Independent Contractors”?**

Independent contractors are not covered under Georgia’s Workers’ Compensation Act. The chief test, though not an all-inclusive one, to be applied in determining whether a worker is an independent contractor or an employee is whether the employer has the right to assume control of the manner, method, and time of his work. Golosh v. Cherokee Cab Co., 226 Ga. 636, 176 S.E.2d 925 (1970); Rapid Group, Inc. v. Yellow Cab of Columbus, Inc., 253 Ga. App. 43, 46, 557 S.E.2d 420, 424 (2001); O.C.G.A. § 34-9-2(e). An employer may bring an independent contractor under the purview of workers’ compensation by providing workers’ compensation insurance for him. O.C.G.A. § 34-9-124(b). When an employer of an independent contractor provides workers’ compensation insurance to him, the employer is estopped from denying coverage for a compensable claim even though the employer was not required to provide coverage in the first place. *Murph v. Maynard Fixturecraft, Inc.*, 252 Ga. App. 483, 555 S.E.2d 845 (2001).

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.
59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?


60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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1. **Citation for the state’s workers’ compensation statute.**

Hawaiʻi Revised Statutes, Chapter 386.

**SCOPE OF COMPENSABILITY**

2. **Who are covered “employees” for purposes of workers’ compensation?**

“Any individual in the employment of another person” (Haw. Rev. Stat. § 386-1, Definition of Employee) or any employee, who are not employees as defined by Haw. Rev. Stat. § 386-1, that the employer elects to provide coverage for (Haw. Rev. Stat. § 386-4).

3. **Identify and describe any “statutory employer” provision.**

Haw. Rev. Stat. § 386-1, Definition of Employee. A loaned employee, who is loaned for the purpose of furthering the borrowing employer’s trade, business, occupation, or profession, is considered the employee of the borrowing employer, until control of the employee is returned. However, the employee will be deemed to remain the employee of the original employer if the borrowing employer fails to secure compensation to the employee as provided in Haw. Rev. Stat. § 386-121.

Haw. Rev. Stat. § 386-1, Definition of Employee. An independent contractor is deemed the employer of all employees performing work in the execution of the contract, including employees of the independent contractor’s subcontractors and their subcontractors. However, the direct employer of an employee has primary liability and the other employers have secondary liability in their order. A secondarily liable employer who satisfies a liability is entitled to indemnity against loss from the employer primarily liable.

4. **What types of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or “single occurrence” claims.**

   In order to be compensable, an injury must be caused by an accident, which includes the willful act of a third person directed against an employee because of the employee’s employment, arising out of and in the course of the employment. Haw. Rev. Stat. § 386-3(a). Under the common law, however, one must simply find that “the injury reasonably appears to have flowed from the conditions under which the employee is required to work” (the “Work Connection Test”). *Royal State Nat’l Ins. Co. v. Labor and Indus. Relations Appeals Bd.,* 53 Haw. 32, 487 P.2d 278 (1971).
B. Occupational disease (including respiratory and repetitive use).


5. What, if any, injuries or claims are excluded?

No compensation is allowed for an injury caused by the employee’s willful intention to injure himself or herself or another by actively engaging in any unprovoked non-work related physical altercation other than self-defense, or by the employee’s intoxication. Haw. Rev. Stat. § 386-3(b).

No compensation is allowed for mental stress resulting solely from disciplinary action taken in good faith or under the standards set by a collective bargaining or employment agreement. Haw. Rev. Stat. § 386-3(c).

6. What psychiatric claims or treatments are compensable?

As long as the Work Connection Test is met, the “injury” covered is not limited to physical injuries, nor does it require physical trauma. Haw. Rev. Stat. § 386-3. However, a claim for mental stress arising solely from disciplinary action taken in good faith or under the standards set by a collective bargaining or employment agreement shall not be allowed. Haw. Rev. Stat. § 386-3(c).

7. What are the applicable statutes of limitations?

A written claim must be filed: 1) within two years after the date on which effects of the injury become manifest; and 2) within five years after the date of accident. Haw. Rev. Stat. § 386-82. For chemical or radioactive exposures, a claim must be made within two years after knowledge that the injury was proximately caused by the employment. Haw. Rev. Stat. § 386-82. There is no limitation of time for a mentally incompetent or minor dependent, as long as there is no guardian or next friend. Haw. Rev. Stat. § 386-84. With a showing of substantial evidence, on the ground of a change in or mistake in a determination of fact related to the physical condition of the injured employee, a case may be reopened within eight years after the date of the last payment of compensation. Haw. Rev. Stat. § 386-89(c).

8. What are the reporting and notice requirements for those alleging an injury?

The employee is required to give written notice to the employer as soon as practicable after an accident. Haw. Rev. Stat. § 386-81. However, notice need not be given when: 1) the employer has actual knowledge of the injury; 2) medical benefits have been furnished by the employer; or 3) there is some satisfactory reason why notice was not given and the employer is not prejudiced. Haw. Rev. Stat. § 386-81. The notice defense is waived if the employer is not prejudiced or fails to raise such a defense at the first hearing on the claim. Haw. Rev. Stat. § 386-81.
9. **Describe available defenses based on employee conduct:**

   **A. Self-inflicted injury.**

   Compensation is not allowed for an injury caused by the employee’s willful intention to injure himself or herself by actively engaging in any unprovoked non-work related physical altercation other than in self-defense. Haw. Rev. Stat. § 386-3(b).

   **B. Willful misconduct, “horseplay,” etc.**

   Compensation is not allowed for an injury caused by the employee’s willful intention to injure oneself or another, or actively engaging in any unprovoked non-work related physical altercation other than in self-defense. Haw. Rev. Stat. § 386-3(b). The willful act of a third person directed against an employee must be “because of the employee’s employment” in order to be compensable. Haw. Rev. Stat. § 386-3(a).

   **C. Injuries involving drugs and/or alcohol.**

   Injuries caused by the employee’s intoxication are similarly not compensable. Haw. Rev. Stat. § 386-3(b).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    Penalties for fraud are detailed in Haw. Rev. Stat. § 386-98.

    Criminal penalties: 1) a Class C felony if the value of moneys obtained or denied is not less than $2,000; 2) a Misdemeanor if the value of the moneys obtained or denied is less than $2,000; and 3) a Petty Misdemeanor if the providing of false information did not cause any monetary loss. Haw. Rev. Stat. § 386-98(d). In addition, the person shall be ordered to make restitution to an insurer or any other person for any financial loss sustained by the insurer or other person caused by the fraudulent act.

    Administrative Penalties: In lieu of criminal penalties any person who violates Haw. Rev. Stat. §§ 386-98(a) and 386-98(b), may be subject to the administrative penalties of restitution of benefits to the source from which the compensation was received and one or more of the following: 1) a fine of not more than $10,000 for each violation; 2) suspension or termination of benefits in whole or in part; 3) suspension or disqualification from providing medical care or services, vocational rehabilitation services, and all other services rendered for payment; 4) suspension or termination of payments for medical, vocational rehabilitation and all other services rendered; 5) recoupment by the insurer of all payments made for medical care, medical services, vocational rehabilitation services, and all other services rendered; and 6) reimbursement of attorney’s fees and costs of the party or parties defrauded. Haw. Rev. Stat. § 386-98(e).
11. Is there any defense for falsification of employment records regarding medical history?

Haw. Rev. Stat. Chapter 386 does not establish any statutory defense(s) for the falsification of employment records regarding medical history. Similarly, Hawaiʻi’s common law has not established any defense(s) for the falsification of employment records regarding medical history.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Hawaiʻi follows the unitary work-connection test, which requires a finding of a causal connection between the injury and any incidents or conditions of employment. Ostrowski v. Wasa Elec. Servs., Inc., 87 Hawaiʻi 492, 960 P.2d 162 (App. 1998). With regard to recreational or social activities, the injury is compensable if 1) the activities occur on the employer’s premises during lunch or a recreation period as a regular incident of employment; or 2) employer, by expressly or impliedly requiring participation or by making the activity part of services of the employee, brings the activity within the orbit of employment; or 3) the employer derives substantial direct benefit from the activity beyond intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life. Ostrowski v. Wasa Elec. Servs., Inc., 87 Hawaiʻi 492, 960 P.2d 162 (App. 1998).

13. Are injuries by co-employees compensable?

Yes, as long as the willful act by the co-employee can be shown to be directed against the employee because of the employee’s employment. Haw. Rev. Stat. § 386-3. A causal connection between a willful act and the employee’s employment may be shown by connecting the subject matter of the willful act with the employee’s employment. Zemis v. SCI Contractors, Inc., 80 Hawaiʻi 442, 911 P.2d 77 (1996). For example, if a co-employee assaults an employee because of an automobile accident that occurred between the employee and the co-employee’s wife, then the injuries are not compensable because the subject matter of the assault was not related to the employee’s employment. Zemis v. SCI Contractors, Inc., 80 Hawaiʻi 442, 911 P.2d 77 (1996).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?

No, as long as it can clearly be shown that the third party’s act was not directed against the employee because of the employee’s employment. Haw. Rev. Stat. § 386-3. In other words, the injury is not compensable if the subject matter of the third party’s act cannot be connected to the employee’s employment. Zemis v. SCI Contractors, Inc., 80 Hawaiʻi 442, 911 P.2d 77 (1996).
**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Average weekly wage is to be computed in a manner that most fairly represents the employee’s average weekly wages from all covered employment at the time of the injury. Haw. Rev. Stat. § 386-51. For the calculation of temporary partial disability and temporary total disability benefits, such wages must not be computed to be less than the employee’s hourly pay rate multiplied by 35. Haw. Rev. Stat. § 386-51. Where the employee holds part-time employment of fewer than 35 hours per week, the employee’s average weekly wages is the hourly rate at the average hours worked in the 52 weeks (or portions thereof) preceding the week in which the injury occurred. Haw. Rev. Stat. § 386-51. Other benefits including permanent partial disability, permanent total disability, and death shall be calculated as if the employee had been a full-time employee. Haw. Rev. Stat. § 386-51.

Where appropriate, such computation is made on the basis of earnings from covered employment for twelve months preceding the date of injury, excluding time lost for sickness or personal reasons exceeding one week. Haw. Rev. Stat. § 386-51(1). Unless otherwise provided, the total average weekly wages of any employee are capped by the average weekly wage earned at the time of injury by an employee in comparable employment and employed full-time on an annual basis. Haw. Rev. Stat. § 386-51(4).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Benefits are paid at the weekly benefit rate of sixty-six and two-thirds of the employee’s average weekly wage. Haw. Rev. Stat. § 386-31(b). The rate cannot exceed the state average weekly wage as determined by the Director of Labor and Industrial Relations (the “Director”). Haw. Rev. Stat. §§ 386-31(a) and 386-31(b). If the employee’s weekly wages are less than the minimum weekly benefit rate ($38 or 25% of the state average weekly wage, whichever is higher), the rate is 100% of the employee’s average weekly wage. Haw. Rev. Stat. §§ 386-31(a) and 386-31(b).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

If a claim is not controverted, benefits first become due no later than the tenth day after the employer is notified of the occurrence of total disability. See Haw. Rev. Stat. § 386-31(b).

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out _____ days before recovering benefits for the first _____ days)?**

The employee is not paid for the first three days following the injury. Haw. Rev. Stat. § 386-31(b).
19. **What is the standard/procedure for terminating temporary benefits?**

If the employer/insurer is of the opinion (i.e., has medical evidence) that the employee “is able to resume work,” then it must give the employee and the Director written notification two weeks prior to the date when the last payment is to be made. Haw. Rev. Stat. § 386-31(b). An employer/insurer must provide a reason for stopping payment and must inform the employee of the right to make a written request to the Director for a hearing. Haw. Rev. Stat. § 386-31(b). If an employee has returned to work, there is no need for notification and payments can be stopped. Haw. Rev. Stat. § 386-31(b).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No. However, the employer/insurer can request a credit for voluntary payments made during disability. Haw. Rev. Stat. § 386-52. An employer may, with the approval of the Director, deduct from an amount payable as compensation any advance payments made to the injured employee if the employee had been notified in writing at the time the advance was made that the payments were in lieu of compensation. Haw. Admin. R. 12-10-24.

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement up to $30,000, may be awarded as the Director deems proper and equitable. Haw. Rev. Stat. § 386-32(a). This includes scarring and other disfiguring consequences caused by medical, surgical and hospital treatment. Haw. Rev. Stat. § 386-32(a).

22. **How are permanent partial disability benefits calculated, including minimum and maximum rates?**

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

   Scheduled disabilities are as follows:

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>75</td>
</tr>
<tr>
<td>Index finger</td>
<td>46</td>
</tr>
<tr>
<td>Middle finger</td>
<td>30</td>
</tr>
<tr>
<td>Ring finger</td>
<td>25</td>
</tr>
<tr>
<td>Little finger</td>
<td>15</td>
</tr>
<tr>
<td>One phalanx of thumb or finger</td>
<td></td>
</tr>
<tr>
<td>Thumb</td>
<td>56.25</td>
</tr>
<tr>
<td>Index finger</td>
<td>23</td>
</tr>
<tr>
<td>Middle finger</td>
<td>15</td>
</tr>
<tr>
<td>Ring finger</td>
<td>12.5</td>
</tr>
<tr>
<td>Little finger</td>
<td>7.5</td>
</tr>
</tbody>
</table>
Great toe 38
Other toes 16
One phalanx of toe
  Great toe 19
  Other toe 8
Hand 244
Arm 312
Foot 205
Leg 288
Eye
  Loss of eye by enucleation 160
  Loss of vision (one eye) 140
Ear:
  Loss of hearing in both ears 200
  Loss of hearing in one ear 52
  Loss of both ears 80
  Loss of one ear 40


Where permanent partial disability results from partial loss of use of a scheduled member, compensation is paid for a period that stands in the same proportion to the period specified for total loss of the member as the partial loss of use of that member stands to the total loss thereof. Haw. Rev. Stat. § 386-32(a). The formula for non-whole person recovery is (state average weekly wage) x (period of scheduled disability) x (percentage of permanent impairment). Haw. Rev. Stat. § 386-32(a).

B. Number of weeks for “whole person” and standard for recovery.

Where permanent partial disability must be rated as a percentage of the total loss or impairment of the whole person, the maximum compensation is computed as follows: (312 weeks) x (state average weekly wage rate) x (percentage of permanent impairment). Haw. Rev. Stat. § 386-32(a).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Employees who have or may suffer permanent disability as the result of work injuries may be referred to vocational rehabilitation, if feasible. Haw. Rev. Stat. § 386-25(b). Vocational rehabilitation is not mandatory, and the employee must approve of the proposed rehabilitation plan or program. Haw. Rev. Stat. § 386-25(c). The employee may select the certified provider of rehabilitation services. Haw. Rev. Stat. § 386-25(c). After selection, the employee and the certified provider must give notice to the employer. Haw. Rev. Stat. § 386-25(c).
24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are calculated on two-thirds of the employee’s average weekly wage, not to exceed the state average weekly wage, nor be less than $38 or 25% of the state average weekly wage (whichever is higher). Haw. Rev. Stat. § 386-31(a).

25. **How are death benefits calculated, including the minimum and maximum rates?**

   A. **Funeral expenses.**

   Funeral expenses may be recovered in an amount up to ten times the maximum weekly benefit rate, and burial expenses recovered up to five times the maximum weekly benefit rate. Haw. Rev. Stat. § 386-41(a).

   B. **Dependency claims.**


26. **What are the criteria for establishing a “second injury” fund recovery?**

   A previous partial disability must satisfy an initial threshold of at least 32 weeks of compensation in order to trigger fund involvement in cases of permanent total disability or death. Haw. Rev. Stat. § 386-33(b). Furthermore, fund involvement occurs only after the employer has paid 104 weeks of compensation. Haw. Rev. Stat. § 386-33(a).

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

   Re-opening is permitted upon the application of any party in interest, at any time prior to eight years after the date of last compensation, whether or not a decision awarding compensation has been issued, or at any time prior to eight years after the rejection of a claim. Haw. Rev. Stat. § 386-89(c).

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

   It is within the Director’s discretion both to approve an employee’s attorney fee and to determine whether the fee will be a lien upon compensation payable by the employer.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   A. **Scope of immunity.**

      There has been fairly strict interpretation that workers’ compensation is the exclusive remedy for “work-connected” accidents and resulting injuries. Haw. Rev. Stat. § 386-5.

   B. **Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**


30. **Are there any penalties against the employer for unsafe working conditions?**


31. **What is the penalty, if any, for an injured minor?**


32. **What is the potential exposure for “bad faith” claims handling?**

   The Hawai‘i Supreme Court recognized a claim for bad faith filed by an employee against the workers’ compensation insurer in *Hough v. Pac. Ins. Co.*, 83 Hawai‘i 457,927 P.2d 858 (1996). In this case, the Hawai‘i Supreme Court held that the injuries alleged (including a claim of breach of the common law duty of good faith) were not “work injuries” within the scope of Haw. Rev. Stat. Chapter 386 and claimant was not precluded by the exclusivity provision of Haw. Rev. Stat. § 386-5 from seeking common law tort remedies against the insurer. The common law tort remedies include a claim for bad faith. The court held that a breach of the implied contractual duty of good faith gives rise to the independent tort cause of action for a third-party beneficiary, under the same limitations for punitive damages as discussed in *Best Place, Inc. v. Penn Am. Ins. Co.*, 82 Hawai‘i 120, 920 P.2d 334 (1996).
The Hawai‘i Supreme Court expanded the *Hough* holding in *Catron v. Tokio Marine Mgmt, Inc.*, 90 Hawai‘i 407, 978 P.2d 845 (1999). In *Catron*, the Court held that an insurer’s harassment of an employee which occurred after the settlement of a workers’ compensation claim could support an action for the bad faith handling of a workers’ compensation claim.

33. **What is the exposure for terminating an employee who has been injured?**

Any employee who is discharged because of such work injury shall be given first preference of reemployment by the employer in any position which the employee is capable of performing and which becomes available after the suspension or discharge and during the period thereafter until the employee secures new employment. Haw. Rev. Stat. § 386-142. For descriptions of other unlawful employment practices involving termination of an employee, see Haw. Rev. Stat. §§ 378-2 and 378-32. Remedies can include retroactive hire/promotion/reinstatement; back pay; fringe benefits; injunctive relief; other equitable relief; and reasonable attorneys’ fees and costs. Haw. Rev. Stat. §§ 378-2 and 378-32.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-employees be sued for work-related injuries?**

Co-employees acting within the scope of their employment are immune from suit, but they are not relieved of liability for willful and wanton misconduct leading to injury. See *Wangler v. Hawaiian Elec. Co.*, 742 F.Supp. 1465 (D. Haw. 1990). Willful and wanton misconduct is defined under the law as conduct either 1) motivated by an actual intent to cause injury or 2) committed in circumstances indicating that the injured employee a) has knowledge of the peril to be apprehended, b) has knowledge that the injury is a probable, as opposed to a possible, result of danger, and c) consciously fails to avoid the peril. *Iddings v. Mee-Lee*, 82 Hawai‘i 1, 919 P2d 263 (1996). Willful and wanton misconduct must be proven by clear and convincing evidence. *Iddings v. Mee-Lee*, 82 Hawai‘i 1, 919 P2d 263 (1996).

36. **Is subrogation available?**


**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Yes. An employer/insurer has 60 days from the time of the bill to notify the provider if a claim is being controverted. Haw. Admin. R. 12-15-94(b). Failure to notify renders the
employer/insurer liable for services rendered until it controverts additional services. Haw. Admin. R. 12-15-94(b). The employer/insurer, after accepting liability, must pay all charges billed within sixty calendar days of receipt except where there is a reasonable disagreement. Haw. Admin. R. 12-15-94(c). If more than sixty calendar days lapse between the employer/insurer’s receipt of an undisputed billing and date of payment, payment of billing is increased by one per cent per month of the outstanding balance. Haw. Admin. R. 12-15-94(c). In the event of disagreement, the employer/insurer must pay for all acknowledged charges within sixty calendar days of receipt and must negotiate with the service provider on times in disagreement. Haw. Admin. R. 12-15-94(d).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

The Director may excuse the failure to make a medical report within the prescribed period, or a non-submission of the report, when the Director finds it in the best interest of justice to do so. Haw. Rev. Stat. § 386-96(b). Without such excuse, the delinquent physician will be fined up to $500. Haw. Rev. Stat. § 386-96(b). See also Haw. Admin. R. 12-15-80 (Reports of providers of service).

Generally, an executed medical authorization remains the subject of mutual cooperation between parties. Note re: previous answers to this question: Haw. Admin. R. 12-10-66 has been repealed.

39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.


B. Employer’s right to second opinion and/or Independent Medical Examination.

[Note: In 2017, Haw. Rev. Stat. § 386-79 was amended and will be reinstated to its original form on June 30, 2019. Said amendment does not affect the following answer.] The employee is required to submit to examination, at reasonable times and places, for examination by a duly qualified physician or surgeon designated and paid by the employer. Haw. Rev. Stat. § 386-79. The employee has the right to have his own physician or surgeon present at the examination. Haw. Rev. Stat. § 386-79. If the employee refuses to submit or obstructs the examination, the employee’s compensation benefits can be suspended until the refusal or obstruction ceases. Haw. Rev. Stat. § 386-79. There cannot be more than one IME per case unless good and valid reasons exist with regard to the medical progress of the employee’s treatment. Haw. Rev. Stat. § 386-79.
40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The standard for covered treatment is set forth in Title 12, Chapter 15, Hawai‘i Administrative Rules. These rules address the frequency and extent of treatment allowed for various types of providers: 1) Haw. Admin. R. 12-15-32 (physicians); and 2) Haw. Admin. R. 12-15-34 (providers of service other than physicians) The general standards are as follows: 1) physicians do not need authorization for the initial 15 treatments during the first 60 days, thereafter, the physician must submit a treatment plan for the next 120 days covering a maximum of 15 treatments during that time; 2) other service providers require prescriptions from the attending physician, which may authorize to 15 treatments during the first 60 days, however for therapist, the prescription may authorize 20 treatments during the first 60 days, thereafter, the attending physician must submit a treatment plan for the next 120 days covering a maximum of 15 treatments during that time. Haw. Admin. R. 12-15-32 and Haw. Admin. R. 12-15-34.

41. **Which prosthetic devices are covered, and for how long?**

Where injury results in amputation of an arm, hand, leg or foot, enucleation of an eye, loss of natural or artificial teeth, or loss of vision, the employer must furnish such other aids, appliances, apparatus, and supplies as are required to cure or relieve such injury. Haw. Rev. Stat. § 386-22.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Such expenses may be covered, if proper medical certification is submitted to and approved by the Director. Haw. Rev. Stat. § 386-24.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes, charges for medical services shall not exceed 110% of participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule applicable to Hawaii that is in effect as of January 1 of the year of the injury. Haw. Admin. R. 12-15-90.

44. **What, if any, provisions or requirements are there for “managed care”?**

There are no provisions or requirements for managed care under Haw. Rev. Stat. Chapter 386.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

The employer/insurer files a report of industrial injury denying liability. Haw. Admin. R. 12-10-73(a). When the employer/insurer denies compensation, it must submit a written report to the Director and the employee within 30 calendar days supporting the denial. Haw. Admin. R. 12-10-73(a). If the Director believes the injury to be compensable, the
Director must notify the employer/insurer and give it 30 days to request a hearing. Haw. Admin. R. 12-10-73(b). If the employer/insurer fails to request a hearing, it will be considered a waiver and the Director may issue a decision holding the injury compensable. Haw. Admin. R. 12-10-73(b).

46. What is the method of claim adjudication?

A. Administrative level.

The Director has original jurisdiction over all controversies and disputes over employment and coverage arising under Chapter 386. Haw. Rev. Stat. § 386-73.5. Typically, cases are adjudicated by an administrative hearing at the Disability Compensation Division (DCD). Haw. Admin. R. 12-10-61. The outcome of the DCD hearing can be appealed de novo to the Labor and Industrial Relations Appeals Board (LAB) for another administrative hearing. Haw. Rev. Stat. §§ 386-87(a) and 386-87(b).

B. Trial court.

For all practical purposes, the “trial” of a workers’ compensation case occurs at the DCD and LAB administrative hearings. Local circuit courts are available for enforcement of decisions awarding compensation. Haw. Rev. Stat. § 386-91.

C. Appellate.

A DCD decision can be appealed to the LAB. Haw. Rev. Stat. § 386-87(a). A decision of the LAB can be appealed to the Hawai‘i Supreme Court for review on matters of law only. Haw. Rev. Stat. § 386-88.

47. What are the requirements for stipulations or settlements?

Stipulations and settlements must be approved by the Director. Haw. Rev. Stat. § 386-78(a). Any compromise in which the employee waives or otherwise prejudices his or her right to reopen the claim, or to future medical benefits, requires written approval of the Appeals Board. Haw. Rev. Stat. § 386-87(d).

48. Are full and final settlements with closed medicals available?

Yes. The Director periodically sets an informal minimum amount required to obtain complete waivers of an employee’s re-opening rights. The amounts are presently $9,000 for waiver of future medicals and $6,000 for waiver of future indemnity benefits.

49. Must stipulations and/or settlements be approved by the state administrative body?

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Employers must secure workers’ compensation to their employees through private insurance, security, proof of financial ability to provide self-insurance, or as part of a self-insurance group. Haw. Rev. Stat. § 386-121(a).

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Employers may become self-insured by furnishing to the Director satisfactory proof of their solvency and financial ability to pay compensation and benefits. Haw. Rev. Stat. § 386-121(a)(3). Note re: previous answers to this question: Haw. Admin. R. 12-10-94 has been repealed.

B. For groups or “pools” of private entities.

Workers’ compensation self-insurance groups may be formed by filing appropriate documentation with the Insurance Commissioner, posting the appropriate security, and providing proof that the net worth of all members exceeds $1,000,000.00. Haw Rev. Stat. § 386-194(b).

52. Are illegal aliens entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

The statutes and administrative rules are silent on the entitlement of illegal aliens to workers’ compensation benefits. The State’s statutes would probably be liberally interpreted in favor of finding any illegal alien entitled to benefits.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

The statutes and administrative rules are silent as to terrorist acts or injuries under workers compensation. Haw. Rev. Stat. § 386-85 presumes that in the absence of substantial evidence otherwise any claim for workers’ compensation is for a covered work injury, lending to the possible liberal interpretation finding work injuries as a result of terrorist acts compensable. However, terrorist acts are not those under control of Employer and a strong argument could be made that such injuries are not work related.
54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

Hawai‘i workers compensation law does not impose any specific requirements vis-à-vis the Medicare Secondary Payer Act. However, as settlements require the Director’s approval, addressing the reimbursement of Medicare benefits may be required as part of a settlement, and carriers will generally require satisfaction of Medicare liabilities to protect themselves.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

If the Department of Human Services has provided medical assistance or burial payment to a person who was injured, suffered a disease, or died under circumstances creating a tort or other liability or payment obligation against a third person, the department shall have a right to recover from the third person an amount not to exceed the full amount of the costs of medical assistance or burial payment furnished or to be furnished by the department. Haw. Rev. Stat. § 346-37(c). The department, as to this right of reimbursement, shall also be subrogated to all rights or claims that a claimant has against the third person for all damages not to exceed the full extent of the costs of medical assistance or burial payment furnished or to be furnished by the department. Haw. Rev. Stat. § 346-37(d).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 C.F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). Therefore, the current practice of obtaining medical records could proceed under state law.

There are no specific requirements for confidentiality and privacy records under workers’ compensation law in Hawai‘i. However, a Claimant provides his or her authorization for the release of records upon initiating a claim by filing a WC-5.

There is no state privacy law regarding medical records. Haw. Rev. Stat. Chapter 323C, governing the Privacy of Health Care Information was enacted in 1999 and repealed in 2001. However, the Courts have found that the privacy provisions of the Hawai‘i State Constitution, Article I, Section 6 protects a claimant’s health information against disclosure outside the underlying litigation. *Cohan v. Ayabe*, 132 Hawai‘i 408, 322 P.3d 948 (Hawai‘i 2014).

57. **What are the provisions for “Independent Contractors”?**

Whenever an independent contractor undertakes to perform work for another person pursuant to contract, express or implied, oral or written, the independent contractor is
deemed the employer of all employees performing work in the execution of the contract, including employees of the independent contractor’s subcontractors and their subcontractors. Haw. Rev. Stat. § 386-1, Definition of Employee. However, the liabilities of the direct employer of an employee who suffers an injury is primary and that of the others secondary in their order. Haw. Rev. Stat. § 386-1, Definition of Employee. An employer secondarily liable who satisfies a liability under this chapter is entitled to indemnity against loss from the employer primarily liable. Haw. Rev. Stat. § 386-1, Definition of Employee.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific statutes or regulations regarding professional employment organizations/temporary service companies/temporary service companies. However, by custom and in practical application before the DCD and LAB, the Department considers the claimant to be the employee of the PEO, temp agency, or leasing company.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

No.

60. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**


Haw. Rev. Stat. § 329-122(c) specifically states “[t]he authorization for the medical use of cannabis … shall not apply to … [t]he medical use of cannabis … in the workplace of one’s employment . . . .”

Haw. Rev. Stat. Chapter 386 has not yet been amended to address cannabis use.

61. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

No.
1. Citation for the state’s workers’ compensation statute.

Idaho Code § 72-101, et. seq.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

“‘Employee’ is synonymous with ‘workman’ and means any person who has entered into the employment of, or who works under contract of service or apprenticeship with, an employer.” Idaho Code § 72-102(12). Unless an election for coverage is made pursuant to I.C. § 72-213, the following listed employments are exempt from coverage under the Idaho Workers’ Compensation statutes: household domestic service; casual employment; employment of outworkers; family members living within the same dwelling; family members not living in same dwelling if the employer is the owner of a sole proprietorship; employment as the owner of a sole proprietorship, working member of a partnership or limited liability company, employment of an officer of a corporation who at all times during the period involved owns not less than ten percent (10%) of all of the issued and outstanding voting stock of the corporation and, if the corporation has directors, is also a director thereof; employment covered by federal laws; pilots of agricultural spraying or dusting planes; associate real estate brokers and real estate salesmen; volunteer ski patrollers; and officials of athletic contests involving secondary schools. I.C. § 72-212(1)-(11).

3. Identify and describe any “statutory employer” provision.

“‘Employer’ means any person who has expressly or impliedly hired or contracted the services of another, and includes contractors and subcontractors. It includes the owner or lessee of premises, or other person who is virtually the proprietor or operator of a business there carried on, but who, by reason of their being an independent contractor or for any other reason, is not the direct employer of the workers there employed. If the employer is secured, it means his surety so far as applicable.” Idaho Code § 72-102(13)(a). The statutes also extend coverage to employees of contractors and/or subcontractors. I.C. § 72-216; Dewey v. Merrill, 124 Idaho 201, 858 P.2d 740 (1993).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

“Injury” means a personal injury caused by an accident arising out of and in the course of
any employment covered by the workers’ compensation law. I.C. § 72-102(18)(a). “Accident” means an unexpected, undesigned, and unlooked for mishap, or untoward event, connected with the industry in which it occurs, and which can be reasonably located at the time when and place where it occurred, causing an injury. I.C. § 72-102(18)(b). “Injury” and “personal injury” shall be construed to include only an injury caused by an accident, which results in violence to the physical structure of the body. The term shall in no case be construed to include an occupational disease and only such non-occupational diseases as result directly from an injury. I.C. § 72-102(18)(c).

B. Occupational disease (including respiratory and repetitive use).

“Occupational disease” means a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment, but shall not include psychological injuries, disorders, or conditions unless the conditions set forth in § 72-451, Idaho Code, are met. I.C. § 72-102(22)(a). Covered diseases include those specified in Idaho Code § 72-438 and those due to the nature of the employment in which the hazards of the disease actually exist and are peculiar to the trade or employment. “Last exposure rule” fixes liability on the current employer if exposure is at least 60 days. I.C. § 72-439(2).

C. Subsequent injury rule.

If an employee who has a permanent physical impairment from any cause or origin, incurs a subsequent disability by an injury or occupational disease arising out of and in the course of his employment, and by reason of the combined effects of both the pre-existing impairment and the subsequent injury or occupational disease or by reason of the aggravation and acceleration of the pre-existing impairment, suffers total and permanent disability, the employer and surety shall be liable for payment of compensation benefits only for the disability caused by the injury or occupational disease, including scheduled and unscheduled permanent disabilities, and the injured employee shall be compensated for the remainder of his income benefits out of the Industrial Special Indemnity Account. I.C. § 72-332(1).

The claimant has the burden of establishing a prima facie case of total disability within the odd lot category; once the claimant meets his or her initial burden of establishing a prima facie case of total disability within the odd lot category, the burden then shifts to the employer and/or the Industrial Specialty Indemnity Fund to show that some kind of suitable work is readily and continuously available to the claimant. Mapusaga v. Red Lion Riverside Inn, 113 Idaho 842, 748 P.2d 1372 (1987), overruled on other grounds, Archer v. Bonners Ferry Datsun, 117 Idaho 166, 786 P.2d 557 (1990). Burden of proof is on the party seeking to invoke the liability of the Industrial Special Indemnity Fund (ISIF) under the statute, to show that the disability would not have been total “but for” the pre-existing condition. Garcia v. J. R. Simplot Co., 115 Idaho 966, 772 P.2d 173 (1989), overruled on other grounds, Archer v. Bonners Ferry Datsun, 117 Idaho 166, 786 P.2d 557 (1990).
5. **What, if any, injuries or claims are excluded?**

Any claims arising out of employments which are exempt, unless an employer of an exempt occupation elects coverage. I.C. §§ 72-212 & 213. In addition, no compensation shall be allowed to an employee for injury proximately caused by the employee’s willful intention to injure himself or to injure another. If intoxication is a reasonable and substantial cause of an injury, then no income benefits will be paid except where the intoxicants causing the employee’s intoxication were furnished by the employer or where the employer permits the employee to remain at work with knowledge by the employer or his supervising agent that the employee is intoxicated. I.C. § 72-208(1) & (2).

6. **What psychiatric claims or treatments are compensable?**

Psychological injuries, disorders or conditions are generally not compensated under the Idaho workers’ compensation statutes unless the various conditions enumerated under I.C. § 72-451 are met. No compensation shall be paid for such injuries arising from conditions generally inherent in every working situation or from a personnel related action, including, but not limited to, disciplinary action, changes in duty, job evaluation and employment termination. I.C. § 72-451(2).

7. **What are the applicable statutes of limitations?**

Applications for a hearing must be made within one (1) year if no compensation has been paid, and when compensation has been discontinued, employee has five (5) years from the date of the accident causing the injury or date of first manifestation of the occupational disease within which to file the application with the commission. I.C. § 72-706(1)(2). If income benefits have been paid and discontinued more than four (4) years from the date of the accident causing the injury or the date of first manifestation of an occupational disease, the claimant shall have one (1) year from the date of the last payment of income benefits within which to make and file with the commission an application requesting a hearing for additional income benefits. I.C. § 72-706(3). No limitation of time provided in this law shall run against any person who is mentally incompetent or a minor dependent so long as he has no committee, guardian, or next friend. I.C. § 72-705.

This statute does not affect the right to medical benefits under I.C. §72-432(1).

8. **What are the reporting and notice requirements for those alleging injury?**

Notice of an injury must be given to the employer as soon as practicable but not later than sixty (60) days after the happening thereof. I.C. § 72-701. Want of notice or delay in giving notice shall not be a bar to proceedings under the workers’ compensation statutes if it is shown that the employer, his agent or representative had knowledge of the injury or occupational disease or that the employer has not been prejudiced by such delay or want of notice. I.C. § 72-704. Such notice and such claim shall be in writing; the notice shall contain the name and address of the employee, and shall state in ordinary language
the time, place, nature and cause of the injury or disease and shall be signed by him or by a person on his behalf, or, in the event of his death, by any one or more of his dependents, or by a person on their behalf. The notice may include the claim. I.C. § 72-702. A notice shall not be held invalid or insufficient by reason of any inaccuracy in stating that time, place and nature or cause of injury, or disease, or otherwise, unless it is shown by the employer that he was in fact prejudiced thereby. I.C. § 72-704.

9. **Describe available defenses based on employee conduct:**

   **A. Self-inflicted injury.**

   No compensation shall be allowed to an employee for injury proximately caused by the employee’s wilful intention to injure himself or to injure another. I.C. § 72-208(1).

   **B. Willful misconduct, “horseplay”, etc.**

   No compensation shall be allowed to an employee for injury proximately caused by the employee’s wilful intention to injure himself or to injure another. I.C. § 72-208(1). In determining whether an accident arises out of and in the course of employment, each case must be decided upon its own attendant circumstances under a liberal construction of the Workers’ Compensation Act to effectuate its intent and purpose. Colson v. Steele, 73 Idaho 348 (1953). In Colson, the court refused to follow those jurisdictions which had created an automatic exclusion for accidents resulting from on-the-job horseplay. Clark v. Daniel Morine Constr. Co., 98 Idaho 114 (1977).

   **C. Injuries involving drugs and/or alcohol.**

   If intoxication is a reasonable and substantial cause of an injury, no income benefits shall be paid, except where the intoxicants causing the employee’s intoxication were furnished by the employer or the employer permits the employee to remain at work with knowledge by the employer or his supervising agent that the employee is intoxicated. I.C. § 72-208(2).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    If, for the purpose of obtaining any benefit or payment under the provisions of this law, either for himself or for any other person, anyone wilfully makes a false statement or representation, he shall be guilty of a misdemeanor and upon conviction or such offense, he shall forfeit all right to compensation under this law. I.C. § 72-801. An award may be modified within five (5) years of the date of the accident causing the injury, or the date of the first manifestation of an occupational disease, for fraud. I.C. § 72-719(1)(b).

11. **Is there any defense for falsification of employment records regarding medical history?**

    No compensation shall be payable for an *occupational disease* if the employee, at the
time of entering into the employment of the employer by whom the compensation would otherwise be payable, falsely represented himself in writing as not having previously been disabled, laid off, or compensated in damages or otherwise because of such disease. I.C. § 72-441. There does not appear to be a similar statute for pre-existing accidents or injuries.

12. Are injuries during recreational and other non-worker activities paid for or supported by the employer compensable?

Acts done by an employee partly for personal reasons and partly to serve the employer is still within the scope of employment for purposes of workers’ compensation. Mortimer v. Riviera Apartments, 122 Idaho 839, 845, 840 P.2d 383 (1992). In Grant v. Brownfield’s Orthopedic and Prosthetic, 105 Idaho 542, 671 P.2d 455 (1983), the Idaho Supreme Court was asked to decide whether an employee’s accidental death while choking on a piece of meat at the employer’s annual Christmas party was compensable under the Idaho workers’ compensation statutes. Relying on a secondary reference, the court stated:

When the degree of employer involvement descends from compulsion to mere sponsorship or encouragement, the questions become closer, and it becomes necessary to consult a series of tests bearing on work-connection. The most prolific illustrations of this problem are company picnics and office parties. Among the questions to be asked: Did the employer in fact sponsor the event? To what extent was attendance really voluntary? Was there some degree of encouragement to attend in such factors as taking a record of attendance, paying for the time spent, requiring the employee to work if he did not attend, or maintaining a known custom of attending? Did the employer finance the occasion to a substantial extent? Did the employees regard it as an employment benefit to which they were entitled as of right? Did the employer benefit from the event, not merely in a vague way through better morale and good will, but through such tangible advantages as having an opportunity to make speeches and awards?

Grant, 105 Idaho at 543-544 quoting Larson, 1A Workmans’ Compensation Law §22.23, pp. 5-85 to 86 (emphasis in the original). After an extensive examination of these factors, the court found that the employee’s death was compensable under the Idaho workers’ compensation statutes. Grant, 105 Idaho at 551.

13. Are injuries by co-employees compensable?

An injury caused by a co-employee will generally be compensable under the Idaho workers’ compensation statutes if it arises out of and in the course of employment. I.C. §72-102(18)(a); Colson v. Steele, 73 Idaho 348, 252 P.2d 49 (1953). However, an injury by a co-employee will not be considered to arise out of employment when the injury

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., “irate paramour” claims)?

No. Where an employee is assaulted and injuries inflicted upon him through animosity and ill will arising from some cause wholly disconnected with the employer’s business or the employment, the employee cannot recover compensation simply because he was assaulted when he was in the discharge of his duties, since the injury does not, under such circumstances arise out of the course of employment, and employment is not the cause of the injury. Hudson v. Roberts, 75 Idaho 224, 270 P.2d 837 (1954).

BENEFITS

15. What criterion is used for calculating the average weekly wage?

The employee’s average weekly wage, from which benefits during the first fifty-two (52) weeks are calculated (at two-thirds (2/3) of the average weekly wage), is based on: (1) if paid by the week, weekly pay; (2) if paid monthly, monthly wage multiplied by 12 divided by 52; (3) if fixed by year, divided by 52; or (4) if fixed by day, hour or output, the average weekly wage most favorable to the employee is computed by dividing by 13, the employee’s wages earned on first, second, third or fourth of 13 successive calendar weeks prior to the injury or disease manifestation. I.C. § 72-419 (1) - (4). See Idaho Code § 72-419 for additional considerations.

I.C. § 72-419 is used to calculate the rate at which income benefits are paid, which is better suited to mathematical calculation, but when evaluating a claimant’s permanent physical disability, the Industrial Commission is required to consider the factors articulated in I.C. § 72-425 and cannot rely solely upon mathematical calculation. Vassar v. J.R. Simplot Co., 134 Idaho 495, 5 P.3d 475 (2000).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Benefits are paid at two-thirds (2/3) of the employee’s average weekly wage, subject to a maximum of 90% of the state average weekly wage, and a minimum of 45% of the state’s average weekly wage; but during the first 52 weeks of total disability income benefits, no more than 90% of the employee’s average weekly wage, provided that if during the first 52 weeks 90% of the employee’s average weekly wage is less than 15% of the state average weekly wage, then the employee shall receive no less than 15% of the average weekly wage. I.C. §§ 72-408 & 409.

17. How long does the employer/insurer have to begin temporary benefits from the date
disability begins?

An injured employee shall not be allowed income benefits for the first five (5) days of disability for work; provided, if the injury results in disability for work exceeding two (2) weeks, income benefits shall be allowed from the date of disability and be paid no later than four (4) weeks from the date of disability. Provided, further, that the waiting period shall not apply if the injured employee is hospitalized as an in-patient. I.C. § 72-402(1).

18. What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out _____ days before recovering benefits for the first _____ days)?

An injured employee shall not be allowed income benefits for the first five (5) days of disability for work; provided, if the injury results in disability for work exceeding two (2) weeks, income benefits shall be allowed from the date of disability and be paid no later than four (4) weeks from the date of disability. Provided, further, that the waiting period shall not apply if the injured employee is hospitalized as an in-patient. I.C. § 72-402(1). The day on which the injury occurred shall be included in computing the waiting period unless the employee has been paid wages for that day. I.C. § 72-402(2).

19. What is the standard/procedure for terminating temporary benefits?

A workman shall receive written notification within fifteen (15) days of any change of status or condition which directly or indirectly affects the level of compensation benefits to which he might presently or ultimately be entitled. I.C. § 72-806.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No. An employee who suffers a permanent disability less than total and permanent shall, in addition to the income benefits payable during the period of recovery, be paid income benefits for such permanent disability in an amount equal to 55% of the average weekly state wage stated against the impairments listed in I.C. § 72-428.

21. What disfigurement benefits are available and how are they calculated?

There are no special or scheduled disfigurement benefits. See I.C. § 72-430(1). Disfigurement may be treated as “impairment” under the AMA Guidelines Book. Disfigurement is compensable if the commission finds that the physical injury resulted in “disability.”

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?
Scheduled benefits are specified in Idaho Code § 72-428, up to a maximum of 350 weeks. The evaluation of permanent disability includes consideration of all physical impairments that were caused by the claimant’s work-related injury and pre-existing impairments or physical condition. Eckhart v. State, Indus. Special Indem. Fund, 133 Idaho 260, 985 P.2d 685 (1999).

B. Number of weeks for a “whole person” and standard for recovery.

The “whole man” for purposes of computing disability evaluation of scheduled or unscheduled permanent injuries (bodily loss or losses or loss of use) for conversion to scheduled income benefits, shall be a deemed period of disability of 500 weeks. I.C. § 72-426. The evaluation or rating of permanent disability is an appraisal of the injured employee’s present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent non-medical factors as provided in I.C. § 72-430. I.C. § 72-425.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Following a hearing upon a motion of the employer, the employee, or the commission, if the commission deems a permanently disabled employee, after the period of recovery, is receptive to and in need of retraining in another field, skill or vocation in order to restore his earning capacity, the commission may authorize or order such retraining and during the period of retraining or any extension thereof, the employer shall continue to pay the disabled employee, as a subsistence benefit, temporary total or temporary partial disability benefits as the case may be. The period of retraining shall be fixed by the commission but shall not exceed fifty-two (52) weeks unless the commission, following the application and hearing, deems it advisable to extend the period of retraining, in which case the increased period shall not exceed fifty-two (52) weeks. The employer and the employee may mutually agree to a retraining program without the necessity of a hearing before the commission. I.C. § 72-450.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Detailed calculations and limits are specified in I.C. § 72-408. Generally, for the first fifty-two (52) weeks, two-thirds (2/3) of the employee’s average weekly wage; thereafter, two-thirds (2/3) of the average state wage, increasing from year to year.

Such benefits are subject to a minimum of no less than 45% of the average state wage and a maximum of 90% of the average state wage. I.C. § 72-409(1).

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.
If death results from the injury within four (4) years, the employer shall pay to the person entitled to compensation, or if there is none then to the personal representative of the deceased employee, a sum, not to exceed $6,000 for funeral and burial or cremation, together with the actual expenses of transportation of the employee’s body to his place of residence within the United States or Canada. I.C. §§ 72-102(4) and 72-436.

B. Dependency claims.

Dependency shall initially be determined as of the time of the accident causing the injury or of manifestation of an occupational disease for purposes of income benefits therefor, and as of the time of death for purposes of income benefits for death. I.C. § 72-401.

Income benefits for death of an employee are payable for specific periods of time measured either by events or by an income benefit compensation period of five hundred (500) weeks, whichever is lesser in any given circumstance. I.C. § 72-412.

A widow or a widower is paid income benefits until either death or remarriage, but in no case can compensation exceed five hundred (500) weeks. I.C. § 72-412(1). A child will receive income benefits until the child reaches eighteen (18) years of age, and if incapable of self-support after age eighteen (18), for an additional period not to exceed five hundred (500) weeks, deducting the period benefits which were paid prior to eighteen (18) years of age. Provided, income benefits payable to or for any child shall cease when such child marries. I.C. § 72-412(2). A child over the age of eighteen (18) will be paid income benefits if the child is enrolled as a full-time student in any accredited educational institution, or accredited vocational training program, until such child ceases to be enrolled or reaches the age of twenty-three (23) years. I.C. § 72-412(3). A parent or grandparent shall be paid death benefits during the continuation of a condition of actual dependency, but in no case may the benefits exceed five hundred (500) weeks. I.C. § 72-412(4). A grandchild, brother or sister may receive income benefits during a period of dependency, but in no case may the benefits exceed five hundred (500) weeks. I.C. § 72-412(5). In the event the death of the employee occurs after a period of disability, the period of disability will be deducted from the total of compensation. I.C. § 72-412(6).

If death results from the accident or occupational disease within four (4) years from the date of the accident, or manifestation of the occupational disease, the employer shall pay to or for the benefit of the following particular classes of dependents weekly income benefits equal to the following percentages of the average weekly state wage as defined in I.C. § 72-409. I.C. § 72-413. The statute then sets out an exhaustive list of percentages paid to certain dependents of the deceased employee, e.g., dependent widow or widower, if there are no dependent children, is entitled to 45% of the average weekly state wage.

In the event of remarriage of the widow or widower prior to the expiration of five hundred (500) weeks, a lump sum shall be paid to the widow or widower in an amount equal to the lesser of one hundred (100) weeks or the total of income benefits for the remainder of the five hundred (500) week period computed on the basis of a weekly rate
of 45% of the average weekly state wage in effect at the time of remarriage. I.C. § 72-413A.

In case there are two (2) or more classes of persons entitled to compensation under § 72-413, and the apportionment of such compensation as above provided, would result in injustice, the commission may, in its discretion, modify the apportionment to meet the requirements of the class. I.C. § 72-414.

Upon the cessation of the income benefits for death to or on account of any person, income benefits of the remaining persons entitled to income benefits for the unexpired part of the period during which their income benefits are payable shall be that which such person would have received if they had been the only persons entitled to income benefits at the time of the decedent’s death. I.C. § 72-415.

26. **What are the criteria for establishing a “second injury” fund recovery?**

The Idaho Supreme Court has held that to require any contribution from the second injury fund, the party seeking the funds participation in the payment of benefits must prove: (1) the employee had a permanent physical impairment which pre-existed the injury; (2) the permanent physical impairment was “manifest” prior to the current injury; (3) the pre-existing impairment constituted a subjective hindrance or obstacle to obtaining employment or re-employment; (4) the employee has experienced a subsequent work-related injury or occupational disease which is disabling; and (5) the employee is now permanently and totally disabled either as a result of the combined effect of the pre-existing impairment and the subsequent injury or by reason of the aggravation and acceleration of the pre-existing impairment. Dumaw v. J.L. Norton Logging, 118 Idaho 150, 795 P.2d 312 (1990); Garcia v. J.R. Simplot Co., 115 Idaho 966, 722 P.2d 173 (1989); I.C. §72-332.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitation?**

Application for hearing must be made within one year if no compensation has been paid, and when compensation has been discontinued, the employee has five (5) years from the date of the accident causing the injury or the date of first manifestation of the occupational disease within which to file the application with the commission. I.C. § 72-706(1)(2). In addition, if income benefits have been paid and discontinued more than four (4) years from the date of the accident or the first manifestation of the occupational disease, the employee has one (1) year from the date of the last payment of income benefits within which to file an application for hearing. I.C. § 72-706(3). Standard claims may be re-opened and modified within five (5) years of the injury, or first manifestation of exposure if there is a change in condition or disablement, but not more often than once in six (6) months. I.C. § 72-719.

28. **What situation would place responsibility on the employer to pay an employee’s attorney’s fees?**
If the commission or any court for whom any proceedings are brought under the Idaho workers’ compensation laws determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable grounds, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay the injured employee or his dependents the compensation provided by law, or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney’s fees in addition to the compensation provided by this law. In all such cases, the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission. I.C. § 72-804.

IDAPA 17.02.08.033 regulates the amount of fees an attorney can recover from a claimant in a worker's compensation proceeding and has been upheld by the Idaho Supreme Court. Seiniger Law Offices, P.A. v. State Ex. Rel. Indus. Comm'n, ___ Idaho ___, 299 P.3d 773 (4-12-2013).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

I.C. §§ 72-201, 72-209, and 72-211 provide that the Idaho workers’ compensation laws are the exclusive remedy for injuries caused by accidents arising out of and in the course of employment.

B. Exceptions (intentional acts, contractual labor, “dual capacity,” etc.).

The exemption from tort liability given to an employer shall not apply in any case where the injury or death is proximately caused by the wilful or unprovoked physical aggression of the employer, its officers, agents, servants, or employees, the loss of such exemption applies only to aggressor and shall not be imputable to the employer unless provoked or authorized by the employer, or the employer was a party thereto. I.C. §72-209(3). Contractual waiver is not recognized in the state of Idaho. When the employee is employed by two employers and one employer is attempting to use the workers’ compensation law as a shield to avoid third-party liability, it is that employer’s duty to prove that the employee was working for the employer when the accident occurred and the fact that the employee was subject to the direction and control of either employer at moment’s notice was not determinative; what the employer had to prove as claimant was that the employee’s injury arose out of and in the course of his employment with the employer. Basin Land Irrigation Co. v. Hat Butte Canal Co., 114 Idaho 121, 754 P.2d 434 (1988).

30. Are there any penalties against the employer for unsafe working conditions?
An employer can be guilty of a misdemeanor if they fail or refuse to comply with an order of the commission regarding safety. The employer may also be penalized $1 for each employee for every day during which such failure to comply continues. I.C. § 72-723.

If any employer shall fail for a period of ten (10) days to comply with such order of the Commission, he may be enjoined by such district court from carrying on such trade or occupation while such failure continues. I.C. § 72-723.

31. **What is the penalty, if any, for an injured minor?**

None.

32. **What is the potential exposure for “bad faith” claims handling?**

An employer or surety may be liable for reasonable costs of the claimant’s attorney’s fees for bad faith in handling the claim. I.C. § 72-804. The legislature did not intend that a worker should be able to bring a bad faith tort action against his employer’s surety in courts of general jurisdiction, but rather that a worker could receive attorney’s fees and sometimes punitive costs if the employer or surety acted unreasonably. Idaho State Ins. Fund v. Van Tine, 132 Idaho 902, 980 P.2d 566 (1999).

33. **What is the exposure for terminating an employee who has been injured?**

There is no such exposure under the Workers’ Compensation Act. However, such an action may violate the doctrine of the implied covenant of good faith and fair dealing which is recognized by the Idaho civil courts.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. I.C. § 72-223(2).

35. **Can co-employees be sued for work-related injuries?**

Generally a co-employee will not be liable for tort liability based on mere negligence. However, the co-employee may expose himself or their employer to tort liability for intentional acts unrelated to the job. I.C. § 72-209(3).

36. **Is subrogation available?**

Yes. I.C. § 72-223(3).

**MEDICALS**
37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Unless the payor denies liability for the claim or sends a Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. IDAPA 17.02.09.035.04. “Payor” means the legal entity responsible for paying medical benefits under Idaho’s Workers’ Compensation Law.

IDAPA subsections .035.04-.035.10 provide a procedure for resolving disputes over medical fees between Care Providers and Payors. Upon completion of the specified procedure, if the Provider prevails in a dispute over CPT or MS-DRG coded items, Payor shall pay the amount owed, plus an additional thirty percent (30%). However, if the Provider prevails in a dispute over items without CPT or MS-DRG codes, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount due within thirty (30) days of the administrative order.

If the commission or any court for whom any proceedings are brought under the Idaho workers’ compensation laws determines that the employer or his surety … neglected or refused within a reasonable time after receipt of a written claim for compensation to pay the injured employee or his dependents the compensation provided by law, … the employer shall pay reasonable attorney’s fees in addition to the compensation provided by this law. In all such cases, the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission. I.C. § 72-804.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

In filing a workers’ compensation complaint, the claimant is required to sign a release of medical information which allows the employer to have access to any medical documents relating to the claim.

All medical information relevant to or bearing upon a particular injury or occupational disease shall be provided to the employer, surety, manager of the Industrial Special Indemnity Fund or their attorneys or authorized representatives, the claimant, the claimant’s attorneys or authorized representative, or the Commission without liability on the part of the physician, hospital, or other provider of medical services and information developed in connection with treatment or examination for an injury or disease for which compensation is sought and shall not be privileged communication. I.C. § 72-432(11).

39. **What is the rule on (a) Claimant’s choice of physician; and (b) Employer’s right to a second opinion and/or Independent Medical Examination?**

I.C. §72-432(4)(a) states “The employee upon reasonable grounds, may petition the commission for a change of physician to be provided by the employer; however, the
employee must give written notice to the employer or surety of the employee’s request for a change of physicians to afford the employer the opportunity to fulfill its obligation under this section. If proper notice is not given, the employer shall not be obligated to pay for the services obtained... If any dispute arises over the issue of a request for change of physician, the industrial commission shall conduct an expedited hearing to determine whether or not the request for change of physician should be granted.”

I.C. §72-433(1) states that after an injury or contraction of an occupational disease and during the period of disability the employee, if requested by the employer or ordered by the commission, shall submit himself for examination at reasonable times and places to a duly qualified physician or surgeon.

I.C. §72-433(2) allows the employee to have a physician or surgeon designated and paid by himself present at an examination by an employer’s physician or surgeon.

If an injured employee unreasonably fails to submit to or in any way obstructs an examination by a physician or surgeon designated by the commission or the employer, the injured employee’s right to take or prosecute any proceedings under this law shall be suspended until such failure or obstruction ceases, and no compensation shall be payable for the period during which such failure or obstruction continues. I.C. §72-434.

40. **What is the standard for covered treatment** *(e.g., chiropractic care, physical therapy, etc.)*?

An employee shall not be responsible for charges of physicians, hospitals, or other providers of medical services to whom he has been referred for treatment of his injury or occupational disease by an employer designated physician or by the commission, except for charges for personal items or extended services which the employee has requested for his convenience and which are not required for treatment of his injury or occupational disease. I.C. § 72-432(7).

41. **Which prosthetic devices are covered, and for how long?**

Prosthetic devices are authorized under the Idaho workers’ compensation laws. I.C. § 72-432(2). No specific limitation or description is dictated by statute, rule, or case law.

42. **Are vehicle and/or home modifications covered as medical expenses?**

No. Other than necessary travel in obtaining medical care, any employee who seeks medical care in a manner not provided for in I.C. § 72-432 or as ordered by the Industrial Commission pursuant to this section, shall not be entitled to reimbursement of costs of such care. I.C. § 72-432(5) and (13).

43. **Is there a medical fee guide or schedule, or other provision for cost containment?**

No.
44. **What, if any, provisions or requirements are there for “managed care”?**

None.

**PRACTICE/PROCEDURES**

45. **What is the procedure for contesting all or part of a claim?**

If the insurance company or self-insured employer denies a claim, the claimant can file a complaint with the Industrial Commission. I.C. § 72-706. The complaint initiates the formal legal process to bring the issue to the Commission for a hearing and decision. Mediation is also available.

46. **What is the method of claim adjudication?**

**A. Administrative level.**

Hearings are generally held before a referee who submits recommended findings and conclusions to the Industrial Commission, a three-member panel appointed by the governor. I.C. § 72-501(1). The statute requires that not more than one commissioner be a lawyer. I.C. § 72-501(4). A decision of the Commission, in the absence of fraud, shall be final and conclusive as to all matters adjudicated by the Commission upon filing the decision in the Office of the Commission, provided, within twenty (20) days from the date of filing the decision, any party may move for reconsideration or rehearing of the decision, or the Commission may rehear or reconsider its decision on its own initiatives, and in any such event, the decision shall be final upon denial of a motion for rehearing or reconsideration or the filing of the decision on rehearing or reconsideration. Final decisions may be appealed directly to the Supreme Court as provided by I.C. § 72-724. I.C. § 72-718.

**B. Trial court.**

No court of this state shall have jurisdiction to review, vacate, set aside, reverse, revise, correct, amend, or annul any order or award of the Commission, or to suspend or delay the execution or operation thereof, or to enjoin, restrain, or interfere with the Commission in the performance of its duties. I.C. § 72-733.

Courts do have concurrent jurisdiction over issues that may arise in a civil action, such as independent contractor vs. employee status, or the employer being covered under the Workers’ Compensation Act, or being subject to an exemption.

**C. Appellate.**

All decisions of the Industrial Commission may be appealed, as a matter of right, directly to the state’s highest court, the Idaho Supreme Court. I.C. §§ 72-718 and 72-724.
47. **What are the requirements for stipulations or settlement?**

If the employer and the afflicted employee reach an agreement in regard to compensation under this law, a memorandum of the agreement shall be filed with the commission, and, if approved by it, thereupon the memorandum shall for all purposes be an award by the commission and be enforceable under the provisions of section 72-735, unless modified as provided in section 72-719. An agreement shall be approved by the commission only when the terms conform to the provisions of this law. I.C. § 72-711.


48. **Are full and final settlements with closed medicals available?**

Yes.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. A memorandum of the agreement shall be filed with the Commission, and, if approved by it, thereupon the memorandum shall for all purposes be an award by the Commission and be enforceable under the provisions of I.C. § 72-735 unless modified as provided in I.C. § 72-719. An agreement shall be approved by the Commission only when the terms conform to the provisions of this law. I.C. § 72-711.

**RISK FINANCE FOR WORKERS COMPENSATION**

50. **What insurance is required, and what is available (e.g., private care, state fund, assigned risk pool, etc.)?**

Workers’ compensation insurance is required for all injuries incurred by employees arising out of their employment, except for exemptions. I.C. § 72-301. Employers can obtain worker’s compensation insurance through one of four options: (1) private insurance; (2) State Insurance Fund; (3) assigned risk pool; and (4) self insurance. Each employer/insurer contributes part of the basic premium to the Idaho Special Indemnity Fund, Idaho’s “second injury fund,” which is responsible for apportioned benefits attributable to pre-existing conditions or injuries. I.C. § 72-332(1). Idaho Code § 72-306 requires that policies insure all liability under the Workers’ Compensation Act.

51. **What are the provisions/requirements for self-insurance?**

A. For individual entities.
Individual employers may self-insure upon posting security satisfactory to the Industrial Commission. I.C. § 72-301. In order to be considered for approval by the Industrial Commission to self-insure under I.C. § 72-301, an employer shall maintain an average Idaho payroll over the proceeding three (3) years of at least Four Million Dollars ($4,000,000.00). IDAPA 17.02.11.013.01. A self-insured employer shall also deposit an initial security deposit with the Idaho State Treasurer in the form of cash, U.S. obligations, Idaho municipal bonds, or a self-insurer’s bond in substantially the form set forth in the amount of One Hundred Fifty Thousand Dollars ($150,000.00), plus 5% of the first Ten Million Dollars ($10,000,000.00) of the employer’s average annual payroll in the State of Idaho for the three (3) preceding years. IDAPA 17.02.11.013.11.

Additional application requirements for prospective self-insured employers are set forth in IDAPA 17.02.11.013.02 through 17.02.11.013.12. Continuing requirements for self-insured employers are set forth in IDAPA 17.02.11.014.01 through 17.02.11.014.06.

B. For groups or “pools” of private entities.

Groups or pools of private employers may not self-insure as such. In three instances, however, groups of employers have effectively “self-insured” by creating separate entities which qualify as sureties under the Idaho statute. Idaho presently has three reciprocal employer-owned sureties: Truckers Exchange, Associated Loggers, and Workers’ Compensation Exchange.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

“Alien” means a person who is not a citizen, a national, or resident of the United States or Canada. Any person not a citizen or a national of the United States who relinquishes or is about to relinquish his residence in the United States shall be regarded as an alien. I.C. § 72-102(1). There is no specific statute exempting “illegal aliens” from coverage under Idaho’s workers’ compensation laws.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Idaho’s workers’ compensation statute does not address the question.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare's interests pursuant to the Medicare Secondary Payor Act?

Idaho’s workers’ compensation statute does not address the question. However, Medicare will seek reimbursement from a liable party for monies Medicare paid. An attorney should find out the amount of the trust/lien, or “interest” as Medicare calls it,
55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

First, there would be no need for Medicaid or a health insurer to pay medical benefits, and thus be subrogated, if the injury arises out of the course and scope of employment. If a health insurer paid medical expenses as a disputed claim and it was ultimately determined to be compensable, the compensation insurer would be responsible for the expenses and would have to pay off the health insurer or Medicaid.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

All medical information relevant to or bearing upon a particular injury or occupational disease shall be provided to the employer, surety, manager of the Industrial Special Indemnity Fund or their attorneys or authorized representatives, the claimant, the claimant’s attorneys or authorized representative, or the Commission without liability on the part of the physician, hospital, or other provider of medical services and information developed in connection with treatment or examination for an injury or disease for which compensation is sought and *shall not be privileged communication*. I.C. § 72-432(11). (Emphasis added)

Idaho’s workers’ compensation statute does not specifically address the confidentiality and privacy of medical records. The Idaho Administrative Code has a procedure for submitting medical reports. IDAPA 17.02.04.322.02. Whenever possible, billing information shall be coded using the Current Procedural Terminology (CPT). In the case of hospitals, reports shall include a Uniform Billing (UB) Form 92. In the case of physicians and other providers supplying outpatient services, this reporting requirement shall include a Health Care Financing Administration (HCFA) Form 1500.

Depending on the type, there are different statutes for each profession relating to confidential and privileged information. “A physician or surgeon cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient.” I.C. §9-203(4).

45 CFR 160 supercedes state law unless the state law is more restrictive. Since federal HIPAA is more restrictive than Idaho state laws, HIPAA supercedes the Idaho act. HIPAA sets the standard for the disclosure of released medical records and subpoenaed records.

57. **What are the provisions for "Independent Contractors"?**

Independent contractor is defined as, "any person who renders service for a specified
recompense for a specified result, under the right to control or actual control of his principal as to the result of his work only and not as to the means by which such result is accomplished. I.C. § 72-102(17).

Independent contractors are ineligible to recover worker's compensation from the State Insurance Fund. The determination of whether an injured party is an independent contractor or an employee is a factual determination to be made on a case-by-case basis from full consideration of the facts and circumstances established by the evidence. Olvera v. Del's Auto Body, 118 Idaho 163, 795 P.2d 862 (1990).

58. Are there any specific provisions for "Independent Contractors" pertaining to professional employment organizations/temporary service companies/leasing companies?

The only reference to "professional employment organizations" is located in I.C. § 72-103, which states that the parties to a professional employer arrangement have the option to determine for themselves, in writing, whether the temporary employer or the work site employer will be the party to secure liability as required by section 72-301. To the extent the parties do not exercise the option provided, the obligation to secure such liability shall be with the temporary or professional employer. I.C. § 72-103(3).

59. Are there any specific provisions for "Independent Contractors" pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan by contacting the ALFA attorneys at (312) 642-ALFA (2532).
1. Citation for the state's workers' compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Every person in the service of another under any contract of hire and all employees whose contract of hire is in the state or if hired outside the state, where their principal place of business is in the state. 820 ILCS 305/1(b)(2). Employees of a business that has elected to be covered by the Worker's Compensation Act, are covered. There is a long list of businesses declared to be “extra-hazardous” with all employees covered automatically by law. This includes construction, trucking, mining, warehousing, working with molten metal, explosives and sharp tools, bar employees, restaurant employees if they cut food, haircutting, surveying and gas station employees. 820 ILCS 305(3). Exempted are real estate brokers/salespeople on commission and farmers. Jurors are not to be considered “employees” of the jury commission for purposes of the workers’ compensation act. Jaskoviak v. Industrial Commission, 337 Ill. App. 3d 269, 272 (3 Dist. 2003).

3. Identify and describe any "statutory employer" provision.

Where a subcontractor is uninsured, the employee of that subcontractor may recover compensation under the Act from the general contractor or from the individual or entity, if any, that engaged the services of the general contractor. The subcontractor is then liable for indemnification. 820 ILCS 305/1(a)(3).

4. What type of injuries is covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

All injuries arising out of and in the course of the employment are covered. 820 ILCS 305/2. They must have their origin in some risk so connected with, or incidental to, the employment as to create a causal connection. Accident includes repetitive trauma.
B. Occupational disease (including respiratory and repetitive use).

Occupational diseases are covered under a separate Act. 820 ILCS 310/1 et seq. Essentially the same rules and benefits apply but all references are to different sections of the law. Once again a risk of employment must be shown to aggravate or cause a disabling condition.

5. What, if any, injuries or claims are excluded?

Accidental injuries incurred while participating in voluntary recreational programs including athletic events, parties and picnics, do not arise out of or in the course of employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program. Woodrum v. Industrial Commission, 336 Ill. App. 3d 561 (4 Dist. 2003); 820 ILCS 305/11. Accidental injuries while participating as a patient in a drug or alcohol rehabilitation program do not arise out of and in the course of employment even though the employer pays some or all the costs thereof. 820 ILCS 305/11.

6. What psychiatric claims or treatments are compensable?

Physical-mental injuries have always been compensable if the mental disability is traced to an accidental physical injury. Mental-mental cases are mostly denied but can be compensable in extreme situations. “Where an employee experiences a sudden, severe emotional shock which could be the reaction of a person with normal sensibilities, the resulting psychiatric injury is compensable.” Pathfinder Co. v. Industrial Commission, 62 Ill. 2d 556, 563 (1976). The employee there had removed the severed hand of a friend from a machine and it understandably affected her emotionally. Recovery for non-traumatically induced mental disease is limited to those who can establish that: (1) The mental disorder arose in a situation of greater dimensions than the day to day emotional strain and tension which all employees must experience; (2) the conditions exist in reality from an objective standpoint; and (3) the employment conditions, when compared with the non-employment conditions, were “the major contributing cause” of the mental disorder. Chicago Board of Education v Industrial Commission, 169 Ill. App. 3d 459 (1 Dist. 1988). However, in a Mental-physical injury case an employee need not show stress exceeding the stress of coworkers. Rather, an employee need only prove that the usual stress of the workplace is greater than the stress experienced by the general public. Badgett v. Industrial Commission, 201 Ill. 2d 187 (2002).

7. What are the applicable statutes of limitations?

In any case other than where the injury was caused by exposure to radiological materials or equipment, or asbestos, a claim must be filed within three years of the date of accident where no compensation has been paid, or within two years after the date of the last payment of compensation where any has been paid, whichever is later. 820 ILCS
305/6(d). Continuing negotiations with the injured employee by claims adjustors or attorneys can estop the employer from asserting the statute defense.

8. **What are the reporting and notice requirements for those alleging an injury?**

Notice of the accident must be given to the employer as soon as practical, but not later than forty-five days after the accident. 820 ILCS 305/6(c).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

      The available defense would be that such an injury did not arise out of and in the course of the employment. Some suicides have been held compensable if the evidence showed that the suicide was the result of the sequelae of the injury.

   B. **Willful misconduct, "horseplay," etc.**

      Again, the defense would be that the injury did not arise out of and in the course of the employment. Saunders v. Industrial Commission, 189 Ill. 2d 623 (2000).

   C. **Injuries involving drugs and/or alcohol.**

      Pursuant to 2011 amendments to 820 ILCS 320/11, an employee will not be entitled to compensation if the intoxication was the proximate cause of the accidental injury, or if the employee was so intoxicated when the injury occurred that it constituted a departure from the employment. If there is evidence that the blood alcohol level exceeded .08%, or if there is evidence of illegal drugs in the employee’s body, there is a rebuttable presumption that the intoxication was the proximate cause of injury.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    The amendments of 2005 made it illegal to fraudulently file or deny a claim. It is now a class A misdemeanor to make a false report and any person convicted of such acts could have to repay benefits at a multiple level and pay attorney fees and costs. 820 ILCS 305/25(5). The amendments of 2011 also made it illegal for a medical provider to intentionally present a medical bill for payment when there has been no treatment.

11. **Is there any defense for falsification of employment records regarding medical history?**

    No.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**
Accidental injuries incurred while participating in voluntary recreational programs such as athletic events, parties, and picnics, do not arise out of and in the course of the employment, even where the employer pays some or all of the cost thereof. This exclusion does not apply when the employee was ordered or assigned by the employer to participate in the program. 820 ILCS 305/11.

13. **Are injuries by co-employees compensable?**

Yes, if the injury arose out of and in the course of the employment, it is compensable under worker’s compensation. However, if an assault by the co-employee arises out of a personal conflict, the injury caused by the co-employee is not compensable. Additionally, if the injured employee is found to be the aggressor in the assault, benefits should be denied.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

No. Acts that arise from personal aggression do not create a compensable injury. There must be a risk of employment to arise out of employment.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Wages earned in the fifty-two weeks preceding the accident, excluding overtime, are calculated and divided by 52. If a full week is not worked both the total earned and the divisor are reduced so that only full weeks are used in the calculations. 820 ILCS 305/10. Overtime is to be included where the overtime is regular and required by the employer. The case law is inconsistent as to what constitutes regular and required hours. In occupational disease cases, overtime is always included.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The rate for temporary/lost time benefits is two-thirds of the average weekly wage, with a statutory minimum starting at $246.67 if single, and increasing by the number of dependents up to four, but never more than the employee’s actual weekly wage. The maximum rate is 133.34% of the state average weekly wage. From 1/14/20 through 7/14/20, the maximum temporary total disability rate is $1,549.07. See [www.iwcc.il.gov/rates.pdf](http://www.iwcc.il.gov/rates.pdf).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

There is no specific time line but there are substantial penalties if it is later determined that temporary total disability benefits were delayed in an unreasonable or vexatious
manner. The penalties can include attorney fees and costs under 820 ILCS 305/16 and a daily $30 penalty to a maximum of $10,000 since 2/1/06. 820 ILCS 305/19(l)

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

The employee must be out fourteen days before recovering benefits for missing the first three scheduled work days.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary benefits can be terminated if there is a doctor's report stating that the employee is at maximum medical improvement or that he or she is able to work with restrictions and a job is offered within those restrictions. Reliance on such a report is not an automatic defense to the penalties for unreasonable and vexatious withholding of benefits mentioned above, especially if the treating doctor says otherwise.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No.

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement is calculated at the permanent partial disability rate, up to a maximum of 150 weeks, if the injury occurred before 7/20/05 or between 11/16/05 and 1/31/06. 820 ILCS 305/8(c). Between 7/20/05 and 11/15/05 and after 2/1/06, the disfigurement maximum is 162 weeks.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates:**

The compensation rate shall be equal to 60% of the employee’s average weekly wage. For the time period of 7/1/19 to 6/30/20, the maximum rate is $836.69, and the minimum is $246.67.

**A. How many weeks are available for scheduled members/parts, and the standard for recovery.**

Injuries before 7/20/05 and between 11/16/05 and 1/31/06 use the lower number of weeks. Injuries between 7/20/05 and 11/15/05 and after 2/1/06 use the higher number.

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<td></td>
</tr>
<tr>
<td>Amputation at elbow</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>Amputation at shoulder</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>100% loss of the hand</td>
<td>190</td>
<td></td>
</tr>
<tr>
<td>100% loss of the great toe</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>100% loss of the other toes</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>100% loss of use of the thumb</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>100% loss of the index finger</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>100% loss of the middle finger</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>100% loss of the ring finger</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>100% loss of the little finger</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>100% loss of hearing (one ear)</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>100% loss of hearing (both ears)</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>100% loss of one testicle</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>100% loss of both testicles</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>100% loss of the eye</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Enucleation of the eye</td>
<td>160</td>
<td></td>
</tr>
</tbody>
</table>

Injuries arising before September 1, 2011, the standard for recovery is based upon what percentages the parties agree upon, or an arbitrator's decision. 820 ILCS 305/8(e). Beginning September 1, 2011, permanent partial disability shall be determined by a licensed physician using the American Medical Association’s “Guide for Evaluation of Permanent Impairment.” The arbitrator, in making his award, shall consider the rating of the physician, along with other factors such as the occupation, age of the employee at the time of the injury, the employee’s future earning capacity and evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. Unfortunately, few Arbitrators actually apply the AMA ratings as most Illinois physicians are still unfamiliar with the process. As a result, ratings are still generally decided solely by the arbitrator.

The amendments to 2011 further limit the recovery for carpal tunnel permanency to a maximum of 15% of the hand unless there is clear and convincing evidence of more disability, with an upper limit of 30%.

**B. Number of weeks for "whole person" and standard for recovery.**

Loss of 100% of the person as a whole is 500 weeks. 820 ILCS 305/8(d)(2). Again, the standard for recovery is determined by a percentage agreement of the parties or an arbitrator's decision.

**23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

If the employee is unable to return to the previous occupation, then the employer must pay for vocational rehabilitation. While the employee is undergoing vocational rehabilitation, the employer must pay benefits at the temporary total disability rate but the benefits are called “maintenance.” Once the employee has begun working a new job, if
the new rate of pay is less than the employee's old rate of pay, the employee may apply for a wage-loss benefit, instead of permanent partial disability. In that case, the employer must pay two-thirds of the difference between the two for as long as there is a difference. Under the older cases the cap per week is the maximum PPD rate. Under the new law the maximum is 100% of the state average weekly wage. 820 ILCS 305/8(b)4. Pursuant to the 2011 amendments, for injuries arising on or after September 1, 2011, an employee is entitled to his wage loss differential only until age 67 or five years from the date of any final award, whichever is longer. 820 ILCS 305/8(d)1.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Compensation for permanent total disability is paid weekly for life, at a rate equal to two-thirds of the employee's average weekly wage with minimums and maximums determined by the date of accident, changing every six months. For the most recent time period announced, between 7/15/13 and 1/14/14, the minimum is $499.20 and the maximum is $1,331.20 per week.

25. **How are death benefits calculated, including the minimum and maximum rates:**

A. **Funeral expenses.**

$8,000.00. 820 ILCS 305/7(f).

B. **Dependency claims.**

Both total and partial dependency claims may be maintained by certain beneficiaries identified by statute, including a surviving widow, widower, child, parent or grandparent. The amount and duration of benefits are dependent upon facts such as the level of dependency and the familial relationship of the survivor to the deceased employee, as well as the physical and mental capacity of any surviving children, and whether a surviving child is enrolled in an educational institution at the time. 820 ILCS § 305/7.

C. **Rates**

Death benefits are paid weekly at a rate equal to two-thirds of the employee's average weekly wage with minimums and maximums determined by the date of accident, changing every six months. For the most recent time period announced, between 1/15/20 and 7/14/20, the minimum is $580.90 and the maximum is $1,549.07 per week. The cap is 25 years or $500,000 whichever is greater.

26. **What are the criteria for establishing a "second injury" fund recovery?**

It is highly restricted and almost never seen. There must have been a prior 100% loss of an enumerated body part (hand, arm, foot, leg, or eye). Then, in a subsequent independent accident, if the employee suffers 100% loss of another such member, he or
she would be entitled to recovery from the second injury fund. 820 ILCS 305/7-305/8.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Any claim that is settled by a lump sum settlement contract cannot be re-opened except for fraud. If the case has gone to decision by an arbitrator or an agreement has been reached for payments in installments, the case can be reviewed, within thirty months (old law, now 60 months) after such award, by the Commission at the request of either the employer or the employee on the grounds that the disability of the employee has subsequently recurred, increased, diminished, or ended. Only a physical change is considered, not an economic one. 820 ILCS 305/19(h).

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

If the employer, his or her agent, service company or insurance carrier has been guilty of unreasonable or vexatious delay, intentional underpayment of compensation benefits or has engaged in frivolous defenses which do not present a real controversy within the purview of the provisions at 820 ILCS 305/19(k), the employer and/or insurance carrier may be held liable for all or any part of the attorney’s fees and costs. 820 ILCS 305/16.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive:**

   A. **Scope of immunity.**

   The Worker's Compensation Act is the exclusive remedy as to the employee. However, this is an affirmative defense that must be asserted by the employer. A third party defendant can bring the employer back into a civil lawsuit with limitations on recovery.

   B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

   Minors have the same rights and obligations as adults, except that illegally employed minors may reject the Act within six months after an accident, and may then sue at common law.

   An employer can be held liable on a third party action seeking contribution pursuant to the Joint Tortfeasors Contributions Act up to the employer’s relative degree of culpability, but not to exceed the employer’s maximum liability under the Illinois Workers’ Compensation Act. *Kotecki v. Cyclops Welding Corp.*, 146 Ill. 2d 155 (1991) where the Illinois Supreme Court held that an employer’s liability to a third party plaintiff is limited to the amount of workers’ compensation benefits paid to the injured employee. This position is an affirmative defense and must be affirmatively plead or it will be deemed waived. It can also be contractually waived by entering into an agreement with
another entity waiving the protection for contribution to an employee’s injury. *Braye v. Archer Daniels Midland*, 175 Ill. 2d 201 (1997).

30. **Are there any penalties against the employer for unsafe working conditions?**

If the Commission finds that an actual injury was directly and proximately caused by the employer's willful violation of a health and safety standard under the Health and Safety Act, 820 ILCS 225/1, as amended and in force at the time of the accident, the arbitrator or the Commission will allow to the employee, or his or her dependents, additional compensation equal to 25% of the amount which otherwise would be payable under the provisions of the Act. 820 ILCS 305/19(m).

31. **What is the penalty, if any, for an injured minor?**

If the employee is under sixteen years old at the time of the accident, and is illegally employed, the employee or his or her legal representative can within six months after the injury or death elect to reject his or her right to benefits under the Act and pursue his or her common law and statutory remedies to recover damages for such injury or death. Where the employee waives his or her right to reject benefits under the Act in favor of collecting workers' compensation benefits, no payment of compensation shall be made unless such payment and the waiver of the right to reject benefits has first been approved by the Commission, because payment of compensation to the employee is a bar to subsequent rejection of the exclusivity of remedy under the Act. The amount of compensation payable under Act is increased by 50% for an illegally employed minor. 820 ILCS 305/5(a), 820 ILCS 305/7(h)

32. **What is the potential exposure for "bad faith" or claims handling?**

Penalties awarding attorney fees and costs under 820 ILCS 305/16, for failure, without good cause, to pay weekly benefits or medical expenses due to an employee. Also failure to pay temporary total disability, if considered unreasonable or vexatious, results in a daily penalty of $10 under the old law or $30.00 per day under the new law for each day the payment has been so withheld. The old maximum was $2,500 and the new is $10,000.00. 820 ILCS 305/19(l). A delay of 14 days creates a rebuttable presumption that the delay was unreasonable.

If the Commission finds that any employer/insurer practices a policy of delay or unfairness towards employees in the adjustment, settlement or payment of benefits, the Commission may, after reasonable notice and hearing, order that such employer/insurer shall discontinue writing workers' compensation insurance in the state. 820 ILCS 305/4(c).

33. **What is the exposure for terminating an employee who has been injured?**

The employee could have a wrongful discharge action at common law for discriminating against an employee pursuing workers’ compensation benefits. *Kelsay v. Motorola*, 74
Ill. 2d 172 (1978).

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes.

35. Can co-employees be sued for work-related injuries?

Yes. However, the plaintiff must plead and prove that the co-employee acted deliberately and with specific intent to injure. Copass v. Illinois Power Co., 211 Ill.App.3d 205 (4 Dist. 1991).

36. Is subrogation available?

Yes. There is a lien for workers' compensation benefits paid if the employee has filed a suit at common law against the third party. If, within three months of the running of the statute of limitations, the employee has not filed, the employer may file against the third party. 820 ILCS 305/5(b). The employer is to pay a pro rata share of costs and expenses and the attorney is entitled to a statutory 25% fee.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Medical bills are now to be paid within 30 days or interest incurs at a rate of 1% per month. Late payment of medical bills may result in attorney fees pursuant to 820 ILCS 305/19(k) or daily fines for failure to pay if held unreasonable or vexatious. 820 ILCS 305/19(l)

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Any hospital, physician, surgeon or other person rendering treatment or services must, upon written request, furnish full and complete reports and permit their records to be copied in any proceeding for compensation before the Commission. 820 ILCS § 305/8(a). Moreover, the Industrial Commission has the subpoena power to compel the production of medical information.

39. What is the rule on (a) Claimant’s choice of physician; (b) employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of physician.
The employee may choose as many physicians as he or she wishes. However, the employer-insurer is only responsible for payment of the bills for the first two choices and their referrals. These are called “chains of referral.” 820 ILCS 305/8(a). All bills are subject to reasonableness and necessity.

With the amendments of 2011, the employer or its representative can now create a panel of medical providers and submit that panel to the Illinois Department of Insurance for approval. After an injured employee notifies the employer of his injury or files a claim for workers’ compensation, the employer must inform the employee in writing of his or her right to be treated by a physician of his or her choice from the preferred provider network. If the employee accepts the medical provider within the network, that constitutes his or her first choice. An employee may decline in writing to be treated within the network, but the act of declining constitutes a choice, leaving the employee with only one additional choice. 820 ILCS 305/8(a).4

B. Employer’s right to second opinion and/or Independent Medical Examination.

An employee entitled to receive disability shall be required, if requested by the employer, to submit, at the expense of the employer, for an examination by a duly qualified medical practitioner or surgeon selected by the employer, at any time or place reasonably convenient for the employee. 820 ILCS 305/12. Called the IME by defendants, a Section 12 examination by plaintiffs. There is a tendency in the case law to prefer the opinion of a treating doctor over a Section 12 examiner which undercuts the purpose of the examination.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employer/insurer is liable for the payment of reasonable and customary charges for reasonable, necessary and causally related treatment. Chiropractors are frequently used.

41. **Which prosthetic devices are covered, and for how long?**

Almost all prosthetic devices are covered, as long as they are related to the accident. If the device was covered by a settlement agreement, the time can be limited. If the device was part of an award, any future medical need is open.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Yes.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. There is now a medical fee schedule, adjusted yearly, that applies to procedures, treatments or services covered under the Act and rendered on or after 2/1/06. 820 ILCS
305/8(2). Pursuant to the 2011 amendments, the fee schedule has been rolled back for injuries after 9/1/11 by 30%. 820 ILCS 305/8(2)a. Beginning 1/1/12, the geo-zips will be consolidated and there will be four geo-zips for non-hospital fee schedules and fourteen geo-zips for hospital fee schedules, down from the previous twenty-nine geo-zips.

An employer may also engage in utilization review. 820 ILCS 305/8(7). The 2011 amendments state that utilization review shall now be based upon recognized treatment guidelines and evidence based medicine, and will be overseen by the department of insurance. An employer may only deny payment of medical services if an accredited utilization review finds that the scope of the treatment is excessive.

44. What, if any, provisions or requirements are there for "managed care"?

None. In practice, managed care takes place with the permission of plaintiff’s attorney.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

Upon the filing by the employee of an Application for Adjustment of Claim, the matter is assigned to an arbitrator. There is no answer required. The claim is then set before an arbitrator on a "status call" every three months. A party may request a hearing 15 days in advance of the next status call. A petitioner may file for an emergency hearing at any docket, whether set or not, relative to the issues of temporary total disability or payment of medical benefits. At each status call, the claim is automatically continued unless a hearing has been requested. After three years have elapsed from the time of filing, the claim can be dismissed within the discretion of the arbitrator for failure to prosecute. At that point a motion letter is required for continuances and it must show good cause.

46. What is the method of claim adjudication?

A. Administrative level.

Arbitrators hear the initial case. A party not satisfied can file a Petition for Review with the Workers’ Compensation Commission. A Commission panel consisting of three commissioners hears the review. No new evidence may be submitted on review. However, the Commission does have original jurisdiction and may look at issues de novo.

B. Trial court.

Any decision of the Commission may be appealed to the circuit court in the county in which the accident occurred. At that level, the standard is whether the decision of the Commission was against the manifest weight of the evidence or the commission erred as a matter of law.
C. Appellate.

Any decision of the circuit court may be appealed to a special panel of the Appellate Court. This workers' compensation panel consists of one justice from each of the five judicial districts in Illinois. Again, the standard is whether the decision of the Commission was against the manifest weight of the evidence or the commission erred as a matter of law. Appeals to the Supreme Court are very rare.

47. What are the requirements for stipulations or settlements?

Any settlement contract must be approved by an arbitrator or a commissioner.

48. Are full and final settlements with closed medicals available?

Yes, settlement by a lump sum settlement contract closes out medical treatment unless otherwise provided in the contract.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, an arbitrator or commissioner must approve the settlement.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Insurance is required unless an employer elects to be self-insured. A number of private insurers are available. Some entities form assigned risk pools. There is no state fund.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

An application for self-insurance must be filed with the self-insured advisory board. They, in consultation with the Chairman of the Illinois Workers’ Compensation Commission, decide whether the entity meets the requirements for self-insurance, and, if so, what the bond requirements will be. The entity must then either post a bond or a cash equivalent.

B. For groups or "pools" of private entities.

Such groups are subject to the same requirements as individual self-insureds. Some businesses or pools operate with a self-insured retention. This amount can be anywhere from $10,000.00, to $800,000.00. The insurance policy then acts as an excess policy.
52. Are ‘illegal aliens’ entitled to benefits of workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of ‘employee’?

“illegal aliens” are entitled to benefits under the Illinois Workers’ Compensation Act. 820 ILCS § 305/1(b)(2). Benefits have been denied to foreign beneficiaries of illegal aliens normally entitled to death benefits. There is further a question as to whether or not an employer can be required to provide rehabilitation benefits since the illegal aliens cannot be placed in jobs legally. There are no published cases on these issues.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Yes. There is no provision under the Illinois Workers’ Compensation Act that would preclude terrorist acts from being covered.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

Medicaid and health insurers have a right to file a claim in civil court against any parties involved in a workers’ compensation matter for medical bills which should have been covered under a workers’ compensation case.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical
records could proceed under state law. HIPAA will apply to workers’ compensation providers. Therefore, all parties need to be careful in dealing with medical records in worker’s compensation matters.

57. **What are the provisions for “Independent Contractors”?**

Multiple factors are considered although the primary one is the right to control the work. An independent contractor represents the will of the owner only as to the result, not the means by which it was accomplished. Other factors considered are the method of payment, the right to terminate, the skill required to do the work and the furnishing of tools, equipment and materials.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

An employer whose business is hiring, procuring or furnishing employees for other employers is deemed a loaning employer and may be joined as an employer liable for the injury. 820 ILCS 305/1(a)(4).

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

No.

60. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your Workers’ Compensation law?**

Yes, but only for certain medical conditions, including but not limited to ALS, cancer, Crohn’s disease, epilepsy, glaucoma, HIV, multiple sclerosis and spinal cord injury. Recent legislation enacted legal recreational marijuana. Most employers have policies prohibiting use of marijuana during work hours. If a work injury is found to be causally related to the use of alcohol or illegal drugs, all benefits are denied.

61. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Yes, Nonetheless, if a work injury is found to be causally related to the use of alcohol or illegal drugs, all benefits are denied.
1. **Citation for Indiana Worker’s Compensation Statute.**

   Indiana Worker’s Compensation Act, Ind. Code § 22-3-1-1 *et seq.* (2019).


**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of worker's compensation?**

   All employees who suffer personal injury or an occupational-related disease “arising out of and in the course of employment” are considered covered employees. Employees mean every person, including minors, in the service of another, under any contract of hire or apprenticeship, written or implied, except one whose employment is both casual and not in the course of trade, business, occupation, or profession of the employer. I.C. § 22-3-6-1. An executive officer appointed or elected, other than that of a municipal corporation, governmental subdivision, charitable, religious, educational or other nonprofit corporation is also considered an employee. *Id.* An officer of the aforementioned organizations and corporations may be covered under the Indiana Workmen’s Compensation Act (Act) if that officer is specifically identified in the contract of insurance. *Id.* An employee may also include the owner of a sole proprietorship if the owner is actually engaged in the proprietorship business. *Id.* An employee may also include a partner of a partnership if the partner is engaged in the partnership business. *Id.*

   The Act does not apply to railroad employees engaged in the train service as: 1) engineers, 2) firemen, 3) conductors, 4) brakemen, 5) flagmen, 6) baggage men, and 7) foremen in charge of yard engines and helpers. I.C. § 22-3-2-2. The Act does not apply to the employees of a fire department, police department of any municipality who partake in a firefighter’s or police officer’s pension fund. *Id.* The Act does not cover for persons who enter into an independent contractor agreement with a nonprofit organization. *Id.* The Act does not apply to casual laborers, farm or agricultural employees, and household...
employees. I.C. § 22-3-2-9. The Act further does not apply to real estate professionals if: (1) they are licensed real estate agents; (2) substantially all their remuneration is directly related to sales volumes and not the numbers worked; and (3) there is a written agreement with the real estate brokers indicating that they are not to be treated as employees for tax purposes. I.C. § 22-3-6. An independent contractor, as defined under the United States Internal Revenue Code, is not considered an employee under the Act. Id. Additionally, an “owner-operator” that provides a motor vehicle and the services of a driver under a written contract that is subject to federal transportation regulations is not an employee of the motor carrier for purposes of the Act. Id. Finally, the Act does not provide coverage for casual laborers, farm or agricultural employees, and household employees. Id.

Something to monitor regarding those that are exempt from the Act, the Indiana General Assembly has introduced a bill in the Indiana Senate that would allow for a religious exemption from worker’s compensation and occupational diseases coverage for a member of certain religious sects or a division of a religious sect who meets certain requirements and obtains a certificate of exemption from the worker’s compensation board. S.B. 393, 121st Gen. Assemb., 2d Reg. Sess. (In. 2020). In addition to amending I.C. § 22-3-2-9 which lists those already exempt from the Act, the bill would add two new sections, I.C. § 22-3-5-1.5 and I.C. § 22-3-7-34.2, that enumerate the requirements for the religious exemption and the application process.

3. **Identify and describe any "statutory employer" provision.**

Any principal contractor, intermediate contractor, or subcontractor, who sublets work to a subcontractor who is subject to the worker's compensation statute provisions, without requiring the subcontractor to show a certificate of insurance, is liable to the same extent as such subcontractor for the payment of compensation and medical expenses. I.C. § 22-3-2-14(c).

“Employer” includes the state and any political subdivision, any municipal corporation within the state, any individual or the legal representative of a deceased individual, firm, association, limited liability company, limited liability partnership, or corporation or the receiver or trustee of the same, using the services of another for pay. I.C. § 22-3-6-1(a). As of July 2018, the classification of “joint employers” has been expanded to include more business entities, See Id. Additionally, lessors and lessees of employees are considered joint employers. Id. A recent case addressed lessors and lessees of employees as joint employers when an employee of a temporary staffing agency was hurt while working for the agency’s client. Walls v. Markley Enterprises, Inc., 116 N.E.3d 479 (Ind. Ct. App., 2018). After recovering worker’s compensation benefits from her staffing agency, Bridge Staffing, Inc. and its insurer, the plaintiff brought a claim for negligence against the company she was assigned to work for by the staffing agency, Markley Enterprises, Inc. Id. at 482. The Court held that her worker’s compensation claim was the exclusive remedy for her injuries sustained while working at Markley because, despite language in the agreement that plaintiff was “assigned” to work for Markley, under a statutory interpretation of the term “leased,” Bridge remained the lessor and Markley the lessee of the plaintiff. Id. at 487-88.
If the employer is insured, the term includes the employer’s insurer so far as applicable. However, the inclusion of an employer’s insurer within this definition does not allow an employer’s insurer to avoid payment for services rendered to an employee with the approval of the employer. I.C. § 22-3-6-1.

Each employer subject to the Act is required to post, in a form approved by the board, a notice in the employer’s place of business to inform employees that their employment is covered by worker’s compensation containing the name, address, and telephone number of the employer’s insurance carrier or the person responsible for administering the employer’s worker’s compensation claims if the employer is self insured. I.C. § 22-3-22(a)-(b). As the use of mobile and remote employees has increased, employees now must convey the same information to their employees in an electronic format or in the same manner as the employer conveys other related information. I.C. § 22-3-2-22(c).

4. **What types of injuries are covered and what is the standard of proof for each:**

Accidental injuries or occupational diseases arising out of an in the course of the worker’s employment are covered. A worker is entitled to receive benefits if the injury/illness results in: 1) loss of use of part of the body; 2) partial loss of use of part of the body; 3) total permanent disability; 4) permanent reduction of eye sight; 5) permanent reduction in hearing; 6) permanent partial impairment; 7) permanent disfigurement which may cause impairment; 8) occupational diseases; 9) temporary impairment resulting in the inability to earn full wages; and 10) death. I.C. § 22-3-3-10. See also Borgman v. State Farm Insurance Co., 713 N.E.2d 851 (citing Campbell v. Eckman/ Freeman & Assoc., 670 N.E.2d 925, 929 (Ind. Ct. App. 1996)).

In a worker’s compensation case, the claimant who seeks disability benefits bears the burden of persuasion. To carry their burden, an injured employee generally must establish: (1) their “disability;” and (2) the nature of the disability. Walker v. State, 694 N.E.2d 258 (Ind. 1998). To establish a disability, it is not necessary that the employee prove their impairment or loss of bodily function is 100% because an injured worker may experience partial impairment as defined by the Act. Id.

In any action brought forth under the purview of the Act, the burden of proving that an injury or death of an employee was a result of the failure to use due care and diligence at the time of injury or death shall rest with the defendant, but the same may be proved under a general denial. I.C. § 22-3-9-2. It should be noted that an employee cannot be guilty of negligence or contributory negligence under a theory of “assumption of risk” if the employer violated any ordinance or statute, and said violation was the cause of the injury or death. Id.

No compensation is allowed for an injury or death due to the employee's knowingly self-inflicted injury, their intoxication, their commission of an offense, their knowing failure to use a safety appliance, their knowing failure to obey a reasonable written or printed rule of the employer which has been posted in a conspicuous position in the place of
work, or their knowing failure to perform any statutory duty. Ultimately, the burden of proof is on the defendant. I.C. § 22-3-2-8.

A. Traumatic or "single occurrence" claims.

There are two (2) statutory jurisdictional prerequisites that must be met in order for the Act to apply: (1) personal injury or death by accident; and (2) arising out of or in the course of employment; Evans v. Yankeetown Dock Corp., 491 N.E.2d 969 (Ind. 1986); I.C. § 22-3-2-6. An accident “arises out of” employment for purposes of the Act when it takes place within the period of employment, at a place where the employee may reasonably be, and while the employee is fulfilling the duties of employment or while engaged in doing something incidental thereto. Thompson v. York Chrysler, 999 N.E.2d 446 (Ind. Ct. App. 2013). Additionally, a claimant must show a causal relationship between an incident and an injury or death to qualify for worker’s compensation benefits. Id. at 974. The degree of medical proof necessary is less than a “reasonable medical certainty,” but more than a possibility. An expert’s opinion that something is “possible” may be sufficient to sustain a verdict if it is substantiated by other probative evidence that establishes the material fact. See Dial X-Automated Equipment v. Caskey, 826 N.E.2d, 642 (Ind. 2005).

B. Occupational disease.

Occupational Disease means a disease arising out of an in the course of employment. I.C. § 22-3-7-10. Ordinary disease of life to which the general public is exposed outside of the employment shall be compensable, except where such disease follows as an incident of an occupational disease. Id.

The claimant must show that the disease arose out of and in the course of the employment. A disease arises out of employment only if it is apparent to the rational mind that:

1. There is a causal connection between the work conditions and disease;
2. The disease followed as a natural incident of the work as a result of some exposure;
3. The employment is the proximate cause of the disease;
4. The hazard is not equally accessible outside the employment;
5. The disease is incidental to the character of the business;
6. The disease had its origin in a risk connected with the employment; and
7. The disease flowed from that risk as a rational consequence.
5. **What, if any, injuries or claims are excluded?**

There are no specific injuries or claims that are excluded from the Act. If the injury or death was an unexpected result from the usual exertion or exposure of an employee’s job, then it meets the definition of an accident, and if the accident occurred in the course of the employment, then it is compensable. I.C. § 22-3-2-6. See also *Evans v. Yankee town Dock Corp.*, 491 N.E.2d 969 (Ind. 1986). The Act was passed for the benefit of the employee and will be liberally construed so as to not negate the Act’s humane purpose. *Gray v. Daimler Chrysler Corp.*, 821 N.E.2d 431 (Ind. Ct. App. 2005).

The term accident in Indiana Code § 22-3-2-6 establishes that the exclusive provision of the Act is not automatic. *Wiseman v. AutoZone, Inc.*, 819 F. Supp. 2d 804, 825 (N.D. Ind. 2011) (applying Indiana law). The requirement that the plaintiff’s injures arise “by accident” obviously exempts intentional tort claims from the operation of the exclusivity provision. *Id.*

6. **What psychiatric claims or treatments are compensable?**

"Whether the injury is mental or physical, the determinative standard should be the same." *Hansen v. Von Duprin, Inc.*, 507 N.E.2d 573, 576 (Ind. 1987). Accordingly, if the mental injury arose out of and in the course of employment, it is compensable. *Id.*; *Rayford v. Lumbermen's Mutual*, 840 F. Supp. 606 (N.D. Ind. 1993). aff'd, 44 F.3d 546 (7th Cir. 1995). In *Hansen*, the court found compensable a mental injury without any accompanying physical injury and rejected any requirement that the mental injury be the result of some unusual stress in the employee's employment. *Id.* at 576-77. In *Indiana State Police v. Wiessing*, the Indiana Court of Appeals upheld the Worker’s Compensation Board’s determination that an officer’s death was the result of post-traumatic stress disorder that resulted when Wiessing shot and killed a motorist who tried to take his gun. 836 N.E.2d 1038, 1046 (Ind. Ct. App. 2005). The court reasoned that because Trooper Wiessing’s suicide resulted from this condition, it is not considered to be a self-inflicted injury, but rather an injury due to mental trauma that arose out of the officer’s course of employment. *Id.*

7. **What are the applicable statutes of limitations?**

**A. Workers’ compensation cases.**

(1) Generally, unless an employer or their representatives have actual knowledge of the occurrence of an injury or death at the time thereof, as soon as practicable after the injury or death occurs, the employee shall give written notice to the employer of said injury or death. I.C. § 22-3-3-1. Unless such notice is given or acquired within thirty (30) days from the date of the injury or death, no compensation shall be paid until and from the date such notice is given, or
knowledge is obtained. *Id.* Once the employer receives notices, if the employer accepts their employee’s claim without any dispute, then the employer will generally submit the claim to their respective worker’s compensation insurer. The employer then files a “First Notice of Care” with the Worker’s Compensation Board. However, if there is a dispute in the claim, then the employee has two (2) years from the date of injury to file a claim with the Worker’s Compensation Board. I.C. § 22-3-3-3. If no claim is made within two (2) years after the occurrence of the accident, then the claimant’s right to compensation shall forever be barred.

In cases where an accident or death arises from radiation, a claim for compensation shall be filed with the Board within two (2) years from the date on which the employee had knowledge of his injury or by exercise of reasonable diligence should have known that the existence of such injury and its causal relationship to employment. *Id.* However, for progressive types of injuries, with no clear-cut accident date, the statute begins to run when the permanence of the injury is discernible. *Union City Body Co., Inc. v. Lambdin*, 569 N.E.2d 373 (Ind. Ct. App. 1991).

(2) The power and jurisdiction of the Worker’s Compensation Board over each case shall be continuing and from time to time it may, upon its own motion or upon the application of either party, on account of a change in conditions, make such modifications or change in awards, either by agreement or upon a hearing, subject to the maximum and minimum allowable awards under the Act. I.C. § 22-3-3-27. However, the Worker’s Compensation Board may not make such modifications upon its own motion nor shall any application be filed by either party after the expiration of two (2) years from the last day for which compensation was paid. *Id.*

(3) No limitation of time provided in the Act shall run against any person who is mentally incompetent or a minor so long as the person has no guardian or trustee.

B. Occupational disease claims.

No proceedings by an employee for compensation for Occupational Disease shall be maintained unless claim for compensation shall be filed by the employee with the Worker’s Compensation Board within two (2) years after the date of the disablement. I.C. § 22-3-7-32.

Additionally, no proceedings by dependents of a deceased employee for compensation for death for Occupational Disease shall be maintained unless claim for compensation shall be filed by the dependents with the Worker’s Compensation Board within two (2) years after the date of death. *Id.*

8. What are the reporting and notice requirements for those alleging an injury?
As indicated above, if the employer does not have actual knowledge of an injury or death, the employee or his dependents must give written notice as soon as practicable. I.C. § 22-3-3-1. Unless such notice is given or knowledge acquired within thirty (30) days from the date of injury, no compensation shall be paid until the date such notice or knowledge is obtained. \textit{Id.} However, lack of notice is not a bar to compensation unless the employer has been prejudiced by the lack of notice. \textit{Id.}

The notice, as required in Indiana Code § 22-3-3-1 shall state the name and address of the employee, the time, place, nature and cause of the injury or death, and shall be signed by the injured employee or by someone on their behalf in the case of death. I.C. § 22-3-3-2. The notice may be served personally upon the employer, or to other employees of the employer that the injured person was required to report to, or orders had to be followed. \textit{Id.} See also \textit{Pirtle v. National Tea Company}, 308 N.E.2d 720 (Ind. Ct. App. 1974); \textit{Roebel v. Dana Corp.}, 638 N.E.2d 1356 (Ind. Ct. App. 1994).

Within seven (7) days after the occurrence or knowledge of any injury – either actual, alleged, or reported under I.C. 22-3-3-1 – that causes an employee's death or the need for medical care beyond first aid, the employer must mail – or submit electronically – a report to the employer's insurance carrier, or, if the employer is self-insured, to the board. I.C. 22-3-4-13. The insurance carrier, companies without insurance, and third-party administrators that report accident information to the board must report the information via the Electronic Data Interchange (EDI) using the First Report of Injury form (State Form 34401). I.C. 22-3-4-13(b). This report must include: the name, nature, and location of the employer's business; the name, age, sex, wages, and occupation of the injured employee; the date and hour of the accident; the nature and cause of the injury; and such other information as the board may require. I.C. 22-3-4-13(c). The report must be delivered to the worker’s compensation board the later of seven (7) days after receipt of the report or fourteen (14) days after the employer’s knowledge of the injury. I.C. 22-3-4-13(a).

Electronic Data Interchange (EDI) is a process which allows one company to send information to another company electronically rather than with paper. For a list of forms, including those required to be submitted electronically via an approved EDI 3.1 process such as the First Report of Injury or Subsequent Report of Injury, see: \texttt{https://www.in.gov/wcb/2339.htm}

For information on the new EDI Claims Release 3.1 Reporting in Indiana, see: \texttt{https://www.in.gov/wcb/2586.htm}

For information on the EDI Claims Release 3.1 Requirements, see: \texttt{https://inwcbedi.info/requirements}

For the most up-to-date news and information from the Worker’s Compensation Board of Indiana, see: \texttt{https://inwcbedi.info/news}
Describe available defenses based on employee's conduct:

Available affirmative defenses are set forth in I.C. § 22-3-2-8: (a) employee's intoxication; (b) employee's knowingly self-inflicted injury; (c) employee's commission of an offense; (d) employee's failure to use a safety appliance; (e) employee's failure to obey a reasonable written or printed rule of the employer which has been posted in a conspicuous place; or (f) employee's failure to perform any statutory duty. However, a claimant's mere own negligence will not preclude an employee from receiving worker's compensation benefits.


Generally, worker’s compensation third-party actions, as in other tort settings, the comparative fault of the injured employee-plaintiff is factored into the final judgment or settlement. Spangler, Jennings & Dougherty P.C. v. Indiana Ins. Co., 729 N.E.2d 117 (Ind. 2000). And, while the employee is generally required to repay the worker's compensation carrier for benefits and expenses paid while the employee pursued the third-party action, the amount of that reimbursement is likewise reduced by the amount of the employee's comparative fault. Id. The Act governs claims against third persons, and specifically provides that a plaintiff can choose between worker's compensation benefits and third-party judgments so that they may maximize the recovery. Id. However, if the final judgment in a suit brought by an injured employee is less than the amount of the worker’s compensation benefits and medical expenses, the employee can choose to accept the judgment and reimburse the worker’s compensation payor. Id. However, if through settlement or litigation, an employee obtains an amount that is more than the worker’s compensation benefits, then the employee must reimburse the worker’s compensation payor and keep the remainder of the judgment or settlement, thereby effectively relinquishing all rights to worker’s compensation benefits. Id. See also Kornelik v. Mittal Steel USA, Inc., 952 N.E.2d 320, 325 (Ind. Ct. App. 2011).

What, if any, penalties or remedies are available in claims involving fraud?

There are no statutory penalties within the Act relating to claims involving fraud. The Worker’s Compensation Board does, however, have the power in the case of fraud to vacate its approval of a compensation agreement, and to entertain an application for that purpose when made by the employee, employer or insurance carrier. Indiana University Hospitals v. Carter, 456 N.E.2d 1051 (Ind. Ct. App. 1983). At the same time, a party to a worker's compensation agreement can challenge the validity of the agreement in an independent tort action for fraud. Id.

It should be noted that Indiana Code § 22-3-4-12.1 addresses the issue of bad faith on behalf of the employer or employer’s insurance provider in administrating worker’s compensation claims and gives the Worker’s Compensation Board the power to award
damages to the claimant up to $20,000, depending upon the degree of culpability and the actual damages sustained. This section also allows for the reimbursement of attorney fees that are incurred by an employee in bringing forth a claim under this section.

11. **Is there a defense for falsification of employment records regarding medical history?**

   Research has found no Indiana cases on this topic.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**


13. **Are injuries by co-employees compensable?**

   Yes, injuries by co-employees are compensable when the injuries arise out of the course of employment. *Nelson v. Denkins*, 598 N.E.2d 558 (Ind. Ct. App. 1992) (co-worker pushed worker after co-worker told worker to get back to work); *Skinner v. Martin*, 455 N.E.2d 1168 (Ind. Ct. App. 1983) (Workers’ Compensation Act should be liberally construed to include employment-related assaults as compensable accidents).

14. **Are acts by third-parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**

   Where an injury by a third party is one which might be reasonably anticipated because of the general character of the work, or the particular duties imposed upon the workman (i.e., salesman who carried money and was shot and robbed, or a night watchman killed by intruders) such injuries or death may be found to arise out of the employment. *Wayne Adams Buick, Inc. v. Ference*, 421 N.E.2d 733 (Ind. Ct. App. 1981); The court in *K-Mart Corp. v. Novak*, 521 N.E.2d 1346 (Ind. Ct. App. 1988), even went so far as to hold that a store employee's death as a result of a shooting spree by a third party arose out of her employment because her job exposed her to a higher risk of encountering dangerous people.

   However, when the animosity or dispute that culminates in an assault on the employee is imported into the workplace from the claimant’s domestic or private life, and is not exacerbated by the employment, the assault cannot be said to arise out of the employment under any circumstances. *Peavler v. Mitchell & Scott Machine Co.*, 638 N.E.2d 879, 881
15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage is the earnings of an injured employee in the employment in which the employee was working at the time of the injury during the period of fifty-two (52) weeks immediately preceding the date of injury, divided by fifty-two (52), except as follows:

A. If the employee lost seven (7) or more calendar days during this period, then the earnings for the remainder of the fifty-two (52) weeks shall be divided by the number of weeks remaining after the time lost has been deducted;

B. Where employment prior to injury was less than fifty-two (52) weeks, the method of dividing the earnings during that period by the number of weeks which the employee earned wages shall be followed if the results just and fair to both parties will be obtained;

C. Allowances made to an employee in lieu of wages as part of a wage contract are deemed part of his earnings; and

D. For a student employee, the average weekly wage is calculated by multiplying the student employee's hourly wage rate by forty (40) hours.

I.C. § 22-3-6-1(d).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Temporary benefits are calculated by taking 66 2/3% of the employee's average weekly wage times the number of weeks the employee is entitled to the temporary benefits. I.C. § 22-3-3-22. However, there are maximum and minimum average weekly wage limitations. *Id.* The following chart delineates the maximum and minimum average weekly wage figures and the resulting temporary benefits for injuries that occurred on a specific date:

<table>
<thead>
<tr>
<th>Date of Injury</th>
<th>Min. AWW</th>
<th>Max. AWW</th>
<th>Min.* Benefit</th>
<th>Max. Benefit</th>
<th>Compensation (500 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/85-6/30/86</td>
<td>$75</td>
<td>$267</td>
<td></td>
<td></td>
<td>$89,000</td>
</tr>
<tr>
<td>7/1/86-6/30/88</td>
<td>$75</td>
<td>$285</td>
<td></td>
<td></td>
<td>$95,000</td>
</tr>
<tr>
<td>7/1/88-6/30/89</td>
<td>$75</td>
<td>$384</td>
<td></td>
<td></td>
<td>$128,000</td>
</tr>
<tr>
<td>7/1/89-6/30/90</td>
<td>$75</td>
<td>$441</td>
<td></td>
<td></td>
<td>$137,000</td>
</tr>
</tbody>
</table>
*Note: minimum benefit shall not exceed the actual wage earned by the employee, in which case, the employee would receive his entire average weekly wage.

The values listed above remain current, but a bill has been introduced to amend these values after July 1, 2016. S.B. 202, 121st Gen. Assemb., Reg. Sess. (In. 2020). The proposed values are as follows:

For a downloadable version of the tables regarding information on PPI & Weekly Benefits, see: https://www.in.gov/wcb/files/PPIandTTD%20benefits2020.pdf

17. How long does the employer/insurer have to begin TTD benefits from the date disability begins?

The first weekly installment of compensation for temporary disability is due fourteen (14) days after the disability begins. I.C. § 22-3-3-7(b). The employer must file proposed Agreements to Compensation electronically via Electronic Data Interchange (State Form 1043) and serve it on the employee or the employee’s dependents within 15 days of the date the first installment of compensation is due. Id.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ____ days before recovering benefits for the first _____ days)?

Compensation for temporary benefits is to begin on the eighth (8th) day. I.C. § 22-3-3-
7(a). If the disability continues for longer than twenty-one (21) days, then compensation for the first seven (7) days is paid. *Id.*

19. **What is the standard/procedure for terminating temporary benefits?**

Once begun, temporary benefits may not be terminated by the employer unless:

A. The employee has returned to any employment;
B. The employee has died;
C. The employee has refused to undergo a medical examination;
D. The employee has received five hundred (500) weeks of benefits or has been paid the maximum compensation allowed; or
E. The employee is unable or unavailable to work for reasons unrelated to the compensable injury.

In all other cases, the employer must notify the employee in writing of the employer’s intent to terminate that payment of temporary total disability benefits and of the availability of employment, if any, on a form approved by the Worker’s Compensation Board. If the employee disagrees with the proposed termination, the employee must give written notice of disagreement to the Worker’s Compensation Board and the employer with seven (7) days after the notice of intent to terminate benefits. I.C. § 22-3-3-7.

If the Worker’s Compensation Board and the employer do not receive a notice of disagreement under this section, the employee's temporary total disability benefits shall be terminated. Upon receipt of the notice of disagreement, the Worker’s Compensation Board shall immediately contact the parties, which may be by telephone or other means, and attempt to resolve the disagreement. If the Worker’s Compensation Board is unable to resolve the disagreement within ten (10) days of receipt of the notice of disagreement, the Worker’s Compensation Board shall immediately arrange for an evaluation of the employee by an independent medical examiner. The independent medical examiner shall be selected by mutual agreement of the parties or, if the parties are unable to agree, appointed by the Worker’s Compensation Board. I.C. § 22-3-4-11. If the independent medical examiner determines that the employee is no longer temporarily disabled or is still temporarily disabled but can return to employment that the employer has made available to the employee, or if the employee fails or refuses to appear for examination by the independent medical examiner, temporary total disability benefits may be terminated. If either party disagrees with the opinion of the independent medical examiner, the party shall apply to the Worker’s Compensation Board for a hearing under I.C. § 22-3-4-5.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

Yes. An employer may be entitled to a dollar-for-dollar credit against PPI benefits owed
for temporary benefits paid beyond the number of weeks (currently 125) set out in I.C. § 22-3-3-10.

21. **What disfigurement benefits are available and how are they calculated?**

In all cases of permanent disfigurement which may impair the future usefulness or opportunities of the employee, the employee shall receive compensation, at the discretion of the Worker's Compensation Board, not exceeding forty (40) degrees of permanent impairment, to be paid weekly at a rate of sixty-six and two-thirds percent (66 2/3%) of the employee's average weekly wages. I.C. § 22-3-3-10(i)(15).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

For injuries that occur(ed) after July 1, 1991, the percentage of impairment to various body parts are delineated in “degrees” which reflects the loss of body function. The following charts show the value in degrees for the various body part impairments, the compensation per degree of impairment, and the maximum benefit of impairment. Ultimately, an employee will receive weekly payments of sixty-six and two-thirds percent (66 2/3%) of the employee's average weekly wages in accordance with the charts below. However, an employee shall not receive worker’s compensation benefits for the below injuries in an amount exceeding $125.00 weekly. I.C. § 22-3-3-10.

After calculation, a new section of the Indiana Worker’s Compensation Act, I.C. § 22-3-3-10.5, requires employers and worker’s compensation administrators to send the proposed PPI agreement, the associated physician’s statement required by I.C. 22-3-3-6(e), the employer waiver of examination, and a hand/foot chart (if necessary) to the employee no later than fifteen (15) days after the date of the physician’s statement. I.C. § 22-3-3-10.5(a). The employee signed PPI agreement – along with the supporting documentation listed *supra* – must be submitted to the worker’s compensation board within fifteen (15) days after receiving it from the employee. I.C. § 22-3-3-10.5(b). Thirty (30) days after the worker’s compensations board’s approval of the PPI, either the first weekly installment of PPI compensation, or the lump sum amount, must be paid. I.C. § 22-3-3-10.5(c).

**A. How many weeks are available for scheduled member parts, and the standard for recovery?**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Value in Degrees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>12</td>
</tr>
<tr>
<td>Index finger</td>
<td>8</td>
</tr>
<tr>
<td>Second finger</td>
<td>7</td>
</tr>
<tr>
<td>Third finger</td>
<td>6</td>
</tr>
<tr>
<td>Fourth finger</td>
<td>4</td>
</tr>
<tr>
<td>Hand below elbow</td>
<td>40</td>
</tr>
<tr>
<td>Arm above elbow</td>
<td>50</td>
</tr>
</tbody>
</table>
Big toe 12
Second toe 6
Third toe 4
Fourth toe 3
Fifth toe 2
Foot below knee 35
Leg above knee 45
Body as whole 100

PERMANENT PARTIAL IMPAIRMENT COMPENSATION
PER DEGREE OF IMPAIRMENT

<table>
<thead>
<tr>
<th>Date</th>
<th>Degrees</th>
<th>Dollars per Degree of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/91-7/1/92</td>
<td>1-35</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>21-35</td>
<td>$800</td>
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<td></td>
<td>36-50</td>
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<tr>
<td></td>
<td>51-100</td>
<td>$1,500</td>
</tr>
<tr>
<td>7/1/92-7/1/93</td>
<td>1-20</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>21-35</td>
<td>$800</td>
</tr>
<tr>
<td></td>
<td>36-50</td>
<td>$1,300</td>
</tr>
<tr>
<td></td>
<td>51-100</td>
<td>$1,700</td>
</tr>
<tr>
<td>7/1/93-7/1/97</td>
<td>1-10</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>11-20</td>
<td>$700</td>
</tr>
<tr>
<td></td>
<td>21-35</td>
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</tr>
<tr>
<td></td>
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<td>51-100</td>
<td>$1,700</td>
</tr>
<tr>
<td>7/1/98-7/1/99</td>
<td>1-10</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>11-35</td>
<td>$1,100</td>
</tr>
<tr>
<td></td>
<td>36-50</td>
<td>$1,400</td>
</tr>
<tr>
<td></td>
<td>51-100</td>
<td>$1,700</td>
</tr>
<tr>
<td>7/1/99-6/30/00</td>
<td>1-10</td>
<td>$900</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>7/1/00-6/30/01</td>
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<td>$1,100</td>
</tr>
<tr>
<td></td>
<td>11-35</td>
<td>$1,300</td>
</tr>
<tr>
<td></td>
<td>36-30</td>
<td>$2,000</td>
</tr>
<tr>
<td>Period</td>
<td>1-10</td>
<td>11-35</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>7/1/01 - 6/30/07</td>
<td>$1,300</td>
<td>$1,500</td>
</tr>
<tr>
<td>7/1/07-6/30/08</td>
<td>$1,340</td>
<td>$1,545</td>
</tr>
<tr>
<td>7/1/08-6/30/09</td>
<td>$1,365</td>
<td>$1,570</td>
</tr>
<tr>
<td>7/1/09-6/30/10</td>
<td>$1,380</td>
<td>$1,585</td>
</tr>
<tr>
<td>7/1/01-6/30/07</td>
<td>$1,300</td>
<td>$1,500</td>
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<td>7/1/07-6/30/08</td>
<td>$1,340</td>
<td>$1,545</td>
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<tr>
<td>7/1/08-6/30/09</td>
<td>$1,365</td>
<td>$1,570</td>
</tr>
<tr>
<td>7/1/09-6/30/10</td>
<td>$1,380</td>
<td>$1,585</td>
</tr>
<tr>
<td>7/1/10-6/30/14</td>
<td>$1,400</td>
<td>$1,600</td>
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<tr>
<td>Period</td>
<td>1-10</td>
<td>11-35</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>7/1/14-6/30/15</td>
<td>$1,517</td>
<td>$1,717</td>
</tr>
<tr>
<td>7/1/15-6/30/16</td>
<td>$1,633</td>
<td>$1,835</td>
</tr>
<tr>
<td>7/1/16-</td>
<td>$1,750</td>
<td>$1,952</td>
</tr>
</tbody>
</table>

The values listed above remain current, but a bill has been introduced to amend these values after July 1, 2016. S.B. 202, 121st Gen. Assemb., Reg. Sess. (In. 2020). The proposed values are as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>1-10</th>
<th>11-35</th>
<th>36-50</th>
<th>51-100</th>
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<td>7/1/16-6/30/20</td>
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<td>$1,952</td>
<td>$3,186</td>
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</tr>
<tr>
<td>7/1/20-6/30/21</td>
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<td>$1,991</td>
<td>$3,250</td>
<td>$4,141</td>
</tr>
<tr>
<td>7/1/21-6/30/22</td>
<td>$1,821</td>
<td>$2,031</td>
<td>$3,315</td>
<td>$4,224</td>
</tr>
<tr>
<td>7/1/22-</td>
<td>$1,857</td>
<td>$2,072</td>
<td>$3,381</td>
<td>$4,308</td>
</tr>
</tbody>
</table>

The following is an example of the calculations of PPI awards under the "degree" system:

**INJURY FORMULA FOR PERCENTAGE OF PERMANENT PARTIAL IMPAIRMENT**

The doctor has given a PPI rating of 65% for a loss of to the arm above the elbow.
The maximum benefit for the Arm above the Elbow = 50 degrees.

7/1/99

\[
\begin{align*}
50 \text{ degrees} \times 65\% &= 32.5 \text{ degrees.} \\
10 \text{ degrees} \times $900 &= $9,000 \\
22.5 \text{ degrees} \times $1,100 &= $24,750 \\
32.5 \text{ degrees} &= $33,750
\end{align*}
\]

7/1/01

\[
\begin{align*}
50 \text{ degrees} \times 65\% &= 32.5 \text{ degrees.} \\
10 \text{ degrees} \times $1,300 &= $13,000 \\
22.5 \text{ degrees} \times $1,500 &= $33,750 \\
32.5 \text{ degrees} &= $46,750
\end{align*}
\]

B. Number of weeks for a whole person and standard for recovery.

See answer to 20A.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

An injured employee, who as a result of an injury or occupational disease is unable to perform work for which the employee has had previous training or experience, is entitled to vocational rehabilitation services necessary to restore the employee to useful employment. I.C. § 22-3-12-1.

The office of vocational rehabilitation shall, upon receipt of the report of injury, immediately provide the injured employee with a written explanation of: (1) the rehabilitation services that are available for the injured employee; and (2) the method by which the injured employee may apply for these services. I.C. § 22-3-12-4.

The office of vocational rehabilitation shall also determine the eligibility of the injured employee for rehabilitation services, and where appropriate, develop an individualized rehabilitation plan for the employee. I.C. § 22-3-12-4 (b)

Finally, the office of vocational rehabilitation shall implement the rehabilitation plan. After completion of the rehabilitation program, the office of vocational rehabilitation shall provide job placement services to the rehabilitated employee. I.C. § 22-3-12-4 (c).

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?
An injured employee is entitled to total permanent disability benefits when the work-related injuries are so debilitating and disabling so as to prevent the injured employee from engaging in reasonable types of employment for the remainder of his life. *Walker v. State*, 694 N.E.2d 258, 265 (Ind. 1998) (citing *Perez v. United States Steel*, 359 N.E.2d 925 (Ind. Ct. App. 1977)). With respect to injuries occurring on and after July 1, 1976, causing temporary total disability (“TPD”), the employee is entitled to worker’s compensation benefits equal to 66 2/3% of the employee’s average weekly wage for a period not to exceed five hundred (500) weeks or in an amount equivalent to that paid during the period of temporary total disability, whichever is greater. I.C. § 22-3-3-8.

25. **How are death benefits calculated, including the minimum and maximum rates?**

For death occurring on or after July 1, 1976 and before July 1, 1976, the Act provides that when death results from an injury within five hundred (500) weeks, benefits are then payable to the dependents of the deceased. The benefits shall total an amount that is equal to 66 2/3 % of the deceased’s average weekly wage for a time period of five hundred (500) weeks, less any compensation paid to the deceased. I.C. § 22-3-3-17. The employer must also pay for funeral expenses up to $7,500.00. I.C. § 22-3-3-21.

26. **What are the criteria for establishing a "second injury" fund recovery?**

If an employee who has lost a limb or suffered a loss of use of a body part in a subsequent industrial accident, becomes permanently or totally disabled by reason of the loss, the employer shall be liable only for the compensation payable for such secondary injury. I.C. § 22-3-3-13. However, in addition to such compensation and after the completion of the payment therefor, the employee shall be paid the remainder of the compensation that would be due for such total permanent disability out of a special fund known as the second injury fund. *Id.*

An employee who has exhausted his maximum benefits may access the Second Injury Fund if it is established that the employee is totally permanently disabled, and that the employee is unable to support himself in any gainful employment, not associated with rehabilitative or vocational therapy. I.C. § 22-3-3-13(d)(e) and (f). Compensation would be equal to 66 2/3% of employee's average weekly wage for a period not to exceed one hundred fifty (150) weeks. Such payment is contingent upon evidence that shows the employee is totally and permanently disabled from causes and conditions of which there are or have been objective conditions and symptoms proven that are not within the physical or mental control of the employee, and that the employee is unable to support themselves in any gainful employment, not associated with rehabilitative or vocational therapy. *Id.* The employee may seek renewal of benefits from the Second Injury Fund at the end of each one hundred fifty (150) week period. *Id.*

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

{BWE/MISC/01531338 v1}
The Worker’s Compensation Board, on its own motion or upon the application of either party, on account of a change in conditions, may re-open a claim and make modifications to the award by ending, lessening, continuing or extending payments previously awarded, either by agreement or a hearing. Any modification in benefits is subject to the maximum benefits allowed. I.C. § 22-3-3-27(a). An application by either party, or a modification by the Worker’s Compensation Board, on its own motion, must be done within two (2) years from the last day compensation was paid under the original award. I.C. § 22-3-3-27(c). The Worker’s Compensation Board, at any time, may correct any clerical errors in any finding or award. Id.

28. What situation would place responsibility on the employer to pay a claimant's attorney fees?

A. Whenever the Worker’s Compensation Board determines that the employer has acted in bad faith in adjusting and settling a claim or that the employer has not pursued the settlement of the claim with diligence, the Worker’s Compensation Board shall, if compensation is awarded, fix the amount of the claimant’s attorney fees and such attorney fees shall be paid to the attorney and shall not be charged against the award of the claimant. I.C. § 22-3-4-12. The attorney’s fees payable under Indiana Code § 22-3-4-12.1 may not exceed thirty-three percent (33 1/3) of the amount of the award. Id.

B. The board may award to the employee or his dependents reasonable attorney fees in addition to the compensation and medical expenses in an action before the Worker’s Compensation Board where the employer failed to comply with I.C. § 22-3-5-1 or I.C. § 22-3-7-34(a) or (b) (insurance requirements).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Pursuant to I.C. § 22-3-2-6 an employee's remedy against their employer is exclusively limited to the Act. However, where the injury to the employee is caused by some person other than the employer and not in the same employment, the employee may pursue a separate cause of action against that third person under Indiana Code § 22-3-2-13. If the action against the other person is brought by the injured employee’s dependents and judgment is obtained, accepted, or a settlement has been reached, then the amount received by the employee or dependents shall be paid to the employer or the employer’s compensation carrier, subject to its paying of the pro rata share of the reasonable and necessary costs and expenses of asserting the third party claim, plus the services and products and burial expenses paid by the employer or the employer’s compensation insurance carrier. I.C. § 22-3-2-13.

B. Exceptions (intentional acts, contractual waiver, "dual capacity", etc.).

(2) Tort claims against an employer or co-employee for intentional torts are not barred by the exclusive remedy provision of the Act. *Perry v. Stitzer Buick, GMC, Inc.*, 637 N.E.2d 1282 (Ind. 1994).

(3) The exclusivity provision of Act does not preclude a claim against a medical services coordinator for damages resulting from emotional distress and physical injuries allegedly caused by fraudulent misrepresentations. *Stump v. Crawford & Co.*, 726 F. Supp. 228 (N.D. Ind. 1989).

30. **Are there any penalties against the employer for unsafe working conditions?**

In *Blade v. Anaconda Aluminum Co.*, 452 N.E.2d 1036 (Ind. Ct. App. 1983), plaintiff alleged that employer committed an intentional tort by knowingly violating safety regulations and failing to maintain a safe place to work. Despite noting plaintiff's counsel's compelling argument that employers are shielded from the full consequences of intentionally maintaining unsafe plants, the court held that the exclusivity provision of the Act precluded plaintiff's claim. *Id.* The court further noted that this issue is a matter to be resolved by the General Assembly, if indeed any change is to be made. *See also, Baker v. Westinghouse Electric Corporation*, 637 N.E.2d 1271 (Ind. 1994); *Bailer v. Salvation Army*, 854 F. Supp. 1341 (N.D. Ind. 1994); *Tribbett v. Tay Mor Industries, Inc.*, 471 N.E.2d 332 (Ind. Ct. App. 1984).

31. **What penalty is there, if any, for an injured minor?**

A minor who is employed, required, or permitted to work in violation of I.C. § 20-8.1-4-25 is entitled to double the amount of compensation and death benefits provided in the Act. I.C. § 22-3-6-1(c)(2). The insurance carrier is liable for one-half (1/2) of the benefits, and the employer is liable for the other one-half (1/2) of the benefits. *Id.* If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age and who at the time of the accident is employed, suffered, or permitted to work at any occupation which is not prohibited by law, this subdivision does not apply.

32. **What is the potential exposure for "bad faith" claims handling?**

The Worker’s Compensation Board has the exclusive jurisdiction to determine whether the employer, the employer's worker's compensation administrator, or the worker's compensation insurance carrier has acted with a lack of diligence, in bad faith. I.C. § 22-3-4-12.1. If lack of diligence, bad faith, or an independent tort is proven, the award to the claimant shall be at least five hundred dollars ($500), but not more than twenty thousand dollars ($20,000), depending upon the degree of culpability and the actual damages
sustained. *Id.* This damage will be paid by the employer, worker’s compensation administrator, or worker’s compensation insurance carrier, whomever was responsible for the bad faith acts. *Id.*

33. **What is the exposure for terminating an employee who has been injured?**

Indiana is an employment at will state. There is no obligation under the Act to re-employ an injured worker or to continue an injured worker's employment because of his physical disability. However, there are three (3) exceptions to the employment at will doctrine including a public policy argument. The Indiana Supreme Court has held that the worker’s compensation statute has created a public policy argument in favor of an employee filing a worker’s compensation claim. *Frampton v. Central Indiana Gas Co.*, 297 N.E.2d 425 (Ind. 1973). Thus, when an employee is discharged, whether expressly or constructively, solely for exercising a statutorily conferred right, an exception to the general rule of at will employment is recognized and a cause of action exists in the employee as a result of the retaliatory discharge. *Tony v. Elkhart County*, 851 N.E.2d 1032 (Ind. Ct. App. 2006). Therefore, Indiana case law allows an employee at will to bring an action for retaliatory discharge if the employee was discharged for exercising his or her statutorily conferred right to file a worker's compensation claim. Moreover, the Americans with Disability Act or a worker's union collective bargaining agreement may provide a terminated employee with some additional recourse.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the Claimant?**

Yes, an injured employee may file a civil lawsuit to recover damages received from a work-related accident which was caused by a person, manufacturer, or a sub-contractor not of the same employment as the person injured. I.C. § 22-3-2-13. Additionally, the Indiana Court of Appeals, as a matter of first impression, held that an injured employee “is not required to file a WCA claim against her employer prior to pursuing litigation against a third-party tortfeasor. *Brenner v. All Steel Carports, Inc.*, 122 N.E.3d 872, 881 (Ind. Ct. App. 2019)

35. **Can co-employees be sued for work-related injuries?**

A co-employee is not immune from tort suit just by having the same employer as the injured employee; a co-employee is entitled to immunity only when acting in course of employment at time of incident. *Nelson v. Denkins*, 598 N.E.2d 558 (Ind. Ct. App. 1992). The exclusive remedy provision will apply to co-worker’s actions were within the scope of employment. I.C. 22-3-2-6. *See also Hatke v. Fiddler*, 868 N.E.2d 60 (Ind. Ct. App. 2007).

36. **Is subrogation available?**

If an injured employee agrees to receive compensation from the employer or the
employer's compensation insurance carrier, the employer or employer's carrier has a lien upon any amount which the employee receives from a third party. I.C. § 22-3-2-13; I.C. § 22-3-7-36 (occupational disease). An employer or worker’s compensation carrier can choose to file suit on its own behalf for recovery of disability and medical benefits regardless of whether an employee files a third-party suit. See Deup, Inc. v. Farmer, 847 N.E.2d 160 (Ind. 2006). Also see Answer to #9.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

After an injury and prior to an adjudication of permanent impairment, an employer is required to furnish, free of charge, physician, surgical, nursing and hospital services as needed prior to the determination of permanent impairment. I.C. § 22-3-3-4. If an employer refuses to provide medical attention, then the injured employee may see his own doctor, and such expenses, subject to approval of the Worker’s Compensation Board, shall be paid by the employer. I.C. § 22-3-3-4(d). Additionally, an employer’s insurance carrier may not delay the provision of emergency medical care whenever emergency medical care is considered necessary in the professional judgment of the attending health care facility physician. I.C. § 22-3-3-4(e). The Indiana Code does not specifically address a time limit for medical bills to be paid. However, a medical service provider or its agent may not knowingly collect or attempt to collect the payment of a charge for medical services or products covered under the Act from an employee or the employee’s estate or family members. I.C. § 22-3-3-5.1(a).

In 2018, several amendments were enacted regarding civil penalties for failing to comply, report, or timely pay under the Act. For the specific civil penalties, see I.C. § 22-3-4-15.

38. What, if any, mechanisms are available to compel the production of medical information at the administrative level?

A. Medical reports.

Generally, the Indiana Trial Rules do not govern or bind the Worker’s Compensation Board. However, if the Board specifically adopts certain trial rules, then those rules will govern the proceedings of claims in front of the board. Riley v. Heritage Products, Inc., 803 N.E.2d 1185 (Ind. Ct. App. 2004). For example, the discovery rules (Trial Rules 26 through 37) are a recognized exception. As such, the Worker’s Compensation Board has authority to compel discovery. Josam Manufacturing Co. v. Ross, 428 N.E.2d 74 (Ind. Ct. App. 1981); Ind. R. Trial P. 28(F). Such discovery includes interrogatories, depositions and/or requests for production to obtain relevant medical records.

B. Executed authorization.

Pursuant to Indiana Trial Rule 28(F), the Worker’s Compensation Board does have
authority to compel discovery. *Josam Manufacturing Co. v. Ross*, 428 N.E.2d 74 (Ind. Ct. App. 1981). Although research produced no cases concerning the Board compelling a claimant to sign a medical record release, such authority does exist in a non-administrative venue. *Cua v. Morrison*, 600 N.E.2d 951 (Ind. Ct. App. 1992). Additionally, the employer and insurance carrier have a statutorily guaranteed right to require the claimant to be examined by physicians of their choice. I.C. § 22-3-3-6. The Board is also vested with wide discretion to appoint its own physician for purposes of medical examinations and testimony. *Hilltop Concrete Corp. v. Roach*, 366 N.E.2d 218 (Ind. Ct. App. 1977); I.C. § 22-3-4-11.

39. **What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

   **A. Claimant’s choice of a physician.**

   The employer has the right to choose the physician. I.C. § 22-3-3-4. However, the employer and employee can enter into an agreement on the selection of healthcare providers. I.C. § 22-3-3-4(h). Moreover, an employee may choose a physician in an emergency or when an employer does not provide a physician. I.C. § 22-3-3-4(d).

   **B. Employer’s right to a second opinion and/or Independent Medical Examination.**

   Both parties have the right to request an Independent Medical Examination. The Worker's Compensation Board must immediately arrange for independent medical examination (IME) if it is unable to resolve disagreement between employer and employee within ten days of receipt of employee's notice of disagreement with termination of temporary total disability benefits. *Woehnker v. Cooper Tire & Rubber Co.*, 764 N.E.2d 688 (Ind. Ct. App. 2002).

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

   As long as an employee is either temporarily totally disabled or a permanent impairment has not been adjudicated, the employee is entitled to the continuation of all medical benefits without regard to whether they are, in fact, limiting or reducing the employee's impairment or disability. I.C. § 22-3-3-4(a) and (b). Where the injury has been adjudicated on the basis of permanent partial impairment, additional medical benefits may be awarded to the employee only upon a showing that the benefits are “necessary to limit or reduce the amount and extent of the employee's impairment.” I.C. § 22-3-3-4(c); *Jones v. State*, 477 N.E.2d 353 (Ind. Ct. App. 1985); *Grand Lodge Free & Accepted Masons v. Jones*, 590 N.E.2d 653 (Ind. Ct. App. 1992).
41. **Which prosthetic devices are covered, and for how long?**

Where an injury results in the amputation of an arm, hand, leg or foot, the enucleation of an eye, or the loss of natural teeth or prosthodontics, the employer is required to furnish an artificial member, proper braces, and prosthodontics. I.C. § 22-3-3-4(f). The employer shall, when medically required (“medically required,” as used in this section, does not include normal wear and tear), provide replacements for artificial members. *Id.*

If an accident occurs, in the course of employment after 1997, results in the loss or damage to an artificial member, a brace, eyeglass, an implant, or other prosthodontics, the employer shall repair the artificial limb, brace, or member or furnish an identical or reasonably equivalent replacement. I.C.I.C. § 22-3-3-4(g)

42. **Are vehicle and/or home modifications covered as medical expenses?**

Given the broad language of I.C. § 22-3-3-4, vehicle and/or home modifications could be included as medical benefits to the extent the board deems them necessary to limit or reduce the amount and extent of the employee's impairment. I.C. § 22-3-3-4; *Jones & Laughlin Steel Corp. v. Kilburne*, 477 N.E.2d 345 (Ind. Ct. App. 1985). In *Kilburne*, the Court of Appeals upheld the board's award requiring the employer to provide the injured employee with wheelchairs, special soft shoes, grab bars in bathroom, ramps to garage and home, and remodeling to enlarge a bathroom to accommodate a wheelchair.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

The pecuniary liability of the employer for medical, surgical, hospital and nurse service herein required shall be limited to such charges as prevail in the same community for a like service or product to injured persons. I.C. § 22-3-3-5. With respect to these “balance billing” disputes, the Worker’s Compensation Board has exclusive jurisdiction to determine the reasonable value of medical services provided to injured employees.

44. **What, if any, provisions/requirements are there for “managed care”?**

There are no specific provisions or requirements within the Indiana Worker’s Compensation Act concerning managed care. The employer/insurer has the right to choose the treating physician, which may include a managed care type provider. I.C. § 22-3-3-4. Additionally, employer/insurers may utilize third-party administrators, with captive managed care providers, for claims administration purposes.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

A denial of claim must be made in writing to the injured employee within thirty (30) days after knowledge of the injury. I.C. § 22-3-3-7(b). If an employer is unable to make a determination regarding liability within the first thirty (30) days, the Board may approve
an additional thirty (30) days upon a written request of the employer or the employer’s insurance carrier that sets forth the reasons that the determination could not be made within thirty (30) days and states the facts or circumstances that are necessary to determine liability within the additional thirty (30) days. More than thirty (30) days of additional time may be approved by the worker’s compensation board upon filing of a petition with the board that states 1) the extraordinary circumstances that have precluded determination of liability within the initial sixty (60) days; 2) that status of the investigation on the date of the petition is filed; 3) the facts or circumstances that are necessary to make a determination; and 4) a timetable of completion remaining on the investigation. *Id.* State Form 48557 can be utilized for the purpose of requesting additional time in accordance with the foregoing.

46. **What is the method of claim adjudication?**

   **A. Administrative level.**

   If the employer denies the injured employee's claim, then the injured employee has the right to file (Form No. 29109) for a hearing before the Worker’s Compensation Board to resolve the dispute. After the employee files a claim, the case is set for a hearing before a single member of the Board. Unless otherwise agreed, the hearing must be held in the county where the injury occurred. The defendant/employer may file a responsive pleading any time prior to the hearing date. 631 I.A.C. 1-1-8. However, no such answer is required unless the defendant relies upon the special defenses enumerated in Indiana Code § 22-3-2-8. *Id.* In such cases, the defendant must plead by an affirmative answer such special defenses no later than forty-five (45) days before the hearing date. *Id.* In all hearings proof may be made by oral testimony, or by depositions. 631 I.A.C. 1-1-12. The hearing judge is not bound by any technical rules of practice in conducting hearings. 631 I.A.C. 1-1-3. A physician's statement that meets the requirements set out in I.C. § 22-3-3-6(e) is admissible into evidence unless the statement is ruled inadmissible on other grounds. The single hearing member after due consideration determines the dispute in a summary manner and forwards a copy of the decision to each party. I.C. § 22-3-4-6.

   **B. Trial court.**

   If either party is not satisfied with the decision of the award made by less than all the members, an application for review may be filed with the board within thirty (30 days). I.C. § 22-3-4-7. If the first hearing was not held before the full board, the board shall review the evidence, or if deemed advisable hear the parties at issue and make an award and file the same with finding of the facts on which it is based and send a copy thereof of the parties in dispute. I.C. § 22-3-4-7. If there is a failure to file an application within this time period will cause the appeal to be automatically dismissed. I.C. § 22-3-4-8. The application for review is usually heard by all the members of the board. The full board hearing is a trial de novo. *Burton v. Rock Road Construction Co.*, 235 N.E.2d 210 (Ind. Ct. App. 1968). Therefore, the full board can make its own findings and determinations. 631 I.A.C. 1-1-15. The full board has the discretion of admitting new or additional
evidence. Id. Usually oral argument, although not required, is presented to the full board on the evidence submitted to the single hearing member. Either party may file with the board no later than thirty (30) days prior to the review date, a brief or statement setting forth the errors alleged. Id. The opposing party has the right to file a rebuttal no later than ten (10) days prior to the review date. The full board after due consideration will render a decision and forward a copy of same to each party. I.C. § 22-3-4-7. If not appealed, the full board's decision is final. Id.

C. Appellate.

An award of the board by less than all of the members, if not reviewed pursuant to a written petition mentioned above, shall be final and conclusive. I.C. § 22-3-4-8. Either party may within thirty (30) days from the date of the full board's decision appeal the case to the Court of Appeals for errors of law under the same terms and conditions as govern appeals in ordinary civil actions. Id. Any party desiring to appeal must file with the secretary of the board within fifteen (15) days from the full board's decision, a written praecipe designating specifically the pleadings to be incorporated into the transcript for such appeal. 631 I.A.C. 1-1-22. The only assignment of error that is necessary is that the full board's decision is contrary to law. I.C. § 22-3-4-8. Further appeal must be filed with the Indiana Supreme Court.

47. What are the requirements for stipulations or settlements?

The parties to any proceeding before the board may stipulate the facts in writing from which the board will make its order or award. 631 I.A.C. 1-1-11. Where the stipulation covers a permanent partial impairment, it is necessary to file with the stipulation a report of a physician furnished by the employer and also a report of the claimant's physician. Id. The employee may waive examination by a physician other than the one provided by the employer. Id. The board highly encourages this type of stipulated disposition of a case. Id.

The parties to any proceeding before the board may stipulate the facts in writing from which the board will make its order or award. 631 I.A.C. 1-1-11. Where the stipulation covers a permanent partial impairment, it is necessary to file with the stipulation a report of a physician furnished by the employer and also a report of the claimant's physician. Id. The employee may waive examination by a physician other than the one provided by the employer. Id. The board highly encourages this type of stipulated disposition of a case. Id.

In addition, I.C. § 22-3-2-15 allows for parties to enter into a voluntary settlement agreement of the injured employee's rights under the provisions of the Act. However, no agreement can operate to relieve any employer in whole or in part of any obligation created by the Act. I.C. § 22-3-2-15(a). However, nothing in the Act should be construed as to prevent the parties of a claim to enter into voluntary agreements in settlement. Id. But a settlement cannot waive claimants rights vested in the Act unless approved by the board. Id. No such agreement shall be valid unless made after seven (7) days from the date of
the injury or death. *Id.* In any case where a provider fee application has been filed, the provider must sign off on any settlement agreement between the employee and employer before it will be approved by the Board. In cases where no provider application has been filed, medical expenses must nonetheless be addressed. If all medical treatment has been provided and paid for, this should be spelled out. In all other cases, financial responsibility for the past care provided and any future care must be stated.

A minor dependent, by parent or legal guardian, may compromise disputes and may enter into a settlement agreement, and if approved by the board, the settlement agreement will have the same effect as though the minor had been an adult. *Id.*

Any settlement payment must be made no later than thirty (30) days after the date the worker’s compensation board approves the agreement. *Id.* If an employer fails to make payment within the 30 days, the employer will be subject to the civil penalties. *Id.*

48. Are full and final settlements with closed medical available?

Yes. See answer to #47 above.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. A settlement agreement is not valid until approved by a member of the board, and the member of the board cannot approve an agreement which is not in accordance with the rights of the parties as given in the Act. I.C. § 22-3-2-15.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Every employer who is bound by the compensation provisions of the Act shall insure the payment of compensation to the employer's employees and their dependents or procure from the board a certificate authorizing the employer to carry such risk without insurance. I.C. § 22-3-2-5(a). Excluded from this provision are the state, counties, cities, towns, school townships, other municipal corporations, and banks. *Id.* The state is not allowed to purchase worker’s compensation insurance, but rather is entitled to establish a program of self-insurance to cover its liability. *Id.* Pursuant to I.C. § 22-3-5-1(a), every employer, except those exempted by I.C. § 22-3-2-5, shall:

A. Insure and keep insured the employer's liability in some corporation, association or organization authorized to transact the business of worker's compensation insurance in Indiana; or

B. Furnish to the board satisfactory proof of the employer's ability to pay direct the compensation in the amount and manner when due.
The board may require the deposit of an acceptable security indemnity or bond to secure the payment of compensation liabilities as they are incurred. *Id.*

Subject to the approval of the board, any employer may enter into any agreement with the employees to provide a system of compensation, benefit, or insurance in lieu of the compensation and insurance provided by the Act. I.C. § 22-3-5-4(a). However, no substitute system will be approved unless it confers benefits at least equivalent to the benefits provided by the Act, nor if it requires contributions from the employees unless it confers benefits in addition to those provided under the Act at least commensurate with such contributions. *Id.* Such a system may be terminated by the worker’s compensation board on reasonable notice and hearing to the interested parties if it appears that the same is not fairly administered, its operation discloses latent defects threatening its solvency, or if for any substantial reason it fails to accomplish the purpose of the Act. *Id.* Additionally, groups of employers may form mutual insurance associations or reciprocal or interinsurance exchanges subject to such reasonable conditions and restrictions as may be fixed by the department of insurance. I.C. § 22-3-6-2.

There is also available a special fund known as the Residual Asbestos Injury Fund. The purpose of this fund is to provide compensation to employees who become totally and permanently disabled from exposure to asbestos while in employment within Indiana and who are eligible under I.C. § 22-3-11-1. The fund is used only for the payment of awards of compensation and expense of medical examinations made and ordered by the board and chargeable against the fund. I.C. § 22-3-11-1(b). I.C. § 22-3-11-2 sets forth the assessment criteria against insurance carriers and self-insured employers for deposit in the fund.

To the extent that a principal retains an independent contractor, the employer must verify in writing that each independent contractor (specifically, their respective employer) carries worker’s compensation insurance. I.C. § 22-3-2-14. If a principal does not comply with Indiana Code § 22-3-2-14 and ensure the independent contractor carries worker’s compensation insurance, then the principal shall be liable to the same extent as such independent contractor for the payment of compensation, physician fees, hospital fees, nurse’s charges and burial expenses on account of injury or death of any employee of the independent contractor due to an accident arising out of the and in the course of the performance of the work covered by such subcontract. *Id.*

An employer’s failure to carry worker’s compensation insurance is a Class A criminal misdemeanor. I.C. § 22-3-7-34. It should be noted that there is no criminal penalty for a principal failing to verify or ensure that its independent contractor maintains proper worker’s compensation insurance.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

See answer to #50 above. Moreover, the employer upon application for certificate of
self-insurance, must certify that it has adequate facilities for making necessary accident reports, executing compensation agreements and other necessary documents, and that it has placed in charge of this work a person(s) within the state familiar with the Act and the rules of the board. 631 I.A.C. 1-1-29. In addition, the Worker’s Compensation Board may require the deposit of an acceptable security, indemnity or bond to secure the payment of compensation liabilities. I.C. § 22-3-5-1(b). There is an initial application fee of $500.00 to be paid along with the proof of financial ability, and a renewal fee of $250.00 if the employer holds a certificate of self-insurance. I.C. § 22-3-5-1(b)(1) and (2).

B. For groups or "pools" of private entities.

See answer to #50 above. For the purposes of complying with I.C. § 22-3-5-1, groups of employers are authorized to form mutual insurance associations or interinsurance exchanges subject to such reasonable conditions and restriction as maybe set by the department of insurance. I.C. § 22-3-6-2. Additionally, membership in such groups so approved, together with evidence of the payment of premiums due, is evidence of compliance with I.C. § 22-3-5-1. Id.

52. Are “illegal aliens” entitled to benefits of worker’s compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

The Indiana Code does not contemplate worker’s compensation benefits for illegal aliens, nor has case law addressed this issue. However, an illegal alien, who is a dependent of an employee who is legally entitled to receive worker’s compensation benefits, will be considered a dependent authorized to collect worker’s compensation money. See Miami Coal Co. v. Peskir, 139 N.E. 684 (Ind. Ct. App. 1923).

53. Are terrorist acts or injuries covered or excluded under worker’s compensation law?

It is likely that terrorist acts or injuries are compensable under the Act although no Indiana case has specifically addressed the issue. When determining whether an injury “arises out of” one’s employment, the three possible risk categories are: 1. Risks associated with the employment and those are compensable; 2. Risks that are neutral and have no specific relationship to the employer or employee; and 3. Risks that are personal to the employee and therefore not compensable. Indiana courts have often applied the “positional risk” test if the risk appears “neutral.” Examples of neutral risks include “cases of stray bullets, roving lunatics, and other situations in which the only connection of the employment with the injury is that its obligations place the employee in a particular place at a particular time when they were injured by some neutral force.” Conway v. School City of East Chicago, 734 N.E.2d 594, 599 (Ind. Ct. App. 2000) (citing K-Mart Corp. v. Novak, 521 N.E.2d 1346, 1349 (Ind. Ct. App. 1988). As a result, under the positional risk test, it is likely that injuries resulting from terrorist acts are covered under Indiana worker’s compensation law as they arise out of a worker’s employment
and obligations to be at a certain place at a specific time.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

Under Medicare regulations (42 C.F.R. 411.46), Medicare is secondary payer to the payment of worker’s compensation by a worker’s compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a worker’s compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 C.F.R. 404, 411; 42 USC §1395)

At this time, Indiana has not added any additional requirements for satisfying Medicare’s interests, and it is anticipated that Indiana will follow the national trend in this regard.

For more information on Workers’ Compensation Medicare Set Aside Arrangements, please visit the Centers for Medicare & Medicaid Services at:


55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires states to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).
The Medicaid lien statute is found at I.C. 12-15-8-1 and provides a statutory lien “to the extent of the amount paid by the office on any recovery under the claim, whether by judgment, compromise or settlement.” In addition, the lien reduction statute is found at I.C. § 34-51-2-19 and provides that liens are to be diminished by: “(1) comparative fault; or (2) by reason of the uncollectibility of the full value of the claim . . . resulting from limited liability insurance or from any other cause.” In that case, the lien is to be diminished in the same proportion as the claimant’s recovery is diminished. There are no exceptions for worker’s compensation, occupational diseases or Medicaid in the lien reduction statute.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went into effect on April 14, 2003. The law provides an exception for worker’s compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

The law regarding confidentiality of medical records is codified at I.C. § 16-39-6-3. This section states confidential records may be produced on court order in a cause in which the records and proceedings are relevant or material. There is no section specific to worker’s compensation law. The privacy of mental health records is codified at I.C. § 16-39-2, et seq., 16-39-3, et seq. and 16-39-4, et seq. E.G. v. S.L., 76 N.E.3d 157, 170 (Ind. Ct. App. 2017). In addition, no court has yet addressed how those privacy concerns are affected by federal law.

57. What are the provisions for “Independent Contractors”?

Since independent contractors are not employees under Indiana law, an independent contractor who does not make an election under I.C. § 22-3-7-9 is then not subject to the compensation provisions of the Act and must file a statement with the department of state revenue and obtain a certificate of exemption. I.C. § 22-3-7-34.5. The rules for determining who is an independent contractor for Indiana workers 22-3-7-9 compensation purposes are similar to those applied by the Internal Revenue Service. The IRS weighs twenty factors in making such a determination. Per current case law, the Board considers some of these factors and others. Note that there are special procedures concerning independent contractors working in the building and construction trades. A person is an independent contractor in the construction trades and not covered as an employee under the Act if, and only if, the person is an independent contractor under the guidelines of the Internal Revenue Service. I.C. §22-3-6-1(b)(7). These guidelines may be found in IRS Publication 937.

58. Are there any specific provisions for “Independent Contractors” pertaining to
professional employment organizations/temporary service companies/leasing companies?

As employers, all employee leasing services and temporary agencies are required by I.C. §§ 22-3-2-5, 22-3-5-1, and 22-3-5-5 to maintain worker's compensation coverage for all employees. Proof of coverage is required to be furnished to the Worker's Compensation Board.

Worker's compensation coverage is required even though leased and temporary employees may not be directly supervised by officials of the leasing firm or temporary service. While in some cases the business where the temporary employee is filling in may arrange for worker's compensation coverage for employees leased from a temporary agency, the temporary agency may ultimately be liable under Indiana law if no insurance policy is in place and the agency is found to be the employer of the leased worker.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

An owner-operator who provides a motor vehicle and the services of a driver to a motor carrier under a written contract that is subject to I.C. § 8-2.1-24-23, 45 I.A.C. 16-1-13, or 49 C.F.R 376 is not an employee of the motor carrier and is therefore not covered under the Indiana Worker’s Compensation Act. I.C. § 22-3-6-1(b)(8). The owner-operator may elect to be covered and have the owner-operator's drivers covered under a worker's compensation insurance policy or authorized self-insurance that insures the motor carrier if the owner-operator pays the premiums as requested by the motor carrier. Id. An election by an owner-operator under this subdivision does not terminate the independent contractor status of the owner-operator for any other purpose. Id.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

More information, including forms and online services, can be found on Indiana’s Worker’s Compensation Board website: http://www.in.gov/wcb/

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

{BWE/MISC/01531338 v1}
See responses to questions 54 and 55 above. Keep in mind that worker’s compensation settlements will likely require satisfaction of Medicare’s lien interests if Medicare made conditional payments for an injured plaintiff. Both parties’ counsel may be held liable to satisfy the lien if Medicare’s interests are not properly protected. The MMSEA Section 1111 mandates proper reporting of workers’ compensation settlements to the government. Further, as indicated above, certain workers’ compensation settlements are required to contemplate Medicare set-aside agreements to ensure protection of Medicare’s interests. Counsel must know how to determine if a Medicare set-aside is needed, how to determine the proper amount and then how to properly establish these arrangements.

62. Does Indiana permit medical marijuana and what are the restrictions for use and for work activity Indiana’s Worker’s Compensation law?

Indiana law has been silent on medical marijuana throughout the years; however, it is possible that it could pass legislature soon. House Bill 1106 was introduced in January 2018 and “permits the cultivation, dispensing, and use of medical marijuana by persons with serious medical conditions.” Additionally, the bill “prohibits discrimination against medical marijuana users.” H.B. 1106 (2018). If passed, it is very likely that legislation will form restrictions of use and work activity under Indiana Workers’ Compensation laws and the State Department of Health will “implement and enforce the medical marijuana program.” H.B. 1106 (2018).

However, beginning July 1, 2018, it will be legal in Indiana to use cannabis-derived CBD oil (with a THC level of 0.3 percent or lower) and to sell CBD products that comply with new state testing and packaging requirements, including certification that the product is derived from industrial hemp and not marijuana. S.B. 52 (2018). Indiana does not regulate drug testing by private employers which gives wide latitude to type and degree of drug test. It is likely that the passage of this bill will provoke legislation limiting the use of CBD Oil in the workplace due to its relationship with marijuana and drug testing.

63. Does Indiana permit recreational use of marijuana and what are the restrictions for use and for work activity in Indiana Workers’ Compensation law?

Indiana does not permit recreational use of marijuana; therefore, there are no restrictions for use and for work activity under Indiana Workers’ Compensation law. However, as neighboring states such as Illinois and Michigan have legalized recreational use of marijuana in 2019, employers and insurers should evaluate the consequences of out-of-state citizens working in Indiana. See Brenon v. First Advantage Corp., 973 N.E.2d 1116 (Ind. Ct. App. 2012) (holding that Wisconsin resident hired to perform investigative services in Indiana could pursue a claim for benefits in Indiana after being injured in a head-on collision).
1. Citation for the state’s workers’ compensation statute.

Iowa Code § 85.1 et seq. (2019).

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

All employees not specifically excepted are covered. Exceptions are: household employees earning less than $1,500 during 12 months prior to an injury; casual employees not hired for purposes of the employer’s trade or business earning less than $1,500 for 12 consecutive months prior to an injury; agricultural employees where the employer’s nonexempt cash payroll is less than $2,500 for the preceding calendar year; relatives of farm employer and employer’s spouse; officers of family farm corporation; relatives of a partner or partner’s spouse engaged in agricultural pursuits; exchange of labor by owner of farmland or by a farm operator; top officers of a corporation (not to exceed four) who specifically elect against coverage. Iowa Code § 85.1.

3. Identify and describe any “statutory employer” provision.

There is no such provision.

4. What type of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims, and cumulative injury claims.

Any injury, occupational disease, or occupational hearing loss claim against the employer, and any other employee of the employer, arising out of and in the course of the employment, and not caused by a co-employee’s gross negligence so as to amount to wanton neglect for the safety of another, is compensable. Iowa Code § 85.20.

B. Occupational disease (including respiratory and repetitive use).

An occupational disease must be incidental to the character of the business, and a direct causal connection with the employment must be shown. A disease from a hazard where
the employee was equally exposed outside the employment is not compensable. Iowa Code § 85A.8.

5. **What, if any, injuries or claims are excluded?**

Claims against co-employees based on gross negligence; an employee’s willful intent to injure himself or herself or another; injury caused by the employee’s intoxication; or willful act of a third party directed against the employee for personal reasons, are all excluded. Iowa Code §§ 85.16, 85.20. Additionally, an injury caused by an employee’s personal condition is not compensable when the employment does not contribute to the risk or aggravate the injury. *See AARP v. Whitacre*, 834 N.W.2d 870 (table), 2013 WL 2107398, at *1 (Iowa Ct. App. 2013).

6. **What psychiatric claims or treatments are compensable?**

Treatment for a mental injury that arose out of a physical injury is compensable, as is treatment for a mental injury that arose out of a mental injury, i.e. a mental injury as a result of a stress claim. *See Brown v. Quik Trip Corp.*, 641 N.W.2d 725 (Iowa 2002); *Dunlavey v. Econ. Fire & Cas. Co.*, 526 N.W.2d 845 (Iowa 1995).

7. **What are the applicable statutes of limitations?**

Two years from the date of occurrence of the injury, if no weekly benefits have been paid. Three years from the last date of payment in the event that weekly benefits were paid. Following a determination of liability, a review re-opening proceeding may be initiated within three years of the last payment. Iowa Code § 85.26.

8. **What are the reporting and notice requirements for those alleging an injury?**

Notice must be given by the worker to the employer within 90 days of the injury’s occurrence. Iowa Code § 85.23. For occupational disease, within 90 days of the first distinct manifestation of disease. *Id.* § 85A.18.

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

   Total defense. Iowa Code § 85.16.

   B. **Willful misconduct, “horseplay,” etc.**

   Willful intent to injure another is a complete defense. Iowa Code § 85.16. An injury during “horseplay” is not compensable. *Ford v. Barcus*, 155 N.W.2d 507 (Iowa 1968); *see Xenia Rural Water Dist. v. Vegors*, 786 N.W.2d 250 (Iowa 2010).

   C. **Injuries involving drugs and/or alcohol.**
A claim may be barred if intoxication was a “substantial factor” in causing the injury. Iowa Code § 85.16. But see Koehler Elec. & Cont’l W. Ins. v. Wills, 608 N.W.2d 1 (Iowa 2000) (finding a fall from a ladder due to alcohol withdrawal symptoms to be compensable).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

There is no statutory provision for claims involving fraud. An agreement between the employer or its insurance carrier and the claimant may be set aside for fraud by the district court, but not by the industrial commissioner. See Whitters & Sons, Inc. v. Karr, 180 N.W.2d 444, 447 (Iowa 1970); Ford, 155 N.W.2d 507.

11. **Is there any defense for falsification of employment records regarding medical history?**

Yes, for an occupational disease claim. Iowa Code § 85A.7(1).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Yes. See Briar Cliff Coll. v. Campolo, 360 N.W.2d 91 (Iowa 1984).

13. **Are injuries by co-employees compensable?**

Yes, so long as they are not caused by the other employee’s gross negligence amounting to such a lack of care as to amount to wanton neglect for the safety of another. Iowa Code § 85.20.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. “irate paramour” claims)?**

No, not for a willful act of a third party directed against the employee for reasons personal to the employee. Iowa Code § 85.16(3).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

For full time employees, the weekly wage rate is based upon the gross weekly earnings of the employee at the time of injury. Iowa Code § 85.36. The law provides various methods of computing the gross weekly earnings, dependent upon the method of payment of wages and, in some cases, upon the classification of the employee. Id. § 85.61(3). For a full time employee paid on a daily or hourly basis, weekly gross earnings are computed using an average of the last 13 consecutive calendar weeks immediately prior to the injury date that “fairly represent the employee’s customary earnings,” excluding overtime pay, bonuses, expenses, or reimbursement of any expenses. Jacobson Transp. v. Harris, 778 N.W.2d 192, 196–97, 199 (Iowa 2010) (quoting Iowa Code § 85.36(6)). The weekly rate is determined based upon the gross weekly wages, the worker’s marital
status, and the maximum number of exemptions to which the employee is entitled at the

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Temporary Partial Disability: two-thirds of the difference between weekly earnings at
the time of injury and actual gross weekly income from employment during temporary

Healing Period/Temporary Total Disability: weekly compensation benefits are payable
until the employee returns to work, is medically capable of returning to employment
substantially similar to the employment in which the employee was engaged at the time
of the injury, or if is medically indicated that significant improvement from the injury is
not anticipated, whichever occurs first. Id. §§ 85.33, 85.34. The maximum weekly rate
for 2019-2020 is $1,819. The minimum weekly rate for 2019-2020 is the lesser of (1)
$318, which is 35% of the current statewide average weekly wage; or (2) the spendable
weekly earnings of the employee. Iowa Workforce Dev., Ratebook 2020,
iowaworkcomp.gov,
https://www.iowaworkcomp.gov/ratebook-spreadsheet-%E2%80%94-2019%E2%80%932020

17. **How long does the employer/insurer have to begin temporary benefits from the date
disability begins?**

Compensation begins on the fourth day of disability after injury. Iowa Code § 85.32.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be
out ____ days before recovering benefits for the first ____ days)?**

The employee must be out fourteen days before receiving benefits for the first three days.
Iowa Code § 85.32.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary total disability benefits are paid until the employee returns to work or is
medically capable of returning to substantially similar employment, whichever occurs
first. Iowa Code § 85.33(1).

Temporary partial disability benefits are paid for the period of such disability. If
commenced, payments shall be terminated only when the employee returns to work, or
upon 30 days’ notice stating the basis for termination and advising the employee of the
right to file a claim with the Workers’ Compensation Commission. Id. § 86.13(2).

If an employee is temporarily, partially disabled and the employer offers to the employee
suitable work consistent with the employee’s disability, the employee shall accept the
suitable work and be compensated with temporary partial benefits. If the employee
refuses to accept the suitable work, the employee shall not be compensated with
temporary partial, temporary total, or healing period benefits during the period of the refusal. *Id.* § 85.33(3). The Commissioner may consider the distance of available work from the employee’s home in determining whether an employer has offered “suitable work” for purposes of Iowa Code section 85.33(3). *Neal v. Annett Holdings, Inc.*, 814 N.W.2d 512, 524 (Iowa 2012).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

Yes. Iowa Code § 85.34.

21. **What disfigurement benefits are available and how are they calculated?**

The period is determined by the Worker’s Compensation Commissioner according to severity, not to exceed 150 weeks. Iowa Code § 85.34(2)(u).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates:**

A. **How many weeks are available for scheduled members/parts, and the standard for recovery.**

The maximum is 80% per week of average weekly spendable earnings, but no more than $1,819.00 for TTD, HP and PTD and death benefits. The maximum for PPD benefits is $1,673.00. Iowa Workforce Dev., *Ratebook 2020*, iowaworkcomp.gov, [https://www.iowaworkcomp.gov/ratebook-spreadsheet-%E2%80%94-2019%E2%80%932020](https://www.iowaworkcomp.gov/ratebook-spreadsheet-%E2%80%94-2019%E2%80%932020)

Minimum amount for TTD or HP is 35% of state average weekly wage ($318.00) or spendable weekly earnings of the employee, whichever is less. *Id.*

**Schedule** - represents # of weeks payable for 100% loss of use

- thumb 60 weeks
- index finger 35 weeks
- second finger 30 weeks
- third finger 25 weeks
- fourth finger 20 weeks
- **first or distal phalange of thumb or any finger = 1/2 of finger**
- more than 1 phalange = entire finger
- great toe 40 weeks
- other toes 15 weeks each
- **first phalange = 1/2 of toe**
- more than one phalange = entire toe
- hand 190 weeks
- arm, or 2/3 of arm between shoulder, elbow 250 weeks
- foot 150 weeks
leg, or 2/3 of leg between hip and knee  220 weeks

eye  140 weeks
loss of remaining eye  200 weeks

hearing in one ear  50 weeks
hearing in both ears  175 weeks

two arms, two hands, two feet, two legs  500 weeks
disfigurement not to exceed 150 weeks
other  % of disability of body as a whole x 500 weeks.

Iowa Code § 85.34(2).

B.  Number of weeks for “whole person” and standard for recovery.

500 weeks is used to calculate a whole-person impairment (also known as an industrial disability). After the degree of the industrial disability is determined, the number of weeks payable is found by multiplying the total value of the body as a whole (500 weeks) by the percentage rating. Iowa Workforce Dev., Ratebook 2020, iowaworkcomp.gov, https://www.iowaworkcomp.gov/ratebook-spreadsheet-%E2%80%94-2019%E2%80%932020 Lifetime benefits are available for total disability. Iowa Code § 85.34(3).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

An additional benefit of $100.00 per week is available when the employee actively participates in a vocational rehabilitation program. Such payments are not to exceed 13 consecutive weeks but may be extended for an additional period not to exceed 13 weeks if continued training will accomplish rehabilitation. Iowa Code § 85.70.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total disability benefits are paid at 80% of the employee’s weekly spendable earnings. The maximum rate is $1,819.00, which is 200% of the state average weekly wage. The minimum is $318.00 (or 35% of the state’s average weekly wage of $909.43). Iowa Code § 85.34(3). The permanent total benefits are payable as long as the employee remains permanently totally disabled. (See Ratebook 2020)

25. How are death benefits calculated, including the minimum and maximum rates:

A.  Funeral expenses.

Reasonable expenses of burial, up to $10,125.72 (12 times the statewide AWW of $843.81). Iowa Code § 85.28.
B. Dependency claims.

A surviving spouse receives 80% of the employee’s average weekly spendable earnings, for life or until remarriage. Upon remarriage, the spouse receives two years benefits in a lump sum if there are no children entitled to benefits. A dependent child receives benefits until age 18, or 25 if still dependent (full-time student is considered dependent). A child mentally or physically incapacitated from earning wages continues to receive benefits for the duration of such incapacity. Iowa Code § 85.31.

The maximum rate for dependency benefits is $1,819.00, which is 200% of the state average weekly wage. The minimum rate is $318.00, which is 35% of the statewide average. *Id.*

26. What are the criteria for establishing a “second injury” fund recovery?

Such benefits may be recovered when an employee, who has previously lost one hand, arm, foot, leg, or eye, becomes permanently disabled by a compensable injury which has resulted in the loss of another such organ or member. Iowa Code § 85.64.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

Review re-opening within three years of date of last payment of weekly benefits. Iowa Code § 85.26(2).

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

There is no statutory provision for payment of legal fees by the employer to a claimant. Fees or claims for legal services rendered in the district court and appellate courts are subject to approval by a district court judge. Iowa Code § 86.39.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

Yes. Iowa Code § 85.20.

A. Scope of immunity.

Workers’ compensation benefits are the exclusive remedy for all injuries arising out of and in the course of the employment. *Id.*

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

The employee can bring a separate action in district court for damages caused by a co-employee’s gross negligence. Iowa Code § 85.18. Intentional torts such as intentional-
infliction-of-emotional-distress claims also fall outside the exclusive remedy provision. *Smith v. Iowa State Univ. of Sci. & Tech.*, 851 N.W.2d 1, 20 (Iowa 2014). It is not possible to waive immunity contractually. Iowa Code § 85.18.

30. **Are there any penalties against the employer for unsafe working conditions?**

Not under workers’ compensation law, but yes under OSHA.

31. **What is the penalty, if any, for an injured minor?**

None under workers’ compensation statutes.

32. **What is the potential exposure for “bad faith” or claims handling?**

A first party bad faith tort claim is permitted (failure to pay without a reasonable basis). Also, for a denial or a delay in payments, without reasonable cause, additional benefits (called penalty benefits) may be awarded of up to 50% of the amount unreasonably delayed, denied, or terminated. Iowa Code § 86.13(4). This also includes delay or denial pending an appeal of the award.

33. **What is the exposure for terminating an employee who has been injured?**


**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. Iowa Code § 85.22.

35. **Can co-employees be sued for work-related injuries?**

Yes, but only if the injury was the result of a co-employee’s gross negligence.

36. **Is subrogation available?**

Yes. Iowa Code § 85.22.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

None specified.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**
Parties to a workers’ compensation claim have access concerning the employee’s physical or mental condition relative to the claim and further waive any privilege for the release of the information. Iowa Code § 85.27. No institution or person releasing such information to a party or its representative shall be criminally or civilly liable for damages by reason of releasing the information. If release of the information is refused, the party requesting it may apply to the Worker’s Compensation Commissioner for relief, and the information requested will be ordered to be produced if it is relevant and material to the claim. Id.; see also Morrison v. Century Eng’g, 434 N.W.2d 874 (Iowa 1989) (finding a workers’ compensation claimant had no right to have her attorney present when employer’s counsel interviewed claimant’s treating physician; claimant waived any privilege pertaining to release of information concerning physical or mental condition). If a petition for benefits is filed, a waiver must be attached to the petition. Iowa Admin. Code r. 876-4.6 (2018).

39. What is the rule on choice (a) claimant’s choice of physician; (b) employer’s right to a second opinion and/or Independent Medical Evaluation?

A. Claimant’s choice of physician.

Employer has the right to choose physician. Iowa Code § 85.27(4). Claimant may petition for alternate care. Id. The Commissioner may award alternate medical care if the employer’s choice of treatment is not prompt, is not reasonably suited to treat the employee’s injury, or is unduly inconvenient for the employee. Millenkamp v. Millenkamp Cattle, Inc., 832 N.W.2d 384 (table), 2013 WL 1452961, at *4 (Iowa Ct. App. 2013) (citing R.R. Donnelly & Sons v. Barnett, 670 N.W.2d 190, 195 (Iowa 2003)). An employer does not fail the “prompt” requirement when its original choice of physician retires and the employee fails to inform the employer of the retirement, thereby delaying the employer’s choice of a replacement physician. Id. at *7.

B. Employer’s right to a second opinion and/or Independent Medical Examination.

When an employee is injured, the employer may require the employee to “submit for examination at some reasonable time and place and as often as reasonably requested, to a physician or physicians . . . .” Iowa Code § 85.39.

If an employee has been given an impairment rating by a doctor retained by the employer, and the employee believes the rating is too low, the employee can obtain a second opinion or Independent Medical Exam on impairment at the employer’s cost. Iowa Code § 85.39.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

“[R]easonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance and hospital services and supplies.” Iowa Code § 85.27.
41. **Which prosthetic devices are covered, and for how long?**

“[R]easonable and necessary crutches, artificial members, and appliances but shall not be required to furnish more than one set of permanent prosthetic devices.” Iowa Code § 85.27.

42. **Are vehicle and/or home modifications covered as medical expenses?**

In limited circumstances, a Commissioner could reasonably view a van as an appliance as contemplated by the above workers’ compensation statute because a van may be necessary in order to make a claimant’s wheelchair fully useful. *Manpower Temp. Servs. v. Sioson*, 529 N.W.2d 259 (Iowa 1995). On the same basis, a Commissioner could reasonably view modifications to a home to accommodate a wheelchair as an appliance (*Quaker Oats Co. v. CINA*, 552 N.W.2d 143 (Iowa 1996), and that a computer is an appliance (*Stone Container Corp. v. Custle*, 657 N.W.2d 485 (Iowa 2003)).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

No. All fees are subject to approval by the Worker’s Compensation Commissioner.

44. **What, if any, provisions or requirements are there for “managed care”?**

The employer has the right to choose the physician and the obligation to pay for reasonable medical expenses incurred for authorized care causally related to the injury. Iowa Code § 85.27(4).

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

46. **What is the method of claim adjudication?**

   **A. Administrative level.**

   A contested case proceeding is presided over by the Commissioner or a Deputy Commissioner. Iowa Code § 86.17. Appeal is to the Commissioner. *Id.* § 86.24.

   **B. Trial court.**

   Judicial Review to District Court. Iowa Code § 86.26.

   **C. Appellate.**

   Appeal of District Court decision to the Iowa Supreme Court. Iowa Code § 86.26.

47. **What are the requirements for stipulations or settlements?**

   All settlements must be approved by the Worker’s Compensation Commissioner. Iowa Code §§ 85.35, 86.27.

48. **Are full and final settlements with closed medicals available?**

   Yes. Iowa Code § 85.35.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

   Yes. Iowa Code §§ 85.35, 86.13, 86.27.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

    An employer must insure its workers’ compensation risk. Iowa Code § 87.1(1). Insurance is available through private insurers, employer group insurance associations, and self-insured plans.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   For individual employers, a self-insured plan needs to be approved by the Insurance Commissioner. Iowa Code § 87.4(3). A self-insured workers’ compensation plan for cities, counties, or community colleges does not require approval. *Id.* § 87.4(4). The plan (if approval is required) must meet the Commissioner’s established minimum financial standards to adequately cover reasonably anticipated expenses. *Id.* § 87.4(3)(b).

   **B. For groups or “pools” of private entities.**
Groups or “pools” of private entities in the same industry can qualify for group self-insurance. The standards are similar to those for individual self-insurers (e.g., must establish financial ability to pay claims as they come due). See Iowa Code § 87.4.

52. Are “illegal aliens” entitled to benefits or workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of “employee”?

Yes. The Iowa Supreme Court has expressly held an undocumented worker is an employee within the meaning of the Iowa Workers’ Compensation Act; undocumented workers’ employment contracts are not unenforceable on grounds that they are in violation of a statute or have an illegal purpose; and federal Immigration Reform and Control Act of 1986 (IRCA) does not preempt the payment of healing period benefits to undocumented workers under Iowa law. See Staff Mgmt. v. Jimenez, 839 N.W.2d 640 (Iowa 2013), as corrected (Nov. 18, 2013). Illegal aliens are not excluded from the definition of “employee” or “worker” under the workers’ compensation statute. Iowa Code § 85.61(11).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

To be compensable, an injury must arise out of and in the course of employment. A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

There are no specific requirements; however, contingent settlements are now available to allow the parties time to obtain approval from Medicare. Iowa Code § 85.35(5).

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The federal Medicaid statute requires states to include in their plans for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. Id. § 1396k(b).

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?
The law provides an exception for workers’ compensation claims so as to allow the
collection of medical records by employers and insurers. 45 C.F.R. § 164.512(l) (2016).
Pursuant to Iowa Code section 85.27, the employee waives any privilege for the release
of medical information.

57. **What are the provisions for “Independent Contractors”?**

Independent Contractors are not considered employees but may elect to be covered by
purchasing a valid Workers’ Compensation Insurance Policy specifically including the

58. **Are there any specific provisions for “Independent Contractors” pertaining to
professional employment organizations/temporary service companies/leasing
companies?**

There are no specific provisions dealing with Independent Contractors that also
pertain to professional employment organizations/temporary services companies/leasing
companies. *But see Swanson v. White Consol. Indus.*, 77 F.3d 223 (8th Cir.
1996) (holding personal injury judgment against temporary employer was enforceable on
an express contract theory between employer and temporary worker); *Fletcher v. Apache
Hose & Belting Co.*, 519 N.W.2d 839 (Iowa Ct. App. 1994) (summary judgment for an
employer in a temporary employee’s negligence action was proper where the employer
and employee had an employment relationship, thereby barring the claim under the
workers’ compensation statute’s exclusivity provisions).

59. **Are there any specific provisions for “Independent Contractors” pertaining to
owner/operators of trucks or other vehicles for driving or delivery of people or
property?**

An owner-operator who owns a vehicle licensed and registered as a truck, road tractor, or
truck tractor by a governmental agency, is an independent contractor while performing
services in the operation of the vehicle if the owner-operator is responsible for the
maintenance of the vehicle, the operating costs, the operation of the vehicle, is
compensated based on a percentage of the rates, determines the details and means of
performing the services, and enters into a contract which specifies the relationship to be
that of an independent contractor and not that of an employee. Iowa Code §
85.61(11)(c)(3)(a)–(f).

60. **Are there any state specific requirements which must be satisfied in light of the
obligation of the parties to protect Medicare’s interests when settling the right to
medical treatment benefits under a claim?**

The requirement to protect Medicare’s interests when settling the right to medical
treatment benefits under a claim is federally mandated, and every state must therefore
abide by the requirement. Most states handle the requirement similarly. Although some
states require specific language in the settlement confirming that the interests of Medicare
have been considered, Iowa does not.
According to recommendation by the Center for Medicare and Medicaid Services, many states utilize Workers’ Compensation Medicare Set-Asides (WCMSA) to ensure that Medicare interests are protected. See Ctrs. for Medicare & Medicaid Servs., Workers’ Compensation Medicare Set Aside Arrangements, CMS.gov, https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview (last visited February 1, 2020). A WCMSA is a fund established to pay future work-related-injury medical costs that might otherwise be paid for by Medicare. Typically, a WCMSA is based on the particular state’s specific workers’ compensation fee schedule. However, Iowa does not have a fee schedule, and the WCMSA is therefore not based upon a fee schedule.

Iowa operates using a closed file or open file settlement. Iowa Code § 85.35. In an open file settlement, parties reach an agreement that the injury arose out of and in the course of employment, and agree on the extent of the subsequent disability. Id. § 85.35(2). The insurer agrees to pay for medical expenses as they are incurred. Id. In a closed file settlement, which often includes a WCMSA, the injured worker is paid a specific amount of money, and the file is then closed. See id. § 85.35(3). The employee forfeits the right to be reimbursed for claim-related expenses once the settlement funds are used up. See id. The closed file settlement will therefore often include a WCMSA because without it, the employee could simply rely on Medicare once the funds for medical treatment are exhausted.

61. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Yes. A patient who is eighteen years or older and a permanent resident of the state of Iowa may be approved for a medical cannabidiol registration card by the Department of Transportation (DOT) upon 1) submission of a written certification signed by the patient’s health care provider that the patient is suffering from a debilitating medical condition; 2) submission of an application to the DOT containing patient’s identifying information and; 3) submission of a medical cannabidiol registration card fee; so long as the patient has not been convicted of a disqualifying felony offense. Iowa Code § 124E.4(1) (2019).

If a patient has been issued a medical cannabidiol registration card, they are permitted to possess and use medical cannabidiol pursuant to their registration card. A patient may not smoke medical cannabidiol. Iowa Code § 124E.16 (2019).

A claim may be barred if intoxication was a “substantial factor” in causing the injury. See Iowa Code § 85.16. Upon a showing that the medical cannabidiol was not authorized by a medical practitioner or was not used in accordance with the “prescribed” use of the drug, an employee who regularly uses medical marijuana and suffers an injury in the workplace could be denied benefits. See Iowa Code § 85.16 (2019).

62. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**
No.
1. Citation for the state's workers' compensation statute.

Kansas Statutes Annotated §44-501 et seq.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

"Employee," “workman,” or "worker" are defined as “any person who has entered into the employment of or works under any contract of service or apprenticeship with an employer.” K.S.A. §44-508(b).

3. Identify and describe any "statutory employer" provision.

Where any person (in this section "principal") undertakes to execute any work which is a part of his or her trade or business, or which he or she has contracted to perform, and the principal contracts with any other person (in this section "contractor") for the execution by, or under, the contractor of the whole or any part of the work undertaken by the principal, the principal is responsible for payment of benefits to any employee of the contractor as if that employee had been immediately employed by the principal. K.S.A. §44-503(a).

The test used to determine whether the work which gave rise to the injury was a part of the principal's trade or business is whether the work: (1) was necessarily inherent to, and an integral part of, the principal's trade or business; or (2) would ordinarily be done by the principal's employees. If either is answered in the affirmative, work being done is part of the principal's "trade or business," and the employee's sole remedy against the principal is under the Act. Bright v. Cargill, Inc., 251 Kan. 387, 837 P.2d 348 (1992); see also Wescott v. Lafarge North America, Inc., 197 P.3d 906 (Table), 2008 WL 5428211, *3 (Kan. Ct. App. Dec. 24, 2008). K.S.A. 44-503 allows the employee of a contractor to recover workers compensation benefits from either the employee's immediate employer or the principal contractor, so long as the work being done by the employee is either an integral part of the principal's trade or business or is work that
would ordinarily have been done by an employee of the principal. *Id.* Robinett v. Haskell Co., 270 Kan. 95, 98, 12 P.3d 411, 414.

4. **What types of injuries are covered and what is the standard of proof for each:**

The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record. K.S.A. §§44-501b(c), 44-508(h).

Personal injuries by accident, repetitive trauma or occupational disease arising out of and in the course of the employment, are covered. K.S.A. §44-501b(b).

A. **Accident or "single occurrence" claims.**

An accident is an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force K.S.A. §44-508(d). Accidents include situations where the employee is injured under the stress of his or her usual labor. *Gilliland v. Clement Co.*, 104 Kan. 771, 180 P. 793 (1919). Accidents include circumstances where the physical structure of the employee gives out under the stress of his or her usual labor. *Id.* at 796. “Accident” shall in no case be construed to include repetitive trauma in any form. K.S.A. §44-508(d).

B. **Occupational disease claims.**

Occupational diseases arise out of and in the course of the employment, and are the result of the employment in which the employee was engaged. K.S.A. §44-5a01(b). Occupational disease must be a "peculiar hazard" of the employment. *Id.* The statute contains a special exception indicating that for emphysema to be compensable, it must be shown by clear and convincing evidence that the employment was the sole cause of the disease. *Id.*

C. **Repetitive trauma claims.**

Repetitive trauma refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. “Repetitive trauma” shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.

5. **What, if any, injuries or claims are excluded?**

Most injuries or occupational diseases are covered if they fit the criteria for being related to the employment. See answer 9.
6. **What psychiatric claims or treatments are compensable?**


7. **What are the applicable statutes of limitations?**

No proceeding for compensation may be maintained unless an application for hearing is filed with the Office of the Director within the later of three years after the date of accident or two years after the last payment of compensation. K.S.A. §44-534(b). In addition, proceedings for compensation under the workers compensation act shall not be maintainable unless notice of injury by accident or repetitive trauma is given to the employer by the earliest of the following dates:

(A) 20 calendar days from the date of accident or the date of injury by repetitive trauma;

(B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or

(C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer. K.S.A. §44-520(a).

The requirement of written or oral notice is waived if the employee proves that (1) the employer or the employer's duly authorized agent had actual knowledge of the injury; (2) the employer or the employer's duly authorized agent was unavailable to receive such notice within the applicable period; or (3) the employee was physically unable to give such notice. K.S.A. §44-520(b).

8. **What are the reporting and notice requirements for those alleging an injury?**

See answer 7. K.S.A. §44-520. The application of the timely notice requirement has been flexible rather than rigid. *Kotnour v. Overland Park*, 43 Kan. App. 2d 833, 838, 233 P.3d 299, 304 (2010). “This flexibility has been shown when an employee could not reasonably have been expected to realize that an injury was one likely to lead to a compensable disability.” Id. (finding that just cause existed to extend the 10 day notice period for an employee to notify his employer of an accident because he was unaware that he had suffered an injury which could lead to a compensable disability until more
than 10 days had passed).

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

K.S.A. §44-501(a)(1)(A) provides that “Compensation for an injury shall be disallowed if such injury to the employee results from the employee’s deliberate intention to cause such injury.” *Id.*

B. **Willful misconduct, "horseplay," etc.**

Compensation for an injury shall be disallowed if such injury results from the employee's willful failure to use a guard or protection against accident or injury which is required pursuant to any statute and provided for the employee; the employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer; the employee's reckless violation of their employer's workplace safety rules or regulations; or the employee's voluntary participation in fighting or horseplay with a co-employee for any reason, work related or otherwise.  K.S.A. §44-501(a)(1)(B) – (E). However, injuries resulting form an employee’s horseplay may be compensable if the employee proves the horseplay is a regular incident of employment and employer knows of horseplay. *Carter v. Alpha Kappa Lambda Fraternity*, 197 Kan. 374, 417 P.2d 137 (1966). Similarly, injuries resulting from an assault by one employee upon another can only result in benefit eligibility if the employer had reason to anticipate that injury would occur if the employees continued working together. *Harris v. Bethany Medical Center*, 21 Kan.App.2d 804, 909 P.2d 657 (1995). *See also* Answer 13, *infra.*

C. **Injuries involving drugs and/or alcohol.**

A claim is barred if the injury, disability or death was contributed to by the employee's use or consumption of alcohol or any drugs, chemicals or any other compounds or substances, including, but not limited to, any drugs or medications which are available to the public without a prescription from a health care provider, prescription drugs or medications, any form or type of narcotic drugs, marijuana, stimulants, depressants or hallucinogens.  K.S.A. §44-501(b)(1)(A). In the case of drugs or medications which are available to the public without a prescription from a health care provider and prescription drugs or medications, compensation shall not be denied if the employee can show that such drugs or medications were being taken or used in therapeutic doses and there have been no prior incidences of the employee's impairment on the job as the result of the use of such drugs or medications within the previous 24 months.  K.S.A. §44-501(b)(1)(B).

It shall be conclusively presumed that the employee was impaired due to alcohol or drugs if it is shown that at the time of the injury that the employee had an alcohol concentration of .04 or more, or a GCMS confirmatory test by quantitative analysis showing a concentration at or above the levels shown on the chart for the drugs of abuse listed.  K.S.A. §44-501(b)(1)(C). If it is shown that the employee was impaired pursuant to
subsection (b)(1)(C) at the time of the injury, there shall be a rebuttable presumption that
the accident, injury, disability or death was contributed to by such impairment. The
employee may overcome the presumption of contribution by clear and convincing

10. **What, if any, penalties or remedies are available in claims involving fraud?**

The Kansas Legislature has established a fraud and abuse system to monitor, report,
investigate and penalize suspected fraud and abuse relating to workers' compensation.
K.S.A. §44-5,120(a). The provisions apply to employees, employers, insurers and their
adjusters, health care providers and attorneys or other representatives. K.S.A.
§44-5,120(b). Any complaint of a violation of the Fraud and Abuse Act can be made to
the fraud and abuse section of the Director of Workers' Compensation Office. The
statute allows for a monetary penalty of not more than $2,000.00 for each violation, but
not exceeding an aggregate penalty of $20,000.00 for a one year period. K.S.A.
§44-5,120(g)(1). Any person licensed or regulated by the commissioner of insurance,
after notice and a hearing, may be given a monetary penalty for any violation of an order
of the Director or the commissioner of insurance. K.S.A. §44-5,120(i) The monetary
penalty must not exceed $10,000.00 for each and every violation, and must not exceed an
aggregate penalty of $50,000.00 for any six month penalty period. Id..

11. **Is there any defense for falsification of employment records regarding medical
history?**

There is no such defense per se. However, if the employer can show that the employee
knowingly misrepresents: (1) an impairment or handicap; (2) that such employee has
not had any previous accidents; (3) that such employee has not been previously disabled
or compensated in damages or otherwise; (4) misrepresentation that such employee has
not had any employment terminated or suspended due to a prior accident, injury or
illness; (5) misrepresentation of any mental, emotional or psychiatric impairment; or (6)
conceals any facts or information which are reasonably related to the employee's claim;
the employer has the opportunity to implead the Kansas Workers' Compensation Fund
and recover amounts paid to the employee for the claim. K.S.A. §44-567(c).

12. **Are injuries during recreational and other non-work activities paid for or supported
by the employer compensable?**

The Act applies to personal injuries by accident, repetitive trauma or occupational disease
arising out of and in the course of employment. K.S.A. §44-501b(b). Thus, the
question becomes whether injuries from recreational and non-work activities paid for or
supported by the employer “arise out of and in the course of the employment.” This
question is specifically answered by K.S.A. §44-508(f)(3)(C), which states: “The words
‘arising out of and in the course of employment’ as used in the workers compensation act
shall not be construed to include injuries to the employees while engaged in recreational
or social events under circumstances where the employee was under no duty to attend and where the injury did not result from the performance of tasks related to the employee's normal job duties or as specifically instructed to be performed by the employer.” Thus, for the exclusion to apply, both circumstances outlined in §44-508(f)(3)(C) must be met. See Douglas v. Ad Astra Information Systems, L.L.C., 296 Kan. 552, 293 P.3d 723 (2013). It should be noted that a conditional duty to attend does not satisfy the “no duty” to attend requirement. For example, in Douglas, an employee was injured while racing go-carts at a company sponsored recreational/social event. Id. The Kansas Supreme Court noted that that the employee was mandated to be at his regular work station or at the recreational/social event. Id. at 729. The court held that “such a duty to attend cannot be said to fulfill the high hurdle of no duty to attend.” Id.

13. Are injuries by co-employees compensable?


14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

Such acts have been held to be compensable in some situations. See e.g., Hensley v. Carl Graham Glass, 226 Kan. 256, 597 P.2d 641 (1979) (court upheld compensation to an employee shot by a sniper); Orr v. Holiday Inns, Inc., 6 Kan. App. 2d 335, 627 P.2d 1193 (1981), affirmed, 230 Kan. 271, 634 P.2d 1067 (1981) (upheld compensability for a waitress raped in a public rest room on the employer's premises; court noted that the motel's "high crime area" location exposed the employee to a greater risk than the general public.)

BENEFITS

15. What criterion is used for calculating the average weekly wage?

The term wage is defined as "the total of the money and any additional compensation which the employee receives for services rendered for the employer in whose employment the employee sustains an injury by accident arising out of and in the course of such employment." K.S.A. §44-511(a)(3). This includes the “gross remuneration, on an hourly, output, salary, commission or other basis earned while employed by the employer, including bonuses and gratuities” K.S.A. §44-511(a)(1). Additional compensation includes board and lodging and employer paid life insurance, disability insurance, health and accident insurance and employer contributions to pension and profit-sharing plans. K.S.A. §44-511(a)(2)(A).
16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The minimum rate for temporary total disability payments is $25.00 per week. K.S.A. §44-510c(a)(1). The maximum weekly benefit is determined by multiplying the state average weekly wage by 75%. *Id.*

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

No compensation is due for the first week of disability, unless the disability remains for at least three consecutive weeks. K.S.A. §44-510c(b)(1). Payments must begin within twenty days from the date of written demand for compensation or the employer may be subject to a civil penalty up to $100.00 per week for each week any disability compensation is past due and in an “amount for each past due medical bill equal to the larger of either the sum of $25 or the sum equal to 10% of the amount which is past due on the medical bill.” K.S.A. §44-512a.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ____ days before recovering benefits for the first ____ days)?**

The employee must be out three consecutive weeks before recovering temporary total disability benefits for the first seven days. K.S.A. §44-510c(b)(1). The same "waiting" or “retroactive” period applies to permanent partial disability benefits. See K.S.A. §44-510d(a).

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary total benefits may be terminated pursuant to a court order; or if the employee has reached maximum medical improvement and has been released by the physician to return to work, or has returned to work. See e.g., K.S.A. §44-510h(e).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

If the injury results in a general bodily disability, all weeks of temporary total disability compensation after the first fifteen weeks are deducted from the 415 weeks available. K.S.A. §44-510e(a)(2)(F).

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement itself is not compensable, per se. However, disfigurement which results in a functional impairment to either a scheduled member or to the body as a whole is compensable. Functional impairments ratings for dates of injury on and after January 1, 2015 are made by the treating physician using the American Medical Association's
22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

The minimum and maximum weekly benefits are determined as in answer 16. The maximum numbers of weeks for scheduled members are as follows:

- Shoulder: 225 weeks
- Arm: 210 weeks
- Forearm: 200 weeks
- Hand: 150 weeks
- Leg: 200 weeks
- Lower leg: 190 weeks
- Foot: 125 weeks
- Eye: 120 weeks
- Hearing:
  - Binaural: 110 weeks
  - One ear: 30 weeks
- Thumb: 60 weeks
- Index finger: 37 weeks
- Middle finger: 30 weeks
- Ring finger: 20 weeks
- Little finger: 15 weeks
- Great toe: 30 weeks
- Great toe - terminal phalanx: 15 weeks
- Each other toe: 10 weeks
- Other toe - terminal phalanx: 5 weeks

K.S.A. §44-510d(b)

The percentage loss of use of the scheduled member is based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein. K.S.A. § 44-510d(b)(23). That percentage is multiplied times the scheduled weeks for that member to determine the duration of compensation due. See K.S.A. § 44-510d(d). Where an injury results in the loss of or loss of use of more than one scheduled member within a single extremity, the functional impairment attributable to each scheduled member shall be combined pursuant to the fourth edition of the American medical association guides for evaluation of permanent
impairment and compensation awarded shall be calculated to the highest scheduled member actually impaired. K.S.A. § 44-510d(b)(24).

B. Number of weeks for "whole person" and standard for recovery.

The maximum whole body injury and resulting disability is 415 weeks of compensation. K.S.A. §44-510e(a). The amount of compensation for whole body injury is determined by multiplying the payment rate by the weeks payable.

The payment rate is the lesser of: (A) The amount determined by multiplying the average weekly wage of the worker prior to such injury by 66 2/3 %; or (B) the maximum provided in K.S.A. 44-510c, and amendments thereto.

Weeks payable is determined as follows: (A) Determine the weeks of temporary compensation paid by adding the amounts of temporary total and temporary partial disability compensation paid and dividing the sum by the payment rate above; (B) subtract from 415 weeks the total number of weeks of temporary compensation paid as determined in (F)(2)(A), excluding the first 15 such weeks; (3) multiply the number of weeks as determined in (F)(2)(B) by the percentage of functional impairment pursuant to subsection (a)(2)(B) or the percentage of work disability pursuant to subsection (a)(2)(C), whichever is applicable. K.S.A. §44-510e(a)(F).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Vocational rehabilitation is no longer required of employers. Any vocational rehabilitation must be with the consent of the parties. K.S.A. §44-510g(a). “Upon such agreement, the vocational rehabilitation administrator may make recommendations for and supervise such assessment, evaluation, services or training on behalf of the employee and such assessment, evaluation, services or training shall not be arbitrarily terminated by the employer or insurance carrier once such agreement is entered into by the employer or insurance carrier.” Id. Do note that “If the employer or the employer's insurance carrier do not agree to provide vocational rehabilitation services, the employee may request the vocational rehabilitation administrator to refer the employee to an appropriate provider for vocational rehabilitation services to be provided at the employee's expense.” K.S.A. § 44-510g(b).

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

See the answer to 22 for method of calculating benefits. The minimum rate for weekly compensation is $25. K.S.A. §44-510c(a)(1). The limit for permanent total disability, including temporary total, temporary partial, permanent partial and temporary partial disability payments is $155,000. K.S.A. §44-510f(a)(1). The limit for temporary total disability, including any prior permanent total, permanent partial, or temporary partial disability and for permanent partial disability is $130,000. Id. at (a)(2). The limit for
permanent partial disability on a functional impairment basis is $75,000. K.S.A. §44-510f(a)(4). The limit on death is $300,000. K.S.A. §44-510b(h).

25. How are deaths benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

The employer pays the reasonable funeral and burial expenses up to $5,000. K.S.A. §44-510b(f).

B. Dependency claims.

Dependency benefits vary depending upon whether the employee leaves a surviving spouse or wholly dependent child or children or others wholly dependent upon the employee's earnings. See generally K.S.A. §44-510b. Weekly benefits are paid to the surviving spouse for life or remarriage. Id. at Weekly benefits are paid to children to age 18, or until age 23 if enrolled full-time in an accredited institution of higher education or vocational education. If the worker leaves both a spouse and children, benefits are paid to both. K.S.A. §44-510b.

26. What are the criteria for establishing a "second injury" fund recovery?

The workers compensation fund pays the medical expenses and weekly compensation where the employee’s employer is unable to provide said benefits. K.S.A. §44-566a(e). An award of compensation for permanent partial impairment, work disability, or permanent total disability shall be reduced by the amount of functional impairment determined to be preexisting. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment. K.S.A. §44-501(e). If the employer has paid compensation later found to be due from the fund, the employer may be reimbursed by the workers compensation fund. K.S.A. §44-569a.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

An award may be modified at any time before disability ends, or before final payment, by means of an application for review and modification by the Director. K.S.A. §44-528; Doss v. Carneolson & Kelly, 124 Kan. 631, 632, 261 P. 584 (1927); Farr v. Mid.-Continent Lead & Zinc Co., 151 Kan. 51, 98 P.2d 437 (1940) (Noting “a firm determination by this court to hold that it is necessary that a proceedings to modify an award must be started before the final payment of the award has been made.”)

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

In the event compensation, including medical expenses, has been awarded, the employer will owe a penalty and attorneys’ fees related to any collection action if not paid within
20 days of receipt of written demand for payment. K.S.A. §44-512a(b).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The compensation remedy is generally exclusive. K.S.A. §44-501b(d).

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

According to the "dual capacity doctrine," an employer who is generally immune from tort liability to an employee injured in a work-related accident may become liable to the employee as a third party tortfeasor if it occupies, in addition to the capacity as an employer, a second capacity that confers obligations independent of those imposed as an employer. Kimzey v. Interpace Corp., Inc., 10 Kan. App. 2d 165, 694 P.2d 907 (1985). However, “Kansas courts have not yet extended the dual capacity to factual situations other than the one described in Kimzey.” Scott v. Wolf Creek Nuclear Operating Corp., 23 Kan. App.2d 156, 928 P.2d 109 (1996).

30. Are there any penalties against the employer for unsafe working conditions?

No. Generally, an employee injured due to unsafe working conditions may maintain an action only through the Act. See, Quigley v. General Motors Corp., 660 F.Supp. 499 (D. Kan. 1987).

31. What is the penalty, if any, for an injured minor?

There is no specific penalty. See generally K.S.A. § 44-513a.

32. What is the potential exposure for "bad faith" claims handling?

Penalties may be assessed in the amount of $100 per week for each week any disability compensation awarded is past due. K.S.A. §44-512a(a). Moreover, attorney's fees may be awarded if the employee's attorney is forced to file an action in the district court in order to enforce an award of compensation. K.S.A. §44-512a(b).

Fraudulent and abusive practices are punishable by penalties up to $2,000 per act and restitution to the employee. K.S.A. §44-5,120(g)(1). Fraudulent and abusive practices include collecting fees from the employee, failing to pay, failing to pay an award, and failing to confirm medical payments coverage. Id. at §44-5,210(d)(1)-(21)

33. What is the exposure for terminating an employee who has been injured?

In *Murphy*, an employee filed a workers’ compensation claim. He maintained he was offered further employment on the condition that he withdraw the claim. When he refused, he was terminated. A petition was then filed in the district court alleging he was discharged in retaliation for seeking workers’ compensation benefits. The trial court dismissed Murphy’s cause of action, but the Kansas Court of Appeals reversed, holding:

We believe the public policy argument has merit. The Workmen’s Compensation Act provides efficient remedies and protection for employees, and is designed to promote the welfare of the people in this state. It is the exclusive remedy afforded the injured employee, regardless of the nature of the employer’s negligence. To allow an employer to coerce employees in the free exercise of their rights under the act would substantially subvert the purpose of the act. *Id.* at 192.

The Court’s holding in *Murphy* was extended to all employees, not just at-will employees, by the Kansas Supreme Court in *Coleman v. Safeway Stores, Inc.*, 242 Kan. 804, 752 P.2d 645(1988).

To set forth a prima facie case of retaliatory discharge for filing a workers’ compensation claim under Kansas law, plaintiff must show that (1) he or she filed a claim for workers’ compensation benefits or sustained an injury for which he might assert a future claim for such benefits; (2) defendant knew of the claim or injury; (3) defendant terminated plaintiff’s employment; and (4) a casual connection connects the protected activity and the termination of plaintiff’s employment. *Jones v. United Parcel Service*, 411 F. Supp. 2d 1236, 1260 (D. Kan. 2006).

### THIRD PARTY ACTIONS

34. **Can third parties be sued by the employee?**

   Yes. K.S.A. §44-504(a).

35. **Can co-employees be sued for work-related injuries?**


36. **Is subrogation available?**
Yes. K.S.A. §44-504(b). If the subrogation action is brought by the worker, the claim must be instituted within one year from the date of the injury. K.S.A. §44-504(b). If the claim is brought by a dependent or personal representative of a deceased worker, the claim must be instituted within 18 months from the date of such injury. Id. The employee or dependent's failure to bring an action within the time specified operates as an assignment to the employer of any cause of action in tort which the employee or dependents may have against any third party for such injury or death. K.S.A. §44-504(c).

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payments?

Yes. Medical bills must be paid within 20 days from the date of written demand. If not, the employer may be assessed a penalty for each past due bill equal to the larger of either $25 or 10% of the written amount which is past due, plus attorney's fees incurred in a collections action. K.S.A. §44-512a(a),(b).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

After an employee requests worker’s compensation from the employer, the employee must submit to an examination at any reasonable time and place by any one or more reputable health care providers. The employer is given the opportunity to select said provider. In addition, the employee must submit to an examination thereafter at intervals during the pendency of such employee's claim for compensation, upon the request of the employer. The employee, however, will not be required to submit to an examination more than twice in one month, unless the Director orders otherwise. K.S.A. §44-515(a). Medical reports of the physician should be submitted on a periodic basis depending upon the nature and severity of the injuries involved and, in all cases, immediately upon request of the respondent or insurance carrier. A report shall be rendered on the date on which the physician releases the worker to return to work and forwarded to the employer or insurance carrier and to the employee, if requested. K.A.R. §51-9-10(b)(1).

39. What is the rule on (a) Claimant’s choice of physician; (b) employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of physician.

The issue of treating physicians is critical to determining workers compensation claims in the state of Kansas. Oftentimes, the treating physicians will not only provide evidence as to the nature and extent of the claimant’s injuries, they will also provide functional impairment and task loss ratings which will form the basis for future workers compensation awards. Therefore, the selection of the treating physician carries
important implications for the ultimate resolution of any claim.

The issue of whether a claimant is allowed to retain his own health care provider is governed by K.S.A. §44-510h. The statute states, in part, that it is the employer’s duty “to provide the services of a health care provider . . . as may be reasonably necessary to cure and relieve the employee of the effects of the injury.” K.S.A. §44-510h(a).

K.S.A. §44-515 governs the specific duties of the employer and the employee as it relates to medical examinations. The employee must submit to an examination at “any reasonable time and place by any one or more reputable health care providers selected by the employer, and shall so submit to an examination thereafter at intervals during the pendency of such employee’s claim for compensation.” K.S.A. §44-515(a). The statute does contain limitations upon the ability of the employer to require multiple examinations of the employees within a specified period of time. K.S.A. §44-515(a) (employer cannot require employee to submit to more than two (2) examinations per month). The statute also requires that an employer provide funding for the employee should the employer require that the examination occur “in any town or city other than the residence of the employer at the time the employees received the injury.” K.S.A. §44-515(a). An employee may request to have a health care provider of their own choosing present at the time of the examination. K.S.A. §44-515(b).

The employer’s health care provider can only provide evidence of the employee’s condition at the time of the examination if (1) the health care provider provides a report to the employee within fifteen (15) days of the examination as provided in K.S.A. §44-515(a); and (2) the employee has an opportunity to have his/her own health care provider examine him/her within a reasonable time after the employer’s health care provider’s examination in the presence of the employer’s health care provider. K.S.A. §44-515(c).

Additionally, there are provisions for appointment of additional physicians for the purpose of examination and/or treatment. K.S.A. §44-516 provides for the appointment of a neutral health care provider by the director in case of a dispute regarding the injury.

B. Employer’s right to second opinion and/or Independent Medical Examination.

The employer retains the right to provide medical care. In that regard, the employer can select the appropriate health care provider. The employer can require the employee to submit for an examination no more than twice each month. K.S.A. §44-515(a). In the event of a disagreement between the employer and the employee on the fact of injury or the functional impairment, the director may employ one or more neutral physicians to make the determination. K.S.A. §44-516(a).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?
It is the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, and apparatus, and transportation to and from the home of the employee to a place outside the community in which such employee resides, and within the community if the Director, so orders, as may be reasonably necessary to cure and relieve the employee from the effects of the injury. K.S.A. §44-510h(a). “Health care provider” is defined as any person licensed by the proper licensing authority of Kansas, another state, or the District of Columbia, to practice medicine, surgery, osteopathy, chiropractic, dentistry, optometry, podiatry, audiology or psychology. K.S.A. §44-508(j).

41. Which prosthetic devices are covered, and for how long?

Prosthetic devices are covered. K.S.A. §44-510h(a). Vehicle and home modifications may be covered as medical expenses, depending on the length which courts will go to in defining "apparatus" necessary to "cure and relieve" the effects of an injury. Administrative law judges routinely authorize doctor-prescribed mattresses, wheelchairs, beds, and TENS units. However, the majority of reported cases deny such significantly more expensive items as specially equipped vans and swimming pools as not properly being a "medical apparatus." It is presumed that the employer’s obligation to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, and apparatus, terminates upon the employee’s reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. K.S.A. §44-510h(e).

42. Are vehicle and/or home modifications covered as medical expenses?

Whether vehicle or home modifications will be ordered is essentially left to the discretion of the director and will depend upon the facts of the individual case. See answer 41.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes, all fees for medical services are fixed by the Director. K.S.A. §44-510i.

44. What, if any, provisions or requirements are there for "managed care"?

None.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

An application for hearing is filed with the Director for the purpose of docketing the case and getting an administrative law judge assigned. Preliminary issues such as fact of
injury, whether the injury is covered by the Act, timely notice, timely written claim, and necessity of medical treatment are decided in a preliminary hearing. K.S.A. §44-534a. An application for a preliminary hearing can be made no sooner than seven days after written demand for benefits are served on the respondent and insurer.

46. What is the method of claim adjudication?

A. Administrative level.

Preliminary awards are made by administrative law judges, and are subject to review and approval by the Worker’s Compensation Board. Such a request for review is not a prerequisite for judicial review. K.S.A. §44-534a. Appeals to the Board of Review from preliminary orders are allowed only on issues of fact of injury, whether the injury arose out of and in the course of the employment, and whether notice was given and claim timely made. There is no judicial review of these preliminary decisions. K.S.A. §44-534a(a)(2).


B. Trial court.

There is no appeal to the district court.

C. Appellate.

Notice of appeal must be filed within thirty days of the decision by the Board of Review. The Kansas Judicial Review Act (KJRA), K.S.A. 77-601 et seq., provides the grounds upon which relief may be granted in appeals for workers compensation awards entered after October 1, 1993. See K.S.A. §44-556(a).

Under the KJRA an appellate court reviews questions of fact, in light of the record as a whole, to determine whether an agency’s findings are supported to the appropriate standard of proof by substantial evidence, K.S.A. 77-621(c)(7); Kotnour v. Overland Park, 43 Kan. App.2d 833, 836, 233 P.3d 299, 302. An appellate court shall grant relief if it determines that “the agency action is based on a determination of fact, made or implied by the agency, that is not supported by evidence that is substantial when viewed in light of the record as a whole. K.S.A. 77-621(c)(7). K.S.A. 77-621(d) explains that: “[I]n light of the record as a whole means that “the adequacy of the evidence in the record before the court to support a particular finding of fact shall be judged in light of all the relevant evidence in the record … that detracts from such finding as well as all of the relevant evidence in the record … that supports such finding, including any determinations of veracity by the presiding officer who personally observed the demeanor of the witness.”” Thus, the statute requires the appellate courts to consider all of the evidence that detracts agency’s findings when it assess whether the evidence is
substantial enough to support those findings. *Herrera-Gallegos v. H & H Delivery Serv., Inc.*, 42 Kan. App.2d 360, 363, 212 P.3d 239, 241 (2009). Therefore, “the appellate court must determine whether the evidence supporting the agency’s decision has been so undermined by cross-examination or other evidence that it is insufficient to support the agency’s conclusion.” *Id.* Substantial evidence in a workers compensation case is “evidence possessing something of substance and relevant consequence to induce conviction that an award is proper.; it furnishes a basis of fact from which an issue can be resolved reasonably.” *Graham v. Dokter Trucking Group*, 284 Kan. 547, 553, 161 P.3d 695 (2007).

As in civil cases, a decision of the ALJ or Board of Review is also subject to appellate review for errors of law. The appellate court shall only grant relief if it determines that “the [Board or ALJ] has erroneously interpreted or applied the law.” K.S.A. 77-621(c)(4). In determining whether the ALJ or Board erroneously interpreted or applied the law, “[n]o significant deference is due the ALJ’s or the Board’s interpretation or construction of a statute.” *Higgins v. Abilene Machine, Inc.*, 288 Kan. 359, 361, 204 P.3d 1156 (2009).

47. What are the requirements for stipulations or settlements?

Methods for settlements are set forth in the Kansas Administrative Regulations, 51-3-1 *et seq.* Compensable cases may be determined and terminated only by: (1) filing a settlement agreement, final receipt and release of liability as provided by K.S.A. §44-527; (2) hearing and written award; (3) joint petition and stipulation subject to K.A.R. §51-3-16; (4) settlement hearing before an administrative law judge; or, (5) voluntary dismissal by all parties. *See K.A.R. 51-3-1.* The Director reviews all final settlements, and may disapprove a settlement in writing within 20 days of receipt of the settlement. K.S.A. §44-527.

Lump sum settlements can be made. Generally, lump sum settlements extinguish the employer's liability for future medical payments, or any modification of the disability. Awards can be by stipulation leaving the issue of future medical expenses open.

48. Are full and final settlements with closed medical available?

Yes. *See answer 47.*

49. Must stipulations and/or settlements be approved by the state administrative body?

Stipulations and/or settlements must be approved by the Director of Workers' Compensation pursuant to K.A.R. 51-3-1 *et seq.*

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?
Every employer must secure the payment of compensation by: (1) insuring the payment of such compensation with an authorized insurer; (2) qualifying for self-insurance, either individually or as part of a group; or (3) becoming a member in a qualified group-funded workers' compensation pool. K.S.A. §44-532(b). The cost of carrying such insurance or risk must be paid by the employer and not the employee. *Id.*

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   An employer may only become qualified as a self-insurer by obtaining a self-insurance permit from the Division of Workers' Compensation. An employer making such an application must, upon the request of the Director, submit any information that the Director may require to effectively evaluate the financial status of the employer. An applicant for a self-insurance permit or renewal permit must, if the Director requests, pay the fees of a consultant approved by the Division of Workers' Compensation to determine if the employer has the financial ability to become self-insured or to have its permit renewed. K.A.R. 51-14-4.

   **B. For groups or "pools" of private entities.**

   The requirements for group-funded workers' compensation pools are set forth in K.S.A. §44-581: "Five or more employers, regardless of domicile, who are members of the same bona fide trade merchant or professional association, regardless of domicile, which has been in existence for not less than five years and who are engaged in the same, similar or closely related type of business may enter into agreements to pool their liabilities for Kansas workers' compensation benefits and employers' liability…such arrangements shall be known as group-funded workers' compensation pools, which shall not be deemed to be insurance or insurance companies and shall not be subject to the provisions of chapter 40 of the Kansas Statutes Annotated, except as otherwise provided herein." K.S.A. §44-581(a)-(c).

52. **Are "illegal aliens" entitled to benefits of workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of "employee"?**


53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

   A terrorist act would be subject to the same principles applicable to injuries by other third
54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

At this time, there are no state specific statutes in Kansas affecting the federal statutory scheme for satisfying Medicare’s interests under 42 U.S.C. §1395y.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512. Therefore, the traditional current practice of obtaining medical records could proceed under state law.

57. What are the provisions for “Independent contractors”?

Under Kansas law, independent contractors are not contained within the definition of employees under K.S.A. §44-508(b). The test for determining whether an employer/employee relationship exists is to consider whether there is a right to control or exercise authority. Falls v. Scott, 249 Kan. 54, 815 P.2d 1104 (1991); Anderson v. Kinsley Sand & Gravel, Inc., 221 Kan. 191, 558 P.2d 146 (1976). If the individual is not controlled, but rather free to work according to his own methods, he or she is an independent contractor. Evans v. Board of Ed. Of Hays, 178 Kan. 275, 278, 284 P.2d 1068, 1071 (1955). Where it is determined the individual is an independent contractor, coverage for worker’s compensation will be denied as it relates to the contracting principal. Krug v. Sutton, 189 Kan. 96 (1961).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations, temporary service companies, or leasing companies?
There are no specific provisions for “independent contractors” pertaining to professional employment organizations, temporary service companies, or leasing companies, with one exception. K.S.A. §44-505(a)(5), specifically excludes from coverage services of a qualified real estate agent when payment is directly related to sales and not hours worked and there exists a written contract which states that the individual is to be treated as an independent contractor for state tax purposes. Otherwise, no coverage will apply unless the facts demonstrate an employer/employee relationship.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

While there are no specific provisions for “Independent Contractors,” K.S.A. §44-503 states an individual may recover workers compensation benefits from either his immediate employer or a statutory employer. Therefore, if the work being done by the employee is either an integral part of the principals’ trade or business or is work that would ordinarily have been done by an employee of the principal, owners/operators of trucks or other vehicle drivers or deliverers may arguably be able to recover from either. See *Fox v. Loughry*, 2004 WL 90081, 82 P.3d 532 (Kan. App. 2004); Answer 3 for test used to determine whether the work was an integral part of the principal’s trade or business. Since a driver is, under federal law, legally a statutory employee of the Department of Transportation permitted operator, under whose colors he or she is driving, the driver may be able to claim that he or she is entitled to workers compensation benefits from either his employer or the Department of Transportation permitted operator/statutory employer.

60. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

Kansas does not have any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interest when settling the right to medical treatment benefits under a claim. However, it should be noted that Kansas permits claimants to administer their own Workers Compensation Medicare Set-Aside Arrangements (WCMSA).

61. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Kansas does not permit the use of marijuana for medicinal purposes.

62. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Kansas does not permit the recreational use of marijuana.
1. **Citation for the State's workers' compensation statute.**

   Kentucky Revised Statutes § 342.0011 *et seq.*; 803 Kentucky Administrative Regulations. 25:010 *et seq.*

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers' compensation?**

   Covered "employees" include all persons, including minors, lawfully or unlawfully employed under any contract of hire; helpers, paid or not, if hired with the knowledge of the employer; corporate executive officers but not owners or partners of non-corporate business unless coverage is elected; volunteer fire, police, civil defense personnel or trainees and members of the National Guard on active duty; newspaper sellers or distributors. Ky. Rev. Stat. § 342.640.

   Volunteers, those not for hire, are arguably excluded as non-employees, however, the insured may secure coverage. Payment of wages is not required and the possibility of a civil suit would be avoided.

   Specific exemptions include the following: domestic servants, if there are less than two regularly employed in a private home for 40 hours or less per week; maintenance, repair and similar employees employed in a private home if the employer has no other employees subject to the Act; services performed in exchange only for aid or sustenance received from a religious or charitable entity; participants in a car pool; employees covered by federal employers' liability legislation; any employee who elects non-coverage (rejection must be written). Ky. Rev. Stat. § 342.650.

3. **Identify and describe any "statutory employer" provision.**

   An employer is any person, other than one engaged solely in agricultural work, having one or more employees in the state, including non-federal governmental agencies. Ky. Rev. Stat. § 342.630. A prime contractor is liable to the employees of a subcontractor, if the latter fails to secure and maintain compensation coverage. Ky. Rev. Stat. § 342.610.

4. **What types of injuries are covered and what is the standard of proof for each:**

   **A. Traumatic or "single occurrence" claims.**

   "Injury" means any work-related traumatic event or series of events, including cumulative trauma, arising out of and in the course of employment which is the
proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally... shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric or stress-related change in the human organism unless it is the direct result of a physical injury. Ky. Rev. Stat. § 342.0011(1).

Although the effects of the "natural aging process" are specifically excluded, Administrative Law Judges and the Workers Compensation Board have deemed those disabilities compensable if the work played any role in the condition.

B. Occupational disease (including respiratory and repetitive use).

"Occupational disease" means a disease arising out of and in the course of employment and is deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease, and it can be seen to have followed as a natural incident of the work as a result of exposure occasioned by the nature of the employment, which can be traced to the employment as the proximate cause. Ky. Rev. Stat. § 342.0011(2)-(3).

5. What, if any, injuries or claims are excluded?

Kentucky is a "full benefit" jurisdiction. Any claim that can be proven to be a work-related "injury" or "occupational disease" is covered. Psychological claims not stemming from a physical injury are excluded.

6. What psychiatric claims or treatments are compensable?

Work-related psychological, psychiatric or stress injuries which are the direct result of a physical injury sustained in the course and scope of employment are compensable. Ky. Rev. Stat. § 342.0011(1). "Mental-mental" claims are excluded.

7. What are the applicable statutes of limitations?

A claim for benefits must be filed within two years of the date of injury or death or the last voluntary temporary total disability benefit made by the Employer, whichever is later. Ky. Rev. Stat. § 342.185. When temporary total disability benefits have been paid, an IA-2 form must be filed electronically with the Kentucky Department of Workers Claims notifying of the termination of these benefits in order to start the statute running. At that time, the Kentucky Department of Workers Claims issues a letter advising the employee of the applicable statute of limitations. Failure to timely and appropriately file the IA-2 will result in a tolling of the statute of limitations period until such form has been filed and in some cases may bar the affirmative defense even being raised.
In an occupational disease claim, the limitation of action period is three years after the last injurious exposure to the occupational hazard or after the employee first experiences a manifestation of an occupational disease in the form of symptoms reasonably sufficient to advise him that he has contracted the disease, whichever is later; if voluntary payments have been made, notice shall be deemed waived provided, however, that the right to compensation for an occupational disease claim is forever barred unless filed within five years of the last injurious exposure. Ky. Rev. Stat. § 342.185 was amended as of April 4, 1994, to include a limitation period for HIV claims of five years from date of exposure. In a claim for asbestos-related disease, the claim must be filed within twenty years from the last exposure to the occupational hazard. Ky. Rev. Stat. § 342.316.

In a cumulative trauma claim, the employee must give notice to the employer and file the claim within two years from the date the employee is told by a physician that the cumulative trauma is work-related. The claim for cumulative trauma is barred five years from the date the employee is last exposed to the cumulative trauma.

8. What are the reporting and notice requirements for those alleging an injury?

Notice of an accident must be given to the employer "as soon as practicable after the happening thereof." Ky. Rev. Stat. § 342.185. In cases of a repetitive trauma injury the employee must give notice within 2 years of being informed by a physician that the injury is related to employment. Notice of an occupational disease must be given within three years of the last injurious exposure or the first experience of a distinct manifestation of an occupational disease in the form of symptoms reasonably sufficient to apprise the employee that he or she has contracted the disease.

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.


B. Willful misconduct, "horseplay," etc.

In addition to that above, injuries from horseplay are excluded, but the defense is affirmative.

C. Injuries involving drugs and/or alcohol.

If an employee voluntarily introduced an illegal, nonprescribed substance or substances or a prescribed substance or substances in amounts in excess of prescribed amounts into his or her body detected in the blood, as measured by a scientifically reliable test, that could cause a disturbance of mental or physical capacities, it shall be presumed that the
illegal, nonprescribed substance or substances or the prescribed substance or substances in amounts in excess of prescribed amounts caused the injury, occupational disease, or death of the employee and liability for compensation shall not apply to the injury, occupational disease, or death to the employee. Ky. Rev. Stat. § 342.610 (4). Violation of safety rules and failure to follow medical advice may also be affirmative defenses.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

A claim may be barred if the employee gives a written false representation concerning physical condition or medical history upon which the employer substantially relies in hiring and the misrepresentation is casually connected to the injury. Ky. Rev. Stat. § 342.165(2).

Any person who makes false representations designed to cause a reduction in the employer's premium is subject to criminal and civil penalties. Ky. Rev. Stat. § 342.335(2). Fraud investigations are conducted by the Department of Insurance. Ky. Rev. Stat. §§ 304.47-040, 342.335.

11. **Is there any defense for falsification of employment records regarding medical history?**

If an employee knowingly and willfully makes a false representation as to medical history or physical condition, in writing, the employer substantially relies upon the representation in hiring, and there is a causal connection between the representation and the injury, the employee is barred from collecting benefits. Ky. Rev. Stat. § 342.165(2).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

If an employee is injured in a recreational activity associated with the employer, the injury may be viewed as "work-related" if: (1) the injury occurred on the employer's premises during lunch or a recreation period incident to regular employment; or (2) the employer expressly or impliedly required participation in the activity; or (3) the employer derived substantial direct benefit from the activity beyond the intangible value of improvement of employee health and morale; or (4) the employer exerts sufficient control over the activity to bring it within the orbit of employment. *Smart v. Georgetown Cnty. Hosp.*, 170 S.W.3d 370 (Ky. 2005). Any one of these factors is generally sufficient causal connection to the job to establish compensability.

13. **Are injuries by co-employees compensable?**

Injuries by co-employees are generally compensable unless the injury was the result of the employee's involvement in horseplay, assault (so long as the cause of the assault was not causally connected to the employment) and/or a willful violation of a safety policy.
14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?

The test of compensability is whether the assault/injury had a causal connection with the employment. If the assault/injury occurs through personal animosity or over causes wholly unrelated to the employer's business, the employee cannot be compensated even though the assault/injury occurs at work. Compensation will, however, be granted for injuries from an assault by a fellow employee when those injuries are fairly traceable to the conditions of employment.

**BENEFITS**

15. What criterion is used for calculating the average weekly wage?

The workers' compensation commissioner determines the state "average weekly wage" on or before September 1 of each year by taking the total wages reported by Employers divided by average monthly insured workers during preceding 12 months, then dividing by 52 weeks. Beginning in 1997 the average wage calculation is based on wage information in effect two years prior to the calculation. Ky. Rev. Stat. § 342.143.

Income benefits for disability are based on 66 2/3% of the employee's "average weekly wage" but not to exceed 110% of the State maximum average weekly wage for temporary or permanent total disability benefits, not to exceed the State maximum for permanent partial disability benefits or dip below the minimum. A wage statement needs to be obtained for 52 weeks preceding the injury then divided into four 13 week quarters. "Average weekly wage" is based upon the best quarter of earnings during the four quarters preceding the injury. Wages are based on the salary or on the weekly hour or output. The Employee is entitled to include all compensation excluding premium pay. Straight time rate of pay times the number of hours worked, plus earned bonuses, earned vacation pay and other incentives are included. If the employee works a second job, and the employer had knowledge of that second job, wages from concurrent employment are included in determining average weekly wage. Ky. Rev. Stat. § 342.140. If the employee did not work a full thirteen weeks prior to the injury, average weekly wage is calculated based on the wages of similarly situated employees.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Temporary total and permanent disability benefits are based upon 66 2/3% of the employee's average weekly wage but not to exceed 110% of the state maximum average weekly wage and not less than 20% of the state minimum average weekly wage. Ky. Rev. Stat. § 342.730.

The state temporary total disability rates for injuries are: for 2012 injuries, the maximum rate is $736.19 and the minimum is $147.24. For 2013 injuries, the maximum rate is $752.69 and the minimum is $150.54. For 2014 injuries, the maximum rate is $769.06
and the minimum is $153.81. For 2015 injuries, the maximum rate is $773.61 and the minimum is $159.72. For 2016 injuries, the maximum rate is $798.63 and the minimum is $159.72. For 2017 injuries, the maximum rate is $835.04 and the minimum rate is $167.00.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

   Benefits must be instituted no later than the 15th day after the employer has knowledge of an injury or disability, and are to be paid thereafter not less often than semi-monthly. Ky. Rev. Stat. § 342.040. The employee must miss seven days of work before becoming eligible for benefits. On the 15th day, the employer/carrier must pay for the first 7 days of lost time retroactively.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ______ days before recovering benefits for the first ____ days)?**

   The employee must be out 15 days before recovering benefits for the first 7 days. Ky. Rev. Stat. § 342.040.

19. **What is the standard/procedure for terminating temporary benefits?**

   Prior approval does not have to be obtained from the Workers' Compensation Board before terminating temporary total disability benefits. The employer must have reason to believe that injured worker has reached maximum medical improvement or been released to return to customary employment. Notice must be given to the Workers' Compensation Board that benefits were terminated (Electronic filing of Form IA-2). The Board, in turn, sends written notice to employee of his/her right to prosecute a claim. The statute of limitations period in a claim where temporary total disability was paid does not begin to run until the IA-2 is filed.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

   If the employer voluntarily advanced temporary total disability benefits and the employee is subsequently awarded permanent partial disability for that same period at a lesser rate, a dollar for dollar credit can be taken unless that credit is more than future benefits due, in which case only a week for week credit can be taken. The employer is entitled to a credit for salary continuation paid to an injured employee regardless of whether it is paid in lieu of temporary total disability benefits.

21. **What disfigurement benefits are available and how are they calculated?**

   For injuries before December 1996, benefits are awarded for occupational "disability" (a decrease of wage earning capacity due to the injury or loss of ability to compete and
obtain the kind of work employee is customarily able to do, in the area where he lives, taking into consideration age, occupation, education, health impairment or disfigurement.

For injuries on or after December 12, 1996, an injured worker must receive a functional impairment rating under the AMA Guides, most recent edition\(^1\), in order to receive any award for permanent disability. There are no specific disfigurement benefits.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

Not applicable. See answer 22B.

B. Number of weeks for "whole person" and standard for recovery.

Once employee reaches maximum medical improvement, has been released to return to work, or has been given permanent functional impairment and restrictions, temporary total disability benefits should be terminated. At that point permanent partial disability, if any, begins.

For injuries occurring prior to December 12, 1996, it is within the discretion of the Administrative Law Judge to determine the amount of permanent partial occupational disability after taking into consideration the worker's age, education, skills, experience and physical limitations.

For injuries occurring or last date of exposure on or after December 12, 1996 and before July 15, 2000, disability is determined by the table set forth in Ky. Rev. Stat. § 342.730, which utilizes the AMA impairment rating times a multiplication factor. The product of these figures is referred to as the “permanent disability rating.” Age, education and geographical location are not to be considered in determining permanent partial disability.

<table>
<thead>
<tr>
<th>AMA IMPAIRMENT</th>
<th>FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5%</td>
<td>0.75</td>
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<tr>
<td>6 - 10%</td>
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<tr>
<td>11 - 15%</td>
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<tr>
<td>16% - 20%</td>
<td>1.50</td>
</tr>
<tr>
<td>21% - 25%</td>
<td>1.75</td>
</tr>
<tr>
<td>26% - 30%</td>
<td>2.00</td>
</tr>
</tbody>
</table>

\(^1\) Although Kentucky states reference the most recent edition of the AMA Guides, following the passage of the AMA Guides 6th Edition, the Kentucky legislature delayed the application of the use of the 6th edition of the AMA Guides. Until given further notice, impairments should be assessed using the 5th edition.
Benefit duration is 425 weeks for 50% or less permanent disability rating and 520 weeks for greater than 50% permanent disability rating. The permanent disability rating is the AMA functional impairment multiplied by the factor. For older workers benefits cease at age 70 or 4 years after the date of injury or last injurious exposure, whichever last occurs.

Under Ky. Rev. Stat. § 342.730(1)(c)(2), when an employee returns to work at the same or greater average weekly wage (AWW) benefits are reduced by ½ for each week such work continues. If employment ceases for any reason, benefits will be restored to the regular benefit level during unemployment or work at lesser wages than earned at time of injury. However, under § 342.730(1)(c)(1), an employee who does not retain the "physical capacity" to return to the type of work performed at the time of injury is entitled to 1.5 times the benefit to which one would otherwise be entitled.

For injuries occurring on or after July 15, 2000 but before July 14, 2018, permanent partial disability is calculated by taking 66 2/3% of the employee's average weekly wage but not more than 75% of the state's average weekly wage multiplied by the permanent impairment rating caused by the injury or occupational disease as determined by the AMA Guidelines times the factors set forth below; for permanent partial disability for injuries occurring after July 14, 2018, the maximum rate has been increased to 82.5% of the state's average weekly wage with the factors remaining the same:

<table>
<thead>
<tr>
<th>AMA IMPAIRMENT</th>
<th>FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5%</td>
<td>0.65</td>
</tr>
<tr>
<td>6 - 10%</td>
<td>0.85</td>
</tr>
<tr>
<td>11 - 20%</td>
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<tr>
<td>21 - 25%</td>
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<tr>
<td>26 - 30%</td>
<td>1.35</td>
</tr>
<tr>
<td>31 - 35%</td>
<td>1.50</td>
</tr>
<tr>
<td>36 and above</td>
<td>1.70</td>
</tr>
</tbody>
</table>

In addition to the benefits above, the following is to be added to the income benefit multiplier set forth above if the employee does not retain the physical capacity to return to the type of work previously done to compensate for limited education and advanced aging impacts on post injury earning capacity:

If at the time of the injury the employee had:
- Less than 8 years of formal education -- increase multiplier by .4
- Less that 12 years or GED -- increase multiplier by .2

If at the time of the injury the employee was:
- Age 60 or older -- increase multiplier by .6
- Age 55 or older -- increase multiplier by .4
- Age 50 or older -- increase multiplier by .2
If, due to an injury, an employee does not retain the physical capacity to return to the type of work that the employee performed at the time of the injury, the benefit for permanent partial disability shall be multiplied by 3 times the amount otherwise determined under this subsection, but this provision shall not be construed so as to extend the duration of payments; or

If an employee returns to work at a weekly wage equal to or greater than the average weekly wage at the time of the injury, the weekly benefits for permanent partial disability shall be determined under paragraph (b) of this section for each week that the employment is sustained. During any period of cessation of that employment, for any reason, with or without cause, payment of the weekly benefits shall be 2 times the amount otherwise payable under this section.

For permanent partial disability, if an employee has a permanent disability rating of 50% or less as a result of a work-related injury the compensable permanent partial disability period shall be 425 weeks, and if the permanent disability rating is greater than 50%, the compensable permanent partial disability shall be 520 weeks. Benefits payable for permanent partial disability shall not exceed 99% of 66 2/3% of the employee's average weekly wages determined by this chapter and shall not exceed 82.5% of the state's average weekly wage. The employer may elect to pay an award or settlement of permanent partial disability benefits in a lump sum. If this is done, the employer may take a discount to reflect present value. At the time of this publication, the stated 2011 discount allowed by regulation was 2.125% (425 weeks = 390.1578 weeks and 520 weeks = 468.5100).

For all post July 18, 2018 injuries, all income benefits terminate on date on which the employee reaches the age of 70 or 4 years from the date of injury or last injurious exposure, which ever last occurs. Ky. Rev. Stat. § 342.730(4). Benefits will be offset for unemployment benefits or employer funded disability or sickness and accident plan covering same disability unless the plan contains an internal offset provision providing otherwise. Ky. Rev. Stat. § 342.730(6).

For injuries in 2011, the maximum for permanent total is $721.97; the maximum for permanent partial disability is $541.47. For 2012 injuries, the maximum for permanent total is $736.19; the maximum for permanent partial disability is $552.13. For 2013 injuries, the maximum for permanent total is $752.69; the maximum for permanent partial disability is $564.52. For 2014 injuries, the maximum for permanent total is $769.06; the maximum for permanent partial disability is $576.80. For 2015 injuries, the maximum for permanent total is $773.61; the maximum for permanent partial disability is $580.21. For 2016 injuries, the maximum for permanent total is $798.63; the maximum for permanent partial disability is $598.98. For 2017 injuries, the maximum for permanent total is $835.04; the maximum for permanent partial disability is $626.29. Until publication of the 2018 Schedule of Benefits, the maximum for injuries occurring after July 14, 2018 will be 110% of the latest maximum benefit for permanent and temporary total disability benefits.
23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Rehabilitation regulations requiring mandatory referral to "qualified rehabilitation counselors" expired on April 4, 1994. Ky. Rev. Stat. § 342.710 still provides that an Administrative Law Judge may order vocational rehabilitation for a period not to exceed 52 weeks, except in unusual cases. An employee is entitled to vocational rehabilitation when, as a result of the injury, he is unable to perform work for which he has previous training or experience. Preference is given to returning the work to the same employer or similar employment. Vocational rehabilitation may be sought upon application of any party or by the Administrative Law Judge on his or her own motion. Worker's refusal to accept rehabilitation when ordered results in a 50% loss of compensation for the period of refusal.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

There is no 425 or 520 week cap for disability benefits if a worker is determined to be permanently totally disabled. Benefits are available for the worker's life or until she becomes eligible for old age social security, depending upon the date of the injury. Benefits are determined based upon 66 2/3% of worker's "average weekly wage," subject to the state maximum and minimum rates. For injuries occurring on or after April 4, 1994, non-work-related disability shall not be considered in determining the appropriate award of disability.

For injuries occurring on or after December 12, 1996, all income benefits, even permanent total disability, terminate on date on which the employee reaches the age of 70 or 4 years after the date of injury or the employee’s last injurious exposure, whichever last occurs. Ky.Rev.Stat. § 342.730(4).

If employee returns to work while receiving permanent total disability benefits, he must notify the employer and the carrier. Ky.Rev.Stat. § 342.730(7).

25. How are death benefits calculated, including the minimum and maximum rates?

In regards to benefits when death results from a compensable injury:

A. Funeral expenses.

Under Ky. Rev. Stat. § 342.750(6), if death of employee occurs within 4 years from date of injury as a direct result of the injury, a lump sum payment is to be made to estate, from which burial expenses are to be paid. For deaths occurring in 2008, the lump sum amount is $65,813.60, for 2009 it is $68,198.54, and for 2010 it is $69,916.52. This amount is recalculated on an annual basis along with average weekly wage and benefit rates.

B. Dependency claims.
Benefits payable for death are similar to those for total disability, payable directly to the dependents of the employee. A determination of dependency is made at the time of death. Benefits are payable to the surviving spouse based upon 50% of the employee's average weekly wage if there were no dependent children. A surviving spouse, with dependent children, is entitled to 45% of the average weekly wage (or 40% if the children are not living with the spouse). In addition, each dependent child is entitled to 15% of the average weekly wage, but if there are more than two children the 30% benefit is divided equally. If there is no spouse but there are dependent children: one child gets 50% of the average weekly wage; if two children, 15% to the second child; and if more than two, benefits divided equally. Benefits due to a surviving spouse are paid until death or remarriage. In the event of remarriage, two years of indemnity benefits are paid in a lump sum. Ky. Rev. Stat. § 342.730. Benefits due to dependent children are paid until death, marriage or age 18 (or 22 if a full-time student) unless the child is physically or mentally incapable of self-support. Benefits to spouses and dependents terminate on the date that the employee would have reached the age of 70 or 4 years from the date of injury or last injurious exposure, whichever last occurs. Ky. Rev. Stat. § 342.730(4).

If the employee has a compensable injury but dies from unrelated causes before the expiration of the compensable period, unpaid portions, whether or not accrued under an award entered before or after the death, are paid pursuant to a formula similar to that set forth above. Ky. Rev. Stat. § 342.730(3).

Effective July 14, 2018, income benefits otherwise payable for temporary total disability to a professional athlete under the direction and control of an employer that is a professional team located in Kentucky, absent any collective bargaining agreement, shall terminate no later than the date on which the contract for hire upon which the employment is based expires, so long as the professional athlete has been released to return to employment for which he or she has prior training or experience. Ky. Rev. Stat. § 342.730(9).

26. What are the criteria for establishing a "second injury" fund recovery?

The "second injury" fund in Kentucky was known as the "Special Fund." Ky. Rev. Stat. § 342.120 formerly provided that the Special Fund was liable for that portion of permanent disability resulting from a dormant non-disabling disease or condition which was aroused or brought into disabling reality by reason of a compensable injury or occupational disease. However, pursuant to § 342.120(e), the Special Fund has no liability for injuries or occupational disease where the injury or last exposure occurs on or after December 12, 1996. It will continue to process payments for the life of existing awards and to participate in claims and re-openings for injuries and dates of exposure prior to December 12, 1996.

For those injuries for which there is still liability, Ky. Rev. Stat. § 342.1202 provides for an automatic 50/50 apportionment in cases where the pre-existing condition involved the back or the heart. Another formula is set forth for apportionment in occupational disease
claims based upon lengths of employment/exposure. In all other cases apportionment must be proven based upon reasonable medical probability. For injuries occurring between April 4, 1994 and December 12, 1996, the Special Fund's liability for all injury claims, other than back and heart claims which is already set at 50%, shall not exceed 50% of the permanent disability award. Where the Judge finds the portion of aroused previously dormant condition exceeds 50%, the portion exceeding 50% shall be paid by the Employer. Ky. Rev. Stat. § 342.1202(2).

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

A claim may be re-opened upon a showing of a change of occupational disability, mistake, fraud or newly discovered evidence. Ky. Rev. Stat. § 342.125(1). Except for re-openings for medical issues, award of additional temporary total disability benefits, fraud, an employee returning to work under Ky. Rev. Stat. § 342.730(1)(c)(2), or where an employee holding a total award returns to work, a motion to reopen must be made within four years of the date of the original award or order approving settlement or finalizing an appeal. The motion may not be made within one year of a prior motion to reopen. For cases involving black lung, an additional two years of employment with continuous injurious exposure is required prior to a motion to reopen. Any increase in benefits is payable from the date of filing the motion to reopen for the remainder of the compensable period.

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

Attorney fees are paid out of the employee's disability award, either by taking a credit from the end of the award, reducing the weekly installments, or paying from a lump sum settlement. If benefits have been deemed wrongfully denied and the employee seeks a penalty, it could include an attorney fee in addition to (rather than out of) the disability award, plus court costs and 18% interest on past due benefits rather than 12%. There is a $15,000.00 limit on attorney fees for contracts signed between April 4, 1994 and December 12, 1996. Ky. Rev. Stat. § 342.320.

For all cases in which attorney fee contracts were signed after July 14, 2000 but before July 14, 2018, a fee cap is now in place where the maximum fee for the employee's counsel is 20% of the first $25,000, 15% of the next $10,000, and 5% of the remainder up to a maximum fee of $12,000.00 for services.

For attorney fee contracts signed on or after July 14, 2018, twenty percent (20%) of the first twenty-five thousand dollars ($25,000) of the award, fifteen percent (15%) of the next twenty-five thousand dollars ($25,000), and ten percent (10%) of the remainder of the award, not to exceed a maximum fee of eighteen thousand dollars ($18,000).

**EXCLUSIVITY/TORT IMMUNITY**
29. **Is the compensation remedy exclusive?**

**A. Scope of immunity.**

The liability of the employer, so long as payment of compensation was secured (insurance/self-insurance), is exclusive to the employee, legal representative, spouse, parents, dependents, next of kin and anyone else otherwise entitled to recover damages from the employer due to injury or death. Ky. Rev. Stat. § 342.690.

**B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

If the employer failed to maintain workers' compensation insurance, an employee may maintain a civil action in addition to a claim for compensation. The employee is entitled to the larger of either the compensation benefits or the common law damages. Ky. Rev. Stat. § 342.690. In the event of an employer's failure to secure coverage, the defenses of negligence of a co-employee, assumption of the risk, and contributory negligence are not available.

An employee may reject workers' compensation coverage upon hire, so long as it is done in writing and filed with the Department of Workers' Claims. In the event a non-covered employee is injured, that employee may sue the employer. The employer retains all common law defenses available in that situation. Employee rejections of coverage are carefully screened by the Department of Workers' Claims.

The exclusive remedy provision applies to cases in which the employer manufactured a product which caused the employee's death, barring a claim based upon products liability.

The exclusive remedy provision does not preclude a discharged employee from bringing a common law wrongful discharge action where the basis of that action is that the employee was discriminated against for pursuing a lawful workers' compensation claim.

Also, it should be noted that the exclusive remedy provision may extend to a "statutory employer".

30. **Are there any penalties against the employer for unsafe working conditions?**

If an accident is caused by the intentional failure of an employer to comply with a statute or safety regulation, the amount of compensation payable may be increased by 30%. Likewise, if the accident is caused by the intentional failure of an employee to use a safety appliance furnished by the employer, or the employee's intentional failure to obey safety rules and regulations, compensation may be decreased by 15%. Ky. Rev. Stat. § 342.165. False representations, including misrepresentation of hazards designed to cause reduction in the employer's premium are subject to civil and criminal penalties. Ky. Rev. Stat. § 342.335(2).

31. **What is the penalty, if any, for an injured minor?**
All employees, including minors, whether lawfully or unlawfully employed, are covered unless specifically excluded or an election not to be subject to the Act was made. Ky. Rev. Stat. § 342.640. There is no special penalty for injury to a minor.

32. What is the potential exposure for "bad faith" claims handling?

Employer/insurers are now subject to the Unfair Claims Settlement Practices Act in Kentucky. If an employer/insurer engages in unfair settlement practices under Ky. Rev. Stat. § 342 or Ky. Rev. Stat. § 304.12-304, the Commissioner will impose fines of $1,000 to $5,000 for each violation. These fines may be imposed personally. For pattern of violations, the Commissioner may revoke the certificate of insurance. Ky. Rev. Stat. § 342.267. The Kentucky Supreme Court has also overturned a lower Court’s attempt to expand this to create a separate civil action for bad faith if the Commissioner fines a violation of the UCSPA. As such, no private or separate cause of action outside of the administrative proceedings exists for "bad faith" claims in Kentucky Workers Compensation.

33. What is the exposure for terminating an employee who has been injured?

An employee terminated for filing a workers' compensation claim has a cause of action against the employer for compensatory damages even if that employee was terminable at will. It has been held that where the ground for discharging an employee was contrary to public policy, for example when the employee was discharged for refusing to break the law or for pursuing a right conferred upon him or her by legislative enactment (e.g. workers' compensation), the discharge is actionable. The five year statute of limitations for actions based upon liability created by statute was applied rather than the one year statute of limitations for personal injuries.

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes.

35. Can co-employees be sued for work-related injuries?

Generally no, unless the injury which occurred at work was otherwise not related to the employment.

36. Is subrogation available?

Yes. When an injury for which compensation is payable has been sustained under circumstances creating liability in a third party, the employee may proceed against the third party to recover damages and against the employer for compensation, but cannot collect from both. Notice must be given to the employer of any third party action and the
employer may recover indemnity and medical expenses paid, less its portion of the employee's legal fees and expenses. Ky. Rev. Stat. § 342.700. However, if the employee settles with the third party, an employer/insurer is limited to subrogation recovery only to the extent that the employee has settled for the same items of damages for which the employer/insurer has paid. Where the settlement against the third party is for items not paid by the employer/insurer, such as pain and suffering, there is no right of subrogation against the settlement proceeds.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

When a medical bill is presented for payment in a claim where there has been as settlement or award and the bill is being disputed by the Employer/carrier, a motion to reopen the case and Form 112 Dispute must be filed within 30 days of presentment of a "substantially completed statement of services." The Employer/carrier bears the burden of proving the treatment was not reasonable nor necessary. In pre-litigation cases, the worker bears the burden of proving compensability and has the option of interlocutory relief to expedite decision. Otherwise, payments must be made within 30 days of receipt of statement for services. Failure to do so without reasonable grounds for delay could result in fine of $100 - $1,000 for each offense. Ky. Rev. Stat. § 342.990(8)(b).

A revised Hospital and Medical Fee Schedule have been passed. 803 KAR 25:091; 803 KAR 25:089.

38. What, if any, mechanisms are available to compel the production of medical information reports and/or an authorization) at the administrative level?

Medical records and reports are to be produced by providers with a release. If a provider refuses, subpoenas may be procured from an administrative law judge. Most providers tender reports voluntarily with payment requests.

In order to receive medical benefits, an employee must complete a Form 113, Physician Designation and Medical Release. In order to file a claim for benefits (a Form 101 Application for Adjustment of Benefits), a medical release form (Form 106) must be completed by the employee and included.

39. What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion?

A. Claimant’s choice of physician.

The employee is entitled to choose a physician, and must make the designation on a Form 113 Physician Designation and Medical Release Card. The employee may change the designated physician once, and thereafter only upon agreement of the employer, carrier or
Administrative Law Judge. If the employee fails to complete this form, all benefits may be terminated until the employee has complied with the requirement. 803 KAR 25:096 § 3.

Also, a framework for managed care plans has been implemented, but plans must be approved by the Commissioner. Choice of physician must be a component in any managed care plan.

B. Employer’s right to a second opinion and/or Independent Medical Examination.

The employer is entitled to request the claimant submit to a second opinion at any time. The claimant’s refusal will result in the termination/suspension of all benefits until she submits. Ky. Rev. Stat. § 342.205

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The employer must pay for all "reasonable and necessary" medical expenses for the "cure and relief from the effects of an injury or occupational disease." Ky. Rev. Stat. § 342.020. "Cure and relief" has been interpreted to mean "cure and/or relief." Treatment includes medical, surgical, hospital, nursing, surgical supplies and appliances, therapy and chiropractic care. Effective July 14, 2018, when a compensable injury or occupational disease results in the amputation or partial amputation of an arm, hand, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, or permanent total or permanent partial paralysis, medical care is to continue as long as it is needed regardless of the disability award period.

For all other claims where permanent partial disability benefits were awarded, medical care shall be paid for 780 weeks from the date of injury or last exposure. The Commissioner is to provide the employee with notice of the possible termination of medical benefits 754 weeks from the date of injury or last exposure, and benefits may be continued if:

1. An application is filed within seventy-five (75) days prior to the termination of the seven hundred eighty (780) week period;

2. The employee demonstrates that continued medical treatment is reasonably necessary and related to the work injury or occupational disease; and

3. An administrative law judge determines and orders that continued benefits are reasonably necessary and related to the work injury or occupational disease for additional time beyond the original seven hundred eighty (780) week period provided in paragraph (a) of this subsection.
Treatment shown to be unproductive or outside of the type of treatment generally accepted by the medical profession as reasonable, may not be the employer's responsibility. *Square D. Co. v. Tipton*, 862 S.W. 2d 308 (Ky. 1993).

41. **Which prosthetic devices are covered, and for how long?**

Prosthetic devices are covered as may be reasonably required at the time of the injury and thereafter for as long as the employee is disabled.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Possibly. A determination would be made on a case-by-case basis as to whether it is a "reasonable and necessary" medical expense for the "cure and/or relief" of the injury. Home nursing services, particularly involving a spouse, are also often raised and may be compensable.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. There is a medical fee schedule in effect. Balance billing is prohibited. Ky. Rev. Stat. § 342.033(2). Since April 4, 1994, an employer may furnish medical treatment through an approved managed care system. Ky. Rev. Stat. § 342.020. Alternative Dispute Resolution may be used as another cost containment option, so long as it is included in a collective bargaining contract. A revised Hospital Medical Fee Schedule has been passed effective June 2009. 803 KAR 25:091 with The DWC periodically updates the Hospital Medical Fee Schedule.

44. **What, if any, provisions or requirements are there for "managed care"?**

Employers in Kentucky may provide health care services through a managed care program. However, a plan must be filed with the Department of Workers' Claims and approved by the Commissioner. Ky. Rev. Stat. § 342.020.

The managed care system provision states that: (1) co-payments and deductibles may not be required for treatment relating to a work-related injury or occupational disease; (2) the employee has the choice of physicians within the plan; (3) the employee may obtain a second opinion at the employer's expense from an outside source if surgery has been recommended; (4) the employee may obtain service from outside the plan when treatment is unavailable through the managed care system; (5) procedures for Utilization Review for disputed fees and treatment must be in place; and (6) restrictions on care imposed by the managed care system shall not apply to emergency care.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**
When the employee files an application for benefits (the complaint), a schedule to take proof is issued, followed by a Benefit Review Conference and a hearing for a determination of contested issues. A Form 111 Notice of Claim Denial or Acceptance must be filed within 45 days after the claim has been assigned to an Administrative Law Judge. Failure to timely file this Notice of Denial, listing intent to deny a claim and the basis for the denial. Also, a will result in waiver of the defenses. For certain defense, such as statute of limitations, a special answer should also be filed as soon as evidence of the affirmative defense is learned. A notice of resistance of medical expense liability or certain portions of a compensable claim may also be appropriate in pending litigation.

46. What is the method of claim adjudication?

A. Administrative level.

Upon filing an application for benefits, an Administrative Law Judge will be assigned to the claim. The Administrative Law Judge will conduct any proceedings "necessary to the resolution of the claim," including ordering the parties to appear for a benefit review conference (informal conference), submission of medical reports and testimony by deposition. The Administrative Law Judge may also direct the employee to an evaluating physician from the University of Kentucky or University of Louisville medical schools. Ky. Rev. Stat. § 342.315.

The parties are given a proof schedule which gives the Plaintiff 60 days to submit proof, the employer then has 30 days followed by 15 additional days for rebuttal by the employee. The employer/insurer has 45 days to file a notice of claim acceptance or denial from the date of assignment to the Administrative Law Judge. At the close of proof, a Benefit Review Conference will be held at which time settlement will be attempted, and if failing, the parties will enter into stipulations and a final hearing will be scheduled. At the hearing, the parties may present live testimony. Wither oral arguments will be made at the hearing or briefs submitted typically within thirty days. The Administrative Law Judge must issue a decision within 60 days of the hearing.

B. Trial court.

See above.

C. Appellate.

After an Opinion or Award by an Administrative Law Judge, either party may submit a Petition for Reconsideration to the Administrative Law Judge or appeal to the Kentucky Workers Compensation Board where it will be reviewed by a three member panel. Following a decision of the Workers' Compensation Board, a petition for review by the Kentucky Court of Appeals may be filed. Thereafter, there is a direct right of appeal to the Kentucky Supreme Court.

47. What are the requirements for stipulations or settlements?
Settlements must be in writing on forms filed with the Department of Workers' Claims and submitted for approval by an administrative law judge.

No agreement for commuted lump sum payment of future income benefits over $100.00 per week is to be approved unless there is "reasonable assurance" that the employee will have an adequate source of income benefits during disability. This may be shown by submission of an affidavit detailing the employee's current work status.

48. **Are full and final settlements with closed medicals available?**

Yes. There is a specific question on the Form 110 settlement agreement which allows for additional consideration to be paid for closure of future medical expenses. Administrative Law Judge's will review these settlements closely and often request additional documentation or testimony verifying that the Plaintiff understands what he/she is doing and has another source of income to pay for any future medical expenses should they arise. The Settlement Agreement itself requires specific acknowledgements when such waivers are sought. If a Medicare Set-Aside is part of the settlement, it must be disclosed on the Form 110. Such agreements are often approved, especially if the employee is represented and/or compensability is disputed, but must ensure proper acknowledgments and consideration. Parties to such agreements should be aware that they may be set aside as unconscionable or against public policy given the right set of circumstances.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. An Administrative Law Judge must approve all settlements.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Every "employer" must maintain sufficient insurance to satisfy the Department of Workers' Claims of its financial ability to pay compensation as provided under the Act in order to transact business in the state. Ky. Rev. Stat. § 342.340. This can be by means of traditional insurance or self-insurance. Additionally, a state fund was created effective April 4, 1994. A certificate of coverage must be filed with the Department of Workers' Claims. Ky. Rev. Stat. § 342.340.

51. **What are the provisions/requirements for self-insurance?**

Regulations and financial monitoring of self-insured funds are being tightened. There is likely to be an increase in surety and bonding requirements and the formation of a surety association due to reticence on the party of self-insureds to cover each other in the event of insolvency.
An employer seeking self-insured status must file with the Department of Workers' Claims an application for a certificate accompanied by an audit for the preceding fiscal year, and a summary statement regarding workers' compensation claims experience. The Department of Workers' Claims determines whether the applicant has financial soundness and resources sufficient to fully pay and discharge any and all workers' compensation liabilities when and as they become due. In the event the application is approved, a bond, with or without surety, is required.

52. Are “illegal aliens” entitled to benefits of workers compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Ky. Rev. Stat. § 342.640 provides benefits to all employees whether lawfully or unlawfully in the service of a Kentucky employer. Accordingly, an “illegal alien” is entitled to workers compensation benefits in Kentucky. Additionally, alien dependants also qualify for dependents benefits at one-half the rate provided for resident dependents. Ky. Rev. Stat. § 342.130.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Kentucky case law and statute has not yet specifically addressed this issue. However, it would appear that employees injured in the course and scope of their employment as a result of a terrorist act are still entitled to the benefits of workers compensation and these claims would not be per se excluded or barred. Issues to be considered will be whether the injury occurred on the company's property and whether the employee was placed at an increased risk due to the nature or location of employment. Similarly, Kentucky has recognized "Acts of God" injuries under certain circumstances to be compensable.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of worker’s compensation by a worker’s compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a worker’s compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or
- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC §1395)

At this time, Kentucky has added no specific requirements for satisfying Medicare’s interests. The Form 110 Agreement As To Compensation has been modified to reflect whether an Medicare Set Aside Trust is part of the settlement, and if so, the specific terms. Kentucky has not added any additional requirements or reviews for approval of such settlements.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

Both health insurers and Medicaid liens are recoverable in Kentucky workers' compensation claims if the holder of the lien places the parties on notice of the lien and/or intervenes in the action. Recovery on the lien is limited to those expenses related to the work injury and subject to the caps placed upon fees under the Kentucky Workers’ Compensation Fee Schedule.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went into effect on April 14, 2003. The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). As a result your current practice of obtaining medical records could proceed under state law.

In order to pursue workers compensation benefits in Kentucky, an employee is obligated to sign a Form 106 Medical Waiver and Consent Form which entitles the employer and/or carrier to obtain any medical medicals relevant to the claim. The form includes a
waiver of physician-patient, psychiatrist-patient and chiropractor-patient privilege. There is a 180 day time limitation placed on the waiver by the employee is obligated to sign additional waivers as needed throughout the duration of the claim. Failure to sign such waive may result in suspension of benefits or dismissal of the claim. No other privacy or confidentiality provisions have been applied to the obtaining or use of these records. If a provider refuses to produce the records with the authorization form, an Administrative Law Judge may sign and issue a subpoena for the records.

57. **What are the provisions for “Independent Contractors”?**

Under Kentucky law, the Administrative Law Judge has the authority to determine whether an individual is an employee or an independent contractor for purposes of coverage under the Act. Four main factors are considered: the nature of the work performed as it relates to the business of the possible employer, the extent of control of details of the work, the professional skill of the worker and the intentions of the parties. Generally, an independent contractor, as a skilled tradesman, works on his/her own without direct supervision, setting work hours and providing the needed tools and equipment for the job. If truly found to be a contractor, the independent contractor is not entitled to workers’ compensation benefits unless he/she has purchased his/her own policy. Ky. Rev. St. 342.690.

A principal contractor may be liable for workers' compensation benefits for any employee injured while in the employ of an intermediate or subcontractor if the subcontractor fails to secure workers' compensation insurance. This up-the-ladder liability is discussed in Ky. Rev. St. 342.610(2) and 342.700(2) and may shield the principal contractor from civil liability.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

Employee leasing companies are required to register with the Office of Workers Claims and demonstrate that they have secured workers compensation coverage for all job sites where leased employees work. Ky. Rev. St. 342.615. Temporary help service companies are considered employers of temporary employees and must have workers’ compensation insurance coverage.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Kentucky has no specific provisions addressing owner/operators or other drivers. Each case would be analyzed for employment relationship versus independent contractor status as set forth above looking to the nature of the work performed as it relates to the business
of the possible employer, the extent of control of details of the work, the professional
skill of the worker and the intentions of the parties.

Effective July 14, 2018, a new section of the statute dealing with the Department of
Labor (Ky Rev. Stat. § 336) defines a “marketplace contractor” and provides that such an
individual shall not be deemed to be an employee of a marketplace platform. The
legislation has been dubbed “the Uber/Lyft bill” as it appears to be designed solely to
exempt from classification as employees those individuals providing services through the
electronic platform to connect them to customers. Employees who transport freight,
sealed envelopes, parcels and the like are exempted from this definition.

60. What are the "Best Practices" for defending workers' compensation claims and
controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for
every business. The best means for reducing and eliminating that exposure is a strong
and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk
management and in dealing with the inevitable claim. The best approach to ameliorating
a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert,
experienced and business-friendly resource for review of an existing plan or to help write
a "Best Practices" plan to guide your workers’ compensation preparation and response.
No one can predict when the need will arise, so ALFA counsels that you make it a
priority to review your plan with the ALFA Workers’ Compensation attorney for your
state, listed below.

61. Does your state permit medical marijuana and what are the restrictions for use and
for work activity in your state Workers’ Compensation law?

The issue has not been addressed in Kentucky.

62. Does your state permit the recreational use of marijuana and what are the
restrictions for use and for work activity in your state Workers’ Compensation law?

The state does not permit the recreational use of marijuana and the issue is not addressed
in the state’s Workers’ Compensation statues.
1. Citation for the state's workers' compensation statute.

   Louisiana Revised Statutes Annotated §23:1021 et seq.
   Louisiana Revised Statutes Annotated §33:2581 (Heart & Lung Statute for firefighters)

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

   All persons in the service of the state, or a political subdivision thereof, or of any incorporated public board, or under any appointment or contract of hire, except for officials of these bodies; and, except for employees of a contractor having a contract with the state, a political subdivision thereof, or a board or commission, are covered. La. Rev. Stat. Ann. §23:1034.


   If an employee, while working outside the territorial limits of Louisiana, suffers an injury on account of which he or his dependents would have been entitled to workers' compensation benefits under Louisiana law, such employee or his dependents shall be entitled to benefits if, at the time of the employee’s injury, his employment was principally located in Louisiana or he was working under a contract if hire made in Louisiana. La. Rev. Stat. Ann. §23:1035.1(1).

3. Identify and describe any "statutory employer" provision.
The 1997 amendment to Section 1061 by Act No. 315, effective June 17, 1997, was a major overhaul of the statutory employer law. The new law makes a clear statement that a statutory employer relationship shall exist whenever the principal is in the middle of two contracts. That is, the principle has a contract with one party to perform a certain work and then enters into a contract with another to do all or part of that work. This is the "two contract" defense, and it is available to that principal to protect the principal from tort suits by any employee engaged in the work that is the subject of the contract. A party with the two contract defense does not need to have their status as a statutory employer recognized in the contracts. La. Rev. Stat. Ann. §23:1061. However, a principal who is not in the middle of two contracts who has entered into a contract with a contractor to do a particular work cannot be considered a statutory employer of any of the employees working under the contract unless the contract with the contractor specifically recognizes the principal as the statutory employer of the contractor's employees (or statutory employees). When there is such an acknowledgment, there is created a rebuttable presumption of a statutory employer relationship. The presumption can be rebutted by showing that the work is not "an integral part of, or essential to, the ability of the principal to generate its goods, products or services." La. Rev. Stat. Ann. §23:1061.

4. **What types of injuries are covered and what is the standard of proof for each:**

A. **Traumatic or "single occurrence" claims.**

An employee must prove by a preponderance of the evidence that his disability resulted from an accident that arose out of and was in the course of his employment. La. Rev. Stat. Ann. §23:1031(A); *Andrews v. Music Mountain Water Co.*, 637 So. 2d 571, 573 (La. App. 2 Cir. 1994). "Accident" under Louisiana law is defined as an unexpected or unforeseen actual, identifiable, precipitous event happening suddenly or violently, with or without human fault, and directly producing at the time objective findings of an injury which is more than simply a gradual deterioration or progressive degeneration. La. Rev. Stat. Ann. §23:1021(1). Disability is presumed to have resulted from an accident if, before the accident, the employee was in good health, but commencing with the accident, symptoms of the disabling condition appeared and thereafter continuously manifested themselves. *Prudhomme v. DeSoto Professional Home Health Services*, 579 So.2d 1167 (La. App. 2d Cir. 1991).

B. **Occupational disease (including respiratory and repetitive use).**

"Occupational disease" is defined by the Act to mean "only that disease or illness which is due to causes and conditions characteristic of and peculiar to the particular trade, occupation, process, or employment in which the employee is exposed to such disease." Occupational disease includes injuries due to work-related carpal tunnel syndrome. Degenerative disc disease, spinal stenosis, arthritis of any type, mental illness, and heart-related or perivascular disease are specifically excluded. La. Rev. Stat. Ann. §23:1031.1.B.

Generally, the employee must prove by a reasonable probability that he or she contracted an occupational disease. *Dunaway v. Lakeview Regional Medical Center*, 2002 CA 2313 (La. App. 1 Cir. 8/6/03), 859 So. 2d 131, 135. Expert testimony is required to support a finding of an occupational disease. *Jones v. Ruskin Manufacturing*, 36,548-WCA (La. App. 2 Cir. 12/11/02),
834 So. 2d 1126, 1130. In asbestosis cases, the employee must establish, by a preponderance of evidence, exposure to asbestos during the course of employment, that he or she suffers from asbestosis, and, in a claim by a deceased employee's spouse, that asbestosis contributed significantly to the employee's death. *McDonald v. New Orleans Private Patrol,* 569 So.2d 106 (La. App. 4th Cir. 1990).

Effective June 29, 2001, §23:1031(1)(D) was amended to state that if an employee has been working for an employer for less than 12 months and contracts an occupational disease, it is presumed that the occupational disease was not contracted while in the course and scope of such employment. However, an employee may be compensated if he proves, by a preponderance of evidence, he contracted the disease during that period of employment, specifically proving that there is a disability that is related to an employment-related disease, such disease was contracted during the course of employment, and the disease is a result of the work performed. *Johnson v. Johnson Controls, Inc.,* 38,495-WCA (La. App. 2 Cir. 5/12/04), 873 So. 2d 923, 931-32,

Policemen or firefighters, who have completed two or more years of service, who contract hepatitis B or C disease shall be deemed to have an occupational disease or infirmity presumed to have been caused by or resulted from such work performed as a firefighter or policeman due to their exposure to blood and saliva of accident and crime victims. *La. Rev. Stat. Ann.* §33:1948(A).

5. **What, if any, injuries or claims are excluded?**


6. **What psychiatric claims or treatments are compensable?**

The definition of "injury" and "personal injury" includes the following: (1) only mental injury that is caused by a sudden, unexpected and extraordinary stress related to the employment, demonstrated by clear and convenience evidence; and (2) only mental injury that is caused by physical injury and can be demonstrated by clear and convincing evidence. *La. Rev. Stat. Ann.* § 23:1021(8)(b). No mental injury or illness shall be compensable unless the mental injury or illness is diagnosed by a licensed psychiatrist or psychologist and the diagnosis of the condition meets the criteria as established in the most current Diagnostic and Statistical Manual of Mental Disorders presented by the American Psychiatric Association. *La. Rev. Stat. Ann.* §23:1021(8)(c). If the employee is claiming a mental disability injury which is the result of mental stress alone, the employee must show that the mental stress was a result of a sudden, unexpected, and extraordinary stress related to the employment. *La. Rev. Stat. Ann.* §23:1021(8)(b).
7. **What are the applicable statutes of limitations?**

A claim must be brought within one year from the date of accident or death or, in the case that any payment has been made, one year from the date of the last payment. When the injury does not result at the time of, or develop immediately after, the accident, the limitation shall not take effect until the expiration of one year from the time the injury develops, but in all such cases the claim must be brought within two years from the date of accident. La. Rev. Stat. Ann. §23:1209.

If temporary total disability benefits are paid, the employee has three years from the last payment to file for SEB. If SEB benefits are paid, the employee’s right to additional SEB benefits ends after two years if the employee did not receive SEB benefits for 13 consecutive weeks during the two year period. La. Rev. Stat. Ann. §23:1221(3)(d)(1).

8. **What are the reporting and notice requirements for those alleging an injury?**

No claim is allowed unless notice of the injury has been given to the employer within thirty days after the injury or death. La. Rev. Stat. Ann. §23:1301. This requirement, however, is to be construed liberally in favor of the employee so as not to defeat the claim unless a delay resulted in prejudice to the employer. Lloyd v. IMC Fertilizer, Inc., 557 So.2d 1078 (La. App. 2d Cir. 1990). The notice by the employee must: (1) be in writing; (2) contain the employee's name and address; (3) state in ordinary language the time, place, nature and cause of the injury; and (4) be signed by the person giving the notice. La. Rev. Stat. Ann. §23:1303.

The employer is required to post the name of the person to whom an employee may give notice. La. Rev. Stat. Ann. §23:1302(A). The employee may give notice to that person by delivering it or sending it by certified mail, return receipt requested. La. Rev. Stat. Ann. §23:1304. If an employer fails to keep such notice posted, the time within which notice of injury must be given is extended to twelve months from the date of injury. La. Rev. Stat. Ann. §23:1302(B). The notice is not rendered invalid by reason of inaccuracy as to time, place, nature, or cause of the injury unless the employer shows it was misled to its detriment. La. Rev. Stat. Ann. §23:1305.

Within ten days of actual knowledge of injury resulting in death or lost time in excess of one week, the employer is required to report to the insurer, if any, and to the Office of Workers' Compensation Administration, information pertinent to the employee and the injury. La. Rev. Stat. Ann. §23:1306(A). Upon receipt of the employer's report, the Administration mails a brochure to the employer and the employee outlining their respective rights, benefits and obligations. La. Rev. Stat. Ann. §23:1307.

9. **Describe available defenses based on employee's conduct:**

A. **Self-inflicted injury.**


B. **Willful misconduct, "horseplay," etc.**

C. Injuries involving drugs and/or alcohol.

Compensation is not allowed for an injury caused by the employee's intoxication, unless the intoxication resulted from activities which were in pursuit of the employer's interest or in which the employer procured the intoxicating beverage or substance and encouraged its use during the employee's work hours. La. Rev. Stat. Ann. §23:1081(1)(b). There are a number of presumptions available to the employer to aid in proving intoxication, depending upon the percent by weight of alcohol in the employee's blood at the time of the accident. La. Rev. Stat. Ann. §§23:1081(3) and (4). The statute also allows the employer to administer drug and alcohol testing immediately after an alleged job accident. La. Rev. Stat. Ann. §23: 1081(7).

D. Initial Physical Aggressor.

No compensation shall be allowed for an injury to an employee caused to be the initial physical aggressor in an unprovoked physical altercation, unless excessive force was used in retaliation against the initial aggressor. R.S. 23:1081(1)(c). Note that Louisiana law has deleted the provision in 2001 whereby compensation would be disallowed for injury caused by the injured employee's deliberate failure to use an adequate guard or protection against accidents provided for him. La. R.S. 23:1081(1)(c).

10. What, if any, penalties or remedies are available in claims involving fraud?

It is unlawful for any person, for the purpose of obtaining or defeating any benefit or payment, either directly or for another, to willfully make or counsel someone to make a false statement or representation. La. Rev. Stat. Ann. §23:1208(A). Such benefits or payments shall include indemnity benefits, the cost or value of health care, medical case management, vocational rehabilitation, transportation expense, and the reasonable costs of investigation and litigation. La. Rev. Stat. Ann. §23:1208(C)(4). Violation of the statute when the benefits claimed or payments obtained are $10,000.00 or more results in imprisonment for up to ten years, or fines up to $10,000.00, or both. La. Rev. Stat. Ann. §23:1208(C)(1). Violations involving $2,500.00 or more, but less than $10,000.00, result in imprisonment for up to five years, or fines up to $5,000.00, or both. La. Rev. Stat. Ann. §23:1208(C)(2). Violations involving less than $2,500.00 result in imprisonment for up to six months, or fines up to $500.00, or both. La. Rev. Stat. Ann. §23:1208(C)(3).

In addition to the criminal penalties, any person violating the statute may be assessed civil penalties by the Director of not less than $500.00 nor more than $5,000.00 payable to the Kids Chance Scholarship Fund of the Louisiana Bar Foundation, and may be ordered to make restitution for benefits paid up until the time the employer became aware of the fraudulent conduct. La. Rev. Stat. Ann. §23:1208(D). An employee violating the statute shall, upon such a determination by the hearing officer, forfeit any right to compensation benefits. La. Rev. Stat. Ann. §23:1208(E).

11. Is there any defense for falsification of employment records regarding medical history?
Yes. The employer is allowed to inquire about previous injuries, disabilities or other medical conditions. An employee's failure to answer truthfully bars benefits, provided the failure to answer directly relates to the medical condition for which a claim for benefits is made or affects the employer's ability to receive reimbursement from the second injury fund. However, these provisions are unenforceable unless the written form on which the inquiries about previous medical conditions are made contains a notice, prominently displayed in bold faced block letter in of no less than ten point type, advising the employee that his failure to answer truthfully may result in his forfeiture of worker's compensation benefits. La. Rev. Stat. Ann. §23:1208.1.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Recreational or social activities are within the course of employment when: (1) they occur on the premises during a lunch or recreation period as a regular incident of the employment; (2) the employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the ambit of the employment; or (3) the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life. Jackson v. American Ins. Co., 391 So.2d 1339, rev'd, 404 So.2d 218 (La. 1981); Winkler v. Wadleigh Offshore, Inc., 2001CA-1833 (La. App. 4 Cir. 4/24/02), 817 So. 2d 313, 317.

Whether an accident is compensable which occurs while an employee is "standing by" or "on call" is heavily dependent upon the facts in each case. See Fortenberry v. C.R. Bard, Inc., 2001-2195 (La. App. 4th Cir. 10/16/02), 830 So.2d 1025.

13. Are injuries by co-employees compensable?

Yes, as long as the injury was not caused by an intentional act and occurred within the course and scope of the employment. La. Rev. Stat. Ann. §23:1032(B); See Bradley v. Morton Thiokol, Inc., 27,411 (La. App. 2nd Cir. 9/29/95) 661 So.2d 691. However, for example, if two employees engage in a fight unrelated to employment, the employer would have a valid defense. La. Rev. Stat. Ann. §23:1031(E).

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

No. For a claim to be compensable, the worker must suffer an injury by accident which occurs during the course of the employment and which must “arise out of the employment.” La Rev. Stat. Ann. §23:1031. Louisiana courts have generally applied the “increased risk” doctrine to determine whether an accident arises out of the worker’s employment. Under this theory, an accident does not “arise out of” the employment unless the injury was caused by an increased risk to which the employee, as opposed to the general public, was subjected to as a result of his employment. Mundy v. Department of health and Human Resources, 593 So.2d 346 (La. 1992).

Additionally, an injury by accident should not be considered as having arisen out of the employment and thereby not covered if the employer can establish that the injury arose out of a dispute with another person or employee over matters unrelated to the injured employee’s
15. **What criterion is used for calculating the average weekly wage?**

The statute applies specific mathematic formulae, depending upon the method of payment of wages.

A. **Hourly Wages.**

   (1) Employed 40 hours or more: the greater of 40 hours or (hourly rate) x (average actual hours for four weeks preceding accident date).

   (2) Offered at least 40 hours, but regularly and voluntarily works less than 40 hours: average of total weekly earnings for four weeks preceding accident date.

   (3) Part-time employees: (hourly rate) x (average actual hours for four weeks preceding accident date).

   (4) Part-time employees with two or more employers in two or more successive employments, where injury in one employment causes loss of income from other successive employment(s): employer in whose service the employee was injured pays benefits and average weekly wage is calculated as above, using hourly rate in employment when injured and using total hours worked for all employers. However, total hours may not exceed the lesser of 40 hours or the average weekly hours worked.

   (5) Seasonal employment: generally, AWW equals annual income divided by 52, but there are specific provisions for seasonal employees employed one year or less. Season employment is any employment customarily operating only during regularly recurring periods of less than 44 weeks, annually.

B. **Monthly wages:** (monthly salary x 12) divided by 52.

C. **Annual wages:** annual salary divided by 52.

D. There are specific provisions for employees employed on a unit, piecework, commission or other basis.


16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Compensation is paid at sixty-six and two-thirds percent of wages during the period of disability, which disability must be proven by clear and convincing evidence, subject to a statutory maximum compensation rate. The maximum rate is determined each year, however the compensation rate is determined at the time of injury. La. Rev. Stat. Ann. §23:1221. "Wages" means average weekly wages. 

For injuries occurring on or after July 1, 1983, the maximum is seventy-five percent of the average weekly wage paid in all employment subject to the Louisiana Employment Security Law, and the minimum compensation for total disability is not less than twenty percent of such wage. The minimum compensation does not apply to Supplemental Earnings Benefits and Permanent Partial Disability benefits. La. Rev. Stat. Ann. §23:1202(A)(2).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**


18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out _____ days before recovering benefits for the first ___ days)?**


19. **What is the standard/procedure for terminating temporary benefits?**

   Temporary total disability benefits cease when the employee's physical condition has resolved to the point that a reasonable and reliable determination of the extent of disability may be made, and the condition has improved to the point that continued, regular treatment by a physician is not required. La. Rev. Stat. Ann. §23:1221(1)(d).


   An employer/insurer who terminates all benefits must inform the employee by sending a Form 1003 Stop Payment Form.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**


21. **What disfigurement benefits are available and how are they calculated?**

   Where the employee is seriously and permanently disfigured or suffers a permanent hearing loss solely due to a single traumatic accident, or where the usefulness of the physical function or the respiratory system, gastrointestinal system, or genito-urinary system, as contained within the thoracic or abdominal cavities, is serious and permanently impaired, compensation not to exceed sixty-six and two-thirds percent of wages, for a period not to exceed one hundred weeks, may be
How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled member/parts, and the standard for recovery?

The maximum number of weeks for each scheduled member are as follows: Thumb = 50; first finger = 30; any other finger = 20; great toe = 20; any other toe = 10; hand = 150; arm = 200; foot = 125; leg = 175; eye = 100; loss of both hands, or both arms, or both feet, or both legs, or both eyes, or one hand and one foot, or any of two thereof, or paraplegia, or quadriplegia shall, in the absence of conclusive proof of a substantial earning capacity, constitute permanent total disability. La. Rev. Stat. Ann. §§23:1221(4)(a)-(j).

First phalange of the thumb or great toe, or two phalanges of any finger or toe equals the loss of one-half of such member, and the compensation shall be one-half of the amount above specified. More than one phalange of a thumb, or more than two phalanges of any finger or toe equals the loss of the entire member; provided, that the maximum amount is equivalent to the loss of a hand or the loss of a foot as appropriate. Amputation between the elbow and the wrist equals the loss of a hand and amputation between the knee and ankle equals the loss of a foot; a permanent total anatomical loss of the use of a member is equivalent to the amputation of the member. Such benefits are paid at the rate of sixty-six and two-thirds percent of the employee's wages. La. Rev. Stat. Ann. §§23:1221(4)(k)-(n).

No benefits shall be awarded or payable unless anatomical loss of use, or amputation, or loss of physical function is greater than twenty-five percent as established in the American Medical Association "Guides to the Evaluation of Permanent Impairment." La. Rev. Stat. Ann. §23:1221(4)(q).

Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

An employee is entitled to prompt vocational rehabilitation when he or she suffers an injury which precludes him or her from earning wages equal to those earned prior to the injury and, prior to the workers' compensation judge adjudicating the employee to be permanently and totally disabled, the workers' compensation judge determines that there is reasonable probability, with appropriate training or education, that the employee may be rehabilitated to the extent that such employee can achieve suitable gainful employment and that it is in the best interest of such individual to undertake such training or education. La. Rev. Stat. Ann. §23:1226(A), (D).

How are permanent total disability benefits calculated, including the minimum and maximum rates?

disabled, if such employee subsequently has or receives any earnings, including, but not limited to, earnings from odd-lot employment, sheltered employment, or employment while working in pain, such employee shall not receive benefits pursuant to this Paragraph but may receive [supplemental earnings benefits]." La. Rev. Stat. Ann. §23:1221(2)(d). The maximum and minimum benefits are calculated the same as temporary total disability benefits. (See answer 16).

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

In every death case, the employer shall pay, in addition to any other recoverable benefits, reasonable expenses of the burial of the employee up to $8,500. La. Rev. Stat. Ann. §23:1210(A). The statute further provides that if the burial expenses are less than $7,500, the difference between the expenses and $7,500 shall be paid to the heirs in addition to any other benefits. La. Rev. Stat. Ann. §23:1210(B).

B. Dependency claims.

La. Rev. Stat. Ann. §23:1231 provides that for death within two years after the last treatment resulting from the accident, a legal dependent, actually and wholly dependent upon the employee's earnings at the time of the accident and death, receives a weekly sum as provided below:

Payment is computed and divided among dependents as follows:

(1) if the spouse alone, 32 1/2% of wages; (2) if the spouse and one child, 46 1/4% of wages; (3) if the spouse and two or more children, 65% of wages; (4) if one child alone, 32 1/2% of wages; (5) if two children, 46 1/4% of wages; (6) if three or more children 65% of wages; (7) if there are neither spouse or child, then to the father or mother 32 1/2% of wages; and (8) if there are both father and mother, 65% of wages. If none of the aforementioned, then to one brother or sister, 32 1/2% of wages with 11% additional for each brother or sister in excess of one. If other dependents than those enumerated, 32 1/2% of wages for one and 11% additional for each such dependent in excess of one, subject to a maximum of 65% of wages for all, regardless of the number of dependents. La. Rev. Stat. Ann. §§23:1232(1)-(8). Death benefits to a surviving spouse shall terminate upon the death or remarriage of such surviving spouse. La. Rev. Stat. Ann. §23:1233.

If the employee leaves only partial dependents, the weekly compensation to be paid shall be equal to the same proportion of the weekly payments for the benefit of persons wholly dependent as the amount contributed by the employee to such partial dependents in the year prior to the death bears to the earnings of the deceased at the time of the accident. La. Rev. Stat. Ann. §23:1231(B)(1).

If the employee leaves no legal dependents entitled to benefits under any government compensation system, the sum of $75,000.00 shall be paid to each surviving parent of the deceased employee, in a lump sum, which shall constitute the sole and exclusive compensation. La. Rev. Stat. Ann. §23:1231(B)(2).

26. What are the criteria for establishing a "second injury" fund recovery?
An employer who knowingly employs, re-employs, or retains an employee who has a permanent partial disability shall qualify for reimbursement from the Second Injury Fund, if the employee incurs a subsequent injury arising out of and in the course of his employment resulting in a greater liability due to the merger of the subsequent injury with the preexisting permanent partial disability. La. Rev. Stat. Ann. §23:1378(A).

The legislature recently amended the Second Injury Fund statute to specify the knowledge required by employers to be eligible for reimbursement by the Second Injury Fund. To qualify, following criteria must be established: (1) the employer has knowledge that the preexisting PPD was caused by a job accident or occupational disease while employed by the same employer seeking reimbursement from the Fund, (2) the PPD was disclosed to the employer on a form promulgated by the Office of Workers’ Compensation, (3) the employer employs, retains or re-employs employee from the Permanent Partial Disability Employee Registry, and (4) the employer gives the Second Injury Fund Board an affidavit stating that the person signing the affidavit has hire and fire authority, states how and when he acquired knowledge of a PPD, states how the PPD was a hinderance to employment, and the affidavit has an acknowledgment that any false statements may result in penalties.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The Office of Workers' Compensation would be the proper forum to seek modification of an award or order of a workers' compensation judge as such judge’s power and jurisdiction is continuing. La. Rev. Stat. Ann. §23:1310.8(A)(1). There is also jurisprudential support for the extension of the workers' compensation judge's modification jurisdiction to district court judgments. In Ross v. Highlands Ins. Co., 590 So.2d 1177 (La. 1991), the Louisiana Supreme Court, in dicta, acknowledged the jurisdiction of the hearing officer system to modify a district court's judgment.

The party seeking the modification has the burden to prove that there has been a change in conditions. Jeanise v. Cannon, 04-1049 (La. App. 3 Cir. 2/23/05), 895 So. 2d 651, 660. All issues, except disability, are res judicata and cannot be litigated in the modification proceeding. Id. The time limit for filing a motion or suit for modification has generally been recognized as one year from the last payment of weekly benefits. La. Rev. Stat. Ann. §23:1310.8; La. Rev. Stat. Ann. §23:1209. However, the Louisiana Supreme Court has found that prescription is not applicable to claims for modification of a workers’ compensation award. Falgout v. Dealers Truck Equipment Co., 98-C-3150 (La. 10/19/99), 748 So. 2d 399, 407.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

The failure to pay the first installment of compensation for temporary total disability, permanent total disability or death or supplemental earnings benefits within 14 days after the employer has notice of the injury or death and/or the failure to pay medical benefits within 60 days and/or the failure to consent to the employee’s request to select or change a treating physician can result in an award of penalties and attorney’s fees. However, there can be no award of penalties and/or attorney’s fees if the claim is reasonably controverted. La. Rev. Stat. Ann. §§23:1201(A)-(F). Any
employer/insurer who at any time discontinues payment of benefits due, when such discontinuance is found to be arbitrary, capricious, or without probable cause, shall be subject to the payment of all reasonable attorney's fees or the prosecution and collection of such claims. La. Rev. Stat. Ann. §23:1201(I); Smith v. Phillip Morris, U.S.A., 2002 CA 0103 (La. App. 1 Cir. 12/20/02), 858 So. 2d 443, 450. (See also answers 32, 33 and 37).

In addition, in 2013, Louisiana enacted La. Rev. Stat. Ann. §23:1201.1 which provides an employer/insurer with a “Safe Harbor” to protect against the award of penalties and attorney’s fees when suspending, terminating or controverting a claim. To qualify for the protections set forth in the statute, the employer must first accept the claim and send the initial payment to the worker along with a Form 1002 Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation and/or Medical Benefits in accordance with the procedures set forth in La. Rev. Stat. Ann. §23:1201.1. Thereafter, to suspend, terminate or controvert benefits, the employer must continue to follow the procedure set forth in the statute. If an employer follows the procedures set forth, it will not be liable for penalties or attorney’s fees even if benefits are found due.

**EXCLUSIVITY/TORT IMMUNITY**

29. Is the compensation remedy exclusive?

A. Scope of immunity.


B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

If the injury is the result of an intentional act, the employer may be subject to a fine or penalty under any other statute, civil or criminal, in addition to civil or criminal liability. La. Rev. Stat. Ann. §23:1032(B). Immunity shall not extend to: (1) any officer, director, stockholder, partner, or employee of such employer or principal who is not engaged at the time of the injury in the normal course and scope of the employment; or (2) to the liability of any partner in a partnership which has been formed for purpose of evading this section. La. Rev. Stat. Ann. §23:1032(C). No contract, rule, regulation or device whatsoever shall operate to relieve the employer, in whole or in part, from any liability except as provided. La. Rev. Stat. Ann. §23:1033.

30. Are there any penalties against the employer for unsafe working conditions?

Employers may face a surcharge, non-renewal or cancellation for failure to comply with reasonable safety requirements. La. Rev. Stat. Ann. §23:1412(B).

31. What is the penalty, if any, for an injured minor?

There are no such penalties in Louisiana. Ewert v. Georgia Casualty & Surety Co., 548 So. 2d 358, 361 (La. App. 3 Cir. 1989).
32. **What is the potential exposure for "bad faith" claims handling?**

An employer/insurer shall be subject to a penalty not to exceed $8,000.00 and a reasonable attorney fee for the prosecution and collection of such claims for discontinuing payment of claims where such discontinuance is found to be arbitrary, capricious, or without probable cause. La. Rev. Stat. Ann. §23:1201(I); Jeanise v. Cannon, 04-1049 (La. App. 3 Cir. 2/23/05), 895 So. 2d 651, 666.

Note that two provisions of §23:1202.2 were repealed in 1995: (1) the employer/insurer's duty to pay reasonable attorney's fees for the prosecution and collection of a claim where the failure to make payment within sixty days after receipt of written notice is found to be arbitrary, capricious, or without probable cause; (2) if a partial payment or tender has been made in such a case, the employer/insurer is liable for all reasonable attorney's fees for the prosecution and collection of the difference between the amount paid or tendered and the amount due. Whether or not the "discontinuance" language can be construed to encompass a complete failure to pay is uncertain.

In addition, in 2013, Louisiana enacted La. Rev. Stat. Ann. §23:1201.1 which provides an employer/insurer with a “Safe Harbor” to protect against the award of penalties and attorney’s fees when suspending, terminating or controverting a claim. To qualify for the protections set forth in the statute, the employer must first accept the claim and send the initial payment to the worker along with a Form 1002 Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation and/or Medical Benefits in accordance with the procedures set forth in La. Rev. Stat. Ann. §23:1201.1. Thereafter, to suspend, terminate or controvert benefits, the employer must continue to follow the procedure set forth in the statute. If an employer follows the procedures set forth, it will not be liable for penalties or attorney’s fees even if benefits are found due.

33. **What is the exposure for terminating an employee who has been injured?**

An employer cannot refuse to hire a person or discharge them simply because of a compensation claim. La. Rev. Stat. Ann. §23:1361(A). An employer who is found to discriminate against an employee who files a claim is subject to a civil penalty equal to the amount the employee would have earned but for the discrimination, based on the starting salary of the position sought or the earnings of the employee at the time of discharge, not to exceed one year's earnings, plus reasonable attorney's fees and court costs. La. Rev. Stat. Ann. §23:1361(C).

However, note that any party found to have brought a frivolous claim under §23:1361 shall be held responsible for reasonable damages incurred as a result of the claim, including reasonable attorney's fees and court costs. La. Rev. Stat. Ann. §23:1361(E).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-employees be sued for work-related injuries?**
36. **Is subrogation available?**


**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**


Failure to make a timely payment shall result in a penalty of 12% of any unpaid medical benefits or fifty dollars per calendar day, whichever is greater, for each day in which any and all medical benefits remain unpaid, in addition to reasonable attorney's fees. The fifty dollar per calendar day penalty shall not exceed $2,000.00. La. Rev. Stat. Ann. §23:1201(F).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

La. Rev. Stat. Ann. §23:1127 mandates that health care providers who have treated an employee relating to a workers’ compensation claim provide copies of all medical records and information without the need for a medical authorization to the employee, a license vocational rehabilitation specialist, the employer, the workers’ compensation insurer, and other healthcare providers.

Additionally, the normal discovery devices are available to the parties, including interrogatories, requests for production and requests for admission. Failure by a party to respond can result in the filing of a motion to compel, seeking responses and sanctions. Failure to comply with an Order or subpoena issued by a Hearing Officer may ultimately result in the offending party being held in contempt. La. Rev. Stat. Ann. §23:1310.7.

39. **What is the rule on (a) Claimant's choice of physician; (b) Employer's right to second opinion and/or Independent Medical Examination?**

**A. Claimant's choice of a physician.**

The Act requires that employee seek all medical treatment within the State when available. La. R.S. Ann. §23:1203(A).

An employee has the right to select one treating physician in any field or specialty. After the initial choice, the employee must obtain prior consent from the employer or his carrier for a
change of treating physician within the same field or specialty. The employee, however, is not required to obtain approval for change to a treating physician in another field or specialty. La. R.S. Ann. §23:1121(B)(1).

B. Employer's right to second opinion and/or independent medical examination.

An injured employee shall submit himself to an examination by a duly qualified medical practitioner provided and paid for by the employer, as soon after the accident as demanded, and from time to time thereafter as often as may be reasonably necessary. The employer or his carrier shall not require the employee to be examined by more than one duly qualified medical practitioner in any one field or specialty unless prior consent has been obtained from the employee. La. R.S. Ann. §23:1121(A). Case law has recognized that a defendant in a compensation suit is always entitled to have plaintiff examined prior to trial by defendant's physician, so long as examination is reasonable. See Fontenot v. Cox, 68 So.2d 656 (La. App. 1st Cir. 1953); Green v. Liberty Mutual Ins. Co., 184 So.2d 801 (La. App. 3rd Cir. 1966). If the employee refuses to submit himself to a medical examination as best provided in this section, his right to compensation and to prosecute any further proceedings shall be suspended until the examination takes place. La. R.S. Ann. §23:1124(A).

It should also be noted that if any dispute arises as to the condition, capacity to work, or the current medical treatment of the employee, the Court, on application of either party or on its own motion under the circumstances, can order an examination by a physician appointed by the Court. La. R.S. Ann. §23:1123; Johnson v. Coppage, 360 So.2d 275 (La. App. 4th Cir. 1978).

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The employee is entitled to all necessary medical, surgical, hospital services and medicines or any non-medical treatment recognized by the state's laws as legal (e.g., chiropractors). La. Rev. Stat. Ann. §23:1203(A).

On July 13, 2011, new Medical Treatment Guidelines under La. Rev. Stat. Ann. §23:1203.1 went into effect. La. Rev. Stat. Ann. §23:1203.1 give the Office of Workers’ Compensation Medical Director the power to establish certain treatment guidelines for various types of injuries. The statute requires all treating healthcare providers and insurance carriers, absent exigent circumstances, to comply with new medical treatment schedules in providing medical treatment to all injured employees. Under these new guidelines, medical treatment owed by the employer shall mean care, services, and treatment in accordance with the medical treatment schedule. Accordingly, medical treatment that is not within the schedule is not owed by the employer and denial of treatment will not be considered arbitrary and capricious. However, the statute does afford an injured worker the possibility to obtain medical treatment that varies from the schedule if it is demonstrated to the Office of Workers Compensation Medical Director by a preponderance of scientific medical evidence that the variance is reasonably required to cure or relieve the injured worker.

Although additional guidelines are being developed, the guidelines currently address medical treatment for the spine, upper and lower extremities, neurological and neuromuscular disorders, and pain. Specifically, the current categories of Medical Guidelines include Carpal Tunnel

41. Which prosthetic devices are covered, and for how long?


42. Are vehicle and/or home modifications covers as medical expenses?

An award has been made to a paraplegic employee for expenses incurred for an emergency telephone, a ramp, and hand controls on a van. Cottonham v. Rockwood Ins. Co., 403 So.2d 773 (La. App. 3d Cir. 1981), cert. denied, 407 So.2d 732 (La. 1983).

43. Is there a medical fee guide, schedule or other provisions for cost containment?

The obligation to pay is limited to the mean of the usual and customary charges for such care, services, treatment drugs and supplies, as determined under the reimbursement schedule annually published pursuant to La. Rev. Stat. Ann. §23:1203(B).

44. What, if any, provisions or requirements are there for "managed care"?

No provision specifically addresses managed care. However, the broad language of 23:1203(A) probably encompasses such care. See answer 40.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

A. Claims filed with the Office of Workers’ Compensation district courts.

A claim for benefits, the controversy of entitlement to benefits, or other relief under the Act, is initiated by the filing of a LWC-WC Form 1008 "Disputed Claim for Compensation." with the Office of Workers' Compensation Administration. La. Rev. Stat. Ann. §23:1310.3(A). The matter is then assigned to one of nine districts. The district office effects service of process on any named defendant, who must then file an answer within fifteen days of service or within the delay for answering granted by the workers’ compensation judge, not to exceed an additional ten days. La. Rev. Stat. Ann. §23:1310.3(B). At the time the claim is filed, an employee who is a Louisiana domiciliary is required to elect one of the following judicial districts as the situs of necessary hearing by a hearing officer: (1) the judicial district of the parish of domicile at the time of injury; (2) the judicial district of the parish where the injury occurred, or (3) the judicial district of the parish of the employer's principal place of business. Employees who are not Louisiana domiciliaries have more limited options. La. Rev. Stat. Ann. §23:1310.4(A).
In addition, in 2013, Louisiana enacted La. Rev. Stat. Ann. §23:1201.1 which provides an employer/insurer with a “Safe Harbor” to protect against the award of penalties and attorney’s fees when suspending, terminating or controverting a claim. The suspension, termination or controversion can be for several reasons, including the employee’s refusal to submit to a medical examination, failure to provide a Choice of Physician form, fraud, disputes of compensability, employee’s failure to provide a monthly report of earnings, or otherwise to controvert that the employee was injured in a workplace accident. To qualify for the protections set forth in the statute, the employer must first accept the claim and send the initial payment to the worker along with a Form 1002 Notice of Payment, Modification, Suspension, termination, or Controversion of Compensation and/or Medical Benefits in accordance with the procedures set forth in La. Rev. Stat. Ann. §23:1201.1. Thereafter, to suspend, terminate or controvert benefits, the employer must continue to follow the procedure set forth in the statute. If an employer follows the procedures set forth, it will not be liable for penalties or attorney’s fees even if benefits are found due.

B. Claims for treatment in accordance with the Medical Guideline Schedule.

La. R.S. 23:1203.1 also establishes additional deadlines and procedures for authorization and appeal of requested medical treatment under the Medical Guideline Schedule. The statute also establishes deadlines and procedures for authorization and appeal of requested medical treatment. The employee's medical provider must submit a request for authorization of his plan of medical treatment to the employer's workers' compensation insurance carrier/payor. Once the medical provider submits to the payor the request for authorization, the payor must notify the medical provider of their action on the request within five business days of receipt of the request. La. R.S. 23:1203.1(J)

If any dispute arises as to whether the recommended care, services, or treatment is in accordance with the medical treatment schedule, or whether a variance from the medical treatment schedule is reasonably required, La. RS 23:1203.1(J) requires the aggrieved party to file a LWC-WC 1009 “Disputed Claim for Medical Treatment” appeal with the office of workers' compensation administration medical director. To properly challenge a denial of medical services, an injured worker must complete and submit a LWC-WC 1009 Disputed Claim for Medical Treatment form, via mail, to the OWCA Medical Director along with the supporting medical documentation.

The statute requires this appeal to be filed within fifteen calendar days of the denial by the Carrier/Self-insured employer. Additionally, a copy of the completed 1009 form must be mailed to all involved parties. The statute mandates that the Medical Director render a decision as soon as practicable, but in no event, not more than 30 calendar days from date of filing the appeal. The LWC-WC Form 1009 is posted on the website, www.LAWORKS.net and can be accessed using the numerical listing by clicking on Downloads, then on Workers Compensation, then Forms – Numerical.

In the event that either party disagrees with the determination issued by the Medical Director, any party may then appeal the decision by filing a LWC-WC Form 1008 "Disputed Claim for Compensation." However, under the statute, the Medical Director's decision will only be overturned when it is shown by clear and convincing evidence that it was not in accordance with the schedule. La. R.S. 23:1203.1(K).

46. What is the method of adjudication?

A. Administrative level/Trial court.


B. Appellate.

An appeal from a hearing officer's decision may be taken to the circuit court of appeal for the judicial district elected by the employee upon filing the petition. The appeal is taken on the record, no additional evidence may be submitted, and the case is reviewed using "manifest error - clearly wrong" standard of review. An employer who appeals a decision must secure a bond. La. Rev. Stat. Ann. §23:1310.5.

An appeal from the circuit court is heard by the Louisiana Supreme Court. Louisiana does not follow the common law; therefore, the scope of review is the same as any other civil law case.

47. What are the requirements for stipulations or settlements?

A lump sum payment or compromise settlement for full and final discharge and release of the employer/insurer is allowed only: (1) upon agreement between the parties, including the insurer's duty to obtain the employer's consent; (2) when it can be demonstrated that a lump sum payment is clearly in the best interests of the parties; and (3) upon the expiration of six months after termination of temporary total disability. However, such expiration may be waived by consent of the other parties. La. Rev. Stat. Ann. §§23:1271(A)(1)-(3). Additionally, such agreements must be approved by the hearing officer. La. Rev. Stat. Ann. §23:1272(A).

48. Are full and final settlements with closed medicals available?

There is no such specific provision in the Act but full and final settlements with closed medicals are allowed.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. See answer 47.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Employers are required to secure compensation to their employees through one of several available means: (1) by obtaining workers' compensation insurance from an authorized insurer; (2) by entering into an agreement with a group self-insurance fund; (3) by entering into an agreement with an interlocal risk management agency; (4) by using any combination of life, accident, health, property, casualty or other insurance policies offered through authorized companies; or (5) by qualifying as a self-insurer. La. Rev. Stat. Ann. §23:1168.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   The employer must furnish satisfactory proof of ability to pay compensation. The Director, pursuant to rules adopted by the Office for an individual self-insured, shall require that an employer: (1) deposit with the director securities or a surety bond in an amount determined by the director which would be at least an average of the yearly claims for the last three years; and (2) provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of the Workers' Compensation Act. La. Rev. Stat. Ann. §23:1168(A)(5).

   The Director may waive the requirements of La. Rev. Stat. Ann. §23:1168(A)(5) if the employer is able to pay benefits and the requirements of these provisions are unnecessary. Rules which set standards for such waiver must be established. La. Rev. Stat. Ann. §23:1168(B).

   **B. For groups or "pools" or private entities.**

   Five or more employers who are member of the same bona fide trade or professional association, and who meet specified qualifications, may pool their liabilities. La. Rev. Stat. Ann. §23:1195 et seq.

52. **Are "illegal aliens" entitled to benefits of workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of "employee"?**

   The Louisiana Workers' Compensation Act does not exclude illegal aliens from securing workers' compensation benefits when justified. The Act provides a list of employees who are not covered and since there is not clear indication that the Legislature intended to exempt illegal aliens from recovering under the Act, the employer is burdened with showing the application of some specific exclusion under which benefits may be denied. See *Artiga v. M.A. Patout and Son*, 671 So.2d 1138 (La. App. 3rd Cir. 1996).

53. **Are terrorist acts or injuries covered or excluded under workers' compensation law?**

   Terrorist acts are covered. La. Rev. Stat. Ann. §23:1031(A) provides that any employee receiving personal injury "by accident arising out of and in the course of his employment" is entitled to workers' compensation benefits. "Accident" is defined as "an unexpected or unforeseen actual, identifiable, precipitous event happening suddenly or violently, with or without human fault, and

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Pursuant to La. Rev. Stat. Ann. §46:153(E), anyone applying for, and subsequently becoming eligible to receive, or by accepting medical assistance under any provision of the federal Social Security Act “shall be deemed to have made an assignment to the department of his right to any hospitalization, accident, medical, or health benefits owed to applicant or recipient by any third party, as well as rights to such benefits or medical support payments owed by any third party to applicant’s or recipient’s children or any other person for whom applicant or recipient has legal authority to execute such an assignment.” As such, a workers’ compensation claimant who has previously received Medicare benefits cannot settle with and release the employer-carrier to the extent of the Medicare payments as the right to recoup those payments has been assigned to the Louisiana Department of Health and Hospitals. The right to recover those Medicare expenses belongs to the Louisiana Department of Health and Hospitals, who should be included in any purported settlement.

La. Rev. Stat. Ann. §46:153(H) further provides that the Department of Health and Hospitals shall not lose its right to recover the assistance payments and medical expenses the department has paid or was obligated to pay on behalf of an injured, ill, or deceased person in connection with said injury, illness, or death if the department does not intervene or file its own cause of action or take any other action allowed pursuant to the assignment of rights provision of subsection (E) of this section, or La. Rev. Stat. Ann. §46:446.

55. How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396(k)(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396(k)(b).

Pursuant to La. Rev. Stat. Ann. §46:446(F), the Louisiana Department of Health and Hospitals has a privilege for medical payments made to an injured or ill Medicaid recipient (1) on the amount payable to the injured recipient out of the total amount of recovery, whether by judgment or settlement/compromise, from another person and (2) on the amount payable by any insurance company under any contract providing for indemnity or compensation to the injured person. This privilege becomes effective if, prior to the payment of insurance proceeds or the payment of any judgment, settlement or compromise, a written notice containing the name and address of the injured person (and if known, the name of the person alleged to be liable to the injured person on account of the injuries received) is mailed by the Louisiana Department of Health and Hospitals, by certified mail, return receipt requested, to the injured person, his attorney, the person alleged to be liable to any insurance carrier which insured such person against liability and "to any insurance
company obligated by contract to pay indemnity or compensation to the injured person." La. Rev. Stat. Ann. §46:446(G). The privilege is effective against the persons given notice according to these provisions, and is not negated as to those persons given notice due to failure to give similar notice to other persons listed in the statute. Id. Any insurer or other person who, having received notice in accordance with these provisions, pays over any monies subject to the privilege is liable to the Louisiana Department of Health and Hospitals for the amount of the privilege up to the amount paid by the insurer or other person. La. Rev. Stat. Ann. §46:446(H).

As for health insurers, any company which contracts for health care benefits for an employee has a right of reimbursement against the workers' compensation insurer if the health insurer paid health care benefits for which the workers' compensation carrier is liable. La. R.S. §23:1205(B). The amount of reimbursement cannot exceed the amount of the workers' compensation insurer's liability for the workers' compensation benefit.

56. **What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers under state law. 45 C.F.R. §164.512(a)(1).

In any claim for compensation benefits, a health care provider who treated the employee for injuries related to the compensation claim must release any requested medical information and records relative to the employee's injury to the employee, the licensed and approved vocational rehabilitation counselor assigned to the employee's claim, other health care providers examining the employee, the employer and the employer's workers' compensation insurer. La. Rev. Stat. Ann. §23:1127(B). Records relating to other treatment or conditions can be obtained through subpoena or written release by the employee. Nevertheless, "any such records or information furnished to the employer or insurer or any other party pursuant to this Section shall be held confidential by them and the employer or insurer or any other party shall be liable to the employee for any actual damages sustained by him as a result of a breach of this confidence up to a maximum of $1,000.00, plus all reasonable attorney fees necessary to recover such damages." La. Rev. Stat. Ann. §23:1127(C)(4). These strict confidentiality provisions do not appear to create any conflict with federal law or the Health Insurance Portability and Accountability Act (HIPAA).

57. **What are the provisions for “Independent Contractors”?**


“Independent Contractor” means any person who renders service, other than manual labor, for a specified recompense for a specified result either as a unit or as a whole, under the control of his principal as to results of his work only, and not as to the means by which such result is accomplished, and are expressly excluded from the provisions of this chapter unless a substantial part of the work time of an independent contractor is spent in manual labor by him in carrying out the terms of the contract, in which case the independent contractor is expressly covered by the provisions of this chapter.
The courts’ interpretations of the definition of “independent contractor” have stated that the inquiry to determine whether a relationship is that of independent contractor or of employment hinges on a principal test: the control over the work reserved by the principal. The amount of supervision and control actually exercised is not the crucial question, but rather the amount of supervision and control reserved by the principal from the nature of the relationship. Fuller v. United States Aircraft Insurance Group, 530 So.2d 1282 (La. App. 2d Cir. 1988), writ denied, 534 So.2d 444 (La. 1988). There are eight factors to be considered in determining whether an individual would be considered an employee or an independent contractor:

1. The degree of supervision and control actually exercised by the principal over the work performed;
2. Whether the work undertaken can be discontinued or terminated at any time by either party and without a corresponding liability for its breach;
3. Whether the worker renders service for a specified price to be paid for a specified result either as a unit or a whole;
4. The manner in which the worker is carried on the payroll of the principal;
5. The right of the worker, whether exercise or not, to hire helpers and assistants;
6. The source of the materials and equipment to be used by the worker;
7. Whether the worker performing the services is an integral part of the principal’s business or whether he is independent of the principal’s business; and
8. Whether a person performs work for a principal on a continuing and exclusive basis.

Id. at 1289-1292.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

There are no specific provisions for independent contractors pertaining to professional employment organizations/temporary service companies/leasing companies. However, the Louisiana Workers Compensation Act provides tort immunity for both “statutory employers” and “borrowing employers”. With regard to statutory employers, La. Rev. Stat. Ann. §23:1061(A)(1) provides in pertinent part that when any “principal” undertakes to execute any work which is part of his trade, business or occupation and contracts with any “contractor” for the execution by or under the contractor of the whole or any of the work undertaken by the principal, then the principal is entitled to immunity and becomes responsible for the payment of workers compensation benefits. Work is considered to be part of the principal’s trade, business or occupation if it is integral part of or essential to the ability of the principal to generate that individual principal’s goods, products or services.

La. Rev. Stat. Ann. §23:1061(A)(2) states that a statutory employer relationship shall exist whenever the service or work performed by the immediate employer is contemplated by or
included in a contract between the principal and any person or entity other than the employee’s immediate employer. If this section is not satisfied La. Rev. Stat. Ann. §23:1061(A)(3) provides that a statutory employer relationship shall not exist unless there is a written contract between the principal and a contractor which is the employee’s immediate employer or statutory employer, which recognizes the principal as the statutory employer. If such a written contract has been executed there is a rebuttable presumption that a statutory employer relationship exists.

An entity can also be considered an employer for workers compensation purposes pursuant to the “borrowed servant” doctrine. La. Rev. Stat. Ann. §23:1031(C) states in part that when an employee is employed by a borrowing employer and is under the control and direction of the borrowing employer in the performance of the work, the borrowing employer and the immediate employer are jointly liable for the payment of workers compensation benefits. The borrowing employer is also entitled to the exclusive remedy provisions of the Act.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Yes. La. Rev. Stat. Ann. §23:1021(10) defines “owner/operator” and provides that such owner/operators are independent contractors pursuant to the Louisiana Workers’ Compensation Act. The article provides as follows:

“Owner/operator” means a person who provides trucking transportation services under written contract to a common carrier, contract carrier, or exempt haulers which transportation services include the lease of equipment or a driver to the common carrier, contract carrier, or exempt hauler. An owner/operator, and the drivers provided by an owner/operator, are not employees of any such common carrier or exempt hauler for the purposes of this chapter if the owner/operator has entered into a written agreement with the carrier or hauler that evidences a relationship in which the owner/operator identifies itself as an independent contract. For purposes of this chapter, owner/operator does not include an individual driver who purchases his equipment from the carrier or hauler, and then directly leases the equipment back to the carrier or hauler with the purchasing driver.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices"
plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Donald E. McKay, Jr., Esquire
Dmckay@LeakeAndersson.com
Tel: (504) 585-7500
1. Citation for the state's workers' compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

An employee is defined as "every person in the service of another under any contract of hire, express or implied, oral or written." 39-A M.R.S. § 102(11). Owners of businesses may elect to be covered. The term employer excludes independent contractors, and persons engaged in maritime employment who are within the exclusive jurisdiction of admiralty law of the United States. Certain agricultural employees are exempt. See answer 5.

3. Identify and describe any "statutory employer" provision.


4. What type of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

Injuries are in five categories: "traumatic physical, gradual physical, traumatic mental, gradual mental and occupational disease." There is no "by accident" requirement. A single traumatic physical injury is compensable, as is a gradual physical injury that results from a series of repetitive events over time which produce physical symptoms and result in incapacity. The burden of proof is on the employee to demonstrate, by a preponderance of evidence that the injury arose out of and in the course of the employment. Traumatic mental injuries are similarly compensable, with the same burden of proof.
B. Occupational disease (including respiratory and repetitive use).

Occupational disease has been covered since January 1, 1946. The employee has the burden of demonstrating, by a preponderance of the evidence that the disease is due to conditions characteristic of a particular trade, occupation, process or employment and that arises out of and in the course of the employment.

Gradual mental injuries caused by cumulative work-related stress are compensable, but the employee must demonstrate, by clear and convincing evidence: (1) that he or she was subject to greater pressures and stressors than the average employee; and (2) work stress was the predominant cause of the condition complained of.

Moreover, a gradual mental injury is not work-related if it results from disciplinary action, work evaluations, job transfers, layoffs, demotions, terminations, or any similar action taken by the employer in good faith. 39-A M.R.S. § 201(3). If a law enforcement officer, firefighter, or emergency medical services person is diagnosed by a licensed psychiatrist or a psychologist with post-traumatic stress disorder that resulted from work stress which was extraordinary or unusual compared with that experienced by the average employee and the work stress and not some other source of stress was the predominant cause of the post-traumatic stress disorder, the post-traumatic stress disorder is presumed to have arisen out of and in the course of the workers’ employment. This presumption may be rebutted by clear and convincing evidence 39-A M.R.S. § 201(3-A).

5. What, if any, injuries or claims are excluded?

Rideshare - Injuries while participating in a private, group, or employer sponsored car pool, van pool, commuter bus service or other rideshare program are not compensable. The provision does not apply to drivers, mechanics, or anyone else employed in the operation of the car pool or rideshare program. 39-A M.R.S. § 201(2).

Domestic Service - Employees who are "engaged in domestic service" at the time of the injury are not covered by the Act. 39-A M.R.S. § 401.

Miscellaneous Agricultural Injuries - There are several exemptions for injuries sustained in the course of agricultural employment. Employers of seasonal or casual employees in agriculture or aquaculture are not required to provide workers' compensation benefits as long as they maintain employers' liability insurance coverage within specified limits. Further, employers of six or fewer such employees need not provide coverage if they obtain employers' liability insurance coverage and medical payment coverage within certain limits. Finally, those employed by agricultural employers in the harvesting of 150 cords of wood or less per year from farm wood lots are not considered to be employees within the Act. See 39-A M.R.S. §§ 102 & 401.

Maritime Employment - Individuals within the exclusive jurisdiction of the admiralty laws of the United States are not employees within the meaning of the Act.
Employer-Sponsored Athletic Event - Individuals injured while voluntarily participating on an employer sponsored athletic team, or in an employer sponsored athletic event, are not considered employees under the Act. 39-A M.R.S. § 102(11).

Real Estate Brokers - If a real estate broker or salesperson has signed a contract with an agency acknowledging an independent contractor relationship, and if the broker receives pay exclusively through commissions, the broker is not considered an employee. Id.

6. **What psychiatric claims or treatments are compensable?**

   See answer 4.

7. **What are the applicable statutes of limitations?**

   Any claim for injury must be brought within two years after the date of the injury or six years after the date of the most recent payment of benefits made on account of the injury. The two year statute of limitations does not begin to run, however, until an employer files a First Report of Injury as required by the statute. If an injury has been accepted with a compensation payment scheme, the only limitations applicable is that no petition of any kind is allowed after a certain number of years following the last payment of benefits. For injuries occurring on or after October 17, 1991, that is six years. For injuries prior to that date, the period was ten years from the date of the last payment. 39 M.R.S.A. § 95 and 39-A M.R.S. § 306. However, these periods are also tolled until the employer files a required First Report of injury.

8. **What are the reporting and notice requirements for those alleging an injury?**

   For injuries prior to January 1, 2013, an employee is required to give notice of an injury within 90 days after the date of injury. For injuries on or after January 1, 2013 and prior to January 1, 2020, notice must be given within 30 days of the date of injury. For injuries on or after January 1, 2020, notice must be given within 60 days of the day of injury. The notice must include the time, place, cause and nature of the injury, together with the name and address of the employee. 39-A M.R.S. § 301. Failure to give notice does not render a claim invalid if the employer had actual knowledge or if the employee was unable, by reason of physical or mental incapacity, to give timely notice. In cases of death, notice must be given within three months after death. 39-A M.R.S. § 302.

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

      Benefits are not allowed for injury or death occasioned by the employee's willful intention to bring about the injury or death. 39-A M.R.S. § 202.

   B. **Willful misconduct, "horseplay," etc.**
The statute does not specifically mention the term "horseplay," but the Maine Supreme Court has held that injuries which occur as the result of playful misbehavior on the job are not compensable. This is based upon an employee's conduct that represents a substantial departure or deviation from normal employment responsibilities. An innocent victim of horseplay, however, is entitled to compensation. See Bouchard v. Sargent, 127 A.2d 260 (Me. 1957).
C. **Injuries involving drugs and/or alcohol.**

Injury or death resulting from the employee's intoxication while on duty is not compensable, unless the employer knew at the time of the injury that the employee was intoxicated or was in the habit of becoming intoxicated while on duty. 39-A M.R.S. § 202.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

An Abuse Investigation Unit has been established for the purpose of investigating fraud and improper conduct in conjunction with workers' compensation. All parties are required to cooperate with the Unit, and, after concluding its investigation, the Unit reports its findings to the Workers' Compensation Board. If the Board then determines that "a fraud, attempted fraud or violation of this Act or rules of the Board may have occurred," it must report its findings and all supporting information to the office of the Attorney General. The Attorney General may then take appropriate action, including criminal prosecution and a civil action to recover funds paid. 39-A M.R.S. § 360.

In addition, any party may petition the Board to annul a compensation agreement if the agreement was entered into on the basis of mistake of fact or fraud. This section has limited applicability, however, since approved agreements for payment of compensation essentially no longer exist under the current statutory framework. However, the Act provides that any party may petition to re-open a compensation payment scheme where fraud on the part of the opposing party is alleged. Such a petition must be brought within one year after the initiation of the scheme. If the Board finds that fraud occurred, the case may then be re-opened and the Board may either terminate or modify the employee’s obligation to make payment. 39-A M.R.S. § 321.

Finally, the Workers' Compensation Board may assess a civil penalty up to $1,000 for an individual, and $10,000 for a corporation, for "any willful violation of this Act, fraud, or intentional misrepresentation." The Board may also require an employee to repay any compensation received as the result of a violation of the Act, fraud, or intentional misrepresentation, together with interest at a 10% annual rate. Penalties assessed by the Board are enforceable by the Superior Court, and all penalties are payable to the General Fund of the State of Maine. Incidentally, a penalty assessed against an insurer may not be considered an element of loss for the purpose of establishing a rate for workers' compensation insurance. 39-A M.R.S. § 360(2).

11. **Is there any defense for falsification of employment records regarding medical history?**

No.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**
13. **Are injuries by co-employees compensable?**

An innocent victim of horseplay is entitled to compensation. *See* Answer 9B. Injuries resulting from disputes between employees are compensable if the dispute arose out of the requirements of the job or the method of job performance. Injuries related to private disputes that happen to occur at work are not compensable.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

The answer is not clear. The fact that an injury occurs on the employer’s premises has never been sufficient, by itself, to render an injury compensable. *See Barrett v. Herbert Engineering, Inc.*, 371 A.2d 633 (Me. 1977). Compensation was denied to a surviving dependent of an employee who was shot and killed on the job by a crazed gunman. *Hawkins v. Portland Gaslight Co.*, 43 A.2d 718 (Me. 1945). On the other hand, compensation was awarded to a woman who was raped on the job by a non-employee where the location, the lack of lighting, and other circumstances of employment enhanced the risk of such criminal activity.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage includes the amount received at the time of injury for the hours and days constituting a regular full work week, provided the employee was employed for at least 200 full working days during the year prior to the injury. In cases of piece employees or employees whose wages vary from week to week, the wages are averaged by determining the entire amount of wages or salaries earned by the employee during the year preceding the injury and dividing that number by the total number of weeks, any part of which the employee worked, during the same period. For "seasonal workers," the wage is determined by dividing the total wages for the prior calendar year by 52. The average weekly wage does not include fringe benefits or other benefits paid by the employer that continue during disability. Any fringe or other benefit paid by the employer that does not continue during disability must be included for purposes of determining an employee's average weekly wage to the extent that the inclusion will not result in a weekly benefit that is greater than two-thirds of the state average weekly wage at the time of injury. For injuries on or after January 1, 2020, this is increased to greater than two-thirds of 125% of the state average weekly wage at the time of injury.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**
For injuries from January 1, 1993 through December 31, 2012, lost time benefits are based upon 80% of the employee's after-tax average weekly wage, subject to the maximum benefit provided under 39-A M.R.S. § 211, which is 90% of the state
average weekly wage as adjusted annually. As of July 1, 2019, the maximum rate is $771.11 (90% of the 2014 SAWW of $856.79). It will be adjusted again on July 1, 2020, and each July 1 thereafter.

17. For injuries beginning on January 1, 2013, lost time benefits are calculated based upon two thirds of the average weekly wage. For injuries from January 1, 2013 through December 31, 2019 the maximum rate is 100% of the SAWW. As of July 1, 2019, the maximum rate for these injuries is $856.79, and it will be adjusted on July 1, 2020 and on each July 1 thereafter. For injuries beginning on January 1, 2020, the maximum rate is 125% of the SAWW. As of January 1, 2020, the maximum rate for these injuries is $1,070.99, and it will be adjusted on July 1, 2020 and on each July 1 thereafter.

How long does the employer/insurer have to begin temporary benefits from the date disability begins?

The employer must begin payment, or indicate that a controversy exists, within 14 days from the date disability begins.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?

The employee must be out 15 days before recovering benefits for the first 7 days. See 39-A M.R.S. § 204.

19. What is the standard/procedure for terminating temporary benefits?

If the employee returns to work for the employer paying benefits under the Act, the employer may unilaterally terminate benefits by filing a Discontinuance form with the Workers' Compensation Board. In circumstances other than a return to work for the employer paying benefits under the Act, or increase in pay, and if there is no compensation payment scheme in effect, the employer may discontinue or reduce benefits no earlier than 21 days from the date it provides notice to the employee by certified mail of its intent to do so, together with the information relied upon in making that decision. Benefits may then be terminated on the 21st day and an employee who disagrees is entitled to a hearing.

If a compensation payment scheme is in effect and the employee has not returned to work for the employer paying benefits under the Act, the employer/insurer must petition the Board for an order to reduce or discontinue benefits and may not reduce or discontinue benefits until a decision is received on the petition. See 39-A M.R.S. § 205.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

Yes. See 39-A M.R.S. §§ 212-213.
21. **What disfigurement benefits are available and how are they calculated?** For injuries occurring between 1965 and November of 1987, facial disfigurement awards
were allowed as part of the specific loss or permanent impairment provision of the statute. From November of 1987 until December 31, 1992, permanent impairment was based upon whole-person impairment schedules formally published and recognized in the American Medical Association's Guide to the Evaluation of Permanent Impairment. The new statute, effective January 1, 1993, does not appear to provide for awards for disfigurement.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled member/parts, and the standard for recovery?

The statute provides specific schedules of benefits available for losses of certain body parts. The number of weeks varies for each portion of the body involved, and it appears that the benefits are available only for actual amputations or losses of the body parts in questions. 39-A M.R.S. § 212(3).

B. Number of weeks for "whole person" and standard for recovery.

For injuries from January 1, 2006 through December 31, 2012, benefits for partial incapacity must be paid for the duration of the disability if the permanent impairment attributable to the injury, as calculated by the fourth edition of the AMA Guide, is in excess of 12% to the whole body. If the permanent impairment is not in excess of 12%, and the employee is partially incapacitated, incapacity benefits are limited to 520 weeks. For injuries prior to January 1, 2006, consult the Workers’ Compensation Board Rules and Regulations for the applicable permanent impairment threshold. Me. W.C.B. Rule Ch. 2, § 1.

For injuries from January 1, 2013 through December 31, 2019, an injury causing partial incapacity is generally limited to 520 weeks of incapacity benefits. However, extended partial incapacity benefits are available if, at the expiration of 520 weeks of benefits, the employee is working and legitimately demonstrates an earning capacity which is 65% or less of the pre-injury average weekly wage, and if the permanent impairment caused by the injury is in excess of 18%. This provision is designed to provide extended benefits for employees with relatively severe injuries who have returned to work and have a significant long-term loss of earning capacity.

For injuries beginning on January 1, 2020, an injury causing partial incapacity is generally limited to 624 weeks of incapacity benefits.

Regardless of whether the injury is before or after January 1, 2013, an additional possible extended benefit for partial incapacity is available, if the employee can demonstrate that he or she is unable to find work and as a result is experiencing extreme financial hardship.
Regardless of the duration of entitlement, for injuries before January 1, 2013, partial incapacity benefits are based upon 80% of the difference between the employee’s pre-injury, after-tax average weekly wage and the after-tax average
weekly wage that the employee is able to earn post-injury. For injuries after January 1, 2013, benefits are based upon two thirds of the difference between the pre-injury average weekly wage and the amount the employee is able to earn post-injury. All benefits are subject to the maximum benefit level as indicated in 39-A M.R.S.§ 211. See 39-A M.R.S. § 213(1) and Answer 16 supra.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

In the prior Workers’ Compensation Act, Maine had an extensive vocational rehabilitation statute, with rules and regulations promulgated by the Board. These provisions were repealed effective January 1, 1993. At present, it appears that vocational rehabilitation will generally be done on a voluntary basis, though the statute does provide that, if vocational rehabilitation is necessary for a return to employment, it may be mandated by the Workers’ Compensation Board. See 39-A M.R.S. § 217.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

For injuries prior to January 1, 2013, total disability benefits are based upon 80% of the employee's after-tax average weekly wage, subject to the statutory maximum indicated in 39-A M.R.S. § 211. See 39-A M.R.S. § 212. See also Answer 16 supra. For injuries after January 1, 2013, total disability benefits are based upon two thirds of the average weekly wage, subject to the maximum rate.

Benefits are available for the duration of total disability. Once the employee's disability becomes partial, the limitation of benefits set forth in Answer 22 applies.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral Expenses.**

The employer must pay reasonable expenses of burial up to $4,000.00, and an additional payment of $3,000.00 as incidental compensation. The burial expense must be paid to the person who has paid or is responsible for paying the expenses. The incidental compensation must be paid to the employee's estate. See 39-A M.R.S. § 216.”

B. **Dependency claims.**

If death results from the injury, the employer shall pay the employee's dependents a weekly payment equal to 80% of the employee's after-tax average weekly wage, but not more than the maximum benefit referred to above, for a period of 500 weeks from the date of death. For injuries beginning January 1, 2013, the weekly compensation rate is two thirds of the average weekly wage, subject to the maximum rate. If, at the expiration of the 500-week period, any wholly or
partially dependent person is less than 18 years of age, the employer shall continue
to pay weekly compensation until that person reaches age 18. See 39-A M.R.S. §
215.

26. What are the criteria for establishing a "second injury" fund recovery?

There is no such fund at this time.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

In any case where a compensation payment scheme exists, an employee may, at any time up to six years from the date of the last payment, petition the Workers' Compensation Board for increased disability benefits based upon recurring or worsened disability. Conversely, the employer may also petition the Board at any time for a reduction of benefits.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

The Maine statute has changed many times over the past ten years on this issue. For injuries prior to January 1, 1993, the employee's attorney has to establish that he or she "prevailed" in order to recover fees from the employer. The standard has been interpreted very liberally by commissioners and courts, and simply maintaining the protection of the statute has been considered adequate. For injuries on or after January 1, 1993, the statute provides that, in all circumstances, the employees are responsible for their own attorney's fees.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

An employer who has secured the payment of compensation is exempt from civil actions involving personal injury sustained by an employee arising out of and in the course of employment, or from a death resulting from those injuries. The exclusivity applies to all employees, supervisors, officers, and directors of the employer, and is well supported by case law.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

Exclusivity does not apply to an illegally employed minor. 39-A M.R.S. § 408(2).

30. Are there any penalties against the employer for unsafe working conditions?
Yes. In addition to standard OSHA requirements, the Maine criminal law was recently amended and a person is guilty of criminal manslaughter if that person "[h]as direct and personal management or control of any employment, place of employment or other employee, and intentionally or knowingly violates any occupational safety or health standard of this State or the Federal Government, and that violation in fact causes the death of an employee and that death is a reasonably foreseeable consequence of the violation." The provision does not apply to any person who performs a public function on a volunteer basis or to any public employee responding to or acting in a life threatening situation and who is attempting to save a human life. 17-A M.R.S. § 203.

31. **What is the penalty, if any, for an injured minor?**

None, but the employer may be subject to other penalties for violating Maine employment laws. See answer to question 29.

32. **What is the potential exposure for "bad faith" claims handling?**

The statute contains penalties for failure to pay benefits in a timely fashion. Current penalties include payment of up to $50.00 per day for violations, subject to a $1,500.00 maximum. 39-A M.R.S. §§ 205, 324. In addition, case law recognizes a tort remedy for bad faith handling of claims. *Gibson v. National Ben Franklin Ins. Co.*, 387 A.2d 220 (Me. 1978). The damages available are the typical loss of consortium, etc. damages available in any tort action, including pain and suffering. The Maine Supreme Court has recently recognized a cause of action against an insurance carrier and a private investigation company for torts committed in the course of surveillance activity. *Hawkes v. Commercial Union Insurance Co.*, 2001 Me. 8 (January 16, 2001). The Court held that the carrier had immunity for personal injuries such as mental injuries, but that the insurance carrier could be liable for torts that are not personal injuries, such as trespass, intrusion of privacy, or economic injuries.

33. **What is the exposure for terminating an employee who has been injured?**

Maine law prohibits discrimination against an employee who has brought a workers' compensation claim or has testified in a related proceeding. If an employee prevails in a discrimination case, the Administrative Law Judge may award the employee reinstatement to the previous job, back wages, re-establishment of employee benefits, and reasonable attorney's fees. 39-A M.R.S. § 353.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes.

35. **Can co-employees be sued for work-related injuries?**
36. **Is subrogation available?**

Yes. See Me. Rev. Stat. Ann. tit. 39-A, § 107. The basic procedure is that an employee who is receiving compensation benefits has the option of pursuing a third party claim against the nonemployer tortfeasor. If the employee chooses not to do so, after notice, the employer may sue in the employee's name. If the employee controls the suit, he or she must repay benefits from the recovery, less the employee’s proportionate share of costs of collection, including reasonable attorney's fees. If the employer controls the lawsuit and recovers damages in excess of compensation or benefits paid for or for which the employer has become liable, any excess must be paid to the employee, less the proportionate share of the expenses of costs of collections, including attorney's fees. Settlement of subrogation claims and the distribution of proceeds therefrom must be approved by the Superior Court.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Where there is no ongoing dispute, if medical bills are not paid within 30 days after the employer/insurer has received notice of non-payment by certified mail, $50.00 or the amount of the bill due, whichever is less, must be added and paid to the Workers' Compensation Board Administrative Fund for each day over 30 days in which the medical bills are not paid. No more than $1,500.00 may be added to the bill. See 39-A M.R.S. § 205.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

Both the employer and the employee are required to provide copies of medical reports to the opposing party within seven days of receipt. In addition, a party desiring to offer a medical report as an exhibit in a testimonial hearing must serve a copy of the report upon the opposing party at least 14 days before the scheduled hearing. In practice, medical reports and similar documentation are freely exchanged by the parties. 39-A M.R.S. § 206(9).

A signed certificate authorizing the release of medical or health care information for treatment rendered due to an occupational injury is no longer required. 39A M.R.S. § 208.

39. **What is the rule on choice (a) claimant’s choice of physician; (b) employer’s right to a second opinion and/or Independent Medical Evaluation?**

For injuries on or after January 1, 1993, the employer initially has the right to select a
healthcare provider. After 10 days from the inception of treatment, the employee may select a different provider by giving the employer notice of an intention to treat. If the employer objects to the named provider, it may file a petition indicating the objection, which will then be set for dispute resolution proceedings.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Maine law is very liberal with respect to covered treatment and provides for coverage for any reasonable and proper medical, surgical, hospital services, nursing, medicines, mechanical, surgical aids, etc. Case law has allowed treatment by acupuncture and other novel treatment methods. The state does have a medical utilization review procedure that has not been frequently used and the effectiveness of which has not yet been determined.

41. **Which prosthetic devices are covered, and for how long?**

Prosthetic devices determined by a fact-finder to be reasonable and necessary for treatment of the injury are covered for the duration of the need. See 39-A M.R.S. § 206(8).

42. **Are vehicle and/or home modifications covered as medical expenses?**

These are not specifically covered in the statute, but Administrative Law Judges from time to time, have found them to be covered.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes.

44. **What, if any, provisions or requirements are there for "managed care"**

None.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

An employer contests a claim by filing a Notice of Controversy with the Workers' Compensation Board and with the employee. The form must be filed with the Board electronically.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

Maine law was radically revised effective January 1, 1993. The current law
provides for an initial conference to resolve a dispute by informal means. If that is unsuccessful, a disputed claim must undergo mandatory mediation. If that is unsuccessful at totally resolving the claim, all unresolved issues go to formal hearing before an Administrative Law Judge of the Workers' Compensation Board.

The Administrative Law Judge resolves disputed issues of fact and also rules on issues of law. Parties, at their option, may elect to arbitrate disputes rather than go through the formal hearing process. The Rules of Evidence do not apply at proceedings before the Board, but Rules of Privilege do apply.

B. Trial court

Not applicable.

C. Appellate.

Legislation in 2012 established the Appellate Division of the Workers' Compensation Board, comprised of a panel of three Administrative Law Judges other than the Judge who issued the initial decision, to review the initial Administrative Law Judge's decision. An appeal from the decision of the Appellate Division decision may be made to the Maine Supreme Court. Review by the court is discretionary and is restricted to errors of law.

There is also a provision that the Workers' Compensation Board itself, which is comprised of six individuals (three representatives of labor and three representatives of management) and the Executive Director, who serves as a tie-breaker, may review a decision of the Administrative Law Judge if the Judge asks for a review of his or her decision. In that situation, the parties may appeal the decision of the Board to the state Supreme Court, which—as noted above—is a discretionary appeal.

47. What are the requirements for stipulations or settlements?

The parties may stipulate at any point in the proceedings. Stipulations will be incorporated into a mediator or Administrative Law Judge's report. They must be signed by the parties and are thereafter binding. Lump sum settlements of cases must be approved by an Administrative Law Judge.

48. Are full and final settlements with closed medicals available?

Yes. A settlement, in order for it to be approved, must be considered to be in the best interest of all parties. “… A settlement may not occur until six months has passed from the date of injury and requires a recorded hearing before the Workers’ Compensation Board. Generally, this is delegated to Administrative Law Judges. The Administrative Law Judge must review the employee's rights under the statute and the effect of a lump
sum settlement on those rights. The Administrative Law Judge must review the purpose for which the
settlement is requested and take into consideration all of the employee's post-injury earnings and prospects. In the case of a lump sum settlement that requires a release of the Employer from liability for future medical expenses, the Board can approve the settlement only if it finds that the parties would have been unlikely to reach agreement on the amount of the lump sum settlement without the release of those medical expenses. Such approval is routinely given. See 39-A M.R.S. § 352.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. See answer 47.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Every employer must secure coverage. The failure to do so subjects the employer to potential criminal sanctions. Generally, the method for securing compensation is to obtain coverage through an insurer. There is a private, although somewhat restricted, market. An employer unable to obtain coverage through the private market in the past has been relegated to an assigned risk pool, but that entire process was terminated through statutory reform effective January 1, 1993. Since that time, employers unable to secure private insurance must apply to and be accepted by the Maine Employers Mutual Insurance Company (MEMIC), a company owned by the employers who obtain coverage through it.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

In order to be self-insured, an individual employer must submit an appropriate application to the Maine Bureau of Insurance, the essential purpose of which is to satisfy the Bureau of the employer's financial and administrative ability to pay compensation benefits to its employees.

B. For groups or "pools" or private entities.

In cases where an employer is not large enough to obtain self-insurance individually, Maine law does allow trusts of private entities to form which may obtain self-insurance status by pooling assets and liabilities. See 39-A M.R.S. §§ 401 through 409.

52. Control Act indicates that they cannot be employees although most state acts include them within the definition of ‘employee’?

There is no statutory provision or case that directly resolves this issue. The Maine Law
Court, however, has held that a material misrepresentation on an employment application is not a bar to receipt of wage loss benefits. It is the opinion of our firm that defending a case on the basis of no employment relationship because of illegal immigrant status would have less than a 50/50 prospect of success.

53. **Are terrorist acts or injuries covered or excluded under workers-compensation law?**

There are no special provisions relating to injuries caused by terrorist related acts.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

There is no provision in the Maine Workers’ Compensation Act that addresses the Medicare Secondary Payer Act or the issues associated therewith.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers-compensation law and how are they affected by state and federal law (HIPAA)?**

At the present time, the Health Insurance Portability and Accountability Act (HIPAA)—45 C.F.R. parts 160-164 and 65 F.R. 82462—is in effect. The law provides an exception for workers-compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l).] Therefore, the current practice of obtaining medical records could proceed under state law.

See answer to Question 38. Federal and state privacy laws apply to all medical records that are not generated by direct treatment for the work injury. A lawful release or discovery order is required for production of all records of treatment for other (non-work-related) conditions.

57. **What are the provisions for “Independent Contractors”?**

The issues pertaining to “Independent Contractors” are addressed in various provisions
within the Maine Workers’ Compensation Act, including the following:

A. 39-A M.R.S. § 102 (11)(A)(7), which excepts “Independent Contractors” from the general definition of “Employee;”

B. 39-A M.R.S. § 102 (11)(A)(8), which excepts employees of “Independent Contractors” from being employees of the person who hired the “Independent Contractor;”

C. 39-A M.R.S. § 102 (13-A), enacted in 2012, which provides a definition for “Independent Contractors;”

D. 39-A M.R.S. § 105, which allows for a procedure to obtain a predetermination of “Independent Contractor” status;

E. 39-A M.R.S. § 105-A, which was enacted in 2009 to provide a presumption of employee status for a person performing construction work on a construction site, unless the worker (1) is a “construction subcontractor”, the definition of which is the same as that of an independent contractor under §102 (13-A); or (2) owns or leases and operates an item of equipment weighing more than 7,000 pounds and is hired to operate the equipment on the construction site or to use the equipment to transport materials to or from the site.

F. 39-A M.R.S. § 401, which deals with the insurance requirements of private employers; and

G. 39-A M.R.S. § 906, which states that the liability of an employer to employees of an “Independent Contractor” is not barred if the injury was caused by “any defect in the condition of the ways, works, machinery or plant, if they are the property of the employer or are furnished by the employer and if the defect arose, or had not been discovered or remedied, through the negligence of the employer or of some person entrusted by the employer with the duty of seeing that they were in proper condition.”

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

There are no provisions in the Maine Workers’ Compensation Act that discuss “Independent Contractors” in the context of professional employment organizations/temporary service companies/leasing companies. Outside of the Maine Workers’ Compensation Act, however, there are provisions that deal specifically with Employee Leasing Companies and workers’ compensation insurance issues. See 32 M.R.S.A. § 14055.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or
property?

39-A M.R.S. § 105-A of the Maine Workers’ Compensation Act notes that, though there is a presumption that persons performing construction work on a construction site are employees of the person who hired him or her, there is an exemption from employee status if that person owns/operates equipment weighing more than 7,000 pounds. See also answer 57(E) supra.

60. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Maine offers medical marijuana registration cards for patients with debilitating medical conditions. ME. Rev. Stat. tit. 22 § 2425. A person may not be subjected to arrest, prosecution, penalty or disciplinary action, including but not limited to a civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, for lawfully engaging in conduct involving the medical use of marijuana. ME. Rev. Stat. tit. 22 § 2423-E.
Employers cannot discriminate against employees or applicants on the sole basis of their status as qualifying patients. ME. Rev. Stat. tit. 22 § 2423-E(2). However, employers are not required to accommodate marijuana use in any workplace or any employees working under the influence. ME. Rev. Stat. tit. 22 § 2426(2)(B).

61. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Under the Marijuana Legalization Act, persons 21 years or older may use, possess, and transport up to two and a half ounces of marijuana or combination of marijuana and marijuana concentrate; grow up to six flowering marijuana plants, 12 immature plants, and unlimited seedlings, and possess all the marijuana produced by the plants at the person’s residence; and purchase up to two and a half ounces of retail marijuana or up to 12 seedlings or immature plants. 7 M.R.S.A. § 2452.
An employer may not refuse to employ, discriminate, or otherwise penalize a person 21 years or older solely for that person’s consumption of marijuana outside the workplace. 7 M.R.S.A. § 2452(3). However, an employee need not permit or accommodate the use, consumption, or possession of marijuana in the workplace; may enact and enforce workplace policies restricting the use of marijuana by employees; and may discipline employees who are under the influence of marijuana in the workplace. 7 M.R.S.A. § 2452(2).

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1. Citation for the state's workers' compensation statute.

   Maryland Code Ann., Lab & Empl. §9-101 (2014) et seq.; Code of Maryland Regulations (COMAR) Title 14, §09.01.01 et seq.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?


3. Identify and describe any "statutory employer" provision.

   A principal contractor is liable to pay benefits to a covered employee of a subcontractor if the subcontractor does not have sufficient workers' compensation coverage. Md Code Ann., Lab. & Empl. §9-508.

4. What types of injuries are covered and what is the standard of proof for each:

   A. Traumatic or "single occurrence" claims.

   An "accidental personal injury" must arise from a specific traumatic event. Lab. & Empl. §9-101 (b); Schemmel v. T.B. Gatch & Sons Contracting & Building Co., 164 Md. 671, 166 A. 39 (1933). The "accidental injury" requirement can be satisfied by either a traditional trauma (slip, fall, etc.) or by a sufficiently unusual condition of the work at the time of injury. Benefits are available if a new accidental injury simply aggravates a pre-existing condition, but apportionment is available for permanency.
B. Occupational disease (including respiratory and repetitive use).

Maryland specifically recognizes occupational diseases of a gradual and insidious nature. The occupational disease must be caused by, not simply aggravated by, the employment. The occupational disease must be a risk inherent in the nature of the Claimant’s employment. King v. Bd. of Educ. of Prince George's Cty., 354 Md. 369, 731 A.2d 460. The employer/insurer of last injurious exposure is responsible for the entire claim. Md. Code Ann., Lab. & Empl. §9-502.

5. What, if any, injuries or claims are excluded?

Injuries that do not arise from a specific injury causing sudden mechanical change. Injuries must arise out of “and” in the course of “employment”.

6. What psychiatric claims or treatments are compensable?

An employee may recover benefits and medical expenses for harm resulting from an accidental personal injury. Md. Code Ann., Lab. & Empl. §9-660(a)(1). The Maryland Court of Appeals has held that purely emotional or psychological harm, unaccompanied by physical injury, may be compensable if caused by an accidental injury. Belcher v. T. Rowe Price, 329 Md. 709, 621 A.2d 872 (1993).

In Davis v. Dynacorp, 336 Md. 226, 647 A.2d 446 (1994), an employee filed a claim for an alleged occupational disease of a mental disorder resulting from harassment by management and co-workers. The Court of Appeals rejected the compensability of the claim because the alleged mental disorder was not due to the nature of an employment in which hazards of the alleged occupational disease exist. See answer 4B. The Court, however, expressly refused to rule out the possibility that some gradually resulting, purely mental diseases (without physical harm) could be compensable occupational diseases or that there may be circumstances where work induced stress may result in a compensable occupational disease.

More recently, the Maryland Court of Appeals handed down a decision March 4, 1997 in Means v. Baltimore County, 344 Md. 661, 689 A.2d 1238 (1997) finding that a post traumatic stress disorder may be compensable as an occupational disease if the employee presents sufficient evidence to meet the statutory requirements. See answer 4B. The case was remanded to the Circuit Court for further determination as to whether the employee had contracted post traumatic stress disorder, whether it arose out of and in the course of her employment, and whether the nature of her employment as a paramedic regularly exposed to grisly accident scenes entails the hazard of developing post traumatic stress disorder.

7. What are the applicable statutes of limitations?

The period of limitations for filing a claim is generally two years from the date of accidental injury, Md. Code Ann., Lab. & Empl. §9-709 (b) (3); 18 months from the date
of death from an accidental injury, Md. Code Ann., Lab. & Empl. 9-710(b); or, in the
case of occupational disease, two years from disablement or death, or from the date the
employee first knew the disability was caused by the employment, Md. Code Ann. Lab.
& Empl. §9-711. In accidental injury claims, the limitation period is tolled by failure to
file an Employers' First Report of accident if the injury resulted in compensable lost time
of more than three days. Md. Code Ann., Lab. & Empl. §§9-707, 9-708. The
employer/insurer may be "estopped" from raising limitations as a defense if they mislead
the employee about the filing requirements.

8. **What are the reporting and notice requirements for those alleging an injury?**

An employee has 10 days from the date of injury (or thirty days after death) within which
to notify the employer. Md. Code Ann., Lab. & Empl. §9-704. The employee must
notify the employer within one year after he or she knows or has reason to believe that he

9. **Describe available defenses based on employee conduct:**

   **A. Self-inflicted injury.**

Self-inflicted injuries are not compensable. Md. Code Ann., Lab. & Empl.§9-
506(a)(1). However, the law presumes injuries are not as a result of the
employee's deliberate act and the burden is on the employer/insurer to prove the

   **B. Willful misconduct, "horseplay," etc.**

Injuries arising from willful misconduct or "horseplay" in which the employee
actively participated are not compensable. Md. Code Ann., Lab. & Empl. §9-
506(d).

   **C. Injuries or occupational diseases involving drugs and/or alcohol.**

Injuries or occupational diseases caused solely by intoxication or the effects of
drugs not prescribed by a physician are not compensable. Md. Code Ann., Lab. &
Empl.§§9-506(b), 9-506(c).

If the primary cause of an injury or occupational disease is due to intoxication
from drugs not prescribed by a physician then only medical benefits can be

10. **What, if any, penalties or remedies are available in claims involving fraud?**

A person may not knowingly affect or attempt to affect the payment of compensation,
fees, or expenses in a workers' compensation claim by means of a fraudulent
subject to criminal penalties (misdemeanor or felony, depending on the value of benefits involved) and may not receive compensation, fees or expenses. The provision applies not only to the employee, but also to any and all persons in the workers' compensation system, including attorneys, employers, insurers, etc., who affect payment by means of a fraudulent representation.

Furthermore, "if it is established by a preponderance of the evidence that a person has knowingly obtained benefits. . . to which the person is not entitled," the Commission must order the person to reimburse the provider of the benefits for the full value of the benefits, plus interest "at a rate of 1.5% per month from the date the Commission notifies the person of the amount to be reimbursed." Md. Code. Ann., Lab. & Empl. §9-310.1.

11. Is there any defense for falsification of employment records regarding medical history?

Compensation for an occupational disease is prohibited if the covered employee falsely represented in writing that he or she had not previously been disabled, laid off, or compensated due to the occupational disease. Md. Code Ann., Lab. & Empl.§9-502 (e). The Americans with Disabilities Act may, as a practical matter, eliminate this statutory defense.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Injuries sustained during recreational or non-work activities may be compensable if the employer derived a benefit from the activity or sufficiently controlled or directed the employee's participation in it. Sica v. Retail Credit Co., 245 Md. 606, 227 A.2d 33 (1967); Turner v. State of Maryland, 61 Md. App. 393, 486 A.2d 804 (1985).

13. Are injuries by co-employees compensable?

Yes, provided the injury “arose out of and in the course of employment.” Rice v. Revere Copper & Bravo, Inc., 186 Md. 561, 48 A.2d 166 (1996).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?

Yes. When an employee is attacked by a third party, it is only necessary to show that the incident arose “in the course” of the employment; i.e., while the employee was on the job. Md. Code Ann., Lab. & Empl. §9-101(b); Giant Food, Inc. v. Gooch, 245 Md. 160, 225 A.2d 431 (1967). An injury that arises out of but does not occur “in the course of” is not compensable. Doe v. Buccini Pollin Group, Inc., 201 Md.App. 409 (2011).

BENEFITS

15. What criterion is used for calculating the average weekly wage?
The average weekly wage (AWW) is generally the gross average wage earned by the employee, including tips and overtime, during the 14 weeks before the accidental personal injury or last injurious exposure to the hazards of an occupational disease. Md. Code Ann., Lab. & Empl. §9-602; COMAR 14.09.01.07. Periods of involuntary layoff or involuntary authorized absences are not included in the 14 weeks. COMAR 14.09.01.07. Only the wages from the responsible employer, and not other simultaneously held jobs, are considered. Crowner v. Baltimore United Butchers Ass'n, 226 Md. 606, 175 A.2d 7 (1961). For sole proprietors, the AWW is calculated using the sole proprietor’s net profit and not gross receipts. Long v. Injured Workers’ Insurance Fund, 448 Md. 253 (2016).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Temporary total disability benefits are paid at two-thirds of an employee's average weekly wage, not to exceed the state average weekly wage (SAWW). The minimum compensation rate for temporary total disability is $50.00 unless the Claimant’s average weekly wage is less than $50.00 then the average weekly wage is the compensation rate. Md. Code Ann., Lab. & Empl. §9-621. For the year 2018, the maximum compensation rate for temporary total disability is $1,094.00.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

If the Commission finds that an employer/insurer has failed, without good cause, to begin paying an Award within 15 days, it shall assess a fine of up to 20% of the amount of the payment due. The maximum fine rises to 40% if payments are 30 days late. Md. Code Ann., Lab. & Empl. §9-728.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

An employee must be out 14 days before recovering benefits for the first 3 days. Md. Code Ann., Lab. & Empl. §9-620.

19. **What is the standard/procedure for terminating temporary benefits?**

The employer/insurer are entitled to unilaterally terminate temporary benefits when the employee achieves maximum medical improvement, based upon a medical exam or other good faith reason (e.g. surveillance), or when the employee is awarded permanency. Jackson v. Bethlehem-Fairchild Shipyards, 185 Md. 335, 44 A.2d 811 (1945). The employer/insurer must notify the Commission and the employee of the termination by
means of a form (WCC Form C-06), supplied by the Commission, attached to the last benefit check. The employer/insurer may also terminate benefits when the employee returns to work, and may do so without filing the form otherwise required.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**


21. **What disfigurement benefits are available and how are they calculated?**

Mutilations and disfigurements resulting from a compensable injury, or resulting from treatment for the injury, are compensable in the discretion of the Commission. The maximum award for disfigurement is 156 weeks. Md. Code Ann., Lab. & Empl.§9-627(i); *Bethlehem-Sparrows Point Shipyard, Inc. v. Damasiewicz*, 187 Md. 474, 50 A.2d 799 (1947). A Claimant may not simultaneously receive both disfigurement and permanent disability benefits for the same body part.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

For injuries occurring on or after January 1, 1988, Maryland has adopted a three tier system for permanent partial disability benefits. In general, for permanency awards of less than 75 weeks, the compensation rate equals one-third of the employee's average weekly wage, up to a maximum set yearly. (2018 maximum is $183.00). Md. Code Ann., Lab. & Empl. §9-628. This "minor disability" rate does not apply to public safety employees or to injuries to fingers or the great toe. Md. Code Ann., Lab. & Empl.§9-628.

For awards of 75 up to 249 weeks, the rate is two-thirds of the employee's average weekly wage, not to exceed a maximum set annually. (2018 maximum is $365.00). Md. Code Ann., Lab. & Empl. §9-629. The "serious disability" provision applies if the employee is entitled to 250 weeks or more of permanency benefits. For serious disability awards, the number of weeks of benefits is increased by one-third, and the compensation rate is two-thirds of the employee's average weekly wage, not to exceed 75% of the state average weekly wage. (2018 maximum is $821.00). Md. Code Ann., Lab. & Empl. §9-630.

**A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

The weeks awarded for loss of a scheduled member are as follows:

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<tr>
<th>Bodily Part</th>
<th>Maximum Weeks</th>
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B. Number of weeks for "whole person" and standard for recovery.

In all cases of permanent partial disability other than those listed as scheduled members ("Other Cases"), the Commission determines the industrial loss of use sustained by the employee. The award expresses the industrial loss of use as a percentage of loss of use of the whole body, which is 500 weeks. In determining industrial loss of use, the Commission considers evidence of anatomical disability, loss of wage-earning capacity, and the age, experience, occupation and training of the employee. Md. Code Ann., Lab. & Empl.§9-627(k).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Yes. When an employee is physically disabled by compensable injuries from performing work for which he or she was qualified at the time of the injury, the employee is entitled to vocational rehabilitation. Md. Code Ann., Lab. & Empl. §9-672. The employer/insurer pays the cost of the vocational rehabilitation assistance plus benefits as if the employee were temporarily totally disabled. Md. Code Ann., Lab. & Empl.§9-674.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total disability payments are two-thirds of the employee's average weekly wage, not to exceed the state average weekly wage ($1,1,094.00 in 2018). Md. Code Ann., Lab. & Empl. §9-637. Payments are made at least until they reach a total of

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<tr>
<th>Bodily Part</th>
<th>Maximum Weeks</th>
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<tr>
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<td>Middle finger</td>
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<td>Little finger</td>
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<td>Other toes</td>
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<td>Bodily Part</td>
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<td>Eye</td>
<td>250</td>
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<td>Loss of hearing:</td>
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<td>125</td>
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<td>Both ears</td>
<td>250</td>
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$45,000.00, but continue beyond that amount for so long as the employee remains totally disabled. *Id.*

25. **How are death benefits calculated, including the minimum and maximum rates?**

   **A. Funeral expenses.**

   Reasonable Funeral Expenses are payable up to $7,500.00. Md. Code Ann., Lab & Empl. §9-689.

   **B. Death benefits calculation.**

   Under the new law, for claims arising as of 10/1/11, the death benefits will be calculated by determining the total family income (the combined income of the decedent and all of the decedent’s dependents) and then dividing the decedent’s average weekly wage by the family income.

   The percent of the family income earned by the decedent is then multiplied by the "death benefit" rate (2/3 of the average weekly wage), to determine the amount payable to the dependents.

   For example, if the decedent’s average weekly wage was $600 and the other dependents earned an additional collective $600, the family income is $1200. The decedent’s income is 50% of the family income. The death benefit (just like the temporary total disability rate) is 2/3 of the average weekly wage, or $400. Therefore, since the decedent earned 50% of the family income, the dependents' benefits will be paid at 50% of the death benefit or at $200 per week.

   A cost of living adjustment (COLA) will apply to the death benefits.

   **C. Dependency benefits duration.**

   The dependents' benefits will be paid for 144 months (12 years), with certain exceptions.

   In all cases, benefits are payable for at least five years after the decedent’s death.

   If the surviving dependent is incapable of self-support due to a mental or physical disability that pre-exists the decedent’s injury, benefits will be paid for the duration of that dependent’s disability.

   Benefits will terminate two years after a dependent spouse remarries.

   If a dependent is a minor child, benefits will continue until 18, or for an additional 5 years if the dependent child remains in school.

   No benefits are payable after what would have been the decedent’s 70th birthday.
Again, all of these exceptions are subject to the rule that in all cases, a minimum of 5 years of benefits are payable.

D. **Death benefit savings.**

This new bill creates numerous savings for the defense, as all benefits will take into account the percentage of family income that the decedent contributed and all benefits will stop as of the 70th birthday of the decedent, rather than continuing into the "retirement" years until the survivors’ date of death.

No dependent will receive lifetime benefits, as benefits stop after 12 years, unless that dependent is already unable to support him- or herself, or is a minor child or a child in school.

E. **Conclusion.**

The new Death Benefits bill is effective for claims arising as of 10/1/11. It eliminated partial dependency but also eliminated a significant amount of total dependency claims.

26. **What are the criteria for establishing a "second injury" fund recovery?**

The Subsequent Injury Fund is responsible for paying the pre-existing portion of a permanency award only when 1) the previous impairment and subsequent impairment results in a permanent or partial impairment that is substantially greater due to the combined effects, than would have been from the subsequent impairment; 2) the combined effects of the previous and subsequent impairment result in a permanent disability of more than 50% to the whole body; and 3) the employee is entitled to a minimum of 125 weeks of benefits from the subsequent injury and 125 weeks from the pre-existing impairment (work-related or not). If all conditions are not met, the employee does not recover for the pre-existing disability, only for the new injury. Md. Code Ann., Lab. & Empl. §9-802.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

The Commission retains power and jurisdiction to readjust compensation for aggravation, diminution or termination of disability. This power can only be exercised if an application for re-opening is made within five years after the date the last compensation payment is received by the Claimant. Md. Code Ann., Lab. & Empl. §9-736. Payment of medical benefits does not constitute "compensation" for purposes of the five year limitations period. *Holy Cross Hosp. v. Nichols*, 290 Md. 149, 428 A.2d 447 (1981).

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**
The Commission sets the fees for employees' attorneys at a percentage of the award. Payment of the attorney's fees is deducted from the last weeks of the award. Md. Code Ann., Lab. & Empl. §9-731; COMAR 14.09.01.24. The Commission has discretion to award an attorney's fee in addition to the employee's award if the lawyer's time was necessitated by frivolous issues. Md. Code Ann., Lab. & Empl.§9-734.

EXCLUSIVITY/TORT IMMUNITY

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**


B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**


30. **Are there any penalties against the employer for unsafe working conditions?**

If a covered employee is injured or killed as a result of the *deliberate intent* of the employer, the employee may choose to proceed in tort rather than under workers' compensation. Md. Code Ann., Lab. & Empl. §9-509(d). However, deliberately placing an employee in a dangerous position, and willfully violating government regulations, does not constitute such a deliberate intent. *Johnson v. Mountaire Farms of Delmarva, Inc.*, 305 Md. 246, 503 A.2d 708 (1986). Once one remedy is chosen and pursued, the employee may not thereafter pursue the other remedy. *Wagner v. Allied Chem. Corp.*, 623 F.Supp. 1412 (D. Md. 1985).

31. **What is the penalty, if any, for an injured minor?**

A minor (under 18) who is employed without a work permit may, in the Commission's discretion, be awarded double compensation. The employer alone, not the insurer, must pay such additional benefits. Md. Code Ann., Lab. & Empl. §9-606.

32. **What is the potential exposure for "bad faith" claims handling?**

An employer/insurer may be liable in tort for emotional distress claims if its conduct is intentional, reckless, extreme and outrageous. *Gallagher v. Bituminous Fire & Marine*
In addition, in 1994 the Maryland Legislature amended the statutory provision relating to fraudulent representations, so that all persons in the workers' compensation system are subject to the same rule that had previously extended only to the employee: "[a] person may not knowingly affect or knowingly attempt to affect the payment of compensation, fees or expenses. . . by means of a fraudulent representation." Md. Code Ann., Lab. & Empl. §9-1106.

33. **What is the exposure for terminating an employee who has been injured?**

An employer may not discharge a covered employee solely because the employee has filed a claim. Md. Code Ann., Lab. & Empl §9-1105; *Ewing v. Koppers Co.*, 312 Md. 45, 537 A.2d 1173 (1988). It is a misdemeanor to wrongfully discharge an employee. Upon conviction, the terminating party is subject to a fine not to exceed $500.00 or imprisonment not exceeding 1 year or both (An. Code 1957, Art. 101, §39A; 1991, Ch. 8, §2). However, an employer may fill a position based on economic necessity when an employee has not returned to work. *Kern v. South Baltimore General Hosp.*, 66 Md. App. 441, 504 A.2d 1154 (1986).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-employees be sued for work-related injuries?**

Yes, co-employees are generally amenable to suit individually. *Hutzell v. Boyer*, 252 Md. 227, 249 A.2d 449 (1969). In addition, under certain limited circumstances the co-employee may "stand in the shoes" of the employer, making the employer vicariously liable, if the co-employee was the "alter ego" of the employer at the time of the occurrence. *Schatz v. York Steak House Sys.*, 51 Md. App. 494, 444 A.2d 1045 (1982). *But see, Federated Dep't Stores, Inc. v. Le*, 324 Md. 71, 595 A.2d 1067 (1991). Note, however, a supervisory co-employee who performs the nondelegable duty of the employer does not thereby assume a personal duty toward his or her fellow employee with respect to negligence actions. *Athas v. Hill*, 300 Md. 133, 476 A.2d 710 (1984).

36. **Is subrogation available?**

Yes. The employer/insurer has the exclusive right to bring suit against a third party within two months after the Commission makes an award. Md. Code Ann., §9-902. Once the two month period has elapsed, the employee and the employer/insurer each have the right to sue the third party. The employer/insurer have a lien against any third party recovery in the amount of benefits paid. The lien must be repaid "off the top" of any
third party recovery, less a prorated share of costs and attorneys' fees. In addition, the employer/insurer are entitled to a credit, for any excess above the lien recovered by the employee, against further compensation paid to the employee. *Id.*

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Generally, medical bills must be paid "promptly." Md. Code Ann., Lab. & Empl. §9-660. Unless the employer can show good cause, the Employer must pay within 45 days after the Commission issues its Order approving the fee, or treatment. The Commission may assess a fine, payable to the Commission, not to exceed 20% of any medical fee not paid promptly. Md. Code Ann., Lab & Empl. §9-664. COMAR 14.09.01.22.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The parties and their agents and attorneys are required to promptly provide to each other copies of all relevant medical information, including reports, evaluations, bills, etc., throughout the pendency of the claim. COMAR 14.09.01.10(A). In addition, upon request by the Commission or any party, a health care provider is required to provide copies of routine medical reports, records or bills in order to justify payment of medical bills. COMAR 14.09.01.10(B). "[U]nless the Commission orders otherwise for good cause shown, a party shall provide to any party, on written request, a medical authorization." COMAR 14.09.01.10(C). Counsel for the parties are authorized to issue subpoenas, under the authority of the Commission, to medical care providers. However, the opposing party must be given 30 days advance notice before a subpoena can be issued. If no objection is noted, subpoena can be issued after 30 day notice period. If objection is noted, a hearing will be held on validity of subpoena.

The fees for preparation and copying of such documents are limited to 50 cents per page for copying and mailing, plus a maximum fee of $15.00 for preparation and retrieval, and actual costs for postage and handling. Md. Code Ann., Health-General §4-304 I. Additionally, if a health care provider knowingly refuses to disclose a medical record within a reasonable time after a person in interest requests the disclosure, the health care provider is liable for actual damages. Md. Code Ann., Health-General I §4-309.

There are also certain procedures which relate to medical records at the permanent disability stage of the claim: not later than ten (10) days after the date of the Commission's Notice of Hearing relative to permanent disability, copies of evaluations and reports must be provided to other parties. In addition, the "Commission need not consider as evidence of permanent disability any medical information not completed or provided to other parties," unless the parties consent to the admission and the document is submitted not later than the date of the hearing. COMAR 14.09.01.12 (B).
39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Evaluations?**

In general, the employee selects treating physicians. The employer cannot control selection of treating physician. The employer may choose any physician to perform an independent medical examination.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Medical benefits are payable so long as they are reasonable, necessary, and causally related to the accidental injury or occupational disease. The Commission has discretion to determine whether the employer is liable for treatment. Md. Code Ann., Lab. & Empl. §9-660; *Queen v. Agger*, 287 Md. 342, 412 A.2d 733 (1980).

41. **Which prosthetic devices are covered, and for how long?**

If a compensable injury causes the need for a prosthetic device, or eyeglasses, the expense is reimbursable so long as it is required by the nature of the injury. Md. Code Ann., Lab. & Empl. §9-660. An employer/insurer must also repair or replace a prosthetic device damaged by accident during the course of employment. Md. Code Ann., Lab. & Empl.§9-661.

42. **Are vehicle and/or home modifications covered as medical expenses?**


43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. The "Guide of Medical and Surgical Fees", issued by the Workers' Compensation Commission, regulates medical and surgical fees. The "fee guide" also applies to fees charged by out-of-state providers on a Maryland claim. Providers may not seek further reimbursement directly from the employee. Md. Code Ann., Lab. & Empl. §9-663; COMAR 14.09.03.01. The fee guide has been held to be constitutional. *Falik v. Prince George's Hosp. & Medical Center*, 322 Md. 409, 588 A.2d 324 (1991).

44. **What, if any, provisions or requirements are there for "managed care"?**

None in Maryland.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**
When a claim is filed, the Commission notifies the employer/insurer by a copy of the claim form and a "C-40" form. The employer/insurer may contest any and all parts of the claim by filing "issues" prior to the "consideration date" established by the Commission and indicated on the C-40. Md. Code Ann., Lab & Empl. §9-713.

46. What is the method of claim adjudication?

A. Administrative level.

Any disputed issues in claims are initially heard before the Maryland Workers' Compensation Commission. The hearings are relatively informal, and there is no discovery. Live testimony is taken from the employee and lay witnesses, but expert evidence is introduced through written reports unless special provision is made (rarely done) for live expert testimony.

B. Trial court.

A party aggrieved by a decision of the Workers' Compensation Commission may appeal, as a matter of right, to the circuit court in the venue where the appellant resides, where the injury occurred or where the employer has their principal place of business. Md. Code Ann., Lab. & Empl. §§9-737 through 9-740. Such an appeal must be filed within 30 days of the Commission's decision. Trial in the circuit court is essentially de novo, with full discovery and the right to a jury trial, although there is a presumption in favor of the Commission's decision. Md. Code Ann., Lab. & Empl. §9-745.

As a general rule, an appeal does not "stay" an award, and the compensation ordered must be paid while an appeal is pursued by an employer/insurer. Md. Code Ann., Lab. & Empl. §9-741. However, an appeal does operate as a "stay" with respect to medical bills incurred prior to the date of an appealed order. University of Md. Medical Sys. Corp. v. Erie Ins. Exch., 89 Md. App. 204, 597 A.2d 1036 (1991). In addition, any attorneys fees that are ordered by the Commission may be held in escrow during the pendency of the appeal. COMAR 14.09.01.24(A)(4). If an award is reversed on appeal, the employer/insurer cannot recover from the employee amounts already paid, absent fraud by the employee. St. Paul & Marine Ins. Co. v. Treadwell, 263 Md. 430, 283 A.2d 601 (1971).

C. Appellate.

A party aggrieved by the decision of a circuit court may appeal as a matter of right to the Maryland Court of Special Appeals, with the same scope of review as in common law actions. Md. Code Ann., Lab. & Empl. § 9-750. A party aggrieved by a decision of the Court of Special Appeals must seek a writ of certiorari to the Court of Appeals of Maryland, the state's highest court.

47. What are the requirements for stipulations or settlements?
The Commission must approve any settlement of a workers' compensation claim. Md. Code Ann., Lab. & Empl. §9-722. The Commission will not approve a settlement agreement without a hearing, unless the agreement is accompanied by the employee's notarized affidavit, on the Commission form, waiving such a hearing. COMAR 14.09.01.19. In practice, such affidavits are generally provided and hearings are only held when the Commission initially disapproves the proposed settlement. Generally, the Commission requires the Agreement to account for Medicare’s interests and that future medicals be addressed, when appropriate.

A stipulated award for permanent disability must also be approved by the Commission. The proposed stipulation must be submitted on the form provided by the Commission, and must include specified information. Additional documentation is required if the employee is not represented by an attorney. COMAR 14.09.01.12(c).

48. **Are full and final settlements with closed medicals available?**

Yes.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

The employer must be insured for workers' compensation or qualify as a self-insurer. Md. Code Ann., Lab. & Empl. Code §9-402. The insurers available are acceptable private insurers or the state Injured Workers' Insurance Fund. There is no assigned risk pool in Maryland.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

Individual employers may self-insure with Commission approval. Md. Code Ann., Lab. & Empl. §9-403. The applicant must: (1) establish financial ability to pay claims as they become due; (2) post a required security (can be a letter of credit); (3) purchase excess insurance; (4) maintain an office in Maryland to handle claims; and (5) provide periodic

**B. For groups or "pools" of private entities.**

Group self-insurance is permitted. Md. Code Ann., Lab. & Empl. §9-402. The members of such a group must be engaged in the same or a similar type of business or be members of a bona fide trade or professional association which has been in existence for at least five years. COMAR 09.30.73.03. Such a group must obtain a certificate of authority from the insurance commissioner. Md. Code Ann., Lab. & Empl §9-404(d); COMAR 09.30.73.07.

The requirements are similar to those for individual self-insurance. The minimum annual collective premium is $250,000.00, and excess insurance must be purchased. Members of the group must agree to be jointly and severally liable for claims. COMAR 09.30.73.07.

**52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within definition of “employee”?

Yes, they are entitled to benefits.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Although there are no specific statutes or case law addressing coverage for such injuries, it is presumed that they would be compensable if they were found to constitute “accidental injuries arising out of and in the course of employment.”

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No. But, Maryland does recommend parties to address whether a party requires future medical care and to obtain a medical cost allocation for any settlement that contemplates closure of medicals.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

It is presumed that federal statutes addressing this issue would be dispositive. Maryland does require settlement agreements to address employers’ obligation to reimburse
Medicare for any provisional payment made on the Claimant’s behalf. Medical payments are controlled by a fee guide, and health insurers would only be entitled to enforce a lien to the extent coverage was required under the guide.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by the state and federal law (HIPPA)?**

At present, there are no Maryland statutes or case law addressing the applicability of HIPPA. In general, claimants sign releases to allow their employers to obtain copies of their medical reports and bills. Claimants are required to provide copies of all records and bills to the employer and/or insurer. Claimants are also required to sign a HIPAA compliant release with their claim forms.

57. **What are the provisions for “Independent Contractors”?**


58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Yes. Md. Code Ann., Lab. & Empl. §9-218(b). An individual who is an owner-operator is not a covered employee if (1) the individual and motor carrier make a written agreement for permanent or trip leasing; and (2) under the agreement: (i) there is no intent to create an employer-employee relationship; (ii) the individual is paid rental compensation; and (3) for federal tax purposes as an independent contractor.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.
Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

If a settlement exceeds $250,000 or the Claimant is a Medicare beneficiary, or anticipates becoming a Medicare beneficiary, a Medicare Set-Aside (MSA) must be included as part of the settlement and approved by the Centers for Medicare and Medicaid Services (“CMS”). The Commission is vested with the sole power of the approval of any settlement. Md. Code Ann., Lab. & Empl. §9-722.

62. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

Maryland has allowed for medical marijuana since 2014. The Maryland Medical Marijuana statute permits marijuana to be prescribed for: PTSD, a chronic or debilitating disease or medical condition that results in a patient being admitted into hospice or receiving palliative care; or a chronic or debilitating disease or medical condition or the treatment of a chronic or debilitating disease or medical condition that produces: cachexia, anorexia, or wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms. A physician may also prescribe marijuana to treat patients with a condition that is: (1) severe; (2) for which other medical treatments have been ineffective; and (3) if the symptoms reasonably can be expected to be relieved by the medical use of cannabis.

However, at this time there is no authority in Maryland indicating if medical marijuana is a treatment that can be provided under Workers’ Compensation, although some Commissioners are now ordered reimbursement of medical marijuana.

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Recreational marijuana remains illegal in Maryland.
1. Citation for the state's workers' compensation statute.

Massachusetts General Laws, Chapter 152.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for the purposes of workers' compensation?

An employee is defined as any person in the service of another under any contract of hire, express or implied, oral or written, who does not fall within one of the specific exclusions contained in Mass. Gen. L. c. 152, §1. A corporate officer or stockholder can also be considered an employee if employed by the corporation. Emery's Case, 271 Mass. 46 (1930). This chapter shall be elective for an officer or director of a corporation who owns at least 25 per cent of the issued and outstanding stock of the corporation. For the purpose of this chapter, a sole proprietor at his option or a partnership at its option shall be an employee. A sole proprietor or partnership may elect coverage by securing insurance with a carrier. Where there is a dispute whether an injured worker is an employee subject to coverage or an independent contractor, several factors inform the decision, but the most important is the right to direct and control the individual performance of the work. Camargo v. Publishers Circulation Fulfillment, Inc., 2016 WL 7335381 (Rev Bd. 12/9/16) (factors are as developed by workers compensation case law; the statutory tests of Mass. Gen. L. c. 149, §148B do not apply).

3. Identify and describe any "statutory employer" provision.

The most common statutory employer relationship is where an insured employer contracts to have part of its work performed by an uninsured independent contractor and an employee of the contractor suffers an industrial injury. Mass. Gen L. c. 152, §18.

4. What type of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.
For an injury to be compensable, it must arise out of and in the course of the employment. Mass. Gen. L. c. 152, §26. Any injury is compensable if it arises out of the "nature, conditions, obligations, or incidents of employment... looked at in any of its aspects." Matthews v. Liberty Mutual Insurance Co., 354 Mass. 470, 473 (1968). "Personal injury, as the term is used in the Act, encompasses physical as well as mental/emotional disabilities and is not limited to “bodily injury” or “physical impairment or damage.” Modica v. Sheriff of Suffolk County, 477 Mass. 102 (2017).

B. Occupational disease (including respiratory and repetitive use).

The definition for personal injury is the same whether the injury is classified as traumatic or an occupational disease. "Personal injury" includes infectious or contagious diseases if the employment exposes the employee to the risk of contracting such disease. Mass. Gen. L. c. 152, §1(7A).

5. What, if any injuries or claims are excluded?

None which arise out of and in the course of the employment. Generally, injuries on the employer’s premises are compensable whether or not the employee was actually performing work – the “going and coming” rule. See Kelbe’s Case, 85 Mass. App. Ct. 1125, 2014 WL 2608272 (2014).

However, if a compensable injury combines with a non-compensable, pre-existing condition to cause or prolong disability, the resultant condition is compensable only to the extent that the industrial injury remains a major cause of the disability or need for treatment. Mass. Gen. L. c. 152, §1(7A).

6. What psychiatric claims or treatments are compensable?

A psychiatric or emotional injury may be compensable if it resulted from a specific incident or series of specific incidents in the work place. However, no mental or emotional disability arising principally out of a bona fide personnel action, including a transfer, promotion, demotion or termination, is compensable, unless the action amounts to intentional infliction of emotional harm. Mass. Gen. L. c. 152, §1(7A). For injuries occurring on or after December 23, 1991, a claim for mental or emotional disability is only compensable when the predominant contributing cause of such disability is an event or series of events occurring within the employment. An employee may also be entitled to workers’ compensation benefits if he can show that the emotional disability was sequelae to a compensable physical injury. The intentional infliction of emotional distress on an employee is a compensable injury. Uwakwe v. Pelham Academy, 286 F.Supp. 3d 213 (D.Mass. 2017). An employee may receive permanent loss of function benefits under Mass. Gen. L. c. 152, , §36(1)(j) for a psychiatric injury. Litchfield’s Case, 86 Mass. App. Ct. 216 (2014); Yeshaiau v. Mount Auburn Hospital, 27 Mass. Workers Comp. Rep. (2013). Dependents of deceased employees who took their own lives are not "precluded from recovery … if it be shown by the weight of the evidence that, due to the injury, the employee was of such unsoundness of mind as to make him

7. **What are applicable statutes of limitations?**

A claim must be filed within four years of the date the employee first became aware of the causal relationship between the disability and the employment. Mass. Gen. L. c. 152, §41. In the event of death, a claim must be made within four years after the death. Payment of compensation, or the filing of a claim, tolls the statute of limitations for any benefits due as a result of that injury. See Mass. Gen. L. c. 152, §§41, 49. Statute of limitations is an affirmative defense which must be raised in proceedings at the DIA or is waived. *Barbosa v. Massachusetts General Hospital Corp.*, 2018 WL 1061316 (DIA Reviewing Board 2/9/18).

8. **What are the reporting and notice requirements for those alleging an injury?**

Under Mass. Gen. L. c. 152, §41, the employee is required to provide notice of claim to the employer or insurer "as soon as practicable after the happening thereof." The statute further provides, however, that want of notice shall not bar the proceedings unless the insurer was prejudiced. Mass. Gen. L. c. 152, §44. The employee has the burden of showing lack of prejudice.

9. **Describe available defenses based on employee conduct:**

**A. Self-inflicted injury.**

There is no provision barring benefits as a result of a self-inflicted injury. However, when an employee commits suicide, his or her dependents cannot recover benefits unless it is shown, by the weight of the evidence, that due to a work-related injury, the employee was of such unsoundness of mind that he or she could not be held responsible for the act of suicide. Mass. Gen. L. c. 152, §26A. *Chaput’s Case*, 85 Mass. App. Ct. 1113, 2014 WL 1385532 (2014).

**B. Willful misconduct, "horseplay," etc.**

A claim for injury caused by serious and willful misconduct is barred. Mass. Gen. L. c. 152, § 27. Serious and willful misconduct is defined as conduct quasi-criminal in nature, the intentional doing of something either with knowledge that it is likely to result in serious injury or with wanton and reckless disregard of its probable consequences. *Durgin's Case*, 251 Mass. 427 (1925). The employee’s misconduct must proximately cause the injury, and not be merely a coincident condition. *McDonald v. Brand Energy Services, Inc.*, 2015 WL 151663. Mere negligent conduct on the part of an employee does not preclude benefits. *Lawrence's Case*, 330 Mass. 244 (1953). An injury in the course of “horseplay” may not arise “in the course of employment.” Minor acts of horseplay may not result in non-compensability of a resulting injury. “[W]hether
initiation of horseplay is a deviation from course of employment depends on: (1) the extent and seriousness of the deviation, (2) the completeness of the deviation..., (3) the extent to which the practice of horseplay had become an accepted part of the employment, and (4) the extent to which the nature of the employment may be expected to include some such horseplay.” Kulisich v. Greater Lowell Family YMCA, 14 Mass. Workers’ Comp. Rep. 137 (2000), quoting 2A Larsen Workers’ Compensation Law, §23.01 (1999).

C. Injuries involving drugs and/or alcohol.


10. What, if any, penalties or remedies are available in claims involving fraud?

Any party, including an attorney or expert medical witness, who is found to have engaged in fraudulent conduct in connection with any proceeding must be reported to the general counsel of the Insurance Fraud Bureau. Fraudulent conduct includes concealing or knowingly failing to disclose that which is required by law to be revealed, knowingly using perjured testimony or false evidence, knowingly making a false statement of fact or law or otherwise engaging in conduct that such party knows to be illegal. Mass. Gen. L. c. 152, §14(2).

Regardless of any action taken by the Bureau, any party violating the statute will be assessed the entire cost of the proceedings, including attorney's fees, and must also pay a penalty to the aggrieved party in the amount of not less than the average weekly wage in the Commonwealth multiplied by six. Attorneys and physicians who are found to engage in fraudulent activity will be reported to their respective professional disciplinary boards.

The provision also contains criminal penalties of "imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment." Mass. Gen. L. c. 152, §14(3).

11. Is there any defense for falsification of employment records regarding medical history?

Benefits are barred when an employee knowingly and willfully made a false representation as to his or her physical condition at the time of hire and the employer relied upon the false representation in hiring the employee. Mass. Gen. L. c. 152, §27A.
In order for the misrepresentation to act as a bar, the employer must show that the employee knew or should have known that it was unlikely he or she could fulfill the duties of the job without incurring a serious injury. An employee may rectify any misrepresentation made to the employer regarding physical condition, subsequent to hire, as long as it is done prior to injury.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Recreational and non-work activities paid for or supported by the employer are generally not compensable. Mass. Gen. L. c. 152, §1(7A). However, if participation in the activity was compelled in part by the employer, benefits may be recovered. See Tigno v. Acme Boot Company, 8 Mass. Workers’ Comp. Rep. 145 (1994).

13. Are injuries by co-employees compensable?

Yes, if the injury is deemed to have arisen out of and in the course of employment. Matthews v. Liberty Mutual Insurance Company, 354 Mass. 470, 473 (1968).

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

If the act by a third parties is unrelated to work, it would not meet the statutory requirement that the injury arise out of employment.

BENEFITS

15. What criterion is used for calculating the average weekly wage?

The average weekly wage is calculated by taking the earnings of the employee during the 12 month period immediately preceding the injury and dividing that amount by 52. The previous 12 month period is to be used even though the employee was promoted before the injury to a higher pay rate that would have taken effect at a later date but for the injury. Harris v. Massachusetts General Hospital, 2015 WL 5330591. In situations where, because of the short duration of employment, it is impracticable to compute the wage according to that formula, the wages of a person employed in the same grade and in the same class of employment may be utilized. Mass. Gen. L. c. 152, §1(1). The average weekly wage of a seasonal employee with a "determinate duration" such as a landscaper is calculated on the basis of fifty-two weeks rather than the actual weeks worked. Bunnell v. Wequassett Inn, 12 Mass. Workers’ Comp. Rep. 152 (1998). When an employee “is employed in the concurrent service of more than one insured employer,” all such earnings are considered. Mass. Gen. L. c. 152, §1(1); Lubofsky v. Lowe’s Home Centers, Inc., 2015 WL 4507832 (concurrent service with an uninsured employer generally not considered unless covered by Workers Compensation Trust Fund).

16. How is the rate for temporary/lost time benefits calculated, including minimum and
maximum rates?

For injuries occurring before December 23, 1991, an employee is entitled to two-thirds of the pre-injury average weekly wage, not to exceed the state average weekly wage, for temporary total disability. For injuries occurring on or after December 23, 1991, an employee is entitled to 60 percent of the pre-injury average weekly wage, not to exceed the state average weekly wage, for TTD. The state average weekly wage is set by the Commissioner of the Division of Employment Security on October 1st of each year. The minimum weekly compensation rate is 20% of the state average weekly wage.

Temporary partial disability is calculated based on 60% of the difference between pre-injury average weekly wage and actual post-injury earnings or earning capacity as established under Mass. Gen. L. c. 152, §35D. Gradziel v. Berkshire Medical Center, 2015 WL 8519319.


17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

An insurer has 14 days from the receipt of a first report of injury or claim in which to pay or deny a claim for benefits. Mass. Gen. L. c. 152, §7.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

For injuries occurring before December 23, 1991, an employee must be out for 5 days before recovering benefits. For injuries occurring on or after December 23, 1991, an employee must be out 21 days before recovering benefits for the first 5 days.

19. **What is the standard/procedure for terminating temporary benefits?**

An insurer may commence the payment of weekly benefits on a without prejudice basis within 14 days of receipt of either a first report of injury or the employee's claim. Mass. Gen. L. c. 152 § 7. For injuries occurring before December 23, 1991, benefits may be paid without prejudice for a period of 60 days and can be extended to a maximum of 120 days. For injuries occurring on and after December 23, 1991, benefits can be paid without prejudice for 180 days and extended up to a maximum of 360 days. As long as an insurer is within the payment without prejudice period, it may terminate benefits for essentially any reason. Mass. Gen. L. c. 152, § 8. Once compensability has been established, benefits may only be terminated by judicial order, return to work, or release by a treating or impartial physician accompanied by a suitable job offer from the employer. Mass. Gen. L. c. 152, §8(2).
20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

Massachusetts does not recognize permanent partial disability, but it does recognize temporary partial incapacity benefits based upon a diminution in the employee's earning capacity. The overall maximum is 364 weeks, with different maximums with respect to the amount an employee is entitled to receive in temporary total (156 weeks) and temporary partial disability benefits (260 weeks). Mass. Gen. L. c. 152 §§34, 35.

21. What disfigurement benefits are available and how are they calculated?

Disfigurement benefits are calculated by using guidelines promulgated by the Department of Industrial Accidents, Mass. Gen. L. c. 152, § 36(1)(k), and are limited by statute to $15,000.00 for all types of disfiguring injuries (scars, non-scar-based disfigurements such as limp, etc.). Marino v. Progression Systems, 2016 WL 1402832. Compensable scarring is limited by Section 36(1)(k) to face, neck and hands.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

Massachusetts does not recognize permanent partial disability. It does, however, recognize temporary partial incapacity based upon a diminution in an employee's earning capacity. If any employee returns to work after sustaining an injury and earns less than the pre-injury earnings, or is determined to have a reduced earning capacity, for dates of injury occurring before December 23, 1991, he or she is entitled to receive two-thirds of the difference between the average weekly wage before and after the injury. For injuries occurring on or after December 23, 1991, an employee is entitled to receive 60% of the difference between the average weekly wage before the injury and the wage he or she is capable of earning after the injury. Mass. Gen. L. c. 152, §35. The employee, however, may not receive benefits in excess of the maximum compensation rate in effect on the date of the injury nor can such benefits exceed 75% of the temporary total disability benefits the employee would be entitled to receive. For injuries prior to December 23, 1991, up to 600 weeks of partial benefits are available to the employee. Injuries on or after that date are afforded up to 260 weeks of partial benefits. In certain very limited situations, an employee may be awarded up to 520 weeks for a partial disability.

A. How many weeks are available for scheduled members/parts, and the standard for recovery.

B. Number of weeks for "whole person" standard for recovery.

The statute is in general based upon a diminution in an employee's earning capacity, with the losses of function under Mass. Gen. L. c. 152, §36 paid in addition to weekly benefits. These are paid under formulas that compensate for losses concerning specific body parts, not “whole person.”

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

For any injury occurring after November 1, 1986, the employee is entitled to receive vocational rehabilitation services when necessary to return such employee to suitable employment. Mass. Gen. L. c. 152, §§30E, 30G. However, before an employee is entitled to vocational rehabilitation, he or she first must be deemed suitable for those services by the Office of Education and Vocational Rehabilitation of the Department of Industrial Accidents. Participation in an approved vocational rehabilitation plan is a factor to be considered in assessing entitlement to and calculation of weekly benefits. Roberts v. Thomas G. Gallagher, Inc., Reviewing Board No. 035970-12 (12/21/16).

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

An employee determined to be permanently and totally disabled (i.e., incapacity would “continue for an indefinite period which is likely never to end, even though recovery at some remote or unknown time is possible:” Rivera v. Department of Corrections, 2015 WL 4507834) is eligible to receive two-thirds of the pre-injury wage, but not more than the maximum rate, nor less than the minimum compensation rate, in effect on the date of injury as calculated according to the state average weekly wage promulgated annually by the Division of Employment Security. Mass. Gen. L. c. 152, §34A. The employee may also be entitled to receive annual cost of living adjustments. Mass. Gen. L. c. 152, §34B.

25. How are death benefits calculated, including the minimum and maximum rates:

While death benefits are divided into several sections regarding the payment of weekly death benefits, a spouse who satisfies certain criteria, as long as he or she remains unmarried, receives two-thirds the average weekly wage of the deceased employee, but not more than the average weekly wage in Massachusetts on the date of death. In no instance shall said spouse receive less than $110.00 per week. Benefits are payable to a maximum of 250 times the state average weekly wage on the date of death, but can continue beyond that time if the spouse is found to be not fully self-supporting (a determination made based upon income compared to expenses at the time of the claim, not of the death: Freedman v. Suffolk County Sheriff’s Office, 2016 WL 4167001). Also, under certain circumstances, there may be other individuals, such as children and dependents of the employee, who may be eligible to receive weekly benefits under Section 31. If an employee is entitled to receive loss of function or disfigurement benefits under Section 36, but dies before fully collecting these benefits, the benefits are
payable in a lump sum to the employee's legal representative. Mass. Gen. L. c. 152, §36A.

A. Funeral expenses.

For injuries occurring before December 23, 1991, the insurer is required to pay reasonable burial expenses up to $2,000.00. For injuries occurring on or after December 23, 1991, the maximum is $4,000.00. For injuries occurring on or after March 24, 2015, the insurer shall pay the reasonable costs of burial, not exceeding 8 times the average weekly wage in the Commonwealth as determined pursuant to subsection (a) of Section 29 of Chapter 151A. Mass. Gen. L. c. 152, §33.

B. Dependency claims.

Sections 31, 32 and 35A of the Act set forth the guidelines for the payment of claims to survivors, and dependents. Essentially, a surviving spouse, child, or parent of a deceased employee may be entitled to benefits if they can establish that they were wholly or partially dependent upon the deceased employee at the time of the injury or death.

26. What is the criteria for establishing "second injury" fund recovery?

An insurer must establish that the employee had a known physical impairment due to a previous accident, disease or congenital condition which was likely to be a hindrance or obstacle to employment, and who sustained a compensable injury. In order to be entitled to such a recovery, the insurer must show that the resulting disability is substantially greater by reason of the combined effects of the known physical impairment and the subsequent personal injury, than the disability which would have resulted from the subsequent personal injury alone. Mass. Gen. L. c. 152, §37. For injuries occurring on or after December 23, 1991, recovery will only pertain to claims that involve permanent and total disability under §34A, death claims under §31, §32, §33, and §36A, and, where benefits are due under any of these sections, medicals under §30. Furthermore, the insurer must also prove that the employer had personal knowledge of the existence of such pre-existing physical impairment within thirty days of the date of employment or retention of employment.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitation periods?

A case can be settled by the payment of a lump sum. Normally, if such a settlement is reached prior to liability being established, an employee is foreclosed for seeking further benefits for that injury. However, a claim for further medical benefits can be filed where the employee has "suffered a substantial deterioration of his medical condition which (i) could not reasonably have been foreseen at the time said agreement was entered into, and (ii) is the result of an injury for which the insurer would have been liable". Such a claim must be filed within one year of when the employee first became aware of the causal relationship between the deterioration and his employment. Mass. Gen. L. c. 152, § 48.
28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

Pursuant to Mass. Gen. L. c. 152, §13A, insurers are liable for payment of an attorney’s fee to the employee’s counsel if the employee “prevails” (essentially on any aspect of the claim) or, in certain circumstances, if the parties enter into an agreement. The amount of the fee is generally a specific amount set by statute, subject to annual adjustment based on changes in the state average weekly wage. A judge can award an enhanced fee beyond the statutory amounts due to the complexity of the dispute or the effort expended, if based on evidence of record. Jones v. National Grid, et al., 2017 WL 2324245 (DIA Reviewing Board 5/18/17). The fee can also be reduced on the same basis, if warranted by the evidence. §13A(5).

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive:**

If an employee files a claim, accepts payment of compensation or submits to a proceeding before the Department of Industrial Accidents, such action constitutes a release to the employer/insurer of all claims and demands at common law arising from the injury. Furthermore, unless an employee notifies the employer at the time of hire of intent to retain a common law right of action, or, if the contract of hire was made before the employer became an insured person or self-insurer, if the employee shall not have given the said notice within thirty days of the time said employer became an insured person or self-insurer, the employee and dependents are precluded from filing a civil action against the employer for a compensable injury. Mass. Gen. L. c. 152, §24. Provisions of a contract of hire under a purported independent contractor agreement that the injured worker waives workers compensation rights are invalid. Mass. Gen. L. 152, §41; Nguyen v. Eastern Connection Operating, Inc., 85 Mass. App. Ct. 1126, 2014 WL 2776893.

**A. Scope of immunity.**

In order to be immune from an action at common law, an employer must establish: (1) it is an insured entity liable for the payment of compensation; and (2) it is the direct employer of the employee. Lang v. Edward J. Lamothe Company, 20 Mass. App. Ct. 231, 232 (1985). Directors of a corporation are “employers” subject to immunity. Moulton v. Puopolo, 467 Mass. 478 (2014).

**B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

The dual capacity doctrine is recognized and the exclusivity bar does not necessarily pass to a successor corporation. Gurry v. Cumberland Farms, Inc., 406 Mass. 615 (1990). In addition, an employee who files a workers’ compensation claim is not barred from bringing an action for discrimination under Mass. Gen. L. c. 151B. Intentional torts can

30. **Are there any penalties against the employer for unsafe working conditions?**

An employee is entitled to double compensation if the employer is guilty of serious and willful misconduct causing the injury. Mass. Gen. L. c. 152, § 28. If the provision applies, the insurer pays double the amount of indemnity and medical benefits to the employee, and the employer is required to reimburse the insurer for the doubling increment. If the employer is unable to reimburse the insurer, the insurer must pay the doubling increment without reimbursement. *CNA v. Sliski*, 433 Mass. 491 (2001).

31. **What is the penalty, if any, for an injured minor?**

There is no penalty, per se. However, if the minor is employed in violation of the applicable Child Labor Laws, he or she is entitled to double compensation. Mass. Gen. L. c. 152, §28.

32. **What is the potential exposure for "bad faith" or claims handling?**

The Department of Industrial Accidents has promulgated regulations regarding such practices by insurers. 452 Code of Mass. Regs. §7.00. The Department may receive complaints on prescribed forms and investigate allegations of questionable claims handling on the part of insurers, self-insurers, self-insured groups, third party administrators, employers, or other entities handling workers’ compensation claims. 452 CMR §7.04.

When a claim is received, the party against whom the allegation has been made has an opportunity to respond in writing within thirty days. The Division of Administration will investigate and report its findings to the Commissioner of Insurance, as well as the parties involved. However, when the alleged conduct involves a self-insured employer, a Department-certified vocational rehabilitation provider, or a Department-approved utilization review agent, the findings of the Division will be reported to the Commissioner of the Department of Industrial Accidents rather than the Commissioner of Insurance.

Where the Division of Administration finds evidence sufficient to support a finding of questionable claims handling or patterns of unreasonably controverting claims, such findings are reported to either the Commissioner of Insurance or Commissioner of the Department of Industrial Accidents, depending on the party involved. The Commissioner of Insurance may undertake such enforcement as license revocation, and/or other actions as may be applicable. In addition, the Commissioner of the Department of Industrial Accidents may also impose a fine against the entity that has engaged in such activity. 452 CMR §7.04.

33. **What is the exposure for terminating an employee who has been injured?**
An employee has a cause of action if he or she is discharged for exercising any right afforded under the Act. Mass. Gen. L. c. 152, §75B(2).

Under circumstances where the payment of benefits has been reduced or terminated upon the insurer’s possession of both a medical report from either the employee’s treating physician or an impartial medical examiner releasing the employee to a suitable and specific written job offer from the employer, any termination of the employee within one year of returning to the job offered will be presumed to have been due to the employee being physically or mentally unable to perform said job duties. Mass. Gen. L. c. 152, §8(2).

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. Mass. Gen. L. c. 152, §15. However, the employer/insurer has a lien on any third party settlement or judgment in the amount of any benefits paid, including the employee’s medical bills. This lien does not apply to the portion of proceeds of a third-party settlement allocated for the loss of consortium or for the employee’s conscious pain and suffering. DiCarlo v. Suffolk Construction, Inc., 473 Mass. 624 (2016); Curry v. Great American Insurance Company, 80 Mass. App. Ct. 592 (2011).

35. Can co-employees be sued for work-related injuries?


36. Is subrogation available?

In essence, yes, although case law describes the insurer’s rights as different than usual subrogation, i.e., not “standing in the shoes of” the injured employee but rather as an independent right of recovery against the tortfeasor for benefits it paid for the injury. Atlantic Charter Insurance Co. v. Kantrovitz & Associates, P.C., 90 Mass. App. Ct. 1116, 2016 WL 6817452. The employee has the exclusive right to bring such an action for seven months from the injury, and must honor the insurer’s interest if the employee does bring such an action. If the employee fails to bring an action within that period and the insurer has paid compensation, the insurer may file a civil action against the negligent third party in the employee's name. Mass. Gen. L. c. 152, §15. Either way, whether enforced as a lien on the employee’s action or as a direct assertion of its rights by the insurer, the result is the same: if the action is successful, the insurer stands to be paid back what it paid in compensation benefits.

MEDICALS
37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

An employee is entitled to reasonable and necessary medical care for an industrial injury. There is no time limitation, per se, with respect to the payment of medical bills. If an insurer denies the payment of medical bills, the employee may bring a claim against the insurer.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Once a claim or complaint is filed, any party may serve a request for production of medical records on any other party. 452 CMR, §1.12(2). Requests must be accompanied by a statement providing the relevance of the information sought. The party on whom a request is made must respond within twenty days after service of the request. If a party does not respond or refuses to produce records, a motion to compel may be filed with the administrative judge, who can order that the records in question be produced. Id. Additionally, in practice, parties routinely subpoena medical records directly from health care providers (452 CMR, §1.12(7)) and, with an administrative judge's permission, the parties may depose a physician. (452 CMR, § 1.12(5)). An administrative judge also has the authority to issue a subpoena for medical records or witnesses and a party may move for issuance of such a judicial subpoena. Mass. Gen. L. c. 152, §11B.

39. What is the rule on (a) claimant’s choice of physician; (b) employer’s right to a second opinion and/or Independent Medical Examination?

A. Claimant’s choice of physician?

Prior to July 1, 1992, an employee could essentially choose any physician and there was no limitation as to the number of physicians with whom an employee could consult. For injuries occurring after July 1, 1992, an employee may choose a treating physician, but may only switch to another physician once. In addition, effective July 1, 1992, the statute allows employers to enter into preferred provider arrangements. If the employer has such an arrangement, it can require the employee to treat with a physician under the plan for the first scheduled visit for medical treatment. Pursuant to a collective bargaining agreement, an employee can be limited to a set list of providers for medical treatment. Mass. Gen. L. c. 152, §30. However, under such an arrangement, an employee is only required to treat with a physician under the plan for the first scheduled visit for medical treatment. Mass. Gen. L. c. 152, §10C.

B. Employer’s right to second opinion and/or Independent Medical Examination?

Under Mass. Gen. L. c. 152, §45, an employee must submit to an examination by a physician furnished and paid for by either the insurer or the employer. The employee is then entitled to reimbursements for reasonable travel expenses and lost wages resulting from such examination. The employee also has the right to have his own physician
present during the examination, although this is rarely done. If the report of such an examination "is to be used as the basis of any order", it must be filed with the Division of Dispute Resolution. An employee who refuses to submit to a medical examination at the request of an insurer or employer or in any way obstructs it has his right to compensation suspended and his compensation during the period of suspension may be forfeited.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

As long as the treatment is “adequate and reasonable” and related to the employee's industrial injury, it is allowed. If, however, an insurer declines to make payment on a specific form of treatment, that issue can then be litigated before the Department of Industrial Accidents. Mass. Gen. L. c. 152, §§13, 30.

41. **Which prosthetic devices are covered, and for how long?**

The prosthetic devices covered are set by the Rate Setting Commission and are accompanied by a fee schedule. There is no time limit on the use of a prosthetic device as long as it is reasonable and necessary and related to the employee's industrial injury.

42. **Are vehicle and/or home modifications covered as medical expenses?**

As long as the modification is determined to be reasonable and necessary, an insurer may be required to pay for it, Mass. Gen. L. c. 152, §§13, 30, or to pay for at least so much of the expense as exceeds “normal” costs (e.g., for housing, food, special motor vehicles, etc.). *Marino v. Progression Systems*, 2016 WL 1402832; *DeOliveira v. Calumet Construction Corp., et al.*, 2015 WL 6680125. An insurer can also be required to pay for long-term care (e.g., nursing home) if the industrial injury and its complications constitute one of the contributing factors for the employees need for 24-hour skilled nursing care in a long-term care facility. The insurer can also be required to pay for appointment and services of a guardian for the employee, including attorney fees. *Davidson v. Florida Medicaid, et al.*, ____ Mass. Workers’ Comp. Rep. ____ (DIA Reviewing Board, 3/28/18); Mass. Gen. L. c. 152 §39.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

The Massachusetts Rate Setting Commission sets the rates of payment for specific modalities of treatment. Furthermore, the Reviewing Board of the Department of Industrial Accidents has held that the rates established by the Commission are binding on out of state providers. *Tedeschi v. S.F. Concrete/Alderson v. Foster Forbes*, 6 Mass. Workers' Comp. Rep. 120 (1992).

44. **What, if any, provisions or requirements are there for "managed care"?**

Section 30 of c. 152, as amended by St. 1991 c. 398, provides for the promulgation of regulations regarding the provision of adequate and reasonable health care services.

Section 13 of c. 152, as amended by St. 1991 c. 398, provides for the creation of a health care services board. Among the board's duties is the development of written guidelines for appropriate and necessary treatment based on diagnosis of injuries and illness. Such guidelines were promulgated pursuant to 452 C.M.R. §§6.00-6.07 and were made applicable to health care services rendered on or after October 1, 1993, regardless of the date of injury. Insurers must either contract with agents who provide utilization review services or develop their own utilization review programs. Proposed medical treatment for work-related injuries or illness is subject to utilization review for a determination as to whether the treatment is reasonable and necessary under the treatment guidelines promulgated by the health care services board. Guidelines can be obtained from the Health Care Services Board at the Department of Industrial Accidents.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

An insurer has 14 days upon receipt of a first report of injury or claim in which to deny or commence payment. The insurer is limited to the defenses it asserts in its denial of a claim if that claim is later litigated. Mass. Gen. L. c. 152, §7. Where the insurer commences payment of weekly benefits within said 14 day period the insurer may pay without prejudice for up to 180 days, Mass. Gen. L. c. 152, §8(1) (a year if an extension is agreed to and approved by the Department: Mass. Gen. L. c. 152, §8(6)), with termination upon seven days notice to the employee. The notice shall specify the insurer’s grounds for terminating benefits with said grounds to remain the insurer’s sole basis for noncompensability. Mass. Gen. L. c. 152, §8(1).

46. **What is the method of claim adjudication?**

A. **Administrative level.**

When a claim is filed with the Department of Industrial Accidents it is scheduled for a conciliation, a type of mediation in which the parties attempt to resolve their differences in a non-binding format. If the parties are unable to reconcile their differences, the case is then scheduled for a conference before an administrative judge. Mass. Gen. L. c. 152, §10A. The conferences are informal and the rules of evidence do not apply, but the judge is authorized to issue a binding order with respect to the payment or denial of benefits.

The parties may agree to binding arbitration at any time prior to five days before a conference. Mass. Gen. L. c. 152, §10B. Parties wishing to go to arbitration must sign a written agreement. Once this written agreement is submitted to the Department of Industrial Accidents, no further claims or complaints can be filed until there is an award or written withdrawal from the original arbitration.

B. **Trial court.**
Trials (“hearings”) are conducted within the Department, not in the trial courts. After a conference is conducted and an order issued, each party has the option of appealing the order to a *de novo* hearing before the administrative judge who presided at the conference. At the hearing level, rules of evidence apply and the parties are allowed to elicit testimony from lay witnesses and submit medical testimony by means of deposition. Mass. Gen. L. c. 152, §11. After a conference, but before a hearing, the Department of Industrial Accidents will schedule an examination of the employee with an impartial physician picked by the department. That doctor's report and testimony is the only medical evidence to be considered by the administrative judge, unless there is a showing of inadequacy of the report or complexity of the medical issues. Mass. Gen. L. c. 152 §11A.

C. Appellate.

After a hearing decision is rendered, either party has the option of appealing errors of law to the Reviewing Board of the Department of Industrial Accidents. Normally the Board will assign the case to a single administrative law judge for a preliminary hearing, after which the judge will determine whether to refer the case to a panel of three administrative law judges. A decision is then rendered and a party may appeal the Reviewing Board's decision to the Commonwealth of Massachusetts's Court of Appeals. Mass. Gen. L. c. 152, §§11C, 12.

47. What are the requirements for stipulations or settlements?

Parties may enter into Stipulations of Fact during the course of a hearing. Settlements may be approved either by a conciliator, administrative judge, or an administrative law judge. Mass. Gen. L. c. 152, §48.

48. Are full and final settlements with closed medicals available?

For any injuries occurring on or after November 1, 1986, the employee's right to medical treatment can remain open after the indemnity portion of a claim is settled. If liability has been established, then medicals remain open even after a claim is settled. If liability has not been established, the parties may enter into a settlement which closes out the employee’s right to future medical treatment. Mass. Gen. L. c. 152, §48.

49. Must stipulations and/or settlements be approved by the state administrative body?

In order to be enforceable, a settlement must be approved by a conciliator, administrative judge, or administrative law judge of the Department of Industrial Accidents. Mass. Gen. L. c. 152, §48. Where a workers' compensation and a third party action are settled simultaneously, a settlement petition may be presented to either an administrative law judge or a justice of the Superior Court of The Commonwealth of Massachusetts. Mass. Gen. L. c. 152, §15.

**RISK FINANCE FOR WORKERS' COMPENSATION**
50. **What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**


51. **What are the provisions/requirements for self-insurance?**

   A. **For individual entities.**


   B. **For groups or "pools" of private entities.**

   Any five or more employers who are engaged in the same or similar type of business, industry, trade or profession may petition the Commonwealth of Massachusetts Division of Insurance to be licensed as a self-insured group. Mass. Gen. L. c. 152, §§25A through 25U. The Division of Insurance has also promulgated regulations governing self-insurance groups. 211 Code Mass. Reg. §67.00 et. seq. In addition to workers’ compensation self-insurance groups, public employers may form self-insurance groups covering property and casualty risk including, but not limited to workers’ compensation. Mass. Gen. L. c. 40M.

52. **Are "illegal aliens" entitled to workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of “employee”?**


53. **Are terrorist acts or injuries covered or excluded under workers’ compensation**
law?

Injuries resulting from terrorist acts are not per se excluded under Mass. Gen. L. c. 152. Where it can be shown that the nature of the employment exposed an employee to a particular risk resulting in injury, a claim for benefits would be compensable. Any injury is compensable if it arises out of and in the course of the “nature, conditions, obligations, or incidents of employment . . . looked at in any of its aspects.” Matthews v. Liberty Mutual Insurance Co., 354 Mass. 470, 473 (1968).

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interest pursuant to the Medicare Secondary Payer Act?

There are no state specific requirements in Massachusetts relative to satisfying Medicare’s interests.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396K(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396K(b).

Under Mass. Gen. L. c. 152, §46A, where medical, dental, hospital or lost time weekly benefits have been paid or furnished, the provider, at any time before an award of workers’ compensation benefits or approval of a lump sum settlement is paid, may file with the D.I.A. a claim for reimbursement out of the proceeds of such award or lump sum settlement.

In instances where such a claim is filed, an accident and health insurer or hospital, medical or dental service corporation, the Department of Public Welfare, the Division of Medical Assistance or employer shall have a lien against any award of benefits or lump sum settlement amount. In cases where lien holder and employee are unable to agree on an amount to discharge a lien against a lump sum settlement the D.I.A. Reviewing Board shall have the right to determine the fair and reasonable amount to be paid out of the lump sum settlement to discharge the lien.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

The Health Insurance Portability and Accountability Act (HIPAA) specifically excludes workers’ compensation. Under Massachusetts Workers’ Compensation law there is no
requirement that a claimant provide an insurer or employer with consent to obtain medical records. However, 452 CMR 1.12(2) provides that: “On or after the filing of any claim or complaint, any party may serve on any other party a request to produce, and permit the party making the request to inspect and copy, any medical report, or record of wages earned subsequent to the alleged injury.” On written motion of a party the administrative judge to whom the case has been assigned may issue an order to comply and failure to comply with said order without good cause may trigger the assessment of penalties pursuant to Mass. Gen. L. c. 152, §14.

57. What are the provision for “Independent Contractors”?

Under the Massachusetts independent contractor statute, Mass. Gen. L. c. 149, §148B, any individual performing any service shall be considered to be an employee rather than an independent contractor unless such individual meets all requirements of a three pronged test.

(1) Such individual has been and will continue to be free from control and direction in connection with the performance of such service under his contract: and

(2) Such service is performed either outside the usual course of the business for which the service is performed or is performed outside of all places of business of the enterprise: and

(3) Such individual is customarily engaged in an independently established occupation, profession or business of the same nature as that involved in the service performed.

However, the Reviewing Board has held that for workers’ compensation purposes, the test requires a more multi-factorial, 12-point analysis, the most important point being the right to direct and control the individual performance of the work. *Camargo v. Publishers Circulation Fulfillment, Inc.*, 2016 WL 7335381 (12/9/16).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

There are no such specific provisions. However, with respect to employee leasing companies Mass. Gen. L. c. 152, §14A(c) defines an employee leasing company as a sole proprietorship, partnership, corporation or other form of business entity whose business consists largely of leasing employees to one or more client companies under contractual arrangements that retain for such employee leasing companies a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers provided by the employee leasing company; provided, however, that the leasing arrangement is long term and not an arrangement to provide the client company temporary help services during seasonal or unusual conditions. Mass. Gen. L. c. 152, §14 provides for the assessment of costs, fines and criminal penalties for knowingly misclassifying employees or engaging in deceptive leasing practices for the purpose of avoiding full payment of insurance premiums.
59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

There are no such specific provisions.

60. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

Many, if not most, claims will settle in a manner which does not allow for redeeming medical benefits, i.e., reasonable and related medical expenses remain compensable after settlement of weekly indemnity, so Medicare interests will not come into play. In situations where medical benefits are redeemable, there are no state specific requirements in Massachusetts relative to satisfying Medicare’s interests.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Yes, effective 2013, by passage by the voters of initiative petition in November 2012. By state law, a Medical Use of Marijuana Program ID card is required ($50 fee), as well as a certification (up to $200 fee) from a physician with whom the employee has a “bona fide physician-patient relationship” and who participates in the employee’s ongoing treatment and care, following a complete examination and documentation of the debilitating condition requiring marijuana usage. Lawful possession for medical purposes is generally limited to a 60-day supply or 10 ounces. There are no restrictions specific to the Workers Compensation Act. DIA Treatment Guidelines address chronic pain treatment, including medication, and provide an “Opioid/Controlled Substance Protocol,” but do not address marijuana specifically. There is as yet no definitive ruling regarding use of medical marijuana in a workers compensation case, although the requirement of provision of “adequate and reasonable health care services, and medicines if needed” is clear in the Act. Mass. Gen. L. c. 152 §30. Some insurers have denied claims for medical marijuana due to its continuing illegality under federal law, but have paid for the therapy if ordered by a DIA administrative judge. Several trial level decisions have been entered, but there has been no ruling yet by the Reviewing Board or the appellate courts. There are no specific restrictions for work activity. As with alcohol, intoxication likely would not in and of itself serve as a bar to compensation. See Question 9, supra.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Yes, effective July 2018, by passage by the voters of initiative petition in November 2016. Retail sales will be allowed as of July 1, 2018, within extensive regulation on such sales (73 pages of regulations approved in March 2018). There are licensing restrictions on retail shops, and many municipalities have banned or placed moratoriums on such businesses. Possession of one ounce on one’s person and ten ounces at home (or six to
twelve plants) is allowed. Usage in public is prohibited, as is usage while driving. There are no specific restrictions for work activity under the Workers Compensation Act. As with alcohol, intoxication likely would not in and of itself serve as a bar to compensation. See Question 9, supra.

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1. Citation for the state’s workers’ compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered ‘employees’ for purposes of workers’ compensation?

“Every” employee is subject to the Act except as otherwise provided. Mich Comp Laws Ann §418.111. Exclusions exist for small employers; the burden is on the employer as an affirmative defense to show it is excluded. Mich Comp Laws Ann §418.115(a) and (b); Alford v. Pollution Control Industries of America, 222 Mich. App 693 (1997). Exclusions also exist for certain agricultural employers, Mich Comp Laws Ann §418.115(d) and (e), certain household domestic servants, Mich Comp Laws Ann §418.118, and certain real estate salespersons or brokers. Mich Comp Laws Ann §418.119. Partners, family members and certain managers or officers of small corporations may be individually excluded. Mich Comp Laws Ann §418.161(2)-(5).


Beginning on or after January 1, 2013, services are employment if the services are performed by an individual whom the Michigan Administrative hearing system determines to be in an employer-employee relationship using the “20-factor test” announced by the IRS of the United States department of treasury in Revenue Ruling 87-41, 1 C. B. 296. An individual for whom an employer is required to withhold federal income tax is prima facie considered to perform services in employment under this act.
3. Identify and describe any “statutory employer” provision.

A principal is liable to pay benefits to the “employee” of a subcontractor if that subcontractor is not subject to the Workers’ Compensation Act or has not complied with the provisions of the Act relative to obtaining insurance coverage. The principal may seek indemnity from the contractor. Mich Comp Laws Ann §418.171 (1)(2); Williams v. Lang (after Remand), 415 Mich 179 (1982). If a principal willingly acts to circumvent the Act, forcing employees to pose as contractors, would be subject to criminal prosecution under Section 641. Note an injured employee may maintain a civil action against his direct employer without adding the statutory employer.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

A personal injury must arise out of and in the course of the employment with the employer who is subject to the Act at the time of injury. A personal injury is compensable if work causes, contributes to, or aggravates pathology in a manner so as to create a pathology that is medically distinguishable from any pathology that existed prior to the injury. Time of injury or date of injury under the Act for cases not involving a single event shall be the last day of work in the employment in which the employee was last subjected to conditions that resulted in the disability or death. Mich Comp Laws Ann §418.301(1). Disability is defined as a limitation of the employee’s wage earning capacity in work suitable to his or her qualifications and training, resulting from a personal injury or work-related disease. Mich Comp Laws Ann §418.301(4).

In Sington v. Chrysler Corp, 467 Mich. 144 (2002), the Supreme Court defined disability as a limitation in “wage earning capacity” in work suitable to the employee’s qualifications and training under Mich Comp Laws Ann §418.301(4). The Court explained that a condition that rendered an employee unable to perform a job, paying the maximum salary, given the qualifications and training of the employee, but leaving the employee free to perform an equally well-paying position suitable to the qualifications and training of the employee would not constitute a disability. 467 Mich 144, 155.

The Supreme Court further defined Sington in the case of Stokes v DaimlerChrysler LLC, 481 Mich 266 (2008). The Court held that the employee must make a good faith attempt to procure post-injury employment if there are jobs at the same salary or higher that he or she is qualified and trained to do. The employee must also prove that all jobs in the same “salary range” suitable to his or her qualifications and training cannot be performed as a result of the work injury or are not reasonably available. The injured worker must disclose his qualifications and training, including education, skills, experience and training. If the employee is capable of performing any of the jobs identified, he or she must show that job cannot be obtained. The burden shifts to the employer to refute the prima facie case of the employee. In order to meet its burden, the employer is entitled to some limited discovery. The employee may then come forward with evidence to refute the evidence of the employer.
In Lofton v. Autozone, Inc., 482 Mich 1005 (2008), appeal after remand, remanded, 483 Mich 1133 (2009), the Supreme Court issued an order, which held that if the plaintiff is disabled, but the limitation in wage earning capacity is only partial, the magistrate must compute wage loss benefits under Mich Comp Laws Ann§ 418.361(1) based on what the employee remains capable of earning.

In Rakestraw v. General Dynamics Land Sys., Inc., 469 Mich 220 (2003), the Supreme Court held that “a claimant attempting to establish a compensable work-related injury must adduce evidence of the injury that is medically distinguishable from the preexisting nonwork-related condition in order to establish the existence of a ‘personal injury’ by a preponderance of the evidence under MCL § 418.301(1).” 469 Mich 220, (2003).

The above cases have all been codified into law under the recent amendments of 2011.

B. Occupational disease (including respiratory and repetitive use).

Occupational disease and/or disabilities which are due to causes and conditions characteristic of and peculiar to the business of the employer, and which arise out of and in the course of the employment are compensable. Ordinary diseases of life, which the general public is exposed to, are not compensable. Mental disabilities and conditions of the aging process, including but not limited to heart and cardiovascular conditions and degenerative arthritis are compensable if contributed to or aggravated or accelerated by the employment in a significant manner. A hernia, to be compensable, must (1) be recent in origin, (2) result from a strain arising out of and in the course of the employment and (3) be promptly reported. Mich Comp Laws Ann §§418.401(1) and (2).

5. What, if any, injuries or claims are excluded?


In Brackett v Focus Hope, Inc, 482 Mich 269 (2008), the Supreme Court in a significant departure from the past case law held that “misconduct” as defined by Mich Comp Laws
Ann §418.305 is not limited to “moral turpitude” type behavior. Such conduct is “intentional and willful misconduct” if it is “improper” and done “on purpose” despite the knowledge that it is against company rules. The rules must be clearly established, understood and consistently enforced for the violation to meet the statutory requirements. *Daniel v. Department of Corrections, 468 Mich 34 (2003)*

6. **What psychiatric claims or treatment are compensable?**


7. **What are the applicable statutes of limitations?**

There is no statute of limitations per se. The claim for compensation must be made either orally or in writing within two years after the occurrence of the injury, disability or death. Mich Comp Laws Ann §§418.381 and 441. Retroactive payment of benefits is limited by the one and two year back rules. Mich Comp Laws Ann §§418.381(2), 381(3) and 833(1).

8. **What are the reporting and notice requirements for those alleging an injury?**

The employee must provide notice of injury to the employer within 90 days after the happening of the injury or within 90 days after the employee knew or should have known of the injury or disability. However, failure to give notice to the employer is excused unless the employer can prove prejudice. Mich Comp Laws Ann §418.381 (1).

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

   There is no specific provision regarding self-inflicted injuries. However, Michigan courts have found suicides compensable when they arise from a compensable mental injury or disability. *Hammons v. Highland Park Police Dept.*, 421 Mich 1 (1984). In construing *Hammons*, the courts have stated that the principals of causal relationship or psychiatric cases as laid out in *Garnder v. Van Buren Public Schools*, must be considered.

   B. **“Wilful misconduct”, “horseplay,” “fights” etc.**

C. Injuries involving drugs and/or alcohol.

There is no specific provision for injuries occurring as a consequence of drugs and/or alcohol, but cases generally have turned on the issue of whether the action constituted a rule violation and whether the rule was strictly enforced. Mich Comp Laws Ann §418.305. In Pierce v. General Motors Corp, 443 Mich 137 (1993), the Supreme Court held that alcoholism is not a personal injury under Chapter 3, and compensation should not be awarded.

10. What, if any, penalties or remedies are available in claims involving fraud?

The Act contains a provision pertaining to fraudulent representations in the employment application. Mich Comp Laws Ann §418.431. See Answer 11. The Act contains few specific references to fraud. Generally, proof of fraud in either the procurement of benefits or in the defense of a claim may be subject to litigation and ruling by the Magistrate. E.g., Fuchs v. General Motors Corp. 118 Mich App 547 (1982) (employer misrepresented the average weekly wage and employee was paid benefits at an incorrect rate; based upon equitable estoppel, the recoupment of benefits by the employee was not limited by the two year back rule.). The newly amended act provides for the Director to coordinate a mechanism to analyze and detect and prevent fraud, waste and abuse of the WC system to be implemented by April 1, 2012. The director is to provide information on number of employees who had benefits reduced as a result of determination of wage earning capacity. Mich Comp Laws Ann § 418.801(7).
11. **Is there any defense for falsification of employment records regarding medical history?**

Compensation for occupational disease is denied if the employee, upon entering the employment, willfully and falsely represents in writing that he or she has not previously suffered from the disease which is the cause of the disability or death. However, if an occupational disease is aggravated by the employment or another disease or infirmity, leading to disability or death, it may be compensable. Mich Comp Laws Ann §418.431. *Dressler v. Grand Rapids Die Casting Corp.*, 402 Mich 243 (1978); *DeVore v. Ford Motor Corp.* 171 Mich App 354 (1988); *Leach v. Detroit Health Corp.*, 156 Mich App 441 (1987).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

The “arising out of and in the course of” test is satisfied when such activities occur on the employer’s premises during lunch or a recreation period incidental to the employment, or if the employer expressly or impliedly requires participation, or if the employer derived a substantial direct benefit from the activity. *Bayerl v. Badger Mfg. Co.*, 169 Mich App 444 (1988). However, if the ‘major purpose’ of the activity is found to be “social or recreational,” it is no longer covered under the Act. Mich Comp Laws Ann §418.301(3). *Nock v M & G Convoy, Inc (On Remand)*, 204 Mich App 116 (1994); *Eversman v Concrete Cutting & Breaking*, 463 Mich 86 (2000).

13. **Are injuries by co-employees compensable?**

Yes. See also Answer 14.

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. ‘irate paramour’ claims)?**

Yes, if an employee is attacked by a third party it is compensable, if the incident arose out of and in the course of employment. However, an injury resulting from a fight unconnected with the employment and motivated by personal reason is not compensable. *Morris v. Soloway* 170 Mich App 312 (1988). In fights involving an “irate paramour” courts have held such occurrence to be unconnected to the employment and have denied compensation. *DeVault v. General Motors Corp.*, 149 Mich App 765 (1986).

**BENEFITS:**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage (AWW) includes the earning of the employee in all employment, inclusive of overtime, premium pay, cost of living, and exclusive of fringe benefits which continue during the disability. The AWW is determined by computing the average of the total wages paid for the highest 39 weeks in the 52 weeks immediately
preceding the date of injury. If less than 39 weeks were worked, the AWW is based on an average determined by the total weeks actually worked. If the employee is injured during the first week of employment or if the AWW cannot be easily ascertained, the wage may be calculated based on the number of hours contracted for times the rate, or in some cases the usual wage for similar services. Mich Comp Laws Ann §418.371.

16. **How is the rate for temporary lost time benefits calculated, including minimum and maximum rates?**

There is no minimum compensation rate and there is no distinction between part-time and full-time employment. The basic rate is 80% of the after-tax AWW of the employee as set forth in the annually published rate tables. The maximum rate is 90% of the State AWW. Mich Comp Laws Ann §§418.351 and 355. The maximum rate for 2017 is $870.00 based on a State AWW of $965.62.

17. **How long does the employer/insurer have to begin temporary benefits from the date of disability begins?**

Compensation benefits are due and payable on the 14th day after the employer has notice or knowledge of a disability and/or death, and are paid thereafter in weekly installments, unless disputed. Mich Comp Laws Ann §418.801. If benefits are not paid within 30 days after becoming due and payable where there is no ongoing dispute, a penalty of $50.00 per day, up to $1,500.00 may be added. Mich Comp Laws Ann §418.801(2).

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**


19. **What is the standard/procedure for terminating temporary benefits?**

The employer/insurer may terminate benefits unilaterally when the employee recovers based on a medical examination, returns to work, or refuses to respond to a *bona fide* offer of reasonable employment within his or her capabilities, without good and reasonable cause if there is no existing bureau order of benefits. Mich Comp Laws Ann §418.301. The employer/insurer notifies the Bureau/Agency of the termination by way of a Form 701, but must also advise the employee in writing that the benefits have been terminated and the reason for termination. A copy of the Form 701 must be furnished to the employee. Mich Admin Code R.408.31 An employer will normally file a Form 107 (Notice of Dispute) with the Bureau with copies to the employee.
20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

Yes, if an employee is receiving weekly benefits and later is determined to have a scheduled loss or to be totally and permanently disabled, the prior benefits will be credited. Mich Comp Laws Ann §418.361.

21. **What disfigurement benefits are available and how are they calculated?**

Mutilations and/or disfigurements resulting from the injury are not specifically addressed in the Act. Reasonable and necessary medicals are covered and the need for cosmetic surgery for disfigurement may be compensable. Lost time associated with disfigurement and/or mutilation arising out of and in the course of employment, if medically substantiated, would be compensable. Mich Comp Laws Ann §418.315.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

Scheduled losses are payable at 80% of the after-tax AWW subject to the usual maximum. Mich Comp Laws Ann §418.361(2). There is a minimum rate of 25% of the state average weekly wage. Mich Comp Laws Ann §418.356(3).

A. **How many weeks are available for scheduled members/parts and the standard for recovery?**

Specific loss/scheduled loss of body parts by amputation or loss of use are set forth by statute ranging from 11 weeks up to 269 weeks depending on the body part and/or member. Mich Comp Laws Ann §418.361.

B. **Number of weeks for ‘whole person’ and standard for recovery.**

Permanent partial disability benefits for non-scheduled injuries are paid at a rate equal to 80% of the difference between the pre-injury after-tax wage of the employee and the post-injury after-tax wage, not to exceed 90% of the State AWW. Such benefit payments continue for the duration of the disability. Mich Comp Laws Ann §418.361.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

If the employee, who suffers an injury, is unable to perform work for which he or she had previous training, the employee is entitled to seek vocational rehabilitation services, including retraining and job placement, as may be reasonably necessary to restore the employee to useful employment. Benefits are payable for 52 weeks and, by special order of the Director, may be extended for an additional 52 weeks. Disputes are submitted to the Director for disposition. Mich Comp Laws Ann §418.319.
24. How are the permanent total disability benefits calculated, including the minimum and maximum rates?

The base rate for total and permanent disability is 80% of the after-tax AWW subject to the usual maximum. Mich Comp Laws Ann §§418.351 and 361(3). There is a minimum benefit of 25% of the State AWW. Mich Comp Laws Ann §418.356(3). A supplement may be available from the Second Injury Fund. Mich Comp Laws Ann §418.352 (1).

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

Reasonable funeral expenses may be recovered, up to $6,000.00, or the actual cost, whichever is less. Mich Comp Laws Ann §418.345. *Paige v. City of Sterling Heights*, 476 Mich 495 (2006).

B. Dependency claims.

The base death benefit rate is the same as the weekly rate for disability claims. It is, however, subject to minimums of 50% of the State AWW. The base duration is 500 weeks. Mich Comp Laws Ann §§418.321, 331, 335 and 356(2). If there are only partial dependents, then a proportional rate is calculated. *Lesner v. Liquid Disposal*, 466 Mich 95 (2002). If there are minor dependents remaining after the 500 weeks, additional benefits may be ordered to age 18 or 21. *Murphy v. Ameritech*, 221 Mich App 591 (1997). Mich Comp Laws Ann §§418.321, 331, 353 and 375. If there are minor dependents remaining after the 500 weeks, additional benefits may be ordered to age 18 (age of majority) or upon a determination by a Magistrate to age 21. *Murphy v. America*, 22 Mich App 591.

26. What are the criteria for establishing a ‘second injury’ fund recovery?

The Second Injury Fund assumes responsibility for benefits after the employer has paid scheduled loss benefits to an employee who had an earlier loss of a hand, arm, foot, leg or eye. The Fund is responsible for paying a portion of the benefits to those employees deemed to be totally and permanently disabled. Mich Comp Laws Ann §§418.352,361 and 521. The Fund reimburses increases in the weekly benefit for certain disabilities extending beyond two years for employees with low weekly rates, or other increases dictated by statute for persons with low weekly rates. Mich Comp Laws Ann §418.356. The Fund also reimburses employers/insureds for the following: (1) benefits paid in excess of the statutory maximum ($25,000.00 or 104 weeks of weekly benefits) in “silicosis and dust disease” cases, Mich Comp Laws Ann §418.531; (2) certain benefits paid in “dual employment” situations, Mich Comp Laws Ann §418.372; and (3) benefits paid beyond 52 weeks for certain employees who were determined to be “vocationally handicapped” prior to employment, Mich Comp Laws Ann §418.921. The Fund continues payments for certain “bankrupt” self-insured employers. Mich Comp Laws Ann §418.501, 418.537.
The Workers Compensation Act under § 418.405 establishes a presumption for members of full paid fire and police departments, county road commissions, county sheriffs, etc. for respiratory and heart disease resulting during the course of the employment, absent evidence to the contrary. § 418.405 (1)(2). A recent amendment has added cancer conditions including bladder, skin, brain, kidney, blood, thyroid, testicular, prostate or lymphatic cancer is covered under the presumption. The provisions is referred to as “First Responder Presumed Coverage” § 418.405 (2-4)

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A case may be re-opened, claiming a worsening or change of condition, if not barred by res judicata. White v. Michigan Consolidated Gas Co., 352 Mich 201 (1958); Flynn v. General Motors Corp., 162 Mich App 511 (1987). See also Answer 7.

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

If the employer/insurer refuses to pay medical benefits, an attorney, who pursues payment of the medical benefits and/or reimbursement may be entitled to a fee from the employer/insurer. Mich Comp Laws Ann §418.315; Watkins v. Chrysler Corp., 167 Mich App 122 (1988).

EXCLUSIVITY/TORT IMMUNITY:

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The benefits provided in the Act constitute the “exclusive remedy” of the employee against the employer for personal injury or occupational disease. Mich Comp Laws Ann §418.131.

B. Exceptions (intentional acts, contractual waiver, ‘dual capacity,’ etc.).

The only statutory exception is for an intentional tort. A tort is “intentional” only when an employee is injured as the result of a deliberate act of the employer and the employer specifically intended the injury. An employer is deemed to have intended to injure if it had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge. Mich Comp Laws Ann §418.131; Travis v. Dreis & Krump Mfg. Co., 453 Mich 149 (1996).”Dual Capacity” may be an exception to the exclusive remedy doctrine depending on the factual situation. Howard v. White, 447 Mich 395 (1994); Wells Fargo v. Firestone Tire & Rubber Co., 421 Mich 64 (1994).
30. Are there any penalties against the employer for unsafe working conditions?

An employee injured or killed as the result of an “intentional act” may proceed in tort, in addition to the workers’ compensation action. Mich Comp Laws Ann §418.131. Placing an employee in unsafe working conditions or dangerous positions and/or violating governmental regulations does not necessarily constitute an intentional tort. Mich Comp Laws Ann §418.131. (See also Answer 29.)

31. What is the penalty, if any, for an injured minor?

Any minor under age 18, who is employed without a work permit, may receive double compensation. However, the fraudulent use of a work permit or a birth certificate would preclude the payment of double compensation. Mich Comp Laws Ann §418.161(1)(l).

32. What is the potential exposure for “bad faith” claims handling?


33. What is the exposure for terminating an employee who has been injured?

The employer may not discharge or in any manner discriminate against an employee because the employee has exercised his or her rights under the Act. Mich Comp Laws Ann §418.301(13). In such instances, the employee may bring a civil action against the employer. Phillips v. Butterball Farms Co. (After2nd Rem), 448 Mich 239 (1995); Clifford v. Cactus Drilling Corp., 419 Mich 356 (1984). Under the recent amendments, effective December 19, 2011, see Mich Comp Laws Ann §418.301(13)

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?


35. Can co-employees be sued for work-related injuries?


36. Is subrogation available?
Where liability lies with a third party, the employee may bring a tort action against that third party. If the employee does not commence an action within one year of the occurrence, the employer/insurer may commence an action within the statute of limitations to enforce liability. If the employee sues and obtains an award, the employer/insurer has a statutory right to subrogation/reimbursement. Mich Comp Laws Ann §418.827. The employer/insurer must pay its proportionate share of the costs and attorney fees. Franges v. General Motors Corp., 404 Mich 590 (1979). Under Michigan Automobile Insurance No Fault Law, there are limitations regarding employer/insurer’s subrogation rights. Bialochowski v. Cross Concrete Pumping Co., 428 Mich 219 (1987); Great American Ins. Co. vs. Queen, 410 Mich 73 (1980).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Medical bills for reasonable and necessary medical expenses must be paid promptly. Mich Comp Laws Ann §418.315. If payments are not made within 30 days after the employer/insurer has received notice of non-payment by certified mail, and there is no ongoing dispute, a $50.00 per day penalty shall be imposed up to $1,500.00. Mich Comp Laws Ann §418.801(3).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

At the time of filing the Application for Hearing, the employee must provide the employer/insurer with any relevant medical records that the employee possesses. Upon filing a response, the employer/insurer must provide the employee with any relevant medical records that are in existence at the time of the filing. Mich Comp Law Ann §418.222. Snyder v. General Safety Corp (On Rem.), 200 Mich App 332 (1993). Additionally, the parties are required to exchange medical examinations conducted in conjunction with the injury and/or claim. Medical information must be furnished to the opposing party within fifteen days of the request. Mich Comp Laws Ann §418.385.

If the employee provides an executed authorization to the employer/insurer, it may obtain any medical information upon which the parties agree. The opposing party must be provided with copies of medical records obtained through the authorization. In addition, either party may subpoena medical records to the Workers’ Compensation Agency on a subpoena which the Agency approves and which counsel signs. Mich Comp Laws Ann §418.853.

39. **What is the rule on (a) Claimant’s choice of physician, and (b) Employer’s right to second opinion and/or Independent Medical Examination?**
A. Claimant’s choice of physician.

The employer has the obligation to furnish the employee reasonable and necessary medical, surgical, hospital services, and medicines, as well as attendant care and/or nursing care as required. After twenty-eight (28) days, the employee may choose a physician by notifying the employer/insurer of the name of the physician and the intention to treat with that physician. An employer/insurer may file an objection to the named physician. Mich Comp Laws Ann §418.315.

B. Employer’s right to second opinion and/or Independent Medical Examination.

The employer/insurer may have the employee examined periodically during the period of disability. If the employee refuses, benefits shall be suspended and may be forfeited. The examination report must be timely provided to the employee or the employer/insurer will be precluded from taking the testimony of the doctor. Mich Comp Laws Ann §418.385. The carrier shall pay travel expenses incidental to the examination. Administrative Code R. 408.45.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

Medical benefits are payable if they are reasonable and necessary and are related to the personal injury. If a dispute develops, the matter may be submitted to the Bureau/Agency. All fees are subject to statutory rules regarding medical cost containment setting forth the maximum rates. Mich Comp Laws Ann §418.315. Attendant care provided by family members is limited to 56 hours per week and does not include non-medical care such as normal meal preparation. Matney v. Southfield Bowl, 218 Mich App 475 (1996).

41. Which prosthetic devices are covered, and for how long?

Medical expenses may include prosthetic devices, including limbs, eyes, teeth, eyeglasses, hearing apparatus or any other appliances necessary to cure, so far as reasonable, and to relieve the effects of the injury. Mich Comp Laws Ann §418.315.

42. Are vehicle and/or home modifications covered as medical expenses?

The magistrate may order modifications and/or additions to the home or vehicle for a medical necessity and/or to rehabilitate the employee. Mich Comp Laws Ann §§ 418.315 and 319. In an exceptional case, a new specially equipped vehicle may be ordered. In Weakland v. Toledo Eng’g Co., 467 Mich 334 (2003), the Supreme Court held that “appliances” within the meaning of §418.315(1) includes necessary modification to a van, but not a new van itself.
43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. Effective June 28, 1989, Michigan adopted the Workers' Compensation Health Care Service Rules, to regulate medical care and the fees charged by physicians, hospitals, etc. The rules comprehensively detail a fee schedule covering virtually all health care services provided to the employee, a requirement that every insurer set up a system for utilization review, a procedure for data collection, and a procedure for dispute resolution. Mich Admin Code R. 418.101-2324.

44. What, if any, provisions or requirements are there for 'managed care'?

The Act has no specific provision or requirements, except that expenses must be reasonable and necessary. Mich Comp Laws Ann §418.315. (See answer 40.)

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

When an Application for Hearing is filed by the employee, the Agency forwards a copy of the Application to the employer/insurer. Within 30 days of receiving the completed Application, the employer/insurer must file a written response on the appropriate form. If the claim is accepted, the employer/insurer files a Form 100/Basic Report of injury with the Agency and a Form 701 indicating the commencement of benefits. If the claim is disputed, the employer/insurer files a Form 107/Notice of Dispute with the Agency setting forth the basis for the dispute. The employer/insurer must file a Carrier Response with the Agency within thirty days of the receipt of the Application for Hearing. The employee and the employer/insurer must each provide the other with any medical records relevant to the claim. Mich Comp Laws Ann §418.222.

46. What is the method of claim adjudication?

A. Administrative level.

Once an Application for Hearing is filed, certain claims will be scheduled for informal mediation by the parties with an Agency appointed representative. The position of mediator has been eliminated. Mediations are limited to cases involving closed periods, medical only claims, no record of coverage, or employees without counsel represented by an attorney. There is a small claims provision for cases under $2000.00. All other cases involving a claim for compensation, petition to stop, or other litigation will be scheduled for a pre-trial conference and then assigned to a Magistrate for hearing. Mich Comp Laws Ann §418.841.
B. Trial court.

Any dispute or controversy concerning compensation or other benefits is submitted to the Agency and assigned to a Magistrate for hearing. The hearing is held in the venue where the injury occurred. The Magistrate makes such inquiries and investigations as deemed necessary, including subpoenaed records. The claimant must prove his entitlement to compensation and benefits under the Act by a “preponderance of the evidence”. Mich Comp Laws Ann §418.851.

C. Appellate.

Once the Decision is received from the Magistrate, either party may file, within thirty days from the mailing date of the Magistrate's decision, a Claim for Review with the Michigan Compensation Appellate Commission. Once the transcript and briefs of the respective parties are filed, the three member Commission panel reviews the evidence and determines whether the fact finding of the Magistrate is supported by competent, material and substantial evidence on the whole record. Either party may file further appeals, by leave, with the Court of Appeals and the Michigan Supreme Court. Mich Comp Laws Ann §§418.859a and 418.861a.

47. What are the requirements for stipulations or settlements?

A claim may be settled by way of compromise and/or stipulation. The agreement must be submitted to the Magistrate for review and approval. A settlement redeeming all liability must be submitted to the Magistrate for approval. All parties must consent to the settlement. The Agency requires specific notification to the employer. Mich Comp Laws Ann §§418.836 and 418.837.

48. Are full and final settlements with closed medicals available?

Yes. See answer 47. A redemption settlement, approved by a Magistrate, with consent of all parties terminates all claims for compensation, including weekly benefits, medical, rehabilitation, etc. Mich Comp Laws Ann §§418.836 and 418.837.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?
Every covered employer must be insured or qualify as a self-insurer. Insurance coverage is available through qualified private insurers. There is an assigned risk pool for certain employers as designated by the Agency. Mich Comp Laws Ann §418.611.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   Individual employers may qualify as self-insurers, subject to approval of the Workers' Compensation Agency. Authorization for self-insurance is dependent upon a showing of solvency, financial ability, and the ability to make payments. The Director may require the furnishing of a bond or other security. Mich Comp Laws Ann §418.611.

   **B. For groups or 'pools' of private entities.**

   Groups or "pools" of private entities in the same industry may qualify for group self-insurance status. Mich Comp Laws Ann §418.611(2).

52. **Are "illegal aliens" entitled to benefits of workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

   "Aliens" are identified as employees, without exception for their illegal status. Mich Comp Laws Ann §418.161(1)(l) In *Sanchez v. Eagle Alloy*, 254 Mich App 651 (2003), the Court of Appeals ruled that an undocumented worker was an employee under the Act. The Court noted that the plaintiff was unable to work due to the commission of a crime, illegal entry into the United States. Once the employer learns of the undocumented status of the employee, the employer can no longer employ him or her. Benefits must be suspended. Conviction is not required, but simply the commission of the crime. The employer must still pay medical and rehabilitation benefits under §418.319. Wage loss benefits may be denied on the basis that the employee is unable to obtain or perform work because of imprisonment or commission of a crime. Mich Comp Laws Ann §418.361(1). *Sweatt v. Department of Corrections*, 468 Mich 172 (2003).

53. **Are terrorist acts or injuries covered or excluded under workers' compensation law?**

   A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**
There are no specific state requirements by way of statute. A magistrate must be satisfied that the interests of Medicare have been properly addressed before agreeing to sign a redemption order or voluntary payment agreement.

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers' compensation by a workers' compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers' compensation matter if at the time of the settlement the employee meets the following criteria:

- The employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or
- There is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 411.404; 42 USC §1395).

Medicare has several options available. It has a direct right of action to recover from any entity responsible for making a payment, including the employer, insurance carrier, plan administrator and third party administrator. Medicare also has the right to suspend payment of Medicare payments on behalf of the employee.

55. **How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

The Michigan statute provides that the State is subrogated to any right of recovery for the cost of hospitalization and medical services not to exceed the amount of funds expended by the State for the care and treatment of the patient. To enforce its subrogation right, the State may either (a) intervene or join in an action or proceeding or (b) institute and

Recent State Guidelines require that the plaintiff, his or her attorney, or the counsel for the employer/insurer contact Medicaid to confirm that no lien exists or to resolve the lien before settlement of any case.

Group disability or hospital service insurers (along with HMOs and Blue Cross Blue Shield) are excepted from the general rule that a workers' compensation payment is not assignable. Mich Comp Laws Ann §418.821(2). This exception for "assignments" extends to reimbursement agreements. *Aetna Life Insurance Co. v. Roose*, 413 Mich. 85 (1982). The health insurer is encouraged to intervene in a proceeding, but notice to the employer or workers' compensation carrier of its right to reimbursement is sufficient to require the employer/carrier to make provision for reimbursement in any settlement reached with the employee. *Ptak v Pennwalt*, 112 Mich. App. 490 (1982).

56. **What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went into effect on April 14, 2003. The law provides an exception for workers' compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(1)] Therefore, the current practice of obtaining medical records could proceed under state law.

At the time of filing their initial pleadings, both the claimant and the carrier shall provide each other with any medical records relevant to the claim that are in their possession. Mich Comp Laws Ann §418.222(2).

57. **What are the provisions for “Independent Contractors”?**

The determination of whether an individual is an Independent Contractor will be based on whether the facts of the case meet the statutory definition of an employee in the Act. Mich Comp. Laws Ann §418.161(1)(n). The Act sets forth that an employee is every person performing service in the course of the trade, business, profession, or occupation of an employer at the time of the injury, if the person in relation to this service does not maintain a separate business, does not hold himself or herself out to and render service to the public, and is not an employer subject to the act. The “economic reality” test no longer is used to decide such questions. *McCaul v Modern Tile & Carpet, Inc*, 248 Mich App 610 (2001); *Hoste v Shanty Creek Management, Inc*. 459 Mich 561 (1999).

Based on the new amendments to the Act, on or after January 1, 2012, the IRS “20-factor test” will be applied to determine if the individual is an employee or independent contractor. A business entity may request the Administrative hearing system to determine whether 1 or more individuals performing service for the entity in this state are in

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary companies/leasing companies?

No. However, the Supreme Court has recognized that in cases involving labor brokers, both the labor broker and the employer are given the protection of the exclusive remedy provision. Mich Comp Laws Ann §418.131; Farrell v Dearborn Mfg Co., 416 Mich 267 (1982); Kidder v Miller-Davis Co, 455 Mich 25 (1997).

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No.

60. What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interest when settling the right to medical treatment benefits under a claim?

Under the Michigan Workers’ Compensation Act, there is no specific requirement. However, as noted, in the event of a settlement under § 418.836, the Magistrate will insist that Medicare’s interest and/or Medicaid’s interest be considered as part of the settlement. The Magistrate will also require the parties to resolve any and all Medicaid liens prior to settlement.
The provisions of Medicare Act 42C FR 411-46 require the state to consider the interest of Medicare. The Federal Medicaid Statute 42 USCA § 1396(K)(b) protects the interest of Medicaid, both on a state and federal level.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state’ workers’ compensation law?**

Under the Michigan Workers’ Compensation Act, § 418.315, requires the employer to furnish reasonable and necessary medical treatment to an injured worker, including medical, surgical and hospital services and medicines, or other attendants or treatment recognized by the laws of this state, as legal, when they are needed. Treatment could include dental services, prosthesis, eye glasses. § 418.315 expressly exempt employers and carriers from paying for “services performed by a profession that was not licensed or registered by the laws of this state on or before January 1, 1998”. The Michigan Appellate Commission has held that this exemption includes the use of medical marijuana, which was not licensed or registered for medical use before January 1, 1998. Subsequently, the legislature passed § 418.315 (A), which indicates that “an employer is not required to reimburse or cause to be reimbursed charges for medical marijuana treatment”.

63. **Does your state permit recreational use of marijuana and what are the restrictions for use and for work activity in your state’ workers’ compensation law?**

Currently, the state legislature is discussing statutory changes for the recreational use of marijuana. The only reference in our state workers’ compensation law is noted in question 62.

Mark D. Robins, Esquire
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Tel: (313) 965-3900 Direct: 313-983-4832
1. Citation for the state’s workers’ compensation statute.

Minnesota Statutes Annotated Ch. 175A and 176, et seq.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

“Employee” means any person who performs services for another for hire. Minn. Stat. Ann. §176.011(9)(1-25). Employee does not include farmers or members of their family who exchange work with other farmers in the same community. §176.011(9a).

3. Identify and describe any “statutory employer” provision.

In an injury or death occur under circumstances creating a legal liability on the part of a party other than employer and that party was insured or self-insured in accordance with the Act, the employee or his dependent may proceed either at law against that party to recover damages or against the employer for benefits but not against both.

The provisions of this section only apply if the employer is liable for benefits and the other party legally liable for damages are insured or self-insured and engaged in due course of business in 1) furtherance of a common enterprise or 2) in the accomplishment of the same or related purpose in operations on the premise where the injury was received at the time of the injury.


4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.
Personal injury means any mental impairment or physical injury arising out of and in the course of employment and includes personal injury caused by occupational disease; but does not cover an employee except while engaged in, on, or about the premises where the employee’s services require the employee’s presence as a part of that service at the time of the injury and during the hours of that service. Where the employer regularly furnished transportation to employees to and from the place of employment, those employees are subject to this chapter while being so transported. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Minn. Stat. Ann. §176.011(16). Predisposition to the disease does not disqualify the claimant from coverage. Swanson v City of St. Paul, 526 NW 2d 366, 369(Minn. Ct. App. 1995).

B. Occupational disease (including respiratory and repetitive use).

“A mental impairment or physical disease arising out of and in the course of employment peculiar to the occupation in which employee is engaged and due to causes in excess of the hazards ordinary of employment” is compensable. Also, “physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable.” Mental impairment is not considered a disease if it results from a disciplinary action, work evaluation, job transfer, etc. Ordinary disease of life to which the public is equally exposed outside of the employment are not compensable, except for if the disease follows an incident of an occupational disease where the exposure particular to the occupation makes the disease an occupational disease hazard. There must be “a direct causal connection between the conditions under which work is performed and it must follow as a natural incident of the employment.” Minn. Stat. Ann. §176.011(15). Predisposition to the disease does not disqualify the employee from coverage. Swanson v. City of St. Paul, 526 N.W. 2d 366, 369 (Minn. Ct. App. 1995).

5. What, if any, injuries or claims are excluded?

Any injury caused by the intentional act of a third person or fellow employee for personal reasons and not directed against the employee as an employee, or because of employment, is excluded. Minn. Stat. Ann. §176.011(16). If injury was intentionally self-inflicted or the intoxication of the employee is the proximate cause of the injury, the employer is not liable, the burden of proof is on the employer. Minn. Stat. Ann §176.021 (1).

Mental impairment is not considered a personal injury or a disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Minn. Stat. Ann. §176.011(15) and (16).

6. What psychiatric claims or treatments are compensable?

Prior to October 1, 2013, any mental injury caused by a job-related stress without physical trauma is not compensable. Minn. Stat. Ann. § 176.021(1); Lockwood v. Independent School District No. 877, 312 N.W.2d 924 (Minn. 1981). However, in
*Middleton v Northwest Airlines*, 600 NW2d 707,711 (Minn. 1999), the Supreme Court ruled that a suicide is compensable even without physical injury if work-related stress can be shown to be the legal and medical cause of the suicide.

Effective October 1, 2013, an employee must be diagnosed with post-traumatic stress disorder by a licensed psychiatrist or psychologist in order to make a compensable mental impairment claim. For the purpose of this chapter, “post-traumatic stress disorder” means the condition as described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. Minn. Stat. Ann. §176.011(15)(d).

7. **What are the applicable statutes of limitations?**

A claim must be filed within three years after the date the employer makes written report of injury to the commissioner or within six years of the date of accident. Minn. Stat. Ann. §176.151(a). In the case of physical or mental incapacity, the period of limitation shall be extended for three years from the date the incapacity ceases. Minn. Stat. Ann. §176.151(c).

8. **What are the reporting and notice requirements for those alleging an injury?**

Unless the employer has actual knowledge of the occurrence of an injury or the employee gives written notice within 14 days after the injury, no compensation is due until notice is given or knowledge is obtained. If notice or knowledge is obtained by the employer within 30 days of the occurrence, compensation will be paid unless the employer can show it was prejudiced by the lack of notice. In any event, if notice is not provided within 180 days, no compensation is allowed excepting extreme circumstances, in which case the amount of compensation is reduced by a sum, which fairly represents the prejudice shown. Minn. Stat. Ann. §§176.141; Service of Notice Form Minn Stat Ann 176.145.

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury, suicide [generally] and intoxication.**

   Minn. Stat. Ann. §176.021 (1) and (1a). See answer 5.

   B. **Willful misconduct, “horseplay,” etc.**

   Generally, where injury-producing conduct is in violation of a specific instruction or order of the employer, benefits are denied unless, contemporaneously with the violation, the employee was performing work in furtherance of the employer’s business. The test is whether the employee departed from the work for which he or she was employed to such an extent that it could not be said to have arisen out of the employment. *Bartley v. C/i-H Riding Stables, Inc.*, 206 N.W. 2d 660 (Minn. 1973); *Van Buren v City of Willmar*, MCCA, No. WC09-5012 (dec’d April 30, 2010), Minn Stat Ann §§176.031
C. **Injuries involving drugs and/or alcohol.**

When an employee becomes so intoxicated that he or she cannot perform any of the usual duties of the employment, an injury sustained while in that condition does not arise out of and in the course of the employment. *Fogarty v. Martin Hotel Co.*, 257 Minn 398 (1960). See also answer 5. Also, if the injury was intentionally self-inflicted or the intoxication of the employee is the proximate cause of the injury, then the employer is not liable for compensation. Minn. Stat. Ann. §176.021(1) and (1a).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Any person who, with intent to defraud, receives workers compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced under the theft statute Minn Stat Ann §609.52. See Minn Stat. Ann. §176.178 (1).

11. **Is there any defense for falsification of employment records regarding medical history?**

False representation as to physical condition or health made by an employee in procuring employment will preclude an award of benefits for an otherwise compensable injury if: (1) the employee knowingly and willfully made the false representation; (2) the employer substantially and justifiably relied on the false representation in hiring the employee; and (3) there is a causal relationship between the false representation and the injury. Minn Stat Ann § 176-178. *Jewison v. Frerichs Const.*, 434 N.W.2d 259 (Minn. 1989).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Generally, injuries are not considered “arising out of or in the course of employment” if the employer did not control or benefit from the recreational or non-work activity. See *McDonald v. St. Paul Fire & Marine Ins. Co.*, 183 NW2d 276 (Minn. 1970). See Answer 9b.

13. **Are injuries by co-employees compensable?**


14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?**

No. Compensable personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of personal reasons, and not directed against the employee as an employee, or because of the employment. Minn. Stat. Ann. §176.011(16).
BENEFITS

15. **What criterion is used for calculating the average weekly wage?**

An employee’s “average weekly wage” is derived by multiplying the daily wage by the number of days and fractional days normally worked in the business of the employer for the employment involved. If the employee normally works less than five days per week or works an irregular number of days per week, the number of days normally worked shall be computed by dividing the total number of days in which the employee actually performed any of the duties of employment in the last 26 weeks by the number of weeks in which the employee actually performed such duties, provided that the weekly wage for part time employment during a period of seasonal or temporary layoff shall be computed on the number of days and fractional days normally worked in the business of the employer for the employment involved. If, at the time of the injury, the employee was regularly employed by two or more employers, the employee’s days of work for all such employment shall be included in the computation of the average weekly wage. Overtime is considered if it is regular or frequent, but not if it is occasional. The maximum weekly compensation must not exceed two-thirds of the product of the daily wage times the number of days normally worked. Minn. Stat. Ann. §176.011(18).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The temporary total disability rate is 66 2/3 percent of the weekly wage at the time of the injury. The maximum weekly compensation payable is $615 per week for dates of injury from 10/01/95 through 09/30/00. For dates of injury from 10/01/00 to 09/30/08, the maximum weekly rate is $750.00. From 10/01/00 to 10/01/13 the maximum weekly rate is $850.00. Commencing on 10/01/13, and each October 1 thereafter, the maximum weekly compensation payable is 102 percent of the statewide average weekly wage for the period ending December 31 of the preceding year. The minimum weekly compensation payable is $104 per week or the employee’s actual weekly wage, whichever is less for dates of injury from 10/01/95 through 09/30/00. For dates of injury on or after 10/01/00, the minimum weekly rate is $130.00 or the actual weekly wage, whichever is less. Temporary total compensation must be paid during the period of disability. Minn. Stat. Ann. § 176.101(1). The maximum period of compensation may not exceed 130 weeks. However, during a period of retraining, the 130 week limitation does not apply, but is subject to the limitation before the plan begins and after the plan ends. Minn. Stat. Ann. § 176.101 (1)(k).

In all cases of temporary partial disability, the compensation is 66 2/3 percent of the difference between employee’s weekly wage at the time of injury and the wage the employee is able to earn in the employee’s partially disabled condition. Such compensation must be paid during the period of disability, with payment to be made at the intervals when the wage was payable, as nearly as may be, and subject to the maximum rate for temporary total compensation. Minn. Stat. Ann. §176.101(2)(a).
17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employer/insurer must commence payment within 14 days of notice to or knowledge by the employer of a compensable injury. It must resume payment within the same time for a new period of temporary total disability, unless it files for an extension with the commissioner within the 14-day period, in which case compensation must commence no later than 30 days from the date of the notice or knowledge of the new period of disability. Minn. Stat. Ann. §176.221(1); Minn. R. 5220.2540.

Once temporary total or permanent total disability benefits have been commenced, they must continue on a regular basis. Payments are due on the date the employee would have received wages from the employer had the employee continued working. The same time limits apply to payments of temporary partial disability benefits. Minn. R. 5220.2540.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out — days before recovering benefits for the first ___ days)?**

In the case of TTD or TPD, no compensation is allowed for the three calendar days after the disability commenced, nor in any case unless the employer has actual knowledge of the injury or is notified within the time period under §176.141. If disability continues for ten calendar days or longer, the compensation is computed from the commencement of the disability. Disability is deemed to commence on the first calendar day or fraction of a calendar day that the employee is unable to work. Minn. Stat. Ann. §176.121.

19. **What is the standard/procedure for terminating temporary benefits?**

The employer/insurer may not discontinue payment of compensation until it provides the employee with written notice of its intention to do so. The notice must be filed with the division and state the date of intended discontinuance and set forth a statement of facts clearly indicating the reason for the action. Copies of medical reports or other written reports relied upon for the discontinuance must be attached to the notice. Minn. Stat. Ann. § 176.238(1)(a).

If the reason for discontinuance is that the employee has returned to work, TTD may be discontinued effective the date the employee returned to work. A written notice shall be served upon the employee and filed with the Workers’ Compensation Division with 14 days. Minn. Stat. Ann. §176.238(1)(b).

Instead of filing a notice of discontinuance, an employer/insurer may serve on the employee and file with the commissioner a petition to discontinue compensation. The petition must include copies of medical reports or other written reports or evidence bearing on the physical condition or other present status of the employee which relate to the proposed discontinuance. Minn. Stat. Ann. § 176.238(5); Minn. R. 5220.2630 (discontinuance of compensation).
20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No.

21. What disfigurement benefits are available and how are they calculated?

There is a provision for disability calculations due to burns. Minn. R. 5223.0240. There is no other specific provision regarding disfigurement. However, under certain circumstances, with respect to certain industries disfigurement may be characterized as a “personal injury” under the statute, which has led to direct wage loss. See Minn. Stat. Ann. §176.011(16).

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

See answer 22B.

B. Number of weeks for “whole person” and standard for recovery.

Payments for permanent partial disability must be made in the following manner: (1) If the employee returns to work, payment is made at the same interval as temporary total payments were made; (2) If temporary total payments have ceased; but the employee has not returned to work, payment is made at the same intervals as temporary total payments were made; (3) If temporary total disability payments cease because the employee is receiving payments for permanent total disability or because the employee is retiring or has retired from the work force, then payment is made at the same intervals as temporary total payments were made; (4) If the employee completes a rehabilitation plan, but the employer does not furnish the employee with work the employee can do in a permanently partially disabled condition, and the employee is unable to procure such work with another employer, then payment is made at the same intervals as temporary total payments were made. Minn. Stat. Ann. §176.021(3a).

Compensation for permanent partial disability must be rated as a percentage of the whole body. Minn. Stat. Ann. §§176.10l(2) and 176.105. The percentage determined pursuant to the rules must be multiplied by the corresponding amount in the following table:

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<tr>
<th>Impairment Compensation</th>
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<tbody>
<tr>
<td>Percent of disability</td>
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<tr>
<td>0 to less than 5.5</td>
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<td>Percentage Range</td>
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<td>5.5 to less than 10.5</td>
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An employee may not receive compensation for more than a 100 percent disability of the whole body, even if he or she sustains disability in two or more body parts. §176.101(2a)(a).

Permanent partial disability is payable upon cessation of temporary total disability. The employee may request a payment in lump sum. If so, he or she must be paid in 30 days. The payment may be discounted to the present value calculated up to a maximum five percent basis. The compensation is also payable in installments at the same intervals and in the same amount as the employee’s temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid. Minn. Stat. Ann. § 176.101(2a)(b).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Such benefits are available and intended to return the employee to a job related to the former employment or to another job which produces an economic status as close as possible to that the employee would have had but for the disability. Rehabilitation to a job with a higher economic status is permitted if it can be demonstrated that it is necessary to increase the likelihood of re-employment. Economic status is measured by both opportunity for immediate and future income. Minn. Stat. Ann. §176.102(1)(b).

A rehabilitation consultation must be provided upon request of the employee, the employer, or the commissioner. Minn. Stat. Ann. § 176.102(4). The employer may select
the consultant, but if the employee objects to the employer’s choice, he or she may select one within 60 days after a rehabilitation plan is filed. Id. The commissioner or a compensation judge determines eligibility for rehabilitation services, and will review, approve, modify, or reject rehabilitation plans. Minn. Stat. Ann. § 176.102(6)(a).

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total disability is defined as: (1) the total and permanent loss of the sight of both eyes, the loss of both arms at the shoulder, the loss of both legs so close to the hips than no effective artificial members can be used, complete and permanent paralysis, total and permanent loss of mental faculties; or (2) any other injury which totally and permanently incapacitates the employee from working at an occupation which brings the employee an income, provided that the employee must also meet the criteria of one of the following clauses: (a) the employee has at least a 17 percent permanent partial disability rating of the whole body; or (b) the employee has a permanent partial disability rating of the whole body of at least 15 percent and the employee is at least 50 years old at the time of the injury; or (c) the employee has a permanent partial disability rating or the whole body of at least 13 percent and the employee is at least 55 years old at the time of the injury, and has not completed grade 12 or obtained a GED certificate. Employees must also show that the above causes result in the fact that the employee is unable to secure anything more than sporadic employment resulting in an insubstantial income other factors non-specified above including the employee’s age, education, training and experience, may only be considered in determining whether an employee is totally and permanently incapacitated after the employee meets the threshold criteria. . Minn. Stat. Ann. §176.101(5) (2) (ii) (iii).

Compensation for permanent total disability is 66-2/3 percent of the daily wage at the time of the injury, subject to a maximum weekly compensation equal to the maximum weekly compensation for a temporary total disability, and a minimum weekly compensation equal to 65 percent of the state average weekly wage. Such compensation is to be paid during the employee’s permanent total disability, but after a total of $25,000 of weekly compensation has been paid, the amount of weekly compensation benefits being paid by the same employer is reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are occasioned by the same injury or injuries which gave rise to payments under the subdivision.. Minn. Stat. Ann. §176.101(4).

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

The employer must pay the expense of burial up to $15,000. Minn. Stat. Ann. §176.111 (9)(12)(14)(15)&(17)

B. Dependency claims.
A spouse, child, parent, grandparent, grandchild, sister, brother, mother-in-law, or father-in-law wholly supported by a deceased employee at the time of death, and for a reasonable time prior thereto, is considered an actual dependent of the deceased employee, and compensation is paid to such dependents in the order named. Minn. Stat. Ann. §176.111(3).

Actual dependents are entitled to take compensation during dependency until two-thirds of the weekly wage of the deceased at the time of injury is exhausted. The total weekly compensation to be paid to full actual dependents of a deceased employee must not exceed, in the aggregate, an amount equal to the maximum weekly compensation for temporary total disability. Minn. Stat. Ann. §176.111(20).

There are also provisions for remarriage of a spouse, orphans, parents, remote dependents, and partial dependents. See generally Minn. Stat. Ann. § 176.111 (9) – (17).

26. **What are the criteria for establishing a “second injury” fund recovery?**


27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Except when a writ of certiorari has been issued by the state supreme court and the matter is still pending in that court, or if as a matter of law the determination of the state supreme court cannot be subsequently modified, the workers’ compensation court of appeals, for cause, at any time after an award, upon application of either party and not less than five working days after written notice to all interested parties, may set the award aside and grant a new hearing and refer the matter for a determination on its merits to the chief administrative law judge for assignment to a compensation judge, who will make findings of fact, conclusions of law, and an order of award or disallowance of compensation or other order based on the pleadings and the evidence produced. Minn. Stat. Ann. § 176.461.

As used in this section, the phrase “for cause” is limited to the following: (1) a mutual mistake of fact; (2) newly discovered evidence; (3) fraud; or (4) a substantial change in medical condition since the time of the award that was clearly not anticipated and could not reasonably have been anticipated at the time of the award. There is no statute of limitations for re-opening a claim. Id.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**
Attorney fees incurred with respect to a disputed recovery of medical or rehabilitation benefits or services are assessed against the employer/insurers only if the attorney establishes that the contingent fee is inadequate to reasonably compensate the attorney for representing the employee in the medical or rehabilitation dispute. Minn. Stat. Ann. §176.081(1a)(l).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The liability of an employer is exclusive and in the place of any other liability to such employee or other person entitled to recover damages on account of such injury or death. If an employer, other than the state or any municipal subdivision thereof, fails to insure or self-insure its liability for compensation, an employee, representative, or if death results from the injury, any dependent, may elect to claim compensation or to maintain a common law action for such injury or death. In such an action, the employer may not plead as a defense: (1) negligence of a fellow servant; (2) assumption of the risk; or (3) contributory negligence, unless such negligence was willful. The burden of proof is upon the employer. Minn. Stat. Ann. §176.031.

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

There is an exception for intentional torts of the employer, with deliberate intent to inflict the injury. See Konken v. Oakland Farmers’ Elevator Co., 425 N.W.2d 302 (Minn. App. 1988). This exception has not been extended to acts taken in intentional disregard of safety standards or circumstances in which the employer knows injury is substantially certain to result from the act. See DeVries v. Emblom, 420 N.W.2d 670 (Minn. App. 1988).

The “dual capacity” doctrine provides that the employer may become liable to employees if it has a second capacity that imposes obligations independent of those imposed as an employer. See Terveer v. Norling Bros. Silo Co., Inc., 365 N.W.2d 279 (Minn. App. 1985).

30. Are there any penalties against the employer for unsafe working conditions?

There is no such specific provision.

31. What is the penalty, if any, for an injured minor?

None.

32. What is the potential exposure for “bad faith” or claims handling?
Up to an additional 30% of benefits paid may be awarded if the employer/insurer has: (1) instituted a proceeding or defense which is frivolous or for delay; (2) unreasonably delayed payment; (3) neglected or refused to pay compensation; (4) intentionally underpaid compensation; (5) frivolously denied a claim; or (6) unreasonably discontinued compensation. Minn. Stat. Ann. § 176.225(1). Where the employer has inexcusably delayed payments, the delayed payments are increased by 25%. Withholding amounts due because the employee refuses to execute a release from further benefits is regarded as inexcusable delay in making payments. Minn. Stat. Ann § 176.225(5) If any sum ordered by the Department is not paid when due, and no appeal of the order is made, it bears interest at 12%. Minn. Stat. Ann. § 176.225(5). There are additional penalties for advising an employee not to obtain an attorney, regularly failing to timely pay weekly benefits, failing to reply, within 30 days, to a written communication from an employee about a claim that requests a response, etc. Minn. Stat. Ann. §§176.194(3) and (4).

33. **What is the exposure for terminating an employee who has been injured?**

A justifiable discharge for misconduct suspends an employee’s right to wage loss benefits, but the suspension of benefits will be lifted if the employee’s work-related disability is the cause of the inability to find or hold new employment. Marsolek v. George A. Horinel Co., 438 N.W.2d 922, 924 (Minn. 1989). Any person discharging or intentionally threatening to discharge an employee for seeking benefits, or obstructing an employee seeking benefits, is liable in a civil action for damages incurred by the employee, including any diminution in benefits caused by such action, including costs and attorney fees, and for punitive damages up to three times the amount of benefits to which the employee is entitled. Damages so awarded will not be offset by any worker’s compensation benefits. Minn. Stat. Ann. § 176.82(1).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes, but the employee must elect to either collect workers’ compensation benefits or pursue such an action against the third party. Minn. Stat. Ann. § 176.061(1). This section applies only if the employer and the other liable party are insured and engaged in business: (1) in furtherance of a common enterprise; or (2) in the accomplishment of the same or related purposes in operations on the premises where the injury was received at the time of the injury. Minn. Stat. Ann. §176.061(4). If the third party is not insured, legal proceedings may be taken by the employee, employer, or by the attorney general on behalf of the Special Compensation Fund, against the third party, notwithstanding the payment of benefits by the employer or the special compensation fund or their liability to pay benefits. Minn. Stat. Ann. § 176.061(5).

35. **Can co-employees be sued for work-related injuries?**

36. **Is subrogation available?**

Yes. The employer/insurer or the attorney general on behalf of the Special Compensation Fund may pursue a third party for the aggregate amount of benefits payable to or on behalf of the employee, regardless of whether such benefits are recoverable by the employee at common law or by statute, together with costs, disbursements, and attorney’s fees. Minn. Stat. Ann. §176.061(3).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The employer/insurer must pay medical bills, or any portion, which is not denied, or deny the bill, within 30 days of written notice to the employee and the provider explaining the basis for any denial. Minn. Stat. Ann. §176.135(6). Penalties, up to 105% (not to exceed $5,000) of the amount owed, may be assessed for late payment, in the commissioners discretion. Minn. Stat. Ann. §176.221(3) and (6 (a)); Alternatively, a penalty of up to $2,000.00 may be assessed for failure to make payment. Minn. Stat. Ann. §176.221(3)(a).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The release of medical data related to a claim to any party, or to the Department, does not require the approval of any party. Medical data not directly related to a claim must not be released without the employee’s prior authorization. The data must be provided within seven working days of a proper request. If any party other than the employee makes the request, it must provide written notice of the request, or discussion with the provider, to the employee. Failure to release medical data as required may be punishable by a fine up to $600. Minn. Stat. Ann. §176.138(a), (b),(c).

An employer/insurer may, for the sole purpose of identifying duplicate billings, disclose information about treatment dates and charges, etc., to other insurers without prior authorization. Such data, however, must not be used for any other purpose, and must be destroyed after verification that there was no duplicate billing. If the data is used in a manner not allowed, the employee has a cause of action for actual and punitive damages of at least $5,000. Minn. Stat. Ann. §176.138(d).

39. **What is the rule on (a) Claimant’s choice of physician; and (b) Employer’s right to a second opinion?**

Employees may choose their own physicians, but must submit to examination by the employer’s physician if requested. Such an examination must be scheduled within 150 miles of the employee’s residence unless the employer can show cause for a more distant location. The employee is entitled upon request to have a personal physician present at
any such examination. The examination shall be completed and the report of the examination shall be served on the employee and filed with the commissioner within 120 days of services of the claim petition. Minn. Stat. Ann. § 176.155(1). Where the injury is disputed, the commissioner of labor and industry, or the compensation judge conducting a hearing, may designate a neutral physician to conduct an examination and report the findings. Minn. Stat. Ann. § 176.155(2).

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employer must furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medical, medicines, chiropractic, and surgical supplies, supplies, crutches and apparatus, including artificial members, or, at the option of the employee, if the employer has not filed the proscribed notice. Christian Science treatment, in lieu of medical treatment, chiropractic medicine and medical supplies, as may be reasonably required at the time of the injury and any timer thereafter to cure and relieve the effects of the injury. The treatment shall also include treatments necessary to physical rehabilitation. Minn. Stat. Ann. §176.135(1)(a).

41. **Which prosthetic devices are covered, and for how long?**

The employer shall furnish replacement or repair artificial members, glasses, spectitals, artificial eyes, podiatric orthotics, dental bridgework, dentures or artificial teeth, hearing aides, canes, crutches or wheelchairs damaged by a reason of an injury arising out of the course of the employment. For purposes of this paragraph, injury includes damaged wholly or in part to artificial member. Minn. Stat. Ann. §176.135(1)(d).

42. **Are vehicle and/or home modifications covered as medical expenses?**

The employer must furnish to an employee who is permanently disabled alterations or remodeling reasonably required to enable the employee to move freely into and throughout the principal residence and to otherwise accommodate the disability. Such payments need only be made if the Division or workers’ compensation court of appeals determines that the injury substantially prevents the employee from functioning within the principal residence. Minn. Stat. Ann. § 176.137(1). Such payments are limited to prevailing costs in the community. The cost of obtaining architectural certification and supervision is included in the statutory limit. Minn. Stat. Ann. §176.137(2). An employee is limited to $75,000 under §137 for each personal injury. Minn. Stat. ann. §176.137(5).

Vehicular modification is not specifically covered. The standard is most likely “reasonableness under the circumstances”.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

44. **What, if any, provisions or requirements are there for “managed care”?**

Any person or entity, other than a workers’ compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified that provides management of quality treatment to employees for compensable injuries and diseases. Application for certification must be made in the form and manner prescribed by law and must set forth information regarding the proposed plan for providing services as the commissioner may prescribe. Minn. Stat. Ann. § 176.1351. The commissioner shall certify a managed care plan. If the commissioner finds the plan satisfies the requirements of the statute. Minn. Stat. Ann § 176.1351 (2) (1-12)

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

The employer/insurer must give the employee written notice of a denial of liability. If liability is denied for an injury, which must be reported to the commissioner, the denial of liability must be filed with the commissioner within 14 days after notice to or knowledge by the employer of the injury. If the employer/insurer has commenced payment but determines that the disability is not compensable, payment may be terminated upon the filing of a notice of denial of liability within 60 days. After that time, payment may be terminated only by the filing of a special notice. Upon termination, payments may be recovered by the employer if the employee’s claim was not made in good faith. Commencement of payment by an employer or insurer does not waive any rights to any defense the employer has on any claim or incident either with respect to the compensability of the claim under this chapter or the amount of compensation due. Minn. Stat. Ann. §176.221(1).

46. **What is the method of claim adjudication?**

A. **Administrative level.**

There are a number of applicable administrative panels. The rehabilitation review panel reviews and makes determinations “with respect to appeals from orders of the commissioner regarding certification approval of qualified rehabilitation consultants and vendors.” The hearings are *de novo* and are appealable to the workers’ compensation court of appeals. Minn. Stat. Ann. § 176.102(3). The rehabilitation panel also reviews decisions related to the eligibility of an employee for rehabilitation. There is a medical services review board, which reviews “clinical results for adequacy and recommend[s] to the commissioner scales for disabilities and apportionment.” Minn. Stat. Ann. §176.103(3). There is also a provision for an administrative conference concerning discontinuance of compensation. Minn. Stat. Ann. § 176.239.
B. Trial court.

The Department of Labor and Industry small claims court, presided over by settlement judges, was established for the purpose of settling small claims. Minn. Stat. Ann. §176.2615(1). When a workers’ compensation issue is present in the district court action, the court may try the action itself, without a jury, or refer the matter to the chief administrative law judge for assignment to a compensation judge to report findings and decisions to the court. Minn. Stat. Ann. §176.301. The court may approve or disapprove such decision in the same manner as it approves or disapproves the report of a referee.

The court enters judgment upon such a decision. Minn. Stat. Ann. § 176.301(1).

Decisions of the district court are appealable. See Minn. Stat. Ann. §176.301(2). When a petition has been filed with the Division, the commission refers the matter presented by the petition for a settlement conference, for an administrative conference, or for a hearing. See Minn. Stat. Ann. §176.305. Hearings on petitions are held before a compensation judge pursuant to a determination by the chief administrative law judge. Minn. Stat. Ann. §176.341(1).

C. Appellate.

The Workers’ Compensation Court of Appeals (WCCA) has statewide jurisdiction to determine all compensation issues in cases appealed to the WCCA or transferred from district court. See Minn. Stat. Ann. §175A.01 (5). A party may appeal within 30 days from a compensation judge’s award or disallowance of compensation or other order. See Minn. Stat. Ann. §176.421(1). A party may also appeal from a decision or determination of the commissioner affecting a right, privilege, benefit, or duty, which is imposed by Chapter 176. Minn. Stat. Ann. §176.442. No direct appeal to the WCCA is allowed if the decision may be heard de novo in another proceeding, including but not limited to a decision from an administrative conference under §§176.102, 176.103, 176.106, 176.239, or a summary decision under §176.305. Minn. Stat. Ann. § 176.442. The grounds for appeal are contained in Minn. Stat. Ann. §176.421.

A party may seek review of the WCCA’s decision by the Minnesota Supreme Court, on certiorari, upon three grounds: (I) the order does not conform with Chapter 176; (2) the WCCA committed any other error of law; or (3) the findings of fact and order were unsupported by substantial evidence in view of the entire record as submitted. See Minn. Stat. Ann. § 176.471(1).

47. What are the requirements for stipulations or settlements?

If the parties agree to stipulated set of facts, the commissioner or compensation judge may determine the matter without a hearing and the determination is appealable to the court of appeals. In any case where facts are stipulated to, the chief administrative law judge immediately assigns the case to a compensation judge, who must issue a determination within 60 days. Minn. Stat. Ann. §176.322.
An agreement to settle any claim is valid if: (1) it is in writing and signed by the parties; and (2) where any party is unrepresented, the commissioner or judge has approved the settlement and made an award thereon. If the matter is on appeal before the district court, the district court is the approving body. Minn. Stat. Ann. § 176.521(1)(a).

If the matter is on appeal before the workers’ compensation court of appeals, the proposed settlement shall be submitted for approval to a compensation judge at the Office of Administrative Hearings. Before the settlement is submitted to the compensation judge, the parties shall notify the workers’ compensation court of appeals and request that it suspend further action on the appeal pending review of the settlement by the compensation judge. Within 14 days after the compensation judge’s final approval or disapproval of the settlement, the parties shall notify the workers’ compensation court of appeals of the compensation judge’s action and shall request that the appeal be dismissed or reactivated. Minn. Stat. Ann. § 176.521(1)(b).

48. Are full and final settlements with closed medicals available?

The commissioner, compensation judge, and the district court exercise discretion in approving or disapproving a proposed settlement. The parties to the agreement of settlement have the burden of proving that the settlement is reasonable, fair, and in conformity with the Act. Minn. Stat. Ann. § 176.521(2).

A settlement agreement where both parties are represented by an attorney is conclusively presumed to be reasonable, fair, and in conformity with the Act, except when the settlement purports to be a full, final, and complete settlement of an employee’s right to medical compensation. A settlement, which purports to do so, must be approved by the commissioner or a compensation judge. The conclusive presumption applies to a settlement agreement entered into on or after January 15, 1982, regardless of the date of injury. Minn. Stat. Ann. §176.521(2).

49. Must stipulations and/or settlements be approved by the state administrative body?

See answer 48. Further, when a settled case is not subject to approval, upon receipt of the stipulation for settlement, the commissioner or a compensation judge must immediately sign the award and file it with the commissioner. Payment pursuant to the award is made within 14 days after it is filed. The commissioner may correct mathematical or clerical errors at any time. Minn. Stat. Ann. §176.521(2a).

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Every employer, except the state and municipal and its subdivisions, liable under this chapter to pay compensation shall ensure payment of compensation with some insurance
carrier authorized to ensure workers’ compensation liability in this state, or obtain a written order from the commissioner of commerce exempting the employer from insuring liability for compensation and permitting self-insurance of liability. The terms governing self-insured shall be established by the commissioner pursuant to Chapter 14. Minn. Stat. Ann. § 176.181(2). With the approval of the commissioner of commerce, any employer may exclude the medical, chiropractic and hospital benefits required. Id. Workers’ compensation insurance is available from private insurers, a state created special compensation fund, and an assigned risk pool. See generally Minn. Stat. Ann. §§176.129, 176.181, 176.183.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**


   **B. For groups or “pools” of private entities.**

   Two or more employers regardless of whether they are in the same industry, may pool for the purpose of qualifying as a group self-insurer. Minn. Stat. Ann. §176.181(2)(a). No association, corporation partnership, sole proprietorship, trust or other business entity shall provide services in the design, establishment or administration of a group self-insurance plan unless it is licensed to do so by the commissioner of commerce. Minn. Stat. Ann. §176.181(2)(b).

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**


53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

   Under Minnesota’s Workers’ Compensation Act, injuries caused by terrorist acts are not excluded.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**
Federal law requires that Medicare’s interests be protected in all workers’ compensation settlements per 42CFR 411.46. It requires that a specific portion of the workers’ compensation claim settlement be allocated to cover future medical expenses that otherwise would be paid by Medicare and a specific set-aside arrangement for paying those future medical expenses be presented to and approved by Medicare before the settlement is finalized. The Centers for Medicare and Medicaid Services (CMS) evaluates, on a case by case basis, Medicare Set Aside Arrangements as a way of complying with the federal law. In order to evaluate whether Medicare’s interests have been reasonably consider, CMS looks at the settlement agreement, the life care plan, documentation that gives the basis for the amount of projected expenses, administrative fee, et cetera.

CMS has created a threshold which states: “An injured individual who is not yet a Medicare beneficiary should only consider Medicare’s interests when the injured individual has a ‘reasonable expectation’ of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement amount for future medical expenses and disability/loss wages over the life or duration of the settlement agreement is expected to be greater than $250,000.”
55. **How are subrogation liens with Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires states to include in their plan for medical assistance provision (1) that the individual will assign to the state any rights to payment for medical care from any third party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The state is authorized to retain such amounts as is necessary to reimburse it (and the federal government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

In practice, a Medicaid lien typically involves monies paid out in advance of the settlement. At the time of settlement, the parties have identified the exact amount of the Medicaid lien which can be compromised before the settlement is finalized.

Health insurers’ liens also typically involve monies paid out in advance of the settlement. At the time of settlement, the parties again have identified the exact amount of the health insurers’ lien which can be compromised before the settlement is finalized.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPPA)?**

See answer to question 38.

HIPPA is a federal statute assigned to establish a national standard for protecting the privacy of, and ensuring a patient’s access to, his or her individual medical information. Compliance became mandatory on April 14, 2003. An exception to the general rule applies to certain very narrowly defined disclosures of protected health information that occurs in the context of workers’ compensation claims. A covered entity may disclose medical information without individual authorization to the extent necessary to comply with a workers’ compensation statute. Other than this, HIPPA requires that the disclosure of medical information in the workers’ compensation context is subject to the general rule requiring a HIPPA-compliant authorization, a court order, “satisfactory assurance” or a qualified protective order.

57. **What are the provisions for “Independent Contractors”?**

Every independent contractor doing commercial or residential building construction or improvements in the public or private sector is an employee of any employer under this chapter for whom the independent contractor is performing service in the course of the trade, business, profession, or occupation of that employer at the time of the injury. Minn. Stat. Ann. §176.041(1). The independent contractor is not an employee of an employer for whom the independent contractor performs work or services only if the following
conditions are met: (1) the individual holds a current independent contractor exemption certificate issued by the commissioner; and (2) the individual is performing services for the person under the independent contractor exemption certificate as provided in subdivision 6. The requirement in clause (1) and (2) must be met in order to qualify as an independent contractor and not as an employee of the person for whom the individual is performing services in the course of the person’s trade, business, profession or occupation. Minn. Stat. Ann §181.723 (4).

A person, partnership, limited liability company, or corporation hiring an independent contractor, as defined by rules adopted by the commissioner, may elect to provide coverage for that independent contractor. A person, partnership, limited liability company, or corporation may charge the independent contractor a fee for providing the coverage only if the independent contractor (1) elects in writing to be covered, (2) is issued an endorsement setting forth the terms of the coverage, the name of the independent contractors, and the fee and how it is calculated. Minn. Stat. Ann. § 176.041(1)(f).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary companies/leasing companies?

No.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

In the trucking and messenger/courier industries, an operator of a car, van, truck, tractor or truck-tractor that is licensed and registered by a governmental vehicle agency is an employee unless each of certain factors is present, and if each factor is present, the operator is an independent contractor. The factors are (1) the individual owns the equipment or holds it under a bona fide lease agreement; (2) the individual is responsible for maintenance of the equipment; (3) the individual is responsible for the operating costs, including fuel, repairs, supplies, vehicle insurance and personal expenses; (4) the individual is responsible for supplying the necessary personal services to operate the equipment; (5) the individual’s compensation is based on factors related to work performed, such as a percentage of any schedule of rates, and not on the basis of hours of time expended; (6) the individual substantially controls the means and manner of performing the services, in conformance with regulatory requirements and specifications of the shipper; and (7) the individual enters into a written contract that specifies the relationship to be that of an independent contractor and not that of an employee. Minn. Stat. Ann. §176.043.

60. What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefits costs and losses?
Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interest when settling the right to medical treatment benefits under a claim?

Under the Minnesota Workers’ Compensation Act, there is no specific requirement. However, as noted, in the event of a settlement the Commissioner will insist that Medicare’s interest and/or Medicaid’s interest be considered as part of the settlement. The Commissioner will also require the parties to resolve any and all Medicaid liens prior to settlement.

The provisions of Medicare Act 42C FR 411-46 requires the state to consider the interest of Medicare. The Federal Medicaid Statute 42 USCA § 1396(K)(b) protects the interest of Medicaid, both on a state and federal level.

The ALFA affiliated counsel who compiled this State compendium offers and expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Mark D. Robins, Esquire
mrobins@plunkettcooney.com
Tel: (313) 965-3900
1. Citation for the state’s workers’ compensation statute.

Section 71-3-1 et. seq., MISS. CODE ANN.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

“Employee means any person, including a minor, whether lawfully or unlawfully employed in the service of an employer under any contract of hire or apprenticeship, written or oral, express or implied, provided that there shall be excluded therefrom all independent contractors . . . .” § 71-3-3(d)

3. Identify and describe any “statutory employer” provision.

Employees of subcontractors without workers’ compensation coverage are statutory employees of the general contractor. The condition precedent is that a general contract be in existence and that the statutory employer not be merely a premises owner. § 71-3-7

4. What type of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrences” claims.

Accidental injury is defined as an injury resulting from an untoward event or events or aggravated or accelerated by the employment in a significant manner, including events causing unexpected results. § 71-3-3(b)

B. Occupational disease (including respiratory and repetitive use).

These injuries are covered and the standard of proof is no different than any “traumatic” injury.
5. **What, if any, injuries or claims are excluded?**

   Intentional acts, intoxication bar receipt of benefits. § 71-3-7

6. **What psychiatric claims or treatments are compensable?**

   Psychiatric claims are covered; however, mental/mental claims require clear and convincing proof of something outside the ordinary employment experience or in excess of the ordinary employment experience.

7. **What are the applicable statutes of limitations?**

   Two year statute of limitations for claims in which no indemnity benefits have been paid. § 71-3-35(1) If indemnity benefits have been paid, there is a one-year statute of limitation that begins to run with the filing of a Commission Form B-31 in the appropriate manner. § 71-3-53

8. **What are the reporting and notice requirements for those alleging an injury?**

   There is a statutory requirement that the employer receive notice of injury within 30 days after its occurrence. However, prejudice must be shown in order to use the absence of notice as a bar to recovery. § 71-3-35(1)

9. **Describe available defenses based on employee’s conduct:**

   A. **Self-inflicted injury.**

      Benefits are barred. § 71-3-7

   B. **Willful misconduct, horseplay, etc.**

      Benefits are barred for willful conduct, including the acts of an aggressor in what might otherwise appear to be a horseplay situation. Simple horseplay, something that falls within the reasonable expectations of interaction between coworkers, will typically not act as a bar, nor will a claim by the object of the aggressor be barred.

   C. **Injuries involving drugs and/or alcohol.**

      Recovery of benefits is barred if the intoxication is the proximate cause of the injury. § 71-3-7. For injuries from July 1, 2012, forward. See also § 71-3-121 regarding presumption of proximate cause in certain cases.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

    The Commission has authority to assess reasonable expenses, including attorney’s fees, and sanctions up to $10,000. § 71-3-59 Additionally, it is a misdemeanor to make any false or misleading statement or representation for the purpose of obtaining benefits, with punishment being a fine not to exceed $1,000 and/or imprisonment not to exceed one year. § 71-3-69
11. Is there any defense for falsification of employment records regarding medical history?

Although employers have asserted fraud in the inducement as a defense, as a practical matter, this argument has not historically worked to defeat compensability.

12. Are recreational and other non-work activities paid for or supported by the employer compensable?

Yes.

13. Are injuries by co-employees compensable?

Yes.

14. Are acts by third-parties unrelated to work, but committed on the premises, compensable (e.g. “irate paramours” claims)?

A case by case analysis is required. If the assault by the third person be totally unrelated to the work, theoretically the injury is not compensable; however, consideration must be given for the “zone of risk”, which may bring compensability into play.

BENEFITS

15. What criterion is used for calculating the average weekly wage?

Fifty-two weeks prior to injury.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Two-thirds of employee’s average weekly wage, subject to the weekly maximum (which is $505.43 for 2020 injuries). The weekly minimum temporary benefit is $25.00 a week.

17. How long does the employer/insurer have to begin TTD benefits from the date disability begins?

Fourteen (14) days.

18. What is the “waiting” or “retroactive” period for temporary benefits?

Must be out five days before receiving any benefits and must be out for 14 days or more to receive benefits retroactive to date disability began. § 71-3-11

19. What is the standard/procedure for terminating temporary benefits?

Temporary benefits may be terminated upon the claimant’s reaching maximum medical improvement and/or returning to work. Additionally, if an individual is deemed to be available for light duty and light duty is provided by the employer, temporary benefits may be terminated if the claimant returns to his pre-injury wage rate. If he is making
something less, you could have a temporary partial situation. From the Commission’s standpoint, a Form B-18 notifying the claimant and the Commission of the termination of benefits and the basis for that termination should also be prepared and filed.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

   Only in cases of permanent total disability or when the combination of the two would exceed the overall maximum. (NOTE: Any payment beyond maximum medical improvement date or return to work date would be treated as permanent benefits, even if denominated as “TTD”.)

21. **What disfigurement benefits are available and how are they calculated?**

   For injuries occurring prior to July 1, 2012, up to $2,000 calculated at the discretion of the Commission. A determination can be made no less than one year after the date of the injury. For injuries occurring on or after July 1, 2012, up to $5,000.00.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

   **A. How many weeks are available for scheduled members/parts, and the standard for recovery.**

   Reference is made to the schedule. § 71-3-17(c)

   **B. Number of weeks for “whole person” and standard for recovery.**

   450 weeks are available for “whole person” injuries. The standard is the loss of wage earning capacity.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

   No, although for injuries occurring prior to July 1, 2012, a claimant may receive up to $10/wk for up to 52 weeks while receiving vocational rehabilitation retraining, at the discretion of the Commission. For injuries occurring on or after July 1, 2012, $25/wk. (This is a limited benefit rarely requested by claimants.)

24. **How are permanent disability benefits calculated, including the minimum and maximum rates?**

   Two-thirds of the claimant’s weekly lost wage earning capacity provides the basis for benefits. Maximum is as previously stated, two-thirds of the state average weekly wage. For injuries after May, 1992, there is no minimum permanency award. For injuries prior to May, 1992, there is a $25.00 minimum if there is a finding of any permanent loss of wage earning capacity.

25. **How are death benefits calculated, including the minimum and maximum rates?**

   § 71-3-25
(The statute should always be reviewed and consulted before payment of benefits.)

A. **Funeral expenses** –

For injuries occurring prior to July 1, 2012, not to exceed $2,000.00. Not to exceed $5,000.00 for injuries from and after July 1, 2012.

B. **Dependency claims** –

For injuries occurring prior to July 1, 2012, if there be a surviving spouse, an immediate lump sum of $250.00 is payable to a surviving spouse. ($1,000.00 for injuries from and after July 1, 2012.) If there be a surviving spouse and no child of the decedent, that surviving spouse shall receive 35% of the average weekly wage of the deceased during widowhood. If there also be a surviving child or children, then each such child shall receive and additional amount of 10% of the average weekly wage; and, in the case of death or remarriage of the surviving spouse, each such child shall have his percentage increased to 15%, all subject to a total cap of 66 2/3% of the average weekly wage, as well as subject to the maximum limitations as to weekly benefits. If there be no surviving spouse, then the surviving children shall each get 25% of the average weekly wage of the decedent, subject to the limitations. If the combination of surviving spouse and child or children does not aggregate 66 2/3% of the average weekly wage of the decedent, subject to the maximum limitations as to weekly benefits, then dependent grandchildren or brothers and sisters or parents and grandparents, would each be entitled to 15% of the average weekly wage, again all subject to the maximum limitations and with the aggregate amount of that category not exceeding the difference between the 66 2/3% of the average weekly wage and the amount payable to the surviving spouse and surviving children. As for children, their entitlement to the benefit, is subject to the 450 week limitation, but will not extend beyond their 18th birthday unless they remain in school, in which case it can extend to their 23rd birthday, again subject to the 450 week limitation.

26. **What is the criteria for establishing a “second injury fund” recovery?**

Only applicable if there is total industrial loss of use of a scheduled member accompanied by a prior total industrial loss of use of a scheduled member by injury or otherwise.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Within one year after the filing of a Commission Form B-31, if claimant can demonstrate a change in condition, a claim can be reopened.

28. **What situation would place responsibility on the employer to pay a claimant’s attorney fees?**

Nothing outside of a sanctions situation.

**EXCLUSIVITY/TORT IMMUNITY**
29. **Is the compensation remedy exclusive?**

   A. **Scope of immunity.**
   
   B. **Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

   The workers’ compensation remedy is exclusive except in the instance of intentional act, including bad faith in claims handling.

30. **Are there any penalties against the employer for unsafe working conditions?**

   No.

31. **What penalty, if any, for an injured minor?**

   Compensation and death benefits shall be doubled if the injured minor was under 18 at the time of the injury and if employed or permitted to work in violation of any provision of the Mississippi Labor Laws. § 71-3-107. The employer alone is liable therefor.

32. **What is the potential exposure for “bad faith” or claims handling?**

   Denials of claims and contests of benefits must have an “arguable basis”. If the denial of a claim or benefit is done without an arguable basis, then the next inquiry is whether the conduct by the claim’s handler was malicious, wanton, or reckless.

33. **What is the exposure for terminating an employee who has been injured?**

   None under the Mississippi Workers’ Compensation Act, although such a discharge does have a substantial detrimental effect on the issue of extent of permanent disability, effectively creating a rebuttable presumption of a total loss of wage earning capacity.

**THIRD-PARTY ACTIONS**

34. **Can third-parties be sued by the Claimant?**

   Yes.

35. **Can co-employees be sued for work-related injuries?**

   No.

36. **Is subrogation available?**

   Yes. § 71-3-71

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**
Providers must supply bills and reports within 20 days of the initial service provided or the claims handler can refuse payment. The Commission has the authority to excuse such failure and order payment. § 71-3-15(1) The Fee Schedule controls payment upon receipt of complete supporting documentation from a provider. Payment of properly documented uncontested bills should be made within 30 days of receipt. If no payment is made within 60 days, the payer may be subject to a 10% penalty for each 30 day period after 60 days.

38. **What, if any mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The Fee Schedule requires that all billings submitted be accompanied by corresponding and supporting medical reports. Bills do not have to be paid without this supporting documentation. As such, from a practical standpoint, if a provider wants to get paid, or be considered for payment, they must provide reports. Of course, in litigated cases, medical records are subject to subpoena. The Commission will also allow the filing of a Notice of Controversion by the employer/carrier as a vehicle for serving a subpoena when a claimant has not otherwise controverted a claim.

39. **What is the rule on choice of physician?**

A. Generally speaking, an injured worker is entitled to choose his own physician. Some restrictions do apply. Notwithstanding statutory language, reasonableness and medical necessity of treatment are the ultimate determinants. For injuries from July 1, 2012, forward, a physician will be deemed as employee’s selection without regard to written acceptance if the employee is treated by an employer’s physician for six months or longer, or the employee has surgery performed by that physician.

B. Pursuant to Rule 1.9, an employer and carrier have the right to an evaluation by a physician of their choosing.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Reasonableness and medical necessity.

40. **Which prosthetic devices are covered, and for how long?**

All; for duration of medical necessity.

41. **Are vehicle and/or home modifications covered as medical expenses?**

Yes.

42. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes.

**PRACTICE/PROCEDURE**
43. **What is the procedure for contesting all or part of a claim?**

Filing of a Petition to Controvert by claimant. A Notice of Controversion may be filed by the employer and carrier, but is only limitedly actionable.

44. **Method of adjudication:**

   A. Administrative level.
   
   B. Trial court.
   
   C. Appellate.

   Initial trial before Administrative Judge. Right to appeal Order/Award to Full Commission, which is deemed the finder of fact. Thereafter, appeal is taken to the Supreme Court, with substantial evidence being the test. The Supreme Court can refer the appeal to the Court of Appeals. Decisions of the Court of Appeals may be reviewed by the Supreme Court on Certiorari.

45. **What are the requirements for stipulations or settlements?**

   Generally speaking, for settlements, claimants must be at maximum medical improvement. Settlements are approved by Commission. Unrepresented claimants are required to be personally interviewed by a Commissioner (or Administrative Judge) prior to approval.

46. **Are full and final settlements with closed medical available?**

   Yes.

47. **Must stipulations and/or settlements be approved by the state administrative body?**

   Yes.

48. **What insurance is required? What is available (e.g. private carriers, state Fund, assigned risk pool, etc.)?**

   Private carriers and state assigned risk pool. § 71-3-77

49. **What are the provisions/requirements for self-insurance?**

   See General Rule 7.

50. **What insurance is required; and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

   Private insurers and a state assigned risk pool are available. § 71-3-77

51. **What are the provisions for “Independent Contractors”?”**
When there is a general contractor, employees of uninsured independent contractors are considered to be employees of the general contractor. § 71-3-7 With regard to whether or not an injured worker is an “employee” or an “independent contractor” outside the context of a general/sub situation, the “relative nature of the work” test is utilized, with factors such as exclusiveness and continuity of the relationship strongly influencing the case-by-case analyses.

52. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Leased workers are considered employees of the leasing company as well as employees of the companies to whom they are leased.

53. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

The same factors are considered.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.

An additional note from Gary Jones and DCH&B. When reviewing the information above, please keep in mind that this summary is a very general summary. Every workers’ compensation claim is case specific, and the application of the Act, as interpreted by the Commission, is quite dynamic. Please feel free to contact us with any questions you might have.

Gary K. Jones, Esquire
gjones@danielcoker.com
Tel: (601) 969-7607
1. Citation for the State's workers' compensation statute.

Chapter 287 R.S.Mo. 2005 for accidents after August 28, 2005

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Any person in the service of an employer under contract of hire, appointment or election, including officers of corporations but excluding owner/operators of leased trucks in interstate commerce. 287.020 Excludes farm labor, domestic servants, family chauffeurs and licensed real estate agents. Also excludes inmates, volunteers of tax-exempt organizations, sports officials, and direct sellers. 287.090

3. Identify and describe any "statutory employer" provision.

A person who has work done which is 1) under contract, 2) on his premises, and 3) part of his usual business is a statutory employer of contractor/subcontractor's employees. Exempts owner of premises having improvements done. 287.040

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

Injuries covered are the result of violence to the physical structure of the body. 287.020 The result must be triggered by an event that arises out of and in the course of employment but need not be an unusual event. Wolfgeher v. Wagner Cartage Service, Inc., 646 S.W.2d 781 (Mo. banc 1983): the focus is whether an injury occurred, not what act or force preceded the injury. As of the 2005 Amendments, an accident means an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. The accident must now be the prevailing factor in causing both the resulting medical condition and disability. Prevailing factor is defined to be the primary factor, in relation to any other factor.

B. Occupational disease (including respiratory and repetitive use).
An OD must be a disease arising out of and in the course of employment. An ordinary disease of life requires clear proof of causal connection to the conditions of employment. Specifically includes, but is not limited to, hearing loss, radiation disability, diseases of the lungs and heart. 287.067 As of the 2005 Amendments, repetitive trauma is now legislatively defined as an occupational disease. To be compensable, an occupational exposure must be the prevailing factor in causing both the resulting medical condition and disability. It must be the primary factor, in relation to any other factor. Gradual deterioration caused by aging or day-to-day activities is not compensable.

A cardiovascular, pulmonary, respiratory, or other disease, or cerebral-vascular accident or myocardial infarction suffered by a worker is an injury only if the accident is the prevailing factor in causing the resulting medical condition. 287.020.

Effective January 1, 2014, Sec. 287.067.11 creates a category of occupational diseases to be known as “occupational diseases due to toxic exposure”. These are limited to mesothelioma, asbestosis, berylliosis, coal worker’s pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome.

5. **What, if any, injuries or claims are excluded?**

Excluded are injuries caused by the employee's self-inflicted act. 287.120(3). Since 8/28/93, gradual deterioration or progressive degeneration of the body caused by aging shall not be compensable, except as an incident of employment. 287.020(3)

6. **What psychiatric claims or treatments are compensable?**

Mental injury from work stress does not arise out of employment unless the stress is unusual and extraordinary by objective standards. 287.120(8). Claims of stress from good faith disciplinary and personnel actions are not compensable. 287.120(9). However, these restrictive rules do not apply to firefighters. 287.120(10). A recent case made a special standard for EMT workers as well. Missouri has historically been conservative on the compensability of psychiatric claims, but has become more liberal in recent years.

7. **What are the applicable statutes of limitations?**

Two years from date of accident or date of the last payment on account of the injury (for either medical expenses or TTD). If the employer failed to file the Report of Injury as required, three years from the date of accident. 287.430. In occupational disease cases the statute does not start to run until the disease is reasonably apparent. 287.063(3). By case law, the same has been held of repetitive trauma claims under the older law. Under the new law, repetitive trauma claims are now clearly OD cases. A claim against the Second Injury Fund may be filed within two years of the date of accident or one year after the claim against the employer is filed, whichever is later. 287.430.
An amendment to Sec. 287.140 has now created a Statute of Limitations applicable to additional payment medical fee disputes. Subsections .4(1) provides that in the case of medical services rendered prior to July 1, 2013, that the application for additional payment must be filed within 2 years from when the provider is first notified of the dispute and .4(2) reduces the statutory period to 1 year in the case of services rendered after July 1, 2013.

8. **What are the reporting and notice requirements for those alleging an injury?**

Written notice (often waived by the mere allegation of actual or oral notice) within thirty days, unless court finds good cause for the employee's failure to notify the employer in a timely manner or if it finds no prejudice to employer. 287.420

For occupational diseases or repetitive trauma, the employee has thirty days after the diagnosis to report it, unless the employee can prove no prejudice by late notice.

9. **Describe available defenses based on employee's conduct:**

A. **Self-inflicted injury.**

Complete statutory defense. 287.120(3)

B. **Willful misconduct, "horseplay," etc.**

Injuries caused by horseplay do not arise out of employment. Gregory v. Lewis Sales Company, 348 S.W.2d 743 (Mo.App. 1961) However, if horseplay is a regular incident of employment, especially when known about by the employer, a participant may still recover. Pullum v. Hudson Foods, Inc., 871 S.W.2d 94 (Mo.App. 1994)

Willful misconduct is not a defense in Missouri unless it violates state safety rules. If the employee fails to use safety devices or fails to obey reasonable rules of safety, the judge can penalize the employee “at least 25% but not more than 50%” of all benefits. 287.120(5).

C. **Injuries involving drugs and/or alcohol.**

For injuries occurring merely in conjunction with the use of alcohol and non-prescribed drugs there is a 50% penalty for accidents arising after 8/28/05 on all benefits, including medical. For injuries medically shown to have been proximately caused by the alcohol or drug use there is a 100% forfeiture of all benefits. There is a rebuttable presumption that the use of alcohol was the proximate cause of the injury if the employee was legally intoxicated (BAC of .08 in Missouri) at the time of the work injury. 287.120(6)(2).

10. **What, if any, penalties or remedies are available in claims involving fraud?**
It is unlawful for any person to be presenting a false claim, presenting multiple claims for the same incident (claimant) or assisting in the filing of such a claim (claimant's attorney), to make multiple claims for payment of medical treatment or a claim for non-existent treatment (claimant and medical providers), to make false statements or misrepresentations to deny benefits or discourage an employee from making a claim (employer, investigators and claims adjusters).

It is unlawful for an insurance company or self-insured to intentionally refuse indisputable compensation obligations, or to discharge or administer obligations in a dishonest manner. A violation of any of the above is a class D felony and carries a fine of $10,000 or double the amount of the value of the fraud, whichever is greater. 287.128. To knowingly misrepresent any fact in order to obtain workers' compensation insurance at a lower rate is a misdemeanor and an employer failing to insure his liability under the Act is subject to a misdemeanor and a fine of three times the annual premium or $50,000, whichever is greater. 287.128.

A health care provider commits fraud in presenting to an insurer a bill involving the practices of unbundling, up-coding, exploding and duplicating entries with intent to defraud. 287.129.

11. Is there a defense for falsification of employment records regarding medical history?

No.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

No. Where participation in recreational activities is the cause of the injury benefits are held to be “forfeited.” This does not apply where the employee is ordered to participate, is paid wages or travel expenses or where the accident is caused by an unsafe condition on the employer’s premises. 287.120(7) Being on a paid break is apparently enough to make an injury compensable under recent interpretations.

13. Are injuries by co-employees compensable?

Yes. Accident is defined to include injury or death caused by unprovoked violence or assault by any person if arising out of employment. 287.120. The Workers’ compensation statutes mandates that workers’ compensation is the exclusive remedy for such injuries unless the employee causing the harm engaged in an affirmative negligent act that purposefully and dangerously caused or increased the risk of injury.

14. Are acts by third-parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?
No. Assaults arising out of personal quarrels are not acts arising out of employment and are not compensable. Scheper v. Hair Repair, Ltd., 825 S.W.2d 1 (Mo.App. 1991). Assaults that are unexplained are assumed to be work-related unless shown otherwise. Lyons v. Lyons Truck Service, 831 S.W.2d 706 (Mo.App. W.D. 1992)

**BENEFITS**

15. **What criteria are used for calculating the average weekly wage?**

Wages include earnings, board, lodging and gratuities to the extent they are reported to the IRS. The average weekly wage is calculated by dividing the actual earnings for the prior 13 weeks by 13. For every five days not worked, the divisor is reduced by one week. If there are less than 2 weeks employment, the average weekly rate is established by hourly rate and the work schedule. In the case of part-timers, the average weekly wage of a full-time worker is used to calculate the PPD rate. Full-time is determined by the practices of the business but shall be no less than 30 hours per week. 287.250.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Two-thirds of the average weekly wage up to a percentage of the state average weekly wage which represents the maximum for the time period in which the state wage was calculated. 287.170. Currently the maximum is 105% of the state average weekly wage and between 7/1/19 and 6/30/20 equals $981.65. The minimum is a flat $40.

17. **How long does the employer/insurer have to begin TTD benefits from the date disability begins?**

No specific requirement, however, 287.160(3) states that interest starts 30 days after the date of accident if the payment is not disputed but not paid. If disputed, interest does not start until 30 days after the first award of TTD also not disputed by the winning party on appeal.

18. **What is the "waiting" or "retroactive" period for temporary benefits?**

Employee must be out 14 days before recovering benefits for the first 3 days. 287.160(1). The three day waiting period is based on assigned workdays when the employer is open.

19. **What is the standard/procedure for terminating temporary benefits?**

The employer shall notify the employee and shall advise the employee of the reason for such termination. 287.203. The employee is requested to sign a Receipt for Compensation (Form 2) which is filed with the Division of Workers' Compensation and notifies them of the termination. (Very rarely complied with.) The standard is MMI
(maximum medical improvement), ability to work full duty according to a medical report or ability to work light duty and such a job is then made available. See, 287.020(7), and Pellitteri v. Blackmer & Post Pipe Co., 50 S.W.2d 662 (Mo.App. 1932). Temporary benefits can be terminated for employees who are terminated for cause.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No. 287.160(3) eliminates any such credits, previously allowed in the law decades ago.

21. **What disfigurement benefits are available and how are they calculated?**

If an employee is seriously and permanently disfigured about the head, neck, hands or arms the court is authorized to award additional amounts for disfigurement up to 40 weeks at the PPD rate. 287.190(4) Disfigurement to the feet or legs is not covered in Missouri.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates:**

Two-thirds of the average weekly wage up to a percentage of the state average weekly wage which represents the maximum for the period of time in which the state average weekly wage was calculated. 287.190(5) For the period between 7/1/19 and 6/30/20 this was 55% of the state average weekly wage or $514.20. The minimum is a flat $40.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery.**

The standard of recovery is the proportionate loss of use of a member.

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<th>PIP/DIP</th>
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<tr>
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<td>Large toe</td>
<td>40</td>
<td>PIP/DIP</td>
</tr>
</tbody>
</table>

Weeks available are as follows:

A. 207
B. 160
C. 155
D. 150
E. 110
F. 40
Other toes                    MP     14             PIP     10            DIP   8
Deafness bilateral             180
Deafness unilateral             49
Loss of sight unilateral        140

287.190(1)

Severance or total loss of a scheduled part is compensated at 110% of whatever weeks are available for that body part. 287.190(2).

B. Number of weeks for "whole person" and standard for recovery.

For permanent injuries other than those listed in the specific loss schedule, including those causing a loss of earning power, compensation is paid for such periods as are proportionate to the relation which the other injury has to specified injuries, but not to exceed 400 weeks. 287.190(3)

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Until 1990, the statute only referred to physical rehabilitation, limited to medical, surgical and hospital treatment, intended to restore an injured employee to a condition of self-support and maintenance as an able-bodied worker. 287.141. In 1990, multiple sections were inserted into the statute comprising a complete rehabilitation package, including definitions, licensing requirements, mandatory reporting requirements, standards, procedures, etc. At the last moment the bill was amended to make all these sections completely voluntary. As a result, the sections are ineffective.

By case law, neither the employer/insurer nor the Second Injury Fund could compel the employee to be evaluated by a rehabilitation expert. State ex rel. Lakeman v. Siedlik, 872 S.W.2d 503 (Mo.App. 1994) As of 8/28/05, the right to such an evaluation has now been given to the employer/insurer but not the Second Injury Fund.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

It is identical to the calculations for TTD above.

25. How are death benefits calculated, including the minimum and maximum rates?

Also identical to the calculations for TTD above.

A. Funeral expenses.

Actual cost up to $5,000. 287.240(1)

B. Dependency claims.
Dependents are relatives by blood or marriage (common-law marriages and live-ins are not recognized) who are actually dependent for support, in whole or part, at the time of the injury. Those presumed to be total dependents include a spouse and a natural, posthumous or adopted child, legitimate or not, under the age of 18 or physically or mentally incapacitated. 287.240(4). There are extensions on time for children who are in school or the military.

26. What are the criteria for establishing a Second Injury Fund recovery?

Where there is a previous disability and a present disability that combine to cause a disability greater than the expected result of the last injury considered alone, the employer/insurer is to pay for the effects of the last injury alone and the Fund is to pay for the greater effect of the combination. 287.220. There are no restrictions on what type of preexisting conditions or parts of the body combine. Case law has read the requirement of a preexisting disability to be an "industrial" disability, meaning a showing must be made that the preexisting condition limited or could have limited job opportunities or caused lost time from work. Wilhite v. Hurd, 411 S.W.2d 72 (Mo. 1967). There is a threshold or a minimum level of severity for each part of the body or condition amounting to at least 50 weeks (12.5% of the person) or 15% of a major extremity. This is true for both the preexisting condition and the primary one.

Effective January 1, 2014, recovery for permanent partial disability is no longer available to employees. Permanent total disability from the Fund is only available (with limited exceptions) when the pre-existing disability which totals disability totaling fifty weeks of disability.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The Commission may, at any time upon rehearing, after due notice, make an award ending, diminishing or increasing the compensation previously awarded. 287.470. "At any time" has been severely restricted by case law. The Commission has been held to lose jurisdiction following the expiration of the time during which the award is to be paid. Johnson v. St. John's Mercy Medical Center, 812 S.W.2d 845 (Mo.App. 1991) This means that if the award is for 100 weeks of permanency, the Commission loses jurisdiction if the application for reopening is not filed within 100 weeks of the date of accident or the last payment of TTD, which ever is later.

Since 8/28/93, a claim can be reactivated if the claimant can show good cause and the claim is for payment of medical procedures involving life-threatening surgery or replacement of a prosthetic device. 287.430(2).

28. What situation would place responsibility on the employer to pay a claimant's attorney fees?
It is considered in two rare situations. If the Division feels that a case has been defended without reasonable ground, it may assess the whole cost of the proceedings under 287.560. This has been held to include claimant's attorney fees. However, under 287.203, which applies to emergency trials only, the court was required to award to the prevailing party the cost of recovery including attorney fees. As of 8/28/05, the section does not make the award of costs and fees mandatory but does allow for it, if warranted.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   Yes. Rights and remedies under the Act shall exclude all other rights of the employee, their spouses, parents, dependents, heirs and legal representatives, etc. on account of the accident or death, except as such rights are not provided under the Act. 287.120(2)

   **A. Scope of immunity**

   Immunity is wide ranging with limited exceptions, such as for affirmative negligent acts of co-workers

30. **Are there any penalties against the employer for unsafe working conditions?**

   Yes. Where the injury is caused by the failure of the employer to comply with any state statute on safety (not OSHA), all compensation and benefits are increased by 15% as a penalty. 287.120(4).

31. **What penalty, if any, for an injured minor?**

   The compensation rate of an employee under 21 may be adjusted in the discretion of the Administrative Law Judge to take into consideration the potential for increased earning power up to the age of 21. 287.250(6). In practice this means that minors usually have a higher compensation rate than would be expected and works as a penalty. If the employer is found to have knowingly employed a minor in violation of state child labor laws, there is potentially a penalty of an additional 50%. 287.250(7).

32. **What is the potential exposure for "bad faith" in claims handling?**

   The doctrine of "first party bad faith" has not been recognized in Missouri. State ex rel. American Motorists Ins. v. Ryan, 755 S.W.2d 399 (Mo.App. 1988).

33. **What is the exposure for terminating an employee who has been injured?**

   Missouri is a termination-at-will state and there is no provision for exposure in the Act except for the termination of an employee specifically for pursuing his workers’ compensation rights. 287.780 creates a civil right of recovery for discrimination based on exercising rights under the Workers Compensation Act only. If the employee is a
qualified individual under the ADA, that Act may apply for discrimination against the disabled.

THIRD-PARTY ACTIONS

34. Can third-parties be sued by the Claimant?
   Yes. 287.150.

35. Can co-employees be sued for work-related injuries?
   Not unless the co-employee causing the harm engaged in an affirmative negligent act that purposefully and dangerously caused or increased the risk of injury.

36. Is subrogation available?
   Yes. 287.150. It is now be subject to comparative fault if determined before settlement.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?
   No time limits in the Act. If the employee has to pay interest to the facility, there would be reimbursement of the interest if the underlying medical was owed by the employer/insurer and not paid. This opinion is based on dictum by the Supreme Court in Martin v. Mid-America Farm Lines, Inc., 769 S.W.2d 105 (Mo. banc 1989). More recent cases have denied interest unless shown to be paid by the employee.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?
   A. Medical Reports

The testimony of any treating or examining physician is admissible in any proceedings, but only if the report has been served on all parties seven days before trial or deposition. 287.210(3). If a party refuses to provide the medical report the physician shall not be permitted to testify. Upon request, the administrative law judge, the Division or the Commission is to be provided with any medical report asked for.

Upon request of a party, the treating physician is required to furnish to the parties, a rating and complete medical report at the expense of the party selecting the physician, along with a complete copy of the physician's clinical record, including copies of records received from other providers. 287.210(6).

The testimony of a treating or examining physician may be submitted by report without
other foundation as evidence when the party gives 60 days notice and provides reasonable opportunity to obtain cross-examination. The specific notice required under this section is to include the report, the curriculum vitae, the clinical records and outside reports in the doctor's file. Because the testimony under this rule would not be admissible against the Second Injury Fund, the claimants' attorneys do not use this section often and depositions are common.

B. Executed Authorizations

Any party shall be entitled to process to compel the attendance of witnesses and the production of books and papers and the Administrative Law Judge can issue subpoenas and authorizations to inspect medical records if they feel they are appropriate. 287.560.

39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to a second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.

The employer (not the carrier) has the right to select the licensed treating physician, surgeon or other health care provider. 287.140(9) The employee’s choice is at his own expense unless the court finds the employer failed to offer reasonable treatment when requested.

B. Employer’s right to a second opinion and/or Independent Medical Examination.

If a situation arises where the employee treats with his own doctor, the employer has a right to a second opinion and/or an IME as often as is reasonable.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

All health care providers offering services within the scope of their licenses are covered. 287.140(9). Nothing in the Act shall prevent an employee from being treated by prayer or spiritual means if the employer does not object. 287.140(8).

41. Which prosthetic devices are covered, and for how long?

The employer may be required by the Division to furnish artificial legs, arms, hands, surgical orthopedic joints, eyes or braces, as needed, for life. 287.140(7).

42. Are vehicle and/or home modifications covered as medical expenses?

Yes, by case law.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?
There is no fee schedule. A health service provider is bound by the court's determination of reasonableness of bills and may not bring an action against the employee for disputed charges. 287.140(3).

44. What, if any, provisions or requirements are there for "managed care?"

The Department of Insurance regulates managed care organizations and certifies them for employers who voluntarily use such organizations. The Department maintains a registry to supply information to employers. Fees are regulated but apply only to those who volunteer to be under the program.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

No formal letter or document is required. If a Claim for Compensation has been filed, the Answer should indicate a denial of all or part of the claim, as appropriate. The denial of any issue can be raised right up to the time of trial when pretrial stipulations are called for. Title 8, Division 50, Chapter 2, 50-2.010(22) Rules and Regulations of the Division of Workers' Compensation

46. Method of adjudication:

A. Administrative level.

The Division, through an Administrative Law Judge, shall hear in a summary proceeding the parties at issue and their witnesses and shall determine the dispute. 287.460. If an application for review is made with the Industrial Commission within twenty days, the Commission shall review the evidence and shall make an award, which is de novo. 287.480. Review by the Commission of temporary or partial awards is restricted to situations where the employer has issued a complete denial, including work injury, or when a temporary award is actually a final award.

B. Trial court.

There is no trial court involvement any longer. 287.490.

C. Appellate.

Appeals from the Commission go directly to the Court of Appeals having jurisdiction over the area where the accident occurred. 287.495. There are three Courts of Appeal: Eastern, Western and Southern Districts. Appeals of temporary or partial awards are limited in the same manner as applications for review to the Commission.
47. **What are the requirements for stipulations or settlements?**

Parties may enter into voluntary agreements in settlement but no such agreement is valid until approved by an Administrative Law Judge. 287.390. The employee who is not represented is usually required to appear personally before the judge in order to conclude the matter.

48. **Are full and final settlements with closed medicals available?**

Yes. The official form for settlements, Stipulation for Compromise Settlement, requires the employee to sign that he understands that he will not receive any more medical treatment for this injury because of the settlement. Since 8/28/98, the form is now qualified by 287.430(2) which allows for reopening medical for life-threatening surgeries and prosthetic devices.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. 287.390.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required? What is available (e.g. private carriers, state Fund, assigned risk pool, etc.)?**

Every policy shall be in accordance with the form approved by the Department of Insurance. 287.310. Private carriers are available. A risk pool is provided for. 287.310(10).

51. **What are the provisions/requirements for self-insurance:**

   **A. For individual entities.**

   An employer may itself carry the liability under the Act upon satisfying the Division of its ability to do so. 287.280. Payroll reports, profit and loss statements, a statement of assets and liabilities and the NCCI rating sheet are usually required. A security bond or escrow of at least $125,000 is required.

   **B. For groups or "pools" of private entities.**

   Same rules and citations apply to groups as to individual entities.

52. **Are illegal aliens entitled to benefits of workers’ compensation as The Immigration Control Act indicates that they cannot be employees, although most state acts include them within the definition of employee?**

This issue has been raised in individual cases but there has been no ruling by the courts.
53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Unless an act of violence, causing injury at work, is aimed at the employee for personal reasons, it is compensable in Missouri. Acts that are neutral as to the employee or caused by irrational or insane behavior are compensable.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

No.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. 1396k(b).

Under federal law, the funds received by claimant in workers’ compensation are subject to an absolute lien. They do not have to be designated as past or future medical expenses. The state statute does not specifically recognize the lien as an exception.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)]. Therefore, your current practice of obtaining medical records could proceed under state law.

Missouri’s workers’ compensation statute does not deal specifically with confidentiality and privacy of medical records. There are individual court rules concerning privacy. HIPAA does not preempt state workers’ compensation laws. (Federal Register, vol. 67, #157, pp. 53266-53273, August 14, 2002). Privacy rule 164.512(l) allows the disclosure of medical records to the extent needed to comply with state statutes on workers’ compensation. The problem is that medical facilities will not make distinctions and exceptions, so, as a practical matter, we will need the employee’s written consent or a
subpoena to get records.

57. **What are the provisions for “Independent Contractors”?**

Independent contractors are by definition not employees; however Missouri will ignore a contract asserting such a relationship if the circumstances show a statutory employee instead. *Ceradsky v. Mid-America Dairymen, Inc.*, 583 S.W.2d 193 (Mo.App. W.D. 1979) said that control was relevant but not the only test. They applied the Restatement of Law, Agency 2d, Section 220, and held that just as important was the length of time the parties worked together, if the relationship was continuous, whether the business of the alleged independent was distinct from the business of the alleged employer, the way the alleged independent was paid and whether special equipment or tools were needed and used.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Yes. The definition of employee excludes the owner and operator of a motor vehicle which is leased or contracted with a driver to a for-hire common or contract motor vehicle carrier operating within a commercial zone as defined in Sections 390.020 or 390.041, or operating under a certificate issued by the transportation division of the department of economic development or by the Interstate Commerce Commission. 287.020 (1). An unpublished opinion held that this exemption did not apply to the driver who was an employee of the owner/operator; it only applied to the owner/operator himself.

60. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your Workers’ Compensation law?**

Yes, but to date it has not gone into effect. If a work injury occurs while the employee is under the influence of alcohol or illegal drugs, all benefits are reduced by 50%. If the injury is found to be causally related to the use of alcohol or illegal drugs, all benefits are denied.

61. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

No. If a work injury occurs while the employee is under the influence of alcohol or illegal drugs, all benefits are reduced by 50%. If the injury is found to be causally related to the use of alcohol or illegal drugs, all benefits are denied.
NOTE: Unless otherwise indicated, all statutory references are to laws in effect as of January 2020. The Montana Supreme Court has consistently held that the statutes in effect as of the time of the claimant’s injury control all benefit determinations. See, e.g., Iverson v. Argonaut Ins. Co., 198 Mont. 340, 342, 645 P.2d 1366 (1982). Consult local counsel to determine laws applicable to any specific injury.

1. Citation for the state’s workers’ compensation statute.

§§ 39-71-101 to -4004, M.C.A.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

Except as provided in § 39-71-401(2), M.C.A., the Workers’ Compensation Act applies to all employers and to all employees. § 39-71-401(1), M.C.A. An “employee” or “worker” is defined as follows:

Each person in this state, including a contractor other than an independent contractor, who is in the service of an employer, as defined by 39-71-117, under any appointment or contract of hire, expressed or implied, oral or written. The terms include aliens and minors, whether lawfully or unlawfully employed, and all of the elected and appointed paid public officers and officers and members of boards of directors of quasi-public or private corporations, except those officers identified in 39-71-401(2), while rendering actual service for the corporations for pay. Casual employees, as defined by 39-71-116, are included as employees if they are not otherwise covered by workers' compensation and if an employer has elected to be bound by the provisions of the compensation law for these casual employments, as provided in 39-71-401(2). Household or domestic employment is excluded. § 39-71-118(1)(a), M.C.A.

“Each employee whose employer is bound by the Workers’ Compensation Act is subject to and bound by the compensation plan that has been elected by the employer.” § 39-71-401(1), M.C.A. The Workers’ Compensation Act does not apply to the following employments:
(a) household or domestic employment;
(b) casual employment;
(c) an employer’s dependent family member for whom an exemption may be claimed under the Internal Revenue Code;
(d) certain employments of sole proprietors, working members of a partnership, limited liability partnership, or member-managed limited liability company;
(e) a real estate, securities, or insurance salesperson paid solely by commission;
(f) employment as a direct seller as defined by 26 U.S.C. 3508;
(g) employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States;
(h) a person performing services in return for aid or sustenance only, except volunteers under 67-2-105;
(i) employment covered by the FELA;
(j) officers at an amateur athletic event;
(k) a newspaper carrier or freelance correspondent if the person acknowledged the services are not covered;
(l) cosmetologist’s and barber’s services;
(m) a person who is employed by an enrolled tribal member or an entity that is at least 51% owned by an enrolled tribal member or members, whose business is conducted within the boundaries of an Indian reservation;
(n) a jockey who is licensed by the board of horseracing if the jockey has acknowledged in writing that he or she is not covered under the Workers’ Compensation Act while performing services as a jockey;
(o) a trainer, assistant trainer, exercise person, or pony person who is licensed by the board of horseracing while on the grounds of a licensed race meet;
(p) an employer's spouse for whom an exemption based on marital status may be claimed by the employer under 26 U.S.C. 7703;
(q) a person who performs services as a petroleum land professional;
(r) certain officers of a quasi-public or a private corporation or, except as provided in subsection (3), a manager of a manager-managed limited liability company;
(s) an officer or a manager of a ditch company as defined in 27-1-731;
(t) service performed by a minister of a church in the exercise of the church’s ministry or by a member of a religious order in the exercise of duties required by the order;
(u) service performed to provide companionship services or respite care when employed directly by a family member or legal guardian;
(v) a person performing the services of an intrastate or interstate common or contract motor carrier when hired by a broker or freight forwarder;
(w) a person who is not an employee or worker in this state as defined in 39-71-118(8);
(x) a person who is working under an independent contractor exemption certificate;
(y) an athlete by or on a team or sports club engaged in a contact sport;  
(z) a musician performing under a written contract.  
§ 39-71-401(2), M.C.A.

Sole proprietors, working members of partnerships, working members of limited liability companies, or working members of a member-managed limited liability company may elect to be exempt from the Act by obtaining an independent contractor exemption certificate from the Department of Labor. Approval of the application is conclusive as to the status of the applicant as an independent contractor, and precludes the applicant from subsequently seeking benefits under the Act. Consult § 39-71-401, M.C.A., for conditions of exclusion.

3. **Identify and describe any “statutory employer” provision.**

“Employer” is defined in § 39-71-117, M.C.A. to include:
- the state; each county, city, city school district, irrigation district, and all other districts established by law; all public- and quasi-public corporations and public agencies; each person; each prime contractor; each firm, voluntary association, limited liability company, limited liability partnership, and private corporation, including any public service corporation and including an independent contractor who has a person in service under an appointment or contract of hire; the legal representative, receiver, or trustee of any deceased employer;
- any association, corporation, limited liability company, limited liability partnership, or organization that seeks permission and meets the requirements set by the department to operate as self-insured under plan No. 1 of this chapter;
- any nonprofit association, limited liability company, limited liability partnership, or corporation or other entity funded in whole or in part by federal, state, or local government funds that places community service participants, as described in 39-71-118(1)(e), with nonprofit organizations or associations or federal, state, or local government entities;
- a religious corporation, religious organization, or religious trust receiving remuneration from nonmembers for manufacturing or construction activities conducted by its members, or agricultural labor and services; and
- An approved and authorized fiduciary, agent, or other person acting as fiscal agent under section 3504 of the Internal Revenue Code, 26 U.S.C. 3504, and 26 CFR 31.3504-1.

There is a rebuttal presumption that an employer who uses the services of a worker furnished by another person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, is presumed to be the employer for workers’ compensation premium and loss experience purposes for work performed by the worker.

An employer who contracts with an independent contractor to perform work of a kind regular to that employer’s business is liable for the payment of benefits if the contractor
has not properly complied with the coverage requirements of the Act. § 39-71-405(1), M.C.A. An employer who contracts with a party other than an independent contractor may also be liable for benefits for that contractor’s employees, if the work performed is part of the employer’s trade or business. § 39-71-405(2). Where an employer contracts any work to be done, wholly or in part for the employer, by an independent contractor, where the work so contracted to be done is casual employment as to such employer, then the contractor shall become the employer. § 39-71-405(3), M.C.A.

4. **What types of injuries are covered and what is the standard of proof for each:**

A. **Traumatic or “single occurrence” claims.**

An injury is covered if it involves (1) internal or external physical harm to the body, as established by objective medical findings, (2) damage to prosthetic devices or appliances other than eyeglasses, contact lenses, dentures, or hearing aids, or (3) death. § 39-71-119(1), M.C.A. An injury must be caused by an accident, which is an unexpected traumatic incident or unusual strain, identifiable by time and place of occurrence and member or part of body affected, and caused by specific event on a single day or during a single work shift. § 39-71-119(2), M.C.A. “Objective medical findings” means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings. § 39-71-116(22), M.C.A. The objective medical findings must contain sufficient factual and historical information concerning the relationship of the workers’ condition to the original injury. § 39-71-407(10), M.C.A.

B. **Occupational disease (including respiratory and repetitive use).**

Montana repealed its Occupational Disease Act effective July 1, 1995. Under the current Workers’ Compensation Act, “occupational disease” means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift, but does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity. § 39-71-116(23), M.C.A. Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter. § 39-71-713(1), M.C.A. When the same medical condition may be claimed as an injury and an occupational disease, compensation payable to the claimant, the claimant’s beneficiaries, or the claimant’s dependents may not be duplicated for the same conditions over the same time period. § 39-71-713(2), M.C.A.

An occupational disease is covered if it is established by objective medical findings, and arises out of or is contracted in the course and scope of employment. § 39-71-407(12), M.C.A. Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease. *Id.* “Major contributing cause” means a cause that is the leading cause contributing to the result when compared to all
other contributing causes. § 39-71-407(16), M.C.A. When compensation is payable for an occupational disease, the only employer liable is that in whose employment the employee was last injuriously exposed to the hazard of the disease. § 39-71-407(13), M.C.A.

A cardiovascular, pulmonary, respiratory, or other disease, cerebrovascular accident, or myocardial infarction suffered by a worker is an injury only if the accident is the primary cause of the physical condition in relation to other factors contributing to the physical condition. § 39-71-119(5), M.C.A. Primary cause means a cause that is responsible for more than 50% of the physical condition with a reasonable degree of medical certainty. Id.

5. **What, if any, injuries or claims are excluded?**

Injuries are compensable only if they meet the statutory definition of “injury” caused by an “accident,” and if the alleged harm arising from the injury can be proven by objective medical findings. § 39-71-119, M.C.A. Physical or emotional conditions arising from emotional or mental stress, or nonphysical stimuli or activity, are excluded. § 39-71-119(3). The Montana Supreme Court has found the exclusion of mental or stress claims without a physical component does not violate equal protection of the law and is constitutional. *Stratemeyer v. Lincoln Cnty.*, 259 Mont. 147, 154, 855 P.2d 506 (1993). Amendments adopted by the 1993 Montana legislature specifically state that so-called “mental-mental” claims and “mental-physical” claims are not compensable either as workers’ compensation or occupational disease claims. § 39-71-105(6)(a), M.C.A.

6. **What psychiatric claims or treatments are compensable?**

See answer to Question 5. Generally, only those claims with a physical component are compensable.

7. **What are the applicable statutes of limitations?**

Other than claims for occupation disease, claims for compensation must be filed within 12 months of the date of the accident, although the time period may be waived by the insurer for up to an additional 24 months on showing of lack of knowledge of disability, latent injury, or equitable estoppel. § 39-71-601, M.C.A. Injuries other than death must be reported to the employer within 30 days of its occurrence. § 39-71-603(1), M.C.A.

Claims for benefits for occupational diseases must be submitted to the employer, the employer’s insurer or the Department in writing, signed by the claimant or the claimant’s representative within 1 year that the claimant knew or should have known that the condition resulted from occupational disease. § 39-71-601(3), M.C.A. When the claim is brought by a beneficiary, the 1-year time limit is based on the date the beneficiary knew or should have known the decedent’s death was related to an occupational disease. Id.

If benefits are denied to a claimant, he or she must petition the Workers’ Compensation Court for relief within two years of the denial. § 39-71-2905(2), M.C.A.
Statutes of limitations are tolled for injured workers who are mental incompetent and without a guardian or who are under 18 years of age and may be without a parent or guardian. § 39-71-602, M.C.A.

8. What are the reporting and notice requirements for those alleging an injury?

See answer to Question 7 above. The notice to the employer must include notice of the time and place where the accident occurred and the nature of the injury. § 39-71-603(1), M.C.A. Notice may be given by the injured employee or someone on his or her behalf. Id. Actual knowledge of the accident and injury on the part of the employer or the employer’s managing agent or superintendent in charge of the work in which the employee was engaged constitutes notice. Id.

The Department provides standardized reporting forms for claims. Employers must file reports of every injury or occupational disease with the Department. § 39-71-307(2), M.C.A. Many insurers now allow claims to be reported electronically (e.g., by phone).

9. Describe available defenses based on employee’s conduct:

A. Self-inflicted injury.

Unknown; likely non-compensable so long as the employee’s conduct is not found to be within the “course and scope of employment”. There is no known case law on this subject.

B. Willful misconduct, “horseplay,” etc.

If an employee is injured by another employer in the course and scope of his employment, the injury is compensable. Penny v. Anaconda Co., 194 Mont. 409, 413, 632 P.2d 1114 (1981). However, the injury is not compensable if it arises from a fight with another employee where the altercation is of a personal nature and has no reasonable connection with the employment. Id. If the fight is reasonably connected to the conditions under which the employee pursues his employment, such as if another employee assaults him due to hostility related to the employment duties, the injury “arises out of and occurs in the course of the employment” and may be compensable. See Pinyerd v. State Comp. Ins. Fund, 271 Mont. 115, 894 P.2d 932, 935 (1995).

If an employee is intentionally injured by an intentional and deliberate act of the employee’s employer or of a fellow employee while performing the duties of employment, the injured employee or his personal representative has a cause of action for additional damages against the person whose intentional and deliberate act caused the intentional injury, in addition to a workers’ compensation claim. § 39-71-413(1)(a), M.C.A.
C. **Injuries involving drugs and/or alcohol.**

An employee is not eligible for benefits if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. § 39-71-407(5), M.C.A. This provision does not apply if the employer knew of and failed to stop the employee’s use of alcohol or drugs (marijuana not included). § 39-71-407(7), M.C.A. If the employee has written certification from a physician for the use of marijuana for a debilitating medical condition, he may still be eligible for benefits unless the use of marijuana is a major contributing cause of the injury or occupational disease. § 39-71-407(6), M.C.A. For additional provisions regarding marijuana, please see Question 62. The burden of proving an employee deviated from the course and scope of his employment is on the employer or workers’ compensation insurer. *Van Vleet v. Mont. Ass’n of Counties Workers’ Comp. Trust*, 2004 MT 367, ¶ 22, 324 Mont. 517, 103 P.3d 544.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under this chapter is guilty of theft and may be prosecuted the criminal theft statute. § 39-71-316(2)(a), M.C.A. A person convicted of theft may be required to pay an amount equal to 10 times the amount paid by an insurer on the false claim, provided that the amount does not exceed $50,000. § 39-71-316(3), M.C.A. The state fund has established a fraud prevention and detection unit. § 39-71-211(a), M.C.A.

A worker may not accept temporary total disability, permanent total disability, or rehabilitation benefits and wages without the written consent of the insurer. §§ 39-71-701(7); -702(6); and -1006(7). A worker receiving both wages and any of these benefits is guilty of theft and may be prosecuted under Montana criminal laws. *Id.* Further, if the Workers Compensation Court determines that a claim is false or fraudulent, the claim may be dismissed with prejudice.

11. **Is there any defense for falsification of employment records regarding medical history?**

Unknown. The Workers’ Compensation Court has held that liability for an injury is decided on the basis of whether the job accident proximately caused injury and/or disability, as shown by objective medical findings.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

To be compensable, an injury must arise out of “and in the course of employment.” § 39-71-407(1). An injury is not in the course of scope of employment if the employee is on a paid or unpaid break, not at a worksite of the employer, and not performing any specific
tasks for the employer during the break; or engaged in social or recreational activity, regardless of whether the employee pays for any portion of the activity. § 39-71-407(2), M.C.A. However, the exclusion for recreational activities does not apply to an employee who is paid while participating in the social or recreational activity or whose presence at the activity or required or requested by the employer, such that the employer asks the employee to assume duties for the activity so that the employee’s presence is not completely voluntary. Id.

An employee who suffers an injury or dies while traveling is not covered unless: “(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee’s benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or (ii) the travel is required by the employer as part of the employee’s job duties.” § 39-71-407(4)(a). “A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered while traveling.” § 39-71-407(4)(b).

The factors to be considered in determining whether a deviation from the scope of employment is substantial enough to take an employee out of the employment context are as follows: (1) the amount of time taken up by the deviation; (2) whether the deviation increases the risk of injury; (3) the extent of the deviation in terms of geography; and (4) the degree to which the deviation caused the injury. Dale v. Trade St., 258 Mont. 349, 353; 854 P.2d 828, 830 (1993). See generally Van Vleet, 2004 MT 367.

13. Are injuries by co-employees compensable?

Yes, if committed within the course and scope of employment. See answer to Question 9B.

14. Are acts by third-parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?

Section 39-71-412, M.C.A., provides:

Liability of third party other than employer or fellow employee -- additional cause of action. The right to compensation and medical benefits as provided by this chapter is not affected by the fact that the injury, occupational disease, or death is caused by the negligence of a third party other than the employer or the servants or employees of the employer. Whenever injury, occupational disease, or death occurs to an employee while performing the duties of employment and the event is caused by the act or omission of some persons or corporations other than the employee's employer or the servants or employees of the employee's employer, the employee or in case of death the employee's heirs or personal representative, in addition to the right to receive
compensation under this chapter, has a right to prosecute any cause of action that the employee or heirs may have for damages against the persons or corporations.

BENEFITS

15. **What criterion is used for calculating the average weekly wage?**

“Wages” mean all remuneration paid for services performed by an employee for an employer, including the cash value of all remuneration paid in any medium other than cash. § 39-71-123(1), M.C.A. Wages includes monetary commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and periods of sickness; backpay or any similar pay made for or in regard to previous service by the employee for the employer, other than retirement or pension benefits from a qualified plan; tips or other gratuities received by the employee to the extent that tips or gratuities are documented by the employee to the employer for tax purposes; income or payment in the form of a draw, wage, net profit, or money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration; payments made to an employee on any basis other than time worked, including but not limited to piecework, an incentive plan, or profit-sharing arrangement; board if it constitutes a part of the employee's remuneration and is based on its actual value; and lodging, rent, or housing if it constitutes part of the employee's remuneration and is based on a value as set by administrative rule. The values set by administrative rule must address the general geographic proximity to available housing and may consider other reasonable factors that affect value. *Id.* Wages do not include expense reimbursements; accrued but not paid sick leave; special monetary rewards; and monetary and other benefits paid as part of public assistance. § 39-71-123(2), M.C.A.

Generally, wages are calculated based on the average actual earnings for the four pay periods immediately preceding the injury, except if the term of employment is less than four pay periods, the wages are the hourly rate times the number of hours worked in a week for which the employee was hired to work. § 39-71-123(3)(a), M.C.A. “For good cause shown, if the use of the last four pay periods does not accurately reflect the claimant's employment history with the employer, the wage may be calculated by dividing the total earnings for an additional period of time, not to exceed 1 year prior to the date of injury, by the number of weeks in that period, including periods of idleness or seasonal fluctuations.” § 39-71-123(3)(b), M.C.A.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury, but the payments may not exceed certain maximum benefits, set by statute, based on the prior calendar year’s state average weekly wage. § 39-71-701(3), M.C.A. Temporary total disability benefits must be paid
for the duration of the worker’s temporary disability. *Id.* The weekly benefit amount may not be adjusted for cost of living. *Id.*

Benefits for temporary partial disability are the difference between the injured worker's average weekly wage received at the time of the injury, subject to a maximum of 40 hours a week, and the actual weekly wages earned during the period that the claimant is temporarily partially disabled, not to exceed the injured worker's temporary total disability benefit rate. § 39-71-712(2), M.C.A.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The insurer must accept or deny the claim for benefits within 30 days of receipt of a claim. § 39-71-606, M.C.A.

An insurer may pay the claim under reservation of rights so long as notice to do so is made within 30 days of receipt of claim, but an insurer may not make payments under a reservation of rights for more than 90 days without: (a) written consent of the claimant; or (b) approval of the department. § 39-71-608, M.C.A.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

Compensation may not be paid for the first 32 hours or 4 days’ loss of wages, whichever is less, that the claimant is totally disabled and unable to work because of an injury. § 39-71-736(1)(a), M.C.A. A claimant is eligible for compensation starting with the 5th day. *Id.* Separate benefits of medical and hospital services must be furnished from the date of injury. § 39-71-736(b), M.C.A. 39-71-736(1).

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary total benefits may be terminated on the date the worker has been released to return to work in some capacity. § 39-71-609(2), M.C.A. Temporary total benefits terminate if the treating physician releases the working to the same, modified, or alternate position that the worker is able and qualified to perform with the same employer, even if the worker has not reached maximum healing. § 39-71-701(4), M.C.A.

If the worker has been released by the treating physician to return to a modified or alternate position that he is able and qualified to perform with the same employer, the wages, when combined with the temporary partial disability benefits, would result in an equivalent or higher wage than at the time of injury, and the worker refuses to accept the position, he is not eligible for temporary partial disability or temporary total disability benefits. § 39-71-712(3), M.C.A.

An insurer may only terminate biweekly compensation benefits with 14 days’ written notice to the claimant, his representative, and the department, except if the insurer has
knowledge the claimant has returned to work, compensation benefits may be terminated as of the time the claimant returned to work. § 39-71-609(1), M.C.A.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

The amount may be credited in some situations, usually where the claimant has reached maximum healing and continues receiving temporary total benefits, where the insurer has advised it will credit those benefits. It is recommended that, if there is a basis to convert, it should be done immediately and temporary total payments should be discontinued.

Temporary **partial disability** may not be credited against any **permanent partial disability** award or settlement. § 39-71-712(4), M.C.A.

21. **What disfigurement benefits are available and how are they calculated?**

In addition to permanent partial disability, a maximum benefit award of $2,500.00 may be paid for serious face, head or neck disfigurement. § 39-71-708, M.C.A.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

Benefits are calculated by adding percentage of impairment received under AMA Guidelines, and appropriate assigned percentages for (1) age, (2) education, (3) the extent of wage loss, and (4) degree of physical restriction, and then multiplying the result by 400 weeks. § 39-71-703(3), (5), M.C.A. The actual weekly benefit is equal to 66 2/3% percent of the “time of injury” wage, subject to a maximum of one-half of state average weekly wage. § 39-71-703(6), M.C.A.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

Schedules were abolished effective July 1, 1987.

B. **Number of weeks for “whole person” and standard for recovery.**

See above.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

A claimant is eligible for total rehabilitation benefits if he meets the definition of a disabled worker as provided in 39-71-1011; or (2) the worker has, as a result of the work-related injury, a whole person impairment rating of 15% or greater, as established by objective medical findings, and has no actual wage loss. § 39-71-1006(1)(a), M.C.A. A rehabilitation provider must be appointed to develop a rehabilitation plan showing reasonable vocational goals and reemployment opportunity. § 39-71-1006(1)(b), M.C.A.
If the worker is eligible due to impairment rating, the employee must have a reasonable increase in wages compared to the wages at time of injury with rehabilitation. § 39-71-1006(1)(b), M.C.A. If the worker is eligible due to wage loss, the employee must have a reasonable reduction in the actual wage loss with rehabilitation. Id.

A disabled worker is entitled to receive biweekly rehabilitation benefits at the temporary total disability rate for the period specified in the rehabilitation plan, not to exceed 104 weeks. § 39-71-1006(2), M.C.A. A worker may not receive temporary total benefits or wages, and rehabilitation benefits at the same time. § 39-71-1006(4), (7), M.C.A. A worker injured after July 1, 1997, may receive payment for tuition, fees, books, and other retraining expenses as specified in the rehabilitation plan. § 39-71-1006(3), M.C.A.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Weekly compensation benefits for injury resulting in permanent total disability are 66 2/3% of the wages received at the time of the injury, but the payments may not exceed certain maximum benefits, set by statute, based on the prior calendar year’s state average weekly wage. § 39-71-702(3), M.C.A. A worker’s benefit amount must be adjusted for a cost-of-living increase on the next July 1 after 104 weeks of permanent total disability benefits have been paid and on each succeeding July 1. § 39-71-702(5), M.C.A. The adjustment must be the percentage increase, if any, in the state’s average weekly wage. Id. Permanent total disability rates must be paid for the duration of the disability. § 39-71-702(1), M.C.A.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Such expenses may be recovered not exceeding $4,000. § 39-71-725, M.C.A.

B. **Dependency claims.**

To a surviving spouse, an unmarried child under 18, an unmarried child under 22 who is a full-time student, or an invalid child over 18 who is dependent on the decedent, weekly compensation benefits for an injury causing death are 66 2/3% of the decedent's wages. § 39-71-721(2), M.C.A. The maximum weekly compensation benefit may not exceed the state's average weekly wage at the time of injury. Id. The minimum weekly compensation benefit is 50% of the state's average weekly wage, but in no event may it exceed the decedent's actual wages at the time of death. Id.

To a dependent parent or brother or sister under 18, if the beneficiaries list above do not exist, weekly benefits must be paid to the extent of the dependency at the time of the injury, subject to a maximum of 66 2/3% of the decedent's wages. § 39-71-721(3), M.C.A. The maximum weekly compensation may not exceed the state's average weekly wage at the time of injury. Id.
If the decedent leaves no beneficiary, a lump-sum payment of $3,000 must be paid to the decedent's surviving parent or parents. § 39-71-721(4), M.C.A. There is a 500-week cap on benefits to a surviving spouse (subject to termination on remarriage prior to expiration of 500 weeks.) § 39-71-721(5), M.C.A.

Section 39-71-723 provides for apportionment of payment among more than one beneficiary.

26. **What are the criteria for establishing a “second injury” fund recovery?**

An individual certified as a person with a disability may qualify. § 39-71-905(1), M.C.A. “Person with a disability” means a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the person should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection. § 39-71-901(3), M.C.A. If certified and hired, the subsequent employer’s liability for a new injury is limited to 104 weeks, after which time liability is shifted to a state-run Subsequent Injury Fund. § 39-71-907(2), M.C.A.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Claims are “open” unless settled on a compromise basis. Settlements are considered contracts and governed by Montana contract law. Settled claims may be reopened upon a showing of mutual mistake of material fact in entering into the settlement agreement. *Kienas v. Peterson*, 191 Mont. 325, 624 P.2d 1 (1980). The statute of limitations for alleged mistake is 2 years from date of discovery of the mistake. § 27-2-203, M.C.A. A worker or an insurer may petition the Workers’ Compensation Court for a change in disability status if medical conditions underlying the disability have changed. § 39-71-2909, M.C.A.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

The claimant must show that the insurer’s decision to deny benefits or terminate benefits was unreasonable, and the claim is later adjudged compensable. § 39-71-611(1), M.C.A. If an insurer denies a claim, and the Workers’ Compensation Court finds it compensable and deems the denial unreasonable, reasonable attorney fees and costs may be awarded. § 39-71-611(1), M.C.A.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**
There is general immunity subject to some exceptions. § 39-71-411, M.C.A.

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

(1) Intentional and deliberate acts: An injured employee has a cause of action for damages against an employer or the employer’s employee only if the employer or fellow employee causes an injury by an intentional and deliberate act that is specifically and actually intended to cause injury and there is actual knowledge than an injury is certain to occur. § 39-71-413(1), M.C.A. However, the employer is not vicariously liable for the intentional and deliberate acts of any employee. § 39-71-413(2), M.C.A.


(3) Contractual waiver: Employees may not voluntarily waive rights under the Act. § 39-71-409, M.C.A.


30. Are there any penalties against the employer for unsafe working conditions?

While there are no penalties against an employer for unsafe working conditions, all employers must institute and administer a safety program in accordance with rules adopted by the Montana Department of Labor & Industry. §§ 39-71-1504 and -1505, M.C.A. The Department may issue a safety recommendation to an employer who fails to comply with the requirements or with rules adopted by the Department. § 39-71-1504(3), M.C.A. Insurers must offer safety consultation services to insured employers requesting assistance in developing and implementing a safety program. §§ 39-71-1507, M.C.A. Also, an insurer may offer financial incentives, including a premium discount, to employers instituting and implementing a safety program. §§ 39-71-421, M.C.A.

31. What penalty, if any, for an injured minor?

None.

32. What is the potential exposure for “bad faith” claims handling?

Claims for bad faith are governed by provisions of the Montana Insurance Code, specifically the Montana Unfair Trade Practices Act, §§ 33-18-101 through -1006, M.C.A. Claims are limited in part to certain proscribed activities by the insurer. reasonable basis in law or fact for contesting claim is a defense. A claim cannot be brought until the underlying action is settled or reduced to judgment. Exemplary or punitive damages may be available. Bad faith claims are cognizable only in separate state
district court proceedings at the conclusion of the dispute over compensation benefits.

A workers’ compensation court finding of “unreasonableness” in determining whether fees are awarded is not a finding of unfair claims practices within the meaning of the insurance code. §§ 39-71-611(2), -612(3). Similarly, a worker’s compensation court finding of “unreasonableness” for delay in paying or refusal to pay does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions. § 39-71-2907(3), M.C.A.

33. **What is the exposure for terminating an employee who has been injured?**

Terminations are governed by the Montana Wrongful Discharge from Employment Act, §§ 39-2-901 through -915, M.C.A. Furthermore, termination for filing a claim is a violation of the Workers’ Compensation Act. § 39-71-317(1), M.C.A. Finally, the state Human Rights Act, Tit. 9, M.C.A., incorporates federal American with Disabilities Act definitions of disability and reasonable accommodation. Termination due to disability may be actionable depending upon the circumstances.

**THIRD-PARTY ACTIONS**

34. **Can third-parties be sued by the employee?**

Yes. § 39-71-412, M.C.A.

35. **Can co-employees be sued for work-related injuries?**

Only if the injury was caused by an intentional and deliberate act, or one that is specifically and actually intended to cause injury and there is actual knowledge than an injury is certain to occur. § 39-71-413(1), M.C.A.

36. **Is subrogation available?**

Yes, but the right to assert subrogation has been limited by Montana Supreme Court decisions. Generally, the Act provides for certain subrogation rights. § 39-71-414, M.C.A. An insurer is entitled to full subrogation rights unless the claimant is able to demonstrate damages in excess of the workers’ compensation benefits and the third-party recovery combined. § 39-71-414(6), M.C.A. Court decisions have effectively limited subrogation rights where there is evidence of lack of full legal redress obtained in third-party actions or claims. See, e.g., Francetich v. State Comp. Mut. Ins. Fund, 252 Mont. 215, 827 P.2d 1279 (1992). As a result of this and related decisions, subrogation often cannot be asserted. Insurers interested in subrogation should consult local counsel for the specifics.

**MEDICALS**
37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

An insurer must make payments at the fee schedule rate within 30 days of receipt of medical bills for an accept claim where no other disputes exist. § 39-71-704(6), M.C.A. The Workers’ Compensation Court may find that delay in paying medicals was unreasonable and award a penalty of 20 percent of medical benefits. § 39-71-2907, M.C.A.

38. **What, if any, mechanisms are available to compel the production of medical information at the administrative level?**

An employee is required to file with the insurer “all reasonable information needed by the insurer to determine compensability.” § 39-71-604(1), M.C.A. The employee’s physician is required to “lend all necessary assistance . . . without charge to the worker.” *Id.*

“A signed claim for workers’ compensation or occupational disease benefits authorizes disclosure to the workers’ compensation insurer . . . by the health care provider. The disclosure authorized by this subsection authorizes the physician or other health care provider to disclose or release only information relevant to the claimant’s condition. Health care information relevant to the claimant’s condition may include past history of the complaints of or the treatment of a condition that is similar to that presented in the claim, conditions for which benefits are subsequently claimed, other conditions related to the same body part, or conditions that may affect recovery. A release of information related to workers’ compensation must be consistent with the provisions of this subsection. Authorization under this section is effective only as long as the claimant is claiming benefits.” § 39-71-604(2), M.C.A.

“A signed claim for workers’ compensation or occupational disease benefits or a signed release authorizes a workers’ compensation insurer . . . to communicate with a physician or other health care provider about relevant health care information . . . without prior notice to the injured employee.” § 39-71-604(3), M.C.A.

The Montana Administrative Procedures Act grants subpoena power to the Montana Department of Labor’s hearings examiners in contested case hearings. This power can be used to access medical information. Comparable powers are granted to the Workers’ Compensation Court.

39. **What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

A. **Claimant’s choice of physician.**

A worker may choose the initial treating physician. § 39-71-1101(1), M.C.A. If that person agrees to assume the responsibilities, that person become the treating physician. *Id.* However, the insurer, after accepting liability, may designate or approve a treating physician, or direct the worker to a managed care organization. § 39-71-1101(2), M.C.A.
Notice must be provided to the individual worker of the right to choose the initial treating physician. §§ 39-71-1101 and -1102, M.C.A.

B. Employer’s right to a second opinion and/or Independent Medical Examination.

Claimants may be required from time to time to report for an independent medical examination. § 39-71-605(1)(a), M.C.A. Scheduling examinations must be done with regard for the claimant’s convenience, physical condition, and ability to attend at a time and place as close to the claimant’s residence as is practical. § 39-71-605(1)(b), M.C.A. An examination outside the state is not necessarily forbidden. The claimant has the right to have his or her treating physician present. Id. The insurer may also require a functional capacities evaluation. § 39-71-605(4), M.C.A. Compensation benefits can be suspended if a claimant unreasonably refuses to attend an independent medical examination. § 39-71-605(1)(b), M.C.A.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The insurer is responsible for primary medical services, defined as those services necessary for achieving medical stability. §§ 39-71-704(1)(a) and -116(29), M.C.A. Secondary medical services, defined as those not medically necessary for achieving medical stability, are the responsibility of the insurer only if there is a clear demonstration of the cost-effectiveness of the services in returning the worker to actual employment. §§ 39-71-116(34)(a) and -704(1)(b), M.C.A. “Secondary medical services” include spas and hot tubs, work hardening, physical restoration programs, and comparable programs designed to address disability and not impairment. § 39-71-116(34)(a), M.C.A.

Insurers are not obliged to furnish palliative or maintenance care after the worker reaches medical stability, except in cases of permanent total disability where such care is necessary to monitor medications, for monitoring and replacing prosthetic devices, or when the treating physician believes the care is appropriate to enable the worker to continue current employment or there is a clear probability of returning to employment. § 39-71-704(1)(g), M.C.A.

With the exception of repair and replacement of prostheses, or the worker is permanently totally disabled, medical benefits terminate 60 months from the date of injury or diagnosis of occupational disease, but the worker may request reopening of medical benefits. § 39-71-704(1)(f), M.C.A.

The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. § 39-71-704(1)(d)(i), M.C.A. Reimbursement must be at the rates allowed for reimbursement for state employees. Id.

41. Which prosthetic devices are covered, and for how long?
They are generally covered; there are no limitations.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Unknown at this time. They are likely not covered, as they probably fall within the “secondary services” exception outlined above.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

A medical fee guide is in effect. § 39-71-704(2), M.C.A. As discussed in § 39-71-1102, M.C.A., cost containment is addressed primarily through managed care, which is discussed below.

44. **What, if any, provisions or requirements are there for “managed care”?**

As explained in 39A, a worker may choose the initial treating physician. If an insurer directs the worker to a managed care organization or preferred provider organization, a health care provider who otherwise qualifies as a treating physician but who is not a member may not provide treatment unless authorized by the insurer. § 39-71-1101(9), M.C.A.

The Department of Labor is responsible for establishing criteria for medical providers wishing to serve as managed care organizations. § 39-71-1103(2), M.C.A. Once a group of physicians or institution is approved as a managed care organization, an insurer can then contract with that group or institution to provide the medical services authorized under the Act. § 39-71-1103(3), M.C.A.

If a worker unreasonably refuses to participate in the managed care program, fails to submit to medical treatment prescribed by the medical provider (except for invasive procedures); or fails to provide access to health care information, the insurer can terminate any benefits upon 14 days notice to the worker and the Department of Labor. § 39-71-1106, M.C.A.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

An employee initiates the claim process by filing with the Department of Labor a claim for compensation. § 39-71-601, M.C.A. Employers are obliged to file a comparable first report of injury. § 39-71-307(1), M.C.A. The Department makes available a combined form reporting the circumstances of the injury, with a section to be signed by the worker.

After the filing of a claim, the insurer must investigate and either accept or deny the claim within 30 days of receipt. The insurer must accept or deny the claim for benefits within 30 days of receipt of a claim. § 39-71-606, M.C.A. If the insurer decides to contest
the claim, it must notify the claimant in writing. *Id.* It may accept the claim and pay benefits under a reservation of rights, but acceptance of the claim under these conditions must also be communicated to the claimant in written notice. § 39-71-608, M.C.A. Payments in this circumstance cannot exceed 90 days without consent of the claimant or approval of the department. *Id.*

46. What is the method of claim adjudication?

A. Administrative level.

Generally, all disputes over benefits must first be mediated before the Department of Labor. § 39-71-2401, M.C.A. Mediation is informal and confidential. § 39-71-2410, M.C.A.

B. Trial court.

The party aggrieved of a mediator recommendation may then bring a petition before workers’ compensation court. § 39-71-2905, M.C.A. A petition for hearing before the workers’ compensation court must be filed within 2 years after benefits are denied. *Id.*

C. Appellate.

The Montana Supreme Court hears all appeals from workers’ compensation court. § 39-71-2904, M.C.A.

47. What are the requirements for stipulations or settlements?

The requirements vary. Generally, only a claim involving payment of permanent total or permanent partial benefits can be compromised. Payments may be annuitized, but an insurer is ultimately liable if the annuity company becomes insolvent; an insurer not permitted to make complete assignment of benefit payments.

Statutorily, there is a limit of $20,000 on lump-sum conversion of permanent total benefits. § 39-71-741(2)(c), M.C.A.

The Workers’ Compensation Court has on occasion approved lump-sum settlements outside the provisions of the aforementioned statutes through the use of a “stipulated judgment” procedure. Parties in litigation may settle their differences on the basis of payment of an agreed-upon sum, and the Court can then enter a “stipulated judgment” for that amount in a lump sum.

48. Are full and final settlements with closed medicals available?

Generally, only on disputed liability cases. The Department and/or the Court may also approve settlements in some cases where liability was initially accepted and medicals paid if subsequent disputes develop over whether new and additional medical may be
49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes, the Employment Relations Division of the Montana Department of Labor. § 39-71-741, M.C.A.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Coverage is available through “Plan 1,” self-insurance, Tit. 39, ch. 71, pt. 21; “Plan 2,” authorized private companies, pt. 22; or, for state agencies and public corporations, “Plan 3,” the state fund, pt. 23.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   Generally, proof of solvency subject to State Labor Department guidelines. § 39-71-2101 and -2105, M.C.A. Security of $250,000 or average of liabilities for prior 3 of 4 years, whichever is greater, is required. § 39-71-2106, M.C.A.

   **B. For groups or “pools” of private entities.**

   Similarly, proof of solvency subject to State Labor Department guidelines. Security of $250,000 or average of liabilities for prior 3 years, whichever is greater, required, and the Department may require additional security.

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

   By statute, the terms “worker” and “employer” include aliens, whether lawfully or unlawfully employed. § 39-71-118(1)(a), M.C.A. Whether the federal act preempts coverage has yet to be litigated in this state.

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

   A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer to Question 14 above.
54. Are there any state specific requirements that must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 11396k(b).

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. See 45 C.F.R. 164.512(l).

57. What are the provisions for “Independent Contractors”?

Of course, the definition of “employee” for worker’s compensation purposes does not include independent contractors. § 39-71-118(1)(a), M.C.A. A certified independent contractor need not obtain a personal workers’ compensation insurance policy. § 39-71-417(1)(b), M.C.A. A person may not perform as an independent contractor unless the person has an independent contractor exemption certificate, is not required to have a certificate, or elects to be bound personally by the provisions of a worker’s compensation plan. § 39-71-419(1)(a), M.C.A.

The Worker’s Compensation Act does not apply to “employment of a person who is working under an independent contractor exemption certificate.” § 39-71-401(2)(x), M.C.A. There is a conclusive presumption that the holder of a current, valid independent contractor exemption certificate is an independent contractor. § 39-71-105(2), M.C.A. Except for exempt officers or managers, a “person who regularly and customarily performs services at a location other than the person’s own fixed business location shall apply to the department for an independent contractor exemption certificate. . . .” § 39-71-417(1)(a), M.C.A. “To obtain an independent contractor exemption certificate, the applicant shall swear to and acknowledge the following: (i) that the applicant has been and will continue to be free from control or direction over the performance of the person’s own services, both under contract and in fact; and (ii) that the applicant is
engaged in an independently established trade, occupation, profession, or business and will provide sufficient documentation of that fact to the department.” § 39-71-417(4)(a), M.C.A.

An employer that hires an independent contractor is liable for worker’s compensation payments to the employees of that independent contractor if the independent contractor has not properly complied with the coverage requirements of the Worker’s Compensation Act. §39-71-405(1), M.C.A. Where an employer contracts to have any work done by a contractor other than an independent contractor, the employer is liable to pay all benefits under the Worker’s Compensation Act. § 39-71-405(2), M.C.A. The procedure for resolving disputes regarding independent contractor status is set forth in § 39-71-415, M.C.A.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Yes. Under the Worker’s Compensation Act, a temporary service contractor is the employer of a temporary worker. § 39-71-117(2), M.C.A. “Temporary service contractor” means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects. § 39-71-116(38), M.C.A. “Temporary worker” means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects. § 39-71-116(40), M.C.A.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Yes. The Worker’s Compensation Act does not apply to the “employment of a person performing the services of an intrastate or interstate common or contract motor carrier when hired by an individual or entity who meets the definition of a broker or freight forwarder, as provided in 49 U.S.C. 13102.” § 39-71-401(2)(v), M.C.A.

Further, an interstate or intrastate common or contract motor carrier that maintains a place of business in Montana and uses an employee or worker in Montana is considered the employer of that employee under the Worker’s Compensation Act unless: (a) the worker has an independent contractor exemption certificate; or (b) the company furnishing employees or workers in this state to a motor carrier has obtained Montana workers' compensation insurance on the employees or workers in Montana both at the inception of employment and during all phases of the work performed. § 39-71-117(4), M.C.A.
60. **What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

61. **Are there any state-specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

No state-specific requirements.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Generally, an employee is not eligible for workers’ compensation benefits if they are using alcohol or drugs not prescribed by a physician, and the alcohol or drugs are the major contributing cause to the accident. However, specific provisions were passed for marijuana, which is legal for medicinal purposes in Montana. Although medicinal marijuana is legal, if it is the major contributing cause of an injury or occupational disease, workers’ compensation benefits are not owed. Carriers are also not required to reimburse or pay for medicinal marijuana treatment. Finally, the benefits owed by an insurer may not be increased due to a workers’ use of medicinal marijuana. The insurer is only liable for the benefits that would be owed absent the marijuana use.

Additionally, any affirmative defense a worker could claim with other prescription drugs does not apply to marijuana. For purposes of the Montana workers’ compensation statute, marijuana is not considered a prescription drug. § 39-71-407(5-7), M.C.A.

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Recreational marijuana is not legalized in the State of Montana.
Douglas J. Kotarek, Esquire
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Tel:  (303) 628-3300
1. **Citation for the state's workers' compensation statute.**

   Nebraska Revised Statutes § 48-101 *et. seq.*

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers' compensation?**

   The Nebraska Workers' Compensation Act covers employees of the state, every governmental agency created by it, and every employer in Nebraska, including non-resident employers performing work in the state employing one or more employees in the regular trade, business, profession, or vocation of such employer.

   **A. Employees excluded from coverage.**

   Household domestic servants; workers employed by an employer who is engaged in an agricultural operation and employs only related employees; workers employed by an employer who is engaged in an agricultural operation and employs unrelated employees unless such service is performed for an employer who during any calendar year employs ten or more unrelated, full-time employees; and employees of railroad companies engaged in interstate or foreign commerce are excluded from coverage by the Act. Neb. Rev. Stat. § 48-106.

   Independent contractors, and self-employed individuals may secure coverage under the Act by notifying the insurer in writing of the intent to be covered. Neb. Rev. Stat. §48-115(10). Executive officers of a corporation who own 25 percent or more of the corporation’s common stock may elect to be covered under the Act by written notification to the insurer and the corporation secretary of the election to be covered. Neb. Rev. Stat. § 48-115(9).

3. **Identify and describe any "statutory employer" provision.**
Section §48-116 of the Act represents the Nebraska "statutory employer" provision. In essence it provides that any person, entity, or employer which requires another business to perform work and fails to require the other business to procure workers' compensation insurance is liable as a statutory employer. Rogers v. Hansen, 211 Neb. 132, 317 N.W.2d 905 (1982). ‘Perform work’ means to conduct tasks that are part of the ‘regular trade’ of the employer; not occasional tasks that are merely incidental to the business. Hassan v. Trident Seafoods, 302 Neb. 44, 50, 921 N.W.2d 146, 151 (2019). ‘Procure a policy’ means more than just obtaining a Certificate of Insurance, it means verifying the status of the policy before beginning the work. Martinez v. CMR Construction & Roofing of Texas, 302 Neb. 618, 628, 924 N.W.2d 326, 336 (2019).

4. What type of injuries are covered and what is the standard of proof for each:

A personal injury or death caused to an employee by an accident or occupational disease arising out of and in the course of the employment is compensable. The employee must establish the right to compensation by a preponderance of the evidence. Neb. Rev. Stat. § 48-101.

A. Traumatic or "single occurrence" claims.

Such injuries are compensable. See Neb. Rev. Stat. § 48-151(2).

B. Occupational disease (including respiratory).

Occupational disease claims are compensable so long as they are due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process, or employment. Neb. Rev. Stat. § 48-151(3). Ordinary diseases of life to which the general public is exposed are excluded. There is, however, no statutory or administrative listing of covered diseases. That determination is made on a case-by-case basis. The Nebraska Supreme Court has found that noise-induced hearing loss was not an occupational disease under the Act and should be viewed as a cumulative trauma injury. Risor v. Nebraska Boiler, 277 Neb. 679, 765 N.W.2d 170 (2009).

C. Repetitive use or cumulative trauma injuries.

The compensability of conditions resulting from cumulative effects of repeated work-related trauma is tested under the definition of accident. In order to prove that an accident has occurred in the context of a repetitive use or cumulative trauma claim, the plaintiff must prove that either the cause was reasonably limited in time or the result materialized at an identifiable point. Dawes v. Wittrock Sandblasting & Painting, 266 Neb. 526, 667 N.W.2d 167 (2003).

5. What, if any, injuries or claims are excluded?

Except in the case of mental-mental injuries suffered by first responders (see response to

6. **What psychiatric claims or treatments are compensable?**

Psychiatric conditions caused by or resulting from a physical injury are compensable. *VanWinkle v. Electric Hose and Rubber Co.*, 214 Neb. 8, 332 N.W.2d 209 (1983). Mental injuries or illness suffered by first responders, even though unaccompanied by physical injury, are compensable if such injuries or illness are the result of extraordinary and unusual conditions in comparison to the normal conditions of the particular employment and the injuries or illness are not incidental to normal employer and employee relations. See Neb. Rev. Stat. § 48-101.01.

7. **What are the applicable statutes of limitations?**

All claims for compensation are forever barred unless within two years after the accident, or if payments of compensation have been made, within two years of the time of the making of the last payment, a petition for compensation is filed with the Nebraska Workers' Compensation Court. See Neb. Rev. Stat. § 48-137.

The statute of limitations may be tolled:
1) When the employee has sustained a latent and progressive injury;
2) When any employer, risk management pool, or insurer fails, neglects, or refuses to file a First Report of Accident (NWCC Form 1). Such failure tolls the statute of limitations until such report is filed. See Neb. Rev. Stat. § 48-144.04;
3) When there is a material change in the employee’s condition which necessitates additional medical care. See *Snipes v. Vickers*, 251 Neb. 415, 557 N.W.2d 662 (1997).

The statute of limitations will not be a defense to claims for payment of medical bills even though more than two years passed without the payment of benefits, if the claimant received a prior award from the Workers’ Compensation Court that specifically made a provision for payment of future medical benefits. *Foote v. O’Neil Packing*, 262 Neb. 467, 632 N.W.2d 213 (2001).

8. **What are the reporting and notice requirements for those alleging an injury?**

The employee must give notice of injury to the employer ‘as soon as practicable’ after the happening thereof. Neb. Rev. Stat. § 48-133. An employee need not give notice to any one person, notifying a “foreman, supervisor, or superintendent. . .” is enough to impute constructive notice on the employer. *Kaiser v. Metropolitan Utilities District*, 26 Neb. App. 38, 49, 916 N.W.2d 448, 457 (2018). The Nebraska Supreme Court has defined the phrase "as soon as practicable" as meaning "capable of being done, effected, or put into practice with available means, i.e., feasible." *Snowden v. Helget Gas Products, Inc.*, 15
Neb. App. 33, 721 N.W.2d 362 (2006); Williamson v. Werner Enterprises, Inc. 12 Neb. App. 642, 682 N.W.2d 723 (2004). The determination as to whether notice was given “as soon as practicable” is made on a case-by-case basis. Approximately five months has been determined to be not “as soon as practicable” (Williamson v. Werner Enterprises, Inc., 12 Neb. App. 642 (2004)), and most recently 5 weeks was determined to be too late. Bauer v. Genesis Healthcare Group, 27 Neb.App. 904, 914 (2019).

An employee is not required to tell the employer that his injury is work-related. Notice to an employer is sufficient if a reasonable person would conclude that the injury is potentially compensable and that the employer should investigate the matter further. Risor v. Nebraska Boller, 277 Neb. 679, 765 N.W.2d 170 (2009). If the employer's failure to investigate the matter further is the reason the employer was unaware that the injury is work-related, notice will not be a viable defense. Scott v. Pepsi Cola Co., 249 Neb. 60, 541 N.W.2d 49 (1995).

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

Under Neb. Rev. Stat. § 48-101, a claimant cannot recover workers' compensation benefits if the employee was willfully negligent. See Hannon v. J. L. Brandeis & Sons, Inc., 186 Neb. 122, 181 N.W.2d 253 (1970), overruled on other grounds, Friedeman v. State, 215 Neb. 413, 339 N.W.2d 67 (1983). Willful negligence consists of a deliberate act, conduct evidencing a reckless indifference to safety, or intoxication at the time of injury without consent, knowledge, or acquiescence of the employer. See Neb. Rev. Stat. § 48-151(7). Committing suicide generally constitutes willful negligence within the meaning of this language and thereby bars recovery under the workers' compensation law. See Hannon v. J. L. Brandeis & Sons, supra. However, Nebraska law has recognized an exception to the rule that suicide constitutes willful negligence when the evidence shows that suicide was involuntary. See Friedeman v. State, supra. In Friedeman, the decedent suffered a work injury that left her with chronic pain, making it very difficult for her to engage in any of her pre-accident activities, such as working, helping on the family farm, and looking after her family. She had difficulty moving around and getting to sleep and became "a mere shadow of her former self." Id. at 415, 339 N.W.2d at 70. Several years after the accident, decedent committed suicide, leaving behind a note explaining that she "'just [could not] stand the pain any longer.'" Id. Her doctor later expressed the opinion that the pain from her work injury, rather than depression, drove her to commit suicide and that her decision to do so was involuntary and beyond her control. Friedeman v. State, supra. The Nebraska Supreme Court agreed, acknowledging that there are factors which can override a person's free will and that scientific testimony to such can be admitted as evidence the suicide was not willful, thereby allowing for recovery. Id. In so ruling, the Supreme Court carved out an exception from the general rule of Hannon, finding that an involuntary suicide does not constitute willful negligence. See Friedeman v. State, supra.

B. Willful misconduct, "horseplay," etc.
Willful negligence can be a bar to recovery. However, willful negligence is defined to include a deliberate act or such conduct as evidences reckless indifference to safety. Neb. Rev. Stat. § 48-151. In fact, the employee must manifest a reckless disregard for the consequences, coupled with a consciousness that injury will naturally result and mere negligence or violation of safety rules is insufficient. Guico v. Excel Corp., 260 Neb. 712, 619 N.W.2d 470 (2000). Accidents and injuries which occur as a result of “horseplay” are compensable if (1) the deviation is insubstantial and (2) the deviation does not measurably detract from the work. Varela v. Fisher Roofing Co., Inc., 253 Neb. 667, 572 N.W.2d 780 (1998).

C. Injuries involving drugs and/or alcohol.

Neither the employee nor the beneficiaries are entitled to recover for injuries caused by being in a state of intoxication. Intoxication includes use of an illegal controlled substance by the employee. The burden of proving that the accident was caused by reason of the employee’s intoxication rests with the employer. Neb. Rev. Stat. § 48-127.

D. Violation of a Safety Rule.

An employee's deliberate or intentional defiance of a reasonable safety rule will disqualify that employee from receiving benefits if (1) the employer has a reasonable rule designed to protect the health and safety of the employee, (2) the employee has actual notice of the rule, (3) the employee has an understanding of the danger involved in the violation of the rule, (4) the rule is kept alive by bona fide enforcement by the employer, and (5) the employee does not have a bona fide excuse for the rule violation. These factors are not applicable when an employee has accidentally violated a safety rule. Spaulding v. Alliant Foodservice, 13 Neb. App. 99 (2004).

10. What, if any, penalties or remedies are available in claims involving fraud?

A person who presents a false or fraudulent insurance claim, or proof in support of a false or fraudulent claim, knowing the claim to be false or fraudulent, is guilty of a Class IV misdemeanor. Neb. Rev. Stat. § 28-106. Or a person who presents a false or fraudulent insurance claim may be subject to an imposition of a civil fine initiated by the Director of Insurance pursuant to the Insurance Fraud Act, Neb.Rev.Stat. §§ 44-6601 to 44-6608 (Reissue 1999).

11. Is there any defense for falsification of employment records regarding medical history?

Yes. No compensation shall be allowed if, at the time of or in the course of entering into employment or at the time of receiving notice of the removal of conditions from a conditional offer of employment: (1) the employee knowingly and willfully made a false representation as to his or her physical or medical condition by acknowledging in writing that he or she is able to perform the essential functions of the job with our without
reasonable accommodation based upon the employer’s written job description; (2) the employer relied upon the false representation and the reliance was a substantial factor in the hiring, and (3) a causal connection existed between the false representation and the injury. Neb. Rev. Stat. §48-148.01.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

"Recreational or social activities are within the course of employment when (1) they occur on the premises during a lunch or recreation period as a regular incident of the employment; or (2) the employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment; or (3) the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life." Shade v. Ayars & Ayars, Inc., 247 Neb. 94, 525 N.W.2d 32 (1994).

13. Are injuries by co-employees compensable?


14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

Probably not. There is little case law on point. Assault on an employee after work in employer provided parking lot was an “accident” within the meaning of the workers' compensation law. Zoucha v. Touch of Class Lounge, 269 Neb. 89, 690 N.W.2d 610 (2005). In Zoucha the employee worked at a bar and was assaulted by a patron who had approached her during her shift. In a case where the reason for the assault is truly unrelated to employment, the argument for noncompensability of the claim could be made.

BENEFITS

15. What criteria are used for calculating the average weekly wage?

Wages under the Nebraska Workers' Compensation Act are construed to mean the money rate at which the service rendered was recompensed under the contract of hire in force at the time of the accident. Wages do not include gratuities received from the employer or others, nor do they include board, lodging, or similar advantages received from the employer, unless the money value of such advantages shall have been fixed by the parties at the time of hiring, except that if the insurer shall have collected a premium based upon the value of such board, lodging, or similar advantages then the value shall become a part of the basis of determining compensation benefits. Neb. Rev. Stat. § 48-126. Net profits of a subchapter S corporation are not included as wages in determining the average weekly wage of an employee-shareholder. Bortolotti v. Universal Terrazzo and Tile Co., 304 Neb. 219, 234, 933 N.W.2d 219, 862 (2019)(citing Neb. Rev. Stat. § 48-126).
In order to compute the average weekly wage in continuous employments, if immediately prior to the accident the rate of wages was fixed by the day or hour or by the output of the employee, his or her weekly wages shall be based upon the hours worked and the wages earned by the claimant during the twenty-six week period prior to the accident, or so much thereof preceding the date of accident during which the claimant was employed. Neb. Rev. Stat. § 48-126. Only the weeks with hours worked which ordinarily constitute the plaintiff’s work week will be used. Canas v. Maryland Cas., 236 Neb. 164, 459 N.W.2d 533 (1990). The hourly rate used to compute the average weekly wage should be “prorated” to reflect the wage actually in effect during each of the weeks utilized in computing the average weekly wage. Ramsey v. State, 259 Neb. 176, 609 N.W.2d 18 (2002). Overtime pay is not included within the average weekly wage calculation unless the compensation insurer collects a premium based upon the overtime pay. Neb. Rev. Stat. § 48-126.

Where a worker has insufficient work history to be able to calculate his average weekly income based on as much of the preceding six months as he worked for the same employer, then what would “ordinarily” constitute the employee’s work week and average weekly wage should be estimated by considering other employees working similar jobs for similar employers for the six month period prior to the accident. Powell v. Estate Gardeners, Inc. and Auto Owners Insurance, 275 Neb. 287, 745 N.W. 2d 917 (2008).

In accordance with Neb. Rev. Stat. §§ 48-121 and 48-122 for permanent partial disability and death benefit purposes, the weekly wages shall be taken to be computed on the basis of a work week of a minimum of five days if the wages are paid by the day, or upon the basis of a work week of a minimum of 40 hours if the wages are paid by the hour or the greater of the two if wages were based on the output of the employee.

The Employee has the burden to prove his/her average weekly wage. Bortolotti v. Universal Terrazzo and Tile Co., 304 Neb. 219, 236, 933 N.W.2d 219, 863 (2019). Without supporting documentation, an employee’s testimony, or allegation in the petition, are an insufficient based upon which to establish the average weekly wage. Id. at 228, 859. When the evidence is clear that the employee received a wage, but there is insufficient evidence to determine what that wage was, the lowest statutorily permissible wage will apply. Id. at 236, 863.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum begins?

Indemnity benefits are two-thirds of the employee's average weekly wage, subject to the applicable maximum weekly benefit. If that calculation yields a weekly benefit of less than the minimum ($49.00 per week), the employee is entitled to $49.00 per week. If the employee's average weekly wage at the time of the accident is less than the statutory minimum, the employee is entitled to the actual wage received. The minimum and maximum benefits are as follows:
Table of Maximum & Minimum Compensation Rates [Neb. Rev. Stat. § 48-121.01]:

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<tr>
<th>Applicable Dates</th>
<th>Maximum Rate</th>
<th>Minimum Rate</th>
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<td>July 12, 1974 - August 23, 1975</td>
<td>89.00</td>
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<td>July 12, 1974 - August 23, 1975</td>
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<td>Jan 1, 2001- Dec 31, 2001</td>
<td>508.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Jan 1, 2002 - Dec 31, 2002</td>
<td>528.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Jan 1, 2003 - Dec 31, 2003</td>
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<td>49.00</td>
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<td>Jan 1, 2004 - Dec 31, 2004</td>
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<td>49.00</td>
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<td>49.00</td>
</tr>
<tr>
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<td>49.00</td>
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</tr>
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<td>49.00</td>
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<td>49.00</td>
</tr>
<tr>
<td>Jan 1, 2010 - Dec. 31, 2010</td>
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<td>49.00</td>
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<tr>
<td>Jan 1, 2011 – Dec. 31,2011</td>
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<td>Jan 1, 2012 – Dec. 31, 2012</td>
<td>710.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Burial: July 19, 2012 - $10,000</td>
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<td></td>
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<tr>
<td>Jan 1, 2013 – Dec. 31, 2013</td>
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<td>49.00</td>
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<td>Jan 1, 2014 – Dec. 31, 2014</td>
<td>747.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Jan 1, 2015 – Dec. 31, 2015</td>
<td>761.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Jan 1, 2016 – Dec. 31, 2016</td>
<td>785.00</td>
<td>49.00</td>
</tr>
</tbody>
</table>
Commencing January 1, 1996, and each January 1 thereafter, the maximum weekly rate shall be 100 percent of the state average weekly wage.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Unless there is a reasonable controversy, the employer/insurer must begin payment of benefits within 30 days after notice has been given of disability or within 30 days after notice has been given of outstanding medical expenses. Neb. Rev. Stat. § 48-125. Failure to pay such benefits in the absence of a "reasonable controversy" concerning the employer/insurer's obligation to pay the indemnity or medical benefits exposes the employer/insurer to a 50 percent waiting time allowance on the past due indemnity benefits, as well as to an attorney's fee on any unpaid medical expenses. Waiting for an employee's response about possible settlement, or on-going settlement discussion, is not justification for withholding payment of benefits. The “after thirty days’ notice” language only applies to an employer’s failure to timely pay benefits pending trial and the Workers’ Compensation Court is not authorized to impose waiting-time penalties absent a final adjudication when a party appeals. *Lageman v. Nebraska Methodist Hospital*, 277 Neb. 335, 762 N.W.2d 51 (2009).

18. **What is the "waiting" or "retroactive" period for temporary benefit (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

The employee must be out more than six weeks before recovering benefits for the first seven days. Neb. Rev. Stat. § 48-119.

19. **What is the standard/procedure for terminating temporary benefits?**

If an Award has not been entered by the court, an employer or insurer may unilaterally terminate or reduce temporary disability benefits when evidence is sufficient to support such a termination or reduction. An employee is entitled to temporary disability until he has reached maximum medical improvement, unless evidence exists which justifies terminating such benefits. The level of a worker's disability depends on the extent of diminished employability or impairment of earning capacity, and does not directly correlate to current wages. *Damme v. Pike Enterprises, Inc.*, 856 N.W.2d 422, 289 Neb. 620 (2014).

If an Award has been entered which provides for temporary benefits on an ongoing basis, temporary disability benefits may not, generally speaking, be discontinued without a modification from the court or agreement of the parties. *Hagelstein v. Swift-Eckrich*, 261 Neb. 305, 622 N.W.2d 663 (2001); *Holmes v. Chief Industries, Inc.*, 16 Neb. App. 589,
747 N.W.2d 24 (2008). However, if Award directed the cessation of temporary benefits and conversion to permanent benefits upon the happening of an identified event, a modification action may not be necessary to terminate temporary benefits. *Weber v. Gas ’N Shop, Inc.*, 786 N.W.2d 671, 280 Neb. 296 (2010).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

Yes, credit may be taken for the number of weeks of temporary disability benefits paid, but only in the case of whole body injuries. Temporary disability payments are not credited toward the amount the employee is entitled to receive for permanent disability benefits for scheduled member injuries.

21. **What disfigurement benefits are available and how are they calculated?**

There is no specific provision in the Act providing for specific benefits as a result of disfigurement. Disfigurement can conceivably decrease earning capacity and thus result in a greater level of permanent benefits.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled members/parts, and the standard recovery?**

<table>
<thead>
<tr>
<th>Member</th>
<th>Weeks Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>60 weeks</td>
</tr>
<tr>
<td>1st Finger</td>
<td>35 weeks</td>
</tr>
<tr>
<td>2nd Finger</td>
<td>30 weeks</td>
</tr>
<tr>
<td>3rd Finger</td>
<td>20 weeks</td>
</tr>
<tr>
<td>4th Finger</td>
<td>15 weeks</td>
</tr>
<tr>
<td>Great Toe</td>
<td>30 weeks</td>
</tr>
<tr>
<td>Other Toe</td>
<td>10 weeks</td>
</tr>
<tr>
<td>Hand</td>
<td>175 weeks</td>
</tr>
<tr>
<td>Arm</td>
<td>225 weeks</td>
</tr>
<tr>
<td>Foot</td>
<td>150 weeks</td>
</tr>
<tr>
<td>Leg</td>
<td>215 weeks</td>
</tr>
<tr>
<td>Eye</td>
<td>125 weeks</td>
</tr>
<tr>
<td>Ear</td>
<td>25 weeks</td>
</tr>
<tr>
<td>Hearing (One ear)</td>
<td>50 weeks</td>
</tr>
<tr>
<td>Hearing (Both ears)</td>
<td>100 weeks</td>
</tr>
<tr>
<td>Nose</td>
<td>50 weeks</td>
</tr>
</tbody>
</table>

*See* Neb. Rev. Stat. § 48-121(3).

Additionally, for accidents occurring on or after January 1, 2008, if the employee sustains injuries to two or more scheduled members in the same accident, and it is determined that the benefits pursuant to the schedule will not “adequately compensate” the employee, the court, in its discretion, may award the employee a loss of earning power, if the loss of earning power is 30% or more. *See* Neb. Rev. Stat. § 481-21(3).

Under certain circumstances injuries to scheduled members may also be considered in determining the loss of earning power. The Nebraska Supreme Court has held that when
a worker sustains a scheduled member injury and a whole body injury in the same accident, the Act does not prohibit the court from considering the impact of both injuries in assessing the loss of earning capacity. Zavala v. ConAgra Beef Co., 265 Neb. 188, 655 N.W.2d 692 (2003). If the loss of earning capacity for a whole body injury cannot be fairly and accurately assessed without also considering a scheduled member injury sustained in the same accident, then the court is permitted to consider both the scheduled member and the body as a whole injuries to determine the plaintiff's loss of earning power. The claimant may not recover both a loss of earning that takes into account a scheduled member injury and indemnity for the permanent impairment of the scheduled member injury. Bishop v. Speciality Fabricating Co., 277 Neb. 171, 760 N.W.2d 352 (2009); Zavala v. ConAgra Beef Co., 265 Neb. 188, 655 N.W.2d 692 (2003); Madlock v. Square D Co., 269 Neb. 675, 695 N.W.2d 412 (2005).

B. Number of weeks for "whole person" and standard for recovery.

For "whole person" disabilities resulting in less than total disability, the employee is entitled to temporary total disability and permanent partial disability/loss of earning capacity benefits for an aggregate of 300 weeks. In calculating the amount of permanent partial indemnity benefits payable, the average weekly wage is multiplied by two-thirds and then by the percentage amount of permanent loss of earning capacity or disability. For example, an employee with an average weekly wage of $450.00 and a permanent loss of earning capacity of 15 percent would be entitled to a weekly permanent partial disability benefit of $45.00 per week based upon the following calculation: $450 x 2/3 x 15% = $45.00. This amount would be payable for 300 weeks reduced by the number of weeks already paid for temporary total disability benefits. See, Neb. Rev. Stat. § 48-121(2).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

The employee is entitled to vocational rehabilitation if, because of the work related injuries, the employee is no longer able to perform “suitable” employment. The employer is obligated to pay temporary disability benefits to the employee during the period of vocational retraining. Neb. Rev. Stat. § 48-162.01. The cost of vocational retraining, including tuition, books, lodging, and mileage expense is paid from a separate vocational rehabilitation fund administered by the Nebraska Workers' Compensation Court. The period of vocational retraining is theoretically unlimited. Vocational retraining has been interpreted to include everything from formal schooling to direct job placement programs. Vocational rehabilitation counselors must abide by the following priorities in evaluating an employee's need for vocational rehabilitation and what appropriate vocational retraining should be: (1) return to the previous job with the same employer; (2) modification of the previous job with the same employer; (3) a new job with the same employer; (4) a job with a new employer; or (5) formal retraining designed to lead to employment in another occupation. Neb. Rev. Stat. § 48-162.01.

Illegal aliens who may not be lawfully employed in the United States and who intend on

In certain instances, the Trial Court may reduce payment of Plaintiff's indemnity benefits under Neb. Rev. Stat. § 48-162.01(7) due to Plaintiff's failure to participate in previously ordered vocational rehabilitation. Defendant has the burden to prove the employee refused to participate in the vocational program and that the refusal was unreasonable. *Lowe v. Drivers Management, Inc.*, 274 Neb. 732, 743 N.W.2d 82 (2007).

24. **How are the permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are two-thirds of the employee's average weekly wage subject to the applicable maximum weekly benefit. Permanent total disability benefits are payable for so long as the employee remains permanently and totally disabled. There is no "working life" cap on payment of permanent total disability benefits. Maximum and minimum rates are identical to those set forth in #16 above.

25. **How are death benefits calculated, including the minimum and maximum rates?**

Payable to spouse in above maximums and minimums. If children, then 60% of AWW to spouse and 15% of AWW to children but when combined benefit reaches maximum then spouse received 80% of maximum benefit and children receive 20% of maximum benefit. § 48-122.01(1) & (2). The surviving spouse receives two years balloon payment on remarriage and children then receive full benefits divided equally so long as they meet the dependency criteria of § 48-122.01(5).

A. **Funeral expenses.**

A burial benefit up to $10,000.00 is payable. Neb. Rev. Stat. § 48-122(3).

B. **Dependency claims.**

Natural, minor children of the decedent and a spouse with whom the decedent was living at the time of the accident are conclusively presumed to be dependent. Posthumous children and adopted children are considered dependents. Others seeking dependency must establish actual dependency which requires the dependent to show that more than one-half of his or her support was derived from the employee at the time of death. See Neb. Rev. Stat. § 48-124. The actual dependency requirement as imposed between natural, legitimate children of the deceased and illegitimate or stepchildren was found to be unconstitutional, *Findaya v. A-Team Co.*, 249 Neb. 838, 546 N.W.2d 61 (1996). The method of apportioning death benefits among various dependents is set forth in Neb. Rev. Stat. § 48-122.01.

26. **What are the criteria for establishing a "second injury" fund recovery?**
Nebraska does not have a Second Injury Fund.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

Application for modification may be made by either the employee or the employer at any time after six months from the date of any agreement or award, on the ground of increase or decrease in incapacity due solely to the injury. The applicant must show an increase or decrease in the employee's physical condition which would allow a modification of the award. Such an application must be filed within two years of the applicant's knowledge of the change in condition. Neb. Rev. Stat. § 48-141; McKay v. Hershey Food Corp., 16 Neb. App. 79, 740 N.W.2d 378 (2007); Hubbart v. Hormel Foods Corp., 15 Neb. App. 129, 723 N.W.2d 350 (2006); Bronzynski v. Model Electric, 14 Neb. App. 355, 707 N.W.2d 46 (2005).

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

If the court determines there is no reasonable controversy justifying a delay of payment of an indemnity benefit or medical bill for more than 30 days, the court will order the employer or carrier to pay an attorneys' fee to the employee. In addition, if the employer appeals an award of the Compensation Court and fails to secure a reduction in the court's award, the employee is entitled to an attorney's fee award. Neb. Rev. Stat. § 48-125.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   A. **Scope of immunity.**

   The workers' compensation remedy is exclusive except for injury or death proximately caused by the willful and unprovoked physical aggression of a co-employee, officer, or director. Neb. Rev. Stat. §§ 48-109, 48-111.

   B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc).**


30. **Are there any penalties against the employer for unsafe working conditions?**

    No.

31. **What is the penalty, if any, for an injured minor?**
32. **What is the potential exposure for "bad faith" claims handling?**

None.

33. **What is the exposure for terminating an employee who has been injured?**

There is no specific penalty pursuant to the workers’ compensation act for terminating the employment of an employee who has been injured at work. Of course, any time an employee is terminated while recovering from a workers’ compensation injury, there is additional risk of liability for temporary benefits as well as the risk of liability for wrongful termination premised upon retaliation, disability discrimination, the Family Medical Leave Act and various other state and federal antidiscrimination provisions. For example, a public policy exception to the at-will employment doctrine applies to allow a cause of action for retaliatory discharge when an employee is fired for filing a workers' compensation claim. *Jackson v. Morris Communications Corp.*, 265 Neb. 423, 657 N.W.2d 634 (2003). Similarly, a cause of action for retaliatory demotion exists when the employer demotes an employee for filing a workers’ compensation claim. *Trosper v. Bag ‘N Save*, 273 Neb. 855, 734 N.W.2d. 704 (2007).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes.

35. **Can co-employees be sued for work-related injuries?**

Only where the injury or death is proximately caused by the willful and unprovoked physical aggression of such co-employee, officer, or director of the employer. Neb. Rev. Stat. § 48-111.

36. **Is subrogation available?**

Yes. The distribution of the third party proceeds shall be on a “fair and equitable” basis. Neb. Rev. Stat. § 48-118. In making a fair and equitable distribution of third party proceeds, the district court must order a “reasonable” division of the proceeds between the parties. *Burns v. Nielsen*, 273 Neb. 724, 735, 732 N.W.2d 640, 650 (2007). There is no exact formula to be used in making a reasonable distribution. However, the “made whole” doctrine of equitable subrogation is not applicable in an action under § 48-118 and may not be used to bar recovery of a subrogation interest. *Turco v. Schuning*, 271 Neb. 770, 716 N.W.2d 415 (2006). Additionally, equitable doctrines, such as unclean hands and estoppel, may not be used to bar recovery of a § 48-118 subrogation interest. *Burns v. Nielsen*, 273 Neb. 724, 735, 732 N.W.2d 640, 650 (2007).
37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Medical expenses must be paid within 30 days of being presented to the employer/insurer so long as there is no reasonable controversy concerning the compensability of the bill. If timely payment is not made, the employer/insurer is subject to an attorney's fee to be determined by the Compensation Court. Neb. Rev. Stat. § 48-125.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

All medical and hospital information relevant to an injury for which workers' compensation benefits are sought are to be made available to the employer/insurer on demand. Neb. Rev. Stat. § 48-120. Relevant information developed in connection with treatment or examination of such an injury is not considered a privileged communication for purposes of the claim. Thus the statute directs medical providers to provide that information to the employer/insurer on demand. The employer/insurer is required to pay the cost of any information requested. Medical care providers' obligation to release this information is not dependent upon the filing of a lawsuit, but requires only that the employee request or demand benefits, either indemnity or medical.

After a lawsuit commences, an employer/insurer can secure medical records through normal discovery means. An employer/insurer can also subpoena those records and in most cases secure a court order which obligates the employee to execute an authorization directed to the medical care provider authorizing the release of the records to the employer/insurer.

39. **What is the rule on (a) Claimant’s choice of physician and (b) Employer’s right to a second opinion and/or Independent Medical Evaluation?**

The only situation in which an employer may designate the primary treating physician is if the employer provides the employee with a Form 50 as soon as possible after being notified of the injury, and on the Form the employee either defers to the employer’s choice, or the employee does not have a physician who has maintained the medical records and has a documented history of treatment with the employee or an immediate family member prior to the date of injury, and the employer has accepted the compensability of the injury. In all other cases the employee may choose the primary treating physician. Rule 50.

Employers can also enter into managed care plans where choice of physician is controlled by the plan, except that so long as the employee designates a physician prior to or at the time of injury the employee can always seek treatment from the designated physician with any referrals thereafter to be made into the managed care plan. Neb. Rev. Stat. § 48-
When there is a dispute regarding a plaintiff’s medical condition or related issues, either party may request an Independent Medical Examination (IME). The parties may either agree on an independent medical examiner or may request that the court appoint an IME provider. If the provider chosen to perform the IME is not on the court-approved list of providers, the doctor chosen must agree to the court’s rules. The cost of the IME is paid by the employer/insurer regardless of which party requests the IME. Neb. Rev. Stat. § 48-134.01. Both sides to the disagreement may ask questions of the doctor. If the court is asked to assign the doctor, the person making the request includes questions on the request form. The other party may also ask questions but must send the questions to the court which will send them on to the independent medical examiner.

Additionally, the employer/insurer has the right from time to time during the period of an employee’s alleged work-related disability to have the employee examined by a physician of its choosing in a Defense Medical Examination (DME). The employee has the right to have a physician provided and paid for by the employee present at the examination. Unreasonable refusal to submit to a DME may deprive the employee of right to compensation under the Workers’ Compensation Act during the period of such refusal. The period of refusal is deducted from the period during which compensation would otherwise be payable. See Neb. Rev. Stat. § 48-134.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc)?**

The employer/insurer is obligated to pay for all reasonable medical, surgical, and hospital services, including plastic or reconstructive surgery (but not cosmetic surgery), appliances, supplies, prosthetic devices, and medicines required by the nature of the injury and which will relieve pain or promote and hasten the employee's restoration to health and employment. Chiropractors are defined as physicians. Neb. Rev. Stat. § 48-120.

41. **Which prosthetic devices are covered, and for how long?**

Prosthetic devices which are required by the nature of the injury, and which will relieve pain or promote and hasten the employee’s restoration to health and employment are compensable and are subject to replacement for the life of the employee, so long as the applicable two year statute of limitations does not run. Dental appliances, hearing aids, or eyeglasses are replaceable only if damage or destruction to the item resulted from an accident which also caused personal injury entitling the employee to compensation therefore for disability or treatment.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Home modifications are covered where the modifications are required by the nature of the injury and will relieve pain or promote and hasten the employee’s restoration to
health and employment. *Miller v. E.M.C. Insurance Co.*, 259 Neb. 433, 610 N.W.2d 398 (2000). While neither the Nebraska Supreme Court nor the Nebraska Court of Appeals has specifically passed upon vehicle modifications, the trial judges routinely award such modifications and as such, they are voluntarily paid in most instances.

43. **Is there is medical fee guide or schedule, or other provisions for cost containment?**

Yes. It is administered by the Nebraska Workers' Compensation Court per Neb. Rev. Stat. § 48-120. The Nebraska Workers' Compensation Court Schedule of Medical and Hospital Fees can be found on the court’s website at http://www.wcc.ne.gov.

Effective January 1, 2008, Nebraska utilizes a Diagnostic Related Group In-Patient Hospital Fee Schedule (DRG Fee Schedule) for inpatient hospital services. Nebraska law requires that insurers, employer, and self insureds (payors) must notify the provider within 15 business days of receiving a claim for payment if additional information is needed to process the bill. If no such notification is provided, it is assumed that the payor has all information needed to pay the claim. Payors must provide payment within 30 business days after receipt of all information needed to pay the claim. If the payor fails to comply with these provisions, the payor cannot obtain the benefits of the DRG Fee Schedule.

44. **What, if any, provisions or requirements are there for "managed care"?**

Neb. Rev. Stat. § 48-120.02 specifically allows the implementation of a managed care plan by employer/insurers. Such a plan must be certified by the Workers' Compensation Court before it can be implemented. Neb. Rev. Stat. § 48-102.02, together with court rules 51-61, identify the requirements for certification and operation of a managed care plan.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

The employee, employer or insurer can file a petition with the Clerk of the Nebraska Workers' Compensation Court to commence an action or adjudication of a claim.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

The Nebraska workers' compensation system is a judicial system without administrative hearings.

B. **Trial court.**

Following the filing of a petition, cases are heard before a single judge of the
Compensation Court.

C. Appellate.

If either party is dissatisfied with the decision, it must appeal directly to the Nebraska Supreme Court. The Court will either accept the case or assign the case to the Nebraska Court of Appeals. The review is "on the record" and applies a "clearly erroneous" standard in evaluating the trial court's factual findings.

47. What are the requirements for stipulations or settlements?

Settlements may be finalized either by submission to and approval by the Nebraska Workers' Compensation Court, or, when appropriate, via Release, which does not require approval of the Court. See Number 49 below.

48. Are full and final settlements with closed medicals available?


49. Must stipulations and/or settlements be approved by the state administrative body?

Matters may be settled on a full and final basis using either a Release, which does not require Court approval, or Settlement Agreement, which does require Court approval. Court approval of a settlement agreement is required, and a Release may not be used, if:

1) The employee is not represented by counsel;  
2) The employee, at the time the settlement is executed, is eligible for Medicare, is a Medicare beneficiary, or has a reasonable expectation of becoming eligible for Medicare within thirty months after the date the settlement is executed;  
3) Medical, surgical, or hospital expenses incurred for treatment of the injury have been paid by Medicaid and Medicaid will not be reimbursed as part of the settlement;  
4) Medical, surgical, or hospital expenses incurred for treatment of the injury will not be fully paid as part of the settlement; or  
5) The settlement seeks to commute amounts of compensation due to dependents of the employee.

If none of these conditions exist, a Release may be used. Note, that while a Release does not require Court approval, a Release can only discharge liability once payment is made and the Court enters an order of dismissal. Dragon v. Cheesecake Factory, 300 Neb. 548, 556, 915 N.W.2d 418, 424 (2018). Whether a case is settled by Release filed with the Court, or a Court Approved Settlement Agreement, either approach will result in a full and complete discharge from further liability on account of the accident and injury so long as it was not procured by fraud. Neb. Rev. Stat. § 48-139.
50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc)?**


51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

To qualify as a self-insurer, the employer must furnish the State Treasurer proof of ability to pay plus security in an amount equal to two and one-half percent of the prospective loss costs for like employment. The Workers' Compensation court must approve the self-insurance plan, and is the sole judge of the appropriate "prevailing rate." Neb. Rev. Stat. § 48-145. The court will usually require the applicant for self-insurance to post a surety bond, the amount of which the Court determines based upon the number of employees.

   **B. For groups or "pools" of private entities.**

The procedure for self-insured individual entities applies to self-insurance pools. To qualify as a pool, the group of employers must be engaged in like businesses. Neb. Rev. Stat. § 48-145.

52. **Are ‘illegal aliens’ entitled to benefits of workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of ‘employee’?”**

The Nebraska Supreme Court has ruled that illegal aliens are “employees” covered by the Nebraska Workers' Compensation Act and that illegal aliens are entitled to workers’ compensation benefits, including medical benefits, temporary disability benefits, and permanent disability benefits. *Moyer v. Quality Pork Intern.*, 284 Neb. 963, 825 N.W.2d 409 (2013); *Visoso v. Cargill Meat Solutions*, 285 Neb. 272, 826 N.W.2d 845 (2013). However, the Court has further determined that illegal aliens are generally not entitled to vocational rehabilitation because their illegal work status prevents them from satisfying the statutory priorities required for vocational rehabilitation to be granted. Specifically, because the employee’s illegal employment status prevents the employee from returning to a job with the same or a new employer, the court is precluded from ordering vocational retraining because the work lower priorities set forth in the vocational rehabilitation statute have not been met. *See Moyer v. Quality Pork Intern.*, 284 Neb. 963, 825 N.W.2d 409 (2013); *see also Ortiz v. Cement Products*, 270 Neb. 787, 708 N.W.2d 610.
(2005). In death cases, a ‘nonresident alien dependent’ can designate any suitable person residing in Nebraska to as as attorney in fact during workers’ compensation proceedings if the court determines that the interests of the nonresident alien dependent will be better served by such a person rather than by the consular officer.  See Neb. Rev. Stat. §48-122(5)(a)(i).

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

The Nebraska Workers’ Compensation Act does not specifically address whether such injuries are covered by the Act. There are no current cases on point.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

The Nebraska Workers’ Compensation Court (Court) has set forth Guidelines for Medicare Set Aside Arrangements to be followed in submitting lump sum settlements to the Court. The Guidelines generally provide that for situations that meet the current “workload review thresholds” established by the Centers for Medicare & Medicaid Services, any settlement application submitted to the Court for approval must “address Medicare’s interest”. The Guidelines established by the Court also provide that the set aside amount cannot be included as indemnity due. The settlement amount alone must be sufficient to cover the amount of indemnity due. The proposed order of approval submitted to the Court with the settlement application must list the settlement amount and the set aside amount separately. In situations where the settlement application does not need to address Medicare’s interests (where a set aside is voluntary), the entire amount of the settlement can be used to calculate indemnity coverage. A comprehensive chart addressing these requirements may be obtained from the Nebraska Workers’ Compensation Court website at:


Additionally, the Nebraska Workers’ Compensation Act allows for parties to settle claims by using a release, without Court approval, under certain circumstances. The provision for settlements via release specifically states Court approval of a settlement is required if the claimant currently is a Medicare beneficiary, is eligible for Medicare, or has a reasonable expectation of becoming one within thirty months after the date when the settlement is executed.  See Neb. Rev. Stat. 48-139.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law.**
The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C. § 1396k(b).

The Nebraska Workers’ Compensation Court will not allow any third-party supplier or payor of medical services to become a party to an action. However, if the Court determines that the plaintiff has incurred medical expenses as a result of the work related accident and some or all of the medical expenses were paid for by some other source (i.e Medicaid or Group Health Carrier) the court will order the employer to make payment directly to the supplier of the service or reimbursement to anyone who has paid the medical bills. Neb.Rev.Stat. § 48-120(8).

If Medicaid has paid for treatment due to a work accident, parties may settle a claim by a Release of Liability only if Medicaid has been or will be fully reimbursed as part of the settlement. Neb. Rev. Stat. § 48-139(3). If Medicaid will not be fully reimbursed as part of the settlement, parties must proceed with an Application for Lump Sum Settlement providing the Court a basis to approve the settlement absent full reimbursement.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

The Nebraska Workers’ Compensation Act has no confidentiality or privacy requirements. The rights of an employer and workers’ compensation carrier to obtain records pursuant to State law is outlined in response to Question No. 38.

Additionally, an employer, insurance carrier, or its agent may communicate *ex parte* with medical providers as the normal patient-physician privilege is inapplicable regarding injuries alleged to arise out of the work-related accident. *Scott v. Drivers Management*, 14 Neb. App. 630, 646, 714 N.W.2d 23, 35 (2006).

57. **What are the provisions for “Independent Contractors”?**

In determining whether or not a worker is an employee, as distinguished from an Independent Contractor, there is no single test by which the determination may be made. Such a determination must be made from all the facts in the case. In making this determination 10 factors are considered and weighed, no one of which may be conclusive. The factors to be considered are: (1) the extent of control which, by the agreement, the employer may exercise over the details of the work, (2) whether the one employed is engaged in a distinct occupation or business, (3) the kind of occupation, with
reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision, (4) the skill required in the particular occupation, (5) whether the employer or the one employed supplies the instrumentalities, tools, and the place of work for the person doing the work, (6) the length of time for which the one employed is engaged, (7) the method of payment, whether by the time or by the job, (8) whether the work is part of the regular business of the employer, (9) whether the parties believe they are creating an agency relationship, and (10) whether the employer is or is not in business. Larson v. Hometown Communications, Inc., 248 Neb. 942, 540 N.W.2d 339 (1995).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Persons in the service of a temporary agency are generally not considered independent contractors. When a general employer, such as a temporary agency loans an employee to another for the performance of some special service, that employee may become the employee of the party to whom his or her services have been loaned (special employer). When a general employer lends an employee to a special employer, the special employer becomes liable for workers’ compensation only if (1) the employee has made a contract of hire, express or implied, with the special employer; (2) the work being done is essentially that of the special employer; and (3) the special employer has the right to control the details of the work. When all three of the above conditions are satisfied in relation to both employers, both employers are liable for workers’ compensation. Kaiser v. Millard Lumber, Inc., 255 Neb. 943, 587 N.W.2d 875 (1999).

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No. The Nebraska Workers’ Compensation Act does not contain special provisions regarding owner/operators of trucks or other vehicles for driving or delivery of people or property. The 10 factor assessment (see Item 57 above) would apply to determine if an owner/operator of a truck or other vehicle is an employee or an independent contractor.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits, costs and losses?

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. Financial exposure to workers’ compensation is an expensive and complex challenge for all businesses. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.
The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response.

No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorneys for your state, listed at the beginning of this section.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

Yes. See Answer to Question 54.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No.

Dallas D. Jones, Esq.
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1. Citation for the state’s workers’ compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

Every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and including, but not exclusively:

A. Aliens and minors.

B. All elected and appointed paid public officers.

C. Members of boards of directors of quasi-public or private corporations while rendering actual service for such corporations for pay.

D. Musicians providing music for hire, including house bands.

E. Volunteer health practitioners, as defined in NRS 415A.180, who are providing health or veterinary services pursuant to 415A. NRS 415A.180 defines a “Volunteer health practitioner” as a provider of health or veterinary services whether or not the practitioner receives compensation for those services.


Also included in the definition of “employee” are the following:

A. Participants in programs of job training/to obtain training for employment administered by the welfare division of the department of human resources.
A. Volunteer workers in program for public service; private, incorporated, nonprofit organization which provides services to the general community; or for private organizations as part of public programs. Nev. Rev. Stat. §§ 616A.130 and 616A.135.


J. Person vending or delivering newspaper or magazines. Nev. Rev. Stat. § 616A.175.


M. Certain members of state, county and local departments, boards, commissions, agencies or bureaus; adjunct professors of Nevada System of Higher Education; members of Board of Regents. Nev. Rev. Stat. § 616A.190.


3. **Identify and describe any “statutory employer” provision.**

“Employer” means:

A. The state, and each county, city, school district, and all public and quasi-public corporations therein without regard to the number of persons employed.

B. Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire.

C. The legal representative of any deceased employer.

D. The Nevada Rural Housing Authority.

E. An owner or principal contractor who establishes and administers a consolidated insurance program.


Further, this statutory definition has been broadened by the Nevada Supreme Court wherein it found that “a company that ‘has in service any person under a contract of hire,’ is that person's statutory employer under the NIIA [Nevada Industrial Insurance Act]. The scope of this ‘statutory employer’ definition is broadened for principal contractors, however, which are usually deemed the statutory employers not only of their directly hired employees, but also of the employees of their subcontractors and independent contractors. Therefore, under the NIIA, a principal contractor must generally ensure that those subcontractors' and independent contractors' employees receive workers' compensation coverage. *Richards v. Republic Silver State Disposal, Inc.*, 122 Nev. 1213, 1218 148 P.3d 684, 687 (2006) (Nev. Rev. Stat. § 616A.285(1) defines a “principal contractor” as a person who (1) Coordinates all the work on an entire project; (2) Contracts to complete an entire project; (3) Contracts for the services of any subcontractor or independent contractor; or (4) is responsible for payment
4. **What types of injuries are covered and what is the standard of proof for each:**

   **A. “Injury” and “personal injury” claims.**

   A sudden and tangible happening of a traumatic nature, producing an immediate or prompt result which is established by medical evidence, including injuries to prosthetic devices. Nev. Rev. Stat. § 616A.265(1). The exposure of an employee to a contagious disease while providing medical services, including emergency medical care, in the course and scope of his employment shall be deemed to be an injury by accident sustained by the employee arising out of and in the course of his employment. Nev. Rev. Stat. § 616A.265(2). The exposure to a contagious disease of a police officer or a salaried or volunteer fireman who was exposed to the contagious disease upon battery by an offender, or while performing the duties of a police officer or fireman, shall be deemed to be an injury by accident arising out and in the course of his employment if the exposure is documented by the creation and maintenance of a report concerning the exposure. *Id.* The term “battery” includes, without limitation, the intentional propelling or placing, or causing to be propelled or placed, of any human excrement or bodily fluid upon the person of an employee. Nev. Rev. Stat. § 616A.035(4).

   A preponderance of the evidence must establish that injury arose out of and in the course of employment. Nev. Rev. Stat. § 616C.150(1). There is a rebuttable presumption that the injury did not arise out of and in the course of employment if employee’s notice of injury is filed after termination of employment. Nev. Rev. Stat. § 616C.150(2).

   Injury or disease caused by stress may be compensable if employee proves by clear and convincing medical or psychiatric evidence that he has a mental injury caused by extreme stress in time of danger, primarily caused by an event arising out of course and scope of employment NOT caused by layoff, termination or disciplinary action. Nev. Rev. Stat. § 616C.180. Any ailment, disorder, or death shall not arise out of and during the course of employment if it is deemed to be caused by any gradual mental stimulus. Nev. Rev. Stat. § 616C.180(2).

   **B. Occupational disease (including respiratory and repetitive use).**


   Covered “employees” are defined differently than under Ch. 616A-616D. *See* Nev. Rev. Stat. §§ 617.070, 617.091, 617.100 and 617.105. Employees who are disabled or die because of an occupational disease, arising out of and in the course of employment in the State of Nevada, or their dependents, are entitled to compensation. Nev. Rev. Stat. § 617.430(1). In cases of tenosynovitis, prepatellar bursitis, and infection or inflammation of the skin, however, they are not entitled to compensation unless for 90 days preceding the contraction of the disease, the employee has been a Nevada resident, or employed by a self-insured
employer, a member of an association of self-insured public or private employers, or an employer insured by a private carrier that provides coverage for occupational diseases. Nev. Rev. Stat. § 617.430(2).

An occupational disease shall be deemed to arise out of and in the course of the employment if: (a) there is a direct causal connection between the conditions under which the work is performed and the occupational disease, (b) it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment, (c) it can be fairly traced to the employment as the proximate cause, and (d) it does not come from a hazard to which workmen would have been equally exposed outside of the employment. Nev. Rev. Stat. § 617.440(1). The disease must be incidental to the character of the business and not independent of the relation of employer and employee. Nev. Rev. Stat. § 617.440(2). The disease need not have been foreseen, but the contraction must appear to have had its origin in a risk connected with the employment, and to have flowed from that source as a natural consequence. Nev. Rev. Stat. § 617.440(3). In cases of disability resulting from radium poisoning or exposure to radioactive properties or substances, or to roentgen rays (X-rays) or ionizing radiation, the poisoning or illness resulting in disability must have been contracted in the State of Nevada. Nev. Rev. Stat. § 617.440(4). The claimant must show, by a preponderance of the evidence that the disease arose out of and in the course of employment. Nev. Rev. Stat. 617.358(1); Manwill v. Clark County, 162 P.3d 876 (Nev. 2007). See also City of Las Vegas v. Evans, 301 P.3d 844, 847, 129 Nev. Adv. Rep. 31 (Nev. 2013). However, NRS 614.457(1) waives this requirement for claimants who are disabled by heart disease after having continuously worked as full-time firefighters for five or more years, by conclusively presuming that the heart disease is a sufficiently work-related occupational disease. Id.

A degenerative joint disease aggravated by overuse of hands in the performance of job as a masseuse qualified as an occupational disease arising out of and in the course of employment. Desert Inn Casino & Hotel v. Moran, 792 P.2d 400 (Nev. 1990).

Some diseases, such as cancer, lung disease, and heart disease, developed by firemen or police officers are conclusively presumed to have arisen out of and in the course of employment under certain circumstances. Nev. Rev. Stat. §§ 617.453, 617.455, and 617.457. There are also statutes that apply to specific occupational diseases, such as silicosis, diseases related to asbestos, and diseases of respiratory tract resulting from exposure to dusts. Nev. Rev. Stat. §§ 617.460 and 617.470.


Nev. Rev. Stat. § 617.450 lists specific occupational diseases, along with a description of the processes in which such diseases are contracted.
5. **What, if any, injuries or claims are excluded?**

Coronary thrombosis, coronary occlusion, or any other ailment or disorder of the heart, and any death or disability ensuing therefrom are excluded. Nev. Rev. Stat. § 616A.265(2)(a). For stress claims, any ailment or disorder caused by any gradual mental stimulus, and any death or disability ensuing therefrom are excluded. Nev. Rev. Stat. § 616C.180(2). Diseases claimed to be caused by environmental tobacco smoke present in the work place are not covered when the smoke is not uniquely incidental to the character of the business, such as in a casino. *Palmer v. Del Webb’s High Sierra*, 838 P.2d 435 (Nev. 1992).

6. **What psychiatric claims or treatments are compensable?**

Injury or disease that is caused by stress only if the employee proves by clear and convincing medical or psychiatric evidence that (a) he has a mental injury caused by extreme stress in time of danger, (b) the primary cause of the injury was an event that arose out of and during the course of is employment, and (c) the stress was not caused by his layoff, termination or any disciplinary action taken against him. Nev. Rev. Stat. § 616C.180(3). Any ailment or disorder caused by any gradual mental stimulus, and any death or disability ensuing therefrom are excluded. Nev. Rev. Stat. § 616C.180(2).

7. **What are the applicable statutes of limitations?**

There are specific notice requirements pursuant to Nev. Rev. Stat. § 616C.015, discussed below. These notice requirements act as jurisdictional or time-related defenses.

Claims for compensation on account of silicosis or a disease related to asbestos, or occupational diseases of respiratory tract resulting from dusts exposure, are barred unless application is made to the insurer within 1 year after the date of disability or death and within 1 year after the claimant knew or should have known of the relationship between the disease and the employment. Nev. Rev. Stat. § 617.460(2). Recovery is barred if the provisions regarding the notice of an occupational disease to the employer and the claim for compensation to the insurer are not followed and are not excused by the insurer. Nev. Rev. Stat. § 617.346.

8. **What are the reporting and notice requirements for those alleging an injury?**

Whenever any accident occurs to any employee, he shall forthwith report the accident and the injury resulting therefrom to his employer. Nev. Rev. Stat. § 616C.010(1). An employee or, in the event of his death, one of his dependents, shall provide written notice to the employer as soon as practicable, but within 7 days after the accident. Nev. Rev. Stat. § 616C.015(1). The notice must be on a duplicate, signed form prescribed by the administrator, explaining the procedure for claim filing and allowing a description of the accident. Nev. Rev. Stat. § 616C.015(2).

An injured employee, or a person acting on his behalf, shall file a claim for compensation
with the insurer within 90 days after an accident if: (a) the employee has sought medical
treatment for an injury arising out of and in the course of his employment, or (b) the
employee was off work as a result of an injury arising out of and in the course of his
employment. Nev. Rev. Stat. § 616C.020(1). In the event of the death of the employee
resulting from the injury, a person acting on his behalf shall file a claim for compensation
with the insurer within 1 year after the death of the employee. Nev. Rev. Stat. §
616C.020(2). The claim must be filed on a form prescribed by the administrator. Nev. Rev.
Stat. § 616C.020(3).

Where death results from injury, the claimant(s) must make application for compensation to
the insurer. Nev. Rev. Stat. § 616C.035. It must be accompanied by proof of death and of
claimant’s relationship to deceased employee; certificates of attending physician, if any; and
other proof as required by the regulations. Id. An employee, or if dead, one of his
dependents, shall provide written notice of an occupational disease for which compensation
is payable to the employer as soon as practicable, but within 7 days after the employee or
dependent has knowledge of the disability and its relationship to the employment. Nev. Rev.
Stat. § 617.342.

An employee who has incurred an occupational disease, or a person acting on his behalf,
shall file a claim for compensation with the insurer within 90 days after the employee has
617.344(1). If the employee dies from the disease, a person acting on his behalf shall file a
claim for compensation with the insurer within 1 year after the death of the employee. Nev.
Rev. Stat. § 617.344(2).

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

Compensation is not payable for an injury caused by the employee’s willful intention to
occupational diseases when disability or death is wholly or in part caused by the willful

Compensation may be reduced or suspended if an employee persists in an injurious practice
that imperils his recovery, or refuses to submit to medical or surgical treatment that is
necessary to promote his recovery, or if the employee is unable to undergo such treatment
because of a correctable, non-industrial condition. Nev. Rev. Stat. § 616C.230(4). If such
refusal causes or aggravates the employee’s disability, no compensation is payable for such
disability. Id.

However, compensation is payable in the case of suicide by an insured if the claimant is able
to demonstrate: (1) the employee suffered an industrial injury; (2) the industrial injury caused
some psychological condition severe enough to override the employee’s rational judgment;
and (3) the psychological condition caused the employee to commit suicide. If a sufficient
“chain of causation” can be established, the suicide will not be considered “willful” under the

B. Willful misconduct, “horseplay,” etc.

Compensation is not payable for an injury caused by the employee’s willful intention to
injure himself or another. Nev. Rev. Stat. § 616C.230(1). No compensation is payable for
occupational diseases when disability or death is wholly or in part caused by the willful

Compensation is not payable while an employee is in a state of intoxication, unless the
employee can prove by clear and convincing evidence that the intoxication was not the cause
of the injury. Nev. Rev. Stat. § 616C.230(1)(c). For purposes of this statute, the employee is
intoxicated if the level of alcohol in the bloodstream if the employee meets or exceed the

Compensation is not payable for an injury proximately caused by the employee’s use of a
controlled substance. Nev. Rev. Stat. § 616C.230(1)(d). If the employee had any amount of
a controlled substance in his system at the time of his injury for which the employee did not
have a current and lawful prescription issued in his name, the controlled substance must be
presumed to be a proximate cause unless rebutted by evidence to the contrary. Id. A
claimant can rebut this presumption if the claimant is able to establish by a preponderance of
the evidence that the controlled substance found in the claimant’s system did not cause the
claimant’s injuries. See Desert Valley Construction v. Hurley, 120 Nev. 499, 96 P.3d 739
(2004); Construction Industry Workers’ Compensation Group v. Chalue, 119 Nev. 348, 74

C. Employee’s refusal to submit to physical exam.

If an employee is properly directed to submit to a physical examination and the employee
refuses to permit the treating physician or chiropractor to make an examination and to render
medical attention as may be required immediately, no compensation may be paid for the
injury claimed to result from the accident. Nev. Rev. Stat. § 616C.075. However, the
employee can receive treatment through prayer in accordance with the tenets and practice of

D. Failure to Follow Medical Advice.

No compensation is payable for the death, disability or treatment of an employee if the
employee’s death is caused or aggravated by an unreasonable refusal or neglect to submit to
or to follow any competent and reasonable surgical treatment or medical aid. Nev. Rev. Stat.
§ 616A.230(3). Further, if any employee persists in an unsanitary or injurious practice that
imperils or retards his or her recovery, or refuses to submit to such medical or surgical
treatment as is necessary to promote his or her recovery, the employee’s compensation may
be reduced or suspended. Nev. Rev. Stat. § 616A.230(4)

10. **What, if any, penalties or remedies are available in claims involving fraud?**

A person who engages in fraudulent practices, by act or omission, to obtain any benefit or authorization to provide benefits shall be punished: (a) for a category D felony if the amount of the charge or the value of the accident benefits obtained or sought to be obtained was $650 or more, and, in addition, the court shall order the person to pay restitution; or (b) for a misdemeanor if the amount of the charge or the value of the accident benefits obtained or sought to be obtained was less than $650, and the offender must be sentenced to restore any accident benefits so obtained, if it can be done, or tender payment for rent or labor. Nev. Rev. Stat. § 616D.370(2).

If an insurer determines an employee knowingly misrepresented or concealed a material fact to obtain any benefit or payment, the insurer may deduct from any benefits or payments due to the employee, the amount obtained by the employee because of the misrepresentation or concealment. Nev. Rev. Stat. § 616C.225(1). The employee shall reimburse the insurer for all benefits or payments received because of the willful misrepresentation or concealment of a material fact. *Id.*

A person who knowingly signs, submits, or causes to be signed or submitted a false invoice for payment for accident benefits provided to an employee is guilty of a gross misdemeanor. Nev. Rev. Stat. § 616D.380(2). Any provider of health care who has been convicted of fraudulent practice may not, for 5 years after the date of the first conviction, or at any time after a second or subsequent conviction, receive or accept a payment for accident benefits allegedly provided to an employee. Nev. Rev. Stat. § 616D.420(1). If that statute is, in turn, violated, the health care provider will be guilty of a gross misdemeanor. Nev. Rev. Stat. § 616D.420(2). An insurer may withhold any payment due a health care provider upon receipt of reliable evidence that the provider knowingly made a false statement or representation or knowingly concealed a material fact to obtain the payment. Nev. Rev. Stat. § 616D.440(1).

A person who receives a payment or benefit to which he is not entitled by reason of fraud is liable in a civil action commenced by the attorney general for: (a) an amount equal to three times the amount unlawfully obtained, (b) not less than $5,000 for each act of deception, (c) an amount equal to three times the total amount of the reasonable expenses incurred by the state in enforcing this section, and (d) payment of interest on the amount of the excess payment. Nev. Rev. Stat. § 616D.430(1). Criminal action need not be first commenced before civil liability attaches.

Similarly, an employer who makes a false statement or representation or knowingly conceals a material fact regarding the eligibility of a person, shall be punished as a misdemeanor if the amount of payment obtained or attempted to obtain was less than $250, and a Class D felony if the amount was greater than $250. Nev. Rev. Stat. § 616D.415.

11. **Is there any defense for falsification of employment records regarding medical history?**
Yes. No compensation may be awarded on account of disability or death from a disease suffered by an employee who, at the time of entering into the employment from which the disease is claimed to have resulted, knowingly and falsely represented himself as not having previously suffered from the disease. Nev. Rev. Stat. § 617.400. No compensation for disability or death due to silicosis or a disease related to asbestos in the event of the failure or omission on the part of the employee truthfully to state, when seeking employment, the place, duration, and nature of previous employment in answer to inquiry made by the employer. Nev. Rev. Stat. § 617.460(3).

However, an employee who willfully makes false representations concerning his medical history on an employment application may not be denied benefits when an industrial injury exacerbates the concealed, preexisting condition. Goldstine v. Jensen Pre-Cast, 729 P.2d 1355 (Nev. 1986).

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Sometimes. Any injury sustained by an employee while engaging in an athletic or social event sponsored by his employer shall be deemed not to have arisen out of or in the course of employment, unless the employee received remuneration for participation in the event. Nev. Rev. Stat. § 616A.265(1). See also Dixon v. State Indus. Insur. Sys., 899 P.2d 571 (Nev. 1995) (A recreational activity can only be characterized as within the course of employment if it is a regular incident of employment; thus, employee injured on bicycle provided by employer for employees for express purpose of getting exercise on breaks is not precluded from recovering under act.)

13. Are injuries by co-employees compensable?

When an employee is injured on the job as a result of the negligence of a fellow employee, his remedy is compensation under the Nevada Industrial Insurance Act. Leslie v. J.A. Tiberti Construction Co., 664 P.2d 963 (Nev. 1983), overruled on other grounds by Tucker v. Action Equipment and Scaffold Co., Inc., 951 P.2d 1027 (Nev. 1997). The Court has held that when a co-employee commits an intentional act, rather than an accident, the claim does not fall exclusively within the worker’s compensation statutes. Fanders v. Riverside Resort & Casino, Inc., 245 P.3d 1159, 1164 (Nev. 2010). It has been held that an employee’s death did arise out of the employment, where he was assaulted in the course of his employment by an insane fellow employee. Where a fellow employee assaulted another employee solely to gratify his feeling of anger or hatred, however, the injury resulted from the voluntary act of the assailant, and cannot be said to arise either directly out of the employment, or as an incident of it, and is not compensable under the Nevada Industrial Insurance Act. Cummings v. United Resort Hotels, Inc., 449 P.2d 245 (Nev. 1969).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?
Coverage for such acts depends on whether the act is the result of the employment. Where an employee is assaulted and injury is inflicted upon him through animosity and ill will arising from some cause wholly disconnected with the employer’s business or the employment, the employee cannot recover compensation simply because he is assaulted when he is in the discharge of his duties. If the employee’s injury resulted from being placed in a position of danger by reason of his employment, rather than being the result of enmity, grudge or other personal relationship, then the injury is compensable under workers’ compensation. *McColl v. Scherer*, 315 P.2d 807 (Nev. 1957).

In *Wood v. Safeway*, the Nevada Supreme Court adopted the rule that the sexual assault or harassment of an employee in the workplace “falls within the NIIA if the nature of the employment contributed to or otherwise increased the risk of assault beyond that of the general public.” “That same assault is not within the NIIA, however, when ‘the animosity of the dispute which culminates in the assault is imported into the place of employment from the injured employee’s private or domestic life, … at least where the animosity is not exacerbated by the employment.’” *Wood v. Safeway*, 121 Nev. 724, 736, 121 P.3d 1026, 1034 (2005).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Nevada calculates wage using the average monthly wage. Nev. Rev. Stat. § 616A.065. The average monthly wage will be calculated by multiplying the average daily wage of an employee during a period of earnings by 30.44. The average daily wage is the gross earnings divided by days in period of earnings. Nev. Admin. Code § 616C.432. The earnings of the injured employee on the date on which the accident occurs will be used to calculate the average monthly wage. Nev. Admin. Code § 616C.441(1). If the employee changes job duties, either permanently or temporarily, the rate of pay, and hours of employment must be calculated only using his primary job at the time of the accident. *City of N. Las Vegas v. Warburton*, 262 P.3d 715 (Nev. 2011), citing Nev. Admin. Code § 444.

A history of earnings for a period of 12 weeks must be used to calculate an average monthly wage. Nev. Admin. Code § 616C.435(1). Yet if a 12-week period of earnings is not representative of the claimant’s average monthly wage, earnings over a period of 1 year or the full period of employment, if it is less than 1 year, may be used. Nev. Admin. Code § 616C.435(2). Earnings over those latter periods must be used if the average monthly wage would be increased. *Id.* If information concerning payroll is not available for a period of 12 weeks, wages may be averaged for the available period, but not for a period of less than 4 weeks. Nev. Admin. Code § 616C.435(4). If information concerning payroll is unavailable for a period of at least 4 weeks, average earnings must be projected using the rate of pay on the date of the accident or illness and the employee’s projected working schedule. Nev. Admin. Code § 616C.435(5). If the earnings are based on piecework and a history of earnings is unavailable for a period of at least 4 weeks, the wage must be determined as being
equal to the average earnings of other employees doing the same work. Nev. Admin. Code § 616C.435(6). If these methods cannot be applied reasonably and fairly, an average monthly wage must be calculated by the insurer at 100 percent of (a) the sum which reasonably represents the average monthly wage of the employee at the time his injury or illness occurs; or (b) the hourly wage on the day the injury or illness occurs, calculated by using the projected working schedule. Nev. Admin. Code § 616C.435(7). “Earnings” means earnings received from the employment in which the injury occurs and in any concurrent employment. Nev. Admin Code § 616C.435(9).

In order to become eligible for disability benefits, the employee must be incapacitated by the occupational disease for at least five cumulative days within a twenty-day period earning full wage. Nev. Rev. Stat. § 617.420. Moreover, in such cases, compensation in terms of average monthly wage must be computed from the date of disability. Id. Wages are calculated for occupational disease claims from the point the employee is unable to continue working. Howard v. City of Las Vegas, 120 P.3d 410 (Nev. 2005).

The rate of pay on the date of the accident or the onset of the disease will be used to calculate the average monthly wage. Nev. Admin. Code § 616C.441. See also Nev. Admin. Code § 616C.438.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

For the period of temporary total disability, benefits are calculated at 66 2/3 percent of the average monthly wage. Nev. Rev. Stat. § 616C.475. For a temporary partial disability, the claimant is entitled to the difference between the wage earned after the injury and the compensation which the injured person would be entitled to receive if temporarily totally disabled when the wage is less than the compensation, but for a period not to exceed 24 months during the period of disability. Nev. Rev. Stat. § 616C.500. Compensation is computed from the date of the injury or disability. Nev. Rev. Stat. § 616C.425. Medical benefits paid under Ch. 617 must be paid from the date of application for payment of medical benefits. Nev. Rev. Stat. § 617.420.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Within 30 days after the insurer has been notified of an industrial accident, every insurer shall: (a) commence payment of a claim for compensation, or (b) deny the claim and notify the claimant and administrator. Nev. Rev. Stat. § 616C.065(1). If the insurer unreasonably delays or refuses payment, the administrator can order payment of three times the amount refused or delayed; this payment is made to the claimant. Nev. Rev. Stat. § 616C.065(4). For a temporary total disability, the first payment must be issued by the insurer within 14 working days after receipt of the initial certification of disability and regularly thereafter. Nev. Rev. Stat. § 616C.475(3).
18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

Compensation benefits must not be paid for an injury or disability which does not incapacitate the employee for at least 5 consecutive days, or 5 cumulative days within a 20-day period, from earning full wages. Nev. Rev. Stat. § 616C.400(1). That prescribed period of time does not apply to accident benefits if the injured employee is otherwise entitled to those benefits. Nev. Rev. Stat. §§ 616C.400, 617.420.

19. **What is the standard/procedure for terminating temporary benefits?**

If a claim is to be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of such to the claimant with a statement describing the effects of closing a claim, if the claimant does not agree, he has a right to request a resolution; the notice should include a suitable form for requesting a resolution of the dispute. Nev. Rev. Stat. § 616C.235(1). If the insurer does not receive a request for the resolution of the dispute, it may close the claim. Id. If during the first 12 months after a claim is opened, the medical benefits required to be paid for a claim are less than $300 then the insurer may close the claim at any time, after sending the required notice. Nev. Rev. Stat. § 616C.235(2). The notice must state that the claim cannot be reopened if the employee does not appeal the closure, or if the appeal is unsuccessful. Id. The insurer must also send the employee who receives less than $300 in medical benefits within 6 months after the claim is opened, circumstances under which the claim may be closed. Nev. Rev. Stat. § 616C.235(3).

The injured worker’s attorney, if any, must be notified of claim closure by first class mail. Notice must include a statement, provided on a separate page, describing the effects of closing a claim plus a statement that prominently displays the time limit to appeal. Id.

Payments for a temporary total disability must cease when: (a) a physician or chiropractor determines that the employee is physically capable of any gainful employment for which the employee is suited, after giving consideration to the employee’s education, training and experience; (b) the employer offers the employee light-duty employment or employment that is modified according to the limitations imposed by a physician or chiropractor; or (c) employee is incarcerated (modified industrial insurance program for offenders in prison industry or work program, per Nev. Rev. Stat. § 616B.028. Nev. Rev. Stat. § 616C.475(5).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

There is no Nevada statute, regulation or case that specifically addresses this issue in practice. But the temporary total disability paid is usually not deducted from the permanent partial disability compensation. If an employee who has received compensation in a lump sum for a permanent partial disability is subsequently injured by an accident arising out of and in the course of employment and is entitled to receive compensation for a temporary total disability, the compensation for the subsequent injury may not be reduced because of the receipt of the lump-sum payment if the subsequent injury is distinct from the previous one.
Nev. Rev. Stat. § 616C.480. If an employee who received compensation in a lump sum for a permanent partial disability is subsequently determined to be permanently and totally disabled, the insurer shall recover the actual amount of the lump sum, but shall: (a) deduct from the compensation for the permanent total disability an amount that is not more than 10 percent of the rate of compensation for a permanent total disability; or (b) upon the request of the employee, accept in a single payment from the employee an amount that is equal to the actual amount of the lump sum paid to the employee for the permanent partial disability, less the actual amount of all deductions made to date by the insurer from the employee for repayment of the lump sum. Nev. Rev. Stat. § 616C.440.

Where there is a prior permanent partial disability rating and then a second injury, where the worker is entitled to a permanent partial disability rating, the percentage of the entire first disability is deducted from the percentage of the previous disability as it existed at the time of the subsequent injury. Nev. Rev. Stat. § 616C.490(9). The percentage of the first injury must be calculated according to the current edition of the AMA Guidelines and then that number can be subtracted from the new permanent partial disability rating, therefore Nev. Admin. Code § 616C.490 was overruled to the extent it did not provide for reconciliation with recent AMA Guidelines. *Public Agency Comp. Trust v. Blake*, 265 P.3d 694 (Nev. 2011).

**21. What disfigurement benefits are available and how are they calculated?**


**22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

**A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

There is no limit to the weeks available for certain parts, but rather, the time for recovery depends on the severity of each individual’s condition. See also Nev. Rev. Stat. § 616C.485.

B. Number of weeks for “whole person” and standard for recovery.

There is no limit to the weeks available for “whole person” recovery, but rather, the time for recovery depends on the severity of each individual’s condition. Nev. Rev. Stat. § 616C.180(5).

Each 1 percent of impairment of the whole man must be compensated by a monthly payment: (a) Of 0.5 percent of the claimant’s average monthly wage for injuries sustained before July 1, 1981; (b) Of 0.6 percent of the claimant’s average monthly wage for injuries sustained on or after July 1, 1981, and before June 18, 1993; (c) Of 0.54 percent of the claimant’s average monthly wage for injuries sustained on or after June 18, 1993, and before January 1, 2000; and (d) Of 0.6 percent of the claimant’s average monthly wage for injuries sustained on or after January 1, 2000. Nev. Rev. Stat. § 616C.490(7). Claimants are not entitled to double payments for death and continued payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal. Nev. Rev. Stat. § 616C.490(12). Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later. Nev. Rev. Stat. § 616C.490(7).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

An employee is eligible for vocational rehabilitation services or the continuation of such services if: (a) the physician or chiropractor approves the return of the employee to work but imposes permanent restrictions that prevent the employee from returning to the position that he held at time of injury; (b) the employer does not offer employment that the employee is eligible for considering the restrictions imposed, the gross wage is less than 80% of the gross wage the employee was earning at the time of the injury, and has the same employment benefits as the position of the employee at the time of injury; and (c) the employee is unable to return to gainful employment at a gross wage that is equal to or greater than 80 percent of the gross wage that he was earning at the time of his injury. Nev. Rev. Stat. § 616C.590(1). Employee or dependents are not entitled to be paid for vocation rehabilitation if employee is incarcerated or if employee refuses vocation rehabilitation services. Nev. Rev. Stat. §§ 616C.590(6)-(7).

If benefits for a temporary total disability will be paid to an injured employee for more than 90 days, a vocational rehabilitation counselor shall, within 30 days after being assigned, make a written assessment of the employee’s ability to return to his prior position or other employment. Nev. Rev. Stat. § 616C.550(1). The assessment must contain a determination as to the employee’s eligibility for vocational rehabilitation services. Nev. Rev. Stat. § 616C.550(3). If the insurer, with the assistance of the counselor, determines he is eligible,
then a plan for a program of vocational rehabilitation must be completed in accordance with Nev. Rev. Stat. § 616C.555. *Id.*

If the counselor determines the employee has existing marketable skills, the plan must consist of job placement assistance only, but for not more than six (6) months after the date on which he was notified that he is eligible only for job placement assistance because he was physically capable of returning to work or he had existing marketable skills. Nev. Rev. Stat. § 616C.555(2). If it is determined that the employee has no existing marketable skills, the plan must consist of a program which trains or educates the employee and provides job placement assistance. Nev. Rev. Stat. § 616C.555(3). The maximum length of time for such a program is between nine (9) month and eighteen (18) months, depending on the percentage of physical impairment. *Id.* If the program is unsuccessful, the insurer may authorize a second program upon good cause shown, and a third program with the approval of the employer. Nev. Rev. Stat. § 616C.555(9)-(10). The insurer’s determination to authorize or deny the third program is not appealable. Nev. Rev. Stat. § 616C.555(10). It is possible to get extensions of the vocational rehabilitation program, for a maximum of 2 to 2-1/2 years. Nev. Rev. Stat. § 616C.560.

Employee may be eligible to receive lump sum payment for vocational rehabilitation in lieu of services. Nev. Rev. Stat. § 616C.595(1). Any payment of compensation in a lump sum in lieu of the provision of vocational rehabilitation services must not be less than 40 percent of the maximum amount of vocational rehabilitation due to the injured employee. Nev. Rev. Stat. § 616C.595(4).

However, the Nevada Supreme Court found that it is proper to deny vocational rehabilitation services when the intended beneficiary did not have proof of eligibility to work in the United States, as such conduct would be in violation of the Immigration Reform and Control Act. *Tarango v. State Industrial Insurance System*, 117 Nev. 444, 25 P.3d 175 (2001).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Compensation per month of 66 2/3 percent of the average monthly wage. Nev. Rev. Stat. § 616C.440(1). An employee is entitled to receive compensation for a permanent total disability only so long as the permanent total disability continues to exist. Nev. Rev. Stat. § 616C.440(3). The insurer has the burden of proving that the permanent total disability no longer exists. *Id.*

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Burial expenses are payable in an amount not to exceed $10,000 plus the cost of transporting the remains of the deceased employee. Nev. Rev. Stat. § 616C.505(1). When the remains of the deceased employee and the accompanying person are to be transported to a mortuary or
mortuaries, the charge of transportation must be borne by the insurer. *Id.*

**B. Dependency claims.**

To the surviving spouse, 66 2/3 percent of the average monthly wage is payable until death. Nev. Rev. Stat. § 616C.505(2). Upon the subsequent death of the surviving spouse, each child of employee must share equally the compensation theretofore paid to the surviving spouse but not in excess thereof, and it is payable until the youngest child reaches the age of 18 years. Nev. Rev. Stat. § 616C.505(4). If there any surviving children of the deceased employee who are not the children of the surviving spouse, (a) to the surviving spouse, 50 percent of the death benefit is payable until the death of the surviving spouse; and (b) to each child of the deceased employee, regardless of whether the child is of the surviving spouse, the child’s proportionate share of 50 percent of the death benefit. Nev. Rev. Stat. § 616C.505(3).

If there is no surviving spouse, then each surviving child under 18 years of age is entitled to his proportionate share of 66 2/3 percent of the average monthly wage. Nev. Rev. Stat. § 616C.505(5). If there is no surviving spouse or children under 18 years, then there must be paid (with an aggregate compensation of not more than 66 2/3 percent of the average monthly wage): (a) to a parent, if wholly dependent for support upon the deceased employee at the time of the injury, 33 1/3 percent of the average monthly wage; (b) to both parents, if wholly dependent for support upon the deceased employee at the time of the injury, 66 2/3 percent of the average monthly wage; and (c) to each brother or sister until he or she reaches the age of 18 years, if wholly dependent for support upon the deceased employee at the time of the injury, his proportionate share of 66 2/3 percent of the average monthly wage. Nev. Rev. Stat. § 616C.505(6). For partial dependents, the monthly compensation must be equal to the same proportion of the monthly payments for the benefit of persons totally dependent as the amount contributed by the employee to the partial dependents bears to the average monthly wage of the employee at the time of the injury. Nev. Rev. Stat. § 616C.505(8). Compensation to partial dependents may not exceed 100 months. *Id.* If a dependent dies before period of compensation to him ends, funeral expenses are payable in an amount not to exceed $10,000. Nev. Rev. Stat. § 616C.505(10).

**26. What are the criteria for establishing a “second injury” fund recovery?**

In Nevada, the “second injury” fund is known as the “subsequent injury account.” Insurers (self-insured employer, association of self-insured employers or private carrier) must submit an application to the subsequent injury account. Compensation is charged to the subsequent injury account when an employee has a permanent physical impairment from any cause or origin and incurs a subsequent disability by injury arising out of and in the course of his employment which entitles him to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone, the compensation due must be charged to the subsequent injury account. If the subsequent injury of such an employee results in his death and it is determined that the death would not have occurred except for the
preexisting permanent physical impairment, the compensation due must be charged to the subsequent injury account. There are separate subsequent injury accounts for self-insured employers, associations of self-insured public or private employers, and private carriers. Nev. Rev. Stat. §§ 616B.545-616B.560 (self-insured employer), §§ 616B.563-616B.581 (associations of self-insured public or private employers), and §§ 616B.584-616B.590 (private carriers).

The insurer may also recover compensation from the subsequent injury account if: (a) the employee knowingly made a false representation as to his physical condition at the time he was hired by the employer; (b) the employer relied upon the false representation and this reliance formed a substantial basis of the employment; and (c) a causal connection existed between the false representation and the subsequent disability. Nev. Rev. Stat. §§ 616B.560, .581, .590; recovery may also be had if the subsequent injury of the employee results in his death and it is determined that the death would not have occurred except for a preexisting permanent physical impairment. Nev. Rev. Stat. §§ 616B.560, 616B.581, 616B.590.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if: (a) the claimant did not meet the minimum duration of incapacity in Nev. Rev. Stat. § 616C.400 as a result of the injury; and (b) the claimant did not receive benefits for a permanent partial disability. Nev. Rev. Stat. § 616C.390(5). If an application to reopen a claim to increase or rearrange compensation is made pursuant to the above rule, or in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if: (a) a change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant; (b) the primary cause of the change is the injury for which the claim was originally made; and (c) the application is accompanied by the certificate of a physician or chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation. Nev. Rev. Stat. § 616C.390(1). If an application to reopen a claim is made in writing within 1 year after the date on which the claim was closed, the insurer shall reopen the claim only if: (a) the application is supported by medical evidence demonstrating an objective change in the medical condition of the claimant; and (b) there is clear and convincing evidence that the primary cause of the change of circumstances is the injury for which the claim was originally made. Nev. Rev. Stat. § 616C.390(4). If the required elements are established, there is no limitations period to reopening in Nevada.

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

If a party petitions the district court for judicial review of a final decision of an appeals officer, the manager or the manager’s designee, and the petition is found by the district court to be frivolous or brought without reasonable grounds, the court may order costs and a reasonable attorney’s fee to be paid by the petitioner. Nev. Rev. Stat. § 616C.385.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   **A. Scope of immunity.**

   In cases where employers are governed by the provisions of the Nevada Industrial Insurance Act for personal injuries by accident sustained by an employee arising out of and in the course of the employment, the employer or any insurer of the employer is relieved from other liability for recovery of damages or other compensation for those injuries unless otherwise provided. Nev. Rev. Stat. §§ 616A.020, 616B.612.

   An injury occurs within the course of employment when there is a causal connection between the injury and the nature of the work or the workplace. *Wood v. Safeway, Inc.*, 121 P.3d 1026, 1032 (2005). The types of risk that an employee may encounter are categorized as those that are solely employment related, those that are purely personal, and those that are neutral. *Rio All Suites Hotel & Casino v. Phillips*, 240 P.3d 2 (2010), citing *K-Mart Corp. v. Herring*, 188 P.3d 140, 146 (Okla. 2008). Nevada has adopted the increased-risk test, in which an employee may recover from a neutral risk only if the employee is subjected to a risk greater than that to which the general public is exposed. *Rio All Suite Hotel & Casino v. Phillips*, 240 P.3d 2 (2010). Once the employee is terminated, whether fired or quits, an injury that occurs while leaving is generally not sustained within the course of employment, except if the employee is subject to an inherent danger of the job site or remains on the employer’s premises for some other duty incidental to termination and is therefore not within the exclusive provision of Worker’s Compensation. *Fanders v. Riverside Resort & Casino, Inc.*, 245 P.3d 1159 (2010).

   Absent an independent duty owed to a third party, employers and co-employees are insulated by the provisions of the Nevada Industrial Insurance Act not only from liability to employees, but also from liability by way of implied indemnity to a third party. *Kellen v. Second Judicial Dist. Court ex rel. County of Washoe*, 642 P.2d 600 (Nev. 1982); *Outboard Marine Corp. v. Schupbach*, 561 P.2d 450 (Nev. 1977). As a matter of law, however, the Nevada Industrial Insurance Act does not void an express contract that requires an employer to indemnify a third-party for compensation the third-party has paid to the employer’s employee for a work related accident. *American Fed. Sav. Bank v. County of Washoe*, 802 P.2d 1270 (Nev. 1990).

   Nevada is different from other states because independent contractors and subcontractors are included in the definition of employees. *Aragonez v. Taylor Steel Co.*, 462 P.2d 754 (Nev.
1969); Nev. Rev. Stat. §§ 616A.020, 616A.210, 616A.285, 616B.612, 616B.603, among other provisions. Given this backdrop, there is a distinct body of opinions related to interpretation of the exclusive remedy doctrine. In Tucker v. Action Equipment & Scaffold Co., 951 P.2d 1027 (Nev. 1997), the Nevada Supreme Court created a distinction between cases involving injuries occurring in the context of building construction work versus those cases where the injury occurs in other work settings. Where someone working on a construction site is injured by the employee of a licensed building contractor who was working under a written construction contract, exclusive remedy would apply to bar the suit. The immunity extended to include the landowner who contracted for the construction work. Harris v. Rio Hotel & Casino, Inc., 25 P.3d 206 (Nev. 2001). In overarching construction-type projects involving several contractors and subcontractors the analysis centered on whether the contractors and their employees were working under a contractor’s license (Nev. Rev. Stat., Ch. 624). However, the Nevada Supreme Court has since withdrawn from the bright line distinction and overruled a construction versus nonconstruction analysis under Tucker. See Richards v. Republic Silver State Disposal, Inc., 148 P.3d 684 (Nev. 2006). Rather, the Court emphasized that immunity determinations must be resolved under Nev. Rev. Stat. § 616B.603. Immunity generally automatically applies to matters involving a project executed within the scope of a licensed contractor's license. All other matters must be further analyzed under NRS 616B.603 and the “normal work test” from Meers v. Haughton Elevator, 701 P.2d 1006 (Nev. 1985). Property owners who hire licensed principal contractors to complete construction projects are not immune, under provisions of the Nevada Industrial Insurance Act that extend employer immunity protections to property owners, from claims arising from risks occurring outside the scope of the licensed work. Republic Silver State Disposal, Inc., 148 P.3d 684.

A property owner is not immune from liability if the injured worker is engaged in “domestic service,” which is exempt from the definition of an employee under Nev. Rev. Stat. § 616A.110 (4). Specifically, pest control services are considered part of home maintenance, like a housekeeper or maid, and fall within the definition of “domestic service” and a homeowner will not be immune as a statutory employer because it is an independent enterprise. Seput v. Lacayo, 134 P.3d 733 (Nev. 2006).

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

The Nevada Industrial Insurance Act system is the employee’s exclusive remedy, even for accidents resulting from an employer’s gross or wanton negligence, or recklessness. Kennecott Copper Corp. v. Reyes, 337 P.2d 624 (Nev. 1959). Recovery by an employee for employer recklessness or gross negligence is exclusive under the State Industrial Insurance Act. A common-law action may not be brought by an employee against an employer for personal injuries unless the employer acted with a deliberate intent to injure the employee. King v. Penrod Drilling Co., 652 F.Supp. 1331 (D. Nev. 1987). But see Switzer v. Rivera, 174 F.Supp.2d 1097 (D. Nev. 2001) and Burns v. Mayer, 175 F. Supp. 2d 1259 (D. Nev. 2001) (referring to the discussion from King regarding intent, as dicta). When an employer commits an intentional tort upon an employee, the intentional act is not an accidental injury within the exclusive provisions of the compensation act. Barjesteh v. Faye’s Pub, Inc., 787
Furthermore, a co-employee’s intentional acts against another employee, is not within the NIIA’s exclusivity provisions. *Fanders v. Riverside Resort & Casino, Inc.*, 245 P.3d 1159, 1164 (Nev. 2010).

Nevada has expressly refused to adopt the “dual capacity doctrine,” thus refusing to permit a party to be sued in negligence just because it acted as both an employer and an owner. *Frith v. Harrah South Shore Corp.*, 552 P.2d 337 (Nev. 1989). 552 P.2d 337


The obligation to pay compensation benefits and the right to receive them exists as a matter of statute independent of any right established by contract; indeed, a contract of employment which waived or modified the terms or liability created by the Nevada Industrial Insurance Act would be void. *MGM Grand Hotel-Reno, Inc. v. Insley*, 728 P.2d 821 (Nev. 1986).

**30. Are there any penalties against the employer for unsafe working conditions?**

An employer has the duty to furnish a work place that is free from hazards that are likely to cause death or serious physical harm to his or her employees and maintain a healthy and safe place of employment. Nev. Rev. Stat. §§ 618.375 and 618.385. Furthermore, the employer must provide information to the employees regarding workplace safety in the form of posters and documentation. Nev. Rev. Stat. §§ 618.375-.376. An employee, representative of an employee, or a government official whose duty it is to ensure safety may notify the Administrator of any violation of Chapter 618, which they have reason to believe violates a regulation, and during the inspection the employer has a right to be present. Nev. Rev. Stat. § 618.435. Any employee who reports a violation is protected from discharge or discrimination. Nev. Rev. Stat. § 618.445.

If an employer is found to be in violation of Chapter 618, the Administrator of the Division of Industrial Relations may issue a citation that reasonably describes the violation, as well as allow a reasonable time for abatement of the violation. Nev. Rev. Stat. § 618.465. An employer has 15 working days from the citation in which to contact the Administrator and contest the citation, if the employer does not the citation is considered final. Nev. Rev. Stat. § 618.475. Any employer who has received a citation for a serious violation must be assessed an administrative fine of not more than $7,000 for each violation. Nev. Rev. Stat. § 618.645. A serious violation exists in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations or processes which have been adopted or are in use of employment unless the employer did not and could not, with the exercise of reasonable diligence, know of the presence of the violation. Nev. Rev. Stat. § 618.625. An employer who fails to correct a violation for which a citation has been issued within the period permitted for its correction may be fined $7,000 for each day during which
the failure or violation continues. Nev. Rev. Stat. § 618.655. Any employer who willfully or repeatedly violates any requirement of this chapter, may be assessed an administrative fine of not more than $70,000 for each violation, but not less than $5,000 for each willful violation. Nev. Rev. Stat. § 618.635. Any employer who violates any requirement of Chapter 618 and causes the death of an employee shall be punished: (1) for a first offense, by a fine of not more than $50,000 or by imprisonment in the county jail for not more than 6 months, or by both fine and imprisonment; and (2) for a second or subsequent offense, by a fine of not more than $100,000 or by imprisonment in the county jail for not more than 1 year, or by both fine and imprisonment. Nev. Rev. Stat. § 618.685.

31. What is the penalty, if any, for an injured minor?

If any employee at the time of an injury is under the minimum age prescribed by law for the employment of a minor in the occupation in which he is engaged when injured, the employer is liable to the division for a penalty of not less than $300 nor more than $2,000, to be collected in a civil action at law by the division. Nev. Rev. Stat. § 616D.290. Even if a minor is employed unlawfully, he is still covered by workers’ compensation. Haertel ex rel. Borregard v. Sonshine Carpet Co., 730 P.2d 428 (Nev. 1986).

32. What is the potential exposure for “bad faith” claims handling?

If the administrator determines that an insurer, organization for managed care, health care provider, third-party administrator, or employer has engaged in certain acts of bad faith, the administrator shall impose an administrative fine of $1,500 for each initial violation, or a fine of $15,000 for a second or subsequent violation. Nev. Rev. Stat. § 616D.120(1)(i). If the administrator determines that they have failed to comply with any provision of the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act, or any regulation adopted pursuant thereto, the administrator may: (a) issue a notice of correction for some violations; (b) impose an administrative fine for a subsequent violation for which a notice of correction was issued or any violation for which a notice of correction may not be issued; or (c) order a plan of corrective action to be submitted to the administrator within 30 days after the date of the order. Nev. Rev. Stat. § 616D.120(2). If the administrator determines that certain kinds of bad faith has occurred, the Administrator shall order the offender to pay to the claimant, within 10 days of the administrator’s determination, a benefit penalty in an amount that is (a) not less than $5,000 and not greater than $50,000; or (b) of $3,000 if the violation involves a late payment of compensation or other relief to a claimant in an amount which is less than $500 or which is not more than 14 days late. Nev. Rev. Stat. § 616D.120(3). See also Nev. Admin. Code § 616D.411. To determine the amount of the benefit payment, the Administrator shall consider the degree of physical harm suffered by the injured employee or the dependents of the injured employee as a result of the violation. Nev. Rev. Stat. § 616D.120(4). The commissioner may withdraw the certification of a self-insured employer, association of self-insured employers, or third-party administrator if, after a hearing, it is shown that the entity engaged in one of the enumerated acts of bad faith. Nev. Rev. Stat. § 616D.120(8). Additionally, the administrator may assess an administrative penalty of up to twice the amount of any underpaid assessment against an insurer who violates any regulation

If an insurer unreasonably delays or refuses to pay the claim within 30 days after the insurer has been notified of an industrial accident, the insurer shall pay upon order of the administrator to the claimant an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. Nev. Rev. Stat. § 616C.065.


33. What is the exposure for terminating an employee who has been injured?

The unlawful discharge of an employee in retaliation for filing a workers’ compensation claim does not preclude the court from providing a remedy for what it concludes to be tortious conduct. Dillard Dep’t Stores, Inc. v. Beckwith, 989 P.2d 882 (Nev. 1999). Since there is no basis for administrative relief for such a tortious act within the framework of the state industrial insurance system, there is no need to exhaust purported administrative remedies before bringing such action. Id.

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. An employee who suffers an injury which is otherwise compensable under the Nevada Industrial Insurance Act under circumstances creating a legal liability in some person other than the employer or a person in the same employ may proceed against such third party in tort. Nev. Rev. Stat. § 616C.215(2). Leslie v. J.A. Tiberti Construction Co., 664 P.2d 963 (Nev. 1983), overruled on other grounds by Tucker v. Action Equipment and Scaffold Co., Inc., 951 P.2d 1027 (Nev. 1997). The amount of compensation the injured employee or his dependents are entitled to receive pursuant to the Nevada Industrial Insurance Act, including future compensation, must be reduced by the amount of the damages recovered. Nev. Rev. Stat. § 616C.125(2)(a).

35. Can co-employees be sued for work-related injuries?

When an employee is injured on the job as a result of the negligence of a fellow employee acting within the course of employment, his remedy is compensation under the Nevada Industrial Insurance Act. Leslie v. J.A. Tiberti Construction Co., 664 P.2d 963 (Nev. 1983), overruled on other grounds by Tucker v. Action Equipment and Scaffold Co., Inc., 951 P.2d 1027 (Nev. 1997); Arteaga v. Ibarra, 858 P.2d 387 (Nev. 1993). The co-employees’ grant of immunity extends only to situations where, apart from the compensation act, the employer


36. **Is subrogation available?**

Yes. If the employee or his dependents receive industrial insurance compensation, the insurer has a right of action against the person so liable to pay damages, including the employer's uninsured or underinsured vehicle coverage insurer, and is subrogated to the rights of the employee or of his dependents to recover. That is a statutory right of intervention. Nev. Rev. Stat. § 616C.215(2)(b). This statutory right of intervention is not, however, absolute. A workers’ compensation insurer may intervene in an injured worker’s litigation to protect its right to reimbursement only if it meets certain requirements, which include showing that the injured worker cannot adequately represent the insurer’s interest in the subject matter of the litigation. *Am. Home Assurance Co. v. Dist. Ct.*, 147 P.3d 1120 (Nev. 2006). The insurer or administrator would also have a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. Nev. Rev. Stat. § 616C.215(5) and (6). (These sections codify an exception to the common law collateral source rule in the workers’ compensation context.) However, the insurer and the administrator are not subrogated to the rights of an injured employee or his dependents under a policy of uninsured or underinsured vehicle coverage purchased by the employee. Nev. Rev. Stat. § 616C.215(3)(b).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Yes. An insurer must approve or deny a bill for accident benefits received from a provider of health care within 30 calendar days after receipt of the bill. Nev. Rev. Stat. § 616C.136(1). If the bill for benefits is approved, the insurer must pay the bill within 45 calendar days after the bill is received. *Id.* Failure to pay within that period, the insurer must pay interest equal to the prime rate at the largest bank in Nevada plus 6 percent to the provider of health care.
until the bill is paid. *Id.* If an insurer needs additional information whether to pay or deny a bill, then the insurer must notify the health care provider and provide the provider with all the specific reasons for the delay, within 20 calendar days of receiving the bill and the healthcare provider must give all information within 20 calendar days of receipt, or the healthcare provider will not be entitled to payment of interest. Nev. Rev. Stat. § 616C.136(2). An insurer must not request a health care provider to resubmit information that the provider has previously provided to the insurer, unless there is a legitimate reason for the request and the purpose of the request is not to delay, harass, or discourage the filing of claims. Nev. Rev. Stat. § 616C.136(3). Upon receipt of request for additional information, the provider must provide the information within 20 calendar days of receipt, if the provider fails to furnish the information then the provider is not entitled to interest for late payment. Nev. Rev. Stat. § 616C.136(2). The insurer must deny the bill within 20 calendar days after receipt of the information from the provider, if the insurer fails to pay the bill within that time period, then the insurer must pay interest at the rate set forth above. *Id.* The payment of interest for late payment may only be waived if the payment was delayed by an act of God or by another cause beyond the control of the insurer. Nev. Rev. Stat. § 616C.136(6).

If the administrator determines that an insurer, organization for managed care, health care provider, third-party administrator or employer has failed to provide or unreasonably delayed payment to an injured employee or reimbursement to an insurer, or has refused to pay or unreasonably delayed payment to a claimant of compensation found to be due him by a hearing officer, appeals officer, court, written settlement agreement or stipulation, or the division, for a certain amount of days for each, then the administrator shall impose the administrative fines proscribed in Nev. Rev. Stat. § 616D.120. See supra text answering question number 32.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

Appeals officers, the administrator, the manager and the manager’s designee, in conducting hearings or other proceedings, may issue subpoenas requiring the production of medical records, and may permit discovery by deposition or interrogatories. Hearing officers, in conducting hearings or other proceedings, may issue subpoenas requiring the production of books, accounts, papers, records and documents that are relevant to the dispute for which the hearing or other proceeding is being held, and may permit discovery by deposition or interrogatories. Nev. Rev. Stat. § 616D.050.

39. **What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

**A. Claimant’s choice of physician.**

Initially, the employer may furnish the names of one or more physicians or chiropractors to ascertain the character of the injury and render medical attention that is required immediately, but may not require the employee to select any particular physician or
chiropractor. Thereupon, the examining physician or chiropractor shall report forthwith to the employer and to the insurer the character and extent of the injury. Nev. Rev. Stat. § 616C.010.

The administrator shall establish a panel of physicians and chiropractors that have demonstrated special competence and interest in industrial health to treat injured employees under the Act. Nev. Rev. Stat. § 616C.090(1). Further medical care for an employee whose insurer has not entered into a contract with an organization for managed care may choose his treating physician or chiropractor from that panel of physicians and chiropractors. Nev. Rev Stat. § 616C.090(2). If the injured employee is not satisfied with first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor from the panel if the choice is made within ninety (90) days after his injury, subject to the approval of the insurer. Id. Any further change is subject to the approval of the insured, which must be granted or denied within ten (10) days after written request for such a change is received from the injured employee. Id.

An injured employee whose employer has entered into a contract with an organization for managed care pursuant to Nev. Rev. Stat. § 616B.527 must choose his treating physician or chiropractor pursuant to the terms of that contract. If he is not satisfied, he may make an alternative choice pursuant to the terms of the contract without the approval of the insurer if the choice is made within ninety (90) days of the injury. Nev. Rev. Stat. § 616C.090(3). If the employee, after choosing his treating physician or chiropractor, moves to a county which is not served by the organization for managed care and the insurer determines that is impractical for the employee to continue treatment with the physician or chiropractor, the employee must choose a treating physician or chiropractor who has agreed to the terms of that contract unless the insurer authorizes the employee to choose another physician or chiropractor. Nev. Rev. Stat. § 616C.090(3).

No employee is required to accept the services of a physician or chiropractor provided by his employer, but may seek professional medical services of his choice as provided in Nev. Rev. Stat. § 616C.090. Nev. Rev. Stat. § 616C.265(6). However, those employees whose insurer has entered into a contract with an organization for managed care must choose a treating physician who is a member of the insurer’s managed care organization (MCO). Because physician-choice under the managed care system is a procedural and remedial means of administering an injured worker’s vested right to workers’ compensation benefits, Nev. Rev. Stat. § 616.090(3) applies retroactively to require workers receiving pre-1993 permanent total disability benefits to choose treating physicians who are members of the MCO that has contracted with their workers’ compensation insurer. Valdez v. Employers Ins. Co. of Nevada, 162 P.3d 148 (Nev. 2007).

B. Employer’s right to a second opinion and/or Independent Medical Examination.

Upon request by the insurer or employer, or by order of an appeals or hearing officer, an employee shall submit himself for medical examination at a time at a place reasonably

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employee is entitled to receive such accident benefits “as may reasonably be required.” Nev. Rev. Stat. § 616C.245(1). See also Nev. Admin. Code §§ 616C.117-144. The division will consider expenditures for the following as expenditures for claims: (a) a surgeon, assisting surgeon, anesthesiologist or consulting physician; (b) charges by a hospital; (c) treatment by a physician or chiropractor; (d) X-ray films, CAT scans, myelograms, MRI, and other diagnostic test and procedures; (e) physical therapy; (f) prescribed drugs and medications, eyeglasses, dental work, prostheses, orthotic devices and corrective shoes by prescription; (g) travel to obtain medical care or supplies; (h) any other accident benefits; (i) compensation for a permanent total, temporary total, permanent partial or temporary partial disability; (j) costs of vocational rehabilitation services for an injured employee; (k) death benefits; and (l) burial expenses. Nev. Admin. Code § 616B.707.

The division will not consider the following expenditures to be expenditures for claims: (a) amounts held in reserve for any anticipated expense in connection with a claim; (b) money paid for a temporary total or temporary partial disability in excess of the average monthly wage; (c) legal expenses, including court costs, attorney’s fees, costs for depositions, investigations and hearings; (d) payment of an award of interest; (e) payment of claims in connection with the Uninsured Employers’ Claim Account; and (f) administrative expenses, including expenses incurred for copying records, reviewing physicians’ reports, or services relating to the management of costs of medical care. Nev. Admin. Code § 616B.707.

41. **Which prosthetic devices are covered, and for how long?**


If compensation is paid to an employee for a mastectomy, the employee is also entitled to receive commensurate compensation for at least two prosthetic devices incident to the surgery. Nev. Rev. Stat. § 616C.185.

42. **Are vehicle and/or home modifications covered as medical expenses?**

An injured employee is entitled to receive a motor vehicle that is modified to allow the employee to operate the vehicle safely if: (a) as a result of an injury arising out of and in the course of his employment, he is quadriplegic, paraplegic or has had a part of his body
amputated; and (b) he cannot be fitted with a prosthetic device which allows him to operate a
motor vehicle safely. Nev. Rev. Stat. § 616C.245(2). The order of preference for such
modification is to a motor vehicle owned by the employee, a used motor vehicle, or, lastly, a
new motor vehicle. Nev. Rev. Stat. § 616C.245(3). The insurer shall purchase or modify a
the motor vehicle as needed and at least every 10 years or 120,000 miles driven, whichever
occurs first. (Added to NAC by Div. of Industrial Relations by R130-14, eff. 9-9-2016)

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. The administrator establishes a schedule of reasonable fees and charges allowable for
accident benefits provided to employees whose insurers have not contracted with an
organization for managed care or with providers of health care services pursuant to Nev. Rev.
schedule from the Division of Industrial Relations in Carson City, Nevada.

Providers of health care shall use the procedure code numbers, unit values, and guidelines
from the “Relative Values for Physicians,” as adopted, to bill for services performed which
are within the scope of their licenses. Nev. Admin. Code § 616C.145. The division adopted
by reference the most current list of eligible codes for surgical centers for ambulatory patients
set forth in the “Centers for Medicare and Medicaid services, CMS Common Procedures
Coding Systems.” Nev. Admin. Code § 616C.147. The insurer may not, in accepting
responsibility for any charges, use fee schedules which unfairly discriminate among

44. **What, if any, provisions or requirements are there for “managed care”?**

A self-insured employer, an association of self-insured public or private employers or a
private carrier may enter into a contract with one or more organizations for managed care (as
defined by Nev. Rev. Stat. § 616A.280) or with the health care providers directly to provide
comprehensive medical and health care services to employees for injuries and diseases that
616B.527. They may also require their employees to obtain medical and health care services
for their industrial injuries from those organizations or persons with whom they have
contracted. *Id.* Except as otherwise provided in subsection 3 of NRS 616C.090, require
employees to obtain the approval of the self-insured employer, association or private carrier
before obtaining medical and health care services for their industrial injuries from a provider
who has not been previously approved by the self-insured employer, association or carrier.
*Id.*

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

A person aggrieved by a decision made by an organization for managed care which has
contracted with an insurer must, within 14 days of the determination and before requesting a
resolution of the dispute, appeal that determination in accordance with the procedure for resolving complaints established by the managed care organization. Nev. Rev. Stat. § 616C.305(3). The procedure must be informal and must include a review of the appeal by a qualified physician or chiropractor who did not make or otherwise participate in making the decision. Nev. Rev. Stat. § 616C.305(2). If a person appeals a final determination pursuant to the procedure for resolving complaints established by an organization for managed care and the dispute is not resolved 14 days after it is submitted, the person may request a resolution of the dispute pursuant to NRS 616C.345 to 616C.385, inclusive. Nev. Rev. Stat. § 616C.305(3).

A person who is aggrieved by a written determination of an insurer, or the failure of an insurer to respond within 30 days to a written request, may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Nev. Rev. Stat. § 616C.315(3). Such a request must be filed within 70 days after the date on which the notice of the insurer’s determination was mailed by the insurer or the unanswered written request was mailed to the insurer, as applicable. Id. The failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of a request. Id. An additional 90 days are afforded to an injured worker if he shows by a preponderance of the evidence that he was diagnosed with a terminal illness or informed of the death/terminal illness of a spouse, child or parent. Nev. Rev. Stat. § 616C.315(4). Failure to file a request for a hearing may be excused if the person aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to request a hearing. Nev. Rev. Stat. § 616C.315(5). The parties to a contested claim may, if the claimant is represented by legal counsel, agree to forego a hearing before a hearing officer and submit the contested claim directly to an appeals officer. Nev. Rev. Stat. § 616C.315(7).

Within 5 days after receiving a request for a hearing, the hearing officer shall set the hearing for a date and time within 30 days after his receipt of the request, give notice at least 15 days before the hearing, and conduct hearings expeditiously and informally. Nev. Rev. Stat. § 616C.330(1). The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada Attorney for Injured Workers. Nev. Rev. Stat. § 616C.330(2). The hearing officer shall render his decision within 15 days after the hearing or when he receives a copy of the report from the medical examination he requested. Nev. Rev. Stat. § 616C.330(8).

46. **What is the method of claim adjudication?**

A. **Administrative level.**

Except with regard to an appeal of a decision of an organization for managed care, a person who is aggrieved by: (a) a written determination of an insurer; or (b) the failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Nev. Rev. Stat. § 616C.315(3). Such a request must be filed
within 70 days after the date on which the notice of the insurer’s determination was mailed by the insurer or the unanswered written request was mailed to the insurer, as applicable. *Id.*

The parties to a contested claim may, if the claimant is represented by legal counsel, agree to forego a hearing before a hearing officer and submit the contested claim directly to an appeals officer. Nev. Rev. Stat. § 616C.315(7). Any claimant who is aggrieved by any final determination of the insurer or the insurer’s staff may appeal from the decision to a hearing officer. Nev. Admin. Code § 616C.270.

Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within 30 days after the date of the decision. Nev. Rev. Stat. § 616C.345(1). If a dispute is required to be submitted to a procedure for resolving complaints regarding a decision of an organization for managed care and: (a) a final determination was rendered pursuant to that procedure; or (b) the dispute was not resolved pursuant to that procedure within 14 days after it was submitted, any party to the dispute may file a notice of appeal within 70 days after the date on which the final decision was mailed to the employee, or the unanswered request for resolution was submitted. Nev. Rev. Stat. § 616C.345(4). Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request. *Id.*

The hearing before the appeals officer to review the hearing officer’s decision is an administrative proceeding governed by particular statutes, such as those relating to rules of evidence, the record of hearing, the reimbursement of employee’s expenses and lost wages, and the stay of the appeals officer’s decision. Nev. Rev. Stat. §§ 616C.350, 616C.355, 616C.360, 616C.365, 616C.375 and 616C.380. A written petition for a rehearing based on good cause or newly discovered evidence may be filed with the appeals officer within 15 days after the service of a notice of the final decision. Nev. Admin. Code § 616C.327.

**B. Trial court.**

No judicial proceedings for judicial review may be instituted unless: (a) a claim is filed within the time limits prescribed, and (b) a final decision by an appeals officer has been rendered on the claim. Judicial proceedings instituted for compensation are limited to review of the decision of the appeals officer. Nev. Rev. Stat. § 616C.370. The petition for judicial review must be filed with district court and name as respondents the Department of Administration and all parties. Special rules of service apply: the petition must be served on the Attorney General, at the Office of the Attorney General in Carson City, Nevada, and the Director of the Department of Administration.

Relief from a decision of the Appeals Officer is clearly provided for under the Administrative Procedure Act and the district court is given very broad supervisory powers to insure that all relevant evidence is considered by the Appeals Officer. *Nevada Indus. Comm’n v. Reese*, 560 P.2d 1352 (Nev. 1977) and Nev. Rev. Stat. § 233B.135. The district court may decide pure legal questions without deference to an agency determination, an agency’s conclusions
of law which are closely related to the agency’s view of the facts are entitled to deference and should not be disturbed if they are supported by substantial evidence. *State Indus. Sys. v. Khweiss*, 825 P.2d 218 (Nev. 1992).

C. Appellate.

The function of the Supreme Court of Nevada in reviewing an administrative decision is identical to that of the district court. *State Indus. Ins. Sys. v. Engel*, 971 P.2d 793 (Nev. 1998). A reviewing court shall not substitute its judgment for that of an agency with regard to a question of fact. Questions of law, however, are reviewed *de novo*. *Id.*

47. **What are the requirements for stipulations or settlements?**

The insurer shall not make or allow any lump-sum settlements, except under the prescribed circumstances for lump-sum payments in lieu of vocational rehabilitation services, death benefits, permanent partial disability awards, or payments pending appeals when the decision is not stayed. Nev. Rev. Stat. § 616C.410. Every injured employee, widow, widower or dependent, is entitled to receive from a qualified employee of the insurer a written explanation of the various alternatives implicit in lump-sum compensation or other settlement and the long-range effects of a determination made as to one or the other kind of settlement. The claimant shall provide his selection in writing to the insurer. Nev. Rev. Stat. § 616C.415.

48. **Are full and final settlements with closed medicals available?**

Nevada statutory and case law has not specifically addressed this issue.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Certificate of authority is not required of an insurer with respect to the settlement of claims under its lawfully written policies. Nev. Rev. Stat. § 680A.070. The parties may stipulate to any fact at issue by written stipulation introduced in evidence as an exhibit or by oral statements shown upon the record, with the approval of the Commissioner. Nev. Admin. Code § 607.420. However, as a practical matter, in pending matters before the appeals officer, settlements are filed on pending matters.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?**

51. **What are the provisions/requirements for self-insurance?**

**A. For individual entities.**

An employer may qualify as a self-insured employer by establishing to the satisfaction of the commissioner that the employer has sufficient administrative and financial resources to make certain the prompt payment of all compensation under Chapters 616A-616D, or 617. The employer has sufficient financial resources if (a) at the time of initial qualification and until the employer has operated successfully as a qualified self-insured employer for 3 years, the employer has a net worth of more than $2,500,000, as evidenced by a statement of net worth completed by an independent CPA to the Division of Insurance of the Department of Business and Industry; or (b) after 3 years of successful operation as a qualified self-insured employer, the employer has net cash flows from operating activities plus net cash flows from financing activities of five times the average of claims paid for each of the last 3 years or $7,500,000, whichever is less. Nev. Rev. Stat. § 616B.300(1). The employer must also deposit with the commissioner a bond executed by the employer as principal, and by a corporation qualified under Nevada law as surety. The bond must be in an amount reasonably sufficient to ensure payment of compensation, but in no event may it be less than 105 percent of the employer’s expected annual incurred cost of claims, or less than $100,000. Nev. Rev. Stat. § 616B.300(2). In lieu of a bond the employer may deposit with the commissioner a like amount of lawful money or other authorized security. The commissioner shall require the employer to submit evidence of excess insurance to protect against a catastrophic loss. Nev. Rev. Stat. § 616B.300(3).

**B. For groups or “pools” of private entities.**

A group of five or more employers may not act as an association of self-insured public employers unless the group: (a) is composed of employers engaged in the same or similar classifications of employment, and (b) has been issued a certificate to act as such an association by the commissioner. Nev. Rev. Stat. § 616B.350(1). A group of five or more employers may not act as an association of self-insured private employers unless each member of the group: (a) is a member or associate member of a bona fide trade association, as determined by the commissioner, which (1) is incorporated in this state, and (2) has been in existence for at least 5 years; and (b) has been issued a certificate to act as such an association by the commissioner. Nev. Rev. Stat. § 616B.350(2). The application for certification requires, among other items, financial statements that show the financial ability of the association to pay all compensation. Nev. Rev. Stat. § 616B.350(5).

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of the Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

Yes. Nevada includes within the definition of employee and/or workman every person in the service of the employer, whether lawfully or unlawfully employed, including, but not limited
to, aliens. Nev. Rev. Stat. § 616A.105. However, although compensation can be paid to an injured undocumented worker pursuant to Nevada’s workers’ compensation scheme, formal vocational training must be denied if that training is solely because of the worker’s immigration status. Tarango v. State Indus. Ins. Sys., 25 P.3d 175 (Nev. 2001).

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

There are no provisions in either the Nevada Revised Statutes or the Administrative Regulations dealing with coverage for terrorist acts. Furthermore, there is no Nevada case law dealing with this issue.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

Not yet.

If an injured worker receives benefits from Medicaid, there may be a subrogation right on the part of the State of Nevada to obtain reimbursement. Nev. Rev. Stat. § 422.293. However, there is not a specific requirement that must be satisfied regarding Medicare.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

Hospital liens, as provided for by Nev. Rev. Stat. § 108.590, are not valid against anyone coming under the provisions of Nev. Rev. Stat. chapters 616A to 616D, inclusive, or chapter 617. As a general matter, the State Department of Human Resources is subrogated to the rights of a Medicaid recipient to the extent of all medical costs paid on behalf of the Medicaid recipient. Nev. Rev. Stat. § 422.293. It is not clear how this statute interacts with the Nevada workers’ compensation law.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and
insurers. 45 C.F.R. §164.512. Therefore, your current practice of obtaining medical records could proceed under state law.

Any information obtained from any insurer, employer or employee is confidential and may not be disclosed or be open to public inspection in any manner which would reveal the person’s identity. Nev. Rev. Stat. § 616B.012. Every patient of a medical facility or facility for the dependent has the right to retain his or her privacy concerning the patient’s program of medical care. Nev. Rev. Stat. § 449.720(2). However, a provider of health care shall make the health care records of a patient available for physical inspection by an investigator for the attorney general investigating an alleged violation of Nev. Rev. Stat. §§ 616D.200, 616D.220, 616D.240 or 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617, or in the provision of benefits for industrial insurance. Nev. Rev. Stat. § 629.061(1)(f).

The effect of Medicare trusts and liens on workers’ compensation settlements is governed by Federal law, dealing with the Medicare Secondary Payer Program. 42. U.S.C. § 1395y(b)(2)(B). There are no Nevada cases wherein this issue was presented to elucidate the interplay between that Federal scheme and Nevada’s workers’ compensation law.

57. What are the provisions for “Independent Contractors”?

Subcontractors, independent contractors, and the employees of either are “employees”. Nev. Rev. Stat. § 616A.210. The most recent case in Nevada interpreting “indirect employees” such as subcontractors or independent contractors, for the purposes of coverage eligibility under Nev. Rev. Stat. § 616A.210 is Hays Home Delivery, Inc. v. Employers Ins. Co. of Nevada, 31 P.3d 367 (Nev. 2001). In Hays, the Nevada Supreme Court found entitlement to workers’ compensation through a principle contractor despite a specific agreement rendering the claimant an independent contractor. The Court applied the “normal work test” from Meers v. Haughton Elevator, 701 P.2d 1006 (Nev. 1985) and Nev. Rev. Stat. § 616B.603, which requires that they are in the ‘same trade’ and that the independent contractor would have performed work that would ‘normally’ be carried through employees.

Despite this finding, Nevada has determined that a hirer of an independent contractor is not vicariously liable for the negligence of the employer of the independent contractor, and the injured independent contractor employee’s exclusive remedy is Workers Compensation, even if the independent contractor is insolvent and did not carry industrial insurance. San Juan v. PSC Indus. Outsourcing, 240 P.3d 1026 (Nev. 2010).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

An employee leasing company must have a certificate of registration to operate. Nev. Rev. Stat. §§ 616B.670 to 616B.697. A “client company” is a company which leases employees, for a fee, from an employee leasing company pursuant to a written or oral agreement. Nev.
Rev. Stat. § 616B.670(2). An “employee leasing company” is a company which, pursuant to a written or oral agreement: (a) Places any of the regular, full-time employees of a client company on its payroll and, for a fee, leases them to the client company on a regular basis without any limitation on the duration of their employment; or (b) Leases to a client company: (1) Five or more part-time or full-time employees; or (2) Ten percent or more of the total number of employees within a classification of risk. Nev. Rev. Stat. § 616B.670(3). An employee leasing company shall be deemed to be the employer of its leased employees for the purposes of chapter 612 of Nev. Rev. Stat. and sponsoring and maintaining any benefit plans, while these provisions do not affect the employer-employee relationship that exists between a leased employee and a client company. Nev. Rev. Stat. § 616B.691.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

There are not any specific provisions regarding owner/operators of trucks or other vehicles for driving or delivery of people or property. *Cf. Hays Home Delivery, Inc. v. Employers Ins. Co. of Nevada*, 31 P.3d 367 (Nev. 2001) (holding that a truck owner/operator was an independent enterprise, separate and distinct from the corporation for whom he delivered, but because the owner/operator and the corporation were in the same trade of delivering merchandise from retailers to end customers, an employment relationship existed between them entitling the owner/operator to workers’ compensation benefits from the corporation’s carrier).

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

No.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one
can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Dalton L. Hooks, Jr., Esquire
dhooks@alversontaylor.com
Tel:  (702) 384-7000
1. Citation for the state’s workers’ compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

“Employee,” with respect to private employment, means any person in the service of an employer subject to the provisions of this chapter under any express or implied, oral or written, contract of hire, except a railroad employee engaged in interstate commerce whose rights are governed by the Federal Employers’ Liability Act. If they elect to be personally covered by this chapter, ‘employee’ includes persons who regularly operate businesses or practice their trades, professions, or occupations, whether individually, in partnership, or association with other persons, whether or not they hire others as employees. Sole proprietors do not need to purchase coverage for themselves although they must for their employees. See RSA 281-A:2,VI(a). A corporation or limited liability company may elect to exclude up to three executive officers or members from the compulsive coverage requirements of the statute. RSA 281-A:18-a. Only direct sellers, real estate brokers, agents or appraisers and people providing services as part of a residential placement for individuals with developmental, acquired or emotional disabilities are not presumed to be employees. RSA 281-A:2,VI(b)(1).

Any person except for a direct seller, qualified real estate broker, agent, or appraiser, or person providing services as part of a residential placement for persons with developmental, acquired or emotional disabilities who is working for a private employer is presumed to be an employee for workers’ compensation purposes. RSA 281-A:2,VI(b). This presumption may be rebutted if ALL 12 of the criteria cited in the statute can be shown to apply.

The strong statutory presumption is that a person who performs services for another, for pay, is an employee. This provision makes it very difficult for an employer to deny coverage on the grounds that the worker is an independent contractor. Employers must carefully document the grounds to support a finding that the injured worker is an
independent contractor. A contemporaneously written agreement signed by both the employer and the person performing services which describes the services to be performed and affirms they will be performed in accordance with the 12 criteria in VI(b)(1)(A)-(L) “is prima facie evidence that the criteria have been met.” RSA 281-A:2,VI(c).

“Employee” also includes public employees, including all legislators, fire fighters, special police officers (even if they are volunteers), volunteer members or trainees of the state emergency management corporation, voluntary forest fire fighters, and voluntary rescue personnel. RSA 218-A:2,VII(a).

Inmates of county or state correctional facilities who are allowed or required to perform services for which no significant remuneration is provided, are excluded from employee status. RSA 281-A:2,VII(b). Also excluded are those performing community service pursuant to a court order or any person providing services as part of residential placement services for individuals with developmental, acquired or emotional disabilities. Id.

Persons participating in a local welfare work program are considered employees unless the local governing body votes to make this chapter not applicable to local welfare work program participants under RSA 165:1,II. RSA 281-A:2,VII(b).

RSA 281-A requires that all homeowners’ policies issued in New Hampshire include coverage of domestics also known as residence employees. The statute defines a domestic as “a person performing domestic services in a private residence of the employer, where the employer is an individual, family, local college club, or local chapter of a college fraternity or sorority and not an agency or other entity engaged in the business of providing domestic workers to the public and the person is not defined as an independent contractor under RSA 281-A:2,VI(b).” RSA 281-A:2,V-a.

3. **Identify and describe any “statutory employer” provision.**

“A contractor who subcontracts all or any part of a contract shall bear the liability of the subcontractor of that contract for the payment of compensation under this chapter to the employees of the subcontractor, unless the subcontractor has secured the payment of compensation as provided for in this chapter.” RSA 281-A:18. Contractors should always obtain certificates of insurance from their subcontractors. A contractor who becomes liable to a subcontractor’s employee under this section may recover the compensation paid from the subcontractor. Id. A homeowner who contracts with another to hire that other to perform work does not thereby become a “contractor” who is liable to injured employees of the uninsured other employer. Appeal of Harleysville Ins. Co., 156 NH 532 (2007).

4. **What type of injuries are covered and what is the standard of proof for each:**

A. **Standard of Proof Applicable to All Injuries**
The claimant must prove both medical and legal causation. Medical causation requires a showing that the disability was actually caused by the work-related event; that the work-related activity caused the disability as a matter of medical fact. Appeal of Newcomb, 141 NH 664 (1997). Legal causation requires a showing that the injury is work connected. Legal causation “defines the degree of exertion that is necessary to make the injury work-connected.” Appeal of Briggs, 138 NH 623, 628 (1994). Where there is no pre-existing condition or if the pre-existing condition was asymptomatic (i.e. degenerative disc disease without symptoms), almost any work-related activity which causes the injury as a matter of medical fact is sufficient to show legal causation. New Hampshire Supply v. Steinberg, 119 NH 223, 231 (1979). Where there is a pre-existing condition that is active, the employment must be shown to have “contributed something substantial” to the medical condition. The work-related conditions must pose a greater risk to cause the condition than those risks encountered in normal non-employment activities whether of the claimant or a regular person. Appeal of Redimix, 158 NH 494 (2009).

New Hampshire Supreme Court recently set forth the increased risk test for compensable injuries. Injuries caused by risks associated with the employment are always compensable. Injuries caused by risks personal to the claimant are never compensable. Injuries caused by a “mixed risk” (combination of a personal risk and an employment risk) are usually compensable, depending on the prior health of the claimant. The occurrence of the personal risk will not defeat compensability where the employment risk was a substantial contributing factor. The fourth category, “neutral risks” are of neither distinctly employment nor distinctly personal character may be compensable depending upon the circumstances when weighed between the contribution of personal and employment risks. Appeal of Margeson, 162 NH 273 (2011).

B. Traumatic or “single occurrence” claims.

The definition of injury under the statute is very broad. It includes all accidental injuries or deaths arising out of and in the course of the employment. RSA 281-A:2,XI.

C. Repetitive Trauma.

Injuries caused by repetitive trauma rather than by a single event are compensable. The date of injury in a cumulative trauma claim is date of first medical treatment. RSA 281-A:16. The date of injury for an aggravation of a cumulative trauma injury is the date of first treatment for the aggravation.

D. Mental Distress.

Disability caused by work related stress is compensable. Even though the cause may be routine and not “accidental,” a claim is compensable if the effect on the worker is unexpected. Appeal of Briand, 138 NH 555 (1994). Where there is a pre-existing condition, claimant must show the employment contributed “something substantial” to aggravate her medical condition. Injury “shall not include a mental injury if it results from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination,
or any similar action, taken in good faith by an employer.” RSA 281-A:2,XI.

E. Occupational disease (including respiratory and repetitive use).

Occupational diseases are compensable if “due to causes and conditions characteristic and peculiar to the particular trade, occupation or employment. It shall not include other diseases or death therefrom unless they are the direct result of an accidental injury arising out of or in the course of employment nor shall it include either a disease which existed at the commencement of the employment.” RSA 281-A:2,XIII. Dustin v. Lewis, 99 NH 404 (1955); Boucher v. John Swenson Granite Co., 104 NH 63 (1962).

5. What, if any, injuries or claims are excluded?

Idiopathic injuries are not compensable. Mental stress injuries without physical manifestation are not compensable. RSA 281-A:2,XI. Injuries caused by the willful intent to injure oneself or another are excluded. Id. Injuries caused in whole or in part by intoxication or the serious and willful misconduct of the employee are also excluded from coverage so long as the employer was unaware of the intoxication. RSA 281-A:14. Injuries resulting from participation in athletic or recreational events, whether on or off premises, are not compensable unless the employee “reasonably expected, based on the employer’s instruction or policy, that such participation was a condition of employment or was required for promotion, increased compensation or continued employment.” RSA 281-A:2,XI. “Injury” or “personal injury” shall not include a mental injury if it results from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or any similar action taken in good faith by an employer. . . . Conditions of the aging process, including but not limited to heart and cardiovascular conditions, shall be compensable only if contributed to or aggravated or accelerated by the injury.” RSA 281-A:2,XI. Injuries caused by “risks that are so clearly personal” are not compensable even if the injury occurs at work. Margeson at 162 N.H. 277.

6. What psychiatric claims or treatments are compensable?

Psychiatric claims are compensable only if there is a physical manifestation of the injury. The physical component may be the injury itself which causes mental stress but if the stress is the only injury, a nervous tic may be sufficient to constitute the physical manifestation. RSA 281-A:2,XI. See also 4D above. If the employee meets definition of “emergency response/public safety worker” under RSA 281-A:2,V-c, “injury” includes acute stress disorder and post-traumatic stress disorder.

7. What are the applicable statutes of limitations?

An employee must give notice to the employer of an injury within two years of the date of the injury or of the date that the employee knew or should have known of the injury and its relationship to the employment if that date is later than the date of injury. Appeal of Phillips, 165 N.H. 226 (2013). RSA 281-A:19. Even where notice of an injury is given in a timely manner, the employee must file a claim for benefits within three years of the
date of injury or the date that the employee knew or should have known of the injury and its relationship to the employment. Failure to request benefits within 3 years of giving notice of the injury bars the claim. RSA 281-A:21-a. If a claim for benefits is made but is denied by the employer, the employee must request a hearing before the Labor Department to contest the denial within eighteen months of the employee’s receipt of the Denial or the claim is barred. RSA 281-A:42(d). Once a claim has been accepted and some period of benefits has been paid, the employee has four years from the date of the last payment of indemnity benefits to file a request with the DOL to have the weekly indemnity benefits be reinstated. If more than four years elapse from the date of the last indemnity payment on an accepted claim, the employee would still be entitled to payment of medical bills but not to any further indemnity payments in the event of a recurrence of disability causally related to the original injury. RSA 281-48,I. Appeal of Gamas, 158 NH 646 (2009). Causally related medical bills are compensable for the life of the employee and may not be settled.

8. What are the reporting and notice requirements for those alleging an injury?

Notice must be given to the employer within two years of the date of injury or the date that the employee knew or should have known of the injury and its relationship to the employment. RSA 281-A:19. If an employer has actual notice of the injury, RSA 281-A:19 is satisfied. Appeal of Gamas, 158 NH 646 (2009); Appeal of Phillips, 165 N.H. 226 (2013). A technical defect in the form of the notice given to the employer will probably not bar the claim. In addition to satisfying RSA 281-A:19, a claim for benefits must also be filed within 3 years of the date of injury. RSA 281-A:21-a.

9. Describe available defenses based on employee conduct:

A. **Self-inflicted injury.**

No compensation is allowed for injury proximately caused by the employee’s willful intention to injure himself/herself or another. RSA 281-A:2,XI.

B. **Willful misconduct, “horseplay,” etc.**

Injuries suffered during “horseplay” are generally compensable. To be considered non-compensable, such activity must be both “serious and willful.” RSA 281-A:14. Only misconduct which is flagrant and of “a grave and aggravated character” or deliberate and premeditated will bar a claim. RSA 281-A:14; Newell v. Moreau, 94 NH 439 (1947).

C. **Injuries involving drugs and/or alcohol.**

If an injury is “caused in whole or in part by the intoxication” of the employee, the injury is not compensable unless the employer knew that the employee was intoxicated. RSA 281-A:14. The intoxication need not be the sole cause of the injury so long as there is some causal connection between the intoxication and the injury. Employer knowledge of the intoxication vitiates the defense. In the recent case of Appeal of Phillips, the court
held that the intoxication defense is barred . . . “only if the employer knew the employee was intoxicated at the time of the injury.” Actual knowledge of the intoxication is required, not mere proof that the employer should have known of the intoxication. Appeal of Phillips, 165 N.H. 226 (2013).

10. What, if any, penalties or remedies are available in claims involving fraud?

If a person knowingly makes a false statement, he or she is subject to prosecution and punishment for false swearing or unsworn falsification under RSA 641:1, 2, and 3. RSA 281-A:56. A violation of this statute is a misdemeanor. Upon conviction for the false statement, the Court may order forfeit all of the person’s rights to the compensation sought and the employer shall be entitled to restitution. RSA 281-A:56, I. This section was broadened to cover false statements made not only by employees, but also employers, insurers or their representatives. Therefore, false statements made in the course of reporting, investigating or adjusting a claim are also actionable. RSA 281-A:56, II.

11. Is there any defense for falsification of employment records regarding medical history?

There is no specific statutory defense unless the falsification is made for the purpose of obtaining benefits. See RSA 281-A:56. Such falsification may serve as a basis to attack the employee’s credibility, and may be actionable under RSA 281-A:56, but it does not automatically bar receipt of benefits unless the person is convicted for false swearing under RSA 641:2, unsworn falsification under RSA 641:3 or perjury under RSA 641:1.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

It depends on the circumstances but generally, injuries suffered during recreational events are not compensable. “Notwithstanding any law to the contrary, ‘injury’ or ‘personal injury’ shall not mean accidental injury, disease, or death resulting from participation in athletic/recreational activities, on or off premises, unless the employee reasonably expected, based on the employer’s instruction or policy, that such participation was a condition of employment or was required for promotion, increased compensation, or continued employment.” RSA 281-A:2, XI; In re: Malouin, 155 NH 545 (2007).

13. Are injuries by co-employees compensable?

They may be so long as the injury caused by the co-employee arises out of and in the course of the employment; i.e., the injury does not arise solely from a risk personal to the claimant. For example, injuries resulting from a fight may be compensable where the quarrel arises due to conditions of the employment rather than from personal causes unrelated to the employment. Appeal of Griffin, 140 NH 650, 656 (1996). See also, Appeal of Margeson, 162 NH 273 (2011). The employee would have a third party action against the co-employee only if the co-employee’s intentional tort caused the injury. To
prove intent, the employee must show that the tortfeasor knew that the conduct was “substantially certain” to result in injury. Thompson v. Forest, 136 NH 215 (1992). The employer/insurer has a lien on any amounts recovered from such a third party to the extent of “compensation, medical, hospital, or other remedial care already paid,” less the expenses and costs of the action. The lien also extends to amounts paid as permanent impairment but not to vocational rehabilitation. RSA 281-A:13,l(b).

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. “irate paramour” claims)?**

Probably not where the injury arises solely from a risk personal to the claimant; i.e., where the dispute between third party and worker is unrelated to work. Where the employee is just performing his job and is an innocent bystander, his injuries probably are compensable. However, where the fight is strictly over a personal issue, i.e., a love affair, the injuries resulting from the fight to the combatant are probably not compensable as a “risk personal to the claimant.” Appeal of Margeson, 162 NH 273 (2011). An employee being hit by a stray bullet shot from outside the workplace, would probably not be compensable. Margeson; Appeal of Kelly, 167 N.H. 489 (2015).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Average weekly wage computation is governed by RSA 281-A:15. Generally, the average weekly wage is based on the gross earnings of the employee for the 26 weeks prior to the injury from all employments. The employee may use a 52 week wage schedule (or a combination of consecutive weeks from 26 to 52 weeks) if that would result in greater indemnity benefits. The employee’s rate is based upon the total amount of all wages in all concurrent employments “subject to this chapter” regardless of which employment the employee was injured in. If one of the employee’s two jobs is solely in another state such that the second employer is not subject to this chapter, those out of state wages cannot be combined. Appeal of HCA Parkland Medical Center, 143 NH 92 (1998); Lab. Rule 506.02(d). If the employee has worked for so short a period of time that an average weekly wage cannot fairly be computed, the Labor Department may look to the rate of hire or to the average weekly wage of other employees in the same position with the employer or to similarly situated employees with other employers. RSA 281-A:15,l(a)-(c).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

In terms of the maximum rate, if an employee’s average weekly wage exceeds 30% of the state average weekly wage ($1,005.00 as of 07/01/2016), the weekly compensation rate shall be 60% of that employee’s average weekly wage or 30% of the state average weekly wage whichever is greater. The compensation rate, in any event, must not exceed 150% of the state average weekly wage. The maximum rate also cannot exceed 100% of
the employee’s after tax earnings. RSA 281-A:28,II. The maximum rate as of 07/01/2016 is $1,507.50 per week.

In terms of the minimum rate, if an employee’s average weekly wage is 30% or less of the state average weekly wage, weekly compensation is the full amount of that employee’s average weekly wage. The maximum allowable weekly compensation rate under this paragraph, however, shall not exceed 90% of the employee’s after tax earnings as determined by RSA 281-A:15. RSA 281-4:28,I. The DOL utilizes the Supplemental Wage Schedule, Form 76 WCA1 to calculate the compensation rate when the average weekly wage is 30% or less of the State’s average. As of 07/01/2016 the State’s minimum compensation rate is $301.50 per week.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employer/insurer has 21 days from the date of receipt of the Notice of Injury to accept the claim and pay benefits or to file a Memo of Denial contesting the claim. Lab. Rule 506.02. If no Memo of Denial is filed within that time period, the employer/insurer must commence and must continue making the statutory payments unless and until it obtains authorization from the Labor Department to terminate or reduce benefits or until the employee returns to work. Payments made no longer than 3 weeks after notice of the injury shall be without prejudice. Lab. Rule 506.02(b); RSA 281-A:41. The employer may unilaterally cease payments during the three week provisional period simply by filing a Memo of Denial. Lab. Rule 506.02(b). After the three week period following notice of the injury, benefits may be reduced or terminated only if the employee returns to employment or if approval is given by the Department of Labor either administratively or through a hearing before a hearing officer. Lab. Rule 506.02.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out days before recovering benefits for the first - days)?**

The employee is entitled to collect benefits on the fourth day of disability. If the disability lasts longer than 14 days, the employee must also be paid retroactively for the first three days of disability. RSA 281-A:22.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary partial or total benefits may be terminated if the employee returns to work at regular wages. Benefits may be reduced to the temporary partial rate if the return to work is restricted by the injury to part time work or a reduced rate of pay. A Memo of Payment must be filed with the Department. Absent a return to work, temporary benefits may not be terminated without Labor Department approval. Generally, the Department will not administratively grant modification on the basis of an independent medical examination. The Department is more likely to administratively modify benefits on the basis of a treating physician’s report. If the employer/insurer terminates benefits without prior Department approval, it is likely that fines will be assessed. If the request for
administrative modification is not granted, a hearing on the issue of extent disability will be scheduled before a hearing officer. Most often benefits will not be terminated or reduced absent a hearing before the DOL. RSA 281-A:48.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No.

21. **What disfigurement benefits are available and how are they calculated?**

Permanent scarring may be compensable in New Hampshire “[i]f an injury . . . involves scarring, disfigurement, or other skin impairment resulting from a burn or burns, an award shall be made on the basis of a maximum of 350 weeks with the appropriate number of weeks to be determined in proportion to the maximum in accordance with the percent of the whole person specified for such bodily losses in the 5th Edition of “Guides to the Evaluation of Permanent Impairment,” published by the American Medical Association. RSA 281-A:32,IX. Scarring that limits the ability to move or use other listed body parts may produce a ratable impairment of that other body part. RSA 281-A:32.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

If the employee has a permanent impairment under RSA 281-A:32, has reached maximum medical improvement and has a partial ability to work, the employer pays benefits equal to 60% of the difference between his pre-injury average weekly wage and the average weekly wage he is able to earn thereafter. Payments shall not continue after the disability ends and in any event, no longer than a total 262 weeks. RSA 281-A:-31-a.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

The number of weeks for a total permanent impairment to each listed member is determined under RSA 281-A:32. Payment of an award shall be made in a single payment. RSA 281-A:32,XI. The disability rate used to calculate the permanent impairment award is based on the employee’s Temporary Total Disability rate at the time of the injury. Appeal of Lorrette, 154 NH 271 (2006). If the employee dies, the balance of an unpaid weekly scheduled award shall be payable to the estate of the employee. The impairment is to be calculated using the 5th Edition of the AMA Guides to Evaluation of Permanent Impairment. The percentage of impairment is multiplied by the number of weeks set forth for the body part and the result is multiplied by the compensation rate.

Payment of the scheduled award “becomes due upon prompt medical disclosure after maximum medical improvement is achieved. . . .” The employer must notify the DOL “no later than 15 days following such disclosure . . .” whether it objects to the disclosed amount of scheduled loss. The employer must schedule a medical examination within 30 days thereafter and request a hearing before the commissioner to determine the amount of
scheduled impairment. Failure to comply with time deadlines negates the employer’s right to object to the amount of the scheduled loss. RSA 281-A:32,XI.

B. Number of weeks for “whole person” and standard for recovery.

The maximum amount of “whole person” benefits is 350 weeks, based on the employee’s compensation rate for temporary total disability. An employee is entitled to a whole person rating if two or more specified bodily members have a permanent impairment or “if the injury is to the spine or spinal column, or to the brain, or involves scarring, disfigurement or other skin impairment from a burn or burns. . . .” RSA 281-A:32,IX. The award is the percentage of whole person impairment x 350 x compensation rate. Loss of individual members of the listed body parts or parts thereof entitle an employee to an award based on a fewer number of weeks as set forth in the statute. The amount of impairment is to be calculated using the 5th Edition of the AMA Guides to the Evaluation of Permanent Impairment.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

If an employee is unable to return to the former employment or other employment for which he or she has training, the employee “shall be entitled to such vocational rehabilitation services, including retraining and job placement, as may be reasonably necessary to restore such employee to suitable employment.” RSA 281-A:25,I. Except in unusual cases, or where necessary to achieve a successful result, vocational rehabilitation training, treatment or service will not extend for more than one year. RSA 281-A:25,III. The Department of Labor uses a hierarchy of vocational services. Depending on the nature of the injury, the severity of the restrictions, and the employee’s prior experience and transferable skills, job placement services are usually the first step. If such services are unsuccessful or if the employee’s restrictions are too severe, the Department may order an on-the-job training program or retraining for the employee. The employee’s entitlement to a particular level of vocational benefits (i.e., new skill training, higher level vs. help to return to a different job with a different employer, lower level) depends on certain factors which include the employee’s transferable skills education, average weekly wage, age and medical factors. Lab. Rule 509.02. Thus, a severely disabled worker with a high average weekly wage will usually be entitled to a higher level of services (i.e., education) than a low wage earner with the same injury (i.e., job placement). However, since indemnity benefits must be paid as long as the disability is total, in some cases, the employer may be well served by providing a higher level of vocational benefits than might be required by law, in order to return the injured worker to employment. If an employee refuses to accept VR services he may lose compensation for each week of refusal. RSA 281-A:25,V.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

For injuries occurring on and after February 8, 1994, a totally disabled employee is
entitled to 60% of his average weekly wage, but no more than 150% of the state average weekly wage. If the employee’s average weekly wage is 30% or less of the state average weekly wage, the rate is the full amount of the weekly compensation rate up to a maximum of 90% of the employee’s after tax earnings. RSA 281:28-a. The employee is entitled to receive benefits for as long as he is totally disabled, however, one cannot be adjudged “permanently” disabled so as to guarantee indemnity payments to the employee for life or “permanently.” Compensation for “Permanent total disability” is payable only “during the continuance of such total disability.” RSA 281-A:28-a. The carrier is always free to contest extent of disability based on a change of condition. The challenge should be based on competent medical evidence. The burden of proof to show a change in condition such that the employee is no longer totally disabled, is on the employer. If, after receiving a combination of total disability and partial disability benefits for more than 262 weeks, a worker is found to be only partially disabled, the weekly indemnity benefits terminate immediately as temporary partial indemnity benefits are available only for a total of 262 weeks. RSA 281-A:31. Such a finding can only be made by the Department of Labor.

25. How are death benefits calculated, including the minimum and maximum rates:

A. Funeral expenses.

The employer/insurer must pay for burial expenses up to $10,000 for deaths occurring after January 1, 2010, RSA 281-A:26,IV.

B. Dependency claims.

Weekly death benefits are calculated at the Temporary Total Disability rate set forth in RSA 281-A:28.

If the work-related injury results in death, the surviving spouse is entitled to weekly benefits until remarriage or death. RSA 281-A:26,II.

Dependent children receive the weekly compensation that would accrue to the employee, until age 18, or to age 25 if the child is enrolled as a full-time student in an accredited institution. In the event that the dependent child is physically or mentally incapacitated, the entitlement to compensation continues as long as the incapacity continues. Compensation ceases if the child becomes married, legally adopted, or is determined to be self supporting. RSA 281-A:26,VI,VII.

The Commissioner determines how the dependency benefit is apportioned between the surviving spouse and minor children. RSA 281-A:26,1.

26. What is the criteria for establishing a “second injury” fund recovery?

In order to qualify for the Second Injury Fund, the employee must have had a permanent pre-existing physical or mental impairment from any cause that constituted a hindrance to
obtaining employment, at the time of hire and the employer must have been aware of this handicap at the time of hire or must have retained the employee if the first injury occurs during the employment. The disability from the combined effects of the pre-existing impairment and the new injury must be greater than the disability from the new injury alone. RSA 281-A:54,I. Also, the employer must have a written document, prepared contemporaneously with the hire, showing knowledge of the predicate impairment at the time of the hire or of the retention. Almost any writing will suffice; even a note on a work application. This requirement is easier to satisfy if the “pre-existing permanent impairment” was caused by an injury suffered while in the employ of the same employer because the First Report of Injury satisfies the requirement for a written document. The employer’s decision to retain a permanently injured employee is given the same consideration as its decision to hire an employee with a pre-existing impairment.

The New Hampshire Department of Labor uses several forms that must be submitted by the employer/insurer in order to qualify for the Second Injury Fund. The employer/insurer must notify the Fund of a possible claim no later than 100 weeks from the date of the subsequent injury. Notification after the 100th week permanently bars utilization of the Second Injury Fund. RSA 281-A:55; NH Code Admin. R. 506.04. The employer/carrier is responsible for payments to the injured employee in the first instance. The carrier shall be reimbursed 100% of indemnity and medical payments made to the claimant, after the first 104 weeks of disability. Prior to the first 104 weeks of disability, the carrier will be reimbursed only at the rate of 50% after the first $10,000 paid on compensation for indemnity or medical benefits. RSA 281-A:54,I.

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

If not done by agreement, the claim can be re-opened based on a change in condition, by the filing of a Petition with the Commissioner to review a Denial or an award of compensation no later than 4 years after the last denial of such benefits or the last payment of weekly indemnity benefits. RSA 281-A:48. The burden of proof is on the party seeking to prove the change in condition. Appeal of Elliot, 140 NH 607 (1996). Generally, if the Petition is filed more than four years from the last payment of indemnity benefits, only medical bills can be re-opened. RSA 281-A:48. Appeal of Dean Foods, 158 NH 467 (2009). However, if medical treatment is “purposefully and intentionally postponed for medical reasons” beyond the 4 year limit, the employee may petition to review the award of benefits “no later than 180 days after the date of the postponed treatment.” RSA 281-A:48,I-a. Causally related medical bills are compensable for life. Permanency awards can be requested at any time “upon prompt medical disclosure after maximum medical improvement is achieved.” RSA 281-A:32,XI. A permanency award may become due several years after the original injury and even though there may be no further entitlement to other benefits under the statute. Petition of Markievitz, 135 NH 455 (1992).

The Supreme Court has held that the Compensation Appeals Board has continuing jurisdiction over cases to reopen and modify its decisions on extent of disability to correct
mistakes of law or mistakes as to the nature or extent of the injury or disability even where there has been no physical change of condition. Appeal of Carnahan, 160 NH 73 (2010).

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

Generally, legal services rendered at an initial hearing at the Department of Labor level are solely the responsibility of the employee. However, even at the DOL level, when an employer or carrier “disputes the causal relationship of a medical bill to the claimant’s injury, or whether a medical bill was required by the nature of the injury, and denies payment of such bill, is after a hearing, ordered to pay or reimburse the bill by the commissioner, the employee shall be entitled to reimbursement of reasonable counsel fees and costs as approved by the commissioner.” RSA 281-A:44,II. Effective 01/01/2011, once a hearing has been scheduled to determine compensability of medical bills, if the carrier reverses its denial of such bills less than seven business days prior to the scheduled hearing, the claimant shall be entitled to reasonable counsel fees and costs. If a Labor Department decision is appealed to the Workers’ Compensation Appeal Panel or to the Supreme Court by either party, and if the employee “prevails” on appeal (regardless of which party filed the appeal), the employee is entitled to “reasonable counsel fees and costs.” RSA 281-A:44,I. To “prevail” means the employee must receive an award for disability benefits, medical, hospital and remedial care, a scheduled permanent impairment award, vocational rehabilitation or reinstatement of the employee which is greater in amount or scope than that awarded in the decision being appealed from. RSA 281-A:44,I(a)(1). If the employer appeals, “prevail” means the decision must be affirmed.

Interest on indemnity awards is calculated from date of injury if compensability is disputed and no indemnity has been paid or from date of termination or reduction if extent of disability is in issue. RSA 281-A:44,III. Interest on permanent impairment awards is calculated from the date payment becomes due. RSA 281-A:44,IV. Interest on awards for medical, hospital, or remedial care is payable only on those amounts the claimant paid out of pocket. RSA 281-A:44,V. Interest is calculated at the same rate as for judgments under RSA 336:1. RSA 281-A:44,II.

Any request for fees must be approved by the Department or the Supreme Court, depending on where the appeal was tried. Although there is no set schedule of fees, the Labor Department routinely approves employees’ attorney fees of $150 to $250 per hour depending on the nature, length, and complexity of the service performed, the usual and customary charge for such services and the benefit accruing to the claimant. RSA 281-A:44,VI.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive:**
A. Scope of immunity.

With certain limited exceptions, employers have immunity even for intentional torts. RSA 281-A:8. Co-employees also have immunity, except for intentional torts. RSA 281-A:8; Thompson v. Forest, supra. The employee may file a third party action against non-excluded parties, including co-employees, for intentional torts, and against manufacturers of defective products. The employee must show that the co-employee knew that his or her conduct was “substantially certain” to cause injury to be “intentional”. Thompson v. Forrest, supra. In the event the employee does not file a third party claim within nine months of the date of injury, the employer can file the action. RSA 281-A:8. Claims for loss of consortium are barred by exclusivity provision unless an exception applies such as for intentional torts.

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

Exclusivity provision does not bar claims for intentional injuries caused by co-employees. RSA 281-A:8,1(b). The dual capacity doctrine is an exception to employer immunity under the workers’ compensation law respecting tort liability but not an exception to co-employee immunity. The doctrine permits suit against the employer if he or she acts, in addition to his or her capacity as an employer, in a second capacity which confers on him or her obligations independent of those imposed on him or her as employer. Ryan v. Hiller, 138 NH 348 (1994). Exclusive remedy provision does not bar employee’s action for wrongful discharge.

30. Are there any penalties against the employer for unsafe working conditions?

Yes. If there is a prior violation of the same kind recorded in the Department or if an employer fails to comply with a written Departmental recommendation applicable to a first violation within reasonable time, the injured employee is entitled to double compensation. The employer is solely liable for the additional amount. RSA 281-A:33. Employers who fail to comply with safety regulations or with written Department of Labor orders regarding safety are also subject to fines.

Employers of fifteen or more employees must prepare a written safety program to be filed biennially with the commissioner on January 1st. RSA 281-A:64,II. Every employer of five or more employees shall create a joint loss management committee composed of equal numbers of employee and employer representatives. RSA 281-A:64,III. The commissioner may assess an administrative penalty of up to $250 per day on employers not in compliance with sections II and III. RSA 281-A:64,VIII

31. What is the penalty, if any, for an injured minor?

If a minor is injured during the course of a hazardous occupation in violation of the Youth Employment Law, RSA 276-A, prohibiting hazardous occupations for youth, and if a prior violation of the same kind is recorded in the Department, the employer shall be liable for double compensation, however, if the employer is insured, the employer and the
carrier shall share equally the compensation under this section. RSA 281-A:33.

32. **What is the potential exposure for “bad faith” or claims handling?**

The Commissioner “shall” assess civil penalties of up to $2,500 but not less than $500 against insurers who fail to pay or deny compensation promptly, fail to give timely notice, or fail to provide vital information in a timely manner as required by statute. Lab. Rule 512.01. There is no prohibition in the statute against filing a common law or statutory claim for damages resulting from bad faith claims handling. RSA 417 provides a cause of action for unfair insurance trade practices.

33. **What is the exposure for terminating an employee who has been injured?**

An employer may terminate an injured employee at any time for good cause unrelated to the mere fact of a work injury. The statute does not bar an employee from filing suit against the employer for wrongful discharge. Damages for lost wages or other benefits of the employment are recoverable. However, the United States District Court for the District of New Hampshire has held that the statute bars a claim for emotional distress damages due to intentional infliction of emotional distress arising solely out of the termination of the employee. *Frechette v. Wal-Mart Stores*, 925 F.Supp. 95 (D.NH 1995); *Schrepfer v. Framatome Connectors USA, Inc.*, 115 F.Supp.2d 182 (DNH 1999).

For injuries that occur on or after February 8, 1994, an injured employee of any employer with five or more employees “shall” be reinstated any time within eighteen months of the date of injury if the position exists and is available and the employee is able to do the work with “reasonable accommodations” for his or her limitations. The position is “available” even if it was filled by a replacement employee during the period of disability. If the position has been eliminated, reinstatement shall be in any other existing position which is within the employee’s limitations. The right to automatic reinstatement terminates: (1) if the treating doctor determines the employee cannot return to work; (2) the employee accepts employment with another employer; or (3) eighteen months from the date of injury. Reinstatement is not required for employees hired as replacements for the injured employee, seasonal or temporary employees or for construction workers if the particular project has been completed. Lab. Rule 504.05. The Commissioner may assess employers in violation of this section all weekly wage benefits retroactive to the date the employee was eligible for reinstatement. RSA 281-A:25-a.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. The employer/insurer retains a lien on any recovery to the extent of compensation, medical, hospital or other remedial care already paid or agreed to be paid or awarded to be paid to the employee, less a pro rata share of expenses and costs of the action. The employer/insurer has a “holiday” on payment of future benefits to the extent of the employee’s net recovery from a third party. RSA 281-A:13.
35. Can co-employees be sued for work-related injuries?

Yes, but only if the co-employee’s intentional tort caused the injury. Thompson v. Forest, 136 NH 215 (1992). See answers 13 and 29.

36. Is subrogation available?

Yes. If the employee or the estate fails to file a third party action within nine months of the date of the injury, the “employer or the employers insurance carrier may so proceed and shall be subrogated to the rights of the injured employee or, in the case of death, to the rights of the administrator to recover against such third person.” RSA 281-A:13,III(b)(1). If there is a subrogation recovery in excess of the statutory lien, which includes expenses and costs of the action, the excess shall be paid to the injured employee or to the estate of a deceased employee. RSA 281-A:13,III(b)(2). The procedure for approval of a settlement and for safeguarding the injured employee’s rights is the same as is provided for protecting the rights of the employer in case of a third party claim filed by the employee. The settlement and the division of costs and expenses, including attorneys’ fees must be approved by the commissioner or the superior court. RSA 281-A:13,IV.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

The employer/insurer has 30 days from the date of the receipt of a medical bill to either pay the bill or issue a Denial for the bill. Failure to pay the bill or issue a Denial within that time period essentially means that the insurer has accepted the bill. RSA 281-A:23,V; Lab. Rule 506.2(i)(j). The Commissioner may assess a civil penalty of up to $2,500 on an employer/insurer who fails either to pay a medical bill within thirty days of receipt or properly deny the bill. The denial “shall give a valid reason for the denial and shall advise the claimant of the right to petition the commissioner for a hearing.” Denials must be sent to the provider, the claimant, and the DOL. RSA 281-A:23,V(e)(2).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

With regard to obtaining medical reports from a treating doctor, the law requires that each treating health care provider submit a report with the bill. Although the statute does not define what constitutes an adequate report, the employer/insurer can deny any medical bills where the accompanying report is not included. The mere fact that a report/treatment note is not enclosed is grounds for denial. The Commissioner may assess a civil penalty of up to $2,500 against a medical provider who fails to provide reports as required by statute. RSA 281-A:23,V(d); Lab. Rule 506.02.

The statute authorizes providers to provide medical records to employers or carriers or
their attorneys without need for an authorization whenever a claimant has filed a claim for benefits. Information regarding prior conditions may be obtained if the prior conditions are similar to that presented in the claim. RSA 281-A:23,V(a). Effective 07/01/2010, every request for medical records based on the statutory authorization must state: “in bold print, in a font size two points larger than used in the request”:

This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient’s workers’ compensation claim, including any past history of complaints of, or treatment of, a condition similar to that presented in the claim.

Further, carriers must not send irrelevant records to others even if received in error or face a $2,500 penalty. Upon request, claimant shall sign a medical authorization for employer to obtain medical records for any condition the claimant claims is related to the work injury or which employer has reason to believe is relevant to the work injury. Lab. Rule 503.01(b). The Department may compel compliance with this rule, generally after a hearing on the issue.

39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Examination?**

**A. Claimant’s choice of physician.**

An employee has a right to select his or her own physician. The employee may switch physicians at will. RSA 281-A:23,I. The carrier may object to treatment as being unrelated or not “reasonable and necessary” for treatment of the injury. In re Filion, 145 N.H. 104 (2000). However, if the employer utilizes a managed care program approved by the DOL, the physician must be a member of the managed care network. RSA 281-A:23-a; Lab. Rule 702.01. The employee may switch providers within the network once as a matter of right. RSA 281-A:38-a; Lab. Rule 704.01. The employee must be given reasonable access to a second medical opinion inside or outside the medical network when the treating doctor remains uncertain about the nature of the injury or the proper course of treatment to cure or alleviate it. Lab. Rule 702.01(a)(8). The employee must ask the Commissioner for permission to seek a second opinion and the Commissioner shall grant one such request as a matter of course. Lab. Rule 703.01.

**B. Employer’s right to a second opinion and/or Independent Medical Examination.**

Any employee entitled to collect weekly indemnity benefits or medical benefits shall submit to an Independent Medical Examination (“IME”) at the carrier’s request. The independent doctor must be “certified by the appropriate specialty board as recognized by the American Board of Medical Specialties …” unless permission is obtained from the Commissioner for a specialty not recognized by those Boards and shall maintain a current practice in that area of specialty. RSA 281-A:38,II. The IME shall take place within a 50 mile radius of the employee’s home, unless, within the discretion of the Commissioner,
examination outside the 50-mile radius is needed to obtain services of a provider who specializes in evaluation and/or treatment of the workers’ specific condition. The worker shall not be required to submit to more than 2 independent examinations per year absent special circumstances. RSA 281-A:38,II.

Effective 01/01/2011, an injured employee may record the independent examination and may have a lay witness present during the exam. If the employee brings a witness to the exam, she must sign an authorization waiving any right she might otherwise have to privacy. RSA 281-A:38,II.

If the employee fails to attend the IME or obstructs the examination, his or her right to weekly payments shall be suspended until the examination takes place and no compensation shall be payable for or during such period. RSA 281-A:39. If the issue is payment of medical bills and the employee refuses to attend the IME, her right to a hearing on compensability of medical bills is suspended. Id.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employer/insurer is required to “furnish or cause to be furnished to an injured employee reasonable medical, surgical and hospital services, remedial care, nursing, medicines and mechanical and surgical aids for such period as the nature of the injury may require.” This includes chiropractic, massage or physical therapy. It could also include more non-traditional forms of treatment. RSA 281-A:23, I. The treatment does not need to be curative to be compensable. “Treatment may be reasonable and required by the injury even though the treatment does not improve the patient’s medical condition.” Appeal of Levesque, 136 NH 211 (1992). There is no state mandated schedule of fees for medical procedures or treatments in New Hampshire. Effective 09/01/2015, the employer must pay the reasonable value of such medical services but if reasonableness of the bills is contested, the health provider now has the burden of proof to establishing its bill for services is reasonable. RSA 281-A:24, I(a),(b).

41. **Which prosthetic devices are covered, and for how long?**

All prosthetic devices are covered, and include artificial limbs, eyes, teeth, orthopaedic appliances and physical and surgical aids. The insurer must pay for all such devices as long as they are necessitated by the causally related injury, for the employee’s life. The insurer may always contest the reasonableness or causal relationship of any medical bill or procedure or prosthetic device. RSA 281-A:23, I.

42. **Are vehicle and/or home modifications covered as medical expenses?**

To the extent that vehicle and/or home modifications are required by the nature of the injury and the physical limitations thereby placed on the employee, such modifications are compensable. However, as with all medical and remedial bills, the insurer has the statutory right to first contest the causal relationship or reasonableness of the bill.
43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

No. Carriers must pay the reasonable value of such services. RSA 281-A:23, I(a). A carrier may request a hearing to challenge medical fees which are excessive and the burden of establishing that the bills are reasonable is on the medical provider. RSA 281-A:24, I(b). RSA 281-A:23. Fees for managed care providers are generally negotiated in advance.

44. **What, if any, provisions or requirements are there for “managed care”?**

Employers who are self-insured or insured on the voluntary market may provide medical treatment required under the statute through a managed care program which has been approved by the Commissioner. RSA 281-A:23-a, I. Each employer who is in the assigned risk pool is required to be a participant in a managed care program. To gain approval of the Commissioner, the care network must be “sufficiently comprehensive with respect to both geography and medical specialties, including reasonable access to treatment for injuries or personal injuries”. RSA 281-A:23-a, I(a). The Plan must “provide for treatment and aids outside of the network” if the necessary treatment cannot be provided within the network or in the event of an emergency. RSA 281-A:23-a, I(b). The Plan must provide for both inpatient and outpatient care and reasonable access to second opinions. RSA 281-A:23-a, I(e)(f). The network must employ a “sufficient number of injury management facilitators ... to manage the injured employee’s medical, hospital and remedial care, vocational rehabilitation, modified duty and return to work plans.” RSA 281-A:23-a, V. If an employee is dissatisfied with a network’s findings regarding “compensability, degree of disability or degree of impairment arising from an injury...”, he or she may request an independent examination of his or her own choice and the Commissioner “shall grant one such authorization as a matter of course”. RSA 281-A:38-a.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

As long as an employer/insurer has not accepted a claim, it can issue a Memo of Denial within twenty one days of its receipt of a First Report of Injury or a Notice of an injury and refuse to pay benefits unless otherwise ordered by the Department after a hearing. Lab. Rule 506.02(a). If a claim is denied, the employee must request a hearing on causal relation or compensability. Once a claim has been accepted or ordered to be paid by the Department, the employer/insurer can request administrative modification of benefits based on a change in circumstances, i.e., a new injury or medical documentation indicating no further disability, or it can request a hearing before the Labor Department on these same issues. RSA 281-A:48. In re: Woodmansee, 150 NH 63 (2003). The employer/insurer can also request a hearing on causal relationship at any point in the life of a claim if that issue has not previously been adjudicated. RSA 281-A:41. Any issue arising under the statute may be addressed by either party requesting a hearing at the
46. **What is the method of claim adjudication?**

### A. Administrative level.

The DOL may issue decisions on certain issues administratively. If a party disagrees with an administrative decision, the procedure is to file an appeal to the Compensation Appeal Board (“CAB”). The DOL rarely issues orders administratively terminating or reducing indemnity benefits; most often, a request to reduce or terminate weekly benefits is decided through a first level hearing.

### B. Trial court.

If an administrative order is not issued, a first level hearing will be held before a DOL hearing officer. Parties must be given notice of a hearing at least 14 days in advance. RSA 281-A:43, I(a). The hearing is supposed to be scheduled within 6 weeks of the initial request. Either party may request the addition of issues with 14 days’ notice prior to hearing. Hearing decisions are to be issued within 30 days of the hearing. Id. A hearing officer’s decision becomes final 30 days after issuance unless appealed to the CAB.

### C. Appellate.

Any party to a DOL Hearing Officer’s decision has the right to a *de novo* appeal to a three member Compensation Appeal Panel of any issue raised before the hearing officer. Each appeal board panel consists of a member who represents labor, a member who represents employers or workers’ compensation insurers and an attorney who serves as a neutral member. RSA 281-A:42 The appeal must be filed within 30 days of the date of the oral or written decision of the hearing officer, whichever is earlier. Although an appeal is *de novo*, the scope of appeal is limited to those issues which were raised at the time of the initial hearing and which were actually appealed to the CAB. Appeal of Staniels, 142 NH 794, 797 (1998). A change in condition which occurs subsequent to the initial hearing may provide the basis for a new hearing at the initial level but is not the basis for a *de novo* appeal hearing. Appeal of Hiscoe, 147 NH 223 (2001).

Decisions of the Appeal Board are appealable only to the state Supreme Court pursuant to RSA 281-A:43 and RSA 541. Effective 01/01/2011, issues of fact are appealable to the Supreme Court. Prior to requesting an appeal to the Supreme Court, the appellant must first file a Request for Rehearing with the CAB within 30 days of the CAB decision. The Request for Rehearing must set forth in detail all alleged errors made by the CAB. The CAB has 30 days to issue a decision on the Request. The appellant then has 30 days to file a Rule 10 Notice of Appeal to the Supreme Court. RSA 541 and RSA 281-A:43, I(b)-(e). A CAB decision becomes final 30 days after its issuance in the absence of an appeal.
47. **What are the requirements for stipulations or settlements?**

The Labor Department requires the use of its “Lump Sum Settlement” forms, and no settlement of a claim that has been accepted or adjudicated as compensable, is valid or enforceable until and unless approved by the Commissioner. RSA 281-A:37; Lab. Rule 511.01. The Commissioner has discretion to approve settlements “where the best interests of all concerned will be served . . .” and settlements will usually be approved only after twelve (12) months of continuous disability. RSA 281-A:37. A hearing is always required before final approval is granted. RSA 281-A:37,III. Attorney fees must also be approved and fee requests are ordinarily limited to 20% of the actual recovery, excluding medical benefits. Lab. Rule 511.02. Once a claimant has settled the case, she no longer has any ability to pay an attorney on a contingent fee basis in the event further litigation is required, i.e., to obtain payment of medical bills. The Commissioner has recently started to withhold approval of settlements unless the claimant’s attorney agrees to represent the claimant in the future if the need arises.

48. **Are full and final settlements with closed medicals available?**

No. Medical benefits in a compensable claim may not be closed regardless of a lump sum settlement. Causally related medical bills are open for the claimant’s life. RSA 281-A:37,II. An employer/insurer may deny bills as not causally related or not reasonable or necessary to treat the work injury. The employee may then request a hearing on such Denials.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

All settlements where compensability is admitted or has been ordered, must be approved by the Labor Department. RSA 281-A:37,III.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

“Employers,” as defined in RSA 281-A:2, must obtain workers’ compensation insurance. Numerous private insurers provide coverage and there is an assigned risk pool. The New Hampshire Guaranty Fund provides coverage for claims against employers whose insurer has become insolvent. Employers may also be self insured if they meet the Department of Labor requirements. RSA 281-A:5-a.

51. **What are the provisions/requirements for self-insurance:**

A. **For individual entities.**

Self-insurance is permitted. The self-insured employer must maintain adequate loss
reserves, maintain excess coverage and make available their administration contracts for review by the Department. The self-insured employer must also obtain a surety bond running to the state in a penal sum equal to the amount of risk retention. RSA 281-A:5-a through d. Lab. Rule 405.03. See Lab. Rule 400 et seq generally.

B. For groups or “pools” of private entities.

Homogeneous groups may become self-insured as an association or group. They must file an application to the Department, specifying all members of the association. The association becomes responsible for payment of benefits and the insolvency or dissolution of a member does not relieve the association of its liabilities under the statute. Otherwise, the requirements are substantially identical to those for individual self-insureds. RSA 281-A:5.

52. Are “illegal aliens” entitled to benefits of workers’ compensation?

Although not specifically addressed in the statute, the Department of Labor has long taken the position that illegal aliens are “employees” and therefore covered under the employer’s policy.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Probably not. Injuries caused by acts of terrorism are not specifically addressed by the statute but recovery may be precluded as caused by a non-related neutral risk of the employment. Neutral risks are not clearly personal or employment related in nature. Appeal of Margeson, 162 N.H. 273 (2011). Whether an injury due to a neutral risk is compensable is a question of fact. The claimant would need to prove both legal and medical causation. Legal causation requires proof that the employment related stress or risk is greater than that which is encountered in normal non-employment life. The employee must show he faces an “increased quantity of a risk” to be compensable.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No specific statutes apply. Medicare’s future interests are usually provided for automatically in a settlement because medical benefits cannot be settled under New Hampshire’s workers’ compensation statute. RSA 281-A:37,II.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical
assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

The New Hampshire statute does not specifically provide a lien to Medicaid or other health insurers. The only statutory lien is that provided to the workers’ compensation carrier under RSA 281-A:13.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 42 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(1)]. Under New Hampshire law, “the act of the worker in applying for workers’ compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant information regarding the worker’s occupational injury or illness to the insurer, the worker’s employer, the worker’s representative, and the department.” RSA 281-A:23,V(a). Commencing 07/01/2010, a written request for records under this statute must contain the following:

This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient’s workers’ compensation claim, including any past history of complaints of, or treatment of, a condition similar to that presented in the claim.

The mandatory language must appear in bold print, in a font size two points larger than used in the request.

57. **What are the provisions for “Independent Contractors”?”**

A true independent contractor is responsible for his own worker’s compensation insurance. However, where the independent contractor fails to procure coverage for his employees, the general contractor becomes liable for coverage for the injured employees of the independent contractor. RSA 281-A:18.

Because there is a strong statutory presumption in favor of finding a worker to be an employee rather than an independent contractor, employers should carefully document all 12 of criteria necessary to rebut the presumption that a worker is an employee. RSA 281-A:2,VI (b)(1)(A)-(L).
As of 01/01/2011, a written agreement signed by the employer and the person providing services, on or about the date such person was engaged, which describes the services to be performed and affirms that such services are to be performed in accordance with each of the [12] criteria is prima facia evidence that the criteria have been met. RSA 281-A:2,VI(c). However, if the DOL finds that an employer misrepresented the employment relationship, the Commissioner can assess fines of up to $2,500 plus $100 per day, per employee. RSA 281-A:2,VI(d).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

No.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No.

60. What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefits costs and losses?”

The “Best Practices” would include:

- Obtain as comprehensive a set of medical records as possible, including prior medicals. Determine whether these are prior injuries and whether prior carriers may be responsible for payment of benefits.

- Obtain a recorded statement from the claimant before memories fade.

- Review employer’s personnel and other files on claimant to determine if Second Injury Fund is applicable.

- Identify and speak with witnesses early on in process.

- Identify whether there is potential for subrogation early on in case. Much of evidence gathered during investigation of the compensation claim may be very helpful to recovery against third party.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

None. Causally related medical bills cannot be closed out through settlement.
Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state workers’ compensation law?

New Hampshire does permit the therapeutic use of cannabis. RSA 126-X. A “qualifying patient” shall not be subject to arrest or prosecution for the therapeutic use of cannabis if she possesses no more than two ounces of usable cannabis or any amount of unusable cannabis. RSA 126-X:2-I. “A qualifying patient may use the cannabis on privately-owned real property only with the written permission of the property owner . . . .” RSA 126-X:3. Nothing in the medical marijuana chapter exempts any person from arrest or prosecution for “being under the influence of cannabis while . . . in his or her place of employment, without the written permission of the employer or [while] operating heavy machinery or handling a dangerous instrumentality.” RSA 126-X:3,II. The workers’ compensation statute provides no exception to allow use of marijuana while working or to require payment for therapeutic use of marijuana prescribed for a work injury.

In Appeal of Panaggio, 172 N.H. 13 (2019) the Court held medical marijuana could be found to be “reasonable, medically necessary and causally related to the work injury” but remanded the case for a determination of whether federal criminal law prohibits carriers from paying for medical marijuana. Id.

Does your state permit the recreational risk of marijuana and what other restrictions for use and work activity in your state workers’ compensation law.

Recreational use of marijuana is not legal per se, however, it has been decriminalized at certain levels. A person knowingly possessing three-quarter of an ounce or less who is over 21 years of age shall be guilty of a violation (RSA 318-B:2-c,II) and subject to a fine of $100 for a first or second offense, or up to $300 for a subsequent offense within any three year period. RSA 318-B:2-c,V. If a person is 18 to 21 years of age, he shall be guilty of a misdemeanor. RSA 318-B:2-c,IV. The N.H. workers’ compensation statute makes no provision for use of marijuana at work.
1. Citation for the state's workers' compensation statute.

New Jersey Statutes Annotated 34:15-1 et seq.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Every employee within the course of employment, with some minor limitations such as maritime accidents, to and from work, independent contractors, householders, and an employee who is willfully negligent, are covered. N.J.S.A. 34:15-36.

All workers in New Jersey are covered by the compensation Act titled N.J.S.A. 34:15-7, et seq. unless they specifically opt out of the act’s coverage provisions.

The following are NOT covered:

  
  Note: the definition of “employee” is a broad definition and is liberally construed so as to bring as many persons as possible within the coverage of the Act.


- Casual employees are excluded from receiving benefits under N.J.S.A. 34:15-36. Such employment arises by chance or is purely accidental; or if not in connection with any business of the employer, as employment not regular, periodic or recurring. N.J.S.A. 34:15-36.

3. Identify and describe any "statutory employer" provision.
There is no such provision. General contractors are not parties to the employment contract between a subcontractor and its employees. They are not required to provide workers' compensation insurance and do not enjoy the immediate employer's immunity from tort liability. Eger v. E.I. DuPont DeNemours Co., 539 A.2d 1213 (N.J. 1988). However, a general contractor, in the event that the subcontractor is uninsured, is liable for any compensation due to an employee or the dependents of a deceased employee of a subcontractor. The general contractor shall then have a right of action against the subcontractor for reimbursement. N.J.S.A. 34:15-79.

4. **What types of injuries are covered and what is the standard of proof for each:**

   **A. Traumatic or "single occurrence" claims.**

   Traumatic injury claims are governed by N.J.S.A. 34:15-7. Such claims involve one-time trauma, physical or psychiatric in nature. In Brunell, the court defined accident as an “unexpected event or mishap resulting in injury.” Brunell v. Wildwood Crest Police Department, 176 N.J. 225, 236-237, 248 (2003).

   Compensation is provided for injuries arising out of and in the course of employment, without regard to negligence. The burden of proof is on the employee to prove the case by a preponderance of the evidence. N.J.S.A. 34:15-7. Cardiovascular or cerebral vascular injuries are compensable if, by a preponderance of credible evidence, the injury is produced by the work effort or strain involving a substantial condition in excess of the wear and tear of the Petitioner's daily living and in a reasonable medical probability caused in a material degree the cardiovascular or cerebral injury. Material degree means an appreciable degree or a degree substantially greater than de minimus. N.J.S.A. 34:15-7.2.

   **B. Occupational disease (including respiratory and repetitive use).**

   All diseases arising out of and in the course of the employment which are due in a material degree to causes and conditions which are or were characteristic of or peculiar to a particular trade, occupation, process or place of employment are compensable. N.J.S.A. 34:15-31(a).

   Under N.J.S.A. 34:15-31, occupational disease claims involve injuries caused by repetitive activity or exposures over a period of days, months, or even years. Examples of occupational illnesses/diseases include Anthrax, Asbestos or Lead poisoning, Mercury poisoning, Arsenic poisoning, Phosphorous poisoning, Poisoning from benzene and its homologues, and all derivatives thereof, Wood alcohol poisoning, Chrome poisoning, Caisson disease, Mesothorium or radium poisoning, Carpal tunnel syndrome when not caused by trauma, cancer claims, stress claims when not based on physical trauma or one time incidents.

5. **What, if any, injuries or claims are excluded?**
In occupational disease cases, the following claims will not be compensable: Deterioration of a tissue, organ or part of the body in which the function of such tissue, organ or part of the body is diminished due to the natural aging process thereof is not compensable. N.J.S.A. 34:15-31(b).

**Idiopathic Injuries**: Injuries caused by a purely personal condition having no work connection whatsoever. I.e: Heart attack or epileptic seizure unrelated to work. However, even if a fall is determined to be idiopathic and thus not work related, any injury resulting from the fall is compensable.

**Subsequent Injuries** unless its directly connected in a chain of physical causation with the compensable injury. (example of a compensable subsequent injury: Petitioner fell while walking on crutches on his way to receive treatment for a work related injury).

6. **What psychiatric claims or treatments are compensable?**

Psychiatric claims can be compensable provided there is demonstrable objective medical evidence that such injuries are connected with the employment. Such evidence must consist of an independent professional analysis apart from the base statement of the employee. See Saunderlin v. E.I. DuPont Co., 508 A.2d. 1095 (N.J. 1986). The New Jersey Supreme Court further defined an "objective material degree" by stating that objectively stressful working conditions must be "peculiar" to the individual's workplace. Goyden v. State, 256 N.J. Super. 438, 607 A.2d 651, aff'd 128 N.J. 54 (1992).


However, when an employee’s worrying is not based on the events, which actually took place involving the employee but only what might have happened to the employee, the case will not be compensable. Stroka v. United Airlines, 835 A.2d 1247 (N.J. Super. Ct. App. Div. 2003). Mrs. Stroka was a flight attendant, scheduled for work on September 11, 2001, but requested a day off. She filed a worker’s compensation claim because she developed a post-traumatic stress syndrome as a result of 9/11 events. Appellate Division reversed the prior award and held that condition was not work related.

7. **What are the applicable statutes of limitations?**

A **traumatic injury claim** must be filed within two years after the date of the accident, within two years of the failure of the employee to receive payment in accordance with an agreement between the employer and employee or within two years after the last payment of compensation is received. N.J.S.A. 34:15-51.
Cases have differentiated between payments of indemnity benefits and medical benefits.

When the last compensation event is a medical treatment, at least one case states that it is two years from the date of treatment, not the date the carrier or employer pays the doctor or hospital bill. Oldfield v. N.J. Realty Co., 61 A.2d 767 (N.J. 1948).

Claims for occupational diseases must be filed within two years after the date the employee first knew the nature of the disability and its relation to the employment, regardless of when the last date of exposure occurred. N.J.S.A. 34:15-34.

In Panzino, Petitioner last work for Respondent in 1966. During his employment, Petitioner was exposed to loud noise and developed a 54% hearing loss. He did not discover that this hearing loss was due to work until 1972, when he filed the claim. The New Jersey Supreme Court held that the claim was not barred because it was filed within 2 years of the date when the hearing loss was discovered to be work related, even though it was not filed until six years after employment ended. Panzino v. Continental Can Co., 364 A.2d 1043 (N.J. 1976).

8. What are the reporting and notice requirements for those alleging an injury?

Unless the employer has actual knowledge of an injury, the employee must notify the employer of the injury within fourteen (14) days after the date of the accident. If the notice is given, or the knowledge obtained within thirty (30) days from the occurrence of the injury, no want, failure, or inaccuracy of a notice shall be a bar to obtaining compensation, unless the employer can show that he was prejudiced by such want, defect or inaccuracy, and then only to the extent of such prejudice. If notice is given within ninety (90) days after the accident, the employer can bar compensation by showing it was prejudiced by the lack of notice. No compensation is allowed if notice is not provided nor knowledge obtained by the employer within ninety (90) days of the date of the accident. N.J.S.A. 34:15-17.

Traumatic Cases: Petitioner must provide verbal or written notice within 90 days of the accident under N.J.S.A. 34:15-17. Actual notice of the accident is sufficient to defeat the notice defense, so that even if the worker has not given formal notice but the employer becomes aware of the accident within 90 days, that is considered sufficient notice.

Occupational Cases: On January 14, 2004, the occupational notice defense was eliminated and the provisions of N.J.S.A. 34:15-33 were repealed. There is therefore no more occupational notice defense in New Jersey.

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

Intentional or self-inflicted injuries are not compensable. N.J.S.A. 34:15-7.
However, the Supreme Court found that “employee’s death by suicide is compensable where the original work-connected injuries result in the employee’s becoming dominated by a disturbance of mind directly cause by his injury and consequences, such as extreme pain and despair, of such variety as to override normal rational judgment.” Kahle v. Plochman, Inc., 428 A.2d 913 (N.J. 1981). In that case, worker suffered an injury, which led to back surgery and a dependency on potent medications. She never returned to work, developed a convulsive disorder from drug withdrawal, arachnoiditis, a neurogenic bladder, anemia, iron deficiency and cystitis and ultimately committed suicide.

B. Willful misconduct, "horseplay," etc.

Injuries incurred through an employee's willful negligent conduct are not compensable. N.J.S.A. '34:15-7. Injuries sustained by employees participating in horseplay are also not compensable. However, employees who do not participate in, but are innocent victims of, horseplay by fellow employees have compensable claims for any injuries sustained. N.J.S.A. 34:15-7.1; Trotter v. Monmouth County, 365 A.2d 1374 (N.J. Super. Ct. App. Div. 1976).

In an unreported case of Wasik v. Borough of Bergenfield, A-794-02T3 (App. Div. December 1, 2003), the Court considered a case in which the instigator himself was injured. Petitioner, who was also the instigator, touched his co-worker between his buttocks, prompting the co-worker to strike him with a hot scraper. The Court stated that “the horsing around by petitioner was neither extensive nor serious and was obviously commingled with the performance of the duty of garbage collection.” The Court found the injury to be compensable because it was caused by a minor deviation from work.

C. Injuries involving drugs and/or alcohol.

Injuries which are the natural and proximate result of intoxication or the unlawful use of controlled dangerous substances are not compensable. N.J.S.A. 34:15-7.


10. What, if any, penalties or remedies are available in claims involving fraud?

The New Jersey Legislature passed two significant bills in 1998 which are having an impact on workers’ compensation. First, an Act concerning workers’ compensation fraud under N.J.S.A. 34:15-57.4. Second, the Health Care Claims Fraud Act found at N.J.S.A. 2C:21-4.2. Employers can now appeal directly to workers’ compensation judge for relief
from actions and statements, which the employer believes, constitute fraud. Employer may seek an order from the judge (1) terminating all benefits and forfeiting the right to all future benefits, or (2) requiring the employee to repay all benefits paid on account of fraud plus simple interest or have the sum owed plus simple interest from future payments, or (3) proceed with a claim against the fraudulent employee for civil damages and counsel fees.

An employee must notify the Director of the Division of Workers' Compensation immediately, in writing, of any increase or decrease in his or her income which may affect his or her eligibility for benefits payable from the "uninsured employer's fund." Ten days after the employee and the Attorney General receive notice, the Director may modify or terminate an award payable from the fund as conditions may require. N.J.S.A. 34:120.12. If the Commissioner of Labor later determines that any payment made to an employee has been procured by fraud, mistake, or an unreported change in condition, the payment is recovered from the employee and deposited in the "uninsured employer's fund." N.J.S.A. 34:120.12.

11. **Is there any defense for falsification of employment records regarding medical history?**

No.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Yes, if they are a regular incident of the employment and produce a benefit to the employer that would be beyond "improvement in employee health and morale." N.J.S.A. 34:15-7.

The vast majority of injuries arising out of recreational or social activities should be denied, unless it is apparent that the activity involved has elements of compulsion by the employer (rendering it a regular incident of employment) and benefits the employer in some way other than health and morale (such as fundraising or education).

13. **Are injuries by co-employees compensable?**

Yes.

14. **Are acts by third parties unrelated to work, but committed on the premises compensable (e.g. "irate paramour" claims)?**

Maybe. See Marky v. Dee Rose Furniture Co., 574 A.2d 546 (N.J. Super. Ct. App. Div. 1990) cert. denied, 585 A.2d 368 (N.J. 1990). (Court held that female employee who was shot by former boyfriend at the place of her employment was not permitted to receive workers' compensation benefits as the court held that the incident did not arise
out of her employment even though the assailant believed there was a romantic relationship between the employee and a co-worker.)

However, if the third party action is unrelated to the employee, it may be considered a 'neutral risk' and therefore compensable. Coleman v. Cycle Transformer Corp., 520 A.2d 1341 (N.J. 1986). See also Gargiulo v. Gargiulo, 97 A.2d 593 (N.J. 1953). In Gargiulo, an employee, while at work in the back yard of his employer's store, was injured when struck by an arrow that a neighborhood boy had shot in the general direction of a tree on the employer's property. The employee received compensation because "but for" the employment, he would not have been in the line of fire and therefore would not have been hit.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The weekly wage is calculated by multiplying the hourly rate by the customary number of hours constituting an ordinary day in the character of the work involved, then multiplying that daily wage by the customary number of working days constituting an ordinary week in the character of the work involved. Board and loading furnished by the employer as part of wages is valued at $25.00 per week, unless otherwise fixed at the time of hiring, and is considered in computing the weekly wage. N.J.S.A. 34:15-37.

16. **How is the wage for temporary/lost time benefits calculated, including minimum and maximum rates?**

Employees receive 70% of their average weekly wage at the time of injury, subject to maximum compensation of 75% of the state average weekly wage and a minimum of 20% of the state average weekly wage. Compensation must not exceed 400 weeks. N.J.S.A. 35:15-12.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Although the statute provides no distinct time period, the unreasonable or negligent delay or refusal to pay temporary disability compensation subjects the employer/insurer to a penalty. In addition, there is a rebuttable presumption that a delay of 30 days or more is negligent or unreasonable conduct. N.J.S.A. 34:15-28.1.

Fact that there may have been question of medical causation in and of itself was not sufficient to overcome statutory presumption of unreasonable delay in payment of temporary disability benefits for purposes of this section authorizing imposition of penalty when payment is unreasonably delayed. Amorosa v. Jersey City Welding & Mach. Works, 518 A.2d 529 (N.J. Super. Ct. App. Div. 1986).

On the other hand, voluntarily taking oneself out of the workplace for personal reasons
negates the receipt of temporary disability benefits. Electronic Associates, Inc. v. Heisinger, 266 A.2d 601 (N.J. Super. Ct. App.Div. 1970). See also Cunningham v. Atlantic States Cast Iron Pipe Co., 901 A.2d 956 (N.J. Super. Ct. App. Div. 2006). In Cunningham, the Court held that although Petitioner was terminated, as opposed to voluntarily leaving his employment, he is entitled to receive temporary disability benefits if he can show actual wage loss, meaning that he was available and willing to work, and would have been working if not for the disability.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out 8 days before recovering benefits for the first 7 days)?**

Employees do not receive temporary total benefits until their disability extends beyond 7 days, at which time the disability benefits are paid retroactive. N.J.S.A. 34:15-14.

The “seven day waiting period” need not immediately follow the accident. Frasier v. L. Bamberger & Co., 160 A. 630 (N.J. 1932), affirmed 166 A. 101 (1933). The seven days also do not need to be consecutive. The injured employee may recover compensation for intermittent periods of recurrent intervals of temporary disability. Colbert v. Consolidated Laundry, 107 A.2d 521 (N.J. Super. Ct. App. Div. 1954). The day that petitioner is unable to continue to work by reason of the accident, whether it be the day of the accident or later, shall count as one whole day of the “waiting period”.

If qualified, the employee is entitled to benefits at a rate of 70% of his average gross weekly wages (SAWW), not to exceed the maximum rate of 75% of SAWW or fall below the minimum rate of 20% of SAWW.

19. **What is the standard/procedure for terminating temporary benefits?**

The temporary total disability (TTD) benefits continue until the employee goes back to work or has reached maximum medical improvement (MMI), a state in which additional treatment will no longer improve his medical condition.

In other words, benefits may be terminated based upon a report from a doctor indicating that the employee is able to return to work. The employee must be notified in writing of the termination. Owens v. Bennett Air Service, 133 N.J.L. 540, 45 A.2d 320 (1946), judgment aff’d, 135 N.J.L. 467, 51 A.2d 111 (1947).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No.

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement is compensable when it is of such a nature and extent that it may reasonably be presumed to impair or interfere with the future earning capacity or

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>75</td>
</tr>
<tr>
<td>Index finger</td>
<td>50</td>
</tr>
<tr>
<td>Middle finger</td>
<td>40</td>
</tr>
<tr>
<td>Ring finger</td>
<td>30</td>
</tr>
<tr>
<td>Little finger</td>
<td>20</td>
</tr>
<tr>
<td>Great toe</td>
<td>40</td>
</tr>
<tr>
<td>Other toes</td>
<td>15</td>
</tr>
<tr>
<td>Hand, or thumb and first and second fingers (on one hand)</td>
<td>245</td>
</tr>
<tr>
<td>or four fingers (on one hand)</td>
<td></td>
</tr>
<tr>
<td>Arm</td>
<td>330</td>
</tr>
<tr>
<td>Foot</td>
<td>230</td>
</tr>
<tr>
<td>Leg</td>
<td>315</td>
</tr>
<tr>
<td>Loss of vision (one eye)</td>
<td>200</td>
</tr>
<tr>
<td>Loss of hearing: One ear</td>
<td>60</td>
</tr>
<tr>
<td>Both ears</td>
<td>200</td>
</tr>
<tr>
<td>Tooth</td>
<td>4 weeks for each tooth lost</td>
</tr>
</tbody>
</table>

N.J.S.A. 34:15-12.

Compensation benefits for permanent partial disability are paid pursuant to a formula and chart contained within the statute. N.J.S.A. 34:15-12. This statutory provision is too complicated and extensive to completely summarize here. For details concerning the calculation of permanent partial disability benefits, please consult the statute or counsel.

B. Number of weeks for "whole person and standard for recovery."

In all lesser or other cases involving permanent loss, or where the usefulness of a member of any physical function is permanently impaired, compensation benefits bear such relation to the periods allowed for scheduled members as the disabilities bear to those produced by the injuries listed in the schedule. Where disability is determined as a percentage of total and permanent disability, compensation is made to a corresponding portion of 600 weeks. N.J.S.A. 34:15-12(c) (22).
23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

None. However, if one is found to be permanently and totally disabled, after the initial 450 weeks of disability, the petitioner may be required to submit to a vocational rehabilitation evaluation.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Compensation is paid at 70% of the average weekly wage, not to exceed 75% nor be less than 20% of the state average weekly wage. Compensation ceases after 450 weeks unless the employee submits to physical or educational rehabilitation as may have been ordered and can show that it is impossible to earn wages equal to his or her pre-injury wage, in which case compensation continues in an amount equal to the difference between the pre-injury and post-injury wages. N.J.S.A. 34:15-12(b).

25. **How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

If death results from the work accident or occupational disease, whether there be dependents or not, burial and funeral expenses are allowable up to $3,500.00. N.J.S.A. 34:15-13(h).

**B. Dependency claims.**

Dependents generally include all relatives who are dependent upon the employee at the time of the accident or at the time of death. N.J.S.A. 34:15-13(f).

N.J. no longer uses a graduated death benefit calculation. It is now a flat 70% of the deceased workers' wages, regardless of the number of dependents. N.J.S.A. 34:15-13.

Insofar as medical and hospital bills are concerned, they are paid as any claim would be paid, provided they relate to the condition produced by the compensable accident that occasioned death.

**Partial vs. Total Dependent:**

A total dependent is the one who receives from another all the ordinary necessities of life. In contrast, partial defendant receives only some or a portion of these necessities including food, clothes and shelter. Gladstone v. Trenton Lehigh Coal Co., 3 N.J. Misc. 27 (Dept. Labor 1924).
Total dependency is conclusively presumed in the case of a surviving spouse and natural children under 18 years of age, who are actually a part of decedent’s household at the time of death.

In the case of partial dependents, the compensation shall be “such proportion of the schedule percentage as the amounts actually contributed to them by the deceased for their support constituted of his total wages…” N.J.S.A. 34:15-13.

The formula for calculating compensation of a partial dependent is: contribution divided by wages times the scheduled percentage. Ricciardi v. Damar Products Co., 45 N.J. 54 (1965), overruled on other grounds.

26. What is the criteria for establishing a "second injury" fund recovery?

Petitioner is entitled to benefits from the Second Injury Fund (“SIF”) when the worker becomes totally and permanently disabled as a result of a last compensable accident, in combination with pre-existing disabilities, regardless of whether the prior disabilities are work related. With regards to medical bills, the SIF does not assume responsibility for any medical treatment. Instead, the employer remains responsible for reasonable and necessary medical treatment only for the injuries associated with the compensable last accident, for the life of the worker. N.J.S.A. 34:15-95.


27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

Claims may be re-opened for a worsening of condition within two years of the date the employee last received payment of compensation. An award, determination and rule for judgment or order approving settlement may be reviewed by the parties at any time on the ground that the disability has diminished or subsequently increased. N.J.S.A. 34:15-27.

One question that comes up often is the effect of ongoing medical monitoring on the statute of limitations. In Milos v. Exxon Co. U.S.A., 656 A.2d 1300 (N.J. Super. Ct. App. Div. 1995), aff’d, 671 A.2d 120 (N.J. 1996), the court held that a reopener that was filed more than two years after the entry of the original award was not barred by N.J.S.A. 34:15-27 since there was ongoing medical monitoring. If the insured has been ordered to provide annual chest x-rays or the like, that will likely toll or stop the statute from running. Every time the monitoring occurs, petitioner has another two years to file the reopener. It should be noted that IME exams are not considered medical treatment if the

28. **What situation would place responsibility on the employer to pay an employee's attorney fees?**

Generally, any medical bills or temporary disability benefits paid as a result of an Order of the Court results in a fee of up to 20% to be paid by the respondent. Any permanency award will result in a fee of up to 20%, for which the allocation is within the discretion of the Court, but is generally ordered 60% paid by respondent and 40% paid out of petitioner's award. Witness fees are generally split 50-50 between the parties. N.J.S.A. 34:15-64.

Recently signed into law, S1913/A2966 allows a Judge of Compensation the discretion to impose costs, simple interest on money due under an order, add an additional assessment of up to 25% for "unreasonable payment delay", and assess reasonable attorney's fees to enforce an order. The Court may also assess an additional fee not to exceed $5,000 to be paid into the Second Injury Fund for unreasonable delay.

EXCLUSIVITY/TORT IMMUNITY

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**

Unless otherwise agreed, employers are immune from common law tort actions by their employees when compensation benefits are provided. N.J.S.A. 34:15-8.

B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**


30. **Are there any penalties against the employer for unsafe working conditions?**

No.

31. **What is the penalty, if any, for an injured minor?**

Employers are responsible for double the amount of compensation payable under the schedules when an injury to an illegally employed minor occurs. Please note that while the initial compensation is payable by the insurance carrier, the double amount must be
paid directly by the employer. Legally employed minors receive normal compensation benefits. N.J.S.A. 34:15-10.

32. **What is the potential exposure for "bad faith" claims handling?**

There is no special statutory provision or case law for such potential exposure. However, recently signed into law, S1913/A2966 allows a Judge of Compensation the discretion to impose costs, simple interest on money due under an order, add an additional assessment of up to 25% for "unreasonable payment delay", and assess reasonable attorney's fees to enforce an order. The Court may also assess an additional fee not to exceed $5,000 to be paid into the Second Injury Fund for unreasonable delay.

33. **What is the exposure for terminating an employee who has been injured?**

It is unlawful to discharge or discriminate against any employee for claiming compensation benefits. N.J.S.A. 34:15-39.1. Penalties include fines of not less than $100 nor more than $1,000 and/or imprisonment for not more than 60 days.

*If the termination is not in retaliation of the claim, but because of the disabling condition, there may be a claim as per the Americans with Disabilities Act.*

If an employer discontinues employee’s health benefit coverage while they are unable to work as a result of a job related injury, there may be some protection under the Federal Family Medical Leave Act.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. N.J.S.A. 34:15-40.

35. **Can co-employees be sued for work-related injuries?**

No, unless the injury is a result of the co-employee's intent to harm. Intentional harm gets the worker around the section 8 immunity against co-workers, not just employers.

36. **Is subrogation available?**

Yes, the employer/insurer has a lien on the proceeds of a third party settlement or judgment. N.J.S.A. 34:15-40.
37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

No.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

If an employer requests an employee to submit to a physical examination or x-ray, the employee must submit to that examination. The examination or x-ray must occur at some reasonable time and place in New Jersey as often as reasonably requested. If an employee refuses to submit to the examination, the employee loses the right to compensation during the period of time of the refusal. In the event that medical records are not provided, the Rules allow respondent to file a motion to dismiss for lack of prosecution. N.J.A.C. 12:235-3.6(i).

The Director of the Division of Workers' Compensation, each Deputy Director and each referee possess the same power as the Superior Court to issue subpoenas to compel the production of books and papers. N.J.S.A. 34:15-60. Moreover, the employer/insurer must, when directed, file with the Workers' Compensation Bureau, copies of any medical reports or certificates that they possess. N.J.S.A. 34:15-100.

39. **What is the rule on choice (a) Petitioner’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Evaluation?**

**A. Petitioner’s choice of physician.**

The employer controls the petitioner’s choice of a physician and is responsible for payment for authorized treatment only.

All fees and charges for physician’s and surgeon’s treatment shall be reasonable and based on the usual fees and charges which prevail in the same community for similar medical services. N.J.S.A. 34:15-15.

**B. Employer’s right to a second opinion and/or Independent Medical Evaluation.**

The employer must authorize all medical treatment that is reasonable and necessary to cure and relieve the condition. When the Petitioner has reached maximum medical improvement, the respondent may schedule a permanency evaluation.

N.J.S.A. 31:15-19 provides that an employee must submit to a physical examination and X-rays within the state of New Jersey at a reasonable time and place, and as often as may be reasonably requested, by a physician authorized to practice medicine in this state.
40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Employers must furnish such medical, surgical and other treatment and hospital services as are necessary to cure and relieve the employee of the effects of the injury, provided the employee files with the Division of Workers' Compensation a petition stating the need for medical services or appliances which exceed $50.00. The employer is given an opportunity to be heard and the Division makes a determination as to the necessity and reasonableness of such treatment or equipment. **N.J.S.A. 34:15-15.**

41. **Which prosthetic devices are covered, and for how long?**

They are covered, without time limitation. If such devices are damaged, the employer/insurer must replace them. **N.J.S.A. 34:15-12.7.**

As the techniques grow in medical acceptance, they may become treatments that respondents will be required to furnish.

42. **Are vehicle and/or home modifications covered as medical expenses?**


43. **Is there a medical fee guide, or schedule, or other provisions for cost containment?**

No. However, all medical fees must be reasonable and based upon the usual fees and charges which prevail in the same community for similar medical services. **N.J.S.A. 34:15-15.**

44. **What, if any, provisions or requirements are there for "managed care"?**

None.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Within thirty days after service of the petition for benefits, the employer must file an answer to the petition admitting or denying the substantial averments of the petition and stating the employer's contentions concerning the petition. **N.J.S.A. 34:15-52.**

46. **What is the method of claim adjudication?**

A. **Administrative level.**
The Division of Workers' Compensation has exclusive original jurisdiction over all workers' compensation claims. N.J.S.A. 34:15-49. Within twenty days of the filing of an answer, or after expiration of the time period to file an answer, the secretary of the Division schedules a hearing not less than four weeks or more than six weeks after the filing of the petition. N.J.S.A. 34:15-53. Such hearings are informal and the rules of evidence are loosely applied. N.J.S.A. 34:15-56.

B. Trial court.


C. Appellate.

An Appellate Decision can be appealed to the NJ Supreme Court like any other civil decision. N.J.S.A. 34:15-66.

47. What are the requirements for stipulations or settlements?

Parties may agree upon the compensation due and file such agreement with the Division of Workers' Compensation. The agreement is not binding until approved by the Division. N.J.S.A. 34:15-22. When there are disputes regarding the compensability of a claim, full and final settlements may be obtained subject to Division approval on the basis that the settlement is fair and just under all the circumstances. N.J.S.A. 34:15-20.

48. Are full and final settlements with closed medical available?

Yes. See answer number 47.

Section 20 settlements resolve cases by way of on Order Approving Settlement with Dismissal pursuant to N.J.S.A. 34:15-20. This settlement is appropriate when there is a
dispute as to jurisdiction, liability, causal relationship, or dependency. In exchange for dismissal, respondent pays the petitioner lump sum. In turn, petitioner gives up the rights he would otherwise be entitled to if he went to trial. These rights also include the ability to reopen a case should the work-related injury worsen in the future. Petitioner will not be entitled to additional medical treatment, temporary disability benefits or an increase in permanent disability payments.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. The stipulations and/or settlements are subject to the Judge finding them to be fair and just. See answer number 47.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

The employer has three insurance options: private insurer, assigned risk pool, or self-insurance. An employer must be insured to provide complete payment of any obligation, which may be incurred, to an employee or dependents arising out of a compensable injury. N.J.S.A. 34:15-71.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Employers may self-insure by filing an application with the Commissioner of Insurance, demonstrating a satisfactory financial ability to pay compensation. The commissioner, if satisfied of the applicant's financial ability and the permanence of his business, shall by written order exempt the applicant from insuring the whole or any part of his compensation liability. N.J.S.A. 34:15-77.

B. For groups or "pools" of private entities.

Group self-insurance is permitted for hospitals only, and requires that the group be composed of ten or more hospitals. N.J.S.A. 34:15-77.1.

52. Are “illegal aliens” entitled to benefits or workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

New Jersey DOES permit the recovery of benefits for an illegal alien.

In Fernandez-Lopez, the Court made clear that illegal alien status does not negate the protections of the New Jersey Workers’ Compensation Act. Fernandez-Lopez v. Jose
53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act (MSPA)?**

New Jersey does not have any statutory requirements to satisfy in light of the MSPA laws. However, since the Judges must approve all settlements, the court will seek to ensure that the parties have taken Medicare's interests into account and have satisfied the MSPA.

In order for the parties to take Medicare’s interest into account, the parties must request set aside information and inquire as to whether any conditional payments were made. Set-asides involve future payments while conditional payments involve prior payments made by Medicare. While there is no need for a Medicare set-aside if the settlement is not greater than $25,000.00, Medicare must still advise whether any conditional payments were made, regardless of the settlement amount.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. 1396k(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**
HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

Section 164.514 of the Act provides: “A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law, that provide benefits for work-related injuries or illness without regard to fault”. Further, Section 164.512 states: “A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.”

File handling procedures that are a necessary part of the workers’ compensation process are not subject to HIPAA. However, many medical practitioners believe that it covers release of medical information even to carriers or third party administrators, which are paying for authorized treatment. Thus, HIPAA-compliant medical releases have become a standard part of the worker’s compensation practice.

57. **What are the provisions for “Independent Contractors”**?

In determining whether someone is an employee or independent contractor, the Court must first review the language of N.J.S.A. 34:15-36 which provides in pertinent part that: “‘Employer’ is declared to be synonymous with master, and includes natural persons, partnerships and corporations; ‘employee’ is synonymous with servant, and includes all natural persons, excluding officers of corporations, who perform service for an employer for financial consideration, exclusive of... casual employments, which shall be defined, if in connection with the employer’s business, as employment the occasion for which arises by chance or is purely accidental, or if not in connection with any business of the employer, as employment no regular, periodic or recurring;”

It is well-settled and understood that “independent contractors” are excluded from the aforesaid definition of “employee” and therefore from coverage under the Worker’s Compensation Act. It has also long been accepted that, an independent contractor is one who, carrying on an independent business, contracts to do a piece of work according to his/her own methods, and without being subject to the control of his employer as to the means by which the result is to be accomplished, but only as to the result of the work.

To help determine if an individual is an “employee” within the meaning of N.J.S.A. 34:15-36 or an independent contractor, the courts developed two tests: (1) the “control test” and (2) the “relative nature of the work test.” These two tests are basically designed to draw a distinction between those occupations which are properly characterized as separate enterprises and those which are in fact and integral part of the employer’s regular business.
In addressing the “control test,” four factors are reviewed: 1) the degree of control the employer has the right to exercise; 2) the method of payment; 3) who furnished equipment; and 4) the right of termination. New Jersey Property-Liability Guar. Ass’n v. State, 195 N.J. Super. 4, 14 (App.Div.), certify. denied, 99 N.J. 188 (1984).


58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

Where a worker may be supplied through a temporary or professional agency, or may be lent from one company to another, the courts have developed tests to determine if the worker may be considered a "special employee" of the company to which he is lent.

There are 5 listed criteria to be considered, although case law indicates that these are not exclusive - the court may consider other relevant information. The tests include:
1) Whether the is a contract of hire, express or implied, with the "special" employer;
2) Whether the work being done is that of the special employer;
3) Whether the special employer has the right to control the details of the work;
4) Whether the special employer pays wages, either to the employee or back to the leasing agency; and
5) Whether the special employer has the power to hire and fire the employee.


59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Similar to the tests generally given to determine independent contractor status, New Jersey applies the control test and relative nature of the work test. More specific to this industry, the courts will look to the agreement between the owner/operator and the alleged employer. The more control (or right to control) that the employer has, the more likely employment will be found. Leasing the truck to the employer or using an employer-owned truck; agreements to haul exclusively for one company, producing economic dependence; or adding loading and unloading the good of the employer, are all factors that would create a greater likelihood of employment. The control test and relative nature of the work test will be applied independent of any contractual terms that call the worker an ‘independent contractor’, and those tests will determine employment in the workers’ compensation context.


60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Gary H. Hunter, Esquire  
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61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

See answer number 53.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

New Jersey has a medical marijuana program. N.J.S.A. 24:6I-1, et seq. The statute allows medical marijuana to be prescribed for a list of specified conditions. The statute specifically exempts insurers from paying for medical marijuana as well as employers from having to make accommodations for the use of medical marijuana in the workplace. N.J.S.A. 24:6I-14.

However, there have been WCJ’s who have granted motions for medical benefits for medical marijuana. Geany, John, *New Jersey Judge of Compensation Orders Employer to Pay Costs of Medical Marijuana Program and Costs of Filling Prescriptions*, New Jersey Workers’ Comp Blog, [https://njworkerscompblog.com/](https://njworkerscompblog.com/) (December 29, 2016). To date, no reported decision has upheld such an order.

However, the Appellate Division of the Superior Court of New Jersey, in a case of first impression, affirmed an order of a state workers’ compensation judge that required an employer to reimburse its employee for the employee’s use of medical marijuana prescribed for chronic pain following a work related accident. Hager v. M&K Construction, 2020 N.J. Super. LEXIS 4, A-0102-18T3 (appr’d for publication, Jan. 13, 2020).

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

New Jersey does not allow recreational marijuana.
1. Citation for the state’s workers’ compensation statute.


SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

All employees are covered, except those who file a written waiver with the State of New Mexico. Domestic helpers and real estate agents are also exempted.

3. Identify and describe any “statutory employer” provision.

There is no statutory employer provision in the Statute. However, a statutory employer would be entitled to the exclusive remedy provisions of the Act. Enriquez v. Cochran, 1998-NMCA-157.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

Traumatic/single occurrence claims and repetitive trauma claims are covered, as long as the trauma occurred within the course and scope of the employment and arose out of the employment. N.M. Stat. Ann. §§52-1-9, 52-1-28. Repetitive use claims are considered traumatic injuries and are covered by the Workers’ Compensation Act rather than the Occupational Disease Disablement Act.

NMSA Section 52-3-32.1 creates a presumption for firefighters that any heart injury or stroke suffered within twenty-four hours of responding to a fire call or a non-fire
emergency or while engaging in supervised physical training constitutes a work related injury.

B. Occupational disease (including respiratory and repetitive use).

An occupational disease is defined as a disease unique to the employee’s occupation as opposed to a disease to which the general population is at risk to suffer from. The employer with the last injurious exposure which results in disability is responsible. N.M. Stat. Ann. §§52-3-11, 52-3-32, 52-3-33.

NMSA Section 52-3-32.1 creates a rebuttable presumption that causation is established for full-time non-volunteer firefighters for the following diseases: (1) brain cancer after ten years; (2) bladder cancer after twelve years; (3) kidney cancer after fifteen years; (4) colorectal cancer after ten years; (5) non-Hodgkin’s lymphoma after fifteen years; (6) leukemia after five years; (7) ureter cancer after twelve years; (8) testicular cancer after five years if diagnosed before the age of forty with no evidence of anabolic steroids or human growth hormone use; (9) breast cancer after five years if diagnosed before the age of forty without a breast cancer 1 or breast cancer 2 genetic predisposition to breast cancer; (10) esophageal cancer after ten years; (11) multiple myeloma after fifteen years; and (12) hepatitis, tuberculosis, diphtheria, meningococcal disease and methicillin-resistant staphylococcus aureus appear and diagnosed after entry into employment.

5. What, if any, injuries or claims are excluded?

None.

6. What psychiatric claims or treatments are compensable?

Single psychologically traumatic events are covered, as well as psychological conditions resulting from physical injuries. Job stress claims are not otherwise compensable. N.M. Stat. Ann. §52-1-24.

7. What are the applicable statutes of limitations?

A claim must be filed within one year and 30 days from the date of the accident and disability if the employee does not continue in employment where the accidental injury occurred. If the employee maintains employment where the accidental injury occurred, this is extended for an additional year. There is no statute of limitations on medical claims or safety device enhancement claims. N.M. Stat. Ann. §52-1-31.

8. What are the reporting and notice requirements for those alleging an injury?

Notice must either be based on actual knowledge of the event by the employer or it must be given in writing within 15 days. N.M. Stat. Ann. §52-1-29.

9. Describe available defenses based on employee’s conduct:

A. Self-inflicted injury.

B. Willful misconduct, “horseplay,” etc.

Such a claim is barred, unless the employer condoned the conduct. N.M. Stat. Ann. §§52-1-9, 52-1-11, 52-1-28.

C. Injuries involving drugs and/or alcohol.

Such a claim is to be reduced by the degree to which the intoxication or influence contributes to the worker’s injury, provided that the reduction shall be a minimum of ten percent but no more than ninety percent. N.M. Stat. Ann. §52-1-12.1. An employer shall be barred from claiming a reduction in compensation pursuant to this section if the employer fails to implement a written policy that declares a drug- and alcohol- free workplace. N.M. Stat. Ann. §52-1-12.1(H). Reduction or denial of compensation benefits authorized under this section shall not affect payments of benefits to the dependents of a deceased worker. N.M. Stat. Ann. §52-1-12.1(J).

10. What, if any, penalties or remedies are available in claims involving fraud?

The Safety and Fraud Division is attached to the Workers’ Compensation Administration. Upon finding that fraud has been committed, they make appropriate referrals of their findings to a judge assigned to the underlying workers’ compensation claim and also to the appropriate law enforcement agency. N.M. Stat. Ann. §52-5-1.3.

11. Is there any defense for falsification of employment records regarding medical history?

Yes, so long as the misrepresentation is relevant to the injury and the employer relied on the misrepresentation. Only misrepresentations regarding the worker’s physical condition are actionable. N.M. Stat. Ann. §52-1-28.3.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?


13. Are injuries by co-employees compensable?


14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g., “irate paramour” claims)?
15. **What criterion is used for calculating the average weekly wage?**

Wages earned by the employee in the 26 weeks preceding accidental injury, or pro rata if employed less than 26 weeks, are used to calculate the average weekly wage. N.M. Stat. Ann. §52-1-20.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Two-thirds of the difference between the employee’s pre-injury and post-injury wage is paid prior to maximum medical improvement, if the employee returns to work. Otherwise, temporary total disability benefits are applied. After maximum medical improvement is reached, a formula is used to determine permanent partial disability benefits. N.M. Stat. Ann. §§52-1-24.1, 52-1-25, 52-1-25.1, 52-1-26, 52-1-26.1, 52-1-26.2, 52-1-26.3, 52-1-26.4.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**


18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out ____ days before recovering benefits for the first ____ days)?**

The employee must be out four weeks before recovering benefits for the first seven days. N.M. Stat. Ann. §52-1-40.

19. **What is the standard/procedure for terminating temporary benefits?**

There is no requirement that any pleadings be filed to terminate benefits. If benefits are reduced or terminated, the employee must be advised in writing and the reasons for reduction or termination of benefits must be given. N.M. Stat. Ann. §§52-1-28.1, 52-1-31.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**


21. **What disfigurement benefits are available and how are they calculated?**
Only facial (whole head) disfigurement is compensated. The award is discretionary and is capped at $2,500. N.M. Stat. Ann. §52-1-44.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

   A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

   The number of weeks varies, depending on which body member is affected, from 7 weeks for amputation of any finger at the distal joint through 200 weeks for the loss of an arm or leg. There are 43 subparts to the schedule. N.M. Stat. Ann. §52-1-43.

   B. **Number of weeks for “whole person” and standard for recovery.**

   If the employee has a permanent partial disability of less than 80%, 500 weeks are paid for permanent partial disability. If the disability is equal to or greater than 80%, benefits are paid for 700 weeks. Total permanent disability runs for the life of the employee. N.M. Stat. Ann. §§52-1-41, 52-1-42.

   C. **Employer's right to offset.**

   An employer that employs a worker at the time of an injury receives an off-set only for wages and benefits that that employer provides and does not receive an off-set for wages paid to the worker by an employer who employs the worker after the injury. Moya v. City of Albuquerque, 2007-NMCA-057.

   D. **A scheduled injury does not combine with a whole person injury.**

   If a Worker has both a scheduled injury and a whole person injury, they may receive both. However, the combined amounts cannot exceed the average weekly wage. Baca v. Complete Drywall Co., 2002-NMCA-002.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

   The current Workers’ Compensation Act does not provide for vocational rehabilitation benefits, but the Occupational Disease Disablement Law does provide for such benefits.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

   The minimum benefit is $36 weekly and the maximum is a statutory maximum as set by the state each year. N.M. Stat. Ann. §52-1-4.
25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.


B. Dependency claims.

Death benefits are available to the surviving spouse and minor children who the decedent was legally obligated to support. The exact amount that the children and spouse receive depends on the number of children and if there is a surviving spouse. N.M. Stat. Ann. §52-1-46.

26. What is the criteria for establishing a “second injury” fund recovery?

The Subsequent Injury Fund was abolished by 1996 legislation. There may be pending claims for which the previous law is still applicable.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The employee must show an increased disability, and the employee can move to re-open only every six months. A case can be reopened even if there was a settlement if there has been a worsening of the condition. N.M. Stat. Ann. §52-1-56. See answer 7. see Benny v. Moberg Welding, 2007-NMCA-124, 142 N.M. 501, 167 P.3d 949. A review may be obtained upon application of a party in interest filed with the director at any time within two years after the date of the last payment or the denial of benefits upon the following grounds change in condition, et. al. N.M. Stat. Ann. §52-5-9(B).

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

The employer/insurer is responsible for 50% of the employee’s attorney’s fees. The employee’s attorney’s fees cannot exceed a maximum of $22,500 for claims under the Workers’ Compensation Act §52-1-1 and $22,500 for claims under the Occupational Disease and Disablement Law §52-3-1, plus gross receipts taxes unless there has been a finding that the employer/insurer committed bad faith in the handling of the claim and, as a result, the employee suffered an economic loss. If the employee tendered an offer of settlement and the employer/insurer fail to obtain a result better than the offer, the employer/insurer are required to pay the entire fee of the employee’s attorney. N.M. Stat. Ann. §§52-1-54, 52-3-1, et. seq.

EXCLUSIVITY/TORT IMMUNITY
29. **Is the compensation remedy exclusive?**

   **A. Scope of immunity.**


   **B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

   Intentional torts, acts which constitute gross negligence and those individuals filing a written waiver of coverage with the state are excluded from workers’ compensation coverage. N.M. Stat. Ann. §§52-1-7, 52-1-28.

30. **Are there any penalties against the employer for unsafe working conditions?**

   Yes. There can be a maximum 10% increase in compensation benefits. N.M. Stat. Ann. §52-1-10.

31. **What is the penalty, if any, for an injured minor?**

   Yes, up to a maximum 10% increase in compensation. N.M. Stat. Ann. §52-1-10.

32. **What is the potential exposure for “bad faith” claims handling?**

   There is a maximum $5,000 increase for attorney’s fees over and above other attorney’s fees awarded. In addition an award can be made to the Worker of up to 25% of any benefits granted by the presiding Judge. A civil fine of up to $1,000.00 can also be awarded. N.M. Stat. Ann. §§52-1-28.1, 52-1-54.

33. **What is the potential exposure for terminating an employee who has been injured?**

   There is a maximum $5,000 penalty to be paid by the employer so long as it is shown that the termination was occasioned solely because the worker sought workers’ compensation benefits. N.M. Stat. Ann. §§52-1-28.2, 52-1-50.1.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-employees be sued for work-related injuries?**
36. **Is subrogation available?**

Yes. It is commonly called a right of reimbursement. The employer/insurer retain a statutory right to reimbursement, which operates as a lien on any other recovery by the employee. N.M. Stat. Ann. §§52-1-10.1, 52-5-17. Reimbursement is limited to the worker's duplicative recovery. — An employer is not necessarily entitled to a full reimbursement from an employee's fair, but partial, tort recovery, but is entitled to recoup the amount of a worker's duplicative recovery; moreover, those amounts that the employee reasonably receives for injuries not addressed by workers' compensation, such as pain and suffering, may not be recovered by the employer. Gutierrez v. City of Albuquerque, 1998-NMSC-027, 125 N.M. 643, 964 P.2d 807.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

There is no statute of limitations for medical bills. Case law has set 30 days as the standard, which most judges follow. Bad faith can be alleged for late payments. N.M. Stat. Ann. §52-1-49. The employer/insurer has three working days to reject a request for medical services. If the employer does not respond with a rejection within the three days then the employer/insurer can be found to be responsible to payment of those services. Rule 11.4.7.9 K(1) of the Rules and Regulations of the Workers’ Compensation Administration.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

Medical reports are required to be produced by the parties at the time of the mediation of a claim. An employee is required to provide an executed medical release. N.M. Stat. Ann. §52-5-5.

39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Examination?**

**A. Claimant’s choice of physician.**

The employer has the right to make the first choice of health care provider. The employee can make the first selection of the health care provider if the employer waives their right
to do so or if the employer does not adequately advise the employee of his or her right to make the initial selection. After the initial selection has been made, the other party can choose a different health care provider after 60 days. Any subsequent changes of the health care provider must be based on a showing of unreasonable care being provided. N.M. Stat. Ann. §52-1-49.

B. Employer’s right to a second opinion and/or Independent Medical Examination

Either party has a right to request an Independent Medical Examination. N.M. Stat. Ann. §52-1-51 (1991). If the parties cannot agree on the necessity of an Independent Medical Examination or cannot agree on the health care provider to conduct the examination, either party can petition the Workers’ Compensation Administration. The Workers’ Compensation Judge will then decide whether an Independent Medical Examination is necessary and/or select the health care provider to conduct the Independent Medical Examination. The Workers’ Compensation Judge has the right to independently order an Independent Medical Examination if it will further the resolution of the case. If a worker refuses to submit to an Independent Medical Examination benefits may be suspended.

If there is a change of health care provider to a new provider then the party making the initial choice of health care provider is entitled to secure periodic re-examinations with the initial health care provider. N.M. Stat. Ann. §52-1-51(D).

40. What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?

Treatment must be provided by an authorized provider. The services must be reasonable and necessary under the facts of the claim. N.M. Stat. Ann. §§52-1-49, 52-4-1.

41. Which prosthetic devices are covered, and for how long?

All prosthetic devices, which are reasonable and necessary during the employee’s life, are covered. N.M. Stat. Ann. §52-1-49.

42. Are vehicle and/or home modifications covered as medical expenses?

Yes, such modifications are covered as medical expenses as long as they are reasonable and necessary. N.M. Stat. Ann. §52-1-49.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?


44. What, if any, provisions or requirements are there for “managed care”?
There is no specific statutory provision for “managed care.” If the “managed care” is recommended by a designated health care provider, and if the services provided by the “managed care” entity are reasonable and necessary for the treatment of a compensable injury, the employer/insurer are responsible for payment of those services. A utilization review, fee schedule and care management system is set forth in N.M. Stat. Ann. §52-4-3.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Either an employee or an employer can file a claim with the New Mexico Workers’ Compensation Administration. The claim then proceeds to nonbinding mediation. If either party rejects the recommendation(s), it proceeds to an administrative trial. N.M. Stat. Ann. §§52-5-5, 52-5-6.

46. **What is the method of claim adjudication?**

   **A. Administrative level.**

   New Mexico has an administrative workers’ compensation court. There is a mandatory mediation process that generally, within 30-60 days from the date that the complaint was filled, will attempt to bring the parties together to discuss a possible resolution outside of official court proceedings. N.M. Stat. Ann. § 52-5-5. If the parties are unable to resolve the disputes raised in the complaint, then a trial proceeds as with any bench trial in the New Mexico courts of general jurisdiction. N.M. Stat. Ann. §52-5-6.

   **B. Trial court.**

   See above answer 46 A.

   **C. Appellate.**

   Review of decisions of the Workers’ Compensation Judge are to the New Mexico Court of Appeals which utilizes a whole record standard. N.M. Stat. Ann. §52-5-8. Decisions made by the Director of the Workers’ Compensation Administration are reviewed by the State District Court.

47. **What are the requirements for stipulations or settlements?**

In cases where the parties agree to a lump sum for return to work pursuant to statutory conditions set out below, or where the parties agree to a lump sum for debt or an acceleration of benefits, the consent of the parties and approval of the New Mexico
Workers’ Compensation Administration Judge are necessary in order to have a valid settlement. New Mexico restricts lump sum settlements to cases in which an employee returns to work for six months, earning 80% of his or her pre-injury wage. There is a provision for partial lump sum payments for post-disability debts and for the acceleration of weekly indemnity benefits. There is also a provision for settlement of all compensation benefits and medical benefits. Settlement terms must be set out in writing, the worker must demonstrate they are fully informed as to the terms and conditions of settlement and the settlement must be fair and equitable and provide substantial justice to the parties. Testimony in support of the settlement is required. N.M. Stat. Ann. §§ 52-5-12, 52-5-13, 52-5-14.

48. Are full and final settlements with closed medicals available?

The worker and employer/insurer may elect to resolve a claim for injury with a lump-sum payment to the worker for all or a portion of past, present and future payments of compensation benefits, medical benefits or both in exchange for a full and final release or an appropriate release of the employer from liability for such compromised benefits. The proposed lump-sum payment agreement shall be presented to the workers’ compensation judge for approval, and a hearing shall be held on the record. The workers' compensation judge shall approve the lump-sum payment agreement if the judge finds that:

(1) a written agreement describing the nature of the proposed settlement has been mutually agreed upon and executed by the worker and the employer;

(2) the worker has been fully informed and understands the terms, conditions and consequences of the proposed settlement;

(3) the lump-sum payment agreement is fair, equitable and provides substantial justice to the worker and employer; and

(4) the lump-sum payment agreement complies with the requirements for approval set forth in Sections 52-5-13 and 52-5-14

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, lump sum settlements must be approved by an administrative judge. The ALJ must follow the requirements of Sections 52-5-13 and 52-5-14 and Paradiso v. Tipps Equip., 2004-NMCA-009.

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required, and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Two and a half million-dollar net worth and approval by the Director of the Workers’ Compensation Administration is necessary to be a self-insured entity. N.M. Stat. Ann. §§52-8-1, et seq. Rule 11.4.8 (A) (1) of Rules and Regulations of the Workers’ Compensation Administration.

B. For groups or “pools” of private entities.

Three million dollar net worth of combined worth of all members and approval by the Director of the Workers’ Compensation Administration is necessary for a self-insured pool to be certified in New Mexico. N.M. Stat. Ann. §52-6-5 (B)(1).

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

An undocumented worker is entitled to medical benefits under the Act. The status as undocumented worker is a partial defense to payment of modifier benefits. The rule states that employers who cannot demonstrate good faith compliance with federal law in the hiring process cannot use their workers’ undocumented status as a defense to continued payment of modifier benefits under the Workers’ Compensation Act. Gonzalez v. Performance Painting, Inc., 2013-NMSC-021.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There are no specific statutes and there is no specific case law that excludes coverage for terrorist acts or injuries. Any injuries caused by terrorist acts will be analyzed using the traditional “course of employment” and “arising out of employment” analysis.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interest pursuant to the Medicare Secondary Payer Act?
55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The New Mexico Human Services Department has been assigned, and is subrogated to, any right of the Medicaid recipient against a third party recovery of medical expenses to the extent of the Department’s Medicaid payment on the recipient’s behalf. N.M. Stat. Ann. §§27-2-23 (B), 27-2-28 (G). It is not clear whether any medical liens would be subject to the Maximum Allowable Payment schedule or fee schedule involving Medicaid liens. It is presumed that any hospital liens under state law would be subject to the hospital fee ratio, which has been established by rules and regulations and by statute under the New Mexico Workers’ Compensation Act and the Occupational Disease Disablement Law for New Mexico. N.M. Stat. Ann. §52-4-5.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by the state and federal law (HIPPA)?**

There are no specific New Mexico statutes or case law that address the applicability of HIPPA and workers’ compensation acts. It is presumed that the federal statute would preempt New Mexico state statutes, but no cases have specifically addressed that issue. N.M. Stat. Ann. §52-5-21 (2001) allows the release of the Workers’ Compensation Administration’s files involving previous claims to a party involved in a claim being filed against it by a worker. After a filing of the rejection of the Recommended Resolution, the Workers’ Compensation files of the worker maintained by the Workers’ Compensation Administration are open to the public.

57. **What are the provisions for “Independent Contractors”?**

There is no specific definition of independent contractor in case law or statute in New Mexico. There is case law that directs the parties to the criteria set forth in the Restatement Second of Agency. The primary test is that of “control,” N.M. Stat. Ann. §52-1-22. See *Harger v. Structural Servs.*, 1996-NMSC-018, 121 N.M. 657, 916 P.2d 1324.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service company/leasing companies?**

New Mexico has an Employee Leasing Act. N.M. Stat. Ann. §60-13(A)-1 et. seq. Any employee leasing company is required to comply with the New Mexico Workers’ Compensation Act and have workers compensation insurance coverage. A leased

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**


60. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical benefits under a claim?**

Nothing state specific; however, it is advisable to consider Medicare’s interest in all settlements involving medical benefits.

61. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Jonathan A. Elms, Esquire  
jaelms@btblaw.com  
Tel:  (505) 884-0777
1. **Citation for the State's Workers' Compensation statute.**

New York Workers’ Compensation Law.

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of Workers' Compensation?**

Any employee, except the following: Domestic employees working less than 40 hours per week; clergymen and other non-manual employees of religious, charitable or educational institutes; volunteers for non-profit organizations; employees of municipalities and other political subdivisions who are not engaged in hazardous employment; licensed real estate brokers, insurance agents, and media sales representatives, whose services performed are pursuant to contract, and said contract expressly defines the broker as an independent contractor; “black car” livery cab operators; uniformed sanitation workers, firefighters and police officers in the employment of the City of New York; babysitters and minors over the age of 14 engaged in casual employment in and about one-family owner-occupied residences or the premises of non-profit, non-commercial organizations, not involving the use of power driven machinery; longshoremen, harbor workers, railroad employees and Federal employees; anyone engaged in yard work or household chores or making repairs or painting in and about a one-family owner-occupied residence; partners, sole proprietors, and officers of one/two-officer corporations with no subordinates; spouse and minor children of farmers. NY WCL Sections 2 and 3.

3. **Identify and describe any "statutory employer" provision**

An employer who has in employment, one or more employees at least 30 days in any calendar year except an employer of personal or domestic employees in a private home unless the domestic employees work for a minimum of 40 hours per week and are employed at least 30 days in any calendar year. NY WCL Section 355.4.

An employer who by operation of law becomes successor to a covered employer, or who acquires by purchase or otherwise the trade or business of a covered employer, immediately becomes a covered employer. NY WCL Section 202.

Whenever an employee of a covered employer, with the consent of the employer, engages or permits another to do any work in employment for which the employee is employed, the employer shall be deemed for the purpose of this article to be the employer also of such other person, regardless of whether the employee or the employer pays for his service. *Id.*
An employer is not liable for contribution or indemnity to any third person based upon liability for injuries sustained by an employee acting within the scope of his or her employment for such employer unless such third person proves through competent medical evidence that such employee has sustained a “grave injury” which shall mean only one or more of the following: death, permanent and total loss of use or amputation of an arm, leg, hand or foot, loss of multiple fingers, loss of multiple toes, paraplegia or quadriplegia, total and permanent blindness, total and permanent deafness, loss of nose, loss of ear, permanent and severe facial disfigurement, loss of an index finger or an acquired injury to the brain caused by an external physical force resulting in permanent total disability. NY WCL Section 11. “Contribution” and “indemnification” shall not include a claim arising out of a written contract in which the employer expressly agreed to provide contribution or indemnification of the claimant or the person asserting the cause of action. Id.

4. **What type of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or "single occurrence" or “accident” claims.**

   Any injury is compensable under a theory of a single occurrence if it occurs as the result of an accident which arises out of and in the course of employment, except those that are the result of an employee's intent to cause a self-inflicted injury or which are due solely to intoxication of the employee while on duty. NY WCL Section 10(1). There is a presumption that accidents which occur in the course of a worker’s employment are presumed to have arisen out of such employment. NY WCL Section 21. There is also a presumption that an employee did not intend an injury or that it was not solely due to intoxication of the employee. Substantial evidence is required to rebut these presumptions. These injuries can include both direct physical trauma as well as psychological injuries precipitated by a specific psychic trauma, except for purely mental conditions that arise out of a lawful personnel decision made by an employer.

   B. **Occupational disease (including respiratory and repetitive use).**

   Any disease contracted within the course of employment is compensable for any disability that results if the disease is found to be occupational in nature. A disease is occupational if it is the result of a distinctive feature of the kind of work performed by the employee and others similarly employed. Diseases that result because of the peculiar place in which a particular employee happens to work or which are caused by ordinary contact with fellow employees are not occupational diseases.

5. **What, if any, injuries or claims are excluded?**

   As stated above, injuries that have been solely occasioned by intoxication from alcohol or a controlled substance of the injured employee while on duty; or by willful intention of the injured employee to bring about the injury or death of himself or another; or where the injury or occupational disease was sustained by the injured employee in the perpetration of a felony or misdemeanor for which the employee is convicted.
Self-inflicted injuries and injuries which result solely because of an employee's intoxication are excluded. Diseases which arise because of the peculiar place in which a particular employee happens to work or which are caused by ordinary contact with a fellow employee are excluded.

6. **What psychiatric claims or treatments are compensable?**

Any psychiatric claim is compensable as long as it arises out of and in the course of employment or is an occupational disease if the disease is found to be occupational in nature.

7. **What are the applicable statutes of limitations?**

Absent a waiver, failure to file a written claim within two years of the date of accident or disability results in an absolute bar to a claim. NY WCL Section 28. For a hearing loss claim, the date of disablement takes place three months after claimant is removed from the environment causing the hearing loss, however a claim will not be barred for failure to file within two years thereafter, as long as it is filed within 90 days after knowledge that the hearing loss was caused by the nature of employment. NY WCL Section 49-bb. A waiver occurs if the statute of limitations is not raised at the first hearing at which all parties in interest are present. Also, an advance payment of compensation in the form of medical expense payment, lost wage benefit payment or light work or less hours for the same pay because of the injury constitutes a waiver. The statute of limitations is tolled for periods of infancy and incompetence.

In cases of occupational disease, the period for determining the statute of limitations begins to run on the date that claimant “knew or should have known” that the condition was work-related. However, it is within the Law Judge’s discretion to set the “date of disablement” as either the date claimant stopped working, the date claimant started treating, or the date that a physician first determined the condition to be causally related. This can result in the Law Judge making a claim timely when it otherwise would not be.

8. **What are the reporting and notice requirements for those alleging an injury?**

Ordinarily, a claim is reported by the employee filing a written claim on a prescribed form. However, oral notice recognized as being sufficient if the facts of the injury are stated with reasonable certainty and it can be reasonably inferred that a claim for compensation is being made.

Per Section 18, a claimant has 30 days from the date of accident to notify the employer. However, this can be excused where there is no prejudice to the employer, such as where the employer has actual knowledge that the accident happened, notwithstanding any knowledge of any injury.

Per Section 45, a claimant has two years from the date claimant knew, or should have
known, that the condition was work-related, to notify the employer.

9. Describe available defenses based on employee's conduct:

Ordinarily, a claim is reported in writing, specifically with Form C-3.0, by the employee filing a written claim on a prescribed form. However, as stated above, oral notice is recognized as being sufficient if the facts of the injury are stated with reasonable certainty and it can be reasonably inferred that a claim for compensation is being made.

A. Self-inflicted injury.

Self-inflicted injuries are excluded from compensation coverage.

B. Willful misconduct, "horseplay," etc.

Willful misconduct is not an exclusion to a right for compensation benefits as long as the injury arises out of and in the course of the employment.

C. Injuries involving drugs and/or alcohol.

Injuries that are solely due to intoxication are excluded.

10. What, if any, penalties or remedies are available in claims involving fraud?

Section 114-a of the WCL deals directly with claimants who attempt to perpetrate a fraud by obtaining benefits through deceit and/or misrepresentation. Said provision authorizes the disallowance and/or cessation of benefits where it is shown through substantial evidence that a claimant has willfully falsified information before the Board in order to obtain indemnity payments. However, no such disqualification is available against treatment for established injuries.

This provision is separate and distinct from criminal prosecution and, of course, utilizes a different standard of proof. A finding of Section 114-a can result in a vacating of all potential wage and medical benefits as well as a referral to the Fraud Inspector General of the Board, who can further refer the matter to the Attorney General’s Office or a local District Attorney’s office for criminal prosecution. However, no such disqualification is available against treatment for established injuries.

Per the 2007 amendments, the statute was expanded to include sanctions and penalties for “frivolous” claim or defense, which are not necessarily fraud. This provision provides that if the Board determines that a proceeding either has been instituted or continued without reasonable ground, the cost of the proceeding shall be assessed against the party instituting said proceeding (typically a carrier) and the attorney's fees would be assessed against the attorney representing that party (i.e. the defense counsel.) This provision also
prevents the attorney to recoup the penalty assessed from the client.

11. Is there any defense for falsification of employment records regarding medical history?

No.

12. Are recreational and other non-work activities paid for or supported by the employer compensable?

Yes, provided the recreational activity (1) occurs on the premises during a lunch or recreational period as a regular incident of the employment, (2) the employer, by expressly or impliedly requiring participation, or encouraging it, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment, or (3) the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life.

13. Are injuries by co-employees compensable?

Yes.

14. Are acts by third-parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

Yes, as long as the injury arises out of and in the course of employment. An employee who suffered physical injuries due to sexual abuse can seek recovery from compensation as well as other remedies at law or equity.

**BENEFITS**

15. What criteria is used for calculating the average weekly wage?

NY WCL Section 14 authorizes using the 200 (for seasonable workers), 260 (5-day workers), or 300 (6-day workers) multiple in calculating the claimant's average weekly wage. This method takes into consideration the worker's earnings in the 52 weeks prior to the date of accident/disablement, as well as the number of days worked per week.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?
The rate for maximum compensation benefits depends on the year in which the injury occurred, as the Legislature has periodically revised and increased the maximum recoverable benefit. Effective 2010, the maximum weekly benefit is two-thirds of the average weekly wage in New York. For claims with dates of accident or disablement after July 1, 2018, the maximum weekly benefit rate is $904.74. The maximum weekly benefit rate is subject to change when the Commissioner of Labor to the Superintendent of Insurance issues a report on the New York State average weekly wage. However, effective May 1, 2013, the minimum benefit is $150.00 per week in the case of a permanent or temporary partial disability, unless the employee's actual wages at the time of injury are less than $150.00 per week, respectively. In that instance, the employee shall receive full wages.

17. **How long does the employer/insurer have to begin TTD benefits from the date disability begins?**

Where a claim for benefits is not controverted, the first payment is due on the 14th day of disability and must be paid within 4 days thereafter, except that the employer must have had knowledge of the accident for at least 10 days. NY WCL Section 25(1)(b).

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out 14 days before recovering benefits for the first 7 days)?**

There is a seven-day waiting period for recovery of benefits. If an employee is out of work for 0 to 7 days, there is no compensable benefit. If the employee is out from 7 to 14 days, there is a compensable benefit of only those days after the first week of disability. If an employee is disabled for more than 14 days, compensation is payable from the date of disablement. NY WCL Section 12.

19. **What is the standard/procedure for terminating temporary benefits?**

In circumstances where there has not been an award directing the payment of compensation benefits, the carrier may unilaterally suspend payments provided there is medical proof of no disability, or claimant returning to work at full wages, and Form SROI-S1 is filed. Within 16 days of termination of benefits, the employer is required to serve on the claimant and file Form SROI-S1.

If there has been an award from the Board and a direction to continue payments, the employer cannot suspend payments unilaterally, but may request a hearing for an order suspending or terminating benefits. This is accomplished by filing with the Board Form RFA-2 to suspend payments. This form must be served on the claimant and counsel, if any. The carrier still must continue payments until otherwise directed by the Board.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**
No, unless there is an award for “schedule loss of use,” which a finding of permanent
disability to an arm, leg, hand, foot, etc. NY WCL Section 15(3). Then, all prior
payments are credited towards the SLU award.

21. **What disfigurement benefits are available and how are they calculated?**

An award of up to $20,000 for serious facial or head disfigurement the actual amount to
be awarded is within the discretion of the Law Judge. WCL Section 15(3)(t).

22. **How are permanent partial disability benefits calculated including the minimum
and maximum rate?**

**A. How many weeks are available for scheduled members/parts and the
standard for recovery?**

The weeks of compensation applicable to various scheduled members or parts of the
body are determined by statute for schedule loss of use (SLU). They range from 15
weeks for the total loss of the fourth finger to 312 weeks for the total loss of an arm.
Partial loss or loss of use of a member is compensated proportionately by assessment of a
percentage loss, which is used to determine the weeks of compensation that are
recoverable. The permanent partial disability for scheduled awards is paid at a rate of 66
and 2/3 percent of the claimant's average weekly wage.

**B. Number of weeks for "whole person" and standard for recovery.**

Any injury other than for specifically defined parts of the body, usually the back and
neck, fall within a category known as non-scheduled loss. These are paid at a rate of
two-thirds of the difference between the claimant's average weekly wage and his or her
wage earning capacity for a limited number of weeks, based on the percentage of
claimant's Loss of Wage Earning Capacity (LWEC). This ranges from 225 weeks (1-
15% LWEC) to 525 weeks (greater than 95% LWEC).

LWEC is based on a number of factors, specifically the permanent medical impairment as
well as claimant’s vocational abilities (level of education achieved, English language
proficiency, and age). While the medical impairment determination is governed by the
2012 Impairment Guidelines, there is no set formula to calculate LWEC, and it is
determined solely on a case-by-case basis.

In the case of both SLU and LWEC, the minimum benefit is $150.00 per week. The
maximum permanent partial disability rate is dependent on the year in which the injury
occurred, as the Legislature has periodically changed the rates.

23. **Are there any requirements/benefits for vocational rehabilitation and what is the
standard for recovery?**

Vocational rehabilitation is entirely voluntary in New York. Employers are not required
to provide rehabilitation programs and, if provided, employees are not required to submit to them. However, the law does make available to the claimant an opportunity to receive an additional compensation benefit, not exceeding $30 per week, if it is determined by the State Education Department that the employee is able to be rendered fit to engage in a remunerative occupation if rehabilitated.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total benefits are paid at the same rate as those for temporary total disability. The rate depends on the year of injury. The current rate, effective for any disablement or injuries that occur on or after July 1, 2018, is two-thirds of the average weekly wage, with a maximum weekly benefit rate of $904.74. The minimum payment is $150 per week or, if the actual wages were less than $150 per week, then full wages are paid.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Funeral expenses may be paid up to $12,500.00 in Metropolitan New York City counties; up to $10,500.00 in all others.

B. **Dependency claims.**

Surviving spouse with no children: 66 and 2/3 percent of the average weekly wage indefinitely. If the surviving spouse remarries, he/she receives one final lump-sum of two years’ worth of death benefits, and then they cease.

Surviving spouse with children: 36 and 2/3 percent of the average weekly wage paid to the spouse, 30 percent of the average weekly wage paid to the child or children, equally. Child or children with no spouse: 66 and 2/3 percent of the average weekly wage to be paid to the child or children, shared equally.

Children are eligible for death benefits until age 18, or until age 23 if enrolled in school full-time.

No child or children, no spouse, but dependent grandchildren, brothers and sisters: 40 percent of the average weekly wage.

None of the above, but dependent parents and grandparents: 25 percent of the average weekly wage if they are minors, 40 percent if they are otherwise dependent.

None of the above, but surviving non-dependent parents: a lump-sum of $50,000.00.

None of the above, $50,000.00 to decedent’s estate.
Social Security offset: There is a reduction in benefits varying from 5 percent to 50 percent of the benefit, depending on average weekly wage, for Social Security benefits received.

26. What is the criteria for establishing a "second injury" fund recovery?

The 2007 Amendments eliminated the Second Injury Fund for all accidents or occupational diseases occurring prior to July 1, 2007.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A claim can be re-opened because of a worsening of a condition that is not anticipated at the time of final determination by the Workers' Compensation Board. The re-opening requires a statement (Form C-27) by a physician that the condition has worsened and was not otherwise previously anticipated. The period within which a claim can be re-opened for the purposes of seeking further indemnity is 18 years from the date of accident/disablement or eight years after the most recent payment of indemnity, whichever is longer. A claim can be reopened at any time for additional medical treatment. WCL Section 123.

28. What situation would place responsibility on the employer to pay a claimant's attorney’s fees?

Attorney’s fees are paid out of the award made to a claimant and are not an additional responsibility of the employer. The percentage is usually 15% of any “new money moving” to claimant, based on custom and usage.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

In general, the employer is immune from direct action by an employee, unless the employer is uninsured, in which case the claimant can “elect remedies” between seeking compensation from the Uninsured Employers’ Fund, and directly suing the employer. However, the employer is not protected from third-party actions by defendants who have been sued by employees, per the “grave injury” and contractual indemnification set forth in Section 11. Thus, if an employee sues a third-party on some grounds, the defendant in that action can implead the employer under some comparative fault or indemnification theory.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).
There is no exclusivity of rights under the Compensation Law where the statute does not provide a remedy to a particular employee, where the party seeking redress is an employee or is not an employee at the time of the injury. Thus, the Compensation Law will be the exclusive remedy for any employee who suffers an injury as the result of an accident or occupational disease that arises out of and in the course of employment. Since the statute refers to injuries arising out of an accident, the statute does not apply to injuries that result from an intentional act of the employer or the intentional act of a co-employee while that co-employee was acting within the course and scope of his employment. Although the Compensation Law does not provide for recovery of pain and suffering, an employee is precluded under the Compensation Law from presenting an action against the employer for pain and suffering on the theory that the accident which brought about the injury (and thus the pain and suffering) was the result of an accident, thus invoking the exclusive remedy of the Compensation Law. In the event that an employee accepts compensation benefits for an injury that might otherwise create an independent right of action against the employer, the employee generally waives any rights to proceed by an action at law.

30. Are there any penalties against the employer for unsafe working conditions?

Under the WCL, there are no penalties against the employer for unsafe working conditions. However, the New York State Labor Law, which defines obligations to provide safe work places, is often invoked in third-party actions against employers, particularly in construction site accidents.

31. What penalty, if any, for an injured minor?

The average weekly wage of a minor can be increased beyond the amount of his actual average weekly wages under a theory that a minor would expect to have increases in earnings after reaching majority (e.g., minor's "wage expectancy"). However, the Board must have some evidence to substantiate that the particular employee had a reasonable expectation of increased earnings to warrant an increase in the average weekly wage upon which the compensation benefits are to be determined. In rare cases, where it can be established that an employer knowingly employed illegal minors, an injured minor has been found entitled to double compensation.

32. What is the potential exposure for "bad faith" claims handling?

The WCL permits the Board to assess penalties against an employer under certain circumstances:

A. If a claim is not timely controverted, a $300.00 penalty may be imposed. Section 25(2)(a).

B. If an employer objects to the compensation claim without just cause, a penalty of $300.00 shall be imposed. Section 25(2)(c).
C. If an employer fails to timely pay an award made by the Board (10 days from the date of filing of a notice of decision), a penalty of 20% of the total award shall be imposed. This penalty provision does not apply if there is an application for review of the Law Judge's decision.

33. **What is the exposure for terminating an employee who has been injured?**

An employer is not obligated to hold a position for an employee. However, the law does make specific provision for employers who dismiss an employee or who threaten to dismiss an employee for presenting a compensation claim or who has or is about to testify in a compensation proceeding. Discrimination claims under Section 120 of the N.Y. Workers' Comp. Law must be brought before the Compensation Board within two years of the date of the alleged discrimination. If the Board finds discrimination, the employee is entitled to be restored to the same employment and to be compensated for any lost wages arising from the discrimination, together with any fees or allowances determined by the Board for services rendered by an attorney. The employer shall also be fined a penalty of $100 to $500. The penalty and any compensation or fees allowed are the sole responsibility of the employer and cannot be assessed against the employer's compensation carrier.

**THIRD-PARTY ACTIONS**

34. **Can third-parties be sued by the employee?**

In addition to receiving workers' compensation benefits, a claimant may also commence a third-party action against a potential tortfeasor for alleged negligence associated with the compensable injury.

35. **Can co-employees be sued for work-related injuries?**

Generally, a co-employee is protected by the exclusivity of the WCL except in the event of an intentional injury to the employee. That intentional act may be attributable to the employer and, thereby, raise a right of action by the injured employee directly against the employer if the intentional act was performed in the course and scope of the offending employee's job.

36. **Is subrogation available?**

A workers' compensation carrier who has paid benefits may seek recovery from a potential tortfeasor in situations where the claimant has chosen not to commence a third-party action. In those situations where a third-party action has been commenced, the workers' compensation carrier retains a lien on any and all recovery as well as a potential future holiday on future benefits to the claimant. WCL Section 29.
MEDICALS

37. Is there a time limit for medical bills to be paid and are penalties available for late payment?

Employers have 45 days from receipt of the bill to either pay or challenge bills for medical care. Failure to make timely payment entitles the provider to an award of a penalty equaling 1 and 1½ percent interest per month for any unpaid amount. WCL Section 13-g.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

The production of medical information can be compelled at workers’ compensation hearings through subpoena power vested in attorneys representing any party. Alternatively, records can be obtained through executed authorizations. In the event that an employee refuses to execute an authorization, the only option available, other than subpoena, is to request a hearing for the purpose of obtaining an order of the Law Judge to provide authorization for release of medical records.

39. What is the rule on choice (a) claimant’s choice of physician; (b) employer’s right to a second opinion and/or Independent Medical Examination?

An employee is entitled to be treated by any physician authorized by the Workers' Compensation Law. WCL Section 13-a. In New York, the employer and carrier are barred from playing any part in the selection of a claimant’s physician except when there is a contract between the carrier and a Preferred Provider Organization (PPO), as set forth in Sections 13-a(6) and 350-355. Also, the employer can ask claimant to execute Form C-3.1, in which the claimant acknowledges his/her right to select their own physicians, but they may also choose a provider or network that is recommended by the employer or carrier within 30 days following the accident.

The employer/carrier can schedule an IME with a physician of their choosing at any time. However, IME’s are subject to strict deadlines. The notice of examination (Form IME-5) must be served on seven business days’ notice, and must advise the claimant if their right to videotape the exam. Once the exam is held, the report must be forwarded (with Form IME-4), to the Board, the claimant, the attorney, and all treating physicians who treated claimant in the last six months, “on the same day and in the same manner,” within 10 business days of the exam, or face preclusion.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

The employer has a duty to provide any medical treatment that is reasonably necessary or appropriate for the injury or occupational disease. WCL Section 13.
41. **Which prosthetic devices are covered and for how long?**

The employer is obligated to provide any prosthetic devices reasonably necessary or appropriate for the care and treatment of the injury or disease for as long as is required for recovery. WCL Section 13.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Expenses for such modifications can be awarded by the Board, but only upon a showing that the modifications were a medical necessity or a medical apparatus or device. Mere convenience is insufficient to warrant such expenses. WCL Section 13.

43. **Is there a medical fee guide or schedule or other provisions for cost containment?**

Yes. WCL Section 13.

44. **What, if any, provisions or requirements are there for “managed care”?**

Although there is presently a movement towards a general managed care system, New York State still allows for employees to utilize their own primary care physician for treatment related to on-the-job injuries. However, as stated above, carriers can contract with PPO’s, and employers can recommend treatment to claimants who sign Form C-3.1.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

A. Before any awards have been made by the Board, an employer can controvert the claimant by filing with the Board Form FROI-04 or SROI-04. The FROI must be filed with the Board on or before the 18th day after disability or within 10 days of the employer's first knowledge of the injury, whichever is greater. If the claim is not initially controverted, but before it is indexed, a FROI-00 can be followed by a SROI-04. On receipt of the filed form, the Board schedules a hearing for the next available calendar for a preliminary hearing on the question of the employee's right to compensation benefits. At the first hearing, where all parties are present, the employer must raise all of the grounds upon which the compensation is controverted.

B. In the event that an employer does not initially controvert a compensation claim, but at some time prior to awards for compensation having been made without liability, the employer can suspend or reduce payments. WCL Section 21-a. If this is to be done, the employer must file with the Board a SROI-S1 documenting a suspension of payments. The employer is obligated to file this form within 16 after the date on which compensation payments are stopped or modified. The Board will schedule a hearing for the next available calendar to address the question of the employee's entitlements to benefits and the rate of those benefits.
C. After the Board has determined that a claimant is entitled to compensation benefits, benefits cannot be modified or discontinued except by order of the Board. The employer can request a hearing to determine whether benefits can be reduced or discontinued by filing with the Board a Form RFA-2.

46. **What is the method of claim adjudication:**

   **A. Administrative level.**

   The administrative level (Workers’ Compensation Board) is the primary forum for hearings on compensation claims. The Law Judge resolves any controverted claims, determines the rate of compensation, the period of disability, the level of disability and whether a claim is compensable as a scheduled or non-scheduled loss.

   **B. Trial Court.**

   N/A

   **C. Appellate.**

   i. **Application for review:**

   An objection to the decision of the Law Judge is first addressed to the Board Panel by means of an application for review of the Law Judge’s decision. Application for review of the decision must be filed with the full Board within 30 days of the filing of the notice of decision from which application for review is taken. This review is of the entire record. The Board Panel is empowered to reverse, modify or remand for further hearings. It is empowered to review both facts and law.

   ii. **Appeals:**

   An objection to the review by the full Board is appealable to the New York State Appellate Division for the Third Department. The scope of review is whether the Compensation Board's decision is supported by “substantial evidence.”

47. **What are the requirements for stipulations or settlements?**

   All stipulations or settlements must be approved by the Compensation Board and reduced to Board orders or decisions. Absent approval by the Board, no stipulations or settlements are binding.

48. **Are full and final settlements with closed medicals available?**
Yes. While there can also be indemnity-only settlements, full and final settlements, referred to as lump sum settlements, are inclusive of medical expenses under Section 32. There is no right to further medical expenses after lump sum settlement of any claim. The Board must approve the settlement, considering both the question of need for further medical care and the claimant's ability for self-support without the periodic receipt of compensation benefits.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, lump sum settlements are approved by the full Compensation Board. Settlements regarding periods and extent of disability are subject to approval by the Administrative Law Judge assigned to the claim.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required? What is available (e.g. private carriers, State Fund, assigned risk pool, etc.)?

Security for payment of compensation is required for any of the benefits provided by the Workers' Compensation Law. Coverage can be provided through the following:

A. State Insurance Fund

B. Private insurance carrier

C. Approval by the Compensation Chairman of the employer's financial ability to self-insure for compensation benefits

D. Approved group self-insurance. NY WORK COMP § 50.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

In order to qualify for self-insurance, the employer must furnish to the Compensation Chairman satisfactory proof of the employer's ability to pay compensation benefits. The Chairman may require a surety bond and may require that the employer pay any awards for future benefits into the Special Fund of the State Insurance Fund. The Chairman shall also have the authority to deny any application for self-insurance or to revoke a previously granted consent for any good cause. WCL Section 50.

As of July 1, 2007, carriers who are liable to claimants for LWEC permanency awards or death claims must make a deposit into the Aggregate Trust Fund (ATF) of the present value of the unpaid permanency award (after at least six months from classification). Self-insured employers cannot be directed to make this deposit.
B. For groups or "pools" of private entities.

Group self-insurance is available to employers with a related activity in a given industry, and incorporated or unincorporated association of such employers, provided they employ persons who perform work in connection with that industry. Such employers may adopt a plan for self-insurance under which the group assumes liability of all of the employers within the group and pays compensation for which the employers are liable under the Workers' Compensation Law. The group is required to provide satisfactory proof to the Chairman of its ability to pay such compensation benefits and the Chairman shall require the deposit of sufficient securities as may be deemed necessary. The Chairman may also require payment of awards for future benefits into an aggregate trust fund as a condition of being allowed to operate as a group self-insurer. The Chairman has the authority to deny the application of any group or to revoke any previously consent authorization.

As stated above, effective July 1, 2007, the deposit into the Aggregate Trust Fund (ATF) is mandatory for all cases with permanent partial disability classification. This provision requires a carrier to pay the present value of a claim to the ATF when a claimant is classified as having a permanent partial disability by the WCB and remains out of work. The mandatory deposit does not apply to the self-insured employers. It should be noted that the carrier remains liable for the payments of medical treatments, even after the ATF deposit is completed.

The carriers are not required to deposit into the ATF in claims where Section 15-8 apply. In cases where either a third-party action or a 15-8 claim is still pending, the carriers also are not required to make the payments to the ATF.

52. Are “illegal aliens” entitled to benefits of workers’ compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of “employee”?

The WCL does not specifically exclude “illegal aliens” from receiving workers’ compensation benefits. Further, there has been case law stating that they are nevertheless entitled to receive it.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Presently, the New York State Workers’ Compensation Law does not specifically exclude injuries that are sustained as a result of terrorist acts. As such, any injuries which are sustained in the course of employment will be covered under the New York State Workers’ Compensation Law.

Moreover, injuries sustained in the cleanup, recovery, or rescue effort due to work performed in lower Manhattan between September 11, 2001 and September 12, 2001 are also compensable. Per statute, Section 28 does not apply to these claims and the statute
governing the final deadline for same has been continually extended by amendment. See WCL Article 8-A; specifically Section 162.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No. However, per the statute and regulations governing Medicare Set-Asides, any Section 32 Agreement that resolves the medical portion of the claim must indicate that Medicare’s interests are being addressed, either with a CMS letter where required, or through some other form of allocation addressing future medical expenses.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

Although the WCL does not specifically recognize a subrogation right against a compensation carrier as a result of health insurance benefits and/or Medicaid benefits paid on their behalf, these entities certainly have other forms of recovery. For instance, a third-party entity certainly has the right to commence an action in Supreme Court alleging amount improperly paid and seek equitable relief against the compensation carrier.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

At the present time, HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(b)(v)(A)(2)]. Therefore, your current practice of obtaining medical records could proceed under state law.

Presently, the New York State Workers’ Compensation Law does not take into account newly enacted provisions concerning HIPAA compliancy. Health providers, although, are now recognizing the federally mandated legislation by requiring a claimant to execute a detailed authorizations which specifically identify the medical provider. Also included
in these authorizations is a limitation as to what Agency or Entity shall have access to said records, the specifics of exactly what records are to be released, i.e. dates of treatment, and date and nature of injury, purpose of disclosure, and a specific expiration date.

Section 110 provides confidentiality requirements that are even stricter than HIPAA. Only parties of interest to a claim (claimant, employer, carrier, and Board) may have access to materials that are filed, or will be filed, with the Board. The only exception is when claimant executes the Form OC-110A authorization granting access to a Board file to anyone else. If anyone other than the claimant obtains or provides such access, they are guilty of a misdemeanor.

57. **What are the provisions for “Independent Contractors”?**

None.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Yes. The New York State Construction Industry Fair Play Act and the New York State Commercial Goods Transportation Industry Fair Play Act both state that workers in such industries are deemed employees unless there is sufficient proof that they are independent contractors. NY Labor Law 861-B; 862-B Employers and carriers who seek to controvert claims on the basis of no employer/employee relationship therefore seek a higher burden of proof.
1. Citation for the state's workers' compensation statute.

The North Carolina Workers' Compensation Act is codified at Chapter 97 of the North Carolina General Statutes (cited as N.C. Gen. Stat.).

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

"Employment" is generally defined as employment by the state and all political subdivisions thereof, and all public and quasi-public corporations therein and all private employments in which three or more employees are regularly employed in the same business or establishment. N.C. Gen. Stat. §97-2(1) (2003). An "employee," in turn, is generally defined as any person engaged in employment under any employment or contract of hire or apprenticeship, express or implied, oral or written, including aliens and also including minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession or occupation of his or her employer. N.C. Gen. Stat. §97-2(2).

3. Identify and describe any "statutory employer" provision.

A contractor is deemed an employer of the employees of its subcontractors, unless the contractor obtains from the subcontractor a certificate of insurance issued by a workers’ compensation carrier, or a certificate of compliance issued by the Department of Insurance to a self-insured subcontractor. See N.C. Gen. Stat. §97-19. Additionally, motor carriers who contract with independent contractors are liable to the independent contractor and his employees unless insurance has been secured by the independent contractor. See N.C. Gen. Stat.§97-19.1.
4. **What type of injuries are covered and what is the standard of proof for each:**

**A. Traumatic or "single occurrence" claims.**


However, with respect to back injuries and hernias, where the injury arises out of and in the course of the employment and is the direct result of a "specific traumatic incident of the work assigned," the injury is compensable. N.C. Gen. Stat. §§ 97-2(6), 97-9. The onset of pain does not establish that a specific traumatic incident occurred. The evidence must show that there was some event that caused the injury, not a gradual deterioration. *Chambers v. Transit Management*, 360 N.C. 609, 636 S.E.2d 553 (2006).

**B. Occupational disease (including respiratory and repetitive use).**

Diseases are not compensable unless they result naturally and unavoidably from an accident or come within the statutory definition of an occupational disease. N.C. Gen. Stat. §§ 97-2(6), 97-52. Several enumerated diseases are deemed to be occupational, as well as any disease "proven to be due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation or employment, but excluding all ordinary diseases of life to which the general public is equally exposed outside of the employment." N.C. Gen. Stat. § 97-53(13). A disease is "characteristic of" a profession when there is a recognizable link between the nature of the job and an increased risk of contracting the disease. *Booker v. Duke Medical Center*, 297 N.C. 458, 256 S.E.2d 189 (1979). Mere evidence that the job will increase the employee’s risk of experiencing symptoms or an aggravation of an underlying condition not contracted as a result of the employment is insufficient to prove a disease is “characteristic of” the profession. *Futrell v. Resinall Corporation*, 151 N.C. App. 456, 566 S.E.2d 181 (2002), *aff’d*, 357 N.C. 158, 578 S.E.2d 269 (2003). A disease is "peculiar to" a profession if the employment results in a hazard which distinguishes it in character from the general run of occupations and is in excess of that attending employment in general. *Keller v. City of Wilmington Police Dep’t*, 65 N.C. App. 675, 309 S.E.2d 543 (1983), *disc. rev. allowed*, 310 N.C. 625, 315 S.E.2d 690 (1984).

The employment need not be the exclusive cause of the occupational disease but need only be a significant contributing factor to the development of the disease in order for it
5. What, if any, injuries or claims are excluded?

No injuries or claims are expressly excluded.

6. What psychiatric claims or treatments are compensable?


Psychiatric conditions may also be compensable if they independently satisfy the definition of an occupational disease. See Smith-Price v. Charter Pines Behavioral Ctr., 160 N.C. App. 161, 584 S.E.2d 881 (2003). To prove a psychiatric condition is an occupational disease, the employee must prove that the mental illness or injury was due to stresses different than those borne by the general public. Pitillo v. N.C. Dept. of Envt. Health & Natural Res., 151 N.C. App. 641, 566 S.E.2d 807 (2002). To do so, the claimant must show that her psychological condition, or the aggravation thereof, was (1) "due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation or category of employment and that it is not (2) an "ordinary disease of life to which the general public is equally exposed." N.C. Gen. Stat. §97-57(13); Woody v. Thomasville Uphostery Inc., 355 N.C. 483, 562 S.E.2d 422 (2002) (adopting dissent in 146 N.C. App. 187, 202, 552 S.E.2d 202, 211); Clark v. City of Asheville, 161 N.C. App. 717, 589 S.E.2d 384 (2003).

Additionally, a psychiatric condition may be found compensable as an injury by accident. See Jordan v. Central Piedmont Community College, 124 N.C. App. 112, 476 S.E.2d 410 (1996), disc. review denied, 345 N.C. 753, 485 S.E.2d 53 (1997). However, a mental injury is not a compensable "injury by accident" if the relevant events were "neither unexpected nor extraordinary," and it was only the "[claimants'] emotional response to the [events that] was the precipitating factor." Cody v. Snider Lumber Co., 328 N.C. 67, 71, 399 S.E.2d 104, 106 (1991). Personnel actions which are found to be ordinary incidents of employment do not give rise to a psychiatric injury by accident because they do not represent an “interruption of the work routine.” Pitillo, 151 N.C. App. at 646, 566 S.E.2d at 812; compare, Bursell v. General Elec. Co., 172 N.C. App. 73, 616 S.E.2d 342 (2005) (remanded for findings on whether the personnel action leading to injury were the normal work routine or part of an established sequence of operations).

7. What are the applicable statutes of limitations?

Although technically a condition precedent to jurisdiction rather than statute of limitations, N.C. Gen. Stat. §97-24 provides that the right to compensation is forever barred unless a claim or memorandum of agreement is filed with the Industrial
Commission within two years after an accident, or within two years after the last payment of medical compensation when no other compensation has been paid. See, e.g., Reinhardt v. Womens Pavilion, Inc., 102 N.C. App. 83, 401 S.E.2d 138 (1991). With respect to occupational diseases, the employee must file a claim within two years after disability begins, although the two years does not begin to run until the employee is first informed by competent medical authority of the nature and work-related cause of the disease. N.C. Gen. Stat. §97-58(c); Taylor v. J.P. Stevens & Co., 300 N.C. 94, 265 S.E.2d 144 (1980). However, where egregious conduct on the part of the employer induces the employee to refrain from filing a claim, the employer may be estopped from raising the jurisdictional bar. See Reinhardt, 102 N.C. App. 83, 401 S.E.2d 138 (1991).

8. What are the reporting and notice requirements for those alleging an injury?

An employee must give written notice of an accident to the employer as soon as practicable, and is not entitled to medical or disability compensation prior to the giving of such notice, unless the employer had knowledge of the accident or the employee could not give notice by reason of physical or mental incapacity, fraud, or deceit on the part of some third person. N.C. Gen. Stat. §97-22. In addition, unless notice is provided within thirty days after the occurrence of an accident, no compensation is payable unless the employee (1) makes a reasonable excuse to the satisfaction of the Industrial Commission for failing to give such notice and (2) the employer is not prejudiced thereby. Id. With respect to claims for occupational disease, the same time limitations for reporting apply and commence on the date the employee receives advice from competent medical authority that he or she has an occupational disease. N.C. Gen. Stat. §97-58(b).

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

No compensation is payable for an injury proximately caused by the employee's willful intention to injure or kill himself or herself, or another. N.C. Gen. Stat. §97-12(3).

B. Willful misconduct, "horseplay," etc.


C. Injuries involving drugs and/or alcohol.

No compensation is payable where an employee's injury is proximately caused by
intoxication or the influence of any controlled substance under the North Carolina Controlled Substances Act sufficient to cause appreciable impairment to the employee’s mental and/or physical faculties, unless such substance was prescribed for the employee or was supplied by the employer. N.C. Gen. Stat. §97-12. “Intoxication” or being “under the influence” may be proven by a blood or other medical test conducted in a manner generally acceptable to the scientific community, and a positive result creates a rebuttable presumption of impairment. Id.

10. What, if any, penalties or remedies are available in claims involving fraud?

Attorney's fees and costs may be assessed against a party if the case has been prosecuted or defended without reasonable grounds. N.C. Gen. Stat. §97-88.1. Moreover, a person willfully making a false statement for the purpose of obtaining or denying any benefit or payment is subject to civil penalty and guilty of a misdemeanor. N.C. Gen. Stat. §97-88.2. The Commission may enter “such orders as necessary” to ensure the party does not benefit from the unlawful conduct. Id. An agreement between the parties may be set aside upon a showing that there is error in the agreement due to fraud. N.C. Gen. Stat. §97-17. A penalty may also be assessed against any health care provider who fraudulently administers or attempts to collect for inappropriate or unnecessary treatment or services. N.C. Gen. Stat. §97-88.3.

11. Is there any defense for falsification of employment records regarding medical history?

Yes. Pursuant to N.C. Gen. Stat. §97-12.1, compensation shall be barred if the employer proves that: (i) at the time of hire or in the course of entering into employment, (ii) at the time of receiving notice of the removal of conditions from a conditional offer of employment, or (iii) during the course of a post-offer medical examination: (1) the employee knowingly and willfully made a false representation as to the employee’s physical condition; (2) the employer relied upon one or more false representations by the employee, and the reliance was a substantial factor in the employer’s decision to hire the employee; and (3) there was a causal connection between false representation by the employee and the injury or occupational disease.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Injuries sustained during recreation or other non-work activities paid for or supported by the employer are not compensable where an Employee is not required to participate in the activity by his Employer. Frost v. Salter Path Fire & Rescue, 361, N.C. 181, 186, 639 S.E.2d 429, 433 (2007) Likewise, injuries sustained by an Employee during activities that are not a function or duty of his employment, not calculated to directly or indirectly further his Employer’s business to an appreciable degree, and were only authorized for the optional pleasure and recreation of the employee while off-duty are not compensable. Id.
13. Are injuries by co-employees compensable?

Yes.

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

No. When the moving cause of an assault upon an employee by a third person is personal, or the circumstances surrounding the assault furnish no basis for a reasonable inference that the nature of the employment created the risk of such an attack, the injury is not compensable. Robbins v. Nicholson, 281 N.C. 234, 237, 188 S.E.2d 350 (1972).

**BENEFITS**

15. What criterion is used for calculating the average weekly wage?

The preferred method of calculating the average weekly wage is to divide the earnings of the employee in the employment in which he or she was working at the time of injury during the 52-week period immediately preceding the injury by 52. N.C. Gen. Stat. §97-2(5) If the employee lost more than seven consecutive calendar days at one or more times during that 52-week period, then the earnings for the remainder of the 52 weeks are divided by the number of weeks remaining after the time so lost has been deducted. Id. Certain groups of employees, such as minors and volunteer firemen, merit special consideration. Id. Other methods may be employed when the above calculation does not produce a result fair to the parties.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Compensation is paid at the rate of two-thirds of the difference between the average weekly wage and the post-injury earning capacity. N.C. Gen. Stat. §§97-29, 97-30. An employee who is totally disabled is entitled to at least $30.00 per week by statute, but there is no minimum compensation rate for an employee who is partially disabled. N.C. Gen. Stat. §§97-29, 97-30. The maximum compensation rate for either total or partial disability is revised annually. N.C. Gen. Stat. §97-29. For injuries occurring in 2020, the maximum compensation rate is $1,066.00 per week.

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

Where the employee's right to compensation is admitted, the first installment of compensation is due on the fourteenth (14th) day after the employer has written or actual notice of the injury, on which date all compensation then due is to be paid. N.C. Gen. Stat. §97-18(b). The first installment of compensation payable under the terms of an award by the Commission, or under the terms of a judgment of the Court upon appeal
from such an award, becomes due 10 days from the day following the expiration of time for an appeal of the award or the judgment, or after notice waiving the right of appeal by all parties has been received by the Commission, whichever is sooner. N.C. Gen. Stat. §97-18(e). If any payment is not made within 14 days after it "becomes due," 10% must be added to the payment. N.C. Gen. Stat. §97-18(g).

In cases where liability has not been determined, the employer has 30 days to investigate and to make a compensability determination. N.C. Gen. Stat. § 97-18(j).

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out _____ days before recovering benefits for the first _____ days)?

The employee must be out 22 days before recovering benefits for the first 7 days. N.C. Gen. Stat. §97-28.

19. What is the standard/procedure for terminating temporary benefits?

Compensation under an award of the Commission shall continue until the terms of the award are completed. N.C. Gen. Stat. §97-18.1(a). Compensation under an award or agreement for ongoing compensation may be terminated upon: (1) the employee's return to employment for the same or a different employer (and the filing of the appropriate form with the Industrial Commission); (2) approval by the Commission of a compromise settlement agreement or a subsequent agreement for payment of compensation; or (3) approval by the Commission of an application to terminate compensation. N.C. Gen. Stat. §97-18.1(b)(c).

Payment of temporary total disability compensation is capped at 500 weeks from the date of first disability. N.C. Gen. Stat. 97-29(b). An employee may qualify for extended compensation if, after 425 weeks from the date of first disability, he is able to prove by a preponderance of the evidence that the employee has sustained a total loss of wage-earning capacity. N.C. Gen. Stat. 97-29(c).

Applications for termination of compensation (Form 24) must be accompanied by documentation supporting a determination that compensable disability has ended, such as the employee has returned to gainful employment for another employer, the employee has been released to return to work full duty without restrictions, or the employee's unjustified refusal to accept suitable employment offered by an employer.

Where compensation benefits are terminated because the employee has returned to light duty work, the employee is entitled to a nine-month "trial return to work" period. N.C. Gen. Stat. §97-32.1. During the trial return to work period the employee has the right to have benefits resumed should the employee's treating physician indicate that the employee's injury prevents the continuation of the trial return to work. N.C. Gen. Stat. §97-32.1. See also 04 NCAC 10A.0404 of the Workers' Compensation Rules.

In addition, reinstatement of compensation may be applied for where liability has been
established or in admitted claims, and the employee has subsequently been removed from work. N.C. Gen. Stat. § 97-18(k). This does not apply to a request on the grounds of a change of condition.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

An employee is compensated for total disability during the "healing period." After reaching maximum medical improvement the employee may elect to receive benefits for a permanency rating or for continuing total disability. *Arnold v. Wal-Mart*, 154 N.C. App. 482, 571 S.E.2d 888 (2002). This election does not allow for an employee to recover from both methods simultaneously, but is rather entitled to select the statutory compensation which provides the more favorable remedy. N.C. Gen. Stat. § 97-29. Thus, temporary total disability benefits paid after the end of the healing period (date of maximum medical improvement) may be credited against permanency rating benefits if elected by the employee following a return to work or other termination of temporary total disability benefits.

21. **What disfigurement benefits are available and how are they calculated?**

In cases of serious facial or head disfigurement, the Industrial Commission may award compensation not to exceed $20,000.00. N.C. Gen. Stat. §97-31(21). In cases of serious bodily disfigurement for which no compensation is payable under the schedule of benefits, the Commission may award compensation up to $10,000.00. N.C. Gen. Stat. §97-31(22). The determination of whether disfigurement is "serious" turns on whether it will affect the employee's future earning capacity. *See Anderson v. Shoney's*, 76 N.C. App. 158, 332 S.E.2d 93 (1985).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

With respect to permanency ratings, an employee is entitled to compensation for total disability as outlined in answer 16 for the number of weeks derived by multiplying the percentage of disability by the applicable number of weeks under the following schedule:

<table>
<thead>
<tr>
<th>Member</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>75</td>
</tr>
<tr>
<td>First Finger</td>
<td>45</td>
</tr>
<tr>
<td>Second Finger</td>
<td>40</td>
</tr>
<tr>
<td>Third Finger</td>
<td>25</td>
</tr>
<tr>
<td>Fourth Finger</td>
<td>20</td>
</tr>
<tr>
<td>Great Toe</td>
<td>35</td>
</tr>
<tr>
<td>Other Toes</td>
<td>10</td>
</tr>
<tr>
<td>Hand</td>
<td>200</td>
</tr>
</tbody>
</table>
In addition, in case of permanent injury, or total loss of, any important organ or part of the body not listed above the Commission may award compensation up to $20,000.00 N.C. Gen. Stat. §97-31.

### B. Number of weeks for "whole person" and standard for recovery.

North Carolina does not recognize ratings for disability of the "whole person."

### 23. Are there requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

The employer is required to provide medical compensation, including rehabilitative services, reasonably required to effect a cure, give relief, or lessen the period of disability. N.C. Gen. Stat. §§97-25, 97-2(19). Typically, the employer initiates vocational rehabilitation in an effort to decrease potential exposure in cases of continuing wage-loss. Specific guidelines have been instituted regarding an employer's use of vocational rehabilitation specialists. See 04 NCAC 10C.0101 et. Seq. North Carolina Industrial Commission Rules for Utilization of Rehabilitation Professionals in Workers' Compensation Claims.

Vocational rehabilitation, to include a one-time assessment, will be allowed regardless of whether the employee has reached maximum medical improvement. If the employee is out of work or earning partial wage loss benefits and his post-injury wages are less than 75 percent of his pre-injury wages, the employee may request vocational rehabilitation to include course in the North Carolina community college and university systems. N.C. Gen. Stat. §97-32.2(a). Vocational rehabilitation services may only be terminated by agreement of the parties or by order of the Commission. N.C. Gen. Stat. §97-32.2(e). An employee’s refusal to cooperate with vocational rehabilitation services when ordered by the Industrial Commission will result in a bar of further compensation until such refusal ceases. N.C. Gen. Stat. §97-32.2(g).

### 24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Compensation rates for total disability are computed as outlined in answer 16.

The employee may qualify for permanent total disability benefits if the employee can prove that one or more of the following limitations must have resulted from the injury:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm</td>
<td>240</td>
</tr>
<tr>
<td>Foot</td>
<td>144</td>
</tr>
<tr>
<td>Leg</td>
<td>200</td>
</tr>
<tr>
<td>Eye</td>
<td>120</td>
</tr>
<tr>
<td>Hearing in One Ear</td>
<td>70</td>
</tr>
<tr>
<td>Hearing in Both Ears</td>
<td>150</td>
</tr>
<tr>
<td>Back</td>
<td>300</td>
</tr>
</tbody>
</table>

In addition, in case of permanent injury, or total loss of, any important organ or part of the body not listed above the Commission may award compensation up to $20,000.00 N.C. Gen. Stat. §97-31.
(1) loss of both hands, both arms, both feet, both legs, both eyes, or any two thereof; (2) spinal injury involving severe paralysis of both arms, legs or the trunk; (3) severe brain or closed head injury as evidence by severe and permanent: (a) sensory or motor disturbances, (b) communication disturbances, (c) complex integrated disturbances of cerebral function, or (d) neurological disorders; (4) second degree or third-degree burns to thirty-three percent or more of the total body surface. N.C. Gen. Stat. § 97-29(d).

Permanent total disability entitles the employee to compensation, including medical compensation, during the employee’s lifetime, unless the employee shows by a preponderance of the evidence that the employee is capable of returning to suitable employment. Regardless of the employee’s work status, however, he is entitled to lifetime medical compensation. Id.

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

Burial expenses up to $10,000.00 are payable for compensable death claims. N.C. Gen. Stat. §§97-38, 97-40.

B. Dependency claims.

Generally, death benefits are paid to whole dependants at a rate of compensation for total disability, as calculated in answer 16, for 500 weeks. N.C. Gen. Stat. §97-38. In addition, a spouse who is unable to support himself or herself because of physical or mental disability as of the date of the employee's death is entitled to continuing payments of compensation until death or re-marriage. Id. A dependent child is entitled to continuing compensation until the child reaches the age of 18. Id. Dependents share the weekly compensation, share and share alike. N.C. Gen. Stat. §§97-38, 97-39.

26. What is the criteria for establishing a "second injury" fund recovery?

In general, there are two factual patterns that will support such a recovery. First, where an employee has a pre-existing disability of at least 20% of a member of the body and incurs an additional 20% or more disability to the same member as a result of the second injury, the employee is entitled to compensation for the pre-existing disability from the Second Injury Fund. N.C. Gen. Stat. §§97-33, 97-40.1(b)(1). Second, where an employee has a pre-existing loss of a hand, arm, foot, leg or eye and a second injury results in permanent total disability, the Second Injury Fund will compensate the employee for permanent total disability, less the employer's contribution for the second injury. N.C. Gen. Stat. §§97-35, 97-40.1(b)(2). Recovery, of course, depends on the availability of funds.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?
Any award or agreement for payment of compensation may be reviewed within two years of the last payment of compensation pursuant to a final award upon the showing of a "change of condition." In cases where only medical or other treatment bills have been paid, however, no review shall be made after 12 months from the date of the last payment of bills for medical or other treatment. N.C. Gen. Stat. §97-47. "Change of condition" refers to a substantial change of the employee's physical capacity to earn wages. E.g. Swaney v. George Newton Constr. Co., 5 N.C. App. 520, 169 S.E.2d 90 (1969).

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

If the employer defends a claim without reasonable ground, the Commission has the discretion to assess reasonable attorney's fees against the employer. N.C. Gen. Stat. §97-88.1. In addition, where an unsuccessful appeal has been brought by an employer, the Commission has the discretion to award the costs of the appeal, including reasonable attorney's fees, to be paid by the employer. N.C. Gen. Stat. §97-88.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.


B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

The courts have created an exception for intentional acts by the employer, including intentionally engaging in misconduct known to be substantially certain to cause serious injury. Woodson v. Rowland, 329 N.C. 330, 407 S.E.2d 222 (1991). Co-employees are also protected by the exclusivity provision for negligent acts but may be liable in tort for willful, wanton or reckless acts or omissions. Pleasant v. Johnson, 312 N.C. 710, 325 S.E.2d 244 (1985).

30. Are there any penalties against the employer for unsafe working conditions?

When injury results from the willful failure of the employer to comply with any statutory requirement or any lawful order of the Industrial Commission, compensation is increased by 10%. N.C. Gen. Stat. §97-12.

31. What is the penalty, if any, for an injured minor?

There is no such penalty per se, but a minor who sustains permanent disability or dies leaving dependents is entitled to have the average weekly wage computed based on the weekly wage of an adult employee in a similar or like class of work which the employee would probably have been promoted to if not for the injury. N.C. Gen. Stat. §97-2(5).
that method of computation is not feasible, compensation is to be computed based on the maximum weekly benefit as described in answer 16. *Id.* In addition, compensation for total disability in excess of 52 weeks may be increased to reflect expected earnings. *Id.*

32. **What is the potential exposure for "bad faith" claims handling?**

Defending a hearing without reasonable grounds may subject the employer or carrier to an assessment of attorney's fees under N.C. Gen. Stat. §97-88.1, as discussed in answer 28. Willful misrepresentations are also punishable as misdemeanors, and restitution may be ordered. N.C. Gen. Stat. §97-88.2. The courts have held that the Workers’ Compensation Act is the sole remedy for allegations of fraud, bad faith refusal to pay or settle a valid claim, unfair and deceptive trade practices, intentional infliction of emotional distress and civil conspiracy. *Johnson v. First Union Corp.*, 131 N.C.App. 142, 504 S.E.2d 808 (1998).

33. **What is the exposure for terminating an employee who has been injured?**

No employer may discharge any employee because the employee has instituted a workers' compensation proceeding in good faith, and any employer in violation of this provision may be liable in a civil action for "reasonable damages." N.C. Gen. Stat. §95-240 et. seq.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-employees be sued for work-related injuries?**

Yes. But see answer 29B.

36. **Is subrogation available?**

Yes, in accordance with N.C. Gen. Stat. §97-10.2, so long as the employer's negligence did not contribute to the injury. N.C. Gen. Stat. §97-10.2(e).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Within 30 days of the receipt of any statement for medical services, the employer/insurer must pay the statement, submit the statement to the Commission for approval, or send the provider written objections to the statement. 04 NCAC 10J.0101 of the Workers'
Compensation Rules. Any bill for medical compensation services not paid within 60 days after it has been approved by the Commission and returned to the responsible party is subject to a 10% penalty, unless late payment is excused by the Commission. N.C. Gen. Stat. §97-18(i). If an insurer disputes any portion of a health provider's bill, it must pay the undisputed portion of the bill while the dispute concerning the balance is being resolved. N.C. Gen. Stat. §97-26(e).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

An employer has the right to obtain medical information 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. N.C. Gen. Stat. §97-25.6. In a compensable case, authorization from the employee is not necessary to request medical records. In denied claims, the employer must give contemporaneous notice of the request for medical records to the employee.

In addition to requesting medical records, the employer may communicate with a health care provider in writing, with contemporaneous notice to the employee, and ask for information about diagnosis, treatment recommendations, work restrictions, causation issues, permanent impairment, and the kind of work for which the employee might be eligible. The employer may communicate with a health care provider orally if the employer cannot secure information from the medical records or from written communication. The employee must be provided with notice of the intended oral communication and an opportunity to participate in the communication at a mutually agreeable time. N.C. Gen. Stat. §97-25.6. As summary of the oral communication must be provided to the employee within 10 business days.

Employers are also allowed to provide information not contained in the medical records to the providers for comment. The employer must provide a copy of the proposed communication to the employee at least 10-business days in advance of the transmittal to the doctor, and the employee will have the right to object and file a motion to prohibit the communication. Sanctions may be imposed if either party acts unreasonably by initiating or objecting to the communication. N.C. Gen. Stat. §97-25.6.

Claims representatives may still request medical records, bills or other non-substantive information by phone without notifying the employee. N.C. Gen. Stat. §97-25.6.

39. **What is the rule on (a) claimant’s choice of physician; and (b) employer’s right to a second opinion?**

An employer has the right to direct treatment. *See* N.C. Gen. Stat. §§97-25, 97-27. An employee may make a written request to the employer for a second opinion examination. N.C. Gen. Stat. §97-25. The employer can choose choice whether to authorize the request, suggest an alternate provider or deny the request. *Id.* If a request for a second opinion is denied, or the parties are unable to reach an agreement regarding the provider,
within fourteen days of receipt of the request by the employer, the employee may request
that the Industrial Commission order a second opinion examination. Id.

The employer’s right to direct medical care is also subject to the employee's right to
request a change of treating physician, upon approval by the Industrial Commission. N.C.
Gen. Stat. §97-25. The Commission must find by a preponderance of the evidence that
the change is reasonably necessary to affect a cure, provide relief or lessen the period of
disability. In addition, the employee is encouraged to make a request in writing to the
employer before he seeks treatment. If the employee fails to seek permission in writing
and is evaluated by a doctor without the employer’s authorization, the Commission
“may” disregard that doctor’s opinions.

The employee is also entitled to request a second opinion evaluation, solely on the
percentage of permanent disability per N.C. Gen. Stat. §97-31. The employee may select
his own doctor to perform the evaluation, but the Commission must disregard or give less
weight to the opinions of that physician on issues other than the permanent partial

An employer is also entitled to have plaintiff undergo an independent medical

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy,
etc.)?

The employer is required to provide "medical compensation," which includes medical,
surgical, hospital, nursing and rehabilitative services, and medicines, sick travel and other
treatment including medical and surgical supplies, as may reasonably be required to
effect a cure, give relief or lessen the period of disability. N.C. Gen. Stat. §§97-25, 97-
2(19). Aside from chiropractic care, which is limited to 30 visits without prior written
authorization, there are no limitations on the length or frequency of treatment covered by
the statutory definition of medical compensation. The right to medical compensation
terminates two years after the employer's last payment of medical or disability
compensation unless the Commission approves or orders additional medical

41. Which prosthetic devices are covered, and for how long?

The employer is to provide any original artificial members as may reasonably be
necessary at the end of the healing period and the replacement of such artificial members
when reasonably necessitated by ordinary use or medical circumstances. N.C. Gen. Stat.
§§97-2(19), 97-25.

42. Are vehicle and/or home modifications covered as medical expenses?

Typically, an employer does not have a duty to purchase (or pay to construct) specially
modified housing or vehicles for an employee, but is required to modify existing housing
or vehicles with those accessories necessary to accommodate the employee's disabilities. *See Timmons v. North Carolina Dept. of Transportation*, 123 N.C. App. 456, 473 S.E.2d 356 (1996). However, an employer must furnish specially modified housing where the employee’s existing quarters are not satisfactory and for some exceptional reason structural modification is no practical. *See Derebery v. Pitt County Fire Marshall*, 318 N.C. 192, 347 S.E.2d 814 (1986)

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**


44. **What, if any, provisions or requirements are there for "managed care"?**

The employer/insurer may satisfy its requirement to provide medical compensation through contract with a managed care organization. N.C. Gen. Stat. §97-25.2. The managed care organization may be a preferred provider organization or a health maintenance organization regulated under Chapter 58 of the North Carolina General Statutes. Payment for services rendered by a health care provider to a workers' compensation patient are controlled by contract between the provider and managed care organization, or, if none, by the North Carolina Industrial Commission Medical Fee Schedule. *See* 04 NCAC 10D.0101 et. Seq. Workers Compensation Rules for Managed Care Organizations. Further, any contract between a managed care organization and an employer/insurer shall contain certain specific provisions and is subject to approval by the North Carolina Industrial Commission. *Id.*

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

The employer/insurer is required to promptly investigate reported injuries and admit or deny compensation “at the earliest practicable time.” Within 30 days of lost time or the filing of a claim by the employee (i.e. Form 18), the employer/insurer must accept, deny, or initiate payments without prejudice or liability. N.C. Gen. Stat. §97-18(j). The bases for a defense in a subsequent proceeding may be limited to the grounds set forth in that form. N.C. Gen. Stat. §97-18(f). The Commission may order reasonable sanctions
against an employer/insurer which does not accept, deny or initiate payments within 30
days, but such sanctions cannot include waiver of any defenses to compensability or
liability.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

The Commission may set the case for hearing in the county where the injury occurred, or
a neighboring county. Cases are tried initially before deputy commissioners of the
Industrial Commission, who receive evidence, make findings of fact and conclusions of
law, and render awards of compensation as appropriate. N.C. Gen. Stat. §97-84. Either
party may then appeal to the full Commission (a body of three commissioners) which
may make, delete or amend findings of fact, conclusions of law and awards by de novo

B. **Trial court.**

Not applicable.

C. **Appellate.**

From the full Commission, either party may appeal to the North Carolina Court of
Appeals for a review of issues of law. N.C. Gen. Stat. §97-86. From the Court of
Appeals, either party may petition for discretionary review by the Supreme Court, and in
certain cases the losing party may appeal as a matter of right on questions of law. See

47. **What are the requirements for stipulations or settlements?**

Agreements for payment of permanent partial disability compensation, must be submitted
to the Commission on approved forms, which contain supporting factual stipulations.
N.C. Gen. Stat. §97-82. Compromise settlement agreements or “clinchers” for a full and
final release of a claim must contain certain required language, including agreement by
the parties as to payment of medical expenses. N.C. Gen. Stat. §97-17; 04 NCAC
10A.0502 of the Workers’ Compensation Rules. The parties also must provide a list of
all known medical expenses where the employer/insurer has not agreed to pay all medical
expenses. N.C. Gen. Stat. §97-17(2)-(3). In addition, the Commission requires that all
relevant medical, vocational and rehabilitation reports be submitted. *Id.*

48. **Are full and final settlements with closed medicals available?**


49. **Must stipulations and/or settlements be approved by the state administrative body?**
RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Every employer subject to the Act must: (1) be insured under the Act in any authorized corporation, association, organization or in any mutual insurance association formed by a group of employers so authorized; or (2) self-insure in accordance with the provisions of the Act. N.C. Gen. Stat. §97-93. Insurance is available through private insurers on either a voluntary or assigned risk basis.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

In order to self-insure, an employer must furnish to the Commissioner of Insurance satisfactory proof of the employer's financial ability to directly pay compensation allowed by the Act. N.C. Gen. Stat. §97-170. The Commissioner of Insurance may require the deposit of an acceptable security, indemnity, or bond to secure the payment of compensation obligations as they are incurred. N.C. Gen. Stat. §97-170(e).

B. For groups or "pools" of private entities.

Groups of two or more employers may self-insure as a pool. The requirements are essentially the same as those for individual self-insureds.

52. Are “illegal aliens” entitled to benefits of Workers’ Compensation as The Immigration Control Act indicates they cannot be employees although most state acts include them within the definition “employee”?


53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There is no specific exclusion for injuries as a result of terrorist acts, however, a compensable injury must arise out of the employment. An injury does not arise out of the employment if the employment did not subject the employee to a special hazard or greater risk of the particular injury than that to which he or she would otherwise be exposed simply as a member of the public at large. See Pope v. Goodson, 249 N.C. 690, 107 S.E.2d 524 (1959)(lightning strike); Minter v. Osborne Co., 127 N.C. App. 134, 487...
54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

No, there are no state specific requirements. Consult your ALFA lawyer if there are questions about ensuring a settlement agreement complies with the Medicare Secondary Payer Act.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

If the employee receives assistance in the form of Medicaid benefits, the North Carolina Department of Human Resources is entitled to recover the amounts paid. N.C. Gen. Stat. §108A-57. If the lien is not protected, the Department can make a direct claim against the employee or the employer. *Malloy v. Durham Cty. Dep’t of Social Services*, 58 N.C. App. 61, 293 S.E.2d 285 (1982).

A health insurer that covers an employee under a State regulated plan may only recover reimbursement for medical payments made on the employee’s behalf upon the admission or adjudication that a claim is compensable. N.C. Gen. Stat. §97-90.1 (2002). However, self-funded plans established, maintained and operated under the Employee Retirement Income Security Act (ERISA) of 1974 may include a provision for reimbursement of benefits of injured workers that would preempt North Carolina law.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 C.F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

Subject to any Federal provision, in North Carolina medical reports are not privileged in any workers’ compensation case with respect to a claim pending for hearing before the
57. **What are the provisions for “Independent Contractors”?**

As defined by the North Carolina Workers’ Compensation Act, N.C. Gen. Stat. § 97-2(2), an injured person can recover workers’ compensation benefits only if he is an “employee” of the one from whom he seeks compensation at the time of his injury. An “independent contractor” is “one who exercises an independent employment and contracts to do certain work without being subject to his employer except as to the result of his work.” *Hicks v. Guilford Co.*, 267 N.C. 364, 148 S.E.2d 240 (1966). The North Carolina Supreme Court has established eight factors to consider in determining whether a worker is an employee or an independent contractor, and an independent contractor (1) is engaged in an independent business, calling, or occupation; (2) is to have the independent use of his or her skill, knowledge, or training in the execution of the work; (3) is doing a specific piece of work at a fixed price, or for a lump sum or upon a quantitative basis; (4) is not subject to discharge because he or she adopts one method of doing the work rather than another; (5) is not in the regular employ of the other contracting party; (6) is free to use such assistants as he or she thinks proper; (7) has full control over such assistants; and (8) selects his or her own time. *Hayes v. Board of Trustees*, 224 N.C. 11, 29 S.E.2d 137 (1944). The presence of no one of these indicia is controlling, nor is the presence of all required, but the dominant factor is whether the employer has authority to control how the person hired accomplishes the task to be done. *Id.; Youngblood v. North State Food Truck Sales*, 87 N.C. App. 35, 359 S.E.2d 256 (1987)

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Yes. Motor carriers who contract with independent contractors are liable to the independent contractor and his employees unless insurance has been secured by the independent contractor. See N.C. Gen. Stat. § 97-19.1.

60. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

No. There are no specific provisions in the North Carolina Workers’ Compensation laws for medical marijuana. See Answer to Question 9(c).

61. **Does your state permit the recreational use of marijuana and what are the**

...
restrictions for use and for work activity in your state Workers’ Compensation law?

No. There are no specific provisions in the North Carolina Workers’ Compensation laws for recreational marijuana use. See Answer to Question 9(c).

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1. **Citation for the States’ workers’ compensation statute.**

North Dakota Century Code Title 65 (Chapters 65-01 through 65-10). NOTE: North Dakota has a mandatory state-run fund and, consequently, insurers are not involved in workers’ compensation matters in North Dakota. The fund is administered by the North Dakota Workforce Safety & Insurance Organization (“Organization”). The Organization was formerly known as the North Dakota Workers’ Compensation Bureau.

**SCOPE OF COMPENSABILITY**

2. **Who are covered “employees” for purposes of workers’ compensation?**

The term “employee” is generally defined as every person who performs hazardous services for another for remuneration unless the person is an independent contractor. N.D. Cent. Code § 65-01-02(16).

The term “employee” includes all elective and appointed officials of the state and its political subdivisions, the legislative assembly, elective officials of the state's counties, and all elective peace officers of any city. N.D. Cent. Code § 65-01-02(16)(a)(1). The term also includes aliens, human service zone general assistance workers, and minors. N.D. Cent. Code § 65-01-02(16)(a)(2)-(4).

The term “employee” does not include any person whose employment is both casual and not in the course of the trade, business, profession, or occupation of that person's employer; any person who is engaged in an illegal enterprise or occupation; the spouse or child, under the age of 22, of the employer; in general, any real estate broker or real estate salesperson; the members of the board of directors of a business corporation who are not employed in any other capacity by the corporation; any individual delivering newspapers or shopping news, if substantially all of the individual’s remuneration is directly related to sales; and any employer. N.D. Cent. Code § 65-01-02(16)(b).
Each person who performs services for another for remuneration is presumed to be an employee of the person for whom the services are performed, unless it is proven that the person is an independent contractor. N.D. Cent. Code § 65-01-03. A person who is an independent contractor rather than an employee does not fall within the scope of the workers’ compensation statutes. Schaefer v. North Dakota Workers Compensation Bureau, 462 N.W.2d 179,180 (N.D. 1990).

3. **Identify and describe any “statutory employer” provision.**

Persons employed by a subcontractor, or by an independent contractor operating under an agreement with the general contractor, are deemed to be employees of the general contractor who is liable and responsible for the payments of premiums for the coverage of the employees until the subcontractor or independent contractor has secured the necessary coverage and paid the premium for the coverage. This subdivision does not impose any liability upon a general contractor other than liability to the Organization for the payment of premiums which are not paid by a subcontractor or independent contractor. N.D. Cent. Code § 65-01-02(17)

4. **What types of injury is covered and what is the standard of proof for each:**

   A. **Traumatic or “single occurrence” claims.**

   Injuries which occur by accident and arise out of and in the course of hazardous employment, and which are established by medical evidence supported by objective medical findings, meet the statutory definition of “compensable injury.” See N.D. Cent. Code § 65-01-02(11). Injuries to artificial members are compensable. N.D. Cent. Code § 65-01-02(11)(a)(2). Injuries arising out of employer-required or supplied travel to and from a remote job site or activities performed at the direction or under the control of the employer also are compensable. N.D. Cent. Code § 65-01-02(11)(a)(4). Injuries caused by the willful act of a third person directed against an employee because of the employee’s employment is compensable. N.D. Cent. Code § 65-01-02(11)(a)(5). The claimant has the burden of proving by a preponderance of the evidence that the claimant is entitled to participate in the Workforce Safety & Insurance Fund. N.D. Cent Code § 65-01-11.

   B. **Occupational disease (including respiratory and repetitive use).**

   In general, the term “compensable injury” includes any disease caused by a hazard to which an employee is subjected in the course of employment, and which must be incidental to the character of the business and not independent of the relation of employer and employee. See N.D. Cent. Code § 65-01-02(11)(a)(1). Ordinary diseases of life to which the general public outside of employment is exposed or preventive treatment for communicable diseases are not compensable, except that the Organization may pay for preventive treatment for a health care provider, firefighter, peace officer, correctional officer, court officer, law enforcement officer, emergency medical technician, or an individual trained and authorized by law or rule to render emergency medical assistance or treatment who is exposed to a blood borne
pathogen occurring in the course of employment and for exposure to rabies occurring in the
where there is a direct causal connection between the disease and the work conditions.
N.W.2d 312.

5. **What, if any, injuries or claims are excluded?**

The following injuries are not included in the term “compensable injury:” (1) ordinary
diseases of life to which the general public outside of employment is exposed or preventative
treatment for communicable diseases; (2) an injury caused by the employee’s willful
intention to injure or kill himself or another; (3) an injury caused by the use of intoxicants or
the illegal use of controlled substances; (4) an injury that arises out of an altercation in which
the injured employee is an aggressor, unless the injured employee is required to engage in
altercations as a part of their job duties, such as a police officer or private security personnel;
(5) an injury that arises out of the commission of an illegal act by the injured employee; (6)
an injury that arises out of an employee’s voluntary nonpaid participation in any recreational
activity; (7) injuries attributable to a pre-existing injury, disease, or condition, including
when the employment acts as a trigger to produce symptoms in the pre-existing injury,
disease, or other condition unless the employment substantially accelerates its progression or
substantially worsens its severity; (8) a nonemployment injury that, although acting upon a
prior compensable injury, is established as an independent intervening cause of injury; (9) a
latent or asymptomatic degenerative condition, caused in substantial part by employment
duties, which is triggered or made active by a subsequent injury; (10) a mental injury arising

6. **What psychiatric claims or treatments are compensable?**

Physical injury caused by mental stimulus, if: (1) causally related to the employee’s
employment with reasonable medical certainty; and (2) with reasonable medical certainty, it
is determined that unusual stress is at least fifty percent of the cause of the injury or disease
as compared with all other contributing causes combined. N.D. Cent. Code § 65-01-02(11)(a)(3). A mental or psychological condition caused by a physical injury, but only when
the physical injury is determined with reasonable medical certainty to be at least fifty percent
of the cause of the condition as compared with all other contributing causes combined, and
only when the condition did not pre-exist the work injury. N.D. Cent. Code Ann. § 65-01-02(11)(a)(6). Mental injury arising from mental stimulus is not compensable. N.D. Cent.

7. **What are the applicable statutes of limitations?**

All original claims for compensation must be filed by the employee, or someone on the
employee’s behalf, within one year after the injury or within two years after the death. The
date of injury for the purposes of this section is the first date that a reasonable person knew or
should have known that the employee suffered a work-related injury and has either lost
8. **What are the reporting and notice requirements for those alleging an injury?**

A written claim must be filed within the time specified (see answer 7) by: (1) delivering it at the office of the Organization or to any person whom the Organization by regulation may designate; or (2) depositing it in the mail properly stamped and addressed to the Organization or to any person whom the Organization, by regulation, may designate. N.D. Cent. Code § 65-05-01.

An employee who is involved in an accident while on the job must take immediate steps to notify the employer of the accident and the general nature of the injury, if apparent. N.D. Cent. Code § 65-05-01.2. Notice may be either oral or written and, absent good cause, may not be given later than seven days after the accident occurred or the general nature of the employee's injury became apparent. *Id.* If an employee fails to comply with the notice requirements, the Organization may consider that failure to notify in determining whether the employee's injury is compensable. N.D. Cent. Code § 65-05-01.3.

The employer must file a first report of notice of injury with the Organization within seven days from the date the employer receives the notice of injury from the employee. N.D. Cent. Code § 65-05-01.4. Failure of the employer to file a first report of notice of injury is an admission by the employer that the alleged injury may be compensable. *Id.*

Every claim must be made on forms furnished by the Organization and must contain all of the information required by the Organization. N.D. Cent. Code § 65-05-02. Each claim must be signed by the employee or by the person acting on his or her behalf and, except in the case of death, must be accompanied by a certificate of the employee's doctor stating that the employee was physically examined, stating the nature of the injury and the nature and probable extent of the disability. *Id.*

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

Any injury caused by the employee’s willful intention to injure or kill himself or another is not a compensable injury. N.D. Cent. Code § 65-01-02(11)(b)(2).

B. **Willful misconduct, “horseplay,” etc.**

An exclusion for injuries caused by willful misconduct or horseplay is not explicitly provided for in the workers’ compensation statutes. There is, however, an exclusion for the willful intention to injure or kill another. See N.D. Cent. Code § 65-01-02(11)(b)(2). Term “compensable injury” includes only those injuries caused by accident arising out of and in the course of employment, and which must be established by medical evidence supported by
objective medical findings. See N.D. Cent. Code § 65-01-02(11). Thus, it could be argued that an injury caused by willful misconduct or horseplay does not arise out of and in the course of employment and is therefore not a compensable injury. However, in another context, the North Dakota Supreme Court has found as a matter of law that an employee’s act of horseplay in intentionally pushing the knees out from under a co-employee was not a sufficiently substantial deviation from the course of employment to transform the employee from a co-employee to a third-person tortfeasor. See Mitchell v. Sanborn, 536 N.W.2d 678, 683-86 (N.D. 1995). Fetzer v. North Dakota Workforce Safety and Ins., 2012 ND 73, 815 N.W. 2d 539 (Horseplay not extended to include an employee who fell at work without explanation).

C. Injuries involving drugs and/or alcohol.

Injuries caused by the use of intoxicants or the illegal use of controlled substances are not compensable. N.D. Cent. Code § 65-01-02(11)(b)(3).

10. What, if any, penalties or remedies are available in claims involving fraud?

Any person claiming benefits or payment for services who: (1) willfully files a false claim or makes a false statement; (2) willfully misrepresents that person’s physical condition; or (3) willfully fails to notify the Organization as to the receipt of income, or an increase in income, from employment after the issuance of an order awarding benefits is guilty of a Class A misdemeanor. N.D. Cent. Code § 65-05-33(1). If the act is committed to obtain, or pursuant to a scheme to obtain, more than one thousand dollars in benefits or payment for services, the offense is a class C felony. N.D. Cent. Code § 65-05-33(2). The term “statement” includes any testimony, claim form, notice, proof of injury, proof of return to work status, bill for services, diagnosis, prescription, hospital or doctor records, x-ray, test results, or other evidence of loss, injury, or expense. N.D. Cent. Code § 65-05-33(4). In addition to any other penalties provided by law, the person making a false statement or filing a false claim must reimburse the Organization for any benefits paid based upon the false claim or statement, and must forfeit any additional benefits relative to that injury. N.D. Cent. Code § 65-05-33(3). To trigger any consequences for claims involving fraud, the false statements must be intentional, not inadvertent, and must be material, not peripheral. Horob v. North Dakota Workers Compensation Bureau, 2004 N.D. 114, ¶ 14, 611 N.W.2d 875, 880 (N.D. 2000).

Although compensation and claims are usually exempt from claims of creditors, a claim by the Organization for any payments made due to fraud is not exempt. N.D. Cent. Code § 65-05-29(1)(c)(3). The recipient shall repay the payment, or the unpaid amount of the sum may be recouped from any future payments due to the recipient on any claim with the Organization. Id.

Once it is proven that a false statement has been willfully made, the claimant forfeits any additional benefits relative to that injury. N.D. Cent. Code § 65-05-33(3); Hoplauf v. North Dakota Workers Compensation Bureau, 575 N.W.2d. 436 (N.D. 1998). The false statement
must be sufficiently material to support a forfeiture of future benefits, however. *Horob v. North Dakota Compensation Bureau*, 2000 N.D. 114, ¶ 15, 611 N.W.2d 875. Materiality is proven when the Organization shows the false claim or false statement caused the benefits to be paid in error. *Id.* To trigger the civil penalties, the Organization must prove the fraud by a preponderance of the evidence. *Renault v. North Dakota Workers Compensation Bureau*, 1999 N.D. 187, ¶ 10, 601 N.W.2d 580. If the claimant wrongfully conceals his or her income, which impedes the Organization’s proof of materiality, the claimant suffers the consequences by bearing the burden. *Unser v. North Dakota Workers Compensation Bureau*, 1999 N.D. 129, ¶ 22, 598 N.W.2d 89. When the Organization terminates benefits, the burden shifts to the claimant to prove the right to continued benefits. *Id.*

11. **Is there any defense for falsification of employment records regarding medical history?**

See Answer 10.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Any injury that arises out of an employee’s purely voluntary non-paid participation in any recreational activity, even though the employer pays some or all of the cost of the activity, is not a compensable injury. N.D. Cent. Code § 65-01-02(11)(b)(6).

13. **Are injuries by co-employees compensable?**

Yes, if the injuries meet the statutory definition of “compensable injury” as defined in N.D. Cent. Code § 65-01-02(11).

14. **Are acts by third-parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?**

This is not explicitly provided for in the statute. Generally, the term “compensable injury” includes only those injuries caused by an accident arising out of and in the course of employment, which must be established by medical evidence supported by objective medical findings. See N.D. Cent. Code § 65-01-02(11). Additionally, the statute provides a subrogation right to the Fund in situations where it provides benefits to an employee who was injured under circumstances creating in some person other than the Organization a legal liability to pay damages to the employee. N.D. Cent. Code § 65-01-09.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

Average weekly wage means the weekly wages the employee was receiving from all employments at the date of first disability. In cases where the employee’s wages are not
fixed by the week because the employee is self-employed or is paid hourly, monthly, or biweekly, the employee’s average weekly wage must be determined by using various formulas provided by statute, e.g., monthly rate multiplied by twelve months and divided by fifty-two weeks, biweekly rate divided by two, etc. See N.D. Cent. Code § 65-01-02(6).

Average weekly wage in the state means a determination made of the average weekly wage in the state by Job Service North Dakota on or before July 1 of each year, computed to the next highest dollar. N.D. Cent. Code § 65-01-02(6).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

If an injury causes temporary total disability or permanent total disability, the Organization pays the employee during such disability a weekly compensation equal to sixty-six and two-thirds of the employee's gross weekly wage, subject to a minimum of 60% and a maximum of 125% of the state average weekly wage. N.D. Cent. Code § 65-05-09. There are provisions for a social security offset (N.D. Cent. Code 65-05-09.1) and a retirement offset (N.D. Cent. Code § 65-05-09.2).

If the injury causes temporary partial disability resulting in a decrease of earning capacity, the compensation is sixty six and two-thirds of the difference between the employee's average weekly wages before the injury and the wage earning capacity after the injury in the same or another employment. N.D. Cent. Code § 65-05-10.

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

Upon the filing of a claim, the Organization must send to the employer a copy of the claim along with a form provided for the employer's response. N.D. Cent. Code § 65-01-16. The employer has fourteen days to file or mail a response. Id. The Organization may then make an informal decision on the claim. Id. If the Organization determines that more information is needed to process the claim, but that the information provided indicates that the employee is more likely than not to receive benefits, the Organization may pay preacceptance disability benefits while the claim is pending, equal to the minimum weekly disability benefit allowed under section 65-05-09. N.D. Cent. Code § 65-05-08.2. The Organization may not pay more than sixty days of preacceptance benefits. Id.

18. What is the waiting or retroactive period for temporary benefits?

The employee must be out five consecutive calendar days before recovering benefits for those days. N.D. Cent. Code § 65-05-08.

19. What is the standard/procedure for terminating temporary benefits?

Prior to the expiration of a period of disability certified by a doctor, if a report certifying an
additional period of disability has not been filed, or upon receipt of a report or other evidence indicating a claimant who is receiving disability benefits has been or will be released to return to work, the Organization shall send to the claimant a notice of intention to discontinue benefits. N.D. Cent. Code § 65-05-08.1(6). Such benefits may then be discontinued on the date of release to return to work or 21 days following mailing of the notice, whichever occurs first. Id. The notice must include an explanation of the reason for the action, an explanation of the right to respond, and the procedure for filing the required report or challenging the proposed action. Id.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No. N.D. Cent. Code § 65-05-12.2 provides for procedure by which a claimant receives a permanent partial disability award. No case law addresses this point, either, although the courts have offset a claimant’s award of permanent partial impairment benefits with previously paid permanent partial impairment benefits. See *Witcher v. North Dakota Workers Compensation Bureau*, 602 N.W.2d 704 (N.D. 1999).

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement resulting from an injury is included within the definition of permanent impairment (i.e., permanent partial disability). See N.D. Cent. Code § 65-01-02(27). Benefits would be calculated as set forth in answer 22 below.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

North Dakota uses the terminology permanent partial impairment rather than permanent partial disability. If the injury causes the loss of a scheduled member, the Organization shall pay to the impaired employee a lump sum, calculated by multiplying thirty-five percent of the average weekly wage in the state on the date of the impairment evaluation, rounded to the highest dollar, by the number of weeks set forth in the statutory schedule for various injuries. N.D. Cent. Code § 65-05-12.2. If the injury is not specifically scheduled, the award is determined by reference to the whole person impairment percentages described below.

B. **Number of weeks for whole person and standard for recovery.**

If the injury causes permanent impairment, other than scheduled injuries, the percentage which such impairment bears to total impairment must be determined, and the Fund shall pay to the impaired employee a lump sum, calculated by multiplying thirty-five percent of the average weekly wage in the state on the date of the impairment evaluation, rounded to the
highest dollar, by the number of weeks set forth in the statutory schedule for the percentage of whole body impairment. N.D. Cent. Code § 65-05-12.2.

Any rating of impairment should be in accordance with the standards for the evaluation of permanent impairment as published in the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment unless proven otherwise by clear and convincing medical evidence. *Id.*

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Rehabilitation services are generally provided for under N.D. Cent. Code § 65-05.1. The employee has the burden to seek, obtain, and retain reasonable and substantial employment in order to reduce the period of temporary disability to a minimum. N.D. Cent. Code § 65-05.1-04(1). The goal of rehabilitation is to return the employee to substantial gainful employment, by returning him to the same position, by returning him to a modified position, by training or retraining, etc. N.D. Cent. Code § 65-05.1-01(3). The various rehabilitation options are prioritized (e.g., return to the same position, return to the same occupation, etc.). *See* N.D. Cent. Code § 65-05.1-01(4). Vocational rehabilitation services may be initiated by the Organization on its own motion, or by the employee or the employer if proof exists that the claimant has reached maximum medical recovery, that the claimant is not working, and has not voluntarily retired or removed himself from the labor force, and that the employee has made good faith efforts to seek, obtain, and retain employment. *See* N.D. Cent. Code § 65-05.1-01(8).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

If an injury causes permanent total disability, the Organization pays the employee during such disability a weekly compensation equal to sixty six and two-thirds of the employee's gross weekly wage, subject to a minimum of 60% and a maximum of 125% of the state average weekly wage. N.D. Cent. Code § 65-05-09. There are provisions for a social security offset (N.D. Cent. Code 65-05-09.1) and a retirement offset (N.D. Cent. Code § 65-05-09.2).

25. **How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

If death benefits are payable, funeral expenses are paid subject to a $10,000 maximum. N.D. Cent. Code § 65-05-26.

**B. Dependency claims.**

The spouse or guardian of the children of the decedent receives an amount equal to the
benefit rate for total disability under section 65-05-09. N.D. Cent. Code § 65-05-17(1). These benefits continue until the death of the spouse; or, in the case of a guardian, until the child or children of the decedent no longer meets the definition of a child. Id. Where there is more than one guardian for the children of a decedent, death benefits must be divided equally among guardians. Id.

Each child of the deceased employee receives $15 per week. N.D. Cent. Code § 65-05-17(2). The Organization may make this payment directly to the child of the deceased employee or to the surviving parent or guardian of the child. Id.

In addition, the Organization shall make a payment in the sum of $2,500 to the spouse or guardian of the decedent’s child or children and $800 for each dependent child. N.D. Cent. Code § 65-05-17(3). When there is more than one guardian, the $2,500 must be divided equally among the guardians. Id.

26. What are the criteria for establishing a “second injury” fund recovery?

No North Dakota statutory or case law addresses this issue directly. However, this should be governed by the same criteria applicable to an initial injury as set forth in answers 2 through 14 above.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The Organization has continuing jurisdiction over claims properly filed, and the Organization may at any time, on its own motion or on application, review an award. N.D. Cent. Code § 65-05-04. There is no appeal available from an Organization decision not to re-open a claim after the Organization's order on the claim has become final. Id.

28. What situation would place responsibility on the employer to pay a claimant's attorney fees?

If an employer wrongfully retaliates, or willfully threatens to discharge an employee for seeking payments under this Title, then the employer is liable in a civil action for damages, including reasonable attorney’s fees. N.D. Cent. Code § 65-05-37.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Where the employer has secured payment of compensation by contributing to the Fund, the workers’ compensation statutes are the employee’s exclusive remedy against the employer. See N.D. Cent. Code § 65-01-08. The immunity also extends to staffing agencies and their
client companies who contribute to the Fund. *Id.*

**B. Exceptions (intentional acts, contractual waiver, dual capacity, etc.).**


### 30. Are there any penalties against the employer for unsafe working conditions?

Matters concerning the Organization's role with respect to safety in the work place are provided for in N.D. Cent. Code Ch. 65-03. A violation of any reasonable safety rule or regulation made by the Organization can result in the employer being guilty of an infraction, and the Organization may penalize the premium rating of that employer. N.D. Cent. Code § 65-03-02.

### 31. What is the penalty, if any, for an injured minor?

There are no apparent additional penalties under the statute for injury to minors.

### 32. What is the potential exposure for “bad faith” claims handling?

In North Dakota, the Workforce Safety & Insurance Organization is a state-run fund, and private insurers are not involved.

### 33. What is the exposure for terminating an employee who has been injured?

There are no apparent provisions in the statute addressing this situation. Any potential claims against the employer would be left to other law, e.g., civil actions for wrongful discharge. *See also* answer no. 28.

**THIRD-PARTY ACTIONS**

### 34. Can third parties be sued by the employee?


### 35. Can co-employees be sued for work-related injuries?

No. Under the exclusive remedy provisions of the statute, an employee is prohibited from bringing an action against a co-employee for damages for personal injuries. N.D. Cent. Code § 65-01-08(1).
36. **Is subrogation available?**

Yes. In a third party action, the Fund is subrogated to the rights of the employee or the employee's dependents for 50% of the damages recovered, up to a maximum of the total amount that it has paid or would otherwise pay in the future. N.D. Cent. Code § 65-01-09.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

None provided by North Dakota law.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

A North Dakota employer or the employer’s duly authorized representatives, who are required to have access to an injured worker’s claim file for performance of their duties, may review and have access to any files of their own injured workers with the North Dakota Workforce Safety & Insurance Organization. N.D. Cent. Code § 65-05-32(2). No written authorization from the employee is required.

39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion?**

The employee may choose the doctor to render initial treatment. N.D. Cent. Code § 65-05-28. Upon a determination that the injury is compensable, the Organization may require the employee to begin treating with another doctor, to better direct the medical aspects of the claim. Id. No employee may change doctors while under treatment, or after being released, without the Organization's prior written authorization. N.D. Cent. Code § 65-05-28(1). The Organization may at any time require an employee to submit to an independent medical examination by a doctor designated or approved by the Organization. N.D. Cent. Code § 65-05-28(3). Notwithstanding the provisions of § 65-05-28, any employer may select a preferred provider to render medical treatment to employees who sustain compensable injuries. N.D. Cent. Code § 65-05-28.1.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

As a general rule, the Fund will furnish such reasonable and appropriate medical, surgical, and hospital services and supplies as the nature of the injury may require. N.D. Cent. Code § 65-05-07.

41. **Which prosthetic devices are covered, and for how long?**
The Fund may furnish such artificial members and replacements as in the judgment of the Organization may be necessary to rehabilitate the employee. N.D. Cent. Code § 65-05-07.

42. **Are vehicle and/or home modifications covered as medical expenses?**

If the Organization determines that it is necessary to provide permanent additions, remodeling, or adaptations to real estate to those employees who sustain catastrophic injury, such improvements may be made, but may not exceed $75,000 for the life of the employee, regardless of any subsequent claim. N.D. Cent. Code § 65-05-07(5)(a). The Organization may pay an amount not to exceed one hundred fifty thousand dollars to prove the most cost-effective, specially equipped motor vehicle or adoptions in the case of a catastrophic injury if the Organization determines it is necessary. N.D. Cent. Code § 65-05-07(5)(b).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**


44. **What, if any, provisions or requirements are there for “managed care”?**

The Organization shall establish a managed care program to effect the best medical solution for an employee. N.D. Cent. Code § 65-02-20. The managed care administrator assists the Organization in the medical management of claims within the bounds of workers' compensation law. *Id.* There are provisions for dispute resolution with respect to the recommendations of the managed care program. *Id.*

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

An employer may file a response to an initial claim form within 14 days from the date the response form was mailed to the employer. N.D. Cent. Code § 65-01-16(1). A failure to do so constitutes an admission that the information in the claim form is correct. *Id.* See also answer to 46 below.

46. **What is the method of claim adjudication?**

   **A. Administrative level.**

   The Organization may conduct an informal review on any matter subject to its jurisdiction. N.D. Cent. Code § 65-01-16(2). The Organization shall issue to the parties a notice of its informal decision. N.D. Cent. Code § 65-01-16(3). Following issuance of the notice of
informal decision, any party may request reconsideration within thirty days from the date the notice was mailed. N.D. Cent. Code § 65-01-16(4). The Organization shall thereafter issue its notice of decision reversing the previous decision, or may issue an administrative order. N.D. Cent. Code § 65-01-16(5). Following the issuance of an order, a rehearing may be requested within thirty days. N.D. Cent. Code § 65-01-16(7). A hearing is then held before a hearing officer. N.D. Cent. Code § 65-01-16(8). A post-hearing administrative order may be appealed to district court. N.D. Cent. Code § 65-01-16(10).

B. Trial court.

The statute does not provide for trial court proceedings. However, the state district courts function as an appellate court in appeals from decisions of the Organization. N.D. Cent. Code § 65-01-16(10).

C. Appellate.

An appeal from the administrative level is originally made to the state district court in accordance with the Administrative Agencies Practice Act, N.D. Cent. Code § 28-32-01 et seq. A party aggrieved by the decision of the district court may take an appeal to the North Dakota Supreme Court. See N.D. Cent. Code § 28-32-49.

47. What are the requirements for stipulations or settlements?

If an employee is determined to be permanently and totally disabled, the Organization may pay the employee a lump sum equal to the present value of all future payments of compensation. N.D. Cent. Code § 65-05-25(1). The Organization may not pay the employee a lump sum unless it is first determined that there is clear and convincing evidence that the lump sum payment is in the employee's best interest. Id.

The Organization and any employee may compromise to resolve a disputed claim. N.D. Cent. Code § 65-05-25(2). The contract of settlement made is enforceable by the parties. Id. If the employee breaches the contract, the Organization may require the employee to repay the benefits received under the agreement. Id.

As the employer’s insurer, the Organization will resolve claims on the employer’s behalf. Therefore, there are no provisions in the statute for an employer’s ability to resolve a claim with an employee-claimant. See id.

48. Are full and final settlements with closed medicals available?


49. Must stipulations and/or settlements be approved by the state administrative body?
All agreements are made between the Organization and the employee. See N.D. Cent. Code § 65-05-25.

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Each employer subject to the statute must pay into the state fund annually the amount of premiums determined and fixed by the Organization for the employment or occupation of the employer. N.D. Cent. Code § 65-04-04. Premiums are calculated by taking into account the statewide average annual wage, and other factors. See N.D. Cent. Code § 65-04-04.2.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Not permitted.

B. For groups or “pools” of private entities.

Not permitted.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of an “employee”?

Aliens are considered employees for purposes of this Title. N.D. Cent. Code § 65-01-02(16)(a)(2). There is no differentiation in the statue between ‘illegal’ and ‘legal’ aliens although, § 65-01-02(16)(a)(4) provides that minors, whether lawfully or unlawfully employed, are deemed employees and are entitled to benefits. The statute does provide that any person engaged in unlawful enterprise or occupation is not an employee under this Title. N.D. Cent. Code § 65-01-02(16)(b)(2).

Further, federal preemption would seem to bar the State from adopting a law which states that illegal aliens are incapable of entering a lawful employment contract.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There is no special treatment of terrorist acts or injuries Title 65 of North Dakota’s statute.

54. Are there any state specific requirements which must be satisfied in light of the
obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Under Medicare regulations (42 CFR §411.20, 411.40), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. 42 CFR § 411.32, 411.40, 411.46. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare enrollee and the total settlement amount is greater than $25,000.; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000. See Frazer v. CNA Ins. Co., 374 F.Supp.2d 1067, 1076 (N.D. Ala. 2005).

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Id.

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

There are no special provisions in Title 65 regarding the effect of Medicare trusts and liens on settlements with the Organization. However, the statute provides a retirement presumption and termination of benefits under certain circumstances where the employee begins receiving social security benefits. See N.D. Cent. Code § 65-05-09.3(2).

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

There are no special provisions in Title 65 regarding subrogation liens of Medicaid and health insurers. However, the state is generally entitled to subrogation against worker’s compensation benefits and health insurance providers are generally entitled to subrogation if the individual policies provide that right.
56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

The Health Insurance Portability and Accountability Act of 1996, HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went effect on April 14, 2003. The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512] Therefore, the current practice of obtaining medical records should proceed according to state law.

Under North Dakota’s Title 65, information contained in the claim files and records of injured employees is confidential and not open to public inspection, other than to the Organization employees or agents in the performance of their official duties. N.D. Cent. Code § 65-05-32. Exceptions are provided for: 1) the injured employee or the employee’s agents; 2) the employer or their duly authorized representatives needing access for the performance of their duties; 3) physicians or health care providers treating or examining the claimant or providing medical advice to the Organization regarding the claim; and 4) other persons who are providing assistance to the Organization at any stage in the claim proceedings. Id. The medical portion of the hearing may be closed upon a claimant’s request. Id. The claimant’s name, date of birth, injury date, employer name, type of injury, whether the claim was denied, accepted or remains pending, and whether the claim is in active pay status will be available to the public. Id.

The effect of HIPAA (Health Insurance Portability and Accountability Act of 1996) on the Workforce Safety & Insurance laws is somewhat uncertain. However, the North Dakota Organization has taken the position that it is exempt from the federal HIPAA requirements. The Organization has taken the position that “[a]ll disclosures to workers’ compensation are specifically exempted from HIPAA. A covered entity, as a result, shall disclose protected health information in order to comply with workers’ compensation requirements.” See http://www.nd.gov/risk/workers-comp/workers-compensation.

57. What are the provisions for “Independent Contractors”?

If a person qualifies as an independent contractor under the “common law” test, he or she is not an employee under the North Dakota definition. N.D. Cent. Code § 65-01-02(16). In addition, see answer 2.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment Organizations/temporary service companies/leasing companies?

No, except for certain real estate brokers and real estate salespersons. See answer 2.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or
property?

No, with a limited exception for certain individuals delivering newspapers or shopping news. See answer 2.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

Under Medicare regulations (42 CFR §411.20, 411.40), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. 42 CFR § 411.32, 411.40, 411.46. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

   (1) the employee is already a Medicare enrollee and the total settlement amount is greater than $25,000; or
   (2) there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000. See Frazer v. CNA Ins. Co., 374 F.Supp.2d 1067, 1076 (N.D. Ala. 2005).

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. *Id.*

Although there are no statutory or regulatory provisions that require parties to submit a Workers’ Compensation Medicare Set-Aside Agreement (“WCMSA”), allocating a portion of the settlement towards future medical expenses, parties may choose to submit a WCMSA to the Centers for Medicare and Medicaid services for review and approval so long as the above thresholds are satisfied. DEP’T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, May 11, 2011 Memorandum re: Medicare Secondary Payer-Workers’ Compensation, available at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/May-11-2011-Memorandum.pdf.
There are no special provisions in Title 65 regarding the protection of Medicare’s interests during settlement with the Organization. However, the statute provides a retirement presumption and termination of benefits under certain circumstances where the employee begins receiving social security benefits. See N.D. Cent. Code § 65-05-09.3(2).

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

In November, 2016 North Dakotans voted to legalize medical marijuana creating N.D.C.C. 19-24. The legislature enacted SB 2344, also known as “The Compassionate Care Act” (CCA) on April 17, 2017 when it was signed into law by Governor Doug Burgum. On April 18, 2017, Chapter 19-24 of the N.D.C.C was repealed and ch.19-24.1 was enacted.

House Bill (HB) 1156 was signed by Governor Doug Burgum on April 10, 2017 and enacted into statute. NJ 1603, 65th Sess., at 1603 (N.D. 2017). The amendments to Title 65 prohibit the payment of workers’ compensation benefits for medical marijuana. The definition of medical marijuana is the use of all parts of the plant of the genus cannabis, the seeds of the plant, the resin extracted from any part of the plant and every compound of the plant. It does not include treatments of preparations approved by the United States food and drug administration as a drug product (edibles). Section 65-01-02(22). The Organization may not pay for medical marijuana and “the Organization may not pay wage loss benefits if the wage loss is related to the use or presence of medical marijuana. N.D.C.C. 65-05-07. (8)(l); N.D.C.C. 65-05-08(12).

There is currently no case law in North Dakota outlining whether injuries which occur by accident and arise out of and in the course of employment while under the influence of (state) legalized medical marijuana are a compensable injury. Additionally, an employer may not need to pay compensatory costs because marijuana is a Schedule 1 controlled substance, and is therefore illegal under federal law. 21 U.S.C.; See answer 9(c).

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Currently recreational use of marijuana is illegal under North Dakota and Federal law. See answer 9(c).

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Robert B. Stock, Esquire
1. **Citation for the state's workers' compensation statute.**

Ohio Revised Code §4121.01 *et. seq.*
Ohio Administrative Code §4121-1 *et. seq.*
Ohio Revised Code §4123.01 *et. seq.*
Ohio Administrative Code §4123-01 *et. seq.*
Ohio Revised Code §4125.01 *et. seq.*
Ohio Administrative Code §4125-1-01 *et. seq.*

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers' compensation?**

"Employee" means: Every person in the service of the state, or of any county, municipal corporation, township, or school district therein, including regular members of lawfully constituted police and fire departments of municipal corporations and townships, whether paid or volunteer, and wherever serving within the state or on temporary assignment outside thereof, and executive officers of boards of education, under any appointment or contract of hire, express or implied, oral or written, including any elected official of the state, or of any county, municipal corporation, or township, or members of boards of education. Ohio Rev. Code §4123.01(A)(1)(a).

3. **Identify and describe any "statutory employer" provision.**

Every person in the service of any person, firm, or private corporation, including any public service corporation, that (i) employs one or more persons regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, including aliens and minors, household workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single household and casual workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single employer, or (ii) is bound by any such contract of hire or by any
other written contract, to pay into the state insurance fund the premiums provided by this chapter. Ohio Rev. Code §4123.01(A)(b)

Every person in the service of any independent contractor or subcontractor who has failed to pay into the state insurance fund the amount of premium determined and fixed by the administrator of workers' compensation for the person's employment or occupation or if a self-insuring employer has failed to pay compensation and benefits directly to the employer's injured and to the dependents of the employer's killed employees as required by section 4123.35 of the Revised Code, shall be considered as the employee of the person who has entered into a contract, whether written or verbal, with such independent contractor unless such employees or their legal representatives or beneficiaries elect, after injury or death, to regard such independent contractor as the employer. Ohio Rev. Code §4123.01(A)(b).

4. **What types of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or "single occurrence" claims.**

   “Injury” includes any injury, whether caused by external accidental means or accidental in character and result, received in the court of, and arising out of, the injured employee’s employment. Ohio Rev. Code §4123.01(C). *Village v. General Motors, Corp., G.M.A.D.*, 15 Ohio St.3d 129 (1984).

   B. **Occupational disease (including respiratory and repetitive use).**

   "Occupational disease" means a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general. Ohio Rev. Code §4123.01(F).

5. **What, if any, injuries or claims are excluded?**

   "Injury" does not include: (1) Psychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate; (2) Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body; (3) Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity; (4) A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a substantial aggravation. However, subjective complaints without objective diagnostic
findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation. Ohio Rev. Code §4123.01(C)(1-4).

6. **What psychiatric claims or treatments are compensable?**

Psychiatric claims are not compensable unless the claimant's psychiatric condition has arisen from an injury or occupational disease sustained by the claimant, or where the claimant's psychiatric condition has arisen from sexual conduct that the claimant was forced by threat of physical harm to engage or participate in. Ohio Rev. Code §4123.01(C)(1). *Armstrong v. John R. Jurgensen Co.*, 136 Ohio St.3d 58, 2013-Ohio-2237, 990 N.E.2d 568 (Claimant must establish that his/her mental injury is causally related to his/her compensable physical injuries and not simply his/her involvement in the accident).

7. **What are the applicable statutes of limitations?**

Claims for single occurrence injuries or death are barred unless filed within two years from the date of injury or death. Ohio Rev. Code §4123.84.

In all cases of occupational disease, or death resulting from occupational disease, claims for compensation or benefits are forever barred unless, within two years after the disability due to the disease began, or within such longer period as does not exceed six months after diagnosis of the occupational disease by a licensed physician or within two years after death occurs, application is made to the industrial commission or the bureau of workers' compensation or to the employer if he is a self-insuring employer. Ohio Rev. Code §4123.85. In *White v. Mayfield*, the Ohio Supreme Court held disability due to an occupational disease shall be deemed to have begun on the date on which the claimant first became aware through medical diagnosis that he or she was suffering from such disease, or the date on which claimant first received medical treatment for such disease, or the date claimant first quit work on account of such disease, whichever is latest. *White v. Mayfield*, 37 Ohio St.3d 11, 14 (1988).

Each day that an employer fails to file a report required by Ohio Rev. Code §4123.28 constitutes an additional day within the time period given to a claimant by the applicable statute of limitations for the filing of a claim based on the injury or occupational disease. A failure to file a report shall not extend the applicable statute of limitations for more than two additional years. Ohio Rev. Code §4123.28.

8. **What are the reporting and notice requirements for those alleging an injury?**

A claim must be filed in writing and should be reported on the First Report of Injury (“FROI”) form provided by the Bureau of Workers’ Compensation. The FROI can be completed and submitted online at www.bwc.ohio.gov.

9. **Describe available defenses based on employee conduct:**
A. Self-inflicted injury.

Purposely self-inflicted injuries are not compensable under the workers’ compensation laws in Ohio. Ohio Rev. Code §4123.54 and §4123.46.

B. Willful misconduct, "horseplay," etc.

The general rule in Ohio is that no compensation is recoverable under the Workmen’s Compensation Acts for injuries sustained through horseplay or fooling around which was done independently of, and disconnected from, the performance of any duty of the employment. Sanders v. Fridd, 2013-Ohio-4338, 998 N.E.2d 526, ¶ 27 (10th Dist.) (citing Indus. Comm. v. Bankes, 127 Ohio St. 517, 522 (1934)). Exceptions to the general rule exist where the employee who is injured through horseplay or fooling around by other employees took no part in the fooling around, but was attending to his duties and where the employee is injured by horseplay commonly carried on by the employees with the knowledge and consent or acquiescence of the employer. Id.

C. Injuries or occupational diseases involving drugs and/or alcohol.

Employees are not entitled to receive compensation or benefits under this division if the employee’s injury or occupational disease is caused by the employee being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marijuana if the employee being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marijuana is the proximate cause of the injury. Ohio Rev. Code §4123.54(A)(2) and (B).

In order for compensation to be denied on the basis that an employee was intoxicated, “the employee must be so intoxicated, as shown by the evidence, that the court can say, as a matter of law that the injury arose out of his drunken condition and not out of his employment.” Phelps v. Positive Action Tool Co., 26 Ohio St.3d 142 (1986).

10. What, if any, penalties or remedies are available in claims involving fraud?

The Ohio Revised Code provides no person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do any of the following: Receive workers' compensation benefits to which the person is not entitled; Make or present or cause to be made or presented a false or misleading statement with the purpose to secure payment for goods or services rendered under Chapter 4121., 4123., 4127., or 4131. of the Revised Code or to secure workers' compensation benefits; Alter, falsify, destroy, conceal, or remove any record or document that is necessary to fully establish the validity of any claim filed with, or necessary to establish the nature and validity of all goods and services for which reimbursement or payment was received or is requested from, the bureau of workers' compensation, or a self-insuring employer under Chapter 4121., 4123., 4127., or 4131. of the Revised Code; Enter into an agreement or conspiracy to defraud the bureau or a self-insuring employer by making or presenting or causing to be made or presented a false claim for workers’ compensation benefits; Make or present or cause to be made or
presented a false statement concerning manual codes, classification of employees, payroll, paid compensation, or number of personnel, when information of that nature is necessary to determine the actual workers' compensation premium or assessment owed to the bureau by an employer; Alter, forge, or create a workers' compensation certificate to falsely show current or correct workers' compensation coverage; Fail to secure or maintain workers' compensation coverage as required by Chapter 4123. of the Revised Code with the intent to defraud the bureau of workers' compensation. Ohio Rev. Code §2913.48.

Whoever violates Ohio Rev. Code §2913.48 is guilty of workers’ compensation fraud which is a misdemeanor of the first degree, and can be a felony depending on the value. Ohio Rev. Code §2913.48(B).

11. **Is there any defense for falsification of employment records regarding medical history?**

No compensation shall be awarded on account of disability or death from disease suffered by an employee who, at the time of entering into the employment from which the disease is claimed to have resulted, willfully and falsely represented himself as not having previously suffered from such disease. Ohio Rev. Code §4123.70.

There is also a statutory defense to occupational disease claims for silicosis, asbestosis or coal miners’ pneumoconiosis in the event of a failure or omission on the part of the employee to truthfully state, when seeking employment, the place, duration and nature of previous employment in answer to an inquiry made by the employer. Ohio Rev. Code §4123.68.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Yes, unless a waiver is signed. Ohio Rev. Code §4123.01(C)(3)

Such waivers must be signed for each specific recreational activity and are good for two years. Ohio Adm. Code 4121-3-31.

13. **Are injuries by co-employees compensable?**

Injuries caused by co-employees are compensable, unless the horseplay defense applies. Co-employees are immune from suit if the injury is compensable. Ohio Rev. Code §4123.741; *Caygill v. Jablonski* (1992), 92 Ohio App. 3d 31.
14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**

The essential requirement in order to entitle an injured employee to compensation under Ohio law is the causal connection between the employment and the injury. Where the injury inflicted is personal to the employee and not relating to his employment, the injured employee will not be entitled to compensation under Ohio law. See *Brown v. Industrial Commission*, 86 Ohio App. 256, 82 N.E.2d 878 (10th Dist. 1948).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage ("AWW") is calculated by dividing the total earnings for the year prior to the disability or injury by 52. This calculation includes wage information from all employers during the prior year. Ohio Rev. Code §4123.61. Any period of unemployment due to sickness, industrial depression, strike, lockout, other causes beyond the employee’s control, or when special circumstances exist, are deleted. The burden is on the employee to prove that the 52 weeks is an accurate denominator under the circumstances. Special circumstances are not defined by the statute, but can be invoked if the standard calculation yields a result that is substantially unjust. *State ex rel. Wireman v. Indus. Comm.*, 49 Ohio St.3d 286 (1990). In calculating the AWW, two considerations dominate. First, the AWW must do substantial justice to the claimant. Second, it should not provide a windfall. *Id.*

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The Ohio Bureau of Workers’ Compensation (“OBWC”) (or a self-insuring employer) considers earnings from all employers that employed the injured worker during the 52 weeks prior to the date of injury when setting wages. OBWC (or a self-insuring employer) bases the full weekly wage (FWW) on a comparison of earnings for the first six weeks prior to the date of injury and the first full week of earnings prior to the date of injury. OBWC (or a self-insuring employer) bases the average weekly wage (AWW) on 52 weeks prior to the date of injury.

For the first 12 weeks of missed work, OBWC (or a self-insuring employer) may pay temporary total wages at the rate of 72 percent of the injured worker’s FWW, subject to the statewide maximum for the injury year and any applicable offsets. After 12 weeks of missed work, OBWC (or a self-insuring employer) may pay temporary total wages at the rate of 66 2/3 percent of the injured worker’s AWW, subject to the statewide maximum or minimum for the injury year and any applicable offsets.
17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

In uncontested state-fund claims, payment of compensation is to begin on the date the Administrator completes the investigation of the claim and issues an order of allowance. Such an order is to be issued within 28 days after the Bureau of Workers’ Compensation has notified the employer of its receipt of the claim and the facts alleged therein, unless a medical examination is required by statute.

In contested claims where the employee is successful, compensation is payable after the district hearing order is received, while medical benefits are not payable until after the issuance of the Staff Hearing Officer’s order. (The district hearing is the first, and the staff hearing the second, of three administrative levels of hearings). Ohio Rev. Code §4123.511.

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?

For a work-related injury resulting in the loss of seven or fewer calendar days of work, OBWC (or a self-insuring employer) pays related medical expenses but not compensation to replace lost income. If an injured worker loses eight or more calendar days of work, OBWC (or a self-insuring employer) pays related medical expenses and may pay temporary total for lost wages beginning on the eighth day of disability. When an injured worker is off work for 14 consecutive days due to the work-related injury, OBWC (or a self-insuring employer) pays the injured worker for the first seven days he/she missed work as well as the other days of disability.

19. What is the standard/procedure for terminating temporary benefits?

Temporary total disability may be terminated by a self-insured employer or the OBWC in the event of any of the following: (a) the employee returns to work; (b) the employee’s treating physician finds that the employee is capable of returning to his former position of employment or other available suitable employment; (c) the employee’s treating physician finds the employee has reached maximum medical improvement. Ohio Adm. Code §4121-3-32(B)(1).

Temporary total disability compensation may be terminated after a hearing as follows: (a) upon the finding of a district hearing officer, staff hearing officer, deputy or the industrial commission that either the employee returned to work or the employee’s treating physician finds that the employee is capable of returning to work or the employee’s treating physician finds that the employee has reached maximum medical improvement; (b) upon the finding of district hearing officer, staff hearing officer, deputy or the industrial commission that the employee is capable of returning to his/her former position of employment; (c) upon the finding of a district hearing officer, staff hearing officer, deputy or the industrial commission that the employee has received a written job offer of suitable employment. Ohio Adm. Code §4121-3-32(B)(2).
20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No. A permanent partial award is separate and distinct from temporary total disability compensation. An injured worker may file for a percentage of permanent partial disability 26 weeks after receiving their last payment of temporary total or wage loss, 26 weeks from the date of injury or contraction of an occupational disease if compensation is not paid, or 26 weeks from the date of injury when the employer paid full salary/wages and no other compensation has been paid for claims with dates of injury on or after June 30, 2006. Ohio Rev. Code §4123.57.

21. **What disfigurement benefits are available and how are they calculated?**

In case an injury or occupational disease results in serious facial or head disfigurement which either impairs or may in the future impair the opportunities to secure or retain employment, the administrator shall make an award of compensation as it deems proper and equitable, in view of the nature of the disfigurement, and not to exceed the sum of ten thousand dollars. For the purpose of making the award, it is not material whether the employee is gainfully employed in any occupation or trade at the time of the administrator's determination. Ohio Rev. Code §4123.57(B).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

Permanent partial disability (PPD) awards are based on two-thirds of the injured worker’s statewide average weekly wage, not to exceed a maximum one-third of the average weekly wage. OBWC sets maximum rates each year. The award is based upon a percentage of disability determined by a medical expert examination. Ohio Rev. Code §4123.57(A).

**A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Maximum Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb</td>
<td>60</td>
</tr>
<tr>
<td>Index Finger</td>
<td>35</td>
</tr>
<tr>
<td>Middle Finger</td>
<td>30</td>
</tr>
<tr>
<td>Ring Finger</td>
<td>20</td>
</tr>
<tr>
<td>Little Finger</td>
<td>15</td>
</tr>
<tr>
<td>Loss of Metacarpal</td>
<td>10</td>
</tr>
<tr>
<td>Hand</td>
<td>175</td>
</tr>
<tr>
<td>Arm</td>
<td>225</td>
</tr>
</tbody>
</table>
Great Toe
(Loss of great toe up to the joint is equal to the loss of 1/2 a great toe. Loss of great toe beyond joint is equal to loss of the whole great toe)

Any Other Toe
(2/3 loss equals total loss. No award for less than 2/3)

Foot

Leg

One Eye
(no award for loss less than 25% vision)

Loss of Hearing

One Ear

Both Ears
(no award for less than permanent and total loss of hearing in at least one ear)

Ohio Rev. Code §4123.57(B). This payment is based upon the maximum rate payable for temporary total disability for the year of injury.

B. Number of weeks for "whole person" and standard for recovery.

If the percentage of the permanent disability of the employee equals or exceeds ninety (90%) percent, compensation for permanent partial disability shall be paid for two hundred (200) weeks. Ohio Rev. Code §4123.57(A).

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Vocational rehabilitation is strictly voluntary. To be eligible for rehabilitation services the injured worker must meet the following criteria: (1) Referred claim that is: (a) A claim allowed by an order of the bureau of workers’ compensation or the industrial commission or of its hearing officers with eight or more days of lost time due to a work related injury; or (b) A claim certified by a state university or state agency; or (c) A claim certified by a self-insuring employer. (2) The injured worker must have a significant impediment to employment or the maintenance of employment as a direct result of the allowed conditions in the referred claim. (3) The injured worker must have at least one of the following present in the referred claim: (a) The injured worker is receiving or has been awarded temporary total, non-working wage loss, or permanent total compensation for a
period of time that must include the date of referral. For purposes of this section, payments made in lieu of temporary total compensation (e.g. salary continuation) shall be treated the same as temporary total compensation; or (b) Granted a scheduled loss award under division (B) of section 4123.57 of the Revised Code; or (c) Received or awarded a permanent partial award under division (A) of section 4123.57 of the Revised Code and has job restrictions as a result of that award documented by the physician of record and dated not more than one hundred eighty days prior to the date of referral; or (d) Determined to have reached maximum medical improvement in the claim (with eight or more days of lost time due to a work related injury) by an order of the bureau or the industrial commission, or the injured worker's physician of record has documented in writing that the injured worker has reached maximum medical improvement in the claim, and the injured worker is not currently receiving compensation and has job restrictions in the claim documented by the physician of record and dated not more than one hundred eighty days prior to the date of referral; or (e) Is receiving job retention services to maintain employment or satisfies the criteria set forth in paragraph (E) of this rule on the date of referral; or (f) Sustained a catastrophic injury claim and a vocational goal can be established; or (g) Was receiving living maintenance wage loss not more than ninety days prior to the date of referral, has continuing job restrictions documented by the physician of record as a result of the allowed conditions in the claim, and has lost his or her job through no fault of his or her own. (4) The injured worker must not be working on the date of referral, with the exception of referral for job retention services. Ohio Adm. Code §4123-18-03.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

In cases of permanent total disability, the employee shall receive an award to continue until the employee’s death in the amount of 66 and 2/3 percent of the employee’s average weekly wage. The employee shall not receive more than a maximum amount of weekly compensation which is equal to 66 and 2/3 percent of the statewide average weekly wage in effect on the date of the injury or on the date of the disability due to the occupational disease begins, nor not less than a minimum weekly compensation which is equal to 50 percent of the statewide average weekly wage in effect on the date of injury or on the date the disability due to the occupational disease begins, unless the employee’s average weekly wage is less than 50 percent of the statewide average weekly wage at the time of the injury, in which event the employee shall receive compensation in an amount equal to the employee’s average weekly wage. Ohio Rev. Code §4123.58(A).

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Reasonable funeral expenses up to $5,500 may be recovered. Ohio Rev. Code §4123.66.
B. Death benefits calculation.

If there are no dependents, the disbursements from the state insurance fund is limited to the expenses provided for in section 4123.66 of the Revised Code. Ohio Rev. Code §4123.59(A).

If there are wholly dependent persons at the time of the death, the weekly payment is 66 and 2/3 percent of the average weekly wage, but not to exceed a maximum aggregate amount of weekly compensation which is equal to 66 and 2/3 percent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, and not in any event less than a minimum amount of weekly compensation which is equal to fifty percent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, regardless of the average weekly wage. Ohio Rev. Code §4123.59(B).

C. Dependency benefits duration.

Payment will continue from the date of death of an injured or disabled employee until the death or remarriage of such dependent spouse. If the dependent spouse remarries, an amount equal to two years of compensation benefits at the weekly amount determined to be applicable to and being paid to the dependent spouse shall be paid in lump sum to each spouse and no further compensation shall be paid to such spouse. Ohio Rev. Code §4123.59(B)(1).

The portion of the payment applicable to wholly dependent persons other than a spouse shall continue from the date of death of an injured or disabled employee to a dependent until the dependent: (a) reaches 18 years of age; (b) if pursuing a full-time education program while enrolled in an accredited education institution and program, reaches 25 years of age; (c) if mentally or physically incapacitated from having any earning, is no longer incapacitated. Ohio Rev. Code §4123.59(B)(2)(a).

D. Death benefit savings.

Ohio law does not provide for “death benefit savings.”

E. Conclusion.

The Ohio Bureau of Workers’ Compensation calculates and divides benefits among all eligible dependents. The OBWC distributes benefits every two weeks and they will continue until the dependent is no longer eligible. Individuals who may be eligible include the surviving spouse, dependent children under the age of 18, dependent children 18 to 25 who are attending an accredited education institution full time, dependent children 18 years or older that are physically or mentally incapacitated, and certain other dependent family members.
26. What are the criteria for establishing a "second injury" fund recovery?

Ohio’s “second injury” fund is called Handicap Reimbursement. Ohio’s Handicap Reimbursement program is designed to encourage the hiring and retention of handicapped employees. The employer can request that a percentage of the costs in a workers’ compensation claim be charged to, or refunded from, the Statutory Surplus Fund.

Employers can only be granted reimbursement costs associated to claims of injured workers with certain statutorily specified conditions. Ohio Rev. Code §4123.343(A)(1)-(25).

Requests for handicap reimbursement must be supported by: medical evidence that the employee suffered from one of the conditions listed above and evidence that the condition constituted a handicap within the meaning of the law. Eligible employers include all state-fund employer and all public employers (except state agencies and universities). Employers must file the application for handicap reimbursement while the claim is still within the employer’s experience. Time limitations for filing differ based on the employer type.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

The Industrial Commission and the Administrator of Bureau of Workers' Compensation have continuing jurisdiction over each case, and the Commission may make modifications or changes with respect to former findings or orders as justified in its opinions. For injuries occurring before October 10, 2006, no modifications, changes, findings, or awards shall be made with respect to disability, compensation, dependency, or benefits after six years from the date of injury in the absence of the payment of medical benefits. For injuries occurring on or after October 10, 2006, no such modifications shall be made after five years from the date of injury, in the absence of payment of medical benefits, compensation, or wages in lieu of compensation. Any modifications, changes, findings, or awards made for injuries occurring before October 10, 2006 shall be made within ten years from the date of the last payment of compensation or from the date of death. For those injuries occurring on or after October 10, 2006 such changes shall be made within five years. No modifications, changes, findings, or awards shall be made for a back period of more than two years before the application was filed. Ohio Rev. Code §4123.52; Ohio Adm. Code 4123-3-15(B)(7) (PPD increases).

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

Pursuant to Ohio Rev. Code §4123.512(F), an employee may be reimbursed for his costs, including attorney fees, associated with a successful court appeal seeking participation in the fund. The current cap on the fees is $5,000.00. Holmes v. Crawford, 134 Ohio St.3d 303, 2012-Ohio-5380, 982 N.E.2d 643.
Attorney's fees may be assessed against an employer in a retaliatory action claim under Ohio Rev. Code §4123.90.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   A. **Scope of immunity.**

   Employers shall not be liable to respond in damages at common law or by statute for any injury, or occupational disease, or bodily condition, received or contracted by any employee in the course of or arising out of his employment, or for any death resulting from such injury, occupational disease, or bodily condition occurring during the period covered by such premium so paid into the state insurance fund, or during the interval the employer is a self-insuring employer, whether or not such injury, occupational disease, bodily condition, or death is compensable under Ohio Workers’ Compensation laws. Ohio Rev. Code §4123.74.

   B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

   In an action brought against an employer by an employee, or by the dependent survivors of a deceased employee, for damages resulting from an intentional tort committed by the employer during the course of employment, the employer shall not be liable unless the plaintiff proves that the employer committed the tortious act with the intent to injure another or with the belief that the injury was substantially certain to occur. Ohio Rev. Code §2745.01(A). Substantially certain to occur means that an employer acts with deliberate intent to cause an employee to suffer an injury, a disease, a condition, or death. Ohio Rev. Code §2745.01(B). Deliberate removal by an employer of an equipment safety guard or deliberate misrepresentation of a toxic or hazardous substance creates a rebuttable presumption that the removal or misrepresentation was committed with intent to injure another if an injury or an occupational disease or condition occurs as a direct result. Ohio Rev. Code. §2745.01(C).


   For the dual capacity doctrine to apply, there has to be an allegation and showing that the employer occupied two independent and unrelated relationships with the employee, that at the time of these roles of the employer there were occasioned two different obligations to this employee, and that the employer had during such time assumed a role other than that of employer. *Schump v. Firestone Tire & Rubber Co.*, 44 Ohio St.3d 148 (1989).

30. **Are there any penalties against the employer for unsafe working conditions?**

   The Industrial Commission has the authority to determine claims for additional awards where an employer has failed to comply with any specific requirement for the protection
of the lives, health, or safety of employees. Ohio Const. Art. II §35. To obtain an award for an employer’s violation of a specific safety requirement (VSSR), a claimant must show that his injury resulted from his employer’s failure to comply with a specific safety requirement. A VSSR award is considered an employer penalty, and therefore specific safety requirements are strictly construed in the employer’s favor. State ex rel. Richmond v. Indus. Comm., 2014-Ohio-1604. The amount of a VSSR award can vary from 15% to 50% of all compensation paid to the claimant at the maximum rate, and the penalty will apply to all compensation paid over the entire life of the claim. Ohio Const. Art. II §35.

31. **What is the penalty, if any, for an injured minor?**

A minor employee can bring a claim under his or her name without the intervention of a guardian. No other person has a right to compensation arising from a minor’s work-related injury. However, any lump sum settlement award must be paid to the guardian of the minor. Ohio Rev. Code §4123.89.

Section 4123.89 of the Ohio Revised Code provides for an additional award of 100% of the maximum workers’ compensation award established by law to any minor whose injury, occupational disease, or death was caused by prohibited employment. However, this provision was held unconstitutional because it conflicts with the constitutional provision that any additional award to a claimant for an employer’s violation of a specific safety requirement may not exceed 50% of the maximum award established by law. State, ex rel. Kanter Corp. v. Stringer, 67 Ohio St.2d 8 (1981) (citing Ohio Const. Art. II §35).

32. **What is the potential exposure for "bad faith" claims handling?**

A self-insured employer may be liable in tort for failing to process a workers’ compensation claim in violation of its statutorily-mandated responsibilities. Vandemark v. Southland Corp., 38 Ohio St. 3d 1 (1988). The doctrine of employer-employee immunity is not applicable to such circumstances, as the cause of action is no longer a workers’ compensation claim, but rather a common law action for damages outside the scope of workers’ compensation statutes. Id.

An employee may also bring a cause of action against a self-insured employer for the employer’s intentional and wrongful termination of the employee’s workers’ compensation benefits. Balyint v. Arkansas Best Freight System, Inc., 18 Ohio St. 3d 126 (1985). An employee’s participation in the workers’ compensation scheme does not preclude him from enforcing common-law remedies against his employer for this type of intentional conduct. Id.

33. **What is the exposure for terminating an employee who has been injured?**

No employer shall discharge, demote, reassign, or take any punitive action against an employee because the employee filed a claim or instituted, pursued, or testified in a workers’ compensation proceeding. Ohio Rev. Code § 4123.90. If successful in a civil
suit, the employee is entitled to reinstatement with back pay (if the action is based upon discharge) or an award for lost wages (if the action is based upon demotion, reassignment, or other punitive actions). Id. However, claimants who are currently receiving temporary total compensation may be terminated and are not thereby entitled to a cause of action for wrongful discharge in violation of public policy so long as a termination "for good and just cause" provision is absent from the employee's contract. Bickers v. W. & S. Life Ins. Co., 2007-Ohio-6751.

THIRD PARTY ACTIONS

34. **Can third parties be sued by the employee?**

   Yes. An employee may sue a third-party for the injuries sustained as a result of that party’s negligence, even if the employee has obtained workers’ compensation, and even if both the third party and employer have complied with the Workers’ Compensation Act. George v. City of Youngstown, 139 Ohio St. 591 (1942); Trumbull Cliffs Furnace Co. v. Shachovsky, 111 Ohio St. 791 (1924).

35. **Can co-employees be sued for work-related injuries?**

   No. A co-employee who is responsible for a fellow employee’s compensable workers' compensation claim is immune from suit. Ohio Rev. Code §4123.741.

36. **Is subrogation available?**

   Yes. Payment of compensation or benefits creates a right of recovery in favor of a statutory subrogee against a third party, and the statutory subrogee is subrogated to the rights of a claimant against that third party. Ohio Rev. Code §4123.93 et seq.

   If a claimant, statutory subrogee, and third party settle or attempt to settle a claimant’s claim against a third party, the claimant must receive an amount equal to the uncompensated damages divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered. Id. The statutory subrogee must receive an amount equal to the subrogation interest divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered, except that the net amount recovered may instead be divided and paid on a more fair and reasonable basis that is agreed to by the claimant and statutory subrogee. Id.

   A claimant may establish an interest-bearing trust account for the full amount of the subrogation interest that represents estimated future payments of compensation, medical benefits, rehabilitation cost, or death benefits, reduced to present value, from which the claimant must make reimbursement payments to the statutory subrogee for the future payments of compensation, medical benefits, rehabilitation costs, and death benefits. Id.
Claimants are now required to notify a statutory subrogee and the Attorney General of all third parties against whom the claimant has or may have a right of recovery when the statutory subrogee is a state fund employer. No settlement is final if notice is not given, and if the attorney general is not noticed the claimant and the third party may be jointly liable. *Id.*

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

All medical bills must be filed with the OBWC or Commission within one year of the date on which the service was rendered, or one year after the date the services become payable under Ohio Rev. Code §4123.511(I), whichever is later, or shall be forever barred. Ohio Adm. Code 4123-3-23(A). Medical bills are to be paid no later than 30 days after receipt of a proper invoice by the OBWC or self-insured employer. Ohio Adm. Code 4123-19-03(K)(5). Interest may be assessed on late payments. Ohio Rev. Code §126.30.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

Claimants are required to promptly provide a current signed release of medical information, records, and reports when requested by the employer. Ohio Rev. Code §4123.651(B). If the employee refuses, the right to have the claim considered is suspended during the refusal. Ohio Rev. Code §4123.651(C). The Industrial Commission generally takes the position that an employee must sign an unrestricted medical release form in order to comply. Ohio Adm. Code 4121-3-09(A)(3). An employer may file a motion with the Industrial Commission to compel compliance. Ohio Adm. Code 4121-3-09(A)(4). Each party must provide the opposing party with copies of the evidence they intend to introduce at hearing prior to the hearing. Ohio Adm. Code 4121-3-09(A). The Industrial Commission Hearing Administrator may issue subpoenas, upon request and showing of good cause. *Id.*

The application for benefits is also a release of the physician-patient privilege. Furthermore, privileged communications and acts are waived under Ohio Rev. Code §2317.02 for anyone who files a claim under the Workers’ Compensation Act.

39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Evaluations?**

A. **Claimant’s choice of physician.**

An employee has the right to select a licensed physician for treatment, subject to the provisions and limitations of the managed care rules. Ohio Adm. Code 4123-6-06.2. However, to be eligible for reimbursement, physicians must be OBWC-certified. Ohio Adm. Code 4123-6-02.2.
B. Employer’s right to a second opinion and/or Independent Medical Evaluations.

The employer of a claimant who is injured or disabled in the course of his employment may require, without the approval of the administrator or the Industrial Commission, that the claimant be examined by a physician of the employer’s choice one time upon any issue asserted by the employee or a physician of the employee’s choice or which is to be considered by the Commission. Ohio Rev. Code §4123.651(A). Any further requests for medical examinations shall be made to the Commission, which shall consider and rule on the request. Id. The employer shall pay the cost of any examinations initiated by the employer. Id.

If, without good cause, an employee refuses to submit to any examination scheduled under Ohio Rev. Code §4123.651 or refuses to release or execute a release for any medical information, record, or report that is required to be released under §4123.651 and involves an issue pertinent to the condition alleged in the claim, then the employee’s right to have his claim for compensation or benefits considered—if his claim is pending before the Administrator, Commission, or a district or staff hearing officer, or to receive any payment for compensation or benefits previously granted—is suspended during the period of refusal. Id.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

All medical treatment reasonable and necessary as a result of the injury is covered, including chiropractic care, physical therapy, acupuncture, braces, etc., although some of these treatments require prior approval. Ohio Rev. Code §4123.66. See also answer 44.

41. Which prosthetic devices are covered, and for how long?

Prosthetic devices, including wheelchairs, canes, crutches, walkers and braces, shall be paid for if a claimant requires the purchase or repair of a prosthetic device, as determined by any one of the following: (1) the Amputee Clinic at the Ohio State University Medical Center; (2) the Opportunities for Ohioans With Disabilities Agency; or (3) a multidisciplinary amputee clinic or prescribing physician approved by the administrator or the administrator’s designee. Ohio Adm. Code 4123-6-39.

42. Are vehicle and/or home modifications covered as medical expenses?

These are not specifically covered by statute. These may, however be approved on a case-by-case basis. Ohio Rev. Code §4121.61.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

There is a fee schedule. Fees are limited to the usual, customary and reasonable fee charged for like services in the area in which the services are provided, but in no event
shall such charges be greater than the fee schedule. See answer 44; Ohio Adm. Code 4123-6-01 et seq.

44. **What, if any, provisions or requirements are there for "managed care"?**

Managed Care was authorized in 1993 by House Bill 107. The OBWC’s program is known as the Health Partnership Plan (“HPP”), which requires all state-funded employers to utilize a Managed Care Organization (“MCO”) for the medical management of their workers’ compensation claims. State-fund employers are permitted to self-select an MCO, and the OBWC will select an MCO for a state-fund employer that fails to select an MCO, if necessary. Ohio Adm. Code 4123-6-05.2.

The OBWC approves medical providers who meet its credentialing requirements. Ohio Adm. Code 4123-6-02.2. Those providers must complete a “provider agreement” which requires them to follow a published fee schedule and follow the treatment protocols of an approved MCO. Ohio Adm. Code 4123-6-02.

When an employee is injured, the employer directs the employee to the MCO, which will medically manage the employee’s care. The MCO authorizes treatment, monitors the medical bills, and disburses payment to the providers according to the Bureau fee schedule. If the employee goes to a provider who has not signed an agreement with the OBWC, only the first medical bill will be paid. The employee may go to a provider not enrolled in his or her employer’s MCO, but such a provider will be paid for treatment beyond the first visit only if it applies to the MCO for emergency credentialing as necessary for care and services which are unavailable through like MCO panel providers. Ohio Adm. Code 4123-6-01 et seq. MCOs are paid directly by the OBWC, and no MCO may receive a fee for services, or a portion of a fee, from one of its providers.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Upon submission of a claim application, the employer has the opportunity to accept or reject the claim. If the employer rejects the claim or appeals from a Bureau Order allowing a claim, it is scheduled for hearing before a District Hearing Officer of the Industrial Commission of Ohio for a decision on the allowance of the claim. Ohio Rev. Code §4123.511; Ohio Adm. Code 4123-3-09.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

There is a four-tiered administrative process for adjudicating claims. The Bureau of Workers’ Compensation makes the decision at the first stage in state-fund claims (self-insured claims go directly to the second stage if rejected by the self-insurer). The second level is the district hearing. These decisions are appealable by right to a Staff Hearing
Officer. The decision of a Staff Hearing Officer is subject to a discretionary appeal to the full Industrial Commission of Ohio. Each such appeal must be filed within 14 days of the party’s receipt of the order being appealed. Ohio Rev. Code §4123.511.

B. Trial court.

An employee or employer has the right to appeal a decision of the Industrial Commission of Ohio to the Court of Common Pleas, other than a decision as to the extent of disability. The appeal must be made to the Court of Common Pleas of the county where the injury or exposure occurred, or in which the contract of employment was made if the injury occurred outside of the state. An appeal to the court must be filed within 60 days after the date of receipt of the Industrial Commission’s decision. The appeal is de novo, and the jury is not to consider the amount of compensation to be paid. Ohio Rev. Code §4123.512; Forster v. Ohio Bur. of Workers' Comp., 102 Ohio App.3d 744 (8th Dist. 1995).

C. Appellate.

A decision by the Court of Common Pleas may be appealed to the Appellate Court. An appeal from that Appellate Court to the Ohio Supreme Court is subject to discretionary review.

Decisions of the Industrial Commission regarding extent of disability are not appealable to the Court of Common Pleas, and instead, must be challenged in a mandamus review by the Tenth District Court of Appeals (where the Commission is located) or the Ohio Supreme Court. There is an appeal of right to the Ohio Supreme Court from a mandamus action in an extent of disability case. Ohio Rev. Code §4121.27.

47. What are the requirements for stipulations or settlements?

Claims involving self-insured employers may be settled by agreement, to be approved by the Industrial Commission. The settlement agreement will be deemed approved unless, within thirty days of submission, a Staff Hearing Officer deems it to be clearly unfair or a gross miscarriage of justice. Ohio Rev. Code §4123.65.

Claims involving state-fund employers may also be settled. The application for such a settlement requires: (1) the settlement agreement; (2) the signatures of the claimant and employer, unless: (i) the employer is no longer doing business in Ohio; (ii) the claim is outside the employer's experience as provided in Ohio Rev. Code §4123.34(B) and the claimant is no longer employed with that employer; or (iii) the employer has failed to comply with Ohio Rev. Code §4123.35; and (3) an indication of the parties’ agreement to the terms and a recitation of the circumstances by reason of which the settlement is deemed desirable. Ohio Rev. Code §4123.65(A). The OBWC has the sole authority to approve such a settlement, which will be effective 30 days after approval. Ohio Rev. Code §4123.65(C).
48. Are full and final settlements with closed medicals available?


49. Must stipulations and/or settlements be approved by the state administrative body?

Yes, by the Industrial Commission, but a settlement is deemed approved unless the Industrial Commission specifically disapproves it within 30 days. Ohio Rev. Code §4123.65. The settlement application must clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable in order for the settlement to be validated. State ex rel. Wise v. Ryan, 118 Ohio St. 3d 68 (2008).

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Ohio is a monopolistic state and private insurance is not permitted. All employers must either participate in the state insurance fund or be approved as self-insured.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Generally, employers of more than 500 employees who have done business in Ohio for more than two years may be granted self-insured status by the Administrator by showing they have sufficient financial ability to satisfy and pay compensation to employees and their dependents. Ohio Rev. Code §4123.35(B). Five years of audited financial statements are required. Id. Employers should apply for self-insurance at least 90 days prior to the date they want their self-insurance coverage to take effect.

B. For groups or "pools" of private entities.

State-fund employers may join groups of at least 100 members engaged in similarly conducted business in order to increase their aggregate payroll and take advantage of rate reductions. Ohio Rev. Code §4123.29(A)(4); Ohio Adm. Code 4123-17-61 et seq. There are no provisions for self-insurance based on “pools” of private entities.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within definition of “employee”?

Ohio Rev. Code §4123.01(A) neither includes nor excludes “illegal aliens” from the definition of “employee.” However, an Ohio appellate court found that the statute’s inclusion of the term "alien" in the statutory definition of "employee" also included an
"illegal alien." *Rajeh v. Steel City Corp.*, 157 Ohio App. 3d 722 (2004). Therefore, the court found that an illegal alien is considered an "employee" who is entitled to compensation under Ohio's Workers' Compensation Fund. *Id.*

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Covered. All state fund claims alleging potential non-accidental exposure to anthrax or other biological agents will be automatically referred to OBWC’s medical advisor for occupational disease medical review. Where the worker tests negative for anthrax, OBWC will disallow the claim in accordance with Ohio law. In the event a worker actually contracts anthrax, the claim will be handled as an occupational disease claim. Ohio Rev. Code §4123.68(A).

Emergency medical diagnostic service is necessary to investigate the claim and confirm or rule out an anthrax diagnosis will be paid by OBWC as occupational disease claim investigative costs. Prophylactic antibiotic therapy, initiated in accordance with Ohio Department of Health and the Centers for Disease Control protocol, will also be reimbursed by OBWC. Reimbursement for prophylactic antibiotic therapy initiated prior to substance testing will be considered on a case by case basis and OBWC may limit reimbursement in these cases.

In addition, only individuals who receive the smallpox vaccine as part of Phase 1 of the Centers for Disease Control and Prevention’s (CDC’s) smallpox vaccination program are eligible for workers’ compensation benefits under this policy. This includes healthcare response team volunteers and local health department employees who develop a serious adverse reaction from the vaccine.


54. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

No.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The federal Medicaid statute requires states to include the following provisions in their plan for medical assistance: 1) that the individual will assign to the state any rights to payment for medical care from any third party; and 2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C. §1396k(a). The state is authorized to retain such amount as is necessary to reimburse it (and the federal government as appropriate)
for medical assistance payments and to pay the remainder to the individual. 42 U.S.C. §1396k(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by the state and federal law (HIPPA)?**

HIPPA provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. §164.512(l). Therefore, your current practice of obtaining medical records can proceed under state law. 45 C.F.R. parts 160-164 and 65 F.R. 82462.

The OBWC and Managed Care Organizations (MCO) do not qualify as covered entities under HIPPA, since they do not meet HIPPA’s definition of a “health plan,” “healthcare clearing house,” or “healthcare provider.” 45 C.F.R. §160.102 and §160.103. This means any transaction between OBWC and the MCO, or between OBWC and provider does not have to be conducted in compliance with the HIPAA electronic transaction standards. 45 C.F.R. §162.923(a).

The Ohio Supreme Court held that an independent tort exists for the unauthorized, unprivileged disclosure to a third-party of non-public medical information that a physician or hospital has learned within a physician-patient relationship. *Biddle v. Warren General Hospital*, 86 Ohio St.3d 395 (1999). However, the application for benefits is a release of the physician-patient privilege. Furthermore, privileged communications and acts are waived under Ohio Rev. Code §2317.02 for anyone who files a claim pursuant to Ohio’s Workers’ Compensation Act. Thus, when a physician’s report is “made in the manner prescribed by law,” the physician has not breached his duty towards his patient and is therefore not liable. *Biddle* at 402.

57. **What are the provisions for “Independent Contractors”?**


Ohio Rev. Code §4123.01(A)(1)(c) applies to any person who performs labor or provides services pursuant to a construction contract if there is an issue as to whether that person is an independent contractor. There are twenty factors set forth in the statute that replace the common law "right to control" test in these situations. Those factors are: (1) The person is required to comply with instructions from the other contracting party regarding the manner or method of performing services; (2) The person is required by the other contracting party to have particular training; (3) The person's services are integrated into the regular functioning of the other contracting party; (4) The person is required to perform the work personally; (5) The person is hired, supervised, or paid by the other contracting party; (6) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time; (7) The person's hours of work are established by the other contracting party;
(8) The person is required to devote full time to the business of the other contracting party; (9) The person is required to perform the work on the premises of the other contracting party; (10) The person is required to follow the order of work set by the other contracting party; (11) The person is required to make oral or written reports of progress to the other contracting party; (12) The person is paid for services on a regular basis such as hourly, weekly, or monthly; (13) The person's expenses are paid for by the other contracting party; (14) The person's tools and materials are furnished by the other contracting party; (15) The person is provided with the facilities used to perform services; (16) The person does not realize a profit or suffer a loss as a result of the services provided; (17) The person is not performing services for a number of employers at the same time; (18) The person does not make the same services available to the general public; (19) The other contracting party has a right to discharge the person; (20) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement. If any ten of these twenty factors apply, the person is an employee under the Act. Ohio Rev. Code §4123.01(A)(1)(c).

Independent contractors are required by law to carry workers' compensation coverage for their employees, but must elect to cover themselves. Ohio Rev. Code §4123.01(A).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Ohio has a specific statute which governs professional employment organizations ("PEOs"). A PEO means a sole proprietor, partnership, association, LLC, or corporation that enters into an agreement with one or more client employers for the purpose of co-employing all or part of the client employer’s workforce at the client employer’s work site. Ohio Rev. Code §4125.01. A “client employer” means a sole proprietor, partnership, association, LLC, or corporation that enters into a PEO agreement and is assigned shared employees by the PEO. Id. A “shared employee” is an individual that is intended to be assigned to a client employer on a permanent basis who is co-employed by a PEO and a client employer. Id.

A PEO must register and submit GAAP-audited financial statements on an annual basis to the OBWC. Ohio Rev. Code §4125.05. When a client employer enters into a contract with a PEO, the PEO is the employer of record and the succeeding employer for the purposes of determining a workers’ compensation experience rating. Ohio Revised Code §4125.04(A); Ohio Adm. Code 4123-17-15.1. A PEO agreement experience-transfer table can be found at:

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No. There are no specific provisions in the statute on this issue, however, the definition of "employee" under Ohio Rev. Code §4123.01(A)(1)(c) does provide some guidance. (See Answer to Question No. 57). Although that section of the Code specifically refers to people who perform labor or provide services pursuant to a construction contract, the OBWC applies the same criteria to all employment situations when determining whether an employer is properly reporting payroll in terms of which individuals are independent contractors and which are actual employees. In fact, the questionnaire that the OBWC sends to employers about this classification issue contains the same factors as Ohio Rev. Code §4123.01(A)(1)(c). The OBWC’s questionnaire is available at:

https://www.bwc.ohio.gov/infostation/content/1/1.8/independent%20contractor-employee%20questionnaire.pdf.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?


2. Designate a person to meet with an injured employee as soon as practicable to investigate the injury, getting all details in writing.

3. Once an employee is injured, ask them to sign a medical authorization form, and provide a list of doctors allowing you to communicate with the employee’s doctor.

4. Consider assigning an employee that is injured but still able to work, to a temporary light duty position. Stay in touch with an employee that is injured and unable to work at all.

5. Consider adopting an employee wellness program, however, be wary of employment laws protecting individuals with disabilities.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

Ohio lawyers should note Ohio Supreme Court Ethics Opinion 2011-1. It is improper for a claimant’s attorney to agree to indemnify the opposing party for Medicare secondary payer liability with respect to settlement. It is also improper for the opposing party’s attorney to ask for indemnification.

Notice is provided to the injured worker on the settlement request form and on the final settlement agreement (C-240, C-241). There is a documented allocation of costs.
The Ohio Bureau of Workers’ Compensation will sometimes require the injured worker to obtain a conditional payment letter prior to settlement or establish a Medicare set-aside trust. A conditional payment letter is required if the claim file reflects a significant drop in medical costs, the injured worker has recently obtained a HICN, and there is no obvious explanation for the change in medicals.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Effective September 8, 2016, House Bill 523 legalized medical marijuana in Ohio for certain medical conditions. The law does not require Ohio Bureau of Workers’ Compensation to pay for patient access to marijuana. If medical marijuana is recommended for an injured worker, the OBWC will not provide reimbursement. Additionally, an employee under the influence of marijuana is not covered by workers’ compensation.

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Ohio does not permit the recreational use of marijuana.
1. Citation for the state’s workers’ compensation statutes.

Pre 2/1/2014 injury date:

The Workers’ Compensation Act, 85 O.S. §§ 301-413 (the “Act”).

Post 2/1/2014 injury date:

The Administrative Workers’ Compensation Act, 85A O.S. §§ 1-401.1 (the “Administrative Act”).

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

Pre 2/1/2014 injury date:

Pursuant to 85 O.S. § 308(17), the term “employee” means any person engaged in the employment of an employer covered by the terms of the Act except for such persons as may be excluded elsewhere. Any person excluded as an employee may, if otherwise qualified, be eligible for benefits under the Act if specifically covered by any policy of insurance covering benefits under the Act. “Employee” also includes a member of the Oklahoma National Guard while in the performance of duties only while in response to state orders and any authorized voluntary or uncompensated worker, rendering services as a firefighter, peace officer or emergency management worker. “Employee” also includes a participant in a sheltered workshop program which is certified by the United States Department of Labor.

Post 2/1/2014 injury date:

Pursuant to 85A O.S. § 2(18), the term “employee” means any person in the service of an employer under any written, oral, express, or implied contract for
hire or apprenticeship, “but excluding one whose employment is casual and not in the course of the trade, business, profession, or occupation of his or her employer and excluding one who is required to perform work for a municipality or county or the state or federal government on having been convicted of a criminal offense or while incarcerated.” “Employee” also includes a member of the Oklahoma National Guard while in the performance of duties only while in response to state orders and any authorized voluntary or uncompensated worker, rendering services as a firefighter, peace officer or emergency management worker.

3. Identify and describe any “statutory employer” provision.

**Pre 2/1/2014 injury date:**

Under 85 O.S. § 308(18), the term “Employer” means, unless otherwise expressly stated, “a person, partnership, association, limited liability company, corporation, and the legal representatives of a deceased employer, or the receiver or trustee of a person, partnership, association, corporation, or limited liability company, departments, instrumentalities and institutions of this state and divisions thereof, counties and divisions thereof, public trusts, boards of education and incorporated cities or towns and divisions thereof, employing a person included within the term ‘employee’ as defined in this section. Employer may also mean the employer’s workers’ compensation insurance carrier, if applicable.”

Furthermore, with limited exceptions, pursuant to 85 O.S. § 314(3), “[t]he person entitled to such compensation shall have the right to recover the same directly from the person’s immediate employer, the independent contractor or intermediate contractor, and such claims may be presented against all such persons in one proceeding. If it appears in such proceeding that the principal employer has failed to require a compliance with the [Act] by the independent contractor, then such employee may proceed against such principal employer without regard to liability of any independent, intermediate or other contractor.”

**Post 2/1/2014 injury date:**

Pursuant to 85A O.S. § 2(19), the term “Employer” means, unless, otherwise excluded, “a person, partnership, association, limited liability company, corporation, and the legal representatives of a deceased employer, or the receiver or trustee of a person, partnership, association, corporation, or limited liability company, departments, instrumentalities and institutions of this state and divisions thereof, counties and divisions thereof, public trusts, boards of education and incorporated cities or towns and divisions thereof, employing a person included within the term ‘employee’ as defined in this section. Employer may also mean the employer’s workers’ compensation insurance carrier, if applicable.”

Additionally, if a subcontractor fails to secure required compensation, the prime contractor shall be liable for compensation to the employees of the subcontractor,
unless there is an intermediate subcontractor who has coverage. 85A O.S. § 36(A).

4. What types of injuries are covered and what is the standard of proof for each:

Pre 2/1/2014 injury date:

A. Traumatic or “single occurrence” claims.

“Compensable injury” means “any injury or occupational illness, causing internal or external harm to the body, which arises out of and in the course of employment if such employment was the major cause of the specific injury or illness. An injury, other than cumulative trauma, is compensable only if it is caused by a specific incident and is identifiable by time, place and occurrence unless it is otherwise defined as compensable in this act. A compensable injury must be established by objective medical evidence. The employee has the burden of proof to establish by a preponderance of the evidence that such unexpected or unforeseen injury was in fact caused by the employment. There is no presumption from the mere occurrence of such unexpected or unforeseen injury that the injury was in fact caused by the employment.”  85 O.S. § 308(10)(a).

“Compensable injury” means “a cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death, only if, in relation to other factors contributing to the physical harm, a work-related activity is the major cause of the physical harm. Such injury shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the usual work of the employee, or alternately, that some unusual incident occurred which is found to have been the major cause of the physical harm.”  85 O.S. § 308(10)(b).

“Compensable injury” includes “personal property which is established by objective medical evidence to be medically necessary and which replaces or improves normal physical function of the body, such as artificial dentures, artificial limbs, glass eyes, eye glasses and other prostheses which are placed in or on the body and is damaged as a result of the injury.” 85 O.S. § 308(10)(d).

“Major cause” means “more than fifty percent (50%) of the resulting injury, disease or illness. A finding of major cause shall be established by a preponderance of the evidence. A finding that the workplace was not a major cause of the injury, disease or illness shall not adversely affect the exclusive remedy provisions of this title and shall not create a separate cause of action outside of this act.” 85 O.S. § 308(28).
B. Occupational disease (including respiratory and repetitive use).

“Occupational disease” means only that disease or illness which is due to causes and conditions characteristic of or peculiar to the particular trade, occupation, process or employment in which the employee is exposed to such disease. An occupational disease arises out of the employment only if was the major cause of the resulting occupational disease and such is supported by objective medical evidence, as defined in this section. 85 O.S. § 308(33).

Post 2/1/2014 injury date:

A. Single-event or “Accidental” Injuries:

“Compensable injury” means “damage or harm to the physical structure of the body, or prosthetic appliances, including eyeglasses, contact lenses, or hearing aids, caused solely as the result of either an accident, cumulative trauma or occupational disease arising out of the course and scope of employment.” “Accident” is further defined as “an event involving factors external to the employee that (1) was unintended, unanticipated, unforeseen, unplanned and unexpected, (2) occurred at a specifically identifiable time and place, (3) occurred by chance or from unknown causes, and (4) was independent of sickness, mental incapacity, bodily infirmity or any other cause.” 85A O.S. § 2(9)(a).

An injured employee must prove that he or she has suffered a compensable injury by a preponderance of the evidence. 85A O.S. § 2(9)(e). Additionally, a compensable injury must be established by “medical evidence supported by objective findings.” 85A O.S. § 2(9)(d). “Objective findings” are “those findings which cannot come under the voluntary control of the patient.” 85A O.S. § 2(31).

B. Cumulative Trauma:

“Cumulative trauma” means an injury to an employee that is caused by the combined effect of repetitive physical activities extending over a period of time in the course and scope of employment. Cumulative trauma shall not mean fatigue, soreness or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by the employee’s course and scope of employment. Cumulative trauma shall have resulted directly and independently of all other causes and the employee shall have completed at least one hundred eighty (180) days of continuous active employment with the employer. 85A O.S. §2(14).

Cumulative trauma is to be considered a soft tissue injury governed by 82A O.S. §62.

C. Occupational diseases:
Except as otherwise stated, if an employee suffers from an occupational disease and is disabled or dies as a result of the disease, the employee or his or her dependents shall be entitled to compensation as if the disability or death were caused by injury arising out of work activities within the scope of employment. 85A O.S. § 65(A).

“Occupational disease” means “any disease that results in disability or death and arises out of and in the course of the occupation or employment of the employee or naturally follows or unavoidably results from an injury as that term is used: in the Administrative Act. 85A O.S. § 65(D)(1).

A causal connection between the occupation or employment and the occupational disease must be established by a preponderance of the evidence. 85A O.S. § 65(D)(1).

5. What, if any, injuries or claims are excluded?

Pre 2/1/2014 injury date:

“Compensable injury” shall not include “the ordinary, gradual deterioration or progressive degeneration caused by the aging process, unless the employment is a major cause of the deterioration or degeneration and is supported by objective medical evidence; nor shall it include injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities.” 85 O.S. § 308(10)(c).

“Compensable injury” shall not include “an injury resulting directly or indirectly from idiopathic causes; any contagious or infectious disease unless it arises out of and occurs in the scope and course of employment; or death due to natural causes occurring while the worker is at work.” 85 O.S. § 308(10)(e).

“Compensable injury” shall not include “mental injury that does not arise directly as a result of a compensable physical injury, except in the case of rape or other crime of violence which arises out of and in the course of employment.” 85 O.S. § 308(10)(f).

Post 2/1/2014 injury date:

Pursuant to 85A O.S. § 2(9)(b), the following injuries are expressly excluded from the definition of “compensable injury”:

1. injury to any active participant in assaults or combats which, although they may occur in the workplace, are the result of non-employment-related hostility or animus of one, both, or all of the combatants and which assault or combat
amounts to a deviation from customary duties. Injuries caused by horseplay, however, are not compensable injuries, “except for innocent victims.”

2. Injury incurred while engaging in or performing or as the result of engaging in or performing any recreational or social activities for the employee’s personal pleasure.

3. Injury which was inflicted on the employee at a time when employment services were not being performed or before the employee was hired or after the employment relationship was terminated.

4. Injury where the accident was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician’s orders. If, within twenty-four (24) hours of being injured or reporting an injury, an employee tests positive for intoxication, an illegal controlled substance, or a legal controlled substance used in contravention to a treating physician’s orders, or refuses to undergo the drug and alcohol testing, there shall be a rebuttable presumption that the injury was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician’s orders. This presumption may only be overcome if the employee proves by clear and convincing evidence that his or her state of intoxication had no causal relationship to the injury.

5. Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from the natural results of aging, osteoarthritis, arthritis, or degenerative process including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis.

6. Any preexisting condition except when the treating physician clearly confirms an identifiable and significant aggravation incurred in the course and scope of employment.

6. **What psychiatric claims or treatments are compensable?**

**Pre 2/1/2014 injury date:**

Mental injury not arising directly as a result of a compensable physical injury, except in the case of rape or other crime of violence which arises out of and in the course of employment, is not compensable. 85 O.S. § 308 (10)(f). However, physical injuries caused by work-related mental stress are compensable. *Ponca City Pub. Sch. v. Ritcheson*, 1993 OK CIV APP 42, 853 P.2d 782.

In *Fenwick v. Okla. State Penitentiary*, 1990 OK 47, 792 P.2d 60, the court held that a psychological assistant at a state penitentiary had not suffered “accidental injury,” and thus could not recover workers’ compensation benefits. Although he was suffering from depression, anxiety and posttraumatic stress disorder arising
from a hostage situation, the assistant had not suffered any physical injury.

**Post 2/1/2014 injury date:**

A “mental injury or illness” is not a “compensable injury” unless caused by a physical injury to the employee, and will not be considered an injury arising out of and in the course and scope of employment or compensable unless demonstrated by a preponderance of the evidence. This limitation, however, does not apply to any victim of a crime of violence. 85A O.S. § 13(A).

To be compensable, a mental injury or illness must also be diagnosed by a licensed psychiatrist or psychologist and the diagnosis must meet “the criteria established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders.” 85A O.S. § 13(A).

7. **What are the applicable statutes of limitations?**

**Pre 2/1/2014 injury date:**

The employee must file a claim within two (2) years of the date of the accident or within two (2) years of the date of: (1) the last payment of compensation; or (2) the last payment for authorized medical treatment. 85 O.S. § 318(A).

A cumulative trauma claim must be filed within two (2) years of the date on which the employee was last employed by the employer. 85 O.S. § 318(B).

Asbestosis, silicosis or exposure to nuclear radiation claims causally connected with employment must be filed within two (2) years of the date of last hazardous exposure or within two (2) years from the date said condition first becomes manifest by a symptom or condition from which one learned in medicine could, with reasonable accuracy, diagnose such specific condition, whichever last occurs. 85 O.S. § 318(C).


If a hearing or a final determination is not brought within two (2) years from the date of the filing of the claim or two (2) years from the date of the last payment of compensation or wages in lieu of the claim is barred and shall be dismissed by the Workers’ Compensation Court (the “Court”) for want of prosecution. 85 O.S. § 318(E).

**Post 2/1/2014 injury date:**

Except for claims related to an occupational disease, the employee must file a claim for benefits with the Workers’ Compensation Commission (the “Commission”) within one (1) year from the date of the injury. Moreover, “[i]f
during the one-year period following the filing of the claim the employee receives no weekly benefit compensation and receives no medical treatment resulting from the alleged injury, the claim may also be barred. 85A O.S. § 69(A)(1).

The “date of the injury” is the date an injury is caused by an “accident” as defined by the Administrative Act. 85A O.S. § 69(A)(1); see 85A O.S. § 2(9)(a).

A claim for compensation for disability on account of an occupational disease or infection must be filed with the Commission within two (2) years from the date of the last injurious exposure to the hazards of the disease or infection. 85A O.S. § 69(A)(2)(a).

A claim for compensation on account of silicosis or asbestosis must be filed within one (1) year after the time of disablement, and the disablement must occur within three (3) years from the date of the last injurious exposure to the hazard of silicosis or asbestosis. 85A O.S. § 69(A)(2)(b).

A claim for compensation related to a disease or condition caused by exposure to x-rays, radioactive substances, or ionizing radiation must be filed within two (2) years from the date the condition is made known to the employee following an examination and diagnosis by a medical doctor. 85A O.S. § 69(A)(2)(c).

A claim for compensation on account of death must be filed within two (2) years of the date of the death. 85A O.S. § 69(A)(3).

If no request for a hearing has been made within six (6) months after the claim is filed, the claim may, on motion and after hearing, be dismissed with prejudice. 85A O.S. § 69(A)(4). In an unpublished opinion, the Oklahoma Court of Civil Appeals has interpreted this to mean that a request for a hearing by any party, not just the claimant, tolls the six month dismissal period.

A claim for additional compensation must be filed within one (1) year from the date of the last payment of disability compensation, or two (2) years from the date of the injury, whichever is greater. 85A O.S. § 69(B)(1).

Failure to file a claim within the applicable limitations period will not bar the right to benefits unless objection to the failure is made at the first hearing on the claim in which all parties have been given a reasonable notice and opportunity to be heard. If no request for a hearing has been made within six (6) months after the claim is filed, the claim may, on motion and after hearing, be dismissed with prejudice. 85A O.S. § 69(E).

The right to claim compensation for benefits from the Multiple Injury Trust Fund, 85A O.S. § 31, shall be forever barred unless a notice of claim, on a form prescribed by the Commission, shall be filed with the Commission within two (2) years of the date of the last order for permanent partial disability from the latest claim against the employer. When a claim for benefits from the Fund is filed, the
claimant must request a hearing and final determination within three (3) years of filing. 85A O.S. § 33(A)-(B).

8. What are the reporting and notice requirements for those alleging an injury?

**Pre 2/1/2014 injury date:**

A rebuttable presumption that an injury is not work related arises unless an employee gives oral or written notice to the employer within thirty (30) days of the date an injury occurs or the employee receives medical attention from a licensed physician during the thirty-day period from the date a single event injury occurred. The presumption may be overcome by a preponderance of evidence. 85 O.S. § 323(A).

Similarly, a rebuttable presumption that an occupational disease or cumulative trauma injury does not arise in and out of the course of employment arises unless the employee gives oral or written notification within ninety (90) days of the employee’s separation from employment. Such presumption must be overcome by a preponderance of the evidence. 85 O.S. § 323(B).

**Post 2/1/2014 injury date:**

Unless an employee gives oral or written notice to the employer within thirty (30) days of the date the injury occurs, there shall be a rebuttable presumption that the injury was not work-related. Such presumption must be overcome by a preponderance of the evidence. 85A O.S. §68(A).

Unless an employee gives oral or written notice to the employer within thirty (30) days of the employee’s separation from employment, there shall be a rebuttable presumption that an occupational disease or cumulative trauma injury did not arise out of and in the course of employment. Such presumption must be overcome by a preponderance of the evidence. 85A O.S. §68(B).

Except as otherwise provided, notice of disability resulting from an occupational disease or cumulative trauma shall be the same as in cases of accidental injury. 85A O.S. § 67(A)(1).

Written notice shall be given to the employer of an occupational disease or cumulative trauma by the employee, or a representative of the employee in the case of incapacity or death, within six (6) months after the first distinct manifestation of the disease or cumulative trauma or within six (6) months after death. 85A O.S. § 67(A)(2).

9. Describe available defenses based on employee conduct:

**Pre 2/1/2014 injury date:**
A. Willful/Self-inflicted injury.

An injury occasioned by the willful intention of the employee to bring about injury to himself or herself or another is not compensable. 85 O.S. § 312(1).

Post 2/1/2014 injury date:

There shall be no liability for compensation under the act where the injury or death was substantially occasioned by the willful intention of the injured employee to bring about such compensable injury or death. 85A § 35(A)(2)

B. Willful misconduct, horseplay, etc.

Pre 2/1/2014 injury date:

An injury resulting directly from the willful failure of the injured employee to use a guard or protection against accident furnished for use pursuant to any statute or by order of the Commissioner of Labor is not compensable. 85 O.S. § 312(2).

Except for innocent victims, an injury caused by prank, horseplay or similar willful conduct, is not compensable. 85 O.S. § 312(4).

Post 2/1/2014 injury date:

An injury is not compensable where it is suffered by any active participant in assaults or combats which, although they may occur in the workplace, are the result of non-employment-related hostility or animus of one, both, or all of the combatants and which assault or combat amounts to a deviation from customary duties. 85A O.S. § 2(9)(b)(1).

Injuries caused by horseplay are not compensable injuries, “except for innocent victims.” 85A O.S. § 2(9)(b)(1).

C. Injuries involving drugs and/or alcohol.

Pre 2/1/2014 injury date:

An injury which occurs when an employee’s use of illegal drugs or chemicals or alcohol is the major cause of the injury or accident is not compensable. The employee shall prove by a preponderance of the evidence that the use of drugs, chemicals or alcohol was not the major cause of the injury or accident. For the purposes of this paragraph, post-accident alcohol or drug testing results shall be admissible as evidence. A public or private employer may require an employee to undergo drug or alcohol testing if the employee has sustained an injury while at work. For purposes of workers’ compensation, no employee who tests positive for
the presence of substances defined and consumed pursuant 63 O.S. § 465.20, alcohol, illegal drugs, or illegally used chemicals, or refuses to take a drug or alcohol test required by the employer, shall be eligible for such compensation. 85 O.S. § 312(3).

**Post 2/1/2014 injury date:**

An injury is not compensable where the accident was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician’s orders. If, within twenty-four (24) hours of being injured or reporting an injury, an employee tests positive for intoxication, an illegal controlled substance, or a legal controlled substance used in contravention to a treating physician's orders, or refuses to undergo the drug and alcohol testing, there shall be a rebuttable presumption that the injury was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders. This presumption may only be overcome if the employee proves by clear and convincing evidence that his or her state of intoxication had no causal relationship to the injury.” 85A O.S. § 2(9)(b)(4).

D. Injuries not during employment.

**Pre 2/1/2014 injury date:**

An injury occurring at a time when employment services were not being performed before the employee was hired or after the employment relationship was terminated is not compensable. 85 O.S. § 312(5).

An injury which occurs outside the course of employment. Employment shall be deemed to commence when an employee arrives at the employee’s place of employment to report for work and shall terminate when the employee leaves the employee’s place of employment, excluding areas not under the control of the employer or areas where essential job functions are not performed; provided, however, when the employee is instructed by the employer to perform a work-related task away from the employee’s place of employment, the employee shall be deemed to be in the course of employment when the employee is engaged in the performance of job duties directly related to the task as instructed by the employer, including travel time that is solely related and necessary to the employee’s performance of the task. Travel by a policeman, fireman, or a member of a first aid or rescue squad, in responding to and returning from an emergency, shall be deemed to be in the course of employment. 85 O.S. § 312(6).

**Post 2/1/2014 injury date:**

An injury which was inflicted on the employee at a time when employment services were not being performed or before the employee was hired or after the employment relationship was terminated is not compensable. 85A O.S. §
2(9)(b)(3). An injury is only compensable if it occurred in the “course and scope of” employment. Pursuant to 85A O.S. § 2(13), this term does not include (a) an employee’s transportation to and from his or her place of employment, (b) travel by an employee in furtherance of the affairs of an employer if the travel is also in furtherance of personal or private affairs of the employee, (c) any injury occurring in a parking lot or other common area adjacent to an employer’s place of business before the employee clocks in or otherwise begins work for the employer or after the employee clocks out or otherwise stops work for the employer, or (d) any injury occurring while an employee is on a work break, unless the injury occurs while the employee is on a work break inside the employer’s facility and the work break is authorized by the employee’s supervisor. The Supreme Court of Oklahoma, however, recently clarified that, frequently, stairways and parking lots are actually “part of the premises” of the employer, and injuries occurring there on will be compensable. The Court narrowly construed the term “adjacent to an employer’s place of business. See Brown v. Claims Mgmt. Res. Inc., 2017 OK 13, 391 P.3d 111, 117.

10. What, if any, penalties or remedies are available in claims involving fraud?

Pre 2/1/2014 injury date:

Any person who commits workers’ compensation fraud, upon conviction, is guilty of a felony punishable by imprisonment of up to seven years, a fine up to $10,000.00, or both. 21 O.S. §1663.

Post 2/1/2014 injury date:

Any person who commits workers’ compensation fraud, or who aids and abets any person for the purpose of (1) obtaining any benefit or payment, (2) increasing any claim for benefit or payment, or (3) obtaining workers’ compensation coverage under the act, shall be guilty of a felony punishable by imprisonment of up to seven years, a fine up to $10,000, or both. 85A O.S. § 6(A); 21 O.S. § 1663(A).

11. Is there any defense for falsification of employee records regarding medical history?

Pre 2/1/2014 injury date:

No.

Post 2/1/2014 injury date:

No.

12. Are injuries during recreational and other non-work activities paid for or
supported by the employer compensable?

**Pre 2/1/2014 injury date:**

Recreational activities of an employee are within the scope of employment for purposes of workers’ compensation if they meet one of three criteria: the activity occurs on employer’s premises during lunch or recreational period as a regular incident to employment; if employer expressly or implicitly induces employee’s participation in such activity; or if employer derives substantial benefits from activity beyond intangible value activity would generally be expected to have with regard to the employee's health or morale improvement. *Val Gene's & Assocs. v. Balogun*, 1992 OK CIV APP 85, 833 P.2d 1265.

**Post 2/1/2014 injury date:**

An injury incurred while engaging in or performing or as the result of engaging in or performing any recreational or social activities for the employee’s personal pleasure is not compensable. 85A O.S. § 2(9)(b)(2).

13. Are injuries by co-employees compensable?

**Pre 2/1/2014 injury date:**

Although not specifically addressed in the Act, employers are liable for all injuries arising out of the course of an employee’s employment. 85 O.S. § 310(A). Further, injuries by co-employees are not a class of injury listed as a non-compensable injury. See 85 O.S. § 312.

**Post 2/1/2014 injury date:**

No change.

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. “irate paramour” claims)?

**Pre 2/1/2014 injury date:**

An injury to an employee by that employee’s “irate paramour” are not compensable. Where an employee is assaulted by a third person because of animosity, ill-will, or other personal cause wholly unconnected with his or her employment, or where an intentional injury is inflicted by unknown assailant for no apparent reason, the injury is not regarded as arising out of employment and therefore the disability is not compensable. *Mullins v. Tanksleary*, 1962 OK 239, 376 P.2d 590. However, injury by a third party stranger (e.g. robbery) is compensable. When a willful injury is inflicted by a third party aggressor upon an employee performing tasks he is hired to perform, and the assault is not motivated
solely by personal animosity, wholly disconnected from employment, resulting injury is regarded as having arisen out of and in course of employment, for purposes of workers' compensation. *Wal-Mart Stores, Inc. v. Reinholtz*, 1998 OK 11, 955 P.2d 223.

**Post 2/1/2014 injury date:**

The Administrative Act does not specifically address the situation of an injury by an employee’s “irate paramour.” However, an injury is not compensable where it is suffered by “any active participant in assaults or combats which, although they may occur in the workplace, are the result of non-employment-related hostility or animus of one, both, or all of the combatants and which assault or combat amounts to a deviation from customary duties.” 85A O.S. § 2(9)(b)(1). Existing case law discussed *supra* could be instructive in determining whether an injury caused by a third party would be regarded as arising out of and in the course of employment.

**BENEFITS**

15. **What criteria are used for calculating the average weekly wage?**

**Pre 2/1/2014 injury date:**

If the injured employee shall have worked for the same employer for the year immediately preceding the injury, his or her average weekly wage shall be one fifty-second (1/52) of his or her total wages for the fifty-two (52) weeks preceding the injury; provided, however, that if the employee shall have received a pay raise or promotion during the year, the average weekly wage shall be one fifty-second (1/52) of 260 times the average daily wage at the increased rate of pay. 85 O.S. § 331(1).

If the injured employee shall not have worked for the employer for one year prior to the injury, his or her average weekly wage shall be his or her total wages divided by the number of weeks employed; provided, however, that if the employee shall have received a pay raise or promotion during the time employed, the average weekly wage shall be one fifty-second (1/52) of 260 times the average daily wage at the increased rate of pay. 85 O.S. § 331(2).

If either of the foregoing methods of arriving at the annual average earnings of an injured employee cannot reasonably and fairly be applied, the Court may consider average wages in the same or similar employment in the same area of the state where the injury occurred. 85 O.S. § 331(3).

The benefit level for members of the National Guard and any authorized voluntary or uncompensated worker rendering services as a firefighter, peace officer or civil defense worker shall be determined by using the wages of the employee in his or her regular occupation. 85 O.S. § 331(4).
Post 2/1/2014 injury date:

Compensation based on the employee’s average weekly wage is computed by dividing the employee’s gross earnings by the number of full weeks of employment with employer, up to a maximum of fifty-two (52) weeks. 85A O.S. § 59(A)(1).

If the injured employee was working on piece basis, the average weekly wage is determined by dividing the earnings of the employee by the number of hours required to earn the wages during the period, not to exceed fifty-two weeks, preceding the week in which the accident occurred and by multiplying this hourly wage by the number of hours in a full-time workweek in the employment. 85A O.S. § 59(A)(1).

Overtime earnings are to be added to the regular weekly wages and shall be computed by dividing the overtime earnings by the number of weeks worked by the employee in the same employment under the contract of hire in force at the time of the accident, not to exceed a period of fifty-two (52) weeks preceding the accident. 85A O.S. § 59(B).

If, because of exceptional circumstances, the average weekly wage cannot be fairly and justly determined by the above formulas, the Commission may determine the average weekly wage by a method that is just and fair to all parties concerned. 85A O.S. § 59(C).

The benefit level for members of the National Guard and any authorized voluntary or uncompensated worker rendering services as a firefighter, peace officer or civil defense worker shall be determined by using the wages of the employee in his or her regular occupation. 85A O.S. § 59(D).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Pre 2/1/2014 injury date:

In cases of Temporary Total Disability (“TTD”), the injured employee shall be paid seventy percent (70%) of his or her average weekly wages, but not in excess of the state’s average weekly wage, during continuance thereof; provided, there shall be no payment for the first seven (7) days of the initial period of TTD unless the Court declares the employee to be temporarily totally disabled for more than twenty-one (21) days. In that event, compensation shall be due from the first day of the period of temporary total disability. Total payments of compensation for TTD shall not exceed one hundred fifty-six (156) weeks, except if the Court makes a finding of a consequential injury. In that event, the Court may order an additional period of TTD not to exceed fifty-two (52) weeks. Any party may
request overpayment or underpayment of TTD compensation. 85 O.S. § 332(A).

Additionally, see Number 19 infra regarding limitations on payment of TTD disability payments for non-surgical soft tissue injuries.

**In cases of Temporary Partial Disability** (“TPD”), an injured employee shall receive seventy percent (70%) of the difference between the employee’s average weekly wages and the employee’s wage-earning capacity thereafter in the same employment or otherwise, if less than before the injury, during continuance of the partial disability. Total payments of TPD may not exceed one hundred fifty-six (156) weeks. In no event shall the total payment of wages and TPD exceed eighty percent (80%) of the average weekly wage of the injured employee at the time of the accident. 85 O.S. § 332(J).

**Post 2/1/2014 injury date:**

**TTD:** In cases of TTD, the injured employee shall receive compensation equal to seventy percent (70%) of the injured employee’s average weekly wage, not to exceed seventy percent (70%) of the state average weekly wage, for one hundred and four (104) weeks. There shall be no payment for the first three (3) days of the initial period of TTD. If an administrative law judge determines that a consequential injury has occurred and that additional time is needed for medical improvement, TTD compensation may continue for up to fifty-two (52) additional weeks. Such finding shall be based upon a showing of medical necessity by clear and convincing evidence. 85A O.S. § 45(A)(1).

Notwithstanding any other provision of the Administrative Act, no compensation for TTD shall be payable to an employee for any week for which the employee receives unemployment insurance benefits under Oklahoma law, or the unemployment insurance law of any other state. If a claim for TTD is controverted and later determined to be compensable, TTD shall be payable to an injured employee for any week for which the injured employee receives unemployment benefits but only to the extent that the TTD otherwise payable exceeds the unemployment benefits. 85A O.S. § 49.

Notwithstanding the provisions of 85A O.S. § 45, if an employee suffers a nonsurgical soft tissue injury, TTD compensation shall not exceed eight (8) weeks, regardless of the number of parts of the body to which there is a nonsurgical soft tissue injury. An employee who is treated with an injection or injections shall be entitled to an extension of an additional eight (8) weeks. An employee who has been recommended by a treating physician for surgery for a soft tissue injury may petition the Commission for one extension of TTD compensation and the Commission may order an extension, not to exceed sixteen (16) additional weeks. 85A O.S. § 62(A).
“Soft tissue injury” means damage to one or more of the tissues that surround bones and joints. Soft tissue injury includes, but is not limited to, sprains, strains, contusions, tendonitis and muscle tears. Cumulative trauma is to be considered a soft tissue injury. 85A O.S. § 62(B).

**TPD:** In cases of TPD, the employee shall receive compensation equal to the greater of seventy percent (70%) of the difference between the injured employee’s average weekly wage before the injury and his or her weekly wage for performing the alternative work offered by the employer, but only if his or her weekly wage for performing the alternative work is less than the TTD rate. Compensation may not exceed fifty-two (52) weeks. If the employee refuses to perform the alternative work offered by the employer, he or she will not be entitled to TTD. 85A O.S. § 45(B).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

**Pre 2/1/2014 injury date:**

Temporary disability shall be payable without an award by the Court. The first payment of temporary disability compensation shall become due on the tenth day after the employer has received notice of injury. All compensation owed on that date shall be paid and thereafter payments shall be made weekly except when otherwise ordered by the Court. 85 O.S. § 332(N). *But see Number 18 infra* regarding seven (7) day waiting period.

If the employer has actual notice of the injury and the injury is not disputed and weekly TTD payments are not commenced within ten (10) days or if any subsequent installment of TTD is not made within ten (10) days after it becomes due, the insurer of the employer shall pay to the employee a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits. 85 OS. § 332(E).

Further, if the employer has actual notice of the injury, the injury is not disputed, and weekly TTD payments are not commenced within ten (10) days or if any subsequent installment of TTD is not made within ten (10) days after it becomes due, the insurer of the employer shall pay to the employee a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits. 85 O.S. § 332(E).

**Post 2/1/2014 injury date:**

The Administrative Act contains no provisions requiring an employer to pay benefits without a Commission order.

18. **What is the “waiting” or “retroactive” period for temporary benefits?**

**Pre 2/1/2014 injury date:**
There shall be no payment for the first seven (7) days of the initial period of TTD unless the Court declares the employee to be temporarily totally disabled for more than twenty-one (21) days. 85 O.S. § 332(A).

**Post 2/1/2014 injury date:**

There shall be no payment for the first three (3) days of the initial period of TTD. 85A O.S. § 45(A).

19. **What is the standard procedure for terminating temporary benefits?**

**Pre 2/1/2014 injury date:**

When the injured employee is released from active medical treatment by the treating physician for all body parts found by the Court to be injured, or in the event that the employee, without a valid excuse, misses three (3) consecutive medical treatment appointments, fails to comply with medical orders of the treating physician, or otherwise abandons medical care, the employer shall be entitled to terminate TTD by notifying the employee, or if represented, his or her counsel. If there is no objection within ten (10) days, TTD compensation shall be terminated. If, however, an objection to the termination is filed by the employee within ten (10) days, the Court shall set the matter within twenty (20) days for a determination if TTD compensation shall continue or be terminated. The Court shall terminate TTD unless the employee proves the existence of a valid excuse for his or her failure to comply with medical orders of the treating physician or his or her abandonment of medical care. The Court may appoint an independent medical examiner to determine if further medical treatment is reasonable and necessary. The independent medical examiner shall not provide treatment to the injured worker, unless agreed upon by the parties. The employer shall bear the cost of the independent medical examination. 85 O.S. § 332(B).

Temporary compensation may be terminated if the worker has no claim for compensation (Form 3 or Form 3B) on file with the Court. If there is a Form 3 or Form 3B on file, the employer may terminate temporary compensation without a Court order only if one of the following events occur:

1. The claimant returns to full-time employment;

2. The claimant fails to:

   a. object within ten (10) days of receipt of written notification from the employer of the employer’s intent to terminate TTD benefits for any reason provided in 85 O.S. § 332(B). Notification from the employer shall be sent to the claimant’s attorney of record or to the claimant if unrepresented; or
b. object within fifteen (15) days of receipt of written notification from the employer of the employer’s intent to terminate TTD benefits as provided in 85 O.S. § 332(G). Notification from the employer shall be sent to the claimant’s attorney of record or to the claimant if unrepresented.

3. Except as otherwise provided in 85 O.S. § 332(I), the claimant is incarcerated for a misdemeanor or felony conviction in this state or another jurisdiction;

4. The claimant files a permanent partial impairment or permanent total disability rating report or a Form 9 requesting a hearing on permanent partial impairment or permanent total disability;

5. The parties voluntarily agree in writing to terminate temporary compensation;

6. The claimant dies; or

7. Any other event that causes temporary total disability benefits to be lawfully terminated without Court order pursuant to 85 O.S. § 332 or as otherwise permitted in the Act.

In all other instances, temporary compensation may be terminated only by Court order. A respondent may request a hearing on the termination of temporary total disability benefits by filing a Form 13 with the Court and concurrently mailing a copy thereof to the opposing parties. The Form 13 mailed to the opposing parties shall include a copy of all evidentiary exhibits relied upon by the respondent in support of terminating temporary compensation.

If a respondent is found to have improperly terminated temporary compensation, the Court shall order the compensation reinstated retroactive to the date of termination and assess a fifteen percent (15%) penalty against the respondent on all unpaid benefits as of the date of the trial. The Court also may require the respondent to file a new Form 13 and show full compliance with this rule before a trial on the respondent’s request to terminate temporary compensation will be conducted.

If the claimant objects to the termination of TTD benefits, the claimant may request an expedited hearing on the issue of reinstatement of TTD benefits as provided in 85 O.S. § 332(B) or pursuant to 85 O.S. § 332(G), as applicable. Workers’ Compensation Court Rule 15.

In case of a nonsurgical soft tissue injury, in which the employer has provided medical care within seven (7) days after receipt of oral or written notice of the injury, TTD compensation shall not exceed eight (8) weeks, regardless of the number of parts of the body to which there is a nonsurgical soft tissue injury. A
claimant who has been recommended by a treating physician for one or more
injections may petition the Court for one extension of temporary total disability
compensation and the Court may order an extension, not to exceed eight (8)
additional weeks. A claimant who has been recommended by a treating physician
for surgery for a soft tissue injury may petition the Court for one extension of
TTD compensation and the Court may order an extension, not to exceed sixteen
(16) additional weeks, if the treating physician indicates that an extension is
appropriate or as agreed to by all parties. In the event the surgery is not performed
within ninety (90) days of the approval of the surgery by the employer or
employer’s insurance carrier or an order of the Court authorizing the surgery, the
benefits for the extension period shall be terminated by the Court, unless the
Court finds the delay was beyond the control of the claimant. In the event surgery
is performed, the period of TTD is subject to the limitations established by
subsection A of this section. This subsection shall apply to all cases coming
before the Court after the effective date of this act, regardless of the date of injury.
85 O.S. § 332(K).

Post 2/1/2014 injury date:

When the injured employee is released from active medical treatment by the
treating physician for all body parts found by the Commission to be injured, or in
the event that the employee, without a valid excuse, misses three (3) consecutive
medical treatment appointments, fails to comply with medical orders of the
treating physician, or otherwise abandons medical care, the employer shall be
entitled to terminate TTD by notifying the employee, or if represented, his or her
counsel. If, however, an objection to the termination is filed by the employee
within ten (10) days of termination, the Commission shall set the matter within
twenty (20) days for a determination if TTD compensation shall be reinstated.
The TTD shall remain terminated unless the employee proves the existence of a
valid excuse for his or her failure to comply with medical orders of the treating
physician or his or her abandonment of medical care. The administrative law
judge may appoint an independent medical examiner to determine if further
medical treatment is reasonable and necessary. The independent medical
examiner shall not provide treatment to the injured worker, unless agreed upon by
the parties. 85A O.S. § 45(A)(2).

20. Is the amount of TTD credited toward the amount entitled for Permanent
Partial Disability?

Pre 2/1/2014 injury date:

No. 85 O.S. § 345(E).

Post 2/1/2014 injury date:

No. The Administrative Act does not specifically address this issue. However,
“awards for permanent partial disability shall be made pursuant to 85A O.S. §§ 45
and 46, less any sums previously paid which the Workers’ Compensation Commission may find to be a proper credit thereon.” 85A O.S. § 116(A). This provision refers to credit for overpayment of TTD as pre-payment of PPD.

21. What disfigurement benefits are available and how are they calculated?

**Pre 2/1/2014 injury date:**

Benefits up to $50,000.00 can be awarded for serious and permanent disfigurement. An employee cannot recover for disfigurement and Permanent Partial Disability to the same body parts. 85 O.S. § 334.

**Post 2/1/2014 injury date:**

If an injured employee incurs serious and permanent disfigurement to any part of the body, the Commission may award compensation to the injured employee in an amount not to exceed Fifty Thousand Dollars ($50,000.00). No award for disfigurement shall be entered until twelve (12) months after the injury. An injured employee cannot recover compensation for disfigurement if he or she receives an award for Permanent Partial Disability (“PPD”) to the same part of the body. 82A O.S. § 45(F).

22. How is PPD calculated, including the minimum and maximum rates?

**Pre 2/1/2014 injury date:**

In case of PPD, the compensation shall be seventy percent (70%) of the employee’s average weekly wages, and shall be paid to the employee for the period prescribed by a schedule of weeks are available for scheduled members/parts. 85 O.S. § 333(E).

The compensation payments under the provisions of the Act for PPD shall not:

1. Exceed the sum of Three Hundred Twenty-three Dollars ($323.00) per week for injuries occurring on or after August 27, 2010, through August 26, 2015, or fifty percent (50%) of the state’s average weekly wage beginning August 27, 2015;

2. At any time be less than One Hundred Fifty Dollars ($150.00) per week for injuries occurring on or after August 27, 2010. 85 O.S. § 333(F).

**A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

Scheduled members/parts are assigned different weeks. The maximum weeks are: Arm/Leg – 275; Hand/Foot – 220, Thumb – 66, First Finger – 39, Second Finger – 33, Third Finger – 22, Fourth Finger – 17, Big Toe – 33, Other Toes – 11, Ear –
B. **Number of weeks for “whole person” and standard for recovery.**

A “whole person” rating is based upon 500 weeks. 85 O.S. § 333(E).

**Post 2/1/2014 injury date:**

A “whole person” rating is based on three hundred and fifty (350) weeks. 85A O.S. § 45(C)(4)

A. **How many weeks are available for scheduled members/ parts, and the standard for recovery?**

The PPD rate of compensation for amputation or permanent total loss of use of a scheduled member specified in Section 46 of the act shall be seventy percent (70%) of the employee's average weekly wage, not to exceed Three Hundred Twenty-three Dollars ($323.00), multiplied by the number of weeks set forth for the member in Section 46 of this act, regardless of whether the injured employee is able to return to his or her pre-injury or equivalent job. 85A O.S. § 45(C)(9).

Scheduled members/parts are assigned different weeks. The maximum weeks are:
- Arm amputated at or above elbow - 275;
- Arm amputated below elbow – 220;
- Leg amputated at or above knee- 275;
- Leg amputated below knee – 220;
- Thumb – 66;
- First finger – 39;
- Second finger – 33;
- Third finger – 22;
- Fourth finger – 17;
- Foot- 220;
- Great toe – 33;
- Other toes – 11;
- Eye – 275;
- One ear- 110;
- both ears -330;
- One testicle – 53;
- Both testicles – 158.

The determination of PPD shall be the responsibility of the Commission through its administrative law judges. Any claim by an employee for compensation for PPD must be supported by competent medical testimony of a medical doctor, osteopathic physician, or chiropractor, and shall be supported by objective medical findings. The opinion of the physician shall include employee’s percentage of PPD and whether or not the disability is job-related and caused by the accidental injury or occupational disease. A physician’s opinion of the nature and extent of PPD to parts of the body other than scheduled members must be based solely on criteria established by the current edition of the American Medical Association's “Guides to the Evaluation of Permanent Impairment.” 85A O.S. § 45(C)(1).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

**Pre 2/1/2014 injury date:**

When, as a result of the injury, the employee is unable to perform the same
occupational duties the employee was performing prior to the injury, the employee shall be entitled to such vocational rehabilitation services provided by a technology center school, a public or private vocational skills center or public secondary school offering vocational-technical education courses, or a member institution of The Oklahoma State System of Higher Education, which shall include retraining and job placement so as to restore the employee to gainful employment. 85 O.S. § 338(A).

If appropriate, the Court shall refer the employee to a qualified expert for evaluation of the practicability of, need for and kind of rehabilitation services or training necessary and appropriate in order to restore the employee to gainful employment. The cost of the evaluation shall be paid by the employer. Following the evaluation, if the employee refuses the services or training ordered by the Court, or fails to complete in good faith the vocational rehabilitation training ordered by the Court, then the cost of the evaluation and services or training rendered may, in the discretion of the Court, be deducted from any award of benefits to the employee which remains unpaid by the employer. Upon receipt of such report, and after affording all parties an opportunity to be heard, the Court shall order that any rehabilitation services or training, recommended in the report, or such other rehabilitation services or training as the Court may deem necessary, provided the employee elects to receive such services, shall be provided at the expense of the employer. Except as otherwise provided in this subsection, refusal to accept rehabilitation services by the employee shall in no way diminish any benefits allowable to an employee. 85 O.S. § 338(C).

**Post 2/1/2014 injury date:**

A Vocational Rehabilitation Director (“Director”) oversees the Commission’s rehabilitation program, and must help injured workers return to the work force. 85A O.S. § 45(E).

If the injured employee is unable to return to his or her pre-injury or equivalent position due to permanent restrictions as determined by a physician, upon the request of either party, the Director shall determine if it is appropriate for a claimant to receive vocational rehabilitation training or services, and will oversee such training. If appropriate, the Director shall issue administrative orders, including, but not limited to, an order for a vocational rehabilitation evaluation for any injured employee unable to work for at least ninety (90) days. In addition, the Director may assign injured workers to vocational rehabilitation counselors for coordination of recommended services. The cost of the services shall be paid by the employer. 85A O.S. § 45(E)(2).

There shall be a presumption in favor of ordering vocational rehabilitation services or training for an eligible injured employee if the employee’s occupation is:

1. truck driver or laborer and the medical condition is traumatic brain injury, stroke or uncontrolled vertigo,
2. truck driver or laborer performing high-risk tasks and the medical condition is seizures,
3. manual laborer and the medical condition is bilateral wrist fusions,
4. assembly-line worker and the medical condition is radial head fracture with surgical excision,
5. heavy laborer and the medical condition is myocardial infarction with congestive heart failure,
6. heavy manual laborer and the medical condition is multilevel neck or back fusions greater than two levels,
7. laborer performing overhead work and the medical condition is massive rotator cuff tears, with or without surgery,
8. heavy laborer and the medical condition is recurrent inguinal hernia following unsuccessful surgical repair,
9. heavy manual laborer and the medical condition is total knee replacement or total hip replacement,
10. roofer and the medical condition is calcaneal fracture, medically or surgically treated,
11. laborer of any kind and the medical condition is total shoulder replacement,
12. laborer and the medical condition is amputation of a hand, arm, leg, or foot,
13. laborer and the medical condition is tibial plateau fracture, pilon fracture,
14. laborer and the medical condition is ankle fusion or knee fusion,
15. driver or heavy equipment operator and the medical condition is unilateral industrial blindness, or
16. laborer and the medical condition is 3-, 4-, or 5-level positive discogram of the cervical spine or lumbar spine, medically treated.

85A O.S. § 45(E)(3).

Upon the request of either party, or by order of an administrative law judge, the Director shall assist the Commission in determining if it is appropriate for a claimant to receive vocational rehabilitation training or services. If appropriate, the administrative law judge shall refer the employee to a qualified expert for evaluation of the practicability of, need for and kind of rehabilitation services or training necessary and appropriate in order to restore the employee to gainful employment. The cost of the evaluation shall be paid by the employer. Following the evaluation, if the employee refuses the services or training ordered by the administrative law judge, or fails to complete in good faith the vocational
rehabilitation training ordered by the administrative law judge, then the cost of the evaluation and services or training rendered may, in the discretion of the administrative law judge, be deducted from any award of benefits to the employee which remains unpaid by the employer. Upon receipt of such report, and after affording all parties an opportunity to be heard, the administrative law judge shall order that any rehabilitation services or training, recommended in the report, or such other rehabilitation services or training as the administrative law judge may deem necessary, provided the employee elects to receive such services, shall be provided at the expense of the employer. Except as otherwise provided in this subsection, refusal to accept rehabilitation services by the employee shall in no way diminish any benefits allowable to an employee. 85A O.S. § 45(E)(4).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

**Pre 2/1/2014 injury date:**

In case of total disability adjudged to be permanent, seventy percent (70%) of the employee’s average weekly wages, but not in excess of the state’s average weekly wage, shall be paid to the employee during the continuance of the disability until such time as the employee reaches the age of maximum Social Security retirement benefits or for a period of fifteen (15) years, whichever is longer. In the event the claimant dies of causes unrelated to the injury or illness, benefits shall cease on the date of death. Provided, however, any person entitled under provisions of Section 49 to revive the action shall receive a one-time lump sum payment equal to twenty-six (26) weeks of weekly benefits for permanent total disability awarded the claimant. 85 O.S. § 336(A).

**Post 2/1/2014 injury date:**

In case of total disability adjudged to be permanent, seventy percent (70%) of the employee’s average weekly wages, but not in excess of the state’s average weekly wage, shall be paid to the employee during the continuance of the disability until such time as the employee reaches the age of maximum Social Security retirement benefits or for a period of fifteen (15) years, whichever is longer. In the event the claimant dies of causes unrelated to the injury or illness, benefits shall cease on the date of death. Provided, however, any person entitled to revive the action shall receive a one-time lump-sum payment equal to twenty-six (26) weeks of weekly benefits for permanent total disability awarded the claimant. If more than one person is entitled to revive the claim, the lump-sum payment shall be evenly divided between or among such persons. In the event the Commission awards both permanent partial disability and permanent total disability benefits, the permanent total disability award shall not be due until the permanent partial disability award is paid in full. If otherwise qualified according to the provisions of this act, permanent total disability benefits may be awarded to an employee who has exhausted the maximum period of temporary total disability even though
the employee has not reached maximum medical improvement. 85A O.S. § 45(D)(1).

25. **How are death benefits calculated, including the minimum and maximum rates?**

**Pre 2/1/2014 injury date:**

**A. Funeral expenses.**

In the event that no benefits under other provisions of this section are paid to the dependents or the heirs-at-law of the deceased, an amount not to exceed Eight Thousand Dollars ($8,000.00) shall be paid for funeral expenses. 85 O.S. § 337(F).

**B. Dependency claims.**

85 O.S. § 337(A) provides if there is a surviving spouse, to such surviving spouse who shall remain unmarried, seventy percent (70%) of the average weekly wages the deceased was earning. In no event shall this spousal weekly income benefit be diminished by the award to other beneficiaries. In addition to the benefits theretofore paid or due, two (2) years’ indemnity benefit in one lump sum shall be payable to a surviving spouse upon remarriage;

If there is a surviving spouse and a child or children, fifteen percent (15%) of the average weekly wages the deceased was earning for each child. Where there are more than two such children, the income benefits payable for the benefit of all children shall be divided among all children, to share and share alike, subject to the maximum limits in subsection D;

To the children, if there is no surviving spouse, fifty percent (50%) of the average weekly wages the deceased was earning for one child, and twenty percent (20%) of such wage for each additional child, divided among all children, to share and share alike, subject to the maximum limits in subsection D;

The weekly income benefits payable for the benefit of any child under this section shall cease when the child dies, marries, or reaches the age of eighteen (18), unless the child is over eighteen (18) years of age and remains enrolled as a full-time student in high school or is being home-schooled in a high-school course
approved by the Oklahoma Department of Education; or unless a child is over eighteen (18) years of age and is physically or mentally incapable of self-support; or unless the child is under the age of twenty three (23) and enrolled as a full-time student in any accredited institution of higher education or vocational or technology education;

If there is no surviving spouse or children, to each parent, if actually dependent, twenty-five percent (25%) of the average weekly wages the deceased was earning, subject to the maximum limits in subsection D.

Section 337(D) places the maximum amount of the award: The aggregate weekly income benefits payable to all beneficiaries under this section shall not exceed one hundred percent (100%) of the average weekly wages of the employee or one hundred percent (100%) of the state's average weekly wage, whichever is less.

Post 2/1/2014 injury date:

A. Funeral expenses.

The employer shall pay the actual funeral expenses, not exceeding the sum of Ten Thousand Dollars ($10,000.00). 85A O.S. § 47(5)

B. Dependency Claims.

Pursuant to 85A O.S.§ 47(C), if an injury or occupational illness causes death, weekly income benefits are payable as follows:

If there is a surviving spouse, a lump-sum payment of One Hundred Thousand Dollars ($100,000.00) and seventy percent (70%) of the lesser of the deceased employee’s average weekly wage and the state average weekly wage. In addition to the benefits theretofore paid or due, two (2) years’ indemnity benefit in one lump sum shall be payable to a surviving spouse upon remarriage.

If there is a surviving spouse and a child or children, a lump-sum payment of Twenty-five Thousand Dollars ($25,000.00) and fifteen percent (15%) of the lesser of the deceased employee’s average weekly wage and the state average weekly wage to each child. If there are more than two children, each child shall receive a pro rata share of Fifty Thousand Dollars ($50,000.00) and thirty percent (30%) of the deceased employee’s average weekly wage.

If there is a child or children and no surviving spouse, a lump-sum payment of Twenty-five Thousand Dollars ($25,000.00) and fifty percent (50%) of the lesser of the deceased employee’s average weekly wage and the state average weekly wage to each child. If there are more than two children, each child shall receive a pro rata share of one hundred percent (100%) of the lesser of the deceased employee’s average weekly wage and the state average weekly wage. With respect to the lump-sum payment, if there are more than six children, each child
shall receive a pro rata share of One Hundred Fifty Thousand Dollars ($150,000.00).

If there is no surviving spouse or children, each legal guardian, if financially dependent on the employee at the time of death, shall receive twenty-five percent (25%) of the lesser of the deceased employee’s average weekly wage and the state average weekly wage until the earlier of death, becoming eligible for social security, obtaining full-time employment, or five (5) years from the date benefits under this section begin.

26. **What are the criteria for establishing a “second injury” fund recovery?**

**Pre 2/1/2014 injury date:**

For actions in which the subsequent injury occurred on or after November 1, 2005, if such combined disabilities constitute Permanent Total Disability (“PTD”), the employee shall receive full compensation as provided by law for the disability resulting directly and specifically from the subsequent injury. In addition, the employee shall receive compensation for PTD if the combination of injuries renders the employee permanently and totally disabled. The employer shall be liable only for the degree of percent of disability which would have resulted from the subsequent injury if there had been no preexisting impairment. Tit. 85 O.S. § 404(A).

**Post 2/1/2014 injury date:**

**Multiple Injury Trust Fund:** For actions in which the subsequent injury occurred on or after November 1, 2005, if such combined disabilities constitute PTD, the employee shall receive full compensation as provided by law for the disability resulting directly and specifically from the subsequent injury. In addition, the employee shall receive compensation for PTD if the combination of injuries renders the employee permanently and totally disabled. The employer shall be liable only for the degree of percent of disability which would have resulted from the subsequent injury if there had been no preexisting impairment. Tit. 85A O.S. § 32(A).

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

**Pre 2/1/2014 injury date:**

Within the time prescribed by 85 O.S. § 18, the Court may find that the injured employee has suffered a change of condition for the worse and order TTD, additional PPD, PTD, and medical benefits. Provided, that any change of condition shall only be found to those body parts adjudicated by the previous award or as a result of a consequential injury and must be proved by objective
medical evidence of a change of condition. Additional PPD awarded after a change of condition and the PPD from the previous award shall not exceed five hundred twenty (520) weeks, except for additional PPD resulting from amputation or surgery as a result of the change of condition. 85 O.S. § 342.

The jurisdiction of the Court to reopen any cause upon an application based upon a change in condition for the worse shall extend for three (3) years from the date of the last order in which monetary benefits or active medical treatment was provided, and unless filed within such period of time, shall be forever barred. An order denying an application to reopen a claim shall not extend the period of the time set out in this act for reopening the case. A failure to comply with a medical treatment plan ordered by the Court shall bar reopening of a claim. This subsection shall be considered to be substantive in nature. 85 O.S. § 318(F).

**Post 2/1/2014 injury date:**

Except where a joint petition settlement has been approved, the Commission may review any compensation judgment, award, or decision. Such review may be done at any time within six (6) months of termination of the compensation period fixed in the original compensation judgment or award, on the Commission’s own motion or on the application of any party in interest, on the ground of a change in physical condition or on proof of erroneous wage rate. On review, the Commission may make a judgment or award terminating, continuing, decreasing, or increasing for the future the compensation previously awarded, subject to the maximum limits provided for in this act. 85A O.S. § 80(A).

In cases in which any compensation, including disability or medical, has been paid on account of injury, a claim for additional compensation shall be barred unless filed with the Commission within one (1) year from the date of the last payment of disability compensation or two (2) years from the date of the injury, whichever is greater. 85A O.S. § 69(B)(1).

28. **What situation would place responsibility on the employer to pay an employee’s attorney fee?**

**Pre 2/1/2014 injury date:**

There is no statutory or case law authority for the award of attorney fees to the successful employee at the trial court level. However, there are several cases supporting the award of extra attorney fees to the employee’s attorney when the respondent files a frivolous appeal. See, generally, *King Mfg. v. Meadows*, 2005 OK 78, 127 P.3d 584; *Tibbetts v. Sight ’n Sound Appliance Ctrs., Inc.*, 2003 OK 72, 77 P.3d 1042; *Matter of Estate of Sneed*, 1998 OK 8, 953 P.2d 1111; *Melinder v. Southlands Dev., Inc.*, 1985 OK 98, 715 P.2d 1341.

**Post 2/1/2014 injury date:**
No change.

**EXCLUSIVITY/TORT IMMUNITY**

29. Is the compensation remedy exclusive?

**Pre 2/1/2014 injury date:**

A. **Scope of immunity.**

In general, workers’ compensation is the exclusive remedy for an employee against the employer. 85 O.S. § 302(A).

B. **Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

There is an exception to the exclusive remedy provision in the case of an intentional tort or where the employer has failed to secure the payment of compensation for the injured employee. 85 O.S. § 302(A). An intentional tort exists only when the employee is injured as a result of willful, deliberate, specific intent of the employer to cause such injury. Allegations or proof that the employer had knowledge that such injury was substantially certain to result from the employer's conduct co not constitute an intentional tort. 85 O.S. § 302(B).

If an employer has failed to secure the payment of compensation for his or her injured employee as the Act requires, an injured employee, or his or her legal representatives if death results from the injury, may maintain an action in the district court for damages, and the employer may not assert the defenses that the injury was caused by the negligence of a fellow servant, or that the employee assumed the risk of his or her employment, or that the injury was due to the contributory negligence of the employee. 85 O.S. § 302(C).

**Post 2/1/2014 injury date:**

A. **Scope of Immunity**

Like the Act, the rights and remedies granted by the Administrative Act are exclusive, and the negligent acts of co-employees cannot be imputed to the employer. 85A O.S. § 5(A).

B. **Exceptions**

The exclusive remedy provision shall not apply if an employer fails to secure the payment of compensation due to the employee as required by the act. 85A O.S. § 5(B)(1). Additionally, the employee may sue in district court due to the employers willful, deliberate injury of the employee with specific intent. As before,
allegations or proof that the employer knew that injury was substantially certain to result from the employer’s conduct is not an intentional tort. The employee shall plead facts that show it is at least as likely as it is not that the employer acted with the purpose of injuring the employee. The issue of whether an act is an intentional tort shall be a question of law. 85A O.S. § 5(B)(2).

C. Employer Liability for Failure to Pay Award.

If any employer fails to comply with a final compensation judgment or award, any beneficiary of the judgment or award, or the Commission, may file a certified copy of the judgment or award in the district court where the employer’s property may be found. The district court clerk shall enter the judgment or award in the judgment record of the county, and the judgment or award so recorded shall be a judgment and lien as are judgments of the district court, and enforceable as such. 85A O.S. § 79.

30. Are there any penalties against the employer for unsafe working conditions?

**Pre 2/1/2014 injury date:**

There are none.

**Post 2/1/2014 injury date:**

No change.

31. What is the penalty, if any, for an injured minor?

**Pre 2/1/2014 injury date:**

Minors collect the same benefits as adults. A previous statute, located at 85 O.S. § 21(5), provided that if an employee was a minor when injured, and under normal conditions his wages would be expected to increase, that fact could be considered in arriving at his average weekly wages. *Matthews v. Purcell Seed & Grain Co., Inc.*, 1993 OK CIV APP 190, 867 P.2d 1359, 1360. The last version of the Act does not contain a similar provision. 85 O.S. § 331.

An employer who illegally hires a minor is subject to suit and tort damages in district court. The minor can elect coverage under workers' compensation or may pursue damages in the district court. *Baker v. Hunn Roofing, Inc.*, 399 F. Supp. 628 (W.D. Okla. 1975).

**Post 2/1/2014 injury date:**

When an injury or death is sustained by a minor employed in violation of federal or state statutes relating to minimum ages for employment of minors, disability or death benefits provided for by the Administrative Act shall be doubled; provided,
however, such penalty shall not apply when the minor misrepresents his or her age, in writing, to the employer. 85A O.S. § 48.

32. **What is the potential exposure for “bad faith” claims handling?**

**Pre 2/1/2014 injury date:**

Oklahoma courts recognize a common-law tort action for an insurance carrier’s bad faith in refusing to pay a workers’ compensation award. The Oklahoma Supreme Court adopted the rule that where a workers’ compensation claimant has followed the certification requirements set out in 85 O.S. § 346, and the insurer fails to act in good faith and deal fairly by paying the award, the insurer may be liable for bad faith. *Sizemore v. Cont’l Cas. Co.*, 2006 OK 36, 142 P.3d 47. When an insurer has failed to provide court-ordered benefits and cannot demonstrate good cause for its failure to do so, a reasonable inference arises that the reason for the failure to obey the award involves a refusal to comply, not mere negligence. The remedy for such conduct is an action for bad faith. *Summers v. Zurich Am. Ins. Co.*, 2009 OK 33, 213 P.3d 565, 569.

**Post 2/1/2014 injury date:**

It is unlikely that enactment of the Administrative Act will alter the Oklahoma courts’ position on bad faith claim handling.

33. **What is the exposure for terminating an employee who has been injured?**

**Pre 2/1/2014 injury date:**

The Act provides that an employer cannot terminate an employee for filing a workers’ compensation case or during an employee’s period of TTD solely on the basis of absence from work. The exposure for the employer is actual and punitive damages. However, after an employee’s period of TTD has ended, the employer shall not be required to rehire or retain an employee who is determined to be physically unable to perform the assigned duties. 85 O.S. §§ 341(B) and (C).

**Post 2/1/2014 injury date:**

An employer may not discriminate or retaliate against an employee when the employee has in good faith:

1. Filed a claim under the Administrative Act;
2. Retained a lawyer for representation regarding a claim;
3. Instituted or caused to be instituted any proceeding; or

4. Testified or is about to testify in any proceeding.

If the Commission determines that an employer has violated one of these provisions, it may award the employee back pay up to a maximum of One Hundred Thousand Dollars ($100,000.00). Interim earnings or amounts earnable with reasonable diligence by the person discriminated against shall reduce the back pay otherwise allowable. The prevailing party shall also be awarded costs and attorney fees. 85A O.S. § 7(A), (C), (D).

An employer may not discharge an employee during a period of temporary disability for the sole reason of being absent from work or for the purpose of avoiding payment of TTD benefits to the injured employee. However, an employer shall not be required to rehire or retain an employee who, after TTD has been exhausted, is determined by a physician to be physically unable to perform his or her assigned duties, or whose position is no longer available. 85A O.S. § 7(E)-(F).

THIRD PARTY ACTIONS

34. Can an injured employee sue third parties?

**Pre 2/1/2014 injury date:**

Yes. However, a person entitled to compensation under the Act must, before any claim is filed under the Act, elect whether to pursue a remedy against a third party. 85 O.S. § 348. If the person entitled to compensation under the Act elects to receive workers’ compensation benefits, the cause of action against the third party must be assigned to the insurance carrier liable for the payment of benefits.

**Post 2/1/2014 injury date:**

Yes. Pursuant to 85A O.S. § 43(A), the making of a claim for compensation against any employer or carrier for the injury or death of an employee shall not affect the right of the employee, or his or her dependents, to make a claim or maintain an action in court against any third party for the injury. The employer or the employer’s carrier shall be entitled to reasonable notice and opportunity to join in the action.

If the employer or employer’s carrier join in the action against a third party for injury or death, they shall be entitled to a first lien on two-thirds (2/3) of the net proceeds recovered in the action that remain after the payment of the reasonable costs of collection, for the payment to them of the amount paid and to be paid by them as compensation to the injured employee or his or her dependents.
The commencement of an action by an employee or his or her dependents against a third party for damages by reason of an injury to which this act is applicable, or the adjustment of any claim, shall not affect the rights of the injured employee or his or her dependents to recover compensation, but any amount recovered by the injured employee or his or her dependents from a third party shall be applied as follows:

a. reasonable fees and costs of collection shall be deducted,

b. the employer or carrier, as applicable, shall receive two-thirds (2/3) of the remainder of the recovery or the amount of the workers' compensation lien, whichever is less, and

c. the remainder of the recovery shall go to the injured employee or his or her dependents.

35. Can co-employees be sued for work-related injuries?

Pre 2/1/2014 injury date:

No. 85 O.S. § 302. However, if the injury by the co-employee was something such as intentional infliction of emotional distress, sexual harassment, violation of an individual’s civil rights, etc., an action could be maintained in district court.

Post 2/1/2014 injury date:

No. The Administrative Act’s remedies are exclusive of all other rights and remedies of the employee against “the employer, or any principal, officer, director, employee, stockholder, partner, or prime contractor of the employer on account of injury, illness, or death.” 85A O.S. § 5(A).

36. Is subrogation available?

Pre 2/1/2014 injury date:

Yes. The employer/insurer also has the right of subrogation to recover money paid by the employer/insurer for the expenses of the last illness or accident under the Act from third persons. The Act also permits subrogation for death claims. Additionally, the Act grants the employer/insurer a credit against future workers’ compensation benefits in an amount equal to the net recovery of the injured employee in a third-party action. 85 O.S. § 348.

Post 2/1/2014 injury date:
Yes. An employer or carrier liable for compensation under the Administrative Act shall have the right to maintain an action in tort against any third party responsible for the injury or death. However, the employer or the carrier shall notify the claimant in writing that the claimant has the right to hire a private attorney to pursue any benefits to which the claimant is entitled in addition to the subrogation interest against any third party responsible for the injury or death. 85A O.S. § 43(B). The statutory subrogation right of employers or their insurance carriers has been successfully challenged on state constitutional grounds at the district court level, but the issue has not reached an appellate court. See Rogers v. Sims, Grady County District Court No. CJ-2015-2.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

**Pre 2/1/2014 injury date:**

Oklahoma has a medical fee schedule. 85 O.S. § 327, available at [http://www.cec.ok.gov/fee_schedule.htm](http://www.cec.ok.gov/fee_schedule.htm). Medical bills must be paid within forty-five (45) days of the receipt by the employer/insurer, unless the employer/insurer has a good-faith reason to request additional information about an invoice. Thereafter, a judge may assess a penalty up to twenty-five percent (25%) for any amount due under the Fee Schedule that remains unpaid upon the finding by the Court that no good-faith reason existed for the delay in payment. If the Court finds a pattern of an employer/insurer willfully and knowingly delaying payments for medical care, the Court may assess a civil penalty of up to $5,000.00 per occurrence.

**Post 2/1/2014 injury date:**

Payment for medical care as required by the Administrative Act shall be due within forty-five (45) days of the receipt by the employer or insurance carrier of a complete and accurate invoice, unless the employer or insurance carrier has a good-faith reason to request additional information about such invoice. Thereafter, the Commission may assess a penalty up to twenty-five percent (25%) for any amount due under the Fee Schedule that remains unpaid on the finding by the Commission that no good-faith reason existed for the delay in payment. If the Commission finds a pattern of an employer or insurance carrier willfully and knowingly delaying payments for medical care, the Commission may assess a civil penalty of not more than Five Thousand Dollars ($5,000.00) per occurrence. 85A O.S. § 50(H)(11).

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

**Pre 2/1/2014 injury date:**
Oklahoma workers’ compensation judges, although special judge who hear only compensation matters, nevertheless have the full powers of the district-court judges. This means the usual discovery tools are available, as in any other court proceeding, i.e., orders to compel, interrogatories, subpoenas, etc. 85 O.S. § 303(E).

Post 2/1/2014 injury date:

The Commission shall have the power to preserve and enforce order during any proceeding before it, to issue subpoenas for and administer oaths to and compel the attendance and testimony of witnesses, and require the production of books, papers, documents, and other evidence. 85A O.S. § 73.

39. What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

Pre 2/1/2014 injury date:

Within seven (7) days of actual knowledge of an injury, the employer shall provide the employee reasonable and necessary medical care with a physician of the employer’s choice. The physician selected by the employer shall become the treating physician.

The procedure for changing a treating physician differs depending upon whether the employee is covered by a certified workplace medical plan (CWMP).

If the employee is not covered by a CWMP, the employee is entitled to one change of physician for any affected body part upon application to the Court. No change of treating physician can be authorized for a part of the body if no authorized medical care was provided for that part of the body for 180 days before the date of the filing of the application for a change. No more than two changes of physician are allowed in a claim. 85 O.S. §326.

If the employee is covered by a CWMP, the employee may apply for a one-time change of physician to another appropriate physician within the network of the CWMP using the dispute resolution process set out in the CWMP. Once the dispute resolution process has been exhausted, the employee may petition the Court for a change of physician within the plan. If no physician within the plan is qualified to treat the employee’s injuries, a physician outside of the plan may be selected if the physician agrees to comply with all the rules, terms and conditions of the certified workplace medical plan. 85 O.S. § 328.

The Court at any time may appoint an Independent Medical Examiner (“IME”) to assist in determining any issue before the Court. In the event surgery is recommended by a treating physician, upon request of the employer, the Court shall appoint an IME to determine the reasonableness and necessity of the
recommended surgery. 85 O.S. §329(B).

**Post 2/1/2014 injury date:**

The employer shall have the right to choose the treating physician. 85A O.S. § 50(A). If, however, the employer fails or neglects to provide medical treatment within five (5) days after actual knowledge is received of the injury, the employee may select a physician to provide medical treatment. 85A O.S. § 50(B).

If the employer is **covered by a CWMP**, the employee may apply for a change of physician through the dispute resolution process set out in the CWMP on file with the State Department of Health. 85A O.S. § 56(A).

If the employer is **not covered by a CWMP**, the employer shall select the treating physician. The Commission on application of the employee shall order one change of treating physician. The employer shall provide a list of three physicians from whom the employee may select the replacement. 85A O.S. § 56(B).

An administrative law judge may appoint an IME to assist in determining any issue before the Commission. 85A O.S. § 112(B). In the event surgery is recommended by a treating physician, upon request of the employer, the Commission shall appoint an IME to determine the reasonableness and necessity of the recommended surgery. 85A O.S. § 56(B).

**40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

**Pre 2/1/2014 injury date:**

The Act covers treatment from any person licensed in Oklahoma as a medical doctor, chiropractor, podiatrist, dentist, osteopathic physician or optometrist. The Court may accept testimony from a psychologist if the testimony is requested by the Court. 85 O.S. §326(D).

**Post 2/1/2014 injury date:**

An employer must provide an injured employee with medical, surgical, hospital, optometric, podiatric, and nursing services. 85A O.S. § 50(A). The Fee Schedule adopted by the Commission establishes the maximum rates that medical providers shall be reimbursed for medical care, including, but not limited to, charges by physicians, dentists, counselors, hospitals, ambulatory and outpatient facilities, clinical laboratory services, diagnostic testing services, and ambulance services.

**41. Which prosthetic devices are covered, and for how long?**

**Pre 2/1/2014 injury date:**
Employers must furnish necessary prosthetic devices for the lifetime of an injured worker whose compensable injury resulted in certain anatomical losses or the replacement of a joint. Employers must also repair or replace a prosthetic device damaged as a result of a compensable injury. An employer’s duty to provide a prosthetic device is terminated upon subsequent injury to the body part for which the device was provided. 85 O.S. §335.

**Post 2/1/2014 injury date:**

When a compensable injury results in the loss of one or more eyes, teeth, or members of the body, or the replacement of a joint, the employer shall furnish such prosthetic devices as may be necessary as determined by the Commission for the lifetime of the worker. When a worker sustains a compensable injury, arising out of and in the course of his or her employment, which results in damage to a prosthetic device with which such worker is equipped, the employer shall repair or replace such device. Provided, that a subsequent injury to the part of the body for which a prosthetic device is provided shall terminate the obligation of the employer to provide such prosthetic device. 85A O.S. § 114.

42. Are vehicle and/or home modifications covered as medical expenses?

**Pre 2/1/2014 injury date:**

Yes, if they are reasonable and necessary. 85 O.S. § 326; *Okla. Gas & Elec. Co. v. Chronister*, 2004 OK CIV APP 32, 114 P.3d 455.

**Post 2/1/2014 injury date:**

Though vehicle and home modifications are not specifically addressed in the Administrative Act, an employer is responsible for providing all “reasonably necessary” apparatus in connection with the injury. 85A O.S. § 50.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

**Pre 2/1/2014 injury date:**

Yes. For the express purpose of reducing the overall cost of medical care for injured workers in the workers' compensation system by 5%, the Administrator of the Workers’ Compensation Court developed a new “Oklahoma Workers’ Compensation Medical Fee Schedule” that was implemented on January 1, 2012. 85 O.S. § 327, available at [http://www.cec.ok.gov/fee_schedule.htm](http://www.cec.ok.gov/fee_schedule.htm).

**Post 2/1/2014 injury date:**
Yes. The 2012 Fee Schedule can be found at http://www.cec.ok.gov/fee_schedule.htm. The Commission shall conduct a review of the Fee Schedule every two (2) years. The Fee Schedule shall establish the maximum rates that medical providers shall be reimbursed for medical care provided to injured employees. Reimbursement for medical care shall be prescribed and limited by the Fee Schedule as adopted by the Commission, after notice and public hearing, and after approval by the Legislature by joint resolution. 85A O.S. § 50(H).

44. What, if any, provisions or requirements are there for “managed care”?

Pre 2/1/2014 injury date:

Managed-care plans are available and must be certified by the State Commissioner of Health. The criteria for managed-care plans are set forth in tit. 85 O.S. § 328.

Post 2/1/2014 injury date:

Managed-care plans are available and must be certified by the State Commissioner of Health. The criteria for managed-care plans are set for in tit. 85A O.S. § 64.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

Pre 2/1/2014 injury date:

The Court has a pre-printed form with stipulations, defenses, etc., that must be filed with subsequent to the employee filing a request for a hearing in the claim. This form requires all exhibits and all witnesses to be listed twenty (20) days before trial. Workers’ Compensation Court Rule 16. Forms are available here: http://www.cec.ok.gov/court_forms.htm.

Post 2/1/2014 injury date:

Each employer desiring to controvert an employee’s right to compensation shall file with the Commission on or before the fifteenth day following notice of the alleged injury or death a statement on a form prescribed by the Commission that the right to compensation is controverted and the grounds for the controversion, the names of the claimant, employer, and carrier, if any, and the date and place of the alleged injury or death. 85A O.S. § 86(A).

Failure to file the statement of controversion shall not preclude the employer’s ability to controvert the claim or cause it to waive any defenses. The employer
can make additional defenses not included in the initial notice at any time. 85A O.S. § 86(A).

If an employer is unable to obtain sufficient medical information as to the alleged injury or death within fifteen (15) days following receipt of notice, although the employer has acted in good faith and with all due diligence, the employer may apply in writing for an extension of time for making payment of the first installment or controverting the claim. This written application is to be postmarked within the fifteen-day period. The Commission may, in its discretion, grant the extension and fix the additional time to be allowed. Filing of application for an extension shall not be deemed to be a controversion of the claim. This provision shall not apply in cases where the physician is an employee of, on retainer with, or has a written contract to provide medical services for the employer. 85A O.S. § 86(B)-(C).

46. What is the method of claim adjudication?

Pre 2/1/2014 injury date:

A. Administrative level.

Under the Act, there is no administrative level.

B. Trial court.

There are ten workers’ compensation judges. An individual case is heard before one of the judges without a jury. 85 O.S. § 303.

C. Appellate.

Once a final order has been filed by the trial court, review of the trial court’s decision may be sought before a Three Judge Panel comprised of any three judges who did not originally hear the case or directly before the Oklahoma Supreme Court. No new evidence is permitted to be presented to the panel. The panel will only overturn a finding if it is against the clear weight of the evidence or contrary to law.

The next level of appeal is filing a Petition for Review to the Oklahoma Supreme Court (although a party is allowed to skip the Three Judge Panel review and file an appeal directly with the Oklahoma Supreme Court). The Supreme Court will assign the matter to one of the divisions of the Court of Civil Appeals, which will determine whether there is any competent evidence to support the lower court’s finding and which will review the lower court’s judgment for errors of law.

Once the appellate court has rendered a decision, either side may seek certiorari to
the Supreme Court which may modify, reverse, remand for rehearing, or set aside
the order or award upon any of the following grounds: (1) the Court acted without
or in excess of its powers; (2) the order or award was contrary to law; (3) the
order or award was procured by fraud; or (4) the order or award was against the
clear weight of the evidence. 85 O.S. § 340.

Post 2/1/2014 injury date:

A. Administrative Level.

The Administrative Act applies to all claims for injuries and death occurring on or
after February 1, 2014. 85A O.S. § 3. The Commission is comprised of three full-
time commissioners who appoint administrative law judges to hear all
compensation claims. 85A O.S. §§ 19, 20.

The administrative law judges hear all claims without a jury. Except as otherwise
provided, the decision of the administrative law judge shall be final as to all
questions of law and fact. 85A O.S. § 27.

B. Trial court.

The Administrative Act dissolved the Court and renamed it the Workers’
Compensation Court of Existing Claims for the purpose of deciding pre-February
1, 2014 claims. 85A O.S. §§ 3, 400. The Existing Claims Court hears all claims
without a jury.

C. Appellate.

Pursuant to 85A O.S. § 78, any party aggrieved by the judgment, decision, or
award made by the administrative law judge may, within ten (10) days of
issuance, appeal to the Commission. The Commission may reverse or modify the
decision only if it determines that the decision was against the clear weight of the
evidence or contrary to law. All such proceedings of the Commission shall be
recorded by a court reporter, if requested by any party. Any judgment of the
Commission which reverses a decision of the administrative law judge shall
contain specific findings relating to the reversal.

The appellant shall pay a filing fee of One Hundred Seventy-five Dollars
($175.00) to the Commission at the time of filing his or her appeal. The fee shall
be deposited in the Workers’ Compensation Fund.

The judgment, decision or award of the Commission shall be final and conclusive
on all questions within its jurisdiction between the parties unless an action is
commenced in the Oklahoma Supreme Court to review the judgment, decision or
award within twenty (20) days of being sent to the parties; to assure timely filing, calculate the due date from the date the judgment is file-stamped. Any judgment, decision or award made by an administrative law judge shall be stayed until all appeal rights have been waived or exhausted. The Supreme Court may modify, reverse, remand for rehearing, or set aside the judgment or award only if it was:

1. In violation of constitutional provisions;

2. In excess of the statutory authority or jurisdiction of the Commission;

3. Made on unlawful procedure;

4. Affected by other error of law;

5. Clearly erroneous in view of the reliable, material, probative and substantial competent evidence;

6. Arbitrary or capricious;

7. Procured by fraud; or

8. Missing findings of fact on issues essential to the decision.

47. What are the requirements for stipulations or settlements?

Pre 2/1/2014 injury date:

The Court has pre-printed forms for the employees and employers to use to identify the issues upon which the parties can agree and further identify the issues that are in controversy. Using this form, the respondent is required to stipulate to those items not in controversy and advise the court of the matters being controverted. Additionally, on this same form (which functions much like a pre-trial order) the respondent lists witnesses and exhibits to be introduced at trial. Workers’ Compensation Court Rule 19.

Post 2/1/2014 injury date:

If the employer or carrier and the injured employee desire to settle the claim, they shall file a joint petition for settlement with the Commission. After the joint petition has been filed, the Commission shall order that all claims between the parties have been settled. 85A O.S. § 87. The Commission has a “Joint Petition” form that shall be signed by both the employer and employee, or representatives thereof, and shall be approved by an administrative law judge and filed with the Commission. Forms are available at https://ok.gov/wcc/Forms/index.html. In cases in which the employee is not represented by legal counsel, the Commission
or an administrative law judge is authorized to approve a full, final and complete settlement of any issue upon the filing of an Employer's First Notice of Injury. 85A O.S. § 115(A).

In the absence of fraud, a Joint Petition shall be deemed binding upon the parties thereto and a final adjudication of all rights pursuant to this act or the workers' compensation law in effect at the time of the injury or final order of the Court. An official record shall be made by an official Commission reporter of the testimony taken to effect the Joint Petition. 85A O.S. § 115(C).

48. Are full and final settlements with closed medicals available?

Pre 2/1/2014 injury date:
Yes.

Post 2/1/2014 injury date:
Yes. 85A O.S. § 115.

49. Must stipulations and/or settlements be approved by the state administrative body?

Pre 2/1/2014 injury date:
Yes. A settlement must be approved by a judge or by the Administrator of the Workers’ Compensation Court. 85 O.S. § 339.

Post 2/1/2014 injury date:
Yes. A settlement must be approved by an administrative law judge. 85A O.S. § 115(A).
50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

**Pre 2/1/2014 injury date:**

Workers’ compensation insurance is required by statute. This is commonly provided by private insurer. If an employer is large enough, it can qualify to go “own risk”. There are “self insured associations” which are non-profit in nature, e.g. Lumbermens Association, Restaurant Association, etc. CompSource Oklahoma, a quasi state agency, provides coverage which is often less expensive than private insurers offer. 85 O.S. § 351.

**Post 2/1/2014 injury date:**

Pursuant to 85A O.S. § 38, an employer must secure compensation by:

1. insuring and keeping insured the payment of compensation with any stock corporation, mutual association, or other concerns authorized to transact the business of workers’ compensation insurance in Oklahoma;

2. obtaining and keeping in force guaranty insurance with any company authorized to do guaranty business in Oklahoma;

3. furnishing satisfactory proof to the Commission of the employer’s financial ability to pay the compensation;

4. forming a group self-insurance association; or

5. any other security as may be approved by the Commission and the Insurance Department.

51. **What are the provisions/requirements for self-insurance?**

**Pre 2/1/2014 injury date:**

**A. For individual entities.**

An individual entity may self insure if it furnishes satisfactory proof to the Administrator of a financial ability to pay such compensation. 85 O.S § 351. Such proof generally consists of depositing an irrevocable letter of credit or a surety bond and providing proof of excess coverage. All individual own-risk or self-insured risk employers must pay an annual application fee of $1000 to the Administrator. Tit. 85 O.S § 369.

**B. For groups or “pools” of private entities.**
Group self-insurance associations may be formed. 85 O.S. § 398. An employer, upon application to become a member of a group self-insurance association, must acknowledge that it accepts joint and several liability. 85 O.S § 351. All group self-insureds must pay a $1000 annual application fee.

**Post 2/1/2014 injury date:**

**A. For individual entities.**

An employer may self-insure by furnishing satisfactory proof to the Commission of the employer’s financial ability to pay compensation.

If the employer has less than one hundred employees or less than One Million Dollars in net assets, the employer will be required to:

1. deposit with the Commission securities, an irrevocable letter of credit or a surety bond payable to the state, in an amount determined by the Commission which shall be at least an average of the yearly claims for the last three (3) years, or

2. provide proof of excess coverage with such terms and conditions as is commensurate with their ability to pay the benefits required by the provisions of the Administrative Act.


If the employer has one hundred or more employees and One Million Dollars or more in net assets, the employer will be required to:

1. secure a surety bond payable to the state, or an irrevocable letter of credit, in an amount determined by the Commission which shall be at least an average of the yearly claims for the last three (3) years, or

2. provide proof of excess coverage with terms and conditions that are commensurate with their ability to pay the benefits required by the provisions of the Administrative Act.


**B. For groups or “pools” of private entities.**

An employer may form a group self-insurance association consisting of two or more employers which shall have a common interest and which shall have entered into an agreement to pool their liabilities under the Administrative Act. Such agreement shall be subject to rules of the Commission. Any employer, upon application to become a member of a group self-insurance association, shall file with the Commission a notice, in such form as prescribed by the Commission,
acknowledging that the employer accepts joint and several liability. Upon approval by the Commission of such application for membership, said member shall be a qualified self-insured employer. 85A O.S. § 38(A)(4).

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

**Pre 2/1/2014 injury date:**

The Act does not preclude compensation for an employee who is an illegal alien, and the Oklahoma courts have determined that an illegal alien who is injured on the job is entitled to benefits under the Act. *Lang v. Landeros*, 1996 OK CIV APP 4, 918 P.2d 404.

**Post 2/1/2014 injury date:**

Compensation to alien nonresidents of the United States or Canada shall be the same in amount as provided for residents, except that alien nonresident dependents in any foreign country shall be limited to the surviving spouse or children or, if there is no surviving spouse or children, to the surviving father or mother whom the employee has supported, either wholly or in part, for the period of one (1) year before the date of the injury. 85A O.S. § 11.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

**Pre 2/1/2014 injury date:**

Terrorist acts are covered, assuming the terrorist act is not motivated solely by personal animosity toward the employee. A terrorist act is subject to the same principles applicable to injuries by other third parties. See Number 14 supra.

**Post 2/1/2014 injury date:**

No change.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

**Pre 2/1/2014 injury date:**

There are no state specific requirements which must be satisfied in light of the Medicare Secondary Payer Act.
55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

**Pre 2/1/2014 injury date:**

The Federal Medicaid statute requires states to include in their plan for medical assistance provisions (1) that the individual will assign to the state any rights to payment for medical care from any third party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the federal government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

**Post 2/1/2014 injury date:**

No change.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

**Pre 2/1/2014 injury date:**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). Therefore, a HIPAA compliant medical authorization could be used.

**Post 2/1/2014 injury date:**

No change.

57. **What are the provisions for “Independent Contractors”?**

**Pre 2/1/2014 injury date:**

An independent contractor, who cannot claim benefits under the Act, is one who engages to perform certain services for another according to his own manner and method, free from control and direction of the other in all matters connected with
An independent contractor is liable for compensation due to his or her direct employees, or the employees of his or her subcontractor, and the principal employer is also liable for compensation due to all direct employees, employees of the independent contractor, subcontractors, or other employees engaged in the general employer’s business.

If an independent contractor relies in good faith on proof of a valid workers' compensation insurance policy issued to a subcontractor of the independent contractor or on proof of an Affidavit of Exempt Status under the Act properly executed by the subcontractor under 36 O.S. § 924.4, the independent contractor shall not be liable for injuries of any employees of the subcontractor. The independent contractor is not liable for injuries of any subcontractor of the independent contractor unless an employer-employee relationship is found to exist by the Court despite the execution of an Affidavit of Exempt Status under the Act.

A person entitled to such compensation has the right to recover the same directly from the person's immediate employer, the independent contractor or intermediate contractor, and such claims may be presented against all such persons in one proceeding. If it appears that the principal employer has failed to require a compliance with the Act by the independent contractor, then such employee may proceed against such principal employer without regard to liability of any independent, intermediate or other contractor. However, if a principal employer relies in good faith on proof of a valid workers' compensation insurance policy issued to an independent contractor of the employer or to a subcontractor of the independent contractor or on proof of an Affidavit of Exempt Status under the Act properly executed by the independent contractor or subcontractor under 36 O.S. § 924.4, the principal employer shall not be liable for injuries of any employees of the independent contractor or subcontractor. Furthermore, such principal employer shall not be liable for injuries of any independent contractor of the employer or of any subcontractor of the independent contractor unless an employer-employee relationship is found to exist by the Court despite the execution of an Affidavit of Exempt Status. In any proceeding where compensation is awarded against the principal employer under these provisions, the award does not preclude the principal employer from recovering the same, and all expense in connection with the proceeding from any independent contractor, intermediate contractor or subcontractor whose duty it was to provide security for the payment of such compensation. The recovery may be had in supplemental proceedings in the cause before the Court or by an independent action in any court of competent jurisdiction to enforce liability of contracts. 85 O.S. §314.

Post 2/1/2014 injury date:
Independent contractors do not meet the Administrative Act’s definition of “employee” and are therefore not covered. 85A O.S. § 2(18)(a);

If a subcontractor fails to secure compensation required by the Administrative Act, the prime contractor shall be liable for compensation to the employees of the subcontractor unless there is an intermediate subcontractor who has workers' compensation coverage. 85A O.S. § 36(A).

If work is performed by an independent contractor on a single-family residential dwelling occupied by the owner, or the premises of such dwelling, or for a farmer whose cash payroll for wages, excluding supplies, materials and equipment, for the preceding calendar year did not exceed One Hundred Thousand Dollars ($100,000.00), the owner or farmer shall not be liable for compensation under this act for injuries to the independent contractor or his or her employees. 85A O.S. § 36(E).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Pre 2/1/2014 injury date:
No.

Post 2/1/2014 injury date:
No change.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Pre 2/1/2014 injury date:
Yes. The Act does not apply to an owner-operator who owns or leases a truck-tractor or truck for hire, if the owner-operator actually operates the truck-tractor or truck, and if the person contracting with the owner-operator is not the lessor of the truck-tractor or truck. An owner-operator shall not be precluded from workers' compensation coverage, however, if he or she elects to participate as a sole proprietor. 85 O.S. §311.

Post 2/1/2014 injury date:
Yes, an owner-operator is not an “employee” and thus is not covered by the Administrative Act if he or she owns or leases a truck-tractor or truck for hire and
actually operates the truck-tractor or truck, and if the person contracting with the owner-operator is not the lessor of the truck-tractor or truck. 85A O.S. § 2(18)(b)(9).

A “drive-away owner-operator” is not an “employee” if he or she privately owns and utilizes a tow vehicle in drive-away operations and operates independently for hire, if the drive-away owner-operator actually uses the tow vehicle and the person contracting with the drive-away owner-operator is not the lessor of the vehicle. 85A O.S. § 2(18)(b)(10).

In either case, however, an owner-operator shall not be precluded from workers’ compensation coverage if he or she elects to participate as a sole proprietor.

60. What are the “Best Practices” for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Worker's Compensation law?

Oklahoma does not currently permit medical marijuana. On June 26, 2018, however, Oklahoma voters will decide State Question 788, a ballot initiative that, if approved, will legalize the licensed cultivation, use, and possession of marijuana for medicinal purposes. Under the bill, there would be no specific qualifying medical conditions to obtain a state-issued medical marijuana license. An individual would need a board-certified physician’s signature. The law would prevent employers from penalizing persons for holding a medical marijuana license unless failing to do so causes a loss of benefits under federal law.
Employers would be allowed to penalize license-holders who possess or use marijuana while at the holder’s place of employment or during hours of employment. Employers would not be allowed to take action against a license holder based on the results of a drug test showing positive for marijuana.

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Worker’s Compensation law?**

Oklahoma does not permit the recreational use of marijuana.

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1. Citation for the state’s workers’ compensation statute.

Oregon Revised Statutes § 656.001 et seq. This chapter may be cited as the Workers’ Compensation Law. Or. Rev. Stat. § 656.001.

SCOPE OF COMPENSABILITY

2. Who are covered “workers” for purposes of workers’ compensation?

A worker is defined as “any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution, or as part of the eligibility requirements for a general or public assistance grant.” Or. Rev. Stat. § 656.005(30). For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, “worker” does not include a person who has withdrawn from the workforce during the period for which such benefits are sought. Id.

All workers are covered except those specifically excluded as “non-subject” workers under Or. Rev. Stat. § 656.027.

3. Identify and describe any “statutory employer” provision.

An “employer” is defined as a private or public entity “who contracts to pay a remuneration for and secures the right to direct and control the services of any person.” Or. Rev. Stat. § 656.005(13)(a). The “contract” to pay a remuneration may be implied. See Wallowa County v. Fordice, 45 P.3d 963, 965 (Or. Ct. App. 2002).

A “subject employer” is defined as “every employer employing one or more subject workers in the state.” Or. Rev. Stat. § 656.023. A general contractor or intermediate contractor is normally not considered the employer of a sub-contractor or its workers and, therefore, is not protected by the exclusivity provisions of Chapter 656. Martelli v. R.A.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

An accidental injury to a person or his or her prosthetic appliances arising out of and in the course of employment requiring medical services or resulting in disability or death, is compensable. Or. Rev. Stat. § 656.005(7)(a). An injury is accidental if the result is an accident, whether or not it is due to accidental means. Id.

A compensable injury must be established by medical evidence supported by objective findings, with the following limitations: (1) the compensable injury must be the major contributing cause of the consequential condition; and (2) if the compensable injury combines with a pre-existing disease or condition, the resulting condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment. Or. Rev. Stat. § 656.005(7)(a)(A)&(B).

B. Occupational disease (including respiratory and repetitive use).

To be compensable as an occupational disease, the condition must arise in the course of employment and must be caused by circumstances to which a worker is not ordinarily subjected or exposed other than during a period of regular, actual employment. Or. Rev. Stat. § 656.802(1). The worker cannot establish that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred. Or. Rev. Stat. § 656.266(1).

While the burden is normally on the worker to prove, with competent medical evidence, the causal relationship between the work environment and the occupational disease, the Oregon Court of Appeals has ruled that, in appropriate cases, inconclusive medical evidence will not defeat the claim. Mueller v. SAIF, 575 P.2d 673, 674 (Or. Ct. App. 1978).

5. What, if any, injuries or claims are excluded?

Non-compensable injuries include those: (1) to active participants in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties; (2) sustained while engaging in or performing, or as the result of, any recreational or social activities primarily for the worker’s personal pleasure; and (3) where the major contributing cause of which is demonstrated by preponderance of the evidence is the worker’s consumption of alcoholic beverages or cannabis or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged, or had actual knowledge of such consumption. Or. Rev. Stat. § 656.005(7)(b). (See answers to Questions 9 and 12-14).
6. **What psychiatric claims or treatments are compensable?**

A psychological condition arising out of or exacerbated by working conditions may be compensable as an occupational disease. Or. Rev. Stat. §§ 656.802(1), 656.802(2)(a). The worker must establish: (a) the employment conditions producing the mental disorder exist in a real and objective sense; (b) the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles; (c) there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and (d) there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. Or. Rev. Stat. § 656.802(3)(a)-(d). Generally known as “stress claims,” these conditions are subject to a high standard of proof.

7. **What are the applicable statutes of limitations?**

A worker or dependent must give notice of an accident resulting in injury or death immediately, or not later than 90 days after the accident. Or. Rev. Stat. § 656.265(1).

After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. Or. Rev. Stat. § 656.273(1). A claim for additional compensation, also known as an “aggravation claim,” must be filed within five years after the first notice of closure of the claim for a disabling claim, or after the date of injury provided the claim has been classified as non-disabling for at least one year after the date of acceptance. Or. Rev. Stat. § 656.273(4).

All occupational disease claims shall be filed within one year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or the date the claimant became disabled or was informed by a physician that he/she was suffering from an occupational disease. Or. Rev. Stat. § 656.807(1). If the occupational disease results in death, the claim may be filed within one year of the date the worker’s beneficiary first discovered, or in the exercise of reasonable care should have discovered, that the cause of death was an occupational disease. Or. Rev. Stat. § 656.807(2).

8. **What are the reporting and notice requirements for those alleging an injury?**

In order to report a claim, notice of an accident resulting in an injury or death must be given immediately by the worker or a dependent, to the employer, but not later than 90 days after the accident. Or. Rev. Stat. § 656.265(1). The employer then must acknowledge the receipt of such notice. *Id.*

The notice does not need to be in any particular form, as long as it is in writing and apprises the employer of when, where, and how an injury has occurred. Or. Rev. Stat.
§ 656.265(2). A report or statement from a worker, or from the doctor of the worker and signed by the worker, can be considered notice. *Id.* The notice must be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. Or. Rev. Stat. § 656.265(3). If for any reason it is not possible to do so, notice may be given to the Director of the Department of Consumer and Business Services (“the Director”) and referred to the insurer or self-insured employer. *Id.*

Failure to give notice within one year of the date of the accident bars a claim unless: (a) the employer had knowledge of the injury or death; or (b) the worker died within 180 days after the date of the accident. Or. Rev. Stat. § 656.265(4). The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death. Or. Rev. Stat. § 656.265(5).

The Director has uniform forms for workers to report their injuries to their employers. Or. Rev. Stat. § 656.265(6). The worker’s failure to use a specified form shall not, in itself, defeat the claim, if the worker has complied with the requirement that the claim be presented in writing. *Id.*

9. Describe available defenses based on worker conduct:

A. Self-inflicted injury.

Intentionally self-inflicted injury or death is not compensable. Or. Rev. Stat. § 656.156(1).

B. Willful misconduct, “horseplay,” etc.

An employer is not responsible for injury incurred during assaults or combats which are not connected to the job assignment or which amount to a deviation of customary duties. Or. Rev. Stat. § 656.005(7)(b)(A). An injury is not compensable unless it: (1) occurs in the course of employment; and (2) arises out of the employment. Or. Rev. Stat. § 656.005(7)(a). “Course of employment” deals with the time, place and circumstances of the injury. Phrases “arise out of” and “in the course of” are two elements of a single inquiry known as the “work-connection” test. *Redman Indus., Inc. v. Lang*, 943 P.2d 208, 210 (Or. 1997); *Fred Meyer, Inc. v. Hayes*, 943 P.2d 197, 200 (Or. 1997). Both elements must be satisfied, but not necessarily to the same degree. *Id.* (See answer to Questions 13 and 14).

C. Injuries involving drugs and/or alcohol.

An injury is not compensable if the major contributing cause of an injury is shown by a preponderance of the evidence to be the worker’s consumption of alcoholic beverages, cannabis, or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged, or had actual knowledge of such consumption. Or. Rev. Stat. § 656.005(7)(b)(C).
10. **What, if any, penalties or remedies are available in claims involving fraud?**

Any person or entity who knowingly makes a false statement or representation for the purpose of obtaining any benefit or payment, either for themself or any other person, or who knowingly misrepresents the amount of a payroll, or who knowingly submits a false payroll report, is subject to criminal prosecution and punishment by imprisonment of not more than one year or by a fine of not more than $6,250, or both. Or. Rev. Stat. §§§ 656.990(1), 161.635(1)(a), 161.615(1).

Insurers have statutory authority to take a credit or offset of workers’ compensation benefits previously paid against future benefits on cases where a worker admits to having obtained the previous benefits through fraud or in cases where a civil judgment or criminal conviction is entered against the worker for obtaining the previously paid benefits through fraud. Or. Rev. Stat. § 656.268(13).

11. **Is there any defense for falsification of employment records regarding medical history?**

No. An employer/insurer may raise as a defense or basis for denial of a claim if there was a prior injury and the prior injury rather than the current injury is the cause of the worker’s complaints. The issue is then medical causation, regardless of notice or knowledge of the prior injury by the employer/insurer.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Recreational or social activities engaged in primarily for the worker’s personal pleasure are not compensable. Or. Rev. Stat. § 656.005(7)(b)(B). Recreational or social activities are within the course of employment when: (1) they occur on the premises during a lunch or recreational period as a regular incident of the employment; (2) the employer brings the recreational activity within the orbit of employment; or (3) the employer derives substantial direct benefit from the recreational activity. *Colvin v. Indus. Indem.*, 730 P.2d 585, 588 (Or. Ct. App. 1986).

For example, in *Roberts v. SAIF Corp.*, 102 P.3d 752, 755 (Or. Ct. App. 2004), the court held that claimant’s injury – incurred while riding a co-worker’s motorcycle in the employer’s parking lot – was not compensable since the activity was for the worker’s own personal pleasure. Similarly, in *Geoff Saunders*, 57 Van Natta 796 (2005), the claimant injured his elbow while arm-wrestling with a coworker on the employer’s break room table. Arm-wrestling was not one of the claimant’s work-related duties and violated the employer’s conduct code. As such, the court held that claimant’s activities were “recreational, primarily for his “personal pleasure,” and concluded the claimant’s injury was excluded from coverage.

However, in *Liberty NW. Ins. Corp. v. Nichols*, 64 P.3d 1152 (Or. Ct. App. 2003), the
court held that broken tooth which claimant sustained while eating an employer-supplied snack at work was not incurred while engaging in or performing a recreational or social activity primarily for his personal pleasure within meaning of Or. Rev. Stat. § 656.005(7)(b)(B). The court explained that “the ‘activity’ the statute refers to is not the particular action that causes the injury (eating), but the activity within which that action occurs (working or not working).” Id. at 1155 n.4. Since the claimant was working while eating, the court held that the eating was “merely incidental to work.” Id. at 1155.  

13. Are injuries by co-workers compensable?

The exclusion of workers' compensation benefits for a claimant's participation in an assault does not apply unless both statutory elements are met, which are that: 1) claimant was an active participant, and 2) the assault was not connected to the job. C.W. McCallen Const. Co., Inc. v. MacDonald, 19 P.3d 977, 979 (Or. Ct. App. 2001).

Stated another way, assault may be compensable because risk of an assault by a co-worker in the workplace is a risk to which the work environment exposes a worker when an assault is caused by circumstances associated with the work environment. Redman Indus., Inc. v. Lang, supra; Or. Rev. Stat. § 656.005(7). (See answer to Question 14).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?

An employer is not responsible for injury incurred during assaults or combats which are not connected to the job assignment and which amount to a deviation of customary duties. Or. Rev. Stat. § 656.005(7)(b)(A). Although the risk of an assault by a co-worker in the workplace is a risk to which the work environment exposes an employee, that fact does not necessarily lead to the conclusion that an injury resulting from an assault by a co-worker arises out of employment for workers' compensation purposes. Panpat v. Owens-Brockway Glass Container, Inc., 49 P.3d 773, 776 (Or. 2002), on remand 71 P.3d 553 (Or. Ct. App. 2003). In Panpat v. Owens-Brockway Glass Container, supra, a worker of Owens-Brockway killed his former girlfriend (who was also a plant worker) while at work. The Oregon Supreme Court held that the death did not “arise out” of the worker’s employment. The wrongful death claim was therefore not subject to the exclusivity provision of Workers’ Compensation Law.

“When the motivation for an assault by a co-employee is an event or circumstance pertaining to the assailant and the claimant that originated entirely separate from the workplace, and the only contribution made by the workplace is to provide a place for the assault,” the assault does not “arise out of employment” and is not compensable. Redman Indus., Inc., 943 P.2d at 213; see also Sisco v. Quicker Recovery, 180 P.3d 46 (Or. Ct. App. 2008).

BENEFITS

15. What criterion is used for calculating the average weekly wage?
“Average weekly wage” means the average weekly wage of workers in covered employment in Oregon, as determined by the Employment Division of the Department of Human Resources, for the last quarter of the calendar year preceding the fiscal year in which compensation is paid and as computed by the Employment Division as of May 15 of each year. Or. Rev. Stat. § 656.211.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

   Temporary total disability benefits are equal to two-thirds of the worker’s wages, but may not be more than 133 percent of the worker’s average weekly wage, or less than 90 percent of the worker’s average weekly wage or $50 a week, whichever is less. Or. Rev. Stat. § 656.210(1).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

   The first installment of compensation must be paid within 14 days after notice or knowledge of the claim if the attending physician or nurse practitioner authorized to provide compensable medical services. Or. Rev. Stat. § 656.262(4)(a). Or. Rev. Stat. § 656.245 authorizes the payment of temporary disability compensation. Written authorization is required.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

   No disability payment is recoverable for temporary disability during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury, unless the worker is totally disabled after the injury for a period of 14 consecutive days or unless the worker is admitted to a hospital within 14 days of the first onset of total disability. Or. Rev. Stat. § 656.210(3).

19. **What is the standard/procedure for terminating temporary benefits?**

   If there is an accepted claim, temporary total benefits continue until the first of the following occurs: (1) the worker returns to regular or modified employment; (2) the attending physician or nurse practitioner provides the worker a written release to return to regular employment; or (3) the attending physician or nurse practitioner provides the worker a written release to return to modified employment, which is offered to the worker in writing, and the worker fails to begin such employment. Or. Rev. Stat. § 656.268(4)(a)-(c).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**
21. **What disfigurement benefits are available and how are they calculated?**

Scarring or disfigurement without the loss of use of the body or its parts is not considered a permanent disability.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

Permanent Partial Disability benefits may be paid monthly at 4.35 times the rate per week as provided for compensation for temporary total disability at the time the determination is made. In no case is the payment less than $108.75 per month. Or. Rev. Stat. § 656.216(1). A worker may also elect to have her permanent partial disability benefits paid in a lump sum.

If the worker has been released to regular work by the attending physician or nurse practitioner, or has returned to regular work at the job held at the time of injury, disability benefits will be for impairment only. Or. Rev. Stat. § 656.214(2)(a). Impairment benefits are expressed as a percentage of the whole person, ranging from a minimum of 1 percent (for loss of a toe other than the “great toe”) to a maximum of 94 percent (for partial loss of vision in both eyes). Or. Rev. Stat. § 656.214(3). Impairment benefits are determined by multiplying the impairment value times 100 times the average weekly wage. Or. Rev. Stat. § 656.214(2)(a).

If the worker has not been released to regular work, or has not returned to regular work at the job held at the time of injury, disability benefits will be for impairment and work disability. Or. Rev. Stat. § 656.214(2)(b). Work disability benefits will be determined by multiplying the impairment value, as modified by factors of age, education and adaptability to perform a given job, times 150 times the worker’s weekly wage for the job at injury as calculated under Or. Rev. Stat. § 656.210(2). *Id.* The factor for the worker’s weekly wage used for the determination of the work disability may be no more than 133 percent or not less than 50 percent of the average weekly wage. *Id.*

B. **Number of weeks for "whole person" and standard for recovery.**

All disability ratings in Oregon are set forth in degrees of impairment and not determined based on the "whole person." (See answer to Question 22 A).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Workers who have sustained compensable injuries that result in, or are likely to result in,
permanent disability may be eligible to receive vocational assistance. Or. Rev. Stat. § 656.340(6)(a). Workers are entitled to receive temporary disability compensation or special maintenance after becoming medically stationary while actively engaged in an authorized training program. Or. Rev. Stat. § 656.340. The benefits will be proportionately reduced by any sums earned during the training. Or. Rev. Stat. § 656.268(2).

Further, a worker who has sustained a compensable injury must be reinstated by the worker’s employer to the worker’s former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. Or. Rev. Stat. § 659A.043. In the alternative, a worker who has sustained a compensable injury which prevents that worker from performing the duties of the worker’s former regular employment must, upon the worker’s demand, be reemployed by the worker’s employer at employment which is “available and suitable.” Or. Rev. Stat. § 659A.046.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability requires a showing that the worker's disability permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. Or. Rev. Stat. § 656.206(1)(d). The worker has the burden of proving total disability status and must establish a willingness to seek regular gainful employment and that he or she has made reasonable efforts to obtain such employment. Or. Rev. Stat. § 656.206(3). A finding of permanent total disability results in a monthly benefit so long as the worker remains permanently and totally disabled. Permanent total disability status may be rescinded if the worker ceases to meet the criteria for that status. Benefits are equal to two-thirds of wages, not to exceed 133 percent of the state average weekly wage or less than the amount of 33 percent of the state average weekly wage. Or. Rev. Stat. § 656.206(2) Rev. Effective: Jan. 1, 2018.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

The cost of burial, including transportation of the body, is paid but may not exceed twenty (20) times the weekly average wage in any case. Or. Rev. Stat. § 656.204(1).

B. **Dependency claims.**

When a worker dies from an on-the-job injury, occupational disease, or while permanently and totally disabled, the worker’s surviving spouse, children, and other dependents are entitled to death benefits. The surviving spouse is entitled to monthly benefits equaling 4.35 times two-thirds of the average weekly wage until remarriage. Or. Rev. Stat. § 656.204(2)(a). Upon remarriage or cohabitation for an aggregate period for more than one year from which a child has resulted, the surviving spouse must be paid 36
times the monthly benefit in a lump sum. Or. Rev. Stat. § 656.204(2)(b)-(c).

In addition, a surviving spouse with children of the deceased will receive 4.35 times 25 percent of the weekly average wage per month for each child under 19 years of age. The total benefits provided may not exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child must be reduced proportionally. Or. Rev. Stat. § 656.204(3)(a)-(b).

If a worker leaves a dependent, a monthly payment must be made to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury. However, the total benefits may not exceed 4.35 times 10 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each dependent must be reduced proportionally. If a dependent is under the age of 19 years at the time of the accidental injury, the payment to the dependent must cease when the dependent becomes 19 years of age. The payment to any dependent must cease under the same circumstances that would have terminated the dependency had the injury not happened. However, the benefit is the same regardless of the child’s dependence on the worker’s surviving spouse or age at the time of the worker’s death Or. Rev. Stat. §656.204(4)(a)-(b).

If a child or dependent is between 19 and 26 years of age at the time of a worker’s death, or becomes 19 years of age after the worker’s death, monthly benefits must be paid for not more than 48 months until the age of 26 during a period in which the child or dependent is completing secondary education, is obtaining a general educational development certificate or is attending a program of higher education. Or. Rev. Stat. §656.204(6)(a). If a child or dependent who is eligible for benefits while such a program does not have a surviving parent, the child or dependent must receive 4.35 times 66-2/3 percent of the average weekly wage. Or. Rev. Stat. §656.204(6)(b). Rev. Effective: Jan. 1, 2018.

26. What are the criteria for establishing a "second injury" fund recovery?

Under Oregon law, a Reemployment Assistance Program has been established for the benefit of employers and workers. Or. Rev. Stat. § 656.622.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A worker has five years from the date of the first notice of closure made for a disabling claim. Or. Rev. Stat. § 656.273(4)(a). If no determination order was issued and the injury was non-disabling (meaning no time loss benefits accrued), the worker must file a claim within five years of the date of the original injury. Or. Rev. Stat. § 656.273(4)(b). A claim for aggravation must be in writing in a form and format prescribed by the Director and signed by the worker or the worker’s representative as well as the worker’s attending physician. Or. Rev. Stat. § 656.273(3). The employer or
insurer shall process the claim when it receives a completed aggravation form. *Id.* The Director’s forms are available on the DCBS website.

28. What situation would place responsibility on the employer to pay a worker's attorney fees?

Attorney fees are specifically authorized by statute and administrative rule. Or. Rev. Stat. § 656.382 *et seq.* The general principle for attorney fees is that a fee will be allowed only when it is determined that: 1) the employer refused to pay compensation due under an order of an Administrative Law Judge (“ALJ”), board, or court, or otherwise unreasonably resisted payment of compensation; 2) a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer, and the ALJ, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced; or 3) the employer initiated a hearing for purposes of delay. Or. Rev. Stat. § 656.382. The amounts of fees recoverable are set forth in regulations.

**EXCLUSIVITY/TORT IMMUNITY**

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Generally, a worker’s sole remedy against an employer for a “compensable” injury which occurs during the course and scope of a worker’s employment, is reimbursement under the Workers’ Compensation Law. Or. Rev. Stat. § 656.018.

Also, an employer may not be protected where the worker’s injury or death results from an incident of workplace violence unrelated to the worker’s job. In *Panpat v. Owens-Brockway Glass Container, Inc.*, 49 P.3d 773 (Or. 2002), a worker of Owens-Brockway killed his former girlfriend (who was also a plant worker) while at work. The Oregon Supreme Court held that the death did not “arise out” of the worker’s employment. The wrongful death claim was therefore not subject to the exclusivity provision of Workers’ Compensation Act. (See answers to Questions 9 and 12-14).

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

If injury or death results to a worker from the worker’s deliberate intention to produce such injury or death, then neither the worker nor the surviving spouse, child or dependent of the worker shall receive any payment whatsoever under this chapter. Or. Rev. Stat. § 656.156(1).

If injury or death results from the employer’s deliberate intention, then the worker or beneficiaries are entitled to compensation and may also pursue any other remedy against the employer for damages over the amount of compensation payable. Or. Rev. Stat. § 656.156(2).
Workers’ Compensation Law immunity does not extend to legal action against third parties where the injury to a worker is due to the negligence or wrong of a third person not in the same employ. Or. Rev. Stat. § 656.154.

30. **Are there any penalties against the employer for unsafe working conditions?**

The employer may be subject to penalties or assessments for violation of applicable rules under the Oregon Safety and Health Act ("OSHA") or regulations which resulted in injury to the worker. Oregon Safe Employment Act, Or. Rev. Stat. § 654.001 et seq.

Effective January 1, 2018, the DCBS director or an authorized representative, when setting maximum penalties under ORS 654.025(2), shall consider, but may not exceed, the maximum penalties under the federal Occupational Safety and Health Act.

31. **What is the penalty, if any, for an injured minor?**

A minor is included under the definition of a worker even if unlawfully employed. Or. Rev. Stat. § 656.005(30). Absent either a certificate authorizing employment of the minor or a good faith belief that the minor was of age, the minor is entitled to compensation benefits, and the employer is subject to a penalty equal to 25 percent of the amount paid or set apart under statute, but not less than $100 or more than $500, payable to the Consumer and Business Fund. Or. Rev. Stat. § 656.132(3). Potential penalties may also be assessed by the Oregon Bureau of Labor and Industries, which administers Oregon's child labor laws.

32. **What is the potential exposure for "bad faith" claims handling?**

Penalties (up to 25 percent of the amount due to the worker) and reasonable attorney fees up to $4,000, absent a showing of extraordinary circumstances, are to be paid if the employer/insurer unreasonably "refuses" or "delays" payment of compensation, or delays acceptance or denial of a claim. Or. Rev. Stat. § 656.262(11)(a).

33. **What is the exposure for terminating a worker who has been injured?**


**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**


35. **Can co-workers be sued for work-related injuries?**
Under Or. Rev. Stat. § 656.018(3), a worker may not sue a co-worker under workers’ compensation provisions unless the act causing the injury is intentional.

36. **Is subrogation available?**

Yes. The payor has a lien against any cause of action the worker may have against a third person or non-complying employer. Or. Rev. Stat. § 656.580.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Medical bills must be paid or denied within 60 days of receipt and failure to pay or deny will result in a penalty assessment. Or. Rev. Stat. § 656.262.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The filing of the claim constitutes a release of medical records. The employer has a right to obtain the worker's medical records, including any past history of complaints or treatments similar to that presented in the claim. Or. Rev. Stat. § 656.252. Physicians and nurse practitioners treating the worker are obligated to submit a variety of notices and reports to the employer concerning the status of the claim. Or. Rev. Stat. § 656.252(2). Administrative rules provide further information as well as penalties against providers who fail to comply with these reporting requirements.

The employer may also require the worker to submit to an independent medical examination (IME) regarding the claim. Or. Rev. Stat. § 656.325(1). The exam is conducted by a physician selected from a list of qualified physicians established by the Director of the Department of Consumer and Business Services. Or. Rev. Stat. § 656.325(1)(b).

Monetary penalties may be assessed against workers who are not receiving temporary disability benefits and fail to attend an IME. Or. Rev. Stat. § 656.325(1)(b)(B). Sanctions may be imposed against medical services providers who fail to provide diagnostic records required for an IME in a timely manner. Or. Rev. Stat. § 656.325(1)(b)(C).


39. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**
The worker may choose an attending doctor, physician, or nurse practitioner within the State of Oregon. Or. Rev. Stat. § 656.245(2)(a). The worker may choose the initial attending physician or nurse practitioner and may subsequently change attending physician or nurse practitioner two times without approval from the Director. Id. If the worker thereafter selects another attending physician or nurse practitioner the insurer or self-insured employer may require the Director's approval of the selection and, if requested, the Director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. Id. The decision of the Director is subject to a contested case review. Id. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer. Id.

Except as otherwise provided for workers subject to a managed care contract, “attending physician” means a doctor, physician, or physician’s assistant who is primarily responsible for the treatment of a worker’s compensable injury and who is either a medical doctor, an osteopath, a podiatrist, or an oral/maxillofacial surgeon, or who is, for a cumulative total or 60 days from the first visit on the initial claim or for a cumulative total of 18 visits (whichever occurs first), a chiropractor, a physician’s assistant, or a naturopath. Or. Rev. Stat. § 656.005 (12)(b). A worker cannot be denied compensation or benefits because he or she was treated by prayer or spiritual means. Or. Rev. Stat. § 656.010.

As discussed above, the employer may require the worker to submit to a medical examination regarding the claim by a physician chosen by the employer. Or. Rev. Stat. § 656.325.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

Compensable medical treatment includes medical, surgical, hospital, nursing, ambulance and other related services, drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services. Or. Rev. Stat. § 656.245(1)(b). "Physical restorative services" encompasses physical therapy and other therapeutic, recuperative and restorative methods and devices. Medical treatment the Director finds to be unscientific, unproven, outmoded or experimental may be excluded. Or. Rev. Stat. § 656.245(3). The decision to exclude treatment is subject to review under Or. Rev. Stat. § 656.704. Id.

41. Which prosthetic devices are covered, and for how long?

Neither statute nor regulation delineates which devices are covered. A showing of medical necessity and causal relationship to the compensable injury is generally required.

42. Are vehicle and/or home modifications covered as medical expenses?

Vehicle and/or home modifications are not mentioned, but may be covered upon a
showing of medical necessity and causal relationship to the compensable injury.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Medical fee schedules are promulgated by rule of the Director, based on several factors including: (a) the current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein; (b) the average rates of fee schedules of the Oregon health insurance industry; (c) a reasonable rate of markup for the sale of medical devices or other medical services; (d) a commonly used and accepted medical service fee schedule; or (e) the actual cost of providing medical services. Or. Rev. Stat. § 656.248(1)(a)-(e).

44. **What, if any, provisions or requirements are there for "managed care"?**

Or. Rev. Stat. § 656.260 governs certification of managed care organizations and their procedures as well as peer review, service utilization and contract review for managed health care providers. A potential managed care provider must submit a written application to, and its methods and procedures must be approved by, the Director of Oregon's Department of Health and Human Services.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Any party to a worker’s claim, including the Director of the Department of Consumer and Business Services, may within certain time limitations request a hearing on any question concerning the claim. Or. Rev. Stat. § 656.283(1). The limited formal requirements for a hearing request include that it: (1) be in writing; (2) be signed by or on behalf of the party requesting the hearing; and (3) include the party's address. Or. Rev. Stat. § 656.283(2). Administrative rules also require that the party seeking the hearing state the issues to be resolved.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

Upon request (see answer to Question 45), a hearing in front of an ALJ on any question concerning the claim may be held. Upon conclusion of the hearing, or prior thereto with concurrence of the parties, the ALJ shall decide the matter and make an order in accordance with his/her determination within 30 days after the hearing. Or. Rev. Stat. § 656.289(1). This order is considered “final” unless one of the parties requests review by the Workers’ Compensation Board (“the Board”) within 30 days after the date the order is mailed to the parties. Or. Rev. Stat. § 656.289(3).

When review has been requested, the record of such oral proceedings at the hearings before the ALJ shall be transcribed at the expense of the Board and provided to the Board
along with a list of all exhibits received by the ALJ. Or. Rev. Stat. § 656.295(3). The review shall be based upon the submitted records and such oral or written argument as it may receive. Or. Rev. Stat. § 656.295(5).

Notice of the review shall be given to the parties by mail and the Board shall set a date for review not later than 90 days after its receipt of the initial request for review. Or. Rev. Stat. § 656.295(4). The Board may affirm, reverse, modify or supplement the ALJ’s order and make such disposition of the case as it determines to be appropriate. Or. Rev. Stat. § 656.295(6). The Board must make its decision within 30 days after the review. Id. An order of the Board is final unless one of the parties appeals to the Court of Appeals within 30 days after a copy of the order is mailed to the parties. Or. Rev. Stat. § 656.295(8). Practically, it is not uncommon for the ALJs and the Board to take longer than 30 days to issue the opinion.

B. Trial court.

Not applicable.

C. Appellate.

The legislature eliminated the Court of Appeals’ de novo review in workers’ compensation cases replacing it with Administrative Procedure Act (“APA”) -type review. Or. Rev. Stat. § 656.298(7). The review by the Court of Appeals must be on the entire record forwarded by the Board and as provided in Or. Rev. Stat. § 183.482(7). Id. There is no right of appeal, but an aggrieved party may petition for review by the Oregon Supreme Court. That court only accepts cases containing important or legal questions.

47. What are the requirements for stipulations or settlements?

Settlement of any or all matters regarding a claim, except for medical services and/or benefits, may also be resolved by disposition. Or. Rev. Stat. § 656.236. The disposition must be filed with the Board and will be approved unless the ALJ who mediated the agreement or the Board finds the disposition is unreasonable as a matter of law, it is the result of an intentional misrepresentation of material fact, or within 30 days of submitting the disposition, the worker, insurer, or self-insured employer requests that it be disapproved. Or. Rev. Stat. § 656.236(1)(a)(A)-(C). An order approving disposition of a claim is not subject to review, however an order disapproving a disposition is subject to review by the Court of Appeals. Or. Rev. Stat. § 656.236(2).

48. Are full and final settlements with closed medicals available?


49. Must stipulations and/or settlements be approved by the state administrative body?

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

Every employer must maintain assurance with the Department of Consumer and Business Services that workers will receive compensation for compensable injuries by qualifying as: (1) a carrier-insured employer; or (2) a self-insured employer. Or. Rev. Stat. § 656.017(1).

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

To qualify as self-insured, the employer must demonstrate to the Department of Consumer and Business Services that it has: (1) an adequate staff to process claims promptly; and (2) the financial ability to make prompt payment of compensation that may become due. Or. Rev. Stat. § 656.407(1). Proof of financial ability is made by a showing of funds in an amount not less than the employer's normal expected annual claim liabilities and in no event less than $100,000. Or. Rev. Stat. § 656.407(2).

B. For groups or "pools" of private entities.

The Director may certify five or more employers in the same industry as a self-insured employer group, if: (1) as a group they meet the requirements of a self-insured employer; (2)(a) they as a group have insurance with a retention of $100,000 or more, have a combined net worth of $1 million or more, or, (b) if insurance is less than $100,000, they have a combined net worth at least equal to the proportion of $1 million that the retention bears of $100,000; (3) the group is likely to improve accident prevention and claims handling for the employer; (4) each employer agrees in writing that it will be jointly and severally liable for payment due to the Department of Consumer and Business Services incurred by a member of the group; (5) the group is organized as a corporation or cooperative; (6) the group has designated an entity responsible for centralized claims processing and other administrative functions; and (7) the group has presented a method approved by the Director to notify the Department of Consumer and Business Services of an employer’s commencement or termination of membership from the group and its effect on the net worth of the group. Or. Rev. Stat. § 656.430(7).

Effective January 1, 2018, public bodies that do not have the statutory authority to pass ordinances, including some special districts, to form a self-insured employer group for workers’ compensation if they have already established a self-insurance program for tort liability or property damage. Previously, self-insured employer groups made up of public employers were required to be organized as an intergovernmental entity ratified by ordinance.
52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Under Oregon law, a “worker” means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer. Or. Rev. Stat. § 656.005(30) (emphasis supplied). An “illegal alien” is described in Oregon law as an “undocumented alien.” There is no distinction in the statutes between legally authorized workers and undocumented aliens. There is also no case law in Oregon suggesting that undocumented aliens are not considered “workers” under the Oregon statute and in fact, there is at least one case awarding workers’ compensation benefits to an undocumented alien. See Aguilar v. Simplot Co., 742 P.2d 709 (Or. Ct. App. 1987). In Oregon, there is an absolute right to be paid for work performed.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Oregon workers’ compensation law has not addressed the question of whether terrorist acts or injuries are covered or excluded under workers’ compensation.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The federal Medicaid statute requires States to include in their plan for medical assistance provisions: (1) that the individual will assign to the State any rights to payment for medical care from any third party; and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government, as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

When a worker elects to bring an action against a third party or a non-complying employer under Or. Rev. Stat. § 656.578, the paying agency has a lien against the cause of action which is preferred to all claims except the cost of recovering the damages. Or. Rev. Stat. § 656.580. “Paying agency” is defined as “the self-insured employer or insurer paying benefits to the worker or beneficiaries.” Or. Rev. Stat. § 656.576. This definition
appears to include Medicaid if Medicaid paid benefits to the worker or beneficiaries. However, the Oregon Supreme Court has held that the Workers’ Compensation Board has the authority to determine who is a “paying agency” entitled to a share of settlement proceeds. *SAIF Corp. v. Wright*, 817 P.2d 1317, 1320 (Or. 1991). On remand, the Oregon Court of Appeals held that the insurer must be paying benefits at the time of a settlement or distribution in order to qualify as a “paying agency.” *SAIF Corp v. Wright*, 832 P.2d 1238, 1240 (Or. Ct. App. 1992).

The procedures for the paying agency to recover from third persons and non-complying employers is provided for in Or. Rev. Stat. §§ 656.583 to 656.596. The paying agency may require the worker, other beneficiary or legal representative of a deceased worker to exercise the election to bring an action against a third party or a non-complying employer by serving a written demand on the worker, other beneficiary or legal representative. Or. Rev. Stat. § 656.583(1). Unless the election is made within 60 days from the receipt of the demand or unless an action is commenced within the time granted by the paying agency, the worker, beneficiary or legal representative, is deemed to have assigned the cause of action to the paying agency. Or. Rev. Stat. § 656.583(2).

Any compromise by the worker, beneficiary or legal representative of the right of action against a non-complying employer or a third party is void unless made with the written approval of the paying agency or, if there is a dispute between the parties, by order of the Workers’ Compensation Board. Or. Rev. Stat. § 656.587.

An election not to proceed against the non-complying employer or a third party operates as an assignment to the paying agency of the cause of action. Or. Rev. Stat. § 656.591(1). The paying agency may then bring an action in the name of the injured worker or other beneficiaries. Id. The sum recovered by the paying agency in excess of its expenses in making the recovery and the amount expended by the paying agency for compensation, first aid or other medical, surgical or hospital service, together with the present value of the monthly payments of compensation to which the worker or other beneficiaries may be entitled, shall be paid to the worker or other beneficiaries. Or. Rev. Stat. § 656.591(2).

If the worker or the beneficiaries elect to recover damages from the employer or third person, notice shall be given to the paying agency. Or. Rev. Stat. § 656.593(1). The paying agency shall also be given notice of the name of the court in which such action is brought, and a service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency. Id. The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. Id.

The total proceeds shall be distributed as follows: (a) costs and attorney fees not to exceed the advisory schedule of fees established by the Workers' Compensation Board; (b) the worker or the beneficiaries shall receive at least one-third of the balance of such recovery; (c) the paying agency shall be paid and retain the balance of the recovery, but
only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to-be-expected future expenditures for compensation and other costs of the worker's claim; (d) the balance of the recovery shall be paid to the worker or the beneficiaries. Or. Rev. Stat. § 656.593(1). Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the Board. Id.

The amount retained by the worker or the beneficiaries of the worker shall be in addition to the compensation or other benefits to which such worker or beneficiaries are entitled under workers’ compensation. Or. Rev. Stat. § 656.593(2).

Any third-party case may be settled with the approval of the paying agency. Or. Rev. Stat. § 656.593(3). The paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries shall receive the amount to which the worker would be entitled for a recovery under Or. Rev. Stat. § 656.593(1) and (2). Id. Any conflict as to what may be a just and proper distribution shall be resolved by the Board. Id.

The Department of Consumer and Business Services shall be repaid for its expenditures from the proceeds recovered by the paying agency in an amount proportional to the amount of the Department's reimbursement of the paying agency's costs. Or. Rev. Stat. § 656.593(5). All moneys received by the Department shall be deposited in the same fund from which the paying agency's costs originally had been reimbursed. Id.

Prior to and instead of the distribution of proceeds as described in Or. Rev. Stat. § 656.593(1), when the worker or the beneficiaries are entitled to receive payment pursuant to a judgment or a settlement in the third-party action in the amount of $1 million or more, the worker or the beneficiaries may elect to release the paying agency from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of its reasonably expected future expenditures for workers' compensation and other costs of the worker's claim, if certain conditions as stated in the statute are met as part of the claim release. See Or. Rev. Stat. § 656.593(6)(a)-(g).

When a release of further liability, as provided in Or. Rev. Stat. § 656.593(6), has been filed, and when payment to the paying agency has been made, the effect of the release is that the worker or beneficiaries shall have no further right to seek benefits pursuant to the original claim, or any independent workers' compensation claim regarding the same circumstances, and the claim shall not be reasserted, re-filed or reestablished through any legal proceeding. Or. Rev. Stat. § 656.593(7).

If no workers' compensation claim has been filed or accepted at the time a worker or the beneficiaries of a worker recover damages from a third person or non-complying employer, the amount of the damages shall constitute an offset against compensation due the worker or beneficiaries for the injuries for which the recovery is made to the extent of any lien that would have been authorized by Or. Rev. Stat. §§ 656.576 to 656.596 if a
workers' compensation claim had been filed and accepted at the time of recovery of damages. Or. Rev. Stat. § 656.596(1).

The offset shall be recoverable from compensation payable to the worker, the worker's beneficiaries and the worker's attorney. Or. Rev. Stat. § 656.596(2). No compensation payments shall be made to the worker, the worker's beneficiaries or the worker's attorney until the offset has been fully recovered. Id.

The worker or the beneficiaries shall notify the paying agency or potential paying agency of the amount of any damages recovered from a third person or non-complying employer at the time of recovery or when the worker or the beneficiaries of a worker file a workers' compensation claim that is subject to Or. Rev. Stat. §656.576 to 656.596. Or. Rev. Stat. § 656.596(3).

56. **What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPAA)?**

The Health Insurance Portability and Accountability Act (“HIPAA”), 45 C.F.R. parts 160-164 and 65 F.R. 82462, provide an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. § 164.512.

Insurers and claims agents must maintain the confidentiality of worker medical and vocational claim records. Or. Rev. Stat. § 656.360. Worker medical and vocational claim records may be disclosed under the following circumstances:

A. Disclosure is made with the consent of the worker or, if deceased, the worker’s beneficiary

B. Disclosure is made because it is reasonably necessary for the insurer or the claims agent to manage, defend, or adjust the claim, or to perform any other function arising out of the insurer’s or agent’s delineated statutory or contractual duties

C. Disclosure is made to detect or prevent criminal activity, fraud, material misrepresentation or non-disclosure;

D. Disclosure is made pursuant to a written agreement that requires the receiving party to maintain confidentiality; or

E. As otherwise required or permitted by law. Or. Rev. Stat. § 656.360(1)-(5).

Violation of the confidentiality provisions may subject the insurer or claims agent to civil liability. There is no liability for defamation, invasion of privacy or negligence if: (1) the insurer or agent discloses records in accordance with Or. Rev. Stat. § 656.360; and (2) the
disclosure or provision of false information is not made with malice or willful intent to injure. Or. Rev. Stat. § 656.362.

To date, there are no cases that have interpreted the language or discussed the interplay between these statutes, general discovery statutes and the HIPAA, 42 U.S.C. § 201 et. seq.

HIPAA generally requires that a covered entity may disclose protected health information in response to a subpoena, discovery request or other civil process only after obtaining “satisfactory assurances” that the requesting party has made a reasonable effort to notify the patient of the disclosure in writing or obtain a qualified protective order limiting the use of the information. The patient must be given a reasonable opportunity to object and, if necessary, challenge the disclosure in court or in another tribunal.

Oregon Rules of Civil Procedure (“ORCP”) 55 H establishes the method by which “individually identifiable health information” may be obtained from health care providers, health plans, employers, or health care clearinghouses. The statute provides that the issuing party must give at least 14 days notice to the person whose records are sought before serving the subpoena on the hospital, only if the records are being subpoenaed to the issuing attorney. ORCP 55 H(2)(c). ORCP 55 H(2) provides that if disclosure of requested records is restricted or limited by state or federal law, protected records shall not be disclosed in response to a subpoena unless the requesting party has complied with the applicable law.

57. **What are the provisions for “Independent Contractors”?**

“Independent contractor” is defined as a person who provides services for remuneration and who, from the provision of the services, is 1) free from the direction and control over the means and manner of providing the services (subject only to the right of the person for whom the services are provided to specify the desired results); and 2) customarily engaged in an independently established business (with certain exceptions). Or. Rev. Stat. §§ 656.005(31), 670.600(2).

Independent contractors are not considered “subject workers,” however, an independent contractor may submit a written application to an insurer to become entitled as a “subject worker” to compensation benefits. Or. Rev. Stat. § 656.128(1). Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of workers’ compensation computations. *Id.*

When the application is accepted, the independent contractor is subject to the provisions and entitled to workers’ compensation benefits. Or. Rev. Stat. § 656.128(2). The independent contractor shall promptly notify the insurer whenever his or her status as an employer of subject workers changes. *Id.* Any subject worker employed by the independent contractor after the effective date of the election of the independent contractor shall, upon being employed, be considered covered automatically by the same
A worker may be considered both a subject worker and an independent contractor. In Day v. Advanced M & D Sales, Inc., 86 P.3d 678 (Or. 2004), a worker, who was both an employee and an independent contractor for the same employer, first filed a claim for workers’ compensation benefits and then attempted to withdraw the claim after filing suit against the employer for negligence and failure to comply with Employer Liability Law. The employer asserted a defense based on various forms of estoppel, given the exclusive remedy provision of the Workers’ Compensation Act. The Oregon Supreme Court held that estoppel did not bar the claimant’s action against the employer. The court reasoned that the Workers’ Compensation Act’s rapid “pay now, litigate later” approach allows for the possibility that new information later may affect a claimant’s view regarding the compensability of the claim.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Oregon law provides specific provisions for “Worker Leasing Companies.” A “worker leasing company” is defined as “a person who provides workers, by contract and for a fee, to work for a client but does not include a person who provides workers to a client on a temporary basis.” Or. Rev. Stat. § 656.850(1)(a). A person performing services as a worker leasing company must obtain a license from the Director. Or. Rev. Stat. § 656.850(2).

When a worker leasing company provides workers to a client, the worker leasing company must provide workers' compensation coverage for those workers and any subject workers employed by the client unless, during the term of the lease arrangement, the client has proof of coverage on file with the Director that extends coverage to subject workers employed by the client and any workers leased by the client. Or. Rev. Stat. § 656.850(3).

When a worker leasing company provides subject workers to work for a client and also provides workers' compensation coverage for those workers, the worker leasing company must notify the Director in writing. Or. Rev. Stat. § 656.850(5). The notification shall be given in such manner as the Director may prescribe. Id.

A worker leasing company may terminate its obligation to provide workers' compensation coverage for workers provided to a client by giving to the client and the Director written notice of the termination. Id. A notice of termination shall state the effective date and hour of the termination, but the termination shall be effective not less than 30 days after the notice is received by the Director. Id. Notice to the client must be given by mail, addressed to the client at the client's last-known address. Id. If the client is a partnership, notice may be given to any of the partners. Id. If the client is a corporation, notice may be given to any agent or officer of the corporation upon whom legal process may be served. Id.
59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. Financial exposure to workers’ compensation is an expensive and complex challenge for all businesses. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

61. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Oregon permits the use of medical marijuana, but if a worker’s injury is caused by the worker’s consumption of alcohol, cannabis, or the unlawful consumption of a controlled substance, it is not compensable.

Effective April 21, 2017, Senate Bill 302 amended the Uniform Controlled Substances Act to exclude cannabis from the definition of a controlled substance. The bill required changes throughout the Oregon Revised Statutes, adding marijuana or cannabis where language already refers to alcohol, illegal drugs, or controlled substances.

Because marijuana was excluded from the definition of a controlled substance, the workers’ compensation rules were amended to address the impact this definitional change on the compensability of workers’ compensation claims involving marijuana.

The new rule clarifies that an injury is not compensable if the major contributing cause of an injury is shown by a preponderance of the evidence to be the worker’s consumption of alcoholic beverages, cannabis, or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged, or had actual knowledge of such consumption. The statute did not previously make a specific reference to cannabis. Or. Rev. Stat. § 656.005(7)(b)(C).

62. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Please see the response to Question #61. No designation between recreational and medical marijuana use is made in Oregon’s workers’ compensation law.
The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Douglas J. Kotarek, Esquire  
kotarekd@hallevans.com  
Tel: (303) 628-3300
1. Citation for state's workers' compensation statute.

The Workers’ Compensation Act (“the Act”), the Act of June 2, 1915, P.L. 736, No. 338, 77 P.S. § 1 et seq., was amended by both the Act of July 2, 1993, P.L. 190, No. 44 (Act 44) and the Act of June 24, 1996, P.L. 350, No. 57 (Act 57). Note: These were significant amendments to the statute on July 2, 1993 and on June 24, 1996. The 1996 Amendments were intended to address the rising costs of workers’ compensation in the Commonwealth while preserving the rights of employees to be adequately compensated for work-related injuries.

The Act applies to any injury occurring within the Commonwealth of Pennsylvania. The Act will also apply where claimant’s employment is principally located in Pennsylvania or where claimant is working under a contract of hire made in Pennsylvania.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purpose of workers' compensation?

"Employee" includes all natural persons who perform services for another for a valuable consideration, exclusive of persons whose employment is casual in character and not in the regular course of the business of the employer, and exclusive of persons to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished or repaired, or adapted for sale in the worker's own home, or on other premises, not under the control or management of the employer. Except as provided by the clause (c) of section 302 and sections 305 and 321 of the Act, every executive officer of a corporation elected or appointed in accordance with the charter and by-laws of the corporation, except elected officers of the Commonwealth or any of its political subdivisions, is an employee of the corporation. An executive officer of a for-profit or nonprofit organization who serves voluntarily and without remuneration may elect to exempt himself from coverage of the Act. Section 104 of the Act, 77 Pa. C.S. § 22.

Whether an employer-employee relationship exists is a question of law to be decided on

An injured employee may be eligible for benefits for injuries sustained traveling to or from work if:

- A. The employment agreement between a claimant and employer included transportation to and from work;
- B. The employee has no fixed place of work;
- C. The employee is injured while on a special assignment for the employer; or
- D. Special circumstances indicate that the employee was furthering the business of the employer.

The Pennsylvania Supreme Court has held that a temporary employee, who is employed by an agency, never has a fixed place of work. The Court went on to hold that when an agency employee travels to an assigned workplace, the employee is furthering the business of the agency. Therefore, as a matter of law, such a claimant has no fixed place of work and her injury occurred while she was in furtherance of her employer’s business. See Peterson v. Workmen's Compensation Appeal Bd. (PRN Nursing Agency), 528 Pa. 279, 597 A.2d 1116 (1991).

However, in Mackey, the claimant was not entitled to benefits pursuant to the “No Fixed Place Of Work” exception because although she worked for a temporary agency, her assignment, as a home health nurse, was for all actual and practical purposes a permanent assignment requiring her to drive to the same location every day, which she had done for one and a half years. Therefore, the claimant who was involved in a motor vehicle accident on her way driving directly from her home to her patient’s home was not in the course and scope of employment because she had a fixed place of employment. Mackey v. Workmen's Compensation Appeal Bd. (Maxim Healthcare Servs.), 989 A.2d 404 (Pa. Cmwlth. 2010). There were no facts of record upon which the court could conclude that at the time of the accident, the employee was acting as anything other than a commuter on her way to work. In the absence of proof of special circumstances, the fourth exception to the "coming and going" rule did not apply.
Wawa explained that with regard to the fourth exception, the special circumstances entitling an employee to benefits for injuries sustained during a commute must involve an act in which the employee was engaged by order of the employer, express or implied, and not simply for the convenience of the employee. Thus, the 'special circumstances' involve some effort on the part of the employee, requested by the employer, which is involved in either going to or coming from work. Wawa v. Workmen's Compensation Appeal Bd. (Rodgers), 2011 Pa. Commw. Unpub. LEXIS 810. (Manager instructed Claimant not to occupy a parking space in the employer’s lot thus requiring Claimant to park further away down the street from the work location which resulted in a slip and fall on ice while Claimant was walking to work).

3. Identify and describe any "statutory employer" provision.

Five distinct elements define a statutory employer: (1) contract with owner of land or one in the position of an owner; (2) premises occupied or under the control of the contractor seeking statutory employer status; (3) subcontract made by contractor; (4) part of the contractor's regular business is entrusted to the subcontractor under the contract; and (5) an employee of the subcontractor is injured on the premises. Any employer who is in the possession or control of the premises and who permits employees of a subcontractor on the premises is generally referred to as a "statutory employer" and is liable to pay compensation to employees of a subcontractor unless the subcontractor has workers' compensation coverage. Section 302(b) of the Act, 77 Pa. C.S. § 462. However, a statutory employer who is required to pay compensation has a right to indemnification from the subcontractor who is primarily liable.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

Injuries are deemed compensable when arising in the course and scope of employment and related thereto, unless an exclusion applies. "An injury to an employee, regardless of his previous physical condition, arising in the course of his employment and related thereto" need not be pinpointed to a specific event or definable incident. It includes aggravation, reactivation, acceleration or death resulting from the injury. Persons exposed to a serious risk of contracting a disease which is known to be highly contagious or infectious and potentially deadly are "injured" for purposes of workers' compensation. Section 301(c)(1) of the Act, 77 Pa. C.S. § 411(1). Classes of compensable injuries include:

1. Accidental injuries, which consist of conventional accidents, unusual exertion, unusual pathological result and improper medical treatment

2. Cumulative trauma injuries (e.g., carpal tunnel syndrome and repetitive motion injuries)

3. Aggravations of pre-existing conditions)
4. Occupational diseases as defined in Section 108 of the Act
5. Work-related diseases that are not defined as occupational diseases
6. Work-related aggravations of pre-existing diseases
7. Work-related infections
8. Recurrences
9. Heart attacks
10. Systemic reactions
11. Psychological injuries
12. Premises injuries

B. Occupational disease (including respiratory and repetitive use).

There are two basic occupational disease laws, The Pennsylvania Workers' Compensation Act § 101 et seq., 77 Pa. C.S. § 101 et seq., and the 1939 O.D. Act, 77 Pa. C.S. § 1201 et seq. "Compensable" occupational diseases are limited to the following:

1. Poisoning by arsenic, lead, mercury, manganese, or beryllium
2. Poisoning by phosphorous
3. Poisoning by methanol, carbon bisulfide, carbon monoxide, hydrocarbon distillates, halogenated hydrocarbons, toluene diisocyanate or any preparations containing these chemicals
4. Poisoning by benzyl or by nitro, amido, or amino derivatives of benzyl
5. Caisson disease (compressed air illness)
6. Radium poisoning or disability
7. Poisoning by, or ulceration from chromic acid, or bichromate of ammonium, bichromate of potassium, or bichromate of sodium
8. Epitheliomatous cancer due to tar, pitch, bitumen, mineral oil or paraffin
9. Infection or inflammation of skin due to oils, cutting compounds, lubricants, dust, liquids, fumes, gases or vapor
10. Anthrax occurring in any occupation involving the handling of, or exposure to wool, hair, bristles, hides, or skins, or bodies of animals either alive or dead

11. Silicosis, in any occupation involving direct contact with, handling of, or exposure to the dust of silicon dioxide

12. Asbestosis and cancer resulting from direct contact with, handling of, or exposure to the dust of asbestos in any occupation involving such contact, handling or exposure

13. Tuberculosis, serum hepatitis or infectious hepatitis

14. All other occupational diseases to which the employee is exposed by reason of the employment, which are causally related to the industry or occupation, and the incidence of which is substantially greater in that industry or occupation than in the general population

15. Diseases of the heart and lungs after four years or more of service in fire fighting for the benefit or safety of the public

16. Byssinosis

17. Coal worker's pneumoconiosis, anthraco-silicosis and silicosis

Complete or partial noise induced hearing loss may be compensated under the Act. Section 306(c)(8) of the Act, 77 Pa. C.S. § 513. For all claims filed under Act 1, a percentage of hearing loss is assessed using an audiometric testing in conjunction with the American Medical Association guidelines.

5. What, if any, injuries or claims are excluded?

A. Intentionally self-inflicted injury or death – The burden is on the employer to prove that the death was a suicide or that the injury was self-inflicted. However, if the suicide occurred after a work-related injury, the injury caused the employee to be dominated by a disturbance of the mind so severe as to override normal rational judgment, and the disturbance resulted in the suicide, it may be compensable. Halvorsen v. Workmen’s Compensation Appeal Bd. (Congoleum Corp.), 159 Pa. Commw. 35, 632 A.2d 973 (Pa. Cmwlth.1993), alloc. denied, 537 Pa. 636, 642 A.2d 488 (Pa. 1994). See Section 301(a) of the Act, 77 Pa. C.S. § 431.

B. Injuries resulting from the employee’s violation of the law – The employer must prove that the violation caused the injury. If the violation of law is only a summary offense, compensation may not be excluded.
C. Injuries resulting from the employee’s illegal use of drugs – This category of injuries was specifically excluded from coverage under Section 301(a) of the Act as a type of violation of law by the 1993 Amendments to the Act (Act 44). The employer must prove that the illegal use of drugs caused the injury.

D. Injuries resulting from the employee’s intoxication – In cases where the injury or death is caused by intoxication, no compensation shall be paid if the injury or death would not have occurred but for the employee’s intoxication. The burden of proof is on the employer to establish this fact.

F. Injuries caused by personal animosity and physical assault - Intentional injuries by a third person because of personal reasons and not directed against him as an employee or because of his employment are not compensable. Section 301(c)(1) of the Act, 77 Pa. C.S. § 411(1); Haas v. Brotherhood of Transportation Workers, 158 Pa. Super. 291, 44 A.2d 776 (1945). See Helm v. Workmen's Compensation Appeal Board (U.S. Gypsum Co.), 139 Pa. Commw. 587, 591 A.2d 8, 10 (Pa. Cmwlth. 1991) (The burden of proving that the injury was for reasons personal to the assailant rests with the employer.). See also LeDonne v. Workers' Compensation Appeal Bd. (Graciano Corp.), 936 A.2d 124 (Pa. Cmwlth. 2007) (Employer needed only to produce evidence to show that Decedent was killed for reasons unrelated to his work.).

G. The 1993 Amendments exclude injuries sustained while the employee is operating a motor vehicle provided by the employer if the employee is not otherwise in the course of employment at the time of the injury. Section 301(c)(1) of the Act.

6. What psychiatric claims or treatments are compensable?

There are three categories into which mental claims fall. In a physical/mental claim, a claimant must prove by unequivocal medical evidence that the work-related physical trauma or stimulus resulted in the mental illness. School Dist. of Phila. v. Workmen's Compensation Appeal Board (Coe), 163 Pa. Commw. 89, 639 A.2d 1306 (Pa. Cmwlth 1994). See Campbell v. Workers' Comp. Appeal Bd. (Pittsburgh Post Gazette), 954 A.2d 726, 2008 Pa. Commw. LEXIS 336 (claimant has the burden of establishing, by unequivocal medical evidence – i.e. the medical expert, after providing a foundation, testifies that in his professional opinion that he believes a certain fact or condition exists, that his mental injuries developed as a result of his initial physical injury); Donovan v. Workers' Compensation Appeal Board (Academy Med. Realty), 739 A.2d 1156 (Pa. Cmwlth. 1999) (claimant is required to show that the physical stimulus caused the mental injuries); Gulick v. Workers' Compensation Appeal Board (Pepsi Cola Operating Co.), 711 A.2d 585 (Pa. Cmwlth. 1998) (claimant is not required to show abnormal working conditions).

In a mental/physical claim, a claimant must establish by objective evidence that the injury arose from abnormal working conditions and not merely a subjective reaction to a normal working condition. See Farmery v. Workers’ Compensation Appeal Bd. (City of Philadelphia), 776 A.2d 349 (Pa. Cmwlth. 2001) (a claimant employed in a highly
stressful job must show that the event giving rise to the mental injury is so much more stressful that it is abnormal even for that job). Additionally, the claimant must prove by unequivocal medical evidence the causation between the psychological stimulus and the physical injury.

In a mental/mental claim, a claimant has a higher burden of proof, and must prove by objective evidence that a psychic injury was suffered, was causally related to his/her job, and that the injury resulted from more than a subjective reaction to a normal working condition. Scott v. Workers’ Compensation Appeal Bd. (Jeans Hospital), 732 A.2d 29 (Pa. Cmwlth. 1999); McCarron v. Workers’ Compensation Appeal Bd. (Delaware County DA’s Office), 761 A.2d 668 (Pa. Cmwlth. 2000), alloc. denied, 565 Pa. 679, 775 A.2d 811 (Pa. 2001). See also Wilson v. WCAB (Aluminum Co. of Am.), 542 Pa. 614, 669 A.2d 338, 343 (Pa. 1996) (in classifying working conditions as normal or abnormal, a bright line test or a generalized standard is not employed and instead the specific work environment of the claimant is considered).


The determining factor is what is extraordinary or abnormal for a person in the same “line of work”. When an individual Claimant employed as a police officer has not previously encountered a particular type of event one may expect a police officer to become involved in, that experience is merely "subjectively abnormal for the Claimant.” Payes v. Workers’ Compensation Appeal Bd. (Commonwealth/State Police), 5 A.3d 855 (Pa. Cmwlth. 2010) (this case is currently being appealed before the Pennsylvania Supreme Court), alloc. approved, 610 Pa. 402, 20 A.3d 1182 (Pa. 2011).

In RAG (Cyprus) Emerald Res., L.P. v. Workers' Compensation Appeal Bd. (Hopton), 590 Pa. 413, 912 A.2d 1278 (Pa. 2007), claimant asserted that a co-worker's homosexual comments aggravated his PTSD, which was a pre-existing condition. The Supreme Court held that the pre-existing nature of the injury does not disqualify him from receipt of compensation. Furthermore, in footnote 10, the Court cautioned that it could envision that both a single incident could constitute an abnormal working condition, if sufficiently severe and unusual in the context of the relevant working environment, and a relatively minor conduct could result in a determination of abnormal working conditions if that conduct is imposed repeatedly and is demonstrably unusual in that environment. See Cmty. Empowerment Ass'n v. Workers' Comp. Appeal Bd. (Porch), 962 A.2d 1 (Pa. Cmwlth. 2008) (whether something is a religious issue or a cultural issue is not the ultimate question; rather, the pivotal questions are whether it can be said that the events that have been described constitute abnormal working conditions and whether the mental injuries were caused, in part, by these events developed from subjective reactions to normal working conditions).
In PA Liquor Control Bd. v. Workers’ Compensation Appeal Bd. (Kochanowiez), 29 A.3d 105 (Pa. Cmwlth. 2011) (en banc), the claimant, who had worked at the employer's retail store, was diagnosed with post-traumatic stress disorder after an armed robbery at the store. On appeal, the employer argued that the WCJ erred in granting the claimant's claim petition because the employer presented evidence that the armed robbery was "normal" for the industry. The WCJ found the employer provided the claimant with training on workplace violence, some of which was specifically geared toward robberies and thefts. The claimant admitted he attended training and received educational booklets. Given these findings and prior decisions, the court found the claimant could have anticipated being robbed at gunpoint. The employer presented uncontested evidence of 99 robberies of its southeastern Pennsylvania retail stores since 2002, which equated to more than one per month. There had been four retail liquor store robberies in close proximity to the claimant's store within weeks of the robbery at the store. Given the frequency the employer's stores had been robbed and the proximity of recent incidents, the court held that robberies were a normal condition of retail liquor store employment.

7. What are the applicable statutes of limitations?

A claim petition for benefits for injury or death must be filed within three years after the date of injury or death. Section 315 of the Act, 77 Pa. C.S. § 602. Where an employee is exposed to continuing trauma, e.g. carpal tunnel, the statute of limitation period begins to run on the last day of the cumulative injury, usually the last day of work. Section 315 of the Act has been held to be a statute of repose. See Sharon Steel Corporation v. Workmen's Compensation Appeal Board (Myers), 670 A.2d 1194 (Pa. Cmwlth.), alloc. denied, 544 Pa. 679, 678 A.2d 368 (1996).

For hearing loss cases, the claim must be filed within three years of the last date of exposure or the date of trauma. Under the old law, the three year statute began running from the date on which a claimant was advised by a doctor that his hearing loss was complete for all practical intents and purposes and was work-related.

Petitions to Reinstate Compensation Benefits following a termination of workers' compensation benefits must be filed within three years of the last date of payment of compensation. Section 413(a) of the Act, 77 Pa. C.S. § 772. Note: A reinstatement petition that is filed within three years of the date when the employer last paid the claimant compensation is timely, even though the effective date of termination is more than three years prior to the filing of the reinstatement petition. Flannigan v. Workers' Compensation Appeal Bd. (Colt Industries), 726 A.2d 424 (Pa. Cmwlth. 1999).

In calculating this 500 week period for the purpose of gauging the timeliness of a reinstatement petition, periods of suspension are included with periods where partial disability benefits are paid. Kane v. Workers' Compensation Appeal Bd. (Glenshaw Glass Co.), 940 A.2d 572 (Pa. Cmwlth. 2007), alloc. denied, 598 Pa. 770, 956 A.2d 437 (2008).
Where a claimant has been paid partial disability benefits pursuant to a supplemental agreement, he/she must file a Petition to Reinstate Compensation Benefits within three years after the final payment of the 500 week partial disability period. Stewart v. Workers' Compensation Appeal Bd. (Pa. Glass Sand/U.S. Silica), 756 A.2d 655 (Pa. 2000); Romanowski v. Workers' Compensation Appeal Bd. (Precision Coil Processing), 944 A.2d 127 (Pa. Cmwlth. 2008).

8. **What are the reporting and notice requirements for those alleging an injury?**

Notice must be given by an employee within 21 days of the work-related injury or no compensation will be due until notice is given. If notice is not given within 120 days after the occurrence of an injury, no compensation will be allowed. Section 311 of the Act, 77 Pa. C.S. § 663. The employer or an agent of the employer must be informed that the employee sustained an injury in the course of his employment on or about a specified time and at or near a place specified. Section 312 of the Act, 77 Pa. C.S. § 632. Notice in person or by mail to an agent of the employer at the place of business, by the employee or someone on his or her behalf, is sufficient. Section 313 of the Act, 77 Pa. C.S. § 633.

Notice periods do not begin to run until the employee knows or by the exercise of reasonable diligence should have known that the disability was caused by the injury or the occupational disease. Section 311 of the Act, 77 Pa. C.S. § 631.

The *reasonable diligence* standard is an objective standard. The elements of knowledge the claimant must possess in order to trigger the running of the notice period are (1) knowledge or constructive knowledge (2) of disability (3) which exists, (4) which results from an occupational disease [or injury], and (5) which has a possible relationship to the employment. Allegheny Ludlum Corporation v. Workers’ Compensation Appeal Bd. (Holmes), 608 Pa. 670, 13 A.3d 480 (Pa. 2010).

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury** – Intentionally self-inflicted injury or death is not compensable. The burden of proof that a death was a suicide is on the employer. Section 301(a) of the Act, 77 Pa. C.S. § 431.

B. **Willful misconduct, "horseplay," etc.** - "Horseplay" may be compensable, when the activity is merely an innocent or inconsequential departure from work. Where the injury or death is caused by the employee's violation of law and the violation of law is either a misdemeanor or a felony, compensation is not payable even if all other requirements of the Act are met. Section 301(a) of the Act, 77 Pa. C.S. § 431. The employer must establish a causal connection between the violation of law and claimant's injuries. Burns v. Workers’ Compensation Appeal Bd. (State Pipe Services, Inc.), 654 A.2d 81 (Pa. Cmwlth. 1995).

C. **Injuries involving drugs and/or alcohol** - The 1993 amendments to Pennsylvania's Workers' Compensation Act provide that injuries that would not have occurred but for the
intoxication of the employee are excluded. Section 301(a) of the Act, 77 Pa. C.S. § 431. An employer or insurer asserting an employee's intoxication as an affirmative defense in the workers' compensation context must establish that the intoxication was "the cause in fact," as opposed to the proximate cause or substantial factor, of the injury, and the workers' compensation judge makes this determination. Clear Channel Broad. v. Workers' Compensation Appeal Bd. (Perry), 938 A.2d 1150 (Pa. Cmwlth. 2007) citing Mahon v. Workers' Compensation Appeal Board (Expert Window Cleaning), 835 A.2d 420, 429 (Pa. Cmwlth. 2003).

The employer’s sole burden is to convince a fact finder by competent and substantial evidence that claimant would not have fallen and sustained his injuries had he not been intoxicated. It is up to the fact finder to infer from the evidence as a whole whether a claimant’s intoxication caused his injury. Thomas Lindstrom Company, Inc. v. Workers’ Compensation Appeal Bd. (Braun), No. 1815 C.D. 2009, 13 A.3d 480 (Pa. 2010) (decision by Judge Pellegrini, April 13, 2010).

10. What, if any, penalties or remedies are available in claims involving fraud?

The fraud provisions include nine specific offenses that could result in prosecution of an employee, employer/insurer or healthcare provider. New offenses include intentional failure to file reports required under Section 311.1 of the Act, 77 Pa. C.S. § 631.1 and intentional failure to file reports of employment or receipt of total or excessive partial disability benefits while employed or receiving wages.

Civil penalties of up to $5,000 for the first offense, $10,000 for the second offense and $15,000 for each subsequent violation can be issued. Penalties are awarded to the prosecuting authority. That authority can enter into an agreement with an individual where a civil penalty is paid with no admission of guilt with this agreement not being admissible in a subsequent civil or criminal proceeding. There is a five year statute of limitations after the commission of a fraudulent act.

In March 1996, Pennsylvania's Insurance Fraud Section was formally launched to aggressively investigate and prosecute schemes that cost as much as 25 cents of every insurance dollar paid by Pennsylvanians. The Insurance Fraud Section is located at 16th Floor Strawberry Square; Harrisburg, PA 17120 and can be reached by phone: 717-787-0272 or fax: 717-705-0741. An Insurance Fraud Referral Form can be obtained from the Office of the Attorney General's web site at http://www.attorneygeneral.gov/complaints.aspx?id=2903.

11. Is there any defense for falsification of employment records regarding medical history?

While the falsification of employment records regarding medical history is not an affirmative defense, such evidence can be used to impeach the employee's credibility. Further, a Judge may not rely upon the testimony of a medical expert who based his opinion upon a false medical history. Newcomer v. Workmen's Compensation Appeal Board...

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**


13. **Are injuries by co-employees compensable?**

If the injury is sustained during the course and scope of employment because of an act or omission by a co-employee, it will be compensable. Arguments or disputes which arise out of the employment relationship are deemed to occur in the course or employment and thus prevent any cause of action against the employer or co-employee. Repco Products Corp. v. Workmen’s Compensation Appeal Bd., 379 A.2d 1089 (Pa. Cmwlth. 1977); Hammerstein v. Lindsay, 440 Pa. Super. 350, 655 A.2d 597 (1995). If an injury occurs off the employer's premises, the Claimant must prove that the injury arose in the course of employment and the injury was related to the employment. Camiolo v. Workers’ Compensation Appeal Bd. (American Bank Notes), 722 A.2d 1173 (Pa. Cmwlth. 1999) (although work-related animosity led to the injury, petitioner was not acting in furtherance of his employer's interests when the injury occurred); Penn State Univ. v. Workers’ Compensation Appeal Bd. (Smith), 15 A.3d 949 (Pa. Cmwlth. 2011) (typically, a claimant who is at lunch and sustains an injury off the employer’s premises is not acting in furtherance of the employer’s business).
14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

No. Intentional injury by a third person because of personal reasons is not compensable. Section 301 of the Act, 77 Pa. C.S. § 411(1).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage is computed as of the date of injury, not the date of disability. In calculating wages in a 13-week calendar quarter, only wages earned before the injury may be used, and the last 13-week period should end with the last completed pay week prior to the injury. Connors v. Workmen's Compensation Appeal Bd. (B.P. Oil), 663 A.2d 887 (Pa. Cmwlth. 1995).

The Act provides that for injuries on or after June 24, 1996, where wages are fixed by the week, that amount will be the average weekly wage. If the wages at the time of the injury are fixed by the month the average weekly wage shall be the monthly wage multiplied by 12 and divided by 52. Finally, where at the time of the injury the wages are fixed by the year, then the average weekly wage shall be the yearly wage divided by 52.

If wages are not fixed by any manner described above, the average weekly wage is calculated by taking the average of the highest three of the last four consecutive periods of 13 calendar weeks in the 52 weeks immediately preceding the injury. Section 309(d) of the Act, 77 Pa. C.S. § 582(d). In determining the average weekly wage for each of the four periods, the wages, weekly board/lodging, weekly federal reported gratuities and any bonus, incentive or vacation earned in the 13 weeks of the period added and then divided by 13.

Where the employee is not employed by the employer for at least three consecutive periods of 13 calendar weeks in the 52 weeks immediately preceding the injury, then the average weekly wage is calculated by dividing by 13 the total wages earned with the employer for any completed period of 13 calendar weeks preceding the injury and by averaging the total amounts earned during those periods.

The employee who has worked less than a complete period of 13 calendar weeks that does not have a fixed weekly wage, shall have his average weekly wage calculated based on the hourly wage rate multiplied by the number of hours the employee was expected to work per week under his employment agreement. It must be noted that the Act does not define the term "hourly wage." In Triangle Bldg. Ctr. v. Workers' Compensation Appeal Bd. (Linch), 560 Pa. 540, 548, 746 A.2d 1108, 1112 (2000), the Court noted that it was the “General Assembly's intention that the baseline figure from which benefits are calculated should reasonably reflect the economic reality of a claimant's recent pre-injury earning experience, with some benefit of the doubt to be afforded to the claimant in the assessment.” A claimant's hourly wage is a question of fact for the WCJ. Mullen v.
The average weekly wage for employees that are exclusively seasonal is calculated by taking one-fiftieth of the total wages the employee earned from all occupations during the 12 calendar months preceding the injury.

The terms "average weekly wage" and "total wages" as used in Section 309 of the Act include boarding and lodging received from the employer, gratuities recorded to the United States IRS only if they are reported to the IRS for federal income tax purposes. Additionally, fringe benefits provided by the employer are excluded from wage calculations. Bonuses, incentives or vacation payments earned annually are divided by 52 and then added to regular wages.


For injuries occurring on or before June 23, 1996, the form LIBC-494A (Statement of Wages) must be completed. For injuries occurring on and after June 24, 1996, the form LIBC-494C (Statement of Wages) must be completed.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

The benefit rate for temporary total is calculated based upon the workers' compensation rate schedule up to the maximum compensation payable for a given year. Pursuant to the Workers' Compensation Act, Section 105.1, the Department of Labor & Industry has determined the statewide average weekly wage for injuries occurring on and after January 1, 2009, shall be $836.00 per week. For purposes of calculating the update to payments for medical treatment rendered on and after Jan. 1, 2009, the percentage increase in the statewide average weekly wage is 3.6 percent.

For injuries that occurred after August 31, 1993, there are provisions for the calculation of minimum compensation. There are minimum and maximum adjustments provided in the Act, and the benefit rate is set using the annual maximum in place at the time of injury. The maximum is based on the Department of Labor and Industry's calculation of the statewide average weekly wage. Benefits rates will be the lower of 50% of the statewide average weekly wage or 90% of the claimant's average weekly wage.
Rate schedules are changed yearly by the Bureau. To view a complete list of rate schedules, go to:
http://www.dli.pa.gov/Businesses/Compensation/WC/claims/Pages/Statewide-Average-Weekly-Wage-(SAWW).aspx#newer

For example, for injuries occurring on and after January 1, 2018, if a claimant’s average weekly wage is between $1,537.50 and $768.76, they will receive compensation benefits in the amount of 2/3 of their average weekly wage. If the claimant’s average weekly wage is between $768.75 and $569.44, they will receive compensation benefits in the amount of $512.50 per week. If the claimant’s average weekly wage is equal to or less than $569.43, they will receive 90% of their average weekly wage in compensation benefits. The maximum benefit for a 2018 injury is $1,025.00.

The benefit rate for partial disability is two-thirds of the difference between the pre-injury average weekly wage and the earning power, not to exceed the applicable maximum compensation rate for total disability. There is no minimum compensation rate for partial disability. Section 306(b) of the Act, 77 Pa. C.S. § 512.

For injuries prior to June 24, 1996, the extent of partial disability is measured by the loss of earning power. Section 306(b) of the Act, 77 Pa. C.S. § 512. The employer must first establish that disability has changed or been reduced and that work is available to claimant, which claimant is capable of performing. Celio v. Workmen's Compensation Appeal Bd. (Canonsburg Gen. Hosp.), 531 A.2d 552 (Pa. Cmwlth. 1987).

For injuries on and after June 24, 1996, the definition of earning power has changed. "Earning power" is determined by the work the employee is capable of performing and shall be based upon expert opinion evidence which includes job listings with agencies of the department, private job placement agencies and advertisements in the usual employment area. Section 306(b)(2) of the Act, 77 P.S. § 512. In order to establish earning power, an insurer may demonstrate an employee's earning power by providing expert opinion evidence relative to the employee's capacity to perform a job. The evidence must include job listings with agencies of the Department, private job placement agencies and advertisements in the usual employment area within this Commonwealth. Preliminarily, the employer is required to offer the claimant a specific vacancy if such a vacancy exists. If such a vacancy does not exist, then earning power can be established through the use of a labor market survey.

17. How long does the employer/insurer have to begin temporary total disability benefits from the date disability begins?

The employer must begin compensation payments within 21 days after notice or knowledge of the employee's disability. The employer may make payment pursuant to a Notice of Temporary Compensation Payable (form LIBC-501) or a Notice of Compensation Payable (form LIBC-495).
If the employer is uncertain as to the compensability of a claim or the extent of its liability, they may initiate compensation for a period of 90 days from payment is to begin without prejudice pursuant to a Notice of Temporary Compensation Payable filed with the Department of Labor and Industry and sent to the employee. This Notice is not an admission of compensability by the employer. If the employer ceases making payments, a Notice Stopping Temporary Compensation (form LIBC-502) and a Notice of Denial (form LIBC-496) must be sent to the employee and filed with the Department no later than five days after the last payment. Should the employer fail to file the requisite notices of cessation of payment, the employer is deemed to have admitted compensability and the Notice of Temporary Compensation Payable is converted into a Notice of Compensation Payable. Section 406.1 of the Act, 77 Pa. C.S. § 717.1.

If a work-related injury has occurred but the employee does not have a wage loss, a Notice of Compensation Payable (form LIBC-495) should be filed. The box for compensation only for medical treatment must be checked. Note: Numbers 1 through 5 on the form should not be completed.

If the employee's claim is contested, the employer or its insurance carrier must file a Notice of Denial (form LIBC-496) the employer must notify the employee or dependents within 21 days, stating the grounds for denial. Section 306(a) of the Act, 77 Pa. C.S. § 511.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

No compensation is paid during the first seven days after disability begins, but if disability exceeds fourteen days, compensation is paid for the first seven days. Section 306(e) of the Act, 77 Pa. C.S. § 514. After the waiting period, compensation is paid for the duration of total disability. Section 306(a) of the Act, 77 Pa. C.S. § 511.

19. **What is the standard/procedure for terminating temporary benefits?**

When the employee fully recovers from the work injury, the employer is entitled to file a Termination Petition or have the employee sign a Final Receipt (form LIBC-340). The employer is entitled to a special supersedeas hearing if the Termination petition alleges a full recovery and includes an affidavit from the physician who examined the employee within twenty-one (21) days upon the Petition. The special supersedeas hearing will be held within twenty-one (21) days of the assignment of the petition to a judge. The judge must rule within seven (7) days following the hearing of all evidence on a supersedeas request whether benefits should be suspended during the pending litigation.

In a Termination Petition, burden lies with the Employer to prove through medical evidence that all of the employee's disability has ceased. Koszowski v. Workmen's Compensation Appeal Bd. (Greyhound Lines, Inc.), 141 Pa. Commw. 253, 595 A.2d 697 (Pa. Cmwlth. 1991). Where an employer alleges the existence of an independent cause of
Claimant's continuing disability unrelated to the work injury, the burden remains on employer to prove that such cause exists. Beissel v. Workmen's Compensation Appeal Board (John Wanamaker, Inc.), 502 Pa. 178, 465 A.2d 969 (1983); City of Philadelphia v. Workers' Compensation Appeal Board (Fluek), 898 A.2d 15 (Pa. Cmwlth.), alloc. denied, 590 Pa. 662, 911 A.2d 937 (2006). Where claimant’s injuries were previously adjudicated, an employer cannot, in a later action, concede that the claimant is still suffering from those injuries, but that those injuries are not work related. However, earlier opinions of doctors are not "prior determinations" of the nature and extent of the injury as contemplated by the Court in Lewis and Hebden. Paul v. Workers' Compensation Appeal Bd. (Integrated Health Servs.), 950 A.2d 1101, 1106 (Pa. Cmwlth. 2008).

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No.

21. What disfigurement benefits are available and how are they calculated?

Disfigurement of the head, neck or face, if serious, permanent and unsightly, and not usually incidental to the employment, is compensated for a period not exceeding 275 weeks as determined by agreement of the parties, or set at the discretion of the Referee after a hearing. Section § 306(c)(22) of the Act, 77 Pa. C.S. § 513(c)(22). A workers' compensation judge in Pennsylvania has the discretion to award benefits based upon personal observation of the claimant's facial and neck scars, despite documentation of a more limited area of disfigurement. LTV Steel Co. v. Workmen's Compensation Appeal Bd. (Hawk), 161 Pa. Commw. 632, 638 A.2d 292 (Pa. Cmwlth. 1994).

22. How are the permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

Compensation is payable for loss (amputation) or permanent loss of use of members of the body, complete loss of hearing in one or both ears, loss of vision in one or both eyes, and disfigurement. Section 306(c) of the Act, 77 Pa. C.S. § 513, defines the categories of specific loss and disfigurement. Compensation for specific loss is paid without regard to loss of earning power and regardless of whether claimant loses time from work.

Compensation for loss of use requires that the loss be permanent but does not require a 100% uselessness. The practical intents and purposes test requires that the loss be more severe and would prevent the employee from using the injured member in employment (the so-called "industrial loss"). Section 306(c) of the Act, 77 Pa. C.S. § 513(c).

Schedule:
<table>
<thead>
<tr>
<th>Member</th>
<th>Maximum Weeks</th>
</tr>
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<tbody>
<tr>
<td>Hand</td>
<td>335</td>
</tr>
<tr>
<td>Forearm</td>
<td>370</td>
</tr>
<tr>
<td>Arm</td>
<td>410</td>
</tr>
<tr>
<td>Foot</td>
<td>250</td>
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<td>Lower Leg</td>
<td>350</td>
</tr>
<tr>
<td>Leg</td>
<td>410</td>
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<tr>
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<td>275</td>
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<td>60</td>
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<td>40</td>
</tr>
<tr>
<td>Any other toe</td>
<td>16</td>
</tr>
</tbody>
</table>

Section 306(c) of the Act, 77 Pa. C.S. § 513(c). In addition to the payments listed above, payment of a healing period shall be made in accordance with Section 306(c)(25) of the Act.

The loss of use of an eye is determined on the basis of the claimant's eyesight without the use of corrective lenses. *Addy Asphalt Co. v. Workmen's Compensation Appeal Bd. (Sebastianelli)*, 591 A.2d 11 (Pa. Cmwlth. 1991). See *Agnello v. Workers' Compensation Appeal Bd. (Owens-Illinois)*, 907 A.2d 676, 679 (Pa. Cmwlth. 2006) (because corrective lenses were not a permanent procedure, whether the claimant suffered loss of use of that eye was determined based on his uncorrected vision, but had surgery and/or a medical procedure been an option and the claimant refused, the outcome would have been different).

B. **Number of weeks for "whole person" and standard for recovery.**

Pennsylvania does not compensate for percentage of disability for the "whole person." Pennsylvania is a wage loss state.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Under Pennsylvania law, employers have no obligation to offer vocational benefits.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**
Total disability is not defined under Section 306(a) of the Act, 77 Pa. C.S. § 511. It is a concept for the determination of the benefit rate. If the injury occurred prior to June 24, 1996, a claimant is totally disabled if he/she is unable to perform the job held at the time of injury or is unable to performing any and all occupations. If the injury occurred on or after June 24, 1996, total disability is paid if, after an examination, it is determined that a claimant's impairment rating is equal to or greater than 50 percent under the American Medical Association's guidelines.

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.

Burial expenses in the amount of $1,500.00 are payable for an injury occurring on or after February 3, 1975. Funeral expenses were increased from $1,500.00 to $3,000.00 for deaths occurring on or after August 31, 1993. Section 307 of the Act provides for payment of various percentages of the pre-injury average weekly wage of the employee to the various classes. However, in the case of death benefits the pre-injury wage cannot be less than 50% of the statewide average weekly wage in effect on the date of the injury that resulted in the death. Section 307 of the Act, 77 Pa. C.S. § 561.

B. Dependency claims.

Where death results from an injury within 300 weeks from the date of the injury, benefits are available. The claim is considered independent and not conditioned on the right of the employee at the time of death. Even if the employee is receiving compensation for an injury, all elements of liability for the death claim are independent and must be established. Lifetime benefits may be covered in a death petition even though no lifetime petition was filed. The rights of dependents to receive lifetime benefits has been further extended to permit dependents to file a separate petition even though no lifetime benefits were paid.

Recipients of death benefits generally include a spouse, and children under the age of 18. The amount of benefits is determined by the Act in effect on the date of the injury. Various percentages of the pre-injury wage of the deceased will be payable to various classes of recipients. A spouse is entitled to benefits for life unless he or she remarries, in which case the spouse will receive a "dower" or 104 weeks as a lump sum. Section 301(c)(1) of the Act, 77 Pa. C.S. § 411(1).

In order to succeed in its Termination Petition, Employer has the burden of establishing Claimant and her live-in boyfriend had entered into a common law marriage. Reliance on any presumption of common law marriage based on proof of cohabitation and reputation was unavailable to Employer. PPL v. Workers’ Compensation Appeal Bd. (Rebo), 5 A.3d 839 (Pa. Cmwlth. 2010) alloc. denied, 610 Pa. 623, 21 A.3d 1195 (Pa. 2011).

26. What is the criteria for establishing a "second injury" fund recovery?

27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations?**

The Pennsylvania Workers' Compensation Act permits resumption of benefits where benefits have been suspended or terminated provided there is: (1) recurrence of disability after full recovery; (2) recurrence of disability after return to pre-injury job with residual disability; (3) recurrence of disability after return to modified work with residual disability; or (4) recurrence of disability after commutation. Sections 413(a) and 434 of the Act, 77 Pa. C.S. § 772 and §1001.

Petitions to Reinstate Compensation Benefits following a termination of workers' compensation benefits must be filed within three years of the last date of payment of compensation. Section 413(a) of the Act, 77 Pa. C.S. § 772. See Chinh Huynh v. Workers' Compensation Appeal Bd. (Hatfield Quality Meats), 924 A.2d 717 (Pa. Cmwlth. 2007) (to establish a causal connection between his current condition and the prior work-related injury, a claimant must produce evidence that his disability has increased or recurred after the date of the termination and that his physical condition has actually changed in some manner).

Petitions to Reinstate Compensation Benefits filed after 500-week suspension are untimely. Cozzone v. WCAB (PA Municipal/East Goshen Twp., That Court held that because the claimant did not file a Petition for Reinstatement during the period in which compensation for partial disability was payable nor did Claimant petition for reinstatement within three years after his most recent payment, claimant did not retain the right to Petition for reinstatement. *Id.*

To establish entitlement to a reinstatement of workers' Compensation benefits following a return to work in a suspended status, the burden rests with the claimant to prove that (1) through no fault of his/her own, his/her earning power has once again been adversely affected by his/her disability; and (2) the disability which gave rise to the original injury continues. Magulick v. Workers' Compensation Appeal Bd. (Bethlehem Steel Corp.), 704 A.2d 176 (Pa. Cmwlth. 1997); Klarich v. Workers’ Compensation Appeal Bd.
(RAC's Ass'n), 819 A.2d 626 (Pa. Cmwlth. 2003). The Pennsylvania Supreme Court recently removed the "through no fault of his own" construct from its analysis and clarified that the employer may rebut the claimant's evidence in suspended benefits reinstatement cases under Section 413(a) "by showing . . . some circumstance barring receipt of benefits that is specifically described under provisions of the Act or in this Court's decisional law." Trevdan Bldg. Supply & Compservices v. Workers' Compensation Appeal Bd. (Pope), 9 A.3d 1221, (Pa. Cmwlth. 2010), citing Bufford v. Workers' Compensation Appeal Bd. (N. Am. Telecom), 2 A.3d 548, 558 (Pa. 2010). Once a claimant testifies that her work-related injury continues, the burden shifts to the employer to show the contrary, and when an employer fails to do so, the claimant's testimony, if credited by the WCJ, is sufficient to support a reinstatement of suspended benefits. Latta v. Workmen's Compensation Appeal Board (Latrobe Die Casting Co.), 537 Pa. 223, 642 A.2d 1083 (1994).

Where a claimant has been paid partial disability benefits pursuant to a supplemental agreement, he/she must file a Petition to Reinstate Compensation Benefits within three years after the final payment of the 500 week partial disability period. Stewart v. Workers' Compensation Appeal Bd. (Pa. Glass Sand/U.S. Silica), 756 A.2d 655 (Pa. 2000).

It must be noted that the burden of proof is different when a modification of benefits occurs due to the claimant's bad faith. Griffiths v. Workers' Compensation Appeal Bd. (Red Lobster), 760 A.2d 72 (Pa. Cmwlth. 2000). Specifically, where a claimant's benefits are modified due to bad faith conduct, the claimant must establish his medical condition worsened to the point he can no longer perform the employment previously found available. Ward v. Workers' Compensation Appeal Bd. (City of Philadelphia), 966 A.2d 1159 (Pa. Cmwlth. 2009); Nabisco Brands, Inc. v. Workmen's Compensation Appeal Bd. (Almara), 706 A.2d 877 (Pa. Cmwlth. 1998).

28. **What situation would place responsibility on the employer to pay an employee's attorneys fees?**

Counsel fees assessed as a cost against an employer may be awarded unless the employer meets its burden of establishing facts sufficient to prove a reasonable basis for a contest. Section 440 of the Act, 77 Pa. C.S. § 996. The purpose behind awarding attorney's fees under Section 440 of the Act is "to ensure that successful claimants receive compensation benefits that are undiminished by the costs of litigation," as well as "to discourage unreasonable contests of workers' claims." Wertz v. Workmen's Compensation Appeal Board (Department of Corrections), 683 A.2d 1287, 1293 (Pa. Cmwlth. 1996). See Boyer v. Workers' Compensation Appeal Board (First Capitol Insulation, Inc.), 740 A.2d 294, 296 (Pa. Cmwlth. 1999) (finding that "[a]n award of counsel fees is the rule and excluding counsel fees is the exception, to be applied only where the employer meets its burden of presenting sufficient evidence to establish that its contest was reasonable.") (citations omitted). See Wood v. Workers' Compensation Appeal Bd. (Country Care Private Nursing), 915 A.2d 181, 187-188 (Pa. Cmwlth. 2007) (employer's failure to present any evidence either contrary to Claimant's medical evidence or from which a
contrary inference could be drawn, other than one relating to the treating physician not being the operating physician, rendered its contest unreasonable); Jordan v. Workers' Compensation Appeal Bd. (Phila. Newspapers, Inc.), 921 A.2d 27 (Pa. Cmwlth. 2007) (unreasonable contest of claim petition where the employer did not issue an NCP even though it had no fact witnesses or medical evidence that the claimant did not suffer a work injury; rather, the employer disputed the claimant's disability during periods alleged in his claim petition); Johnstown Hous. Auth. v. Workers' Compensation Appeal Bd. (Lewis), 865 A.2d 999 (Pa. Cmwlth. 2005) (unreasonable contest of claim petition where the employer, at the time it filed its answer, had no basis to dispute occurrence of work injury, even though parties disagreed as to length of the claimant's disability).

If the employer is unsuccessful in the litigation of a Termination, Modification or Suspension Petition, but establishes a reasonable basis for filing the Petition, counsel fees will not be assessed against the employer. Mason v. Workmen's Compensation Appeal Bd. (Wheeling-Pittsburgh Steel Corp.), 143 Pa. Commw. 539, 600 A.2d 241 (Pa. Cmwlth. 1991), alloc. denied, 529 Pa. 671, 605 A.2d 335 (Pa. 1992). A reasonable contest is established when medical evidence is conflicting or susceptible to contrary inferences, and there is an absence of evidence that an employer's contest was frivolous or intended to harass a claimant. Orenich v. Workers' Compensation Appeal Board (Geisinger Wyoming Valley Medical Center), 863 A.2d 165, 171 (Pa. Cmwlth. 2004).


EXCLUSIVE/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

77 Pa. C.S. § 481 sets forth that the liability of an employer is exclusive under the Workers' Compensation Act and that an employer, insurance carrier, their servants and agents, employees, representatives, etc. shall not be liable to a third party for damages, contribution, or indemnification unless it is expressly provided for in a written contract entered into by the party alleged to be liable prior to the date of the occurrence which gave rise to the action. See Virtue v. Square D Co., 887 F. Supp. 98 (M.D. Pa. 1995) (statutory employer and temporary employer is covered by exclusivity provision); Wasserman v. Fifth & Reed Hospital, 442 Pa. Super. 563, 660 A.2d 600 (1995) (may sue employer for non-work related injuries); Dennis v. Kraveo Company, 2000 PA Super 319, 761 A.2d 1204 (2000) (if an injury is compensable under the Act, the compensation
provided by the Act is the employee's exclusive remedy).

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

The exclusivity provision of the Act essentially bars tort actions flowing from any work-related injury. However, consistent with the indemnification provision in the Act, 77 Pa. C.S. § 481(b), an employer may enter into an indemnity contract with a third party where the employer expressly assumes liability for the negligence of a third party which results in injury to the employer's employee.

Further, an employee or dependent does have the option to sue in tort or pursue a workers' compensation remedy if the employer is uninsured or not an approved self-insurer. Section 305 of the Act, 77 Pa. C.S. § 501. The 1993 Amendments (Act 44) permit restitution where an employer fails to insure.

Injuries caused by an act of a third person intended to injure an employee for reasons personal to the third person is specifically excluded from the Act. Section 301(c)(1) of the Act, 77 Pa. C.S. § 411(1).

Under the "dual capacity" doctrine, "an employer normally shielded from tort liability by the exclusive remedy principle may become liable in tort to his own employee if he occupies, in addition to his capacity as employer, a second capacity that confers upon him obligations independent of those imposed upon him as employer." Budzichowski v. Bell Telephone Co. of Pennsylvania, 503 Pa. 160, 167, 469 A.2d 111, 114 (Pa. 1983). (quoting from 2A Larson, WORKMEN'S COMPENSATION LAW, § 72.80). See Tatrai v. Presbyterian University Hosp., 497 Pa. 247, 439 A.2d 1162 (Pa. 1982). In order for an employer to be subject to suit to waive its statutory immunity, it must expressly assume liability for damages, contribution or indemnification in a written contract and the interpretation of those indemnity provisions are to be construed against the party seeking protection from liability or indemnification from the employer. Snare v. Ebensburg Power Co., 431 Pa. Super. 515, 637 A.2d 296 (1993) (general language was insufficient for employer to waive the protection of the Workers Compensation Act); Bester v. Essex Crane Rental Corp., 422 Pa. Super. 178, 619 A.2d 304 (1993); Morgan v. Harnischfeger Corp., 791 A.2d 1273 (Pa. Cmwlth 2002) (blanket indemnity clauses will not create liability).

30. Are there any penalties against the employer for unsafe working conditions?

None in the Act. Unsafe conditions may subject the employer to fines by OSHA, in addition to third party suits for intentional acts or knowledge attributable to the employer which was withheld from employees concerning an unsafe working environment.

31. What is the penalty, if any, for an injured minor?

Rights to compensation are not affected if a minor is employed or permitted to be employed in violation of laws relating to minors or if the minor obtains employment by misrepresenting his or her age. Section 301(b) of the Act, 77 Pa. C.S. § 421. If a minor
is employed in violation of Pennsylvania Child Labor law, 50% of the compensation rate may be awarded as a penalty and must be paid by the employer. Section 320 of the Act, 77 Pa. C.S. § 672.

32. What is the potential exposure for "bad faith" claims handling?

For actions claiming fraud in the carrier's handling of the compensation claim, the Act provides remedial provisions. See 77 Pa. C.S. § 701-797. The Supreme Court of Pennsylvania has held that the exclusivity provisions of the Workmen's Compensation Act "prohibit a tort action against the agents of the insurance carrier for injuries allegedly caused by their actions in handling the employee's compensation claim." Alston v. St. Paul Ins. Companies, 531 Pa. 261, 262, 612 A.2d 421, 421 (Pa. 1992). The Court has further indicated that the agents encompass “those individuals or entities who perform or assist in performing the functions of the insurance carrier in handling workmen's compensation claims as agents or employees of the carriers.” Id., 612 A.2d at 423.

As breach of contract claims do not seek redress for an "injury" as defined in the Act, the immunity provisions of the Act do not apply and claimant's claim for breach of contract is not barred either. 77 P.S. § 411(1).

The Pennsylvania Supreme Court has reconsidered the issue of intentional acts where the employer concealed, altered, or intentionally misrepresented information related to the work-related injury which resulted in aggravation of the injury. Liability under the Act is not afforded to compensation or insurance carriers or their agents when their negligent acts result in harm to an employee from a separate, non-work-related injury. Taylor v. Woods Rehab. Serv., 2004 PA Super 89, 846 A.2d 742, 746 (Pa. Super. 2004) Of note, post-injury emotional disorders or aggravations related to an insurance company's modification or termination of benefits do not constitute a compensable injury under the Act because they are not related to the work injury nor do they occur in the course and scope of employment. Gulick v. Workers' Compensation Appeal Board (Pepsi Cola Operating Co.), 711 A.2d 585 (Pa. Cmwlth. 1998).

The immunity of the employer has further been eroded where there was improper use of shock therapy on an employee who prior to the work-related injury suffered from post-traumatic stress syndrome. Taras v. Wausau Insurance Co., 412 Pa. Super. 37, 602 A.2d 882 (1992) (nurse acting on behalf of insurer allegedly told employee he had to undergo electroshock therapy in order to continue his eligibility for benefits). See McGinn v. Valloti, 363 Pa. Super. 88, 525 A.2d 732 (1987) alloc. denied, 517 Pa. 618, 538 A.2d 500 (1988) (employee's allegations that defendant's intentional fraudulent misrepresentation that she would be fired from her job if she sought independent medical advice was outside the scope of the protection guaranteed the employer under the Worker's Compensation Act); Martin v. Lancaster Battery Co. Inc., et al., 530 Pa. 11, 606 A.2d 444 (Pa. 1992) (employer intentionally withheld and altered blood test results for lead, causing aggravation of claimant's injury).

The Pennsylvania Workers' Compensation Act provided for penalties against
employers/insurers for delay in payment or for stopping payment of compensation without an appropriate Court Order or documentation under Section 435 of the Act. The amendments enacted by the legislature on June 24, 1996 (Act 57) in Section 435 increased penalties on employers/insurers up to 50%. Exclusivity provisions of the Worker's Compensation Act precluded employee's claim of bad faith conduct against the workers compensation insurer arising from the insurer's refusal to pay benefits and its general claims handling. Winterberg v. CNA Ins. Co., 868 F. Supp. 713 (E.D. Pa. 1994), affirmed, 72 F.3d 318 (3d Cir. Pa. 1995).

33. What is the exposure for terminating an employee who has been injured?

An employee can be terminated where the basis for the termination is wholly unrelated to the work-related injury, i.e., violation of company policy. The termination of an employee who is currently receiving partial disability benefits while working at a reduced wage entitles the employee to petition for immediate reinstatement of total disability benefits. The termination of an employee who is receiving temporary total disability benefits could result in a suit for wrongful termination against the employer. Section 306(a) of the Act, 77 Pa. C.S. §511; Shepherd v. Workmen's Compensation Appeal Bd., 66 Pa. Commw. 101, 443 A.2d 862 (Pa. Cmwlth. 1982).

Termination from employment is a possible disciplinary measure and the Court is cognizant that such action may ultimately impact a claimant's entitlement to compensation. Vista Int'l Hotel v. Workers' Compensation Appeal Board (Daniel), 560 Pa. 12, 742 A.2d 649 (1999). Where claimant has been terminated, his continued entitlement to benefits turns on whether he was terminated for conduct tantamount to bad faith. Coyne v. Workers' Compensation Appeal Bd. (Villanova Univ. & PMA Group), 942 A.2d 939, 945-6 (Pa. Cmwlth. 2008); See also Shop Vac Corp. v. Workers' Compensation Appeal Board (Thomas), 929 A.2d 1236 (Pa. Cmwlth. 2007) (an "illness" can be a good cause defense to a charge of willful misconduct due to excessive absenteeism and debilitating pain from a work-related injury can also serve as good cause); Greene v. Workers' Compensation Appeal Board (Hussey Copper, Ltd.), 783 A.2d 883 (Pa. Cmwlth. 2001) (employer must present conclusive evidence that the claimant violated that policy in order to rebut any loss of earnings as being through no fault of her own). The bad faith of a claimant is a factual determination to be made by the WCJ. Champion v. Workers' Compensation Appeal Board (Glasgow, Inc.), 753 A.2d 337 (Pa. Cmwlth. 2000).

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. Section 302(a) of the Act, 77 Pa. C.S. § 461; Poyser v. Newman & Company, Inc., 514 Pa. 32, 522 A.2d 548 (Pa. 1987) (Section 205, 77 Pa. C.S. § 72, immunizes an employee from tort actions for harm caused to a fellow employee but an exception is expressly made for the intentional infliction of harm). Note: The employer/insurance carrier has a subrogation right against the recovery of any third-party settlement.
35. **Can co-employees be sued for work-related injuries?**

Absent an intentional act by a third person or co-employee there is no other basis to overcome the immunity of the Act. Even a claim of intentional wrong by an employer may not overcome his immunity. *Poyser v. Newman & Company, Inc.*, 514 Pa. 32, 522 A.2d 548 (Pa. 1987) (no exception made for the intentional infliction of harm by employer under section 303(a) of the Act, 77 Pa. C.S. § 481(a)).

Case law from the Pennsylvania Courts has distinguished intentional acts from negligent failure to act. When an employee pursues a cause of action against a co-employee alleging that the co-employee's actions on the job caused the injury, the matter will be barred by the exclusive remedy provisions of the Act unless the employee is able to produce facts demonstrating that the co-employee's conduct against the employee was for reasons personal and not connected to the employment environment. *See Urban v. Dollar Bank*, 1999 Pa. Super 33, 725 A.2d 815 (1999) (defamation and the tort of malicious abuse of process are not injuries contemplated under the Act and, as such, are not wholly barred by the exclusivity provisions of the Act). Arguments or disputes that arise out of the employment relationship are deemed to have occurred in the course of employment and thus prevent any cause of action against the employer or the co-employee. *Hammerstein v. Lindsay*, 440 Pa. Super. 350, 655 A.2d 597 (1995) (employee's claims against the hospital were barred by the exclusivity provision of the Workmen's Compensation Act because appellant failed to plead facts that fell within the personal animus exception to the Act); *Snyder v. Specialty Glass Products, Inc.*, 441 Pa. Super. 613, 658 A.2d 366 (1995) (where the allegations of a claim have as their ultimate basis an injury compensable under the Act, the claim must be considered within the framework of the statute). *See also*, 77 Pa. C.S. §481.

36. **Is subrogation available?**

The employer is subrogated to the rights of the employee against a third party to the extent of compensation payable by the employer. Reasonable attorney's fees and other proper disbursements incurred in obtaining the recovery or compromised settlement are pro-rated between the employer and the employee. Recoveries against third parties that exceed compensation paid by the employer are paid to the employee. Section 319 of the Act, 77 Pa. C.S. § 671. Note that an employer is entitled to a credit/grace period against future medical payment resulting from the balance of recovery from a third party recovery. *Deak v. Workmen's Compensation Appeal Bd. (USX Corp.)*, 653 A.2d 52 (Pa. Cmwlth. 1994) (payments of medical expenses are compensation payments subject to subrogation rights against a claimant's recovery from a third party, and subject to a credit toward future compensation, where that recovery exceeds compensation paid at the time of the recovery).

Where the parties executed a Third-Party Settlement Agreement, which obliged the employer to pay its pro rata share of attorney fees and costs, and the employer was
subsequently granted its Petition for Modification the employer was entitled to reimbursement from the Supersedeas Fund for the monies paid to the claimant following the execution of the Third-Party Settlement Agreement in the form of its pro rata share of attorney fees and costs over the resulting grace period in addition to the unreimbursed balance of the benefits paid to the claimant. Department of Labor & Indus., Bureau of Workers’ Comp. v. Workers’ Compensation Appeal Bd. (Excelsior Ins.), 987 A.2d 855, 859 (Pa. Cmwlth. 2010).

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

An insurer's obligation to pay a medical bill does not arise until the insurer is in possession of appropriate bills and related reports. 77 Pa. C.S. § 531(5). Amendments under Act 57 require that the employer/insurer make payments to providers within thirty days (Section 306(f.1)(5) of the Act) of receipt of bills and records unless the employer/insurer disputes the reasonableness and necessity of the treatment provided (Section 306(f.1)(6) of the Act). Medical Cost Containment Regulations §§ 127.201 and 127.202, 34 Pa. Code §§ 127.201-127.202, require providers to submit requests for payment of medical bills on either the HCFA Form 1500 or the UB92 Form. Employers are not required to pay for the treatment billed until the bill is submitted on one of those forms. In addition, the Medical Cost Containment Regulations § 127.203, 34 Pa. Code § 127.203, requires that providers submit medical reports on appropriate forms explaining their treatment, and insurers are not obligated to pay for treatment until they receive such a report. Sims v. Workers' Compensation Appeal Bd. (Sch. Dist.), 928 A.2d 363, 369 (Pa. Cmwlth. 2007), alloc. denied, 596 Pa. 748, 946 A.2d 690 (2008).

Of note, in Kuemmerle v. Workers' Compensation Appeal Board (Acme Markets, Inc.), 742 A.2d 229 (Pa. Cmwlth. 1999), the Court held that a provider's failure to submit required written reports to the insurance carrier did not excuse an employer from penalties for failure to pay bills because it did not require medical reports in all instances for payment of medical services. See Seven Stars Farm, Inc. v. Workers' Compensation Appeal Bd. (Griffiths), 935 A.2d 921 (Pa. Cmwlth. 2007).

The determination by employer/insurer to challenge treatment as unreasonable and unnecessary requires that the employer/insurer proceed with Utilization Review Petitions, then Petitions for Reconsideration followed by Petitions for Review which are assigned to workers' compensation judges. Employees are entitled to interest in the amount of 10% on the bills from the date they were due in addition to potential penalties. Of import, an employer may not rely on a UR determination concerning the reasonableness and necessity of treatment rendered by a specific provider to justify nonpayment of medical bills for similar treatment rendered by a different provider. Schenck v. Workers' Compensation Appeal Bd. (Ford Electronics), 937 A.2d 1156, 1157 (Pa. Cmwlth. 2007).

Any employer who unilaterally stops paying an employee's medical bills based solely on causation issues, assumes the risk of exposure to possible penalty liability contingent upon a workers' compensation judge's ruling concerning the causal relationship of the medical cost. Listino v. Workmen's Compensation Appeal Bd. (INA Life Insurance
Furthermore, an employer may not avoid its obligation to pay medical bills based on sections of the Act which require the presentation of medical bills or reports prior to payment when the employer has acted to prevent the very treatment that would generate the bills or reports. McLaughlin v. Workers’ Compensation Appeal Board (St. Francis Country House), 808 A.2d 285 (Pa. Cmwlth. 2002), appeal denied, 573 Pa. 717, 828 A.2d 351 (Pa. 2003). See Brenner v. Workers’ Comp. Appeal Bd. (Drexel Indus.), 856 A.2d 213 (Pa. Cmwlth. 2004) (carrier must continue payment of claimant’s prescription medications according to the prescription card system that it established when claimant was not required by that procedure to submit bills or reports prior to payment and was not given prior warning that she could no longer use the prescription card to obtain the medicines).

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or authorization) at the administrative level?

The Act compels the moving party to assemble and be prepared to supply medical records and reports prior to filing a petition. Section 131.51 of the Special Rules of Administrative Practice and Procedure before Referees. Moreover, the parties must exchange medical information as part of the first hearing procedure, particularly anything intended to be used as evidence or exhibits. Section 131.52 of the Special Rules of Administrative Practice and Procedure before Referees. Additionally, the statute requires that parties exchange documents, records and discovery which are to be used in prosecution or defense of a case. Section 131.61(a) of the Special Rules of Administrative Practice and Procedure before Referees.

Subpoena power is vested in workers' compensation judges. Parties, however, can request the workers' compensation judge to issue subpoenas in a pending proceeding to compel production of medical evidence if it is relevant to the proceedings. Section 131.81 of the Special Rules of Administrative Practice and Procedure before Referees.

Additionally, Section 306(f.1)(2) of the Act requires medical providers to file periodic medical reports with the employer of the injured employee on the form prescribed by the Bureau (form LIBC-9). This section further relieves the employer from payment until a proper report is filed.

39. What is the rule on choice (a) Claimant's choice of physician; (b) Employer's right to a second opinion and/or Independent Medical Evaluation?

Employers must pay for reasonable surgical and medical services rendered by providers. This includes payment for an additional opinion when an invasive surgery may be necessary. Employers must establish a list of at least six designated healthcare providers no more than four of whom may be of a coordinated care organization and with no fewer than three being physicians. Section 306(f.1)(1)(i). The employee may obtain treatment for work-related injuries from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider. The employee may switch from one designated provider to another during this 90 day period. The employees
failure to comply with choice of physician procedures relieve the employer from liability for pay for the applicable period.

Should an invasive surgery be recommended by a panel physician, an additional opinion from a healthcare provider of the employee's choice may be obtained. Section 306(f.1)(i) of the Act. If the subsequent opinion differs, the employee may choose the course of treatment to follow, with the condition that the second opinion must outline with specificity and detail the course of alternative treatment.

Section 314 of the Act requires the Claimant to submit to medical examination by an appropriate health care provider chosen by the employer or insurance carrier. A demand for examination must be made of the Claimant. Then, if the Claimant refuses to attend or fails to attend, the employer must file a Petition to Compel Physical Examination and obtain an order from a Judge compelling the Claimant to attend the next scheduled exam. If the Claimant then fails to attend the next exam, without a reasonable excuse, the employer may file and pursue a Petition to Suspend Benefits. Whether or not the Claimant presents a reasonable excuse is a matter of discretion from each Judge. As a matter of practice, a new exam can be obtained every six months.

Claimant's healthcare provider may "participate" in the examination conducted by an employer's physician. In a concurring opinion, Mr. Justice Barr noted that legislature's enactment of 77 P.S. § 651(b) would permit the opposing expert a first-hand view of the examination process, through attendance and observation, but may not engage in any active conduct which might disturb the examining physician. Furthermore, the provider may be permitted to engage in other passive, non-disruptive activity during the exam, so long as such activity will not interfere with an employer's physician's ability to conduct an examination. Knechtel v. Workers' Comp. Appeal Bd. (Marriott Corporation), 594 Pa. 21, 23 (Pa. 2007).

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Reasonable medical benefits must be made available as and when needed. These include surgical and medical services, services rendered by duly licensed practitioners of the healing arts (including chiropractors), medicine and supplies, orthopedic appliances, and prosthesis. Section 306(f.1) of the Act, 77 Pa. C.S. § 531.

41. **What prosthetic devices are covered, and for how long?**

Prosthetic devices and charges are recoverable. Any prosthesis prescribed by a practitioner of the healing arts is as compensable as any other medical expense. Section 306(f.1) of the Act, 77 Pa. C.S. § 531. The employer is also responsible for artificial limbs, eyes, or other prostheses of the type and kind recommended by a treating physician in connection with the injury. Associated replacement or continuing treatment and medical care, as well as training to adaptation to a prosthetic device, is the responsibility of the employer. Such costs are mandated even where there is no loss of
earning power. Section 306(f.1)(i)(ii) of the Act.

42. Are vehicle and/or home modifications covered as medical expenses?


43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Currently, medical fee guides or schedules and other provisions for cost containment are incorporated into the Act. Section 306(f.1)(3)(i) of the Act; Title 34 Labor and Industry Part 8 Bureau of Workers' Compensation Chapter 127 Workers' Compensation Medical Cost Containment.

Briefly, the medical cost containment provisions cover calculations, medical fee updates, billing transactions, review of medical fee disputes and self-referrals. The complete Regulations can be found at http://www.pacode.com/secure/data/034/chapter127/chap127toc.html.

44. What, if any, provisions or requirements are there for "managed care"?

See answer 39.

PRACTICE AND PROCEDURE

In 2013, the Pennsylvania Department of Labor & Industry began using an electronic, web based system (WCAIS) to allow for electronic communication, online filing, and online document management and access to information. (http://www.portal.state.pa.us/portal/server.pt/community/wcais/20738)

45. What is the procedure for contesting all or part of a claim?

The employer/insurer must issue, within 21 days from an alleged occurrence, either a denial or notice of compensation payable reflecting a brief description of the reasons for the denial or the basis for acceptance of a claim. Section 406.1 of the Act, provides in
pertinent part:

(a): The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in subsection (d), on forms prescribed by the department and furnished by the insurer. The first installment of compensation shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employee’s disability. Interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum. Any payment of compensation prior or subsequent to an agreement or notice of compensation payable or a notice of temporary compensation payable or greater in amount than provided therein shall, to the extent of the amount of such payment or payments, discharge the liability of the employer with respect to such case.

(c): If the insurer controverts the right to compensation it shall promptly notify the employee or his dependent, on a form prescribed by the department, stating the grounds upon which the right to compensation is controverted and shall forthwith furnish a copy or copies to the department.

A workers' compensation claim may be contested and all liability for compensation denied by the use of a Notice of Workers' Compensation Denial that must be forwarded to the employee, served on the Bureau of Workers' Compensation with a date and description of the injury and full and complete reasons for the denial of compensation within 21 days after the employer has a notice or knowledge of an employee's disability. Section 406.1 of the Act, 77 Pa. C.S. § 717.1; Bureau Rules and Regulations § 121.13.

The June 24, 1996 amendments to Pennsylvania's Workers' Compensation Act (Act 57) provided for a Notice of Temporary Compensation Payable which permits the employer/insurer to initiate compensation payments for a period not to exceed 90 days without prejudice or admission of liability where there is uncertainty as to the compensability or extent of liability for an injury.

When the employee suffers no wage loss at the outset of the claim, but medical treatment is rendered, the employee is not considered disabled under the Act. In the past, many claims representatives did not file any Bureau forms, except for the Employer’s Report of Occupational Injury or Disease (form LIBC-344). As a result, courts awarded attorney fees for unreasonable contests pursuant to Section 440(a) of the Act. See Lemansky v. WCAB (Hagan Ice Cream Co.), 738 A.2d 498 (Pa. Cmwlth. 1999) and Waldameer Park, Inc. v. WCAB (Morrison), 819 A.2d 164 (Pa. Cmwlth. 2003). To rectify this situation, the Bureau revised the Notice of Compensation Payable (form LIBC-495) to include a specific section to indicate that only medical bills are being paid pursuant to the Act. If this Bureau document is filed to establish a Medical Only claim, it must clearly be marked as such, or it will be counted as a lost-time claim.
In Zuchelli v. Workers’ Compensation Appeal Bd. (Indiana Univ. of PA), 35 A.3d 801 (Pa. Cmwlth. 2011), the employer filed NCD admitting an injury but denying wage loss. WCJ found that the cause of the claimant's shoulder problems was not obvious and, therefore, unequivocal medical testimony was required, and the WCJ credited the employer's physician's testimony. The court also held that the employer's timely issuance of an NCD acknowledging a work injury, but disputing the claimant's disability, was proper as the claimant admittedly returned to work after the incident. There was no penalty for the employer’s use of NCD.

Medical bills are always subject to review, as well as calculated wages, suggestions for medical treatment, and ongoing payment of benefits. Section 406.1 of the Act, 77 Pa. C.S. § 717.1.

46. What is the method of claim adjudication?

A. Administrative level.

The first level of adjudication is before Workers’ Compensation Judges (formerly known as Referees) confirmed by the Bureau of Workers' Compensation and overseen by the Secretary of Labor and Industry for the state. Hearings are conducted in the same manner as a trial, with the exception of pre-trial hearings at which time stipulations are reached as to matters of fact and issues are narrowed. Cases may continue up to two years or longer until the conclusion of presentation of evidence by all parties.

Determinations in the form of Decisions with written orders are issued by the judges. The employee and the employer/insurer have an immediate right of appeal to the Workers' Compensation Appeal Board. An appeal must be filed within 20 days of the judge's decision.

B. Trial court.

See answer immediately above.

C. Appellate.

Appellate hearings are held initially before the Workers' Compensation Appeal Board. Further appeals are heard by the State Commonwealth Court and, in more limited circumstances, the Pennsylvania Supreme Court. See Pa. R.A.P. 1513.

47. What are the requirements for stipulations or settlements?

Awards of partial disability which extend until the expiration of 500 weeks can be the subject of lump sum commutations, which are subject to approval. Lump sum commutations end the employer's liability for indemnity benefits, but liability continues for medical expenses. Section 407 of the Act, 77 Pa. C.S. § 731. See Rollins Outdoor

A commutation of benefits that provides a lump-sum payment to a workers' compensation claimant is subject to a three year statute of limitations that runs from the date of commutation which requires that a claimant file a Petition to Reinstate Total Disability within three years from the date of the commutation. Mason v. Workmen's Compensation Appeal Bd. (ACME Markets), 156 Pa. Commonwealth 10, 625 A.2d 1271 (Pa. Commonwealth 1993).

The June 1996 amendments (Act 57) have added Section 449, which is known generally as the Compromise and Release section of the Act. This provision permits the parties to compromise and release any and all liability claimed to exist under the Act for an injury or death. The workers' compensation judges after the filing of a Petition with a completed Compromise and Release Form completed by the Bureau of Workers' Compensation must conduct an open hearing and then render a decision. The Compromise and Release Form addresses all phases of the claim from wage benefits to details of injury and vocational implications. The Compromise and Release Agreement requires a vocational rehabilitation evaluation of the employee which may be waived by the parties and particular emphasis must be given by the workers' compensation judge to the complete understanding and acknowledgment of the agreement by the employee. Of course, any employee must be informed of his right to legal representation in these circumstances. See 77 P.S. § 1000.5.

At common law, a compromise and release agreement can be set aside upon a clear showing of fraud, deception, duress or mutual mistake. Emery v. Mackiewicz, 429 Pa. 322, 240 A.2d 68, 70 (1968); Rago v. Nace, 313 Pa. Super. 575, 460 A.2d 337 (Pa. Super. 1983); Greentree Cinemas, Inc. v. Hakim, 289 Pa. Super. 39, 432 A.2d 1039 (Pa. Super. 1981). The party seeking to set aside such an agreement bears the burden of proof. Hanselman v. Consolidated Rail Corp., 158 Pa. Commonwealth 568, 632 A.2d 607 (Pa. Commonwealth 1993). The Court in N. Penn Sanitation, Inc. v. Workers' Compensation Appeal Bd. (Dillard), 850 A.2d 795 (Pa. Commonwealth Ct. 2004) saw no reason why the test for setting aside releases at common law should not be applied to workers' compensation cases. The Court went on to note that compared to fraud, deception or duress, the test to set aside a compromise and release on the basis of mistake is more stringent. See Consolidated Rail Corp. v. Portlight, Inc., 188 F.3d 93 (3d Cir. 1999) (underestimating damages or entering into a settlement before damages are adequately assessed is not a mutual mistake of fact); Bollinger v. Randall, 184 Pa. Super. 644, 135 A.2d 802 (Pa. Super. 1957) (settlements are necessarily based upon facts which are then available to the parties and there is always a risk that injuries may prove to be more serious or less serious than contemplated).

48. Are full and final settlements with closed medicals available?

Yes, in a Compromise and Release Agreement.
49. **Must stipulations and/or settlements be approved by the state administrative body?**

Lump sum commutations must be approved by a workers' compensation judge or have unanimous approval of Workers' Compensation Appeal Board commissioners after a commutation proceeding. However, an employee's degree of disability can be documented by the issuance of a notice of compensation payable and concluded by the execution of a final receipt or supplemental agreement. Such isolated periods of disability can be managed by the employee and the employer/insurer without the intervention of the court. Section 411 of the Act, 77 Pa. C.S. § 752; Special Rules of Administrative Practice Before Referees, Section 131.91(b).

**Mandatory Mediation:** Mandatory Mediations are now being scheduled by all Judges pursuant to Act 147. Following are the policies to be followed:

1) If either party believes the mediation would be futile that party must write to the assigned WCJ at least 14 days before the scheduled mediation.

2) If a party needs a postponement, the request must be made to the mediating WCJ at least 14 days before the scheduled mediation. A postponement of the mandatory mediation will not extend the mandatory trial schedule.

3) A representative of the employer/insurer with authority must present at the mediation. If the representative of the employer/insurer with authority could only be present by phone the mediating WCJ must be advised in advance.

4) A Mandatory Mediation Disclosure Report must be sent to the mediating WCJ at least 5 days before the mediation. It is preferred that the Mandatory Mediation Disclosure Report be sent to the mediating WCJ by mail, especially if there are attachments.

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**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

All employers must carry workers' compensation insurance. Private insurers are available, as well as the state workers' compensation insurance fund which handles states administrative bodies and other employers. Section 305 of the Act, 77 Pa. C.S. § 501.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

In order to be self-insured, an employer must make application to the department, showing financial ability to pay such compensation, along with a $100.00 fee, whereon
the department, if satisfied with the applicant's financial ability, will grant the application. Section 305 of the Act, 77 Pa. C.S. § 501.

B. For groups or "pools" of private entities.

The 1993 amendments include Article 8, which contains a detailed discussion of group insurance pooling. Generally, a group of "homogenous" (meaning employers who have been assigned the same classification series for at least a year or engaged in the same or similar types of business) may propose a self-insurance pool. Such groups must include five or more homogenous employers who band together in good faith for the purpose of becoming a fund. The aggregate net worth of the employers participating must equal or exceed one million dollars. Applications for homogenous employer groups are governed by detailed guidelines. Section 801 of the Act.

52. Are "illegal aliens" entitled to benefits or workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of "employee"?

Illegal aliens were held to be entitled to workers' compensation benefits given that they were actually employed, the absence of exclusionary language in the Act, and policy arguments against employers benefiting from hiring illegal aliens if they were to be denied coverage under the Act. The Reinforced Earth Co. v. Workers' Compensation Appeal Bd. (Astudillo), 810 A.2d 99 (Pa. 2002). Note: This case was a pre-Act 57 case and the employer had argued that due to the Claimant's illegal status, the employer could not show an earning capacity by referring him to open and available employment. The Court held that the employer does not need to satisfy Kachinski's job availability prong in order to prove entitlement to a suspension/modification. See Morris Painting, Inc. v. Workers' Compensation Appeal Bd. (Piotrowski), 814 A.2d 879 (Pa. Cmwlth. 2003) (an employer seeking a suspension of benefits need only demonstrate that a claimant is an unauthorized alien and that he or she has had a change in medical condition). It must be noted that an employer can only seek a suspension of weekly wage benefits and not medical benefits. Mora v. Workers' Comp. Appeal Bd. (DDP Contracting Co.), 845 A.2d 950 (Pa. Cmwlth. 2004).

In Kennett Square Specialties v. Workers' Compensation Appeal Bd. (Cruz), 31 A.3d 325 (Pa. Cmwlth. 2011), the WCJ suspended the claimant's benefits based upon a finding that the claimant was an undocumented alien worker. On appeal, the employer argued that the Board erred in determining that there was not substantial evidence in the record to support the WCJ's finding that the claimant was an undocumented alien. The WCJ's finding that the claimant was an undocumented alien, based solely upon the adverse inference that the WCJ drew from the claimant's refusal to answer the employer's questions regarding his immigration status, was not supported by sufficient evidence. While the WCJ did not err in drawing an adverse inference from the claimant's refusal to testify regarding his immigration status, the WCJ did err in relying solely on that adverse inference in finding that the claimant was an undocumented alien. Without more in the
record, there was insufficient evidence to support the WCJ's finding.

53. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act and are terrorist acts or injuries covered or excluded under workers' compensation laws?

There is no language in the Act excluding terrorist acts or injuries from coverage. However, if the terrorist was the employee, he/she would not be entitled to workers' compensation benefits on the basis that the injuries were self-inflicted.

54. How are workers' compensation settlements affected by Medicare trusts and liens?

Medicare's regulations (42 CFR 411.46) and manuals (MIM §§ 3407.7 and 3407.8 and MCM §§ 2370.7 and 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those settlements that are due to a compromise between the insurance carrier and the claimant. Medicare is a secondary payer to workers' compensation.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an injury that seriously restricts his/her daily living activities. The Regional Office of Medicare and Medicaid can review a proposed settlement including a set-aside arrangement and provide a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the workers' compensation settlement has adequately considered Medicare's interests per 42 CFR 411.46. If there is a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the total settlement date being greater than $250,000.00 Medicare will review the settlement. If the claimant is a Medicare beneficiary at the time of settlement, the Centers for Medicare & Medicaid Services (CMS) should review the proposed settlement, irrespective of the dollar amount.

55. How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?

When an insurance carrier has paid benefits to a claimant on the basis that the injury was not compensable under the Act, the carrier may recover from the workers' compensation carrier the sums paid, provided due diligence is exercised in asserting its claim. Section 319 of the Act, 77 Pa. C.S. § 671. The recovery amount is limited to the amount actually paid by the insurance company. See Associated Hosp. Serv. of Philadelphia v. Pustilnik, 439 A.2d 1149 (Pa. 1981) (where a health insurance carrier had made payments based upon a contractually established formula, the carrier's subrogation right is limited to the amount it can actually prove it paid on the employee's behalf).

56. What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPPA)?
The Act does not provide any requirements for confidentiality and privacy of medical records. As a practical matter, when obtaining psychological or psychiatric records, a records release is almost always required to be signed by claimant.

57. **What are the provisions for “Independent Contractors”?**

An independent contractor is not entitled to workers’ compensation benefits because of the absence of a master/servant relationship. Employee or independent contractor status is the crucial threshold determination that must be made to determine the eligibility for workers’ compensation benefits. A determination regarding the existence of an employer/employee relationship is a question of law that is determined on the unique facts of each case. The claimant bears the burden of establishing an employer/employee relationship in order to receive benefits. 77 Pa. C.S. §§ 21, 22.

In determining employee or independent contractor status, certain criteria serve as guideposts for review. These elements include control of the manner work is to be done, responsibility for result only, terms of agreement between the parties, the nature of the work or occupation or business, which party supplied the tools, whether payment is by time or by the job, whether the work is part of the regular business of the Employer, and the right to terminate the employment at any time. The primary factors to be considered are the control over the work to be completed and the manner in which it is to be performed. Guthrie v. Workers’ Compensation Appeal Bd. (Travelers’ Club, Inc.), 854 A.2d 653 (Pa. Cmwlth. 2004).

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific provisions. However, while numerous factors are considered in determining the existence of a master-servant relationship, “the crucial test, without doubt, is whether the alleged Employer assumes the right of control with regard not only to the work to be done by the alleged employee, but also the manner of performing it.” Heilner v. Workers’ Compensation Appeal Bd. (Aetna Freight Lines) 393 A.2d 1085, 1086 (Pa. Cmwlth. 1978). See Indicia of control may include: control over the manner in which work is to be done; responsibility for result; terms of the agreement; nature of the work or occupation; skills required for performance; which party supplies the tools; whether payment is by the time or by the job; whether the work performed is part of the regular business of the Employer; and the right of the Employer to terminate employment at any time. J. Miller Co. v. Mixter, 277 A.2d 867 (Pa. Cmwlth. 1971).

In Accountemps v. Workers’ Compensation Appeal Bd. (Myers), 120 Pa. Commw. 489, 548 A.2d 703 (Pa. Cmwlth. 1988), the Court addressed when one entity assigned an employee to perform work for another entity. The Accountemps Court held that the entity assigning the employee to the temporary job was the employer because that entity selected the employee for the assignment, determined the amount paid, and paid the salary. Furthermore, the borrowing employer did not have to train or instruct the
59. Are there any specific provisions for “Independent Contractors" pertaining to
owner/operators of trucks or other vehicles for driving or deliver of people or
property?

None. In Kelly, Claimant, a truck driver, was injured while delivering a load, for
defendant, in Pennsylvania. Under the parties’ lease agreement, Claimant was
responsible for providing truck drivers to defendant, who specified the pick-up and drop-
off points but not the delivery route. Evidence revealed that claimant, who was paid by
the load, also paid his own insurance. The Judge concluded that Claimant was an
independent contractor because he controlled the manner of his work performance, being
only responsible for the result. Respondent did not direct Claimant to use any particular
route but rather advised Claimant of where the load was to be picked up and delivered.
Claimant's compensation was based on the load and he was paid the insurance. While
other factors could have influenced the Judge to find that Claimant was an employee,
substantial evidence existed to support the referees findings that Claimant was an
independent contractor. Kelly v. Workers’ Compensation Appeal Bd. (Controlled

With respect to the leased truck situation, specific indicia of control may also include:
which party purchases insurance; which party selects the route to be taken; inspection
requirements; method of payment; whether the lessee's name is displayed on the vehicle;
the lessor's ability to contract with other shippers; and any requirement that the lessor
contract the lessee on a regular basis. Shreiner Trucking Co. v. Workers’ Compensation

60. What are the "Best Practices" for defending workers' compensation claims and
controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for
every business. The best means for reducing and eliminating that exposure is a strong
and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk
management and in dealing with the inevitable claim. The best approach to ameliorating
a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert,
experienced and business-friendly resource for review of an existing plan or to help write
a "Best Practices" plan to guide your workers’ compensation preparation and response.
No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Gary H. Hunter, Esquire
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Tel: (215) 545-7700

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

The parties must state how they are addressing Medicare’s interests, as well as conditional payments, in Paragraph 14 of the Compromise and Release Form (LIBC-755) when settling a workers’ compensation case. The actual language is left to the Parties to include based on the needs of the case. The form includes a subsection on which to allocate monies towards future medical expenses.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Per Act 16 of 2016, Pennsylvania approved a medical marijuana program. The use of medical marijuana is limited to a specific list 17 medical diagnoses:

- Amyotrophic lateral sclerosis;
- Anxiety disorders;
- Autism;
- Cancer, including remission therapy;
- Crohn's disease;
- Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies;
- Dyskinetic and spastic movement disorders;
- Epilepsy;
- Glaucoma;
- HIV / AIDS;
- Huntington's disease;
- Inflammatory bowel disease;
- Intractable seizures;
- Multiple sclerosis;
- Neurodegenerative diseases;
- Neuropathies;
- Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions;
- Parkinson's disease;
• Post-traumatic stress disorder;
• Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain;
• Sickle cell anemia;
• Terminal illness; and
• Tourette syndrome.

The list of approved conditions has been expanded since implementation of the program.

Patients must establish a bona fide relationship with a participating physician. Marijuana is limited to pills, oils, creams, tincture, liquid or vaporizable form. Marijuana flower/leaf/bud is available, but only for vaporizable consumption: smoking is not allowed. The statute specifically exempts insurers from having to cover medical marijuana treatment. 77 P.S. § 10231.2102. Employers are also free to prohibit an employee from working while taking medical marijuana for safety reasons. 77 P.S. § 10231.510.

Marijuana must be distributed through a licensed dispensary. There are 70+ dispensaries distributed widely throughout the state.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Pennsylvania does not allow recreational use of marijuana. Several localities have decriminalized possession of small amounts of marijuana, but such possession remains a civil offense.
1. **Citation for the state's workers' compensation statute.**


**SCOPE OF COMPENSABILITY**

2. **Who are covered “employees” for purposes of workers’ compensation?**

Employee means any person who has entered into the employment of or works under the contract of service or apprenticeship with any employer, except that in the case of a city or town other than the City of Providence, it only means those classes of employees as may be designated by a city, town, or regional school district. Any person employed by the State of Rhode Island, except for sworn employees of the Rhode Island State Police, who are otherwise entitled to the benefits of chapter 45-19 are subject to the state workers' compensation act. It does not include any partner or sole proprietor, independent contractor, or a person whose employment is of a casual nature, and who is employed otherwise than for the purpose of the employer's trade or business, or a person whose services are voluntary or who performs charitable acts, nor the members of the regularly organized fire and police departments of any town or city. Any person who on or after January 1, 1999, was an employee and became a corporate officer remains an employee, unless and until coverage under these chapters is waived. Any person who is appointed a corporate officer between January 1, 1999 and December 31, 2001, and was not previously an employee of the corporation, will not be considered an employee, unless that corporate officer opts back in under the state compensation act by providing the appropriate notice. As of September 1, 2000, corporate officers are considered employees unless they specifically opt out of the workers' compensation system. In addition, the Act applies to all employees, even if the corporation only has one employee.  R.I. Gen. Laws. 28-29-2(4).

It does not include a licensed real estate broker, sales person or appraiser, if substantially all
of the remuneration for their services performed is directly related to sales or other output rather than the number of hours they have worked. R.I. Gen. Laws. 28-29-7.1. It does not include farmers, nursery workers, arborists, or farm laborers unless the employer employs twenty-five or more laborers and meets other requirements. This particular statutory provision relating to arborists was in effect until January 1, 2009. R.I. Gen. Laws. 28-29-7.2.

Effective January 1, 2009, R.I. Gen. Laws §28-29-7.2 WAS amended to include arborists as employees under the Act.

There is a presumption that a person is an independent contractor where that person files a notice of designation as an independent contractor with the director of the Department of Labor on forms provided by the Department of Labor. Independent contractor status is unabated until revoked by the individual. R.I.Gen. Laws. 28-29-17.1

3. **Identify and describe any “statutory employer” provision.**

A general employer includes but is not limited to temporary help companies, employee leasing companies, and one, who for consideration and as the regular course of its business, supplies an employee with or without a vehicle to another person. R.I. Gen. Laws §28-29-2 (6) (i). A special employer means a person who contracts for services with a general employer for the use of an employee, a vehicle, or both. R.I. Gen. Laws §28-29-2(6) (ii). Where a general employer supplies to the special employer an employee and the general employer pays or is obligated to pay the wages or salaries of the supplied employee, then, notwithstanding the fact that the direction and control shall be in the special employer and not the general employer, the general employer, if subject to the provisions of the workers' compensation act, shall be deemed to be the employer. R.I. Gen. Laws §28-29-2(6) (iii).

Whenever the general employer enters into a contract or arrangement with a special employer to supply an employee or employees for work, the special employer shall require written documentation evidencing that the general employer carries workers' compensation insurance with no indebtedness for its employees for the term of the contract or arrangement. In the event that the special employer fails to obtain the written documentation from the general employer, the special employer is deemed to be the employer.

Immunity from civil suit pursuant to the Exclusive Remedy Doctrine applies to the general employer and the special employer.

4. **What types of injuries are covered and what is the standard of proof for each:**

A. **Traumatic or “single occurrence” claims.**

Injuries arising out of and in the course of employment connected with and referable to the employment are compensable. R.I. Gen. Laws § 28-33-1.

B. **Occupational disease (including respiratory and repetitive use).**
More than thirty (30) specific diseases are identified as compensable. R.I. Gen. Laws §28-34-2. The statute also identifies as compensable any disability "arising from any cause connected with or arising from the peculiar characteristics of the employment". R.I. Gen. Laws §28-34-2(33). Repetitive trauma could be considered an occupational disease under that definition. Carpal tunnel injuries, for example, have been characterized as an occupational disease arising from peculiar characteristics of the employment. Vater v. HB Group, 667 A.2d 283 (R.I. 1995). The employee's burden is to prove a disease arose out of and in the course of the employment. R.I. Gen. Laws 28-34-4. Impartial physicians may be appointed by the court to examine claimants and to provide a written opinion to the court. R.I. Gen. Laws 28-34-5.

5. What, if any, injuries or claims are excluded?

The following are excluded:


D. Claims for any period during which the employee was gainfully employed or found capable of gainful employment at an average weekly wage equal to or in excess of the pre-injury average weekly wage he or she was earning at the time of injury. R.I. Gen. Laws 28-33-17.1(a).

E. Weekly indemnity benefits to an employee imprisoned as a result of a conviction of a criminal offense. Further, an employee is not entitled to compensation when disposition of criminal charges results in a conviction and the employee is given credit for time served in that the time served for which he/she is given credit becomes a period served as a result of the conviction. R.I. Gen. Laws §28-33-17.1(c).

F. Employees that are classified as a seaman under the Jones Act do not qualify for recovery under the workers compensation system. Benders v. Bd. Of Governors, 636 A.2d 1313 (R.I. 1994).

6. What psychiatric claims or treatments are compensable?

Disablement from mental injury caused by or accompanied by identifiable physical trauma or from a mental injury caused by emotional stress resulting from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees encounter daily without serious mental injury is compensable. R.I. Gen. Laws § 28-34-2(36).
addition, the Rhode Island Supreme Court has acknowledged that a flow-from psychological injury is compensable where such psychological injury is solely caused by the work-injury. *Amick v. Nat’l Bottle*, 507 A.2d 1352 (R.I. 1986).

7. **What are the applicable statutes of limitation?**

The statute of limitation for all workers compensation claims is two (2) years. The toll begins after the occurrence or manifestation of an injury or death. If an injury or disease is latent or undiscovered, the toll does not begin until the claimant knew or should have known of the existence of the injury and the causal relationship to his or her employment, or disablement, whichever is later. In any case in which weekly compensation benefits have been paid in which the employer has failed to file required notices, the right to petition for benefits shall be preserved without limitation. R.I. Gen. Laws §28-35-57. A claimant may petition to amend a claim without limitation if the purpose of the petition is to include another part of the body that was injured at the same time as the original injury. *Ponte v. Malina Co.*, 745 A.2d 127 (R.I. 2000). However, no claim will be acknowledged if filed more than ten (10) years after the date of the final payment made to the employee or the date of entry of the last decree, whichever is longer.

8. **What are the reporting and notice requirements for those alleging an injury?**

No benefits are paid unless a notice of injury is given to the employer within thirty (30) days of the happening or manifestation of the injury. R.I. Gen. Laws §28-33-30. However, this provision is generally not followed in practice.

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**


   B. **Willful misconduct, “horseplay”, etc.**

   Employers may not allege negligence or assumption of the risk as a defense. R.I. Gen. Laws 28-29-3. The Rhode Island Supreme Court has interpreted this to mean that an employee may recover from injuries sustained where the employee was a participant in horseplay, provided the injury arose in the course of employment. *Carvalho v. Decorative Fabrics Co.*, 366 A.2d 157 (R.I. 1976).

   C. **Injuries involving drugs and/or alcohol.**

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Any employee collecting benefits has an affirmative duty to report any earnings and could be subject to civil and/or criminal liability as well as forfeiture of benefits for failure to do so. An employer may recover overpayments of benefits, along with costs and attorney's fees. A violation is also considered criminal larceny according to the criminal statutes of the State of Rhode Island. R.I. Gen. Laws §28-33-17.2.

It is unlawful to: (1) knowingly make or cause to be made any false or fraudulent material statement or representation for the purpose of obtaining or denying compensation or regarding the continuation, termination or modification of benefits; (2) knowingly make or cause to be made any false or fraudulent statements with regard to entitlement to benefits with the intent to discourage the employee from pursuing them; (3) willfully misrepresent or fail to disclose any material fact in order to obtain workers' compensation insurance at a lower rate; (4) willfully fail to report or provide false or misleading information regarding ownership changes as required by an approved experienced rating plan or regulations promulgated by the Insurance Commissioner; or (5) knowingly assist, aid and abet, solicit, or conspire with any person who engages in any such unlawful act. Anyone who engages in prohibited conduct is subject to criminal fines up to the greater of fifty thousand dollars ($50,000.00) or double the value of the fraud, or by imprisonment of up to five (5) years, or both. R.I. Gen. Laws §28-33-17.3(b).

An uninsured employer who disposes of property in any way with the intent to avoid the payment of compensation is guilty of a misdemeanor which is punishable by a fine that is calculated for each day of noncompliance or by imprisonment of up to one year or both. R.I. Gen. Laws §28-36-16. Upon petition by the employee, employer or other interested party, the Workers' Compensation Court may vacate, modify or amend any final Decree entered within a six (6) month period prior to the filing of the petition if the Decree was procured by fraud. R.I. Gen. Laws §28-35-61.

11. **Is there any defense for falsification of employment records regarding medical history?**

Rhode Island law provides that a claim is barred from the date the employee commences employment for two (2) years if the employee willfully provided false information as to his or her ability to perform the essential functions of the job. R.I. Gen. Laws §28-35-57.1. However, this provision has been rendered void by the implementation of the Americans with Disabilities Act.

An occupational disease claim is not payable if an employee willfully and falsely represents in writing that he or she has not previously had an occupational disease which is the cause of disability or death. R.I. Gen. Laws 28-34-7.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**
No compensation is allowed for the injury or death of an employee occasioned by or during voluntary participation in an employer-sponsored social or non-professional athletic activity. R.I. Gen. Laws 28-33-2.1. However, See, Beauchesne v. David London & Co., 375 A.2d 1920 (R.I. 1977) (when a recreational activity is sufficiently employment-related and the employer permits the use of alcohol, the injury is compensable).

13. Are injuries by co-employees compensable?

Yes, if they arise out of and in the course of the employment. R.I. Gen. Laws 28-33-1. An injury received from fighting with another employee, however, is an injury that falls outside the course of employment. See Gaudet v. Glas-Kraft, 163 A.2d 213 (R.I. 1960).

14. Are acts by third-parties unrelated to work but committed on the premises, compensable (e.g. “irate paramour” claims)?

No. Rhode Island has adopted the “actual risk” theory for determining whether an act may trigger an entitlement to workers’ compensation benefits. The employee bears the burden of showing that the risk of injury was in fact a risk of his or her employment. Maggiacomo v. R.I. Pub. Transit Auth., 508 A.2d 402, 403 (R.I. 1986).

BENEFITS

15. What criteria are used for calculating the average weekly wage?

For full-time or regular employees, divide the gross wages, inclusive of overtime pay, provided that bonuses and overtime shall be averaged over the length of the employment, but not in excess of the preceding fifty two (52) week period, earned by the injured worker at employment by the employer in whose service he or she was injured during the thirteen (13) calendar weeks immediately preceding the week in which he or she was injured by the number of calendar weeks during which, or any portion of which, the worker was actually employed by that employer, including any paid vacation time. When the employment prior to the injury is less than a net period of two (2) calendar weeks, his or her weekly wage is considered to be equivalent to the average weekly wage prevailing in the same or similar employment at the time of the injury. Where the employee has worked for more than one employer during the thirteen (13) weeks immediately preceding an injury, the average weekly wage is calculated based on wages earned from all those employers in that period. Special expenses are not considered part of the employee's wages.

In seasonal occupations, the average weekly wage is taken to be 1/52nd of the total wages which the employee has earned during the twelve (12) calendar months immediately preceding the injury. Wages of part-time employees are the gross wages earned during the number of weeks so employed or of weeks in which the employee worked, up to a maximum of twenty six (26) calendar weeks immediately preceding the date of injury, divided by the number of weeks employed, or by twenty six (26). "Part-time" means working by custom
and practice under a verbal or written employment contract, in force at the time of the injury, where the employee agrees to work or is expected to work on a regular basis less than twenty (20) hours per week. R.I. Gen. Laws §28-33-20.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Weekly compensation is equal to seventy five percent (75%) of the employee's average weekly spendable base wage, inclusive of overtime pay, provided that bonuses and overtime shall be averaged over the length of employment but not in excess of the preceding fifty two (52) week period. Compensation for total disability shall not exceed one hundred and ten percent (110%) of the state average weekly wage. R.I. Gen. Laws §28-33-17(a). There is no minimum. The calendar for temporary partial disability is the same. R.I. Gen. Laws §28-33-18(a). In any event, the employee is not entitled to receive more than eighty percent (80%) of his average weekly wage including dependency benefits, except where death benefits are applicable.

Spendable wages are the employee's gross average weekly wages, including any gratuities reported as income, reduced by an amount determined to reflect amounts which would be withheld from such wages under federal and state income tax laws, and under the Federal Insurance Contributions Act (FICA), relating to Social Security and Medicare taxes. R.I. Gen. Laws §28-33-17(a)(3)(i).

In calculating the average weekly wage for employees who have multiple employers, simply add the aggregate of earnings and divide by the number of weeks worked, up to thirteen (13) weeks preceding the injury for full-time employees and twenty six (26) weeks for part-time employees. R.I. Gen. Laws 28-33-20.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employee may file a petition for payment with the court after waiting twenty one (21) days from the date of the injury. R.I. Gen. Laws 28-35-12(a). There is no requirement that the employer accept or reject a claim.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

The employee must be out for four (4) days before recovering benefits. Compensation, when awarded, commences on the fourth day. R.I. Gen. Laws §28-33-4.

19. **What is the standard/procedure for terminating temporary benefits?**

In practice, there are two practical ways to suspend benefits. First, benefits may be terminated after the employee and employer have signed a suspension agreement. R.I. Gen.
Laws 28-35-7.1. Second, the employer or insurer can terminate benefits by obtaining an order of the court. The first step in obtaining a court order is to notify the court and employee of the intent to discontinue benefits with an affidavit describing the factual basis for discontinuance and a copy of medical reports to further justify discontinuance. This notice must be filed fifteen (15) days prior to the date of proposed discontinuance. R.I. Gen. Laws 28-35-46.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

Yes. R.I. Gen. Laws §28-33-18. The only difference between benefits for total incapacity and partial incapacity is that, when an employee receives total incapacity benefits, he/she is also entitled to dependency benefits at a rate of fifteen dollars ($15.00) per week for each qualified dependent. R.I. Gen. Laws 28-37-10.

21. **What disfigurement benefits are available and how are they calculated?**

Disfigurement is compensable at a maximum of ninety dollars ($90.00) per week and a minimum of forty five dollars ($45.00) per week and is payable in a lump sum within fourteen (14) days of the entry of the Decree, Order or agreement of the parties, in addition to all other applicable sums. The number of weeks awarded for permanent disfigurement may not exceed five hundred (500) weeks. R.I. Gen. Laws §28-33-19 (a) (3) (i).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

A. **How many weeks are available for scheduled member/parts, and the standard for recovery?**

For injuries to scheduled members, an employee receives weekly payments equal to one-half of the average weekly earnings of the injured employee, but in no case more than ninety dollars ($90.00) nor less than forty five ($45.00) per week. For injuries sustained on or after January 1, 2012 specific compensation is compensable at a maximum rate of one hundred and eighty dollars ($180.00) per week and a minimum rate of ninety dollars ($90.00) per week. Scheduled members and corresponding number of weeks of benefits available for each are:

<table>
<thead>
<tr>
<th>Bodily Loss</th>
<th>Number of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of arm at or above the elbow</td>
<td>312</td>
</tr>
<tr>
<td>Loss of leg at or above the knee</td>
<td>312</td>
</tr>
<tr>
<td>Both hands</td>
<td>312</td>
</tr>
<tr>
<td>Loss of Sight in one or both eyes</td>
<td>312</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>312</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>312</td>
</tr>
</tbody>
</table>
One arm 244
One foot 205
Sight in one eye 160
Thumb 35-75
Index finger 25-46
Second finger 16-30
Middle finger 12-25
Fore finger (ring finger) 12-25
Little finger 10-20
Great toe 20-38
Any other toe 10


Proportionate benefits as outlined above shall be paid for the period of time that the partial loss by severance bears to the total loss by severance. R.I. Gen. Laws §28-33-19(a) (1).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total occupational deafness of one ear</td>
<td>75</td>
</tr>
<tr>
<td>Total occupational deafness of both ears</td>
<td>244</td>
</tr>
</tbody>
</table>

Total occupational deafness in one ear and total occupational deafness in both ears shall be paid in addition to all other compensation applicable pursuant to the Rhode Island Workers’ Compensation Act at a weekly rate of not more than ninety dollars ($90.00) per week and not less than forty-five dollars ($45.00) per week.

B. Number of weeks for “whole person” and standard for recovery.

Weekly payment calculation for permanent body disfigurement may not exceed five hundred (500) weeks.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Yes. An employer or injured employee with total disability or permanent partial disability, to whom the insurance carrier has paid compensation for three (3) months or more, may file a petition with the Workers' Compensation Court requesting approval of a rehabilitation program or may mutually agree to a rehabilitation program. R.I. Gen. Laws §28-33-41(b) (1). Thereafter, the Workers' Compensation Court will approve of a program that conforms to the rules of practice of the Rhode Island Workers' Compensation Court. Compensation payments may not be terminated while the employee is participating in a rehabilitation program approved of by the Workers' Compensation Court or agreed to by the parties. However, compensation payments may be suspended where an employee willfully refuses to participate in such plan. R.I. Gen. Laws §28-33-41(c). Upon completion of a vocational rehabilitation plan, the vocational counselor must recommend an earnings capacity.
24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Total disability benefits, whether permanent or temporary, are calculated in the following manner: (1) the employee’s earnings for the thirteen (13) weeks prior to the injury are averaged to determine the “gross wages”; (2) a spendable earnings guide is used to determine what percentage of that gross income should be considered “spendable earnings”, considering also the number of exemptions claimed by the employee; and (3) the employee’s compensation rate is seventy five percent (75%) of the spendable earnings. Bonus payments are averaged over fifty two (52) weeks or the length of employment, whichever is shorter. Overtime pay is specifically included in the calculation of the average weekly wage. Once the base compensation rate is calculated, a total of fifteen dollars ($15.00) per dependent is added to the weekly base compensation rate. The aggregate of those amounts, however, may not exceed eighty percent (80%) of the employee’s average weekly wage (This limit does not apply when receiving weekly benefits resulting from the death of an employee in connection with the work-related injury). R.I. Gen. Laws §28-33-17 and R.I. Gen. Laws §28-33-20. There are no minimum rates. The maximum rate cannot exceed one hundred and ten percent (110%) of the state average weekly wage.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expense.**

The employer pays twenty thousand dollars ($20,000.00). R.I. Gen. Laws §§28-33-16 and 28-33-23.

B. **Dependency claims.**

The employer pays the dependents of the employee, from the date of his or her injury, a weekly payment equal to the rate that would have been payable for total incapacity to the deceased employee. If the dependant is a surviving spouse upon whom there are dependent one or more children of the deceased employee, the employer pays the surviving spouse the weekly rate for total incapacity the deceased employee would have been entitled to receive plus forty dollars ($40.00) per week for each dependent child. Upon remarriage or death of the surviving spouse, or if there is no surviving spouse, then upon the death of the employee, the compensation benefits are paid to the dependent children. Benefits for children terminate at age eighteen (18), or age twenty three (23) if the child is enrolled as a full-time student in an accredited college.

For partial dependents, the employer pays the dependent from the date of the injury weekly compensation equal to the amount of the average weekly contribution by the employee to such partial dependents not exceeding the weekly payments provided for persons wholly dependent. R.I. Gen. Laws §28-33-12.

26. **What are the criteria for establishing a “second injury” fund recovery?**

27. **What are the provisions for reopening a claim for worsening of condition, including applicable limitations periods?**

The Workers’ Compensation Court has discretion to reopen a claim upon its own motion or by petition within ten (10) years from the time of the agreement or Decree. R.I. Gen. Laws §28-35-45. The employee must first request relief from the employer before filing a petition with the Workers' Compensation Court.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

Attorney's fees are awarded to employee's counsel who successfully prosecute petitions for compensation, petitions for medical expenses, petitions to amend a preliminary order or memorandum of agreement, and all other employee petitions, except petitions for lump sum commutations, and to employees who successfully defend, in whole or in part, proceedings seeking to reduce or terminate any or all workers' compensation benefits. R.I. Gen. Laws §28-35-32. In petitions involving commutations and other settlements, the court awards no more than a twenty percent (20%) counsel fee which is deducted from the gross settlement amount paid to the employee. R.I. Gen. Laws § 28-33-25.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

**A. Scope of immunity.**

The right to compensation for an injury is in lieu of all rights and remedies as to that injury now existing, either at common law or otherwise against an employer or its directors, officers, agents or employees. R.I. Gen. Laws §28-29-20.

**B. Exceptions (intentional acts, contractual waiver, “dual capacity”, etc.).**

An employee of an employer subject to the workers compensation statute has waived a right to common law recovery for personal injuries unless the employee expressly notifies the employer in writing that he or she reserves those rights at the time of hire. A copy of this letter must also be sent to the Director of Labor within ten (10) days after the employer was given notice. R.I. Gen. Laws 28-29-27. Since an injury to reputation is not an injury within the meaning of the workers’ compensation statute, the exclusivity provision does not bar an employee from maintaining a defamation action against an employer or co-workers. *Nassa v. Hook-SupeRx*, 790 A.2d 368 (R.I. 2002).
30. **Are there any penalties against the employer for unsafe working conditions?**


31. **What is the penalty, if any, for an injured minor?**

If the minor is illegally employed in violation of the law of the state or of the United States relating to the employment of minors, the compensation is treble the amount otherwise payable. R.I. Gen. Laws §28-33-22(a). In fixing the amount of any compensation due, allowance is made for any sum which the employer may have paid to any minor or to his or her dependents on account of the injury, except such sums as the employer may have expended or directed to be expended for medical, surgical or hospital service. R.I. Gen. Laws §28-33-22(b). Misrepresentation of age at the time of employment does not prevent recovery of additional compensation. *Deignan v. Cowen Plastic Prods. Corp.*, 206 A.2d 534 (R.I. 1965).

32. **What is the potential exposure for “bad faith” claims handling?**

Generally, in Rhode Island, there is no fiduciary obligation between the workers' compensation claimant and the insurance carrier. The insurer is within their right to deny any claim. See, *Cianci v. Nationwide Ins. Co.*, 659 A.2d 662, 664-666 (R.I. 1995). However, if any judge determines that any proceedings have been brought, prosecuted, or defended without reasonable grounds, the entire costs are assessed upon whoever is responsible. If counsel is responsible, the appropriate disciplinary authority is notified. If a subsequent order requires that additional compensation be paid, a penalty of double the amount of retroactive benefits ordered must be paid to the employee and such penalty shall not be included in any formula utilized to establish premium rates for the workers' compensation insurance. R.I. Gen. Laws §28-33-17.3.

33. **What is the exposure for terminating an employee who has been injured?**

If the employee demands and qualifies for his/her “right to reinstatement”, and the employer refuses to reinstate the employee, the Workers' Compensation Court is authorized to order reinstatement, award back pay, and award the cost of fringe benefits lost during such period. The court may also require the employer to reimburse the carrier for indemnity benefits. R.I. Gen. Laws 28-33-47(d).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. The employee may pursue a claim against a third person where the work-related event or occurrence creates legal liability in such person, other than the employer, while pursuing a workers' compensation claim against its employer. The employee may commence
proceedings simultaneously against both the third person and the employer. The employee is entitled to receive both damages and compensation but an employee is prohibited from double recovery because the workers' compensation carrier has a lien with respect to indemnity and medical benefits paid. R.I. Gen. Laws §28-35-58.

35. **Can co-employees be sued for work-related injuries?**


36. **Is subrogation available?**

Yes. When any employer is insured against liability for compensation and the insurer has paid any compensation for which the employer was liable and has assumed the liability of the employer, the insurer is subrogated to all the rights and duties of the employer and may enforce those rights in its own name. R.I. Gen. Laws §28-36-8. The insurer's lien is applied to the gross amount of the employee's settlement. The employer is then responsible for payment of its pro rata share of the employee's costs and attorney's fees.

The insurer and/or the self-insured employer's rights may be subrogated to all the rights and duties of the injured employee. In any case in which the employee, or in the case of death, the administrator of the employee's estate, neglects to exercise the employee's right of action by failing to file a lawsuit against such third person within two (2) years and eight (8) months after the injury, the self-insured employer or the employer's insurance carrier may proceed and shall be subrogated to the rights of the injured employee, or in the case of death, to the rights of the administrator to recover against such person, upon providing the employee or the administrator, in the case of death, with appropriate notice of the impending action. R.I. Gen. Laws §28-35-58.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Compensation for medical expenses and other services is due and payable within twenty one (21) days from the date a request is made for payment. R.I. Gen. Laws §28-33-8(f) (1). In the event payment is not made within twenty one (21) days from the request, the provider may add interest at twelve percent (12%) per annum. R.I. Gen. Laws §9-21-10. The twenty one (21) day period begins on the date the insurer receives a request with the appropriate documentation required to determine whether the claim is compensable and the payment requested is due. R.I. Gen. Laws §28-33-8(f) (2).

The employer has fourteen (14) days to pay court ordered medical bills. R.I. Gen. Laws 28-35-12(a).
38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Any party to a claim must provide to opposing counsel all medical reports and documentary evidence which it possesses and intends to present at the pretrial conference. R.I. Gen. Laws §28-35-20(b). No charges shall be assessed for producing the record if necessary for the purpose of supporting a claim under the provisions of the workers' compensation act upon request by the employee for medical records. The medical provider shall furnish the records requested within thirty (30) days of the request. Moreover, any party may subpoena the records of an employee provided that the employee first receives twenty one (21) days notice of the subpoena. R.I. Gen. Laws §23-17-19.1(16).

39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.

The employee initially has the freedom of choice to obtain health care, diagnosis and treatment. The initial provider may, without prior approval, refer the employee to any qualified specialist. If the employer/insurer has a Preferred Provider Network approved by and kept on record with the Medical Advisory Board, any change by the employee from the initial health care provider can only be to a health care provider listed in the network. If the employee seeks to change to a health care provider not listed, the employee must obtain the employer/insurer's approval. Examination or treatment at a facility providing emergency care or by a physician under contract with the employer/insurer does not constitute the employee's initial choice. The employee may treat with more than one provider. R.I. Gen. Laws §28-33-8(a).

B. Employer’s right to a second opinion and/or Independent Medical Examination.

Upon request by the employer, the employee is required to submit him or herself to an examination by a physician or rehabilitation counselor in cases where the employee has received compensation for a period of more than three (3) months, furnished and paid for by the employer. The employee has the right to have a physician that he/she requests present at the examination. The employer must pay the expenses associated with having that physician present. There is no requirement, according to this provision, that the employee needs to be receiving benefits as a condition precedent to the requirement of an examination. R.I. Gen. Laws §28-33-34. The employer may request or petition the court to appoint an Impartial Medical Examiner or a Comprehensive Independent Health Care Review Team to act as medical examiner, at the cost of the employer. R.I. Gen. Laws §28-33-35.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?
The employer must promptly provide such reasonable medical, surgical, dental, optical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus for a period as necessary in order to cure, rehabilitate or relieve the employee from the effects of his or her injury. R.I. Gen. Laws §28-33-5. The employer/insurer is not responsible for payment for major surgery unless the employee obtains written authorization for same from the Workers’ Compensation Court, the employer or the insurance carrier, except in instances where it would be detrimental or fatal to the employee to do so.

Palliative care may be available, which includes services by a licensed physician for twelve (12) visits, after reaching maximum medical improvement. Additional palliative care must be authorized by the insurer or self-insured employer. R.I. Gen. Laws §28-33-10(c).

41. Which prosthetic devices are covered, and for how long?

The employer provides all medical, optical, dental and surgical appliances and apparatus required to cure, relieve or rehabilitate the employee from the effects of the injury, including, but not limited to the following: ambulance and nursing service, eyeglasses, dentures, braces and supports, artificial limbs, crutches, and other similar appliances. There is no time limit, only a requirement that such care is reasonable and necessary. The employer is not liable to pay for or provide hearing aids or other amplification devices. R.I. Gen. Laws §28-33-5.

42. Are vehicle and/or home modifications covered as medical expenses?

In *Savaria v. DiSano*, 373 A.2d 820 (R.I. 1977), the Rhode Island Supreme Court denied a paralyzed employee's request that he be provided with an automatic lift or elevator, despite his physician's testimony that an elevator would relieve him from the effects of his injury. The Court explained that to be chargeable to the employer under R.I. Gen. Laws § 28-33-5, benefits must be medical in nature.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Any dispute as to the reasonableness of the amount of any medical charge is determined by the Workers' Compensation Court after a hearing. The Director of the Department of Labor and Training has established a schedule of rates of reimbursement for those medical and dental services, excluding non-physician hospital charges, which are most often provided to employees receiving workers' compensation. The liability of the employer/insurer for any such charges and/or payment is limited to the rates of reimbursement set forth in the schedule. Petitions may be filed in cases where the reasonableness of a particular rate is questioned, but the court is limited to a determination as to whether the rate as applied in that particular case is reasonable. The burden is on the petitioner seeking payment of the medical bill to establish by a preponderance of the evidence that the rate is reasonable in light of the peculiar nature of the services performed or other circumstances requiring a greater than normal expertise or expenditure of time or effort in providing the service. R.I. Gen. Laws §§28-33-5, 28-33-7 and 28-33-8.
44. **What, if any, provisions or requirements are there for “managed care”?**

An employer or insurer may petition the Director of the Department of Labor and Training and the Director of Business Regulation for authority to provide health care, diagnosis and treatment through any health plan, health maintenance organization, or managed care provider licensed by the state. The directors have discretion to approve or disapprove such a petition and approval of both directors is required to authorize the managed care program. R.I. Gen. Laws §28-33-8.1.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Any person in interest may file with the administrator of the Workers' Compensation Court a petition setting forth the names and residences of the parties, the facts relating to the employment at the time of the injury, the cause, extent and character of the injury, the amount of wages, earnings, or salary received at the time of the injury, and the employer's knowledge or notice of the occurrence of the injury, and such other facts as may be necessary. There is no burden on the respondent/employer to "controvert" a claim. R.I. Gen. Laws §28-35-12.

46. **What is the method of claim adjudication?**

**A. Administrative level.**

All matters originate at the Workers’ Compensation Court.

**B. Trial court.**

Before any case proceeds to trial, the judge conducts a mandatory informal pretrial conference within twenty one (21) days of the date of filing of a petition to expedite the case and to reduce the issues in dispute. The judge renders a pretrial order at the close of the conference which sets forth in a simplified manner any agreements reached between the parties and grants or denies, in whole or in part, the relief sought by the petitioner. Any payments ordered including, but not limited to, weekly benefits, medical expenses, costs and attorney's fees, must be paid within fourteen (14) days of the entry of the order. R.I. Gen. Laws §28-35-20.

Any party aggrieved by the entry of a judge's order may claim a trial on any issue that was not resolved by agreement at the pretrial conference by filing with the Administrator of the Workers' Compensation Court, within five (5) days of the date of the entry of the order, a claim for trial. If no timely claim for trial is filed, or is filed and withdrawn, the pretrial order becomes a final decree of the court. All trials are assigned for hearing and decision to the same judge who presided over the pretrial conference. All trials are de novo, except that issues resolved by agreement at the conference may not be reopened. If after full trial an
employee's original petition is denied, the insurer may recoup monies paid pursuant to a pretrial order which granted the petition from the State Administrative Fund. The employee is not responsible for reimbursement. R.I. Gen. Laws §28-35-20.

C. Appellate.

Trial decisions may be appealed to the Workers’ Compensation Court Appellate Division by filing with the Administrator of the Court, within five days of the date of the decree, a claim of appeal. Within such time as a judge fixes, the appellant must file the reasons of appeal stating specifically all matters which he or she desires to appeal, together with so much of the transcript of testimony and rulings as he or she deems pertinent. Within ten (10) days thereafter, the parties may file such briefs and memoranda as they may desire. Appellate panels consist of three members of the court. The appellate panel will affirm, reverse or modify the decree appealed from, and by itself take such further proceedings as just, or may remand the matter to the trial judge for further reconsideration. The court may award costs, including reasonable attorney fees, to the prevailing party in the absence of a justiciable issue of either law or fact. R.I. Gen. Laws §28-35-28.

Decrees of the Workers' Compensation Court Appellate Division may, within twenty (20) days from the entry of such final decree, be appealed to the Rhode Island Supreme Court by petition for writ of certiorari. The Supreme Court has discretion to deny the writ without a hearing. R.I. Gen. Laws §28-35-29. The Court may affirm, set aside or modify any decree of the appellate division only upon the following grounds: (1) the Workers' Compensation Court acted without or in excess of its authority; (2) the order, decree or award was procured by fraud; or (3) the appellate division erred on questions of law or equity. R.I. Gen. Laws §28-35-30.

47. What are the requirements for stipulations or settlements?

Where payments have continued for more than six (6) months, the parties may petition the Workers' Compensation Court for an order approving a settlement of the future liability for a lump sum or structured-type periodic payment. The petition will be granted if it is shown that the settlement in lieu of future weekly payments will be in the best interest of all parties, including the employee, the employer and insurer. Any proposed lump sum settlement that exceeds one hundred and four (104) weeks of compensation for partial incapacity may be rejected by the Chief Judge in his or her discretion. No case may be settled to a lump sum payment where the Rhode Island Temporary Disability Insurance Fund and/or the Department of Social and Rehabilitation Services has a claim for payments without making appropriate arrangements for payment out of the proceeds of the settlement. Further, no case for a lump sum can be settled unless it be placed upon the record in open session that the employer has been advised by the insurer of the potential effect of the settlement on its premium and has the opportunity to appear and state its disapproval. R.I. Gen. Laws §28-33-25.

Where liability of the employer has not been finally established, the parties may submit a
settlement proposal, referred to as a denial and dismissal settlement, to the Workers' Compensation Court which, if deemed to be in the best interests of the parties, may be approved. In denial and dismissal settlements, liability is formally denied. Payments made in connection with such settlements are not considered workers' compensation payments. Unlike a commutation settlement, the employee may be required to pay his or her own medical expenses in addition to paying attorney fees out of the gross settlement proceeds. R.I. Gen. Laws §28-33-25.1.

48. Are full and final settlements with closed medicals available?

Yes. All settlements are final, with medicals closed as of the date the Workers' Compensation Court enters a decree approving the settlement. R.I. Gen. Laws §§28-33-25, 28-33-25.1.

49. Must stipulations and/or settlement be approved by the state administrative body?


RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?

All employers, including those with one employee are required to carry workers' compensation insurance. Assigned risks are assigned to the Beacon Mutual Insurance Company, a state chartered, private mutual insurance company. There is a voluntary market. The Beacon Mutual Insurance Company underwrites voluntary as well as assigned risks. There are many insurance companies currently servicing Rhode Island.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

The requirements for individual self-insured entities are similar to those for members of "pools" of private entities. R.I. Gen. Laws §28-47-1 et seq. See answer 51B.

B. For groups or “pools” or private entities.

Any group consisting exclusively of those employers outlined in R.I. Gen. Laws §28-47-1(a) may adopt a plan for group self-insurance. The group must furnish satisfactory proof to the Director of the Department of Labor and Training of its financial ability to pay compensation. The director will require the filing of a bond to secure its liability to pay. R.I. Gen. Laws §28-47-2 et seq.
Each group self-insurer, except any group self-insurer composed of the state, municipal governments, governmental authorities of the state or municipalities, or quasi-municipal subdivisions of the state or municipalities, must pay premium taxes, as close as practicable, on the same basis as insurers. Each group self-insurer must pay assessments for the Administrative Fund, as provided in R.I. Gen. Laws §28-47-12. No group may operate as a self-insurer without maintaining both specific and aggregate reinsurance and/or excess insurance in a form and from a reinsurer and/or insurer approved by the director. R.I. Gen. Laws §28-47-13.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

In Villa v. Eastern Wire Products Co., 554 A.2d 644 (R.I. 1989), the Rhode Island Supreme Court held that the trial court erred in denying benefits to the employee based on the court's disapproval of his illegal entry into the country. The Court cited to cases in other jurisdictions in support of its holding that even an alien residing illegally in this country may not be denied workers' compensation if he or she is otherwise entitled to such benefits. Although the workers' compensation act fails to address whether illegal aliens are entitled to compensation benefits, the case law seems to allow for an entitlement to benefits for illegal aliens if individuals would otherwise have a right to collect such benefits.

More importantly, the Court has held that an employee's benefits cannot be terminated for his/her failure to accept employment where an employee cannot legally accept such employment.

53. Are terrorist acts or injuries covered or excluded under workers' compensation law?

This issue has not been specifically addressed by the Rhode Island Supreme Court or the Workers' Compensation Court. It is anticipated that if an employee was injured or killed by terrorist acts while performing his or her job duties, the impairing condition would be compensable. R.I. Gen. Laws §28-29-2(8)(i).

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

The parties must satisfy the court that the interests of the Center for Medicare and Medicaid Services (CMS) have been considered. The court, in its discretion, must ultimately determine whether the parties have satisfied their obligation in this regard. R. I. Gen Laws §§28-33-25(a) (2) (ii) and 28-33-25.1. The act is silent as to the means for satisfying the court that CMS’ interests have been considered. The court recently implemented a rule requiring counsel to explain, in writing, their justification for the amount agreed upon when the parties agree to a voluntary Medicare Set Aside.
In practice, insurance carriers and or employers generally require that a petitioner/employee make Affidavit that Medicare has not paid for services or items furnished to him/her or on his/her behalf, that he/she has not applied for or become qualified to receive such payments from Medicare and that he/she is not a Medicare beneficiary, has never collected or been qualified to receive Medicare or Social Security benefits, whether for disability or age. That affidavit is marked at the settlement hearing and reviewed by the court. The court will generally reference that affidavit when determining whether the parties have satisfied the court that the settlement is in CMS’ best interests. In the event that the person is a Medicare beneficiary, the parties seek to establish a Medicare Set Aside prior to settlement if the settlement is in excess of twenty five thousand dollars ($25,000.00). Similarly, if the settlement is in excess of two hundred and fifty thousand dollars ($250,000.00), the parties generally seek to have a Medicare Set Aside approved prior to the settlement if the employee reasonably expects to become a Medicare beneficiary within thirty (30) months.

55. How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?

The Federal Medicaid statute requires states to include in their plan for medical assistance provisions (1) that the individual will assign to the state any rights to payment for medical care from any third party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k (a). The state is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k (b).

Please see the response to Question 54 regarding Medicaid subrogation liens. The only enforceable liens which are recognized by the workers' compensation act are those issued by the Department of Human Services and the Department of Labor's Temporary Disability Insurance Division and Unemployment Compensation Division. Therefore, private health insurers do not have any authority under which they can assert a valid lien against a workers' compensation insurer.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPPA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 provides an exception for workers’ compensation claims which allows the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)]

As a general rule, the state's Confidentiality of Health Care Communications and Information Act ("RICHClA"), states that a provider cannot release or transfer confidential health care information without the written consent of the patient or the patient's authorized representative. R.I. Gen. Laws §5-37.3-4. However, subsection 4(b) contains twenty three
(23) exceptions to the general rule, among which is an exception for workers' compensation litigation when the employee's physical or mental condition has been placed at issue. Under such circumstances, no consent or court order is required prior to disclosure.

Likewise, the Federal Health Insurance Portability and Accountability Act ("HIPAA"), protects an individual's right to privacy. In particular, this relates to their privacy rights against the production of medical records. HIPAA also has exceptions in which no prior consent is necessary for the disclosure of an individual's medical records. There are certain circumstances in which no consent is required for the disclosure of health information including instances of legal compulsion where a party demonstrates during pending litigation that medical records exist which may contain information directly related to the pending matter.

57. What are the provisions for “Independent Contractors”?

An independent contractor is not an employee pursuant to the workers’ compensation act. For injuries occurring on or after January 1, 2001, a person is presumed to be an independent contractor upon filing with the director of the Rhode Island Department of Labor and Training a notice of designation form provided by the director indicating that the person is an independent contractor. R. I. Gen. Laws § 28-29-17.1 (a). By filing the notice of designation, an individual declares him/herself an independent contractor pursuant to R.I. Gen. Laws § 28-29-17.1 and acknowledges his/her ineligibility for workers’ compensation benefits. The notice of designation remains in effect until the independent contractor files a written notice with the director on forms provided by the director withdrawing his designation as an independent contractor. Any party may petition the court to vacate the notice of designation if the notice of designation was obtained improperly.

The failure to file the notice of designation form with the director does not preclude the court from finding independent contractor status pursuant to R. I. Gen. Laws §28-29-17.1. In determining independent contractor status, the court examines the degree of control the employer has over the individual in the performance of the essential elements of employment. The court looks to the criteria used by the Internal Revenue Service when classifying individuals as an employee or as an independent contractor as indicia of the individual’s status.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Please see the answer to Question 3.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?
60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Yes. The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act, G.L. 1956 §§ 21-28.6-1 et seq. (the “Hawkins-Slater Act” or “RIMMA”), permits the medical use of marijuana. In the Workers’ Compensation context, there has been no finding that marijuana meets the criteria for compensability under the Workers’ Compensation Statute, or in other words, that it is reasonable and necessary treatment to cure, rehabilitate or relieve the employee from the effects of the work-related injury. However, a recent Rhode Island Superior Court case, *Callaghan v. Darlington Fabrics Corp.*, 2017 WL 2321181 (R.I. Super. May 23, 2017) (hereinafter “Callaghan”), sheds some light on how the RIMMA and the Workers’ Compensation Statute might interact. *Callaghan* stands for the proposition that an applicant for employment has a private right of action to sue for discrimination if denied employment based on his or her status as a cardholder or status as a medical marijuana user under the RIMMA. The significance of this decision in terms of restrictions for use and for work activity in the Workers’ Compensation context lies in the dicta. *Callaghan* reiterates that under RIMMA an employer has no obligation to tolerate an employee rendered incapable of performing his or her duties in a competent manner while under the influence of medical marijuana where it would constitute “negligence” or “professional malpractice.” R.I. Gen. Laws §21-26.6-7(a)(1). An employer need not accommodate the medical use of marijuana in any workplace R.I. Gen. Laws §21-26.6-7(b)(2).

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

No. Please see answer to No. 62.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:
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Note: In 2007, The South Carolina Legislature passed an exhaustive reform of the S.C. Workers’ Compensation Act. The law as amended is applicable to claims with dates of injury occurring after July 1, 2007. This Compendium addresses these changes in the law, while retaining references to the law applicable to claims with dates of injury prior to July 1, 2007.

1. Citation for South Carolina's workers' compensation statute.

Title 42 of the S.C. Code contains all provisions of the South Carolina Workers' Compensation Act. Citation S.C. Code Ann. § 42-1-110 et seq.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

S.C. Code Ann. § 42-1-130 defines "employee" to mean every person "engaged in employment under any appointment, contract of hire or apprenticeship, express or implied, oral or written . . . but exclud[ing] a person whose employment is both casual and not in the course of the trade, business, profession, or occupation of his employer . . . ." A claimant bears the burden to prove by a preponderance of the evidence that an employment relationship exists. Porter v. Labor Depot, 372 S.C. 560, 643 S.E.2d 96 (Ct. App. 2007).

The Act includes all employees of the State and all political sub-divisions thereof, all public and quasi-public corporations therein and all private employments. Notably, the Act specifically includes legally hired as well as illegally hired aliens and minors. The South Carolina Court of Appeals’ recent decision in Curiel v. Environmental Management Services, 376 S.C. 23, 655 S.E.2d 482 (2007), confirmed that illegal aliens are eligible to receive benefits under the Act despite federal laws prohibiting the hiring of illegal alien workers. Certain prisoners injured while in private employment are also covered under the Act. Additionally, all self-proprietors and partners of a business whose employees are covered under the Act may elect to also be covered under the Act if they are actively engaged in the operation of the business and they notify the insurer of their election. The Act also includes clients of vocational rehabilitation who are involved in a program of assessment or work adjustment, as well students of high school, state technical schools and state supported colleges while engaged in work study, distributive education or apprentice
programs while on the premises of private companies.

In Wilkinson v. Palmetto State Transportation Co., 382 S.C. 295, 676 S.E.2d 700 (2009), the Supreme Court of South Carolina significantly changed its approach to the determination of whether a claimant is an employee or an independent contractor for purposes of workers’ compensation coverage. The claimant in that case, a truck driver, entered a contract with the employer that specifically provided that the claimant was an independent contractor, and not an employee. The contract also made the claimant responsible for the majority of business expenses, and required the claimant to purchase an occupational accident insurance policy. The parties’ conduct followed the terms of the contract in every material respect.

The South Carolina Supreme Court reiterated that the applicable test is the traditional common law test of “control,” which examines four factors in the claimant’s relationship with his purported employer: (1) direct evidence of the right or exercise of control; (2) furnishing of equipment; (3) method of payment; and (4) right to fire. According to the court’s prior decision in Dawkins v. Jordan, 341 S.C. 434, 534 S.E.2d 700 (2000), evidence tending to prove one of these factors should be given greater weight than evidence to the contrary. In Wilkinson, however, the court explicitly reversed this approach, overruling Dawkins and other cases that relied on it. See Nelson v. Yellow Cab Co., 349 S.C. 589, 564 S.E.2d 110 (2002); Paschal v. Price, 380 S.C. 419, 670 S.E.2d 374 (Ct. App. 2008). While the court noted that workers’ compensation laws are to be construed in favor of coverage, it recognized that this principle “does not go so far as to justify an analytical framework that preordains the result.” Reasoning that all four factors of the “control test” should be considered “in an evenhanded manner,” the court determined the claimant was an independent contractor for purposes of workers’ compensation coverage, and therefore was not entitled to benefits under the Act.

State officers and employees are specifically and mandatorily covered, except for those officers and employees who are elected by either the people or the general assembly or appointed by the governor. Officers and employees of municipal corporations and political sub-divisions of the state are also included, except those who are: (1) elected by either the people, council, or other governing body of the municipal corporation or political sub-division; (2) who serve in purely administrative capacities and (3) who serve for a definite term of office.

The definition of "employee" also includes members of the State and National Guard while they are performing duties in connection with the membership, except duties performed pursuant to Title 10 of the United States Code.

In Shuler v. Tri County Electric Co-op, Inc., 385 S.C. 470, 684 S.E.2d 765 (2009), the South Carolina Supreme Court held that a member of a rural electric cooperative’s board of trustees who was injured in an automobile accident while driving to a convention on behalf of the cooperative, was not a cooperative “employee” under an appointment, but was instead an elected board official who in turn was not entitled to workers’ compensation benefits. The court based its holding on the language from the Electric Cooperative Act, S.C. Code
Ann. § 33-49-630, which does not require cooperatives to compensate their trustees and indicates that such trustees are not consider to be employees of the cooperative, along with similar language in the defendant cooperative by-laws.

The Act specifically excludes a number of other workers from coverage. These include railway express company employees, federal, casual employees, agricultural employees and certain prisoners. Most recently, independent owner-operators of trucks were added to the list of excluded workers. S.C. Code Ann. § 42-1-360(9) (1985 & Supp. 2007). Also, volunteers are not included within the definition of an employee. In addition, the Act allows private employers and employees to elect to remain outside of the Act. Lastly, independent contractors are not within the scope of the Act unless they are deemed to be statutory employees of the owner. S.C. Code Ann. § 42-1-130.

3. **Identify and describe any "statutory employer" provision.**

S.C. Code Ann. § 42-1-400 is the statutory employer provision in the Act. This provision has been interpreted in Carter v. Florentine Corp., 310 S.C. 228, 423 S.E.2d 112 (1992) and it provides a three-part test in determining whether the employee of a subcontractor is the statutory employee of the owner. The test is as follows:

A. Is the activity an important part of the owner's business?

B. Is the activity a necessary, essential and an integral part of the business?

C. Has the identical activity been performed by employees of the principal employer?

If each part of the test is satisfied, then the injured employee is deemed to be a statutory employee of the owner.

The South Carolina Supreme Court addressed the “statutory employee provision” of the South Carolina Workers’ Compensation Act in the case of Abbott v. The Limited, Inc., 338 S.C. 161, 526 S.E.2d 513 (2000). In Abbott, the claimant was injured while unloading boxes on the premises of The Limited. He was employed by a common carrier that had entered into a contractual agreement with the retailer defendant. He received workers’ compensation benefits from his employer and their carrier, but then filed a negligence action against The Limited. The Supreme Court held that, although it was important to the retailer to receive goods, the delivery of goods was not “integral to” the retailer’s business. Therefore, the mere recipient of goods delivered by a common carrier is not the statutory employer of the common carrier’s employee. In rendering its decision, the Supreme Court also noted that to the extent Neese v. Michelin Tire Corp., 324 S.C. 465, 478 S.E.2d 91 (Ct. App. 1996), and Hairston v. Re: Leasing, Inc., 286 S.C. 493, 334 S.E.2d 825 (Ct. App. 1985), may be read to hold contrary to its holding in the present case, those decisions were hereby overruled.

the plaintiff was the owner-operator of a truck-trailer combination who had entered into a contractual agreement with Hot Shot to lease his equipment and services, was dispatched to the defendant’s (Shakespeare) premises by Hot Shot. While on the defendant’s premises, the plaintiff was injured. Subsequently, the plaintiff filed a negligence action against the defendant (Shakespeare). The defendant alleged as an affirmative defense that the plaintiff was a statutory employee of the defendant, and, thus, the defendant was immune from tort liability under the exclusive remedy provision of the Workers’ Compensation Act.

The Court of Appeals rendered its decision based on Abbott, declaring that Abbott’s holding “is not limited to situations involving a retailer’s receipt of goods.” Furthermore, the Court of Appeals concluded that Abbott “focused on the transportation aspect to determine if the individual is a statutory employee, not whether the purported statutory employer was a shipper or a recipient of goods.”

The Court of Appeals held that the plaintiff, at the time of his accident, was transporting finished product away from the defendant’s manufacturing plant to a customer. The Court also noted that the defendant did not “own or operate any receiving or delivery trucks,” and that the material, which arrived at and leaves the defendant’s plant did so “by common carrier.” As a result, the Court concluded, in light of Abbott, that the plaintiff, as an employee of a common carrier involved only in the transportation of goods, “was not part of the general trade, business, or occupation” of the defendant so as to render the plaintiff a statutory employee.

In the case of Meyers v. Piggly Wiggly No. 24, Inc., 338 S.C. 471, 527 S.E.2d 761 (2000), the claimant, who was employed by a vendor who had entered into a contractual agreement with the purchaser-defendant, sought workers’ compensation benefits for injuries obtained while delivering goods on the purchaser’s premises. The claimant received benefits from the vendor, but then filed a negligence action against the purchaser. The purchaser moved to dismiss on the grounds that the plaintiff was a statutory employee of the purchaser, and, thus, the purchaser was immune from tort liability under the exclusive remedy provision of the Workers’ Compensation Act.

The Supreme Court held that a vendor’s employee is not the purchaser’s statutory employee because the vendor does not perform part of the purchaser’s business, even where the vendor’s employee performed activities that benefited the purchaser. The Supreme Court concluded that although the plaintiff’s stocking and cleaning of shelves containing the vendor’s products may have incidentally benefited the purchaser, these activities related only to the sale of the vendor’s goods, and were insubstantial in the context of the purchaser’s business.

The Meyers test was applied with a different result in Hancock v. Wal-Mart Stores, Inc., 355 S.C. 168, 584 S.E.2d 398 (Ct. App. 2003). The plaintiff was an employee for Tru-Wheels, Inc., one of Wal-Mart’s vendors. He was assembling a Tru-Wheels’ tractor in Wal-Mart when a Wal-Mart employee ran over his foot with a forklift. The plaintiff sued Wal-Mart in
negligence, but the Court of Appeals determined that all three elements of the Meyers test were satisfied and the plaintiff was a statutory employee of Wal-Mart. The plaintiff’s duties were an important part of the store's business as pre-assembled items sold better. Likewise, his assembly of merchandise on regular basis was integral to regular operations and the same assembly duties were often performed by the store's regular employees. Therefore, his sole remedy was under workers’ compensation law.

4. **What type of injuries are covered and what is the standard of proof for each:**

A. **Traumatic or "single occurrence" claims.**

All injuries which “arise out of” and “occur in the course and scope of” a person’s employment are covered, except for those that are self-inflicted, horseplay or injuries involving drugs and/or alcohol as described in question #11. In all cases the claimant has the burden of proof to prove that the injury by accident is compensable under S.C. Code Ann. § 42-1-160. Some specific types of injuries by accident are discussed below in more detail.

In Nicholson v. Department of Social Services, 411 S.C. 381, 769 S.E.2d 1 (2015), the South Carolina Supreme Court affirmed the Commission’s award of benefits, reversing the Court of Appeals, and rejecting the application of the so-called “increased risk” doctrine. See also Barnes v. Charter 1 Realty, 411 S.C. 391, 768 S.E.2d 651 (2015).

The claimant in Nicholson was a DSS case worker who sustained injuries when she fell at work while walking down a hallway. The claimant testified that “friction from the carpet” caused her to fall. She testified that she was carrying ten case files at the time of her fall which, according to the record, weighed approximately 15 pounds. However, she admitted that these files did not contribute to her to fall. The claimant further admitted that there was no defect in the level, carpeted floor that she was walking on at the time of her accident.

The Single Commissioner found that the claim was not compensable, reasoning that the claimant’s fall was “wholly unrelated to her employment,” because there was no defect in the carpet that caused the Claimant’s fall, and she admitted that the files she was carrying did not contribute to her accident. The Full Commission reversed, and found that Ms. Nicholson’s employment was a “contributing cause” to her fall. The Full Commission panel concluded that it was “irrelevant that the fall could have happened on any other level, carpeted surface because the fall happened as a result of the risk associated with the conditions under which she worked.”

The Court of Appeals reversed the Full Commission, and determined that the Single Commissioner correctly denied benefits, relying on precedent that states an injury is not compensable when caused by a “hazard to which the workmen would have been equally exposed apart from the employment.” However, the Supreme Court disagreed, and concluded that the fall was compensable, because it happened as a result of the claimant’s normal work conditions. The Court reasoned that “an employee need only prove a causal
connection between the conditions under which the work is required to be performed and the resulting injury.” In essence, the Supreme Court has found that the test is not whether the claimant could have been injured just as easily, in the same manner, away from work. Rather, the question is whether the claimant’s accident “was causally connected to her employment.” Under these specific facts, the Court found that because the claimant was at work, on her way to a meeting, when she tripped and fell, her fall was compensable.

In Grant v. Grant Textiles, 372 196, 641 S.E.2d 869 (2007), the claimant was a vice-president of a family owned company that sold textile machines. The claimant was also in charge of sales for the company. On the date of his injury, the claimant was driving a company truck on his way to pick up his father, the president of the company, and then to meet with customers. The claimant’s father was at a hunting lodge used by the company to entertain customers. As the claimant was approaching the entrance to the hunting lodge, he had to swerve onto the shoulder of the highway to avoid hitting some debris lying on the road. He stopped his car and got out to remove the debris from the road. As he was walking along the side of the road toward the debris, the claimant was struck by an oncoming truck. The claimant testified that he wanted to move the debris because it was a hazard to those on the road, particularly customers, himself, and his father. The claimant admitted that moving debris from the road was not part of his job duties, however.

The South Carolina Supreme Court found that there are some circumstances where injuries arising out of acts outside the scope of employment may be compensable. Such circumstances include: 1) acts benefiting co-employees, 2) acts benefiting customers or strangers, 3) acts benefiting the claimant, and 4) acts benefiting the employer privately. The court concluded that “an act outside an employee’s regular duties which is undertaken in good faith to advance the employer’s interest, whether or not the employee’s own assigned work is thereby furthered, is within the course of employment.” Accordingly, the claimant’s injuries were compensable.

Similarly, in McGriff v. Worsley Companies, 376 S.C. 103, 654 S.E.2d 856 (Ct. App. 2007), the Court of Appeals held that the claimant’s injury was compensable although it appeared to have occurred outside the scope of his employment. In that case, the claimant was an employee of a service station and was cleaning the parking lot late at night. The claimant saw one of his friends, Chennault, in a truck stopped at a traffic light, and the claimant ran out into the road to talk to him. The claimant was then hit by a car. Chennault testified that their conversation was about the possibility of Chennault getting a job at the service station. There was evidence that the employer asked the claimant to look for good employee prospects. The Court of Appeals held the injury was compensable, because it occurred while the claimant was doing something the employer asked him to do. The court determined that the fact that the claimant was in the middle of the road late at night did not constitute a substantial deviation from his employment.

Hall v. Desert Aire, 376 S.C. 338, 656 S.E.2d 753 (Ct. App. 2007), is another recent case addressing whether an injury arose within the scope of the claimant’s employment. The claimant in that case was a sales manager on a business trip for the employer. He and
another sales manager, Brunner, had dinner and consumed alcohol, after which they took a drive and allegedly discussed further sales plans. Brunner drove the vehicle and the claimant was the passenger. Brunner caused an accident that resulted in the claimant’s injury and Brunner’s death. The employer/carrier argued that the men were too intoxicated to have had a meaningful business related conversation, and produced an expert witness to testify to that effect. The claimant’s expert testified that a meaningful conversation was possible. The court found that substantial evidence supported that the claimant and Brunner had a meaningful conversation, and therefore, the claimant's injury was compensable. Furthermore, the court disagreed with the employer/carrier’s argument that the car ride was a “drunken joy ride” and a substantial deviation from the claimant’s employment. The court determined that this behavior did not constitute a deviation because the employer expected employees to drink and discuss business in such situations.

i. **HERNIAS**

Hernia injuries are subjected to a different and more specific standard than other “injuries by accident” in an attempt to ensure that only “work-induced” hernias are compensable. S.C. Code Ann. § 42-9-40 requires the claimant to prove that: (1) there was an injury resulting in hernia or rupture; (2) the hernia or rupture appeared suddenly; (3) the hernia or rupture was accompanied by pain; (4) the hernia or rupture immediately followed an accident; and (5) the hernia or rupture did not exist prior to the accident for which compensation is claimed. The Act does not specify how disability is determined in hernia cases. In the recent case of **Eaddy v. Smurfit-Stone**, 355 S.C. 154, 584 S.E.2d 390 (Ct. App. 2003), the court held a claimant was totally and permanently disabled due to a hernia. His physicians attributed his predisposition to hernias to the strenuous physical nature of his work, the physician who performed his hernia surgery testified about the life-threatening nature inherent in the pursuit of any physical labor by claimant, and the claimant had no current skills needed to perform any sedentary work.

ii. **REpetitive Trauma**

In the case of **Pee v. AVM, Inc. and Arvin Industries, Inc.**, 352 S.C. 167, 573 S.E.2d 785 (2002), the state supreme court specifically held that repetitive trauma constituted a compensable injury in South Carolina. The Court also addressed the dispute over whether carpal tunnel syndrome should be recognized as an occupational disease or an injury-by-accident. In Pee, the claimant filed a workers’ compensation claim against her employer asserting that she sustained an injury by accident from repetitive trauma to both arms resulting in carpal tunnel syndrome. The employer responded to the claimant’s allegations by denying the claim on the ground that the claimant did not suffer an injury by accident.

The court held that repetitive trauma was a compensable injury by accident under the Worker’s Compensation Act. The employer argued that repetitive trauma was
not an injury by accident because it is not unexpected and lacks definiteness in time. In the alternative, the employer argued that the repetitive trauma is only compensable as an occupational disease.

The court found that the injury itself must be unexpected; the cause need not be unexpected. Also, the court found that an accident need not have definiteness in time when the injury results from a natural and unavoidable accident. The court did not directly make a finding as to the occupational disease issue. Instead, the court stated that a claimant would not have a more difficult time proving an occupational disease, and then it stated that repetitive trauma is compensable as an injury by accident.

Even though the Pee court specifically addresses carpal tunnel syndrome as a repetitive injury by accident, the court’s holding extends to any repetitive trauma injury as long as the claimant is able to show that the injury resulted unexpectedly and unavoidably from the job. For example, under Pee, a claimant who experiences problems with a cervical vertebrae in the neck resulting from holding the phone between the claimant’s shoulder and head, could be compensable as an injury by accident if the claimant shows that the injury arose unexpectedly and unavoidably. However, the claimant must still establish medical causation in most circumstances.

In the same year as Pee, the court also decided Schurlknight v. City of North Charleston, 352 S.C. 175, 574 S.E.2d 194 (2002), holding that a claimant sustained a compensable injury from repetitive, noise-induced hearing loss. The Court also held that the last day of exposure is the date from which the statute of limitations begins to run in a repetitive trauma case, rather than on date the injury was discovered.

The concept of repetitive trauma as a compensable injury by accident was effectively further expanded in 2003 through the case of White v. MUSC, 355 S.C. 560, 586 S.E.2d 157 (Ct. App. 2003). The court of Appeals affirmed that the claimant’s disc herniation was result of repetitive trauma to his back, which arose out of and in course of his employment as a nursing assistant at the Medical University of South Carolina (MUSC). The court therefore applied the principle set forth in Schurlknight, and determined the two-year statute of limitations period began to run on claimant's last day of work, rather than when he initially complained of back pain several years before.

In 2004, the Court of Appeals decided the case of Hargrove v. Titan Textile Co., 360 S.C. 276, 599 S.E.2d 604 (Ct. App. 2004), a very fact-specific case which likely does not have broad-reaching ramifications. The claimant had worked for Dillon Yarn for three years loading yarns into boxes and placing them on a conveyor, before getting a second job at Perdue Farms in March 2000. Three days after working at Perdue, the claimant began complaining of left arm
numbness and swelling, and on March 23, 2000, the claimant’s numbness and swelling was so bad when she finished her shift at Perdue that she was unable to grip objects when she began her shift at Dillon. In an unprecedented decision, the Court of Appeals found both employers equally responsible for the claimant’s injury—stating that the claimant’s long-term repetitious activities at Dillon Yarn caused the carpal tunnel syndrome and her job at Perdue exacerbated the problem. The claimant had worked shifts at both employers on the “last date of injurious exposure” to the repetitive trauma that caused her condition.

§ 42-1-172 (1985 & Supp. 2007), applicable to claims with dates of injury after July 1, 2007, defines “repetitive trauma injury” as “an injury which is gradual in onset and caused by the cumulative effects of repetitive traumatic events.” Claimants must establish, to a reasonable degree of medical certainty, a direct causal relationship between regular job activities and the injury.

iii. HEART ATTACKS AND STROKES

A heart attack or stroke constitutes a compensable accident within the meaning of workers' compensation law if it is induced by unexpected strain or over-exertion in the performance of employment, or by unusual and extraordinary employment conditions. S.C. Code Ann. § 42-1-160 (1985 & Supp. 2007); Bridges v. Housing Auth. of Charleston, 278 S.C. 342, 295 S.E.2d 872 (1982). The heart attack standard was established on the sound presumption that illness, injury, or death resulting from certain vascular calamities is "ordinarily the result of natural physiological causes rather than trauma or particular effort." Price v. B.F. Shaw Co., 224 S.C. 89, 77 S.E.2d 491 (1953). Accordingly, it would be patently unfair to hold an employer liable for such injuries through the workers' compensation system based solely on the fact that the employee was at work when the stroke or heart attack occurred.

In Jennings v. Chambers Development Co., 335 S.C. 249, 516 S.E.2d 456 (Ct. App. 1999), the court held that the “unexplained death” presumption may not be applied to eliminate the normal requirements of a compensable heart attack or other injury to the blood vessels. The claimant in that case was a garbage truck driver. During the course of a normal work day, he pulled his truck over to the side of the road where an EMS worker found him slumped over at the wheel, but still conscious. He was transported to the local hospital where he died of an aneurysm. An autopsy revealed severe coronary artery disease. There was no evidence of unexpected strain or over-exertion in the performance of the claimant’s employment, or unusual and extraordinary employment conditions. The single commissioner denied compensability, and the full commission affirmed. The circuit court reversed the Commission, holding that the claimant’s death was compensable based upon the “unexplained death” presumption, a presumption of fact that a claimant charged with the performance of a duty, who is found injured in the place where the duty required him to be, has sustained a
compensable injury. The Court of Appeals reversed the circuit court, holding that the “unexplained death” presumption cannot be used “to eliminate the test under which an aneurysm becomes a compensable accident.”

In *Watt v. Piedmont Automotive*, 384 203, 681 S.E.2d 615 (Ct. App. 2009) the claimant worked as a service manager for a car dealership. The day after he was terminated from employment in 2001, the claimant suffered congestive heart failure and underwent triple bypass surgery. The claimant had had heart problems since 1991. The claimant filed a workers’ compensation claim claiming that extraordinarily mentally stressful working conditions aggravated his heart condition, culminating in heart failure and total disability on his final day of employment with Employer. Applying the “heart attack standard,” South Carolina Court of Appeals found substantial evidence that the claimant had suffered from a pre-existing heart condition and numerous other health conditions, and that his employment with employer was not “unusual and extraordinary” from the mental stress standpoint alleged by the claimant. Accordingly, the court upheld the Commission’s denial of the claim.

Similarly, in *Jordan v. Kelly Trucking Co., Inc.*, 381 S.C. 483, 674 S.E.2d 166 (2009), the court held that substantial evidence supported a finding that the claimant’s job as a cross-country truck driver did not entail unusual or extraordinary conditions, and that therefore, the claimant’s heart attack was not a compensable injury by accident.

iv. **PHYSICAL BRAIN INJURY**

A claimant who is permanently and totally disabled as a result of compensable physical brain damage is entitled to lifetime benefits under the South Carolina Workers’ Compensation Act. S.C. Code Ann. § 42–9–10(C) reads as follows:

> Notwithstanding the five-hundred-week limitation prescribed in this section or elsewhere in this title, any person determined to be totally and permanently disabled who as a result of a compensable injury is a paraplegic, a quadriplegic, or who has suffered physical brain damage is not subject to the five-hundred-week limitation and shall receive the benefits for life. (Emphasis added.)

South Carolina courts have issued three decisions in the last several years that address a claimant’s burden to prove physical brain damage under this statute. These decisions will likely narrow the application of section 42-9-10(C), and limit the circumstances in which a claimant will qualify for lifetime benefits under this statute.
In Potter v. Spartanburg School District 7, 395 S.C. 17, 716 S.E.2d 123 (Ct. App. 2011), the Court of Appeals affirmed the Workers’ Compensation Commission’s denial of the claimant’s alleged physical brain injury. The claimant fell approximately 12-14 feet onto asphalt and lost consciousness for a few minutes. He fractured his right femur and sustained a cut above his eye. CT scans of his head revealed some initial abnormalities that later resolved. The claimant underwent a neurological consultation with Dr. Thomas Collings about 11 months after his accident. Dr. Collings determined the claimant’s reported problems with disequilibrium were probably not related to his fall. The Claimant later underwent a neuropsychological evaluation with Dr. Randolph Waid, a clinical psychologist. Dr. Waid determined the claimant had “cognitive disorder residuals of traumatic brain injury.” The claimant then returned to Dr. Collings, who stated that he did not believe the claimant had “significant ongoing neurologic difficulty” from the original accident. The single commissioner awarded permanent partial disability benefits with regard to the claimant’s leg, but denied the claimant sustained physical brain injury. The single commissioner’s order stated that Dr. Waid is a clinical psychologist, and his opinion “concerning alleged brain damage is beyond [h]is area of expertise.” The commissioner stated that he gave greater weight to the opinion of the treating physician. The Court of Appeals affirmed, concluding that the Commission did not err in assigning less weight to Dr. Waid’s opinion than the treating physician.

In Sparks v. Palmetto Hardwood, Inc., 401 S.C. 619, 738 S.E.2d 831 (2013) (withdrawn and superseded on denial of rehearing, new citation not yet assigned), the South Carolina Supreme Court affirmed the Commission’s denial of lifetime benefits for the claimant’s alleged brain damage. The court determined that “physical brain damage” as contemplated in S.C. Code Ann. Section 42-9-10 requires “severe and permanent physical brain damage as a result of a compensable injury.” The claimant in that case was working on a machine when a three to four inch piece of metal exploded and struck him in the head. He testified to a number of cognitive problems and other brain-function-related symptoms. Six doctors offered conflicting opinions as to whether and to what extent the claimant had suffered physical brain injury. The Commission found that the claimant’s testimony as to the extent of his brain injury was not credible. The evidence failed to show that the claimant had lost consciousness or experienced any significant post-concussive symptoms. Therefore, the Commission found him to be permanently and totally disabled as a result of other injuries, but denied he was entitled to lifetime benefits related to brain damage, stating that “the claim for physical brain injury borders on the frivolous.” The Court affirmed, concluding that the Commission’s interpretation of section 42-9-10(C) was consonant with the intent of the legislature. Applying rules of statutory construction, the court found that the context of the term “physical brain damage” in the statute – listed along with paraplegia and quadriplegia as exceptions to the 500-week limitation on benefits – suggests that the legislature meant to require “severe, permanent impairment of normal brain function” for a claimant to qualify for lifetime benefits. Accordingly, the court determined the
Commission properly interpreted the statute, and affirmed the Commission’s denial of lifetime benefits as supported by substantial evidence in the record.

Finally, the South Carolina Supreme Court also addressed the claimant’s burden to prove a compensable brain injury in Crisp v. SouthCo., Inc., 401 S.C. 627, 738 S.E.2d 835 (2013). The claimant in Crisp sustained injuries when the bucket of a Bobcat earthmover fell on him. The employer admitted injuries to the claimant’s right hand/arm, neck, and back, but denied the claimant sustained a compensable brain injury. The parties presented voluminous and contradictory medical evidence regarding whether the claimant sustained physical brain damage as contemplated by section 42-9-10(C). The Commission determined that the evidence did not support a finding of physical brain damage, but that the claimant had sustained compensable psychological and neuropsychological injuries. The Commission concluded the claimant had not reached maximum medical improvement related to his head and psychological injuries, and ordered additional medical evaluation and treatment. The Commission’s order was ultimately upheld by the South Carolina Court of Appeals. However, the supreme court determined that the issue was not properly before the court, because the claimant had not reached maximum medical improvement for his head injury. The court remanded the case to the commission for further determination as to whether the claimant had reached MMI, and whether his injury qualifies for lifetime benefits under the statute. To “provide guidance on remand,” the court analyzed the definition “physical brain damage” under the statute, referencing its decision in Sparks v. Palmetto Hardwood (supra). Therefore, it remains to be seen how the Commission and the courts will determine this issue in light of the specific facts and circumstances of this case.

B. Occupational disease (including respiratory and repetitive use).

The Act establishes unique requirements, procedures and defenses for occupational disease claims, which differ from those provided in the remainder of the Act. An occupational disease is defined in S.C. Code Ann. § 42-11-10 (1985 & Supp. 2007). In general, for an occupational disease to be compensable under the Act, it must be shown that the disease meets the following requirements:

i. The disease must arise out of and in the course of the claimant's employment.

ii. That the hazards are particular to the claimant's occupation.

iii. The hazards are in excess of that ordinarily incident to the employment.

iv. The hazards are peculiar to a particular trade, process, occupation or employment. Also, no disease shall be deemed an occupational disease when:

a. It does not result directly and naturally from exposure in this state.
b. The hazard is peculiar to the particular employment.

c. It results from exposure to outside climatic conditions.

d. It is a contagious disease resulting from exposure to fellow employees or from a hazard to which the workman would have been equally exposed outside of his employment.

e. It is one of the ordinary diseases of life to which the general public is equally exposed, unless such disease follows as a complication and natural injury to an occupational disease or unless there is a constant exposure peculiar to the occupation itself which makes such disease a hazard inherent in such occupation.

f. It is any disease of the cardiac, pulmonary or circulatory system not resulting directly from abnormal external gaseous pressure exerted upon the body or natural entrance into the body through the skin or natural orifices thereof of foreign, organic or any organic material under the circumstance peculiar to the employment and the processes utilized therein; or

g. Any chronic disease of the skeletal joints.

This section as amended on July 1, 2007 states explicitly that the claimant bears the burden of proof to demonstrate the existence of an occupational disease. S.C. Code Ann. § 42-11-10(A) (Supp. 2007). The amendment further provides that “no compensation shall be payable for any occupational disease unless the employee suffers a disability as described in § 42-9-10 or § 42-9-20 or § 42-9-30.”

Skinner v. Westinghouse Electric Corp. is a recent landmark decision in which the South Carolina Supreme Court confirmed that a claimant must demonstrate lost earning capacity to sustain his burden to prove a compensable occupational pulmonary disease. 394 S.C. 428, 716 S.E.2d 443 (2011). Prior to this decision, it was unclear whether and to what extent the court would enforce the provision of the Act’s Occupational Disease Chapter that requires proof of lost wages in pulmonary disease claims. S.C. Code Ann. section 42-11-60 (2007).

The claimant in Skinner worked for Westinghouse from 1968 to 1983. He developed asbestosis caused by inhalation of asbestos dust in his employment. He decided to leave Westinghouse in 1983, voluntarily and not because of any medical condition, and began working full time with the National Guard. The claimant earned more in his employment with the National Guard than he did at Westinghouse, and he continued working with the National Guard until at least 2005, after he filed his claim. The court held that S.C. Code Ann. section 42-11-60 barred the Claimant from recovering disability benefits, because he could not prove lost wages caused by his asbestosis. S.C. Code Ann. section 42-11-60 states
that “no compensation shall be paid” for any occupational pulmonary disease, unless the claimant can prove lost wages. Additionally, the statute states that such pulmonary diseases “shall not be compensable” under the code section that sets forth scheduled member disability. The court concluded that the claim “fails because [the claimant] cannot establish any lost wages occasioned by his asbestosis,” and therefore he “does not have a compensable occupational disease.” The court declined to address the appellant’s other ground for appeal, stating that resolution of the wage loss issue was dispositive of the appeal. The court did not explicitly state whether the employer would be required to provide medical treatment in light of this holding. However, it appears from the language of the decision that the claim was completely denied, and the employer would not be responsible for either medical or indemnity benefits.

5. What, if any, injuries or claims are excluded?

There are currently no injuries or claims that are specifically excluded under the Act, except for those claims which do not fall under the definition of an accident as defined under S.C. Code Ann. § 42-1-160 and a case of Stokes v. First National Bank, 306 S.C. 46, 410 S.E.2d 248 (1991), which allowed stress claims without specific accident, if as a result of unusual or extraordinary circumstances within employment. (See #8.) However, in Lee v. Harborside Café, 350 S.C. 74, 564 S.E.2d 354 (Ct. App. 2002), the court held that the legislature did not intend for an injury to the psychological system to be classified as a scheduled member compensable under S.C. Code Ann. § 42-9-30. (See # 8).

6. What psychiatric claims or treatments are compensable?

The law in South Carolina is that mental injuries are compensable if the mental injury is induced either by (1) physical injury or (2) unusual or extraordinary conditions of employment. Conversely, a mental injury is not compensable as an injury by accident if it results from exposure to normal working conditions or is simply brought about by a gradual build-up of emotional stress over a period of time.

The question of whether a purely mental accident that was not manifested by some sort of physical stimuli (“mental-mental” injury) is compensable under the Act was addressed in the case of Stokes v. First National Bank, 306 S.C. 46, 410 S.E.2d 248 (1991). In Stokes, the employee had worked an extraordinary number of hours as a result of a bank merger. The record showed that the employee's work hours increased substantially due to the merger, and this caused the claimant to sustain an emotional breakdown. The merger and the extraordinary additional duties and pressure that accompanied it constituted “unusual and extraordinary circumstances,” and the claimant received benefits under the Act.

These findings were codified on June 18, 1996 by an amendment to S.C. Code Ann. § 42-1-160 which is the statute defining an injury by accident. Under the amendment, the claimant must establish that the stressful employment conditions were “extraordinary and unusual” in comparison to normal conditions. The employer would then, in turn, rebut a claim by showing that the conditions of the job, although stressful, were part of the normal job duties.
The Court of Appeals reiterated the importance of this standard in the recent case of Frame v. Resort Services Inc., 357 S.C. 520, 593 S.E.2d 491 (Ct. App. 2003). In that case, the Workers’ Compensation Commission found the claimant’s “mental-mental” claim compensable, but failed to make a specific finding of fact under § 42-1-160 as to whether the claimant’s breakdown arose from “extraordinary and unusual” conditions. Therefore, the court remanded the case to the Commission for these findings.

The law applicable to claims with dates of injury occurring after July 1, 2007 states explicitly that claimants bear the burden to prove by a preponderance of the evidence that employment conditions are unusual or extraordinary in comparison to the normal conditions of the “particular” employment. Furthermore, claimants must demonstrate, using “medical evidence,” medical causation between the employment conditions and the mental injury. S.C. Code Ann. § 42-1-160(B) (Supp. 2007).

The statute further states that personnel actions, e.g. disciplinary proceedings or demotions, are considered incidental to normal employer-employee relations. Only when the personnel actions are handled in an extraordinary or unusual manner will such a claim be compensable. The law was recently amended to add “mental injuries, heart attacks, strokes, embolisms, or aneurisms” to the rule that stress incidental to normal personnel actions is not compensable. S.C. Code Ann. § 42-1-160(C) (Supp. 2007).

The South Carolina Supreme Court again addressed the issue of psychiatric claims in the case of Shealy v. Aiken County, 341 S.C. 448, 535 S.E.2d 438 (2000). In Shealy, the claimant filed a worker’s compensation claim against an employer for psychological injuries allegedly caused by conditions of his employment as a “deep cover” narcotics agent for the Aiken County Sheriff’s Department. The court found that (1) the claimant’s job conditions were usual to his employment and (2) that claimant had failed to prove his psychological injuries were caused by unusual or extraordinary conditions of employment.

The court went on to state that the “unusual or extraordinary conditions of employment” standard is determined by reference to the claimant’s particular employment and not to employment in general. However, in this case, the court determined that the combination of the varieties of stress of this claimant’s particular employment over several months constituted unusual or extraordinary conditions of employment. Ultimately, however, the court found the claimant did not meet his burden of proving the unusual and extraordinary conditions of his employment were the proximate cause of his mental injuries, as opposed to non-work-related stressors being the proximate cause.

In Lee v. Harborside Café, 350 S.C. 74, 564 S.E.2d 354 (Ct. App. 2002) the claimant filed a workers’ compensation claim against his employer asserting that he sustained an injury by accident and, as a result, was entitled to a scheduled award under S.C. Code Ann. § 42-9-30 for partial loss to his psychological system. The court held that while recent cases have allowed claimants to recover compensation for psychological or mental injuries under the Act, “none of these cases support an award of compensation for such an injury as a
In the recent case of Doe v. S.C. Department of Disabilities, 377 S.C. 346, 660 S.E.2d 260 (2008), the claimant was an LPN who worked with special needs patients. She initially worked with only passive, high functioning patients. However, she was required to begin working with a mix of passive and aggressive patients in the spring of 1997 due to facility downsizing. The number of reported patient incidents in the claimant’s department increased from 11 in March 1997 to 128 in May, 1997. She sustained two minor physical injuries – one in 1997 and one in 1998, as a result of patients kicking or pushing her. The claimant also had significant stress and was seeing a psychiatrist, who prescribed psychotropic medication. The claimant eventually stopped working altogether due to stress. The Commission determined the claimant did not sustain a compensable mental injury under the Act, a ruling which was reversed on appeal to the circuit court, but then affirmed on further appeal to South Carolina Court of Appeals. Ultimately, the South Carolina Supreme Court reversed the Court of Appeals, holding that in this specific instance, working with a mix of passive and aggressive patients qualified as unusual and extraordinary in the claimant’s employment. Accordingly, the claimant had suffered a compensable mental injury under § 42-1-160.

In Tennant v. Beaufort County School District, 381 S.C. 617, 674 S.E.2d 488 (2009) the Supreme Court of South Carolina held that substantial evidence supported the Commission’s finding that the claimant’s job as a special education teacher did not entail unusual or extraordinary conditions, and therefore, the claimant’s mental stress injury was not compensable. The court emphasized that the application of the “heart attack standard” in workers’ compensation claims for mental-mental injuries is consistent with the heightened burden required to prove a tort claim for intentional infliction of emotional distress, which also involves a mental injury with no accompanying physical harm.

In Bentley v. Spartanburg County, 398 S.C. 418, 730 S.E.2d 296 (2012), the Supreme Court of South Carolina denied benefits for police officer’s alleged post-traumatic stress disorder after he killed a suspect in the line of duty. The majority opinion written by Chief Justice Toal recommended that the SC legislature should amend the current law so that the “unusual and extraordinary” standard no longer applied to psychological injury cases in light of new developments in psychological medicine and technology. However, she wrote that under the current standard and case law, use of deadly force is not unusual and extraordinary as compared to the normal conditions of work as police officer. The court determined that the frequency of the event was not the deciding factor, but the fact that officers were required to take regular training courses on the use of deadly force was important in the court’s decision. The court distinguished Shealy (see above), in which an undercover police officer’s stress related PTSD was determined compensable. According to the court, the circumstances in Shealy were unusual and extraordinary because that case involved a combination of numerous stressors over a long period of time, while this case was only one instance of use of deadly force.
7. **What are the applicable statutes of limitations?**

The Act provides that the right of compensation for accidental injuries "shall be forever barred unless a claim is filed with the Commission within two years after an accident, or if death resulted from the accident within two years of the date of death. S.C. Code Ann. § 42-15-40. Also, once a claim has been adjudicated or settled, the claimant has one year from the date of last payment of compensation pursuant to an award to seek additional compensation based upon a change of condition for the worse. S.C. Code Ann. § 42-17-90.

Under S.C. Code Ann. § 42-15-20, the claimant must file a claim within two years of the accident, or the claimant is barred from filing the claim. The leading precedent on this issue is Mauldin v. Dyna-Color/Jack Rabbit, 308 S.C. 18, 416 S.E.2d 639 (1991). In Mauldin, the claimant injured her left knee at work on January 2, 1985. When she went to the emergency room, she was diagnosed with a collateral sprain. During the two-year period after the accident, the claimant experienced swelling and soreness of her knee. Due to the continued trouble with her knee, she saw an orthopedic surgeon, and the surgeon found that she had torn her medial meniscus on November 1, 1987. Unlike her first diagnosis, the surgeon found the claimant required surgery.

Under Mauldin, the statute begins to run when the claimant “knew or should have known” about the injury. In this case, Supreme Court of South Carolina found this occurred when the claimant was diagnosed by the orthopedic surgeon.

In Holmes v. National Service Industries, Inc., the South Carolina Supreme Court affirmed the Commission’s determination that the claim was barred by the statute of limitations. The court held that substantial evidence supported the Commission’s conclusion that the Claimant could have discovered her sarcoidosis was compensable more than two years before she filed a claim. 395 S.C. 305, 717 S.E.2d 751 (2011). The claimant in that case alleged a compensable injury by accident to her lungs and respiratory system arising out of her employment with National on July 12, 2005, the date she alleged she first discovered her sarcoidosis was related to her employment. The court noted that the claimant had breathing problems since 1992. She testified that she was aware the conditions at National were making her breathing problems worse, and she ultimately left her employment at National for that reason. She was diagnosed with sarcoidosis in 1995. The court concluded that these facts constituted substantial evidence to support the Commission’s denial, noting that “[a]lthough reasonable minds may differ as to whether petitioner should have known after being diagnosed with sarcoidosis that she had a compensable injury, this is not sufficient to set aside the judgment of the Appellate Panel.” Notably, the Claimant did not plead her claim as an occupational disease, even though a more lenient statute of limitations applies in occupational disease cases. The court does not address whether the Claimant could have prevailed under an occupational disease theory. Presumably, the Claimant’s attorneys made a strategic decision to plead the case as an injury by accident, in an effort to avoid certain defenses applicable to occupational disease claims that may limit or bar the claimant’s recovery.
The application of the statute of limitations with respect to occupational disease claims is laid out in McGraw v. Mary Black Hosp., 350 S.C. 229, 565 S.E.2d 286 (2002). In this case, the South Carolina Supreme Court specified that the two-year statute of limitations for an occupational disease begins to run “when the claimant receives notice of a definitely diagnosed occupational disease and suffers some compensable injury, that is, some disability.” In that case, the court determined that it was unreasonable to conclude that a doctor’s informal conversations with the claimant, or that the claimant’s understanding her asthma was affected by the workplace chemicals constituted notice of definitive diagnosis of an occupational disease intended under the Act.

Schurlknight v. City of North Charleston, 352 S.C. 175, 574 S.E.2d 194 (2002) discusses the application of the statute of limitations in repetitive trauma claims prior to July 1, 2007. (The 2007 Reform Act amended § 42-15-40 to specifically address the statute of limitations with regard to repetitive trauma claims. The new statute is discussed below.) In Schurlknight, the claimant filed a workers’ compensation claim against his employer claiming his hearing loss was caused by a job related injury. He had worked as a firefighter and was consistently seated in the fire truck next to the siren. In May of 1995, the claimant was diagnosed with bilateral loss of hearing. In February of 1996, he was again diagnosed with hearing loss, and the report stated that extended exposure to loud noises might make the problem worse. The claimant left the department in August of 1997, and in December of 1997 a private physician found that the claimant had experienced a 12.5% hearing loss in both ears. The claimant filed a Form 50 in May of 1998, claiming noise-induced hearing loss in both ears.

The employer argued that, under Mauldin, the claim was barred by the two-year statute of limitations because, at the latest, the claimant knew he had a compensable injury in February of 1996. The Court of Appeals held that the two-year statute of limitations does not begin to run in repetitive trauma cases until the last date of exposure. The court distinguished Mauldin, in which the court held that the statute of limitations begins to run when the claimant knew or should have known that his injury is compensable “but no more than seven years after the last date of injurious exposure.” S.C. Code Ann. § 42-15-40 (1985 & Supp. 2007). The South Carolina Court of Appeals recently interpreted the “discovery rule” in the context of a repetitive trauma claim. In King v. Int’l Knife and Saw, the court held that a claimant alleging repetitive trauma injury cannot discover his claim is “compensable” until the condition either requires medical care or interferes with a claimant’s ability to work. 395 S.C. 437, 718 S.E.2d 227 (Ct. App. 2011).

Finally, the Court of Appeals has determined a claim for benefits was barred by the equitable defense of laches. In Richey v. Dickinson, 359 S.C. 609, 598 S.E.2d 307 (Ct. App. 2004) the claimant filed a Form 50 alleging injuries to his face and ears in 1988.
hearing was scheduled for March 1989 but did not go forward, and the claimant did not file another Form 50 until March 2000—this time alleging injuries to his face, ears, and brain. The Court of Appeals upheld the defendants’ denial based on laches, as the Workers' Compensation Commission, insurance carrier, and employer's original attorney had all destroyed their files; proximate cause of claimant's injuries was difficult to ascertain due to lack of records and time lapse; and the claimant had no reasonable explanation for his delay in pursuing the claim.

8. What are the reporting and notice requirements for those alleging an injury?

S.C. Code Ann. § 42-15-20 dictates that "every employee or his representative shall immediately, on the occurrence of an accident or as soon as practical, give or cause to be given to the employer notice of the accident and the employee shall not be entitled to physician's fees nor to any compensation which may have accrued under the terms of this Title prior to the giving of such notice, unless it can be shown that the employer, his agent or representative, had knowledge of the accident or that the party required to give such notice had been prevented from doing so by reason by physical or mental incapacity or by the fraud or deceit of some third person. Also, no compensation shall be payable unless such notice is given within 90 days after the occurrence of the accident or death, unless reasonable excuse is made to the satisfaction of the Commission for not giving such notice and the Commission is satisfied that the employer has not been prejudiced thereby. S.C. Code Ann. § 42-15-20 provides no specific method of giving notice, the object being that the employer be actually put on notice of the injury so he can investigate it immediately after its occurrence and can furnish medical care for the employee in order to minimize the disability and his own liability. Teigue v. Appleton Co., 221 S.C. 52, 68 S.E.2d 878 (1952).

The South Carolina Court of Appeals addressed this issue in Etheredge v. Monsanto Co., 349 S.C. 451, 562 S.E.2d 679 (Ct. App. 2002), where an employer denied the claimant’s claim on the grounds that the claimant had failed to provide notice of an injury by accident. The court concluded that the company nurse’s receipt of a medical report from the claimant’s treating physician indicating that the claimant’s chest problems were connected to her employment represented the requisite notice under § 42-15-20. The court held that “notice is adequate, when there is some knowledge of accompanying facts connecting the injury or illness with the employment, and signifying to a reasonably conscientious supervisor that the case might involve a potential compensation claim.” In its opinion, the court reiterated that “[t]he provisions of § 42-15-20 regarding notice should be liberally construed in favor of claimants.” See Mintz v. Fiske-Carter Constr. Co., 218 S.C. 409, 63 S.E.2d 50 (1951).

With regard to repetitive trauma claims with dates of injury occurring prior to July 1, 2007, the Court of Appeals held in Bass v. Isochem, 365 S.C. 454, 617 S.E.2d 369 (Ct. App. 2005), that the 90-day notice period begins to run when the employee becomes disabled and could discover with reasonable diligence his condition is compensable. The claimant was a truck driver who delivered heavy drums; she began noticing problems
with her arms in January 2001, but her employer asserted they did not receive notice until November 2001. Citing Schurlknight v. City of North Charleston, the Bass court reiterated that repetitive trauma injuries have a gradual onset caused by the cumulative effect of repetitive traumatic events or "mini-accidents." Therefore, the claimant suffered and sustained a repetitive trauma injury, carpal tunnel syndrome, over a period of time resulting in disability in November of 2001.

On July 1, 2007, the legislature codified the notice requirement for repetitive trauma claims in § 42-15-20(C). That provision states that a claimant must give notice “within ninety days of the date the employee discovered, or could have discovered by exercising reasonable diligence, that his condition is compensable, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been unduly prejudiced thereby.” S.C. Code Ann. § 42-15-20(C) (Supp. 2007). This provision is applicable to claims with dates of injury occurring on or after July 1, 2007; Bass remains applicable to claims for injuries occurring prior to this date.

In King v. Int’l Knife and Saw, the South Carolina Court of Appeals interpreted and applied the Act’s notice requirement for repetitive trauma claims with dates of injury on or after July 1, 2007. 395 S.C. 437, 718 S.E.2d 227 (Ct. App. 2011). The claimant alleged that he injured his right arm and shoulder on May 15, 2008 from repetitively hammering steel saw blades. The Single Commissioner found this claim compensable, but on appeal the Full Commission panel reversed, finding the claimant had not provided notice of an injury within ninety days of discovery under § 42-15-20(C) (2007). The Full Commission found that the claimant noticed symptoms of carpal tunnel syndrome and suspected that the symptoms were work related for years prior to providing Tucker on May 21, 2008. According to the Full Commission, Mr. King could have discovered more than two years before May of 2008 that he had a compensable claim, if he had exercised reasonable diligence. The Court of Appeals reversed the Full Commission, determining the claim was not barred by the Act’s notice provision. The court reasoned that a claimant should not be expected to discover a “compensable claim” upon the first twinge of pain that he believes is work related. The court held that a claimant’s repetitive trauma condition is not compensable, and “the 90-day reporting clock does not start,” until the condition either requires medical care or interferes with a claimant’s ability to work. Id. at 444-45.

9. Describe available defenses based on employee's conduct:

A. Self-Inflicted Injury.

No compensation is payable under the Act if an injury or death is the result of employee's intoxication or the willful intention of the employee to injure or kill himself or another. S.C. Code Ann. § 42-9-60. This defense has been asserted in situations involving employee assaults, suicides, horseplay and intoxication. By statute, however, this constitutes an affirmative defense for which the burden of proof rests upon the one asserting it. S.C. Code
In Dukes v. Rural Metro Corp., 356 S.C. 107, 587 S.E.2d 687 (2003), the claimant sustained an accidental gunshot wound while inspecting a co-employee's handgun during a smoke break. The Supreme Court held the gunshot injury did not "arise out of" the claimant's employment, and thus was not compensable. There was no nexus connecting employee's job as paramedic to his colleague's handgun that they were examining during the smoke break; the gun was not naturally found on the employer's premises, and the gun was in no way connected to employer's business. The court distinguished Mack v. Branch No. 12, which held a cigarette burn during a smoke break was compensable. Unlike a cigarette burn, a gunshot wound is not a “necessarily contemplated” act, and is not a danger that would attend a normal smoke break.

B. Willful Misconduct, "horseplay," etc.

See "a" above.

Additionally, in the case of Pratt v. Morris Roofing, Inc., 353 S.C. 339, 577 S.E.2d 475 (Ct. App. 2003), the Court of Appeals denied benefits to a claimant because he took himself out of the scope of employment by disobeying direct orders of the employer. The claimant had been provided a work truck, but on the night in question, the employer told the claimant that he could not take the truck home because he had made a late delivery. The claimant took the truck home anyway and was involved in an automobile accident in the truck the following morning on his way to work. Therefore, the transportation was not “provided by the employer” and did not qualify for this exception to the general “coming and going” rule.

C. Injuries involving drugs and/or alcohol.

For intoxication to bar recovery under S.C. Code Ann. § 42-9-60, the employer/carrier must prove the claimant was intoxicated and that the intoxication was the proximate cause of the injury. Kinsey v. Champion American Serv. Center, 268 S.C. 177, 232 S.E.2d 720 (1977).

See "a" above generally.

Effective July 1, 2007, the legislature amended § 42-9-60 to clarify that the burden of proof for defenses based on employee conduct lies with the party asserting the defense. S.C. Code Ann. § 42-9-60 (1985 & Supp. 2007).

11. Is there any defense for falsification of employment records regarding medical history?

There is a defense for falsification of employment records regarding medical history and the general rule is that the following factors must be present before a false statement in an employment application will bar benefits:
A. The employee must have knowingly and willfully made a false representation as to his physical condition.

B. The employer must have relied upon the false representations and this reliance must have been a substantial factor in the hiring.


(The Americans with Disabilities Act has made this defense more unlikely in the future due to the requirement of knowledge, but it is certainly still possible. The ADA does not apply to employers with less than fifteen employees and therefore will have no effect on this defense for small businesses.)

There are a number of recent cases addressing fraud in the employment application. In Brayboy v. WorkForce, 383 S.C. 463, 681 S.E.2d 567 (2009), the claimant worked for a temporary agency that provided workers for construction sites. He stated on his employment application that he had no previous injuries and suffered from no health problems. The employment application contained numerous warnings to applicants that giving misleading, inaccurate, or untruthful information voided the employment contract and could cause forfeiture of workers’ compensation benefits. The claimant had signed the application under these provisions. The claimant was working in a physically demanding job when he injured his back while removing a chain link fence. He required lumbar fusion surgery and filed a workers’ compensation claim with the temp agency as his employer. Employer denied the claim on the grounds that the claimant’s material misrepresentations vitiates the employer-employee relationship. The claimant admitted at the hearing before the single commissioner that he had neglected to mention numerous prior physical problems, including a back injury in the Navy, a prior workers’ compensation back injury, and a pinched nerve. He testified that he did so because he did not feel the injuries were relevant to a construction job, and that one back injury in particular “cleared up very quickly.” The single commissioner awarded benefits, finding the claimant credible in his testimony that he did not believe he was impaired or disabled. The full commission and the circuit court affirmed.

The Supreme Court of South Carolina granted certiorari to review the case on appeal. The court applied the 3-factor test from Cooper v. McDevitt Street to determine whether the information supplied by the claimant on the employment application constituted a material representation. The court first found that the claimant had knowingly and willfully made a false representation as to his physical condition. Next, the court found that the employer relied upon the claimant’s false representation, and this reliance was a substantial factor in hiring the claimant. The court further reasoned that the employer’s “reliance was twofold,” pertaining to both hiring of employees and placement of
employees in suitable job assignments. Finally, the court found a causal connection between the false information and the claimant’s back injury, as the claimant admitted that the injury at issue was in the same area as a previous back injury and medical evidence specified that the injury at issue exacerbated his prior military injury. Because the claimant’s false responses amounted to material misrepresentations under the Cooper test, the court held that the employment relationship was vitiated, and that therefore, the claimant was not eligible for workers’ compensation.

The case of Fredrick v. Wellman, Inc., 385 S.C. 8, 682 S.E.2d 516 (2009), addresses an employer’s discovery of fraud in the application at advanced stages of litigation. In Fredrick, a claimant lied about having a prior back injury on her application for employment and later injured her back and sought workers’ compensation benefits. Unaware of her prior injury, the employer admitted the claim and began paying claimant temporary total disability (TTD) and medical expenses. When the claimant refused surgery for her condition, the employer/carrier filed a Form 21 to stop TTD on grounds of refusal of medical treatment.

During discovery, the employer/carrier learned of the claimant’s prior back injury, and in the pre-hearing brief alleged fraud as an additional basis for stopping payment. At the hearing, the claimant alleged that the employer/carrier allegations of fraud were not properly before the Workers’ Compensation Commission. After numerous appeals on the issue, the South Carolina Court of Appeals ruled that fraud was a jurisdictional defense that could be raised at any time, and that therefore, the issue was properly before the Commission. The court also affirmed the lower tribunals’ rulings that the employer/carrier had proved the elements of the fraud defense, namely that the claimant had made a knowing false representation that the employer relied on, and that there was a causal connection between the concealment of the condition and the claimant’s injury. Accordingly, the claimant’s workers’ compensation benefits were terminated.

12. Are recreational and other non-work activities paid for or supported by the employer compensable?

These claims depend upon such factors as the degree of control exercised by the employer over the activity. Whether the activity is voluntary or mandatory, and whether the employee derives a direct, substantial benefit from the activity beyond that common to all such activities such as employee morale. See Grice v. Nat’l Cash Register Co., 250 S.C. 1, 156 S.E.2d 321 (1967). Also as a general rule, employee's injury while engaged in recreational activities is not naturally and logically within the protection of the workers' compensation law, even if the claimant's injury arises out of acts, which are of some benefit to the employer. Williams v. City of Columbia, 218 S.C. 287, 62 S.E.2d 469 (1950).

Most recently, in Pierre v. Seaside Farms, Inc., 386 S.C. 534, 689 S.E.2d 615 (2010), the court discussed the compensability of injuries sustained by workers who live in employer-provided homes on the employer’s premises. In Pierre, the claimant was hired
as a seasonal worker at a tomato farm and packing house. Under the terms of employment, the claimant was to work Monday through Sunday, with no set hours or days for the job. As the company president testified, the nature of the tomato packing business is such that employees must "work as the season dictates and as we can harvest." The employer also offered housing to seasonal workers at no charge. The housing was conveniently located to the packing facility, and most of the seasonal workers resided in the employer-provided housing.

The claimant accepted the employer-provided housing and agreed to start work the next morning. That evening, the claimant decided to explore the housing area, and was injured when he fell on a wet sidewalk as he walked out of the door of his unit. The employer denied the claim. The case made it up to the Supreme Court of South Carolina where the claimant urged the court to adopt the "bunkhouse rule." The bunkhouse rule states that when an employee is required to live on the employer’s premises, either by his contract of employment or by the nature of his employment, and is continuously on call (whether or not actually on duty), the entire period of his presence on the premises pursuant to this requirement is deemed included in the course of employment. An exception to the bunkhouse rule exists for employees with fixed work hours outside of which he is not on call. In those factual scenarios, compensation will be awarded only if the course of the injury was a risk associated with the conditions under which claimant lived because of the requirement of remaining on the premises.

The Pierre court never explicitly adopted the bunkhouse rule. However, it held that the claimant’s accidental injury arose out of and in the course of his employment because he was in essence required to live on the employer’s premises by the nature of his employment, and he was making a reasonable use of the employer-provided premises at the time of his accident.

13. Are injuries by co-employees compensable?

In Strickland v. Galloway, the Court of Appeals found that the immunity provided by the exclusive remedy provision in the Workers’ Compensation Act extends not only to the employer, but also to a coworker when the coworker is operating within the scope of employment. 348 S.C. 644, 560 S.E.2d 448 (Ct. App. 2002).

Injuries by co-employees are compensable even when the claimant is a non-participating victim of the horseplay of another as long as the victim is engaged in his work duties at the time of the accident. S.C. Code Ann. § 42-1-160; Bright v. Orr-Lyons Mills, 285 S.C. 58, 328 S.E.2d 68 (1985); Allsepp v. Daniel Constr. Co., 216 S.C. 268, 276, 57 S.E.2d 427, 430 (1950).

However, when an employee is assaulted by a co-employee due to a personal relationship, the resulting injuries are not compensable. In the case of Stone v. Traylor Brothers, Inc., 360 S.C. 271, 600 S.E.2d 551 (Ct. App. 2004) the claimant was injured when she was assaulted by her estranged boyfriend at work. Her boyfriend was also an employee of the
company. There was evidence that the claimant and Stone had previously fought at home and at work. The Court of Appeals found the claim was not compensable, as the claimant's injuries originated from her personal relationship with boyfriend, rather than out of the workplace. There was no causal connection between the conditions under which the claimant’s work was required to be performed and the resulting injury.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

Injuries inflicted by co-employees or third persons for personal reasons or growing out of matters not connected with employment are generally not compensable. See *Bridges v. Elite, Inc.*, 212 S.C. 514, 48 S.E.2d 497 (1948).

15. **What criterion is used for calculating the average weekly wage?**

In June 18, 1996, S.C. Code Ann. § 42-1-40 was amended to simplify the calculation of wages. Subsequent to this amendment, the average weekly wage is calculated by "taking the total wages paid for the last four quarters immediately preceding the quarter in which the injury occurred as reported on the Employment Security Commission's Employer Contribution Reports divided by fifty-two or the actual number of weeks for which wages were paid." However where an employee has not worked four quarters, the method as described in the above paragraph is utilized. Also, when the time the employee worked is brief, the wages of a like employee should be submitted. This new procedure has been codified in Reg. 67-1603. Additionally, “[w]hen for exceptional reasons the foregoing would be unfair, either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.”

In *Brunson v. Wal-Mart Stores, Inc.*, 344 S.C. 107, 542 S.E.2d 732 (Ct. App. 2001), the court addressed the formula for calculating a claimant’s average weekly wage. In *Brunson*, the claimant suffered compensable and admitted injury while employed with Wal-Mart. While employed with Wal-Mart, however, claimant was simultaneously employed with an additional third-party employer. Following his accident, the claimant filed for benefits, and single commissioner calculated the claimant’s average weekly wage by combining his weekly wages earned with Wal-Mart with one-half of the weekly wages he would have earned with the third-party employer.

On appeal, the South Carolina Court of Appeals found support in a prior line of cases for ruling that the claimant’s dual employment was an exceptional circumstance requiring deviation from the standard method of calculating a claimant’s average weekly wage pursuant to S.C. Code Ann. § 42-1-40. On the other hand, however, the court held that it was “grossly unfair to Wal-Mart to require payments based on Brunson’s dual employment status since he did not intend to work both jobs after the holidays.” The court therefore remanded the case to the Workers’ Compensation Commission to make factual findings as
to how long the claimant would have worked dual-employment during the holidays. The court further held that upon making this determination, the Commission should reconsider the calculation of the claimant’s average weekly wage in light of the exceptional reason of his dual employment solely over the holiday season.

Dual employment may impact the calculation of the claimant’s average weekly rate as noted in Sellers v. Pinedale Residential Center, 350 S.C. 183, 564 S.E.2d 694 (Ct. App. 2002). The claimant, a high school student, suffered a work-related injury while in the course and scope of his employment with Pinedale Residential Center. The claimant was also simultaneously employed with a second employer. The Workers’ Compensation Commission calculated the claimant’s average weekly wage, and corresponding compensation rate, utilizing the wages earned in his dual employment. Subsequently, the claimant submitted wage information from a third employer, and the claimant’s compensation rate was adjusted to reflect the combined wages. The claimant signed a Form 15 providing for the corrected compensation rate.

Thereafter, the claimant filed a Form 50 alleging that circumstances existed that warranted recalculation of the claimant’s average weekly wage and compensation rate to reflect probable future wages. A hearing was conducted wherein a commissioner adjusted the claimant’s average weekly wage and compensation rate based on his future earning capacity as an apprentice, journeyman, and master electrician.

After numerous appeals, the South Carolina Court of Appeals held that S.C. Code Ann. § 42-17-10 provides for adjustments to the compensation rate “if subsequent to filing with the Commission, it is determined that such rate does not reflect the correct average weekly wage of the claimant.” The court further relied upon Reg. 67-508 (repealed after the claimant’s date of accident) to find that the Commission possessed the authority to modify the claimant’s average weekly wage and compensation rate. More importantly, the court held that S.C. Code Ann. § 42-1-40 provides the Commission with the necessary statutory authority to adjust the claimant’s wages to provide for progressively higher wages based upon probable future earnings. Relying upon the decision in Bennett v. Gary Smith Builders, 271 S.C. 94, 245 S.E.2d 129 (1978), the court held that § 42-1-40 “provides an elasticity or flexibility” to consider exceptional circumstances in the approximation of the claimant’s average weekly wage and compensation rate. The claimant satisfied the “exceptional circumstance” through testimony and evidence indicating that the claimant, but for his injury, would have been employed as an electrician and would have earned significantly higher wages in the future.

In 2004 the court revisited the “exceptional circumstances” test in the case of Elliott v. SCDOT, 362 S.C. 234, 607 S.E.2d 90 (Ct. App. 2004). The claimant in Elliott earned a merit-based pay increase eight days prior to her injury. The court held this qualified as an "exceptional reason" to recalculate her average weekly wage, as the claimant earned her pay increase by voluntarily pursuing special certification and licensing; the additional pay was a merit-based reward given in recognition of her efforts to obtain a commercial driver's license and was not merely a standard cost-of-living increase or step increase.
based on longevity of service; and the raise was not speculative, but, rather, was an established, guaranteed amount already in place at the time of the accident.

The 2005 case of Roberts v. McNair Law Firm, 366 S.C. 50, 619 S.E.2d 453 (Ct. App. 2005) clarified that merit raises received after a claimant returns to work following an injury do not constitute “exceptional circumstances” warranting a recalculation of the compensation rate. The court distinguished the facts from those in the Sellers case, and noted that a similar argument could be made in almost every worker's compensation case.

In Forrest v. A.S. Price Mechanical, 373 S.C. 303, 644 S.E.2d 784 (Ct. App. 2007), the court again addressed the issue of calculating average weekly wage when a claimant is employed by several different employers at once. In that case, the claimant was working for two different employers at the time he was injured in an admitted accident that left him a paraplegic. He also had been employed by a third employer on a regular basis prior to his injury, but was not working for that particular employer at the time of his accident. The Commission determined that the claimant’s earnings from all three employers should be considered when calculating the claimant’s average weekly wage. The Commission noted the five “exceptional circumstances” that justified deviation from the standard method of calculating average weekly wage: 1) the claimant’s young age at the time of his injury, 2) the claimant’s demonstration of a strong work ethic and the willingness to work year round for multiple employers, 3) the fact that the claimant had a history of working for two or three different employers at once, 4) the severity of the claimant’s injury, and 5) the fact that the Employer responsible for the claim was aware that the claimant often worked several jobs at once. The Court of Appeals approved the Commission’s reasoning and concluded that a calculation based on income from all three employers would provide the most accurate reflection of the claimant’s “probable future earning capacity.”

Additionally, in Anderson v. Baptist Medical Center and Palmetto Hospital Trust Fund, 343 S.C. 487, 541 S.E.2d 526 (2001), the South Carolina Supreme Court addressed whether the claimant’s fringe benefits should be included in the calculation of her average weekly wage. The court declared that the amount of money per week that the employer paid for the claimant’s medical, disability, and life insurance should not be included in the calculation of her average weekly wage. Relying upon the language of S.C. Code Ann. § 42-1-40 (1985 & Supp. 1999), the court held that before an allowance will be included in the average weekly wage calculation, it must (1) be made in lieu of wages, and (2) be a specified part of a wage contract.

The Anderson court also cited as a basis for its decision the case of Stephen v. Avins Const. Co., 324 S.C. 334, 478 S.E.2d 74 (Ct. App. 1996), in which the court held that the average weekly wage should be calculated based only on the actual sum paid to the employee as his wages, not the totality of payments including reimbursements. Concluding that Stephens was consistent with the majority view of other states, most notably, North Carolina, the Anderson court found that the claimant produced no evidence that her employer paid her insurance premiums in lieu of wages or that the insurance premiums were a specified part of
her wage contract. Additionally, the court ruled that to include fringe benefits, such as insurance, in the calculation of the average weekly wage would alter the practice of workers’ compensation law in South Carolina. Moreover, the court determined that any such change in the calculation of the average weekly wage under the Workers’ Compensation Act is within the purview of the South Carolina legislature.

The Anderson case was recently examined in Bazen v. Badger R. Bazen Company, Inc., 388 S.C. 58, 693 S.E.2d 436 (Ct. App. 2010). In Bazen, the claimant was employed by his father, who as part of an oral employment contract, promised to pay his claimant son $30,000 per year, plus a tank of gas per week, and allow him to use a house and storage building free of charge. The South Carolina Court of Appeals agreed that the claimant’s use of the home and storage facility rent-free was an integral part of the parties' employment contract, and not a mere fringe benefit as discussed in Anderson v. Baptist Medical Center, 343 S.C. 487, 541 S.E.2d 526 (2001). Accordingly, the fair rental value of the home was included in the calculation of the claimant’s average weekly wage.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The rate for temporary lost time benefits is calculated by taking 66 2/3% of a claimant's average weekly wage. This is set forth in S.C. Code Ann. § 42-9-10, which states that the compensation rate is not to be less than $75.00 so long as this amount does not exceed the average weekly salary of a claimant. If this amount exceeds a claimant's average weekly salary, the injured employee is paid his average weekly salary. The injured employee may not be paid more each week than the average weekly wage in the State of South Carolina for the preceding fiscal year. As of January 1, 2015, the maximum compensation rate allowed is $766.05, which equates to an average weekly wage of $1,149.02, and a yearly salary of $59,749.02.

Below is a table the maximum compensation rate in South Carolina, by year, since 1982.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Maximum Compensation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/20</td>
<td>$866.67</td>
</tr>
<tr>
<td>1/1/19</td>
<td>$845.74</td>
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<tr>
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<td>$689.71</td>
</tr>
<tr>
<td>1/1/09</td>
<td>$681.36</td>
</tr>
</tbody>
</table>
17. **How long does the employer/insurer have to begin TTD benefits from the date disability begins?**

Under S.C. Code Ann. § 42-9-200, no compensation shall be allowed for the first 7 calendar days of disability resulting from an injury, but if the injury results in disability of more than 14 days, compensation shall be allowed from the date of the disability. Temporary total benefits may be allowed on the 8th calendar day after the date of incapacity, which is the first day following receipt of full pay from the employer. Under S.C. Regulation 67-503 medical, surgical and hospital treatment is allowed from the first day of injury.

S.C. Code Ann. § 42-9-230 states that the first installment of compensation payable under the terms of an agreement is due on the 14th day after the employer has knowledge of the injury of death, on which date all compensation due must be paid.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out
days before recovering benefits for the first ___ days)?

The waiting period for temporary benefits is set forth in S.C. Code Ann. § 42-9-200 and states that an employee must be out 14 days before recovering benefits for the first 7 days.

19. What is the standard/procedure for terminating temporary benefits?

A. Within 150 Days of the Accident.

According to § 42-9-260, for dates of accident on or after June 18, 1996, the employer may terminate or suspend temporary disability payments within 150 days of the accident if any of the following conditions exist:

i. The claimant returns to work. If the claimant does not remain at work for a minimum of 15 days, the employer must immediately resume temporary disability payments.

ii. The claimant signs a Form 17 indicating that the claimant is able to return to work.

iii. The employer has a good faith basis to deny the claim.

iv. The claimant is released for work without restriction, and the employer offers comparable employment.

v. The claimant is released for limited duty work, and the employer provides limited duty work.

vi. The claimant refused medical treatment, as provided in § 42-15-60 or the claimant refuses an examination or evaluation, as provided in § 42-15-80.

B. At Any Time

An employer may file a Form 21 at any time to request an evidentiary hearing by the Commission to have payments terminated or reduced. After the first 150 days after the Employer’s Notice of Injury, Regulations 67-505 and 67-506 provide the method and procedure by which benefits are suspended and terminated.

Regulation 67-505 states that disability is presumed to continue until the claimant returns to work. The employer’s representative may suspend temporary compensation when the claimant’s treating physician releases the claimant to return to regular or light duty work and the employer provides such work, or when the claimant returns to work with a different employer. Of course, the employer must continue to pay any temporary partial compensation that is due – for instance when a claimant returns to work for less pay or at reduced work hours than he or she was receiving prior to the injury.
If the claimant is unable to complete 15 days of work, the employer shall reinstate temporary compensation. If the claimant completes 15 days, the employer’s representative must present a Form 17 to be signed by the claimant. Temporary compensation will be terminated when the employer’s representative files the signed Form 17. If the claimant refuses to sign a Form 17, the employer’s representative must file a Form 21 requesting a hearing to officially terminate compensation, which has already been suspended.

Regulation 67-506 provides that, aside from those circumstances described in Regulation 67-505, the employer’s representative must request a hearing to terminate temporary compensation after the first 150 days following the claimant’s injury. This applies to those situations where the claimant is unable to or refuses to return to work.

The Commission will not permit a stop payment hearing if the employer is not current with temporary compensation payments. When an employer requests a stop payment hearing, the employer must also file a current Form 18 (Six Month Report) to indicate that the employer has paid all TTD that is due. If, in fact, the employer has unilaterally terminated or suspended TTD payments, the employer will be subject to a twenty-five percent penalty for those unpaid benefits that have accrued pursuant to § 42-9-260(G).

In Pollack v Southern Wine and Spirits of America, 405 S.C. 9, 747 S.E.2d 430 (2013), the South Carolina Supreme Court determined that an injured worker on light duty who is fired for cause is not entitled to temporary total disability benefits. The employer in that case had provided suitable light duty within the restrictions imposed by the treating doctor. The Claimant was subsequently fired for failure to comply with company policy. The Court found that the Claimant was out of work for causes stemming from violation of company policy, not his work related injury, and therefore was not entitled to temporary total compensation. In this case, the Court found that the Commission had “thoughtfully considered the evidence, remaining sensitive to an employer’s possible motivation to look for a reason to fire an injured worker.”

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

In most situations, the amount of temporary total disability paid is not credited toward the amount entitled for permanent partial disability; however, if a claimant is found to be permanently and totally disabled, he is limited to 500 weeks of disability. In that situation, any temporary total disability that has been paid will be included in the 500 weeks. However, as set forth in S.C. Code Ann. § 42-9-10, any claimant who is determined to be totally and permanently disabled, who as a result of a compensable injury, is a paraplegic, a quadriplegic, or who has suffered physical brain damage, is not subject to the 500 week limitation and shall receive the benefits for life.

One other instance where temporary total disability paid may be credited towards the amount of permanent partial disability is a situation where the claimant has been found to
have reached maximum medical improvement, however, has continued to receive temporary total benefits. Under S.C. Code Ann. § 42-9-210, any payments made by an employer to an injured employee during the period of his disability, which by the terms of this Title were not due and payable when made, may, subject to the approval of the Commission, be deducted from the amount to be paid as compensation.

21. **What disfigurement benefits are available and how are they calculated?**

Under the Act, serious disfigurement is a scheduled injury and is controlled by S.C. Code Ann. § 42-9-30 (21). That § states that proper and equitable benefits shall be paid for serious permanent disfigurement of the face, head, neck or other area normally exposed in employment not to exceed 50 weeks. Where benefits are paid or payable for injury to or loss of a particular or organ under other provisions of this title, no additional benefits shall be paid under this paragraph, except that disfigurement shall also include compensation for serious burn scars or keloid scars on the body resulting from injuries, in addition to any other compensation. Normally, disfigurement connotes appearance. Except in cases of facial disfigurement, the deformity or imperfection need not itself be visible, if its results are visible. (e.g., where a noticeable limp follows imperfect union of a broken tibia, the deformity of the bone itself being concealed from observation). Bowen v. Chiquola Manuf. Co., 238 S.C. 322, 120 S.E.2d 99 (1961).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates:**

In South Carolina there are two forms of permanent partial disability benefits. S.C. Code Ann. § 42-9-30 sets forth the amount of compensation and period of disability for injuries to “scheduled members.” With a scheduled member injury, loss of earnings is not required for recovery. Instead, compensation is based solely on the character of the injury. Bateman v. Town and Country Furniture Co., 287 S.C. 158, 336 S.E.2d 890 (Ct. App. 1985). The impairment to scheduled member injuries is determined by the treating physicians, however, the workers' compensation commissioners determine how much disability actually resulted from the impairment. § 42-9-30 sets forth the scheduled members and states that scheduled injuries include injuries to fingers, toes, hand, arm, foot, leg, eye, vision, hearing, back, and disfigurement. Article 11 of the S. C. Regulations also deals with scheduled losses; specifically 67-1101 covers total or partial loss of use of many permanent parts of the anatomy; 67-1102 covers loss of hearing; 67-1103 covers amputation of a finger or toe; 67-1104 covers hernias; and 67-1105 covers loss of vision.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

Under S.C. Code Ann. § 42-9-30:

<table>
<thead>
<tr>
<th>Scheduled Members</th>
<th>Maximum Weeks</th>
</tr>
</thead>
</table>

32
Additional scheduled members, to include internal organs, are listed in Regulation 67-1101.

Another form of permanent partial disability is for non-scheduled injuries and is governed by S.C. Code Ann. § 42-9-20. This section, more commonly known as the “wage loss section,” states that when the incapacity for work resulting from the injury is partial, the employer shall pay, to the injured employee during such disability, a weekly compensation equal to 66 2/3% of the difference between his average weekly wages before the injury and the average weekly wages which he is able to earn thereafter, but not more than the average weekly wage in this state for the preceding fiscal year. In no case shall the period covered by compensation be greater than 340 weeks from the date of injury.

In Gilliam v. Woodside Mills, the South Carolina Court of Appeals determined that the hip is not part of the leg and therefore not a scheduled member under the Act. 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993), aff’d in part, remanded in part 319 S.C. 285, 461 S.E.2d 818 (1995). Therefore an injury to the hip can be covered by the wage loss § 42-9-20. Another dispute that arises under South Carolina law is whether an injury to the shoulder is properly classified as an injury to the “upper extremity” under § 42-9-30, or whether the shoulder is a “non-scheduled member,” thereby permitting an award of permanent partial disability under the wageloss statute.

In Therrell v. Jerry’s, Inc., 370 S.C. 22, 633 S.E.2d 893 (2006), the claimant had injured her rotator cuff/shoulder, and the Commission awarded benefits under § 42-9-30(13) (1985) based on a percentage loss of use of the upper extremity. The claimant argued that the shoulder was not a scheduled member under § 42-9-30 (the scheduled injury provision), and that she was therefore entitled to an award of benefits under § 42-9-10, which awards wage
loss. The Supreme Court of South Carolina first found that the claimant’s injury resulted in no wage loss, and therefore was not properly compensated under § 42-9-10. The court turned next to § 42-9-30, and, analyzing the statute in its entirety, concluded that its application was most consistent with a “situs of the injury” approach – as opposed to a “functional limitation” analysis. Accordingly, an injury to any body part not specifically listed in the scheduled injury provision (or contained in Reg. 67-1101) must be awarded as a percentage of the whole man under the § 42-9-30(20) (1985). Using this analysis, therefore, the court concluded that an injury to the rotator cuff may not be awarded based on percentage loss of use to the upper extremity under the scheduled injury provision, and must be awarded as a percentage of the whole man. As noted above, for injuries occurring on or after July 1, 2007, the shoulder and the hip are now scheduled body parts under S.C. Code Ann. § 42-9-30 (1985 & Supp. 2007).

B. Number of weeks for "whole person" and standard for recovery.

Technically, there is no "whole man/person" scheduled benefit in S.C., but if a claimant is found to be permanently and totally disabled, his recovery is limited to 500 weeks. However, pursuant to S.C. Code Ann. § 42-9-10, the claimant is a paraplegic, a quadriplegic, or has suffered physical brain damage, the claimant will be entitled to receive lifetime benefits.

Furthermore, the law applicable to claims with dates of injury prior to July 1, 2007 provides that a claimant who is found to have suffered 50% or greater disability to his back is also determined permanently and totally disabled and, therefore, entitled to 500 weeks of benefits.

For back injury claims with dates of injury occurring on or after July 1, 2007, permanent disability awards for Claimants with less than 50% disability to the back will continue to be calculated based on a percentage of 300 weeks. However, claimants with 50% or greater impairment to the back are not automatically determined permanently and totally disabled. Instead, greater than 50% disability will create a presumption of permanent and total disability that may be rebutted by the employer/carrier. If the employer/carrier is successful in rebutting this presumption, the claimant’s permanency award will be based on a percentage of 500 weeks. For example, a claimant who has sustained 55% disability to the back and is determined not to be permanently and totally disabled will be entitled to 275 weeks of compensation, or 55% of 500.

In Clemmons v. Lowe’s Home Centers, Inc.-Harbison, 420 S.C. 282, 803 S.E.2d 268 (2017), the South Carolina Supreme Court reversed the Commission’s determination that the Claimant had less than 50% disability related to his back injury. The claimant in that case sustained admitted injuries to his neck and back. The treating physician released the claimant at MMI with 25% medical impairment. Various other physicians and physical therapists also provided their opinions as to the extent of impairment. The Claimant continued working as a cashier for the employer. In the Supreme Court’s analysis of the evidence, it converted the impairment ratings to regional ratings of the cervical and lumbar
spine according to formulas set forth in the AMA Guides. The court made these conversions for each rating despite the fact that in some instances, including the treating physician’s rating, the physicians had not made this conversion themselves. Based upon these conversions, the regional impairment ratings were all greater than 50%. Therefore, the court held that the Commission’s award of less than 50% disability was not supported by substantial evidence and therefore must be reversed. The court remanded to the Commission to determine whether the employer had rebutted the presumption of permanent and total disability. In response to this opinion, employers/carriers should make certain that physicians clearly articulate medical impairment relative to spine injuries and provide their opinions in terms of ratings “to the back” as opposed to “whole person” ratings.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

In South Carolina, the only instance where vocational rehabilitation is required is in the area of ionizing radiation injury. Under S.C. Code Ann. § 42-13-90 an employee whose injury prevents his further employment due to restrictions on radiation exposure and whose skills are not transferable to equivalent work not involving radiation exposure, is entitled to vocational rehabilitation services at the employer's expense. This vocational training will not exceed 52 weeks except in "unusual cases, when the period may be extended for another 26 weeks." If the services are not voluntarily by the employer, the Commission, even upon its own motion, may order an examination by a physician whose report, if such services are indicated, will be used to justify an order to the employer compelling treatment.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

As stated previously, S.C. Code Ann. § 42-9-10 governs the amount of compensation for total disability. That section states that when the incapacity for work resulting from an injury is total, the employer shall pay, or cause to be paid, as provided in this Chapter, to the injured employee during the total disability, a weekly compensation equal to 66 2/3% of his average weekly wages, but not less than $75.00 a week so long as this amount does not exceed his average weekly salary. The injured employee may not be paid more each week than the average weekly wage in this state for the preceding fiscal year. In no case may the period covered by the compensation exceed 500 weeks except as hereinafter provided.

The loss of both hands, arms, feet, legs, or vision in both eyes, or any two thereof, constitutes total and permanent disability to be compensated according to the provisions of S.C. Code Ann. § 42-9-10. In Wigfall v. Tidelands Utilities, 354 S.C. 100, 580 S.E.2d 100 (2003), the Supreme Court reaffirmed the longstanding principle set forth in Singleton v. Young Lumber, 236 S.C. 454, 114 S.E.2d 837 (1960), that a workers' compensation claimant with one scheduled injury is limited to recovery under the scheduled disability statute (§ 42-9-30), and is not eligible for permanent and total disability under § 42-9-10. The recent Court of Appeals decision Dent v. East Richland County Public Service District,
423 S.C. 193, 813 S.E.2d 886 (2018) concluded that a claimant with a back injury and radiculopathy that affected his legs qualified to seek permanent and total disability benefits for a two body-part injury.

The case of Ellison v. Frigidaire Home Products, 371 S.C. 159, 638 S.E.2d 664 (2006), is frequently asserted by claimants in claims with dates of accident prior to July 1, 2007, and which involve the combination of a work-related injury with either a prior work-related injury or pre-existing condition. In Ellison, the claimant sustained a compensable injury to his leg. After this injury he developed sleep apnea, diabetes, hypertension, prostate cancer and congestive heart failure, but there was no evidence that these were causally related to his work injury. He sought an award of permanent and total disability based on the combination of all these problems. The Court of Appeals found the claimant was limited to recovery under the scheduled member statute for his leg, as no causal connection existed between his fractured leg and his sleep apnea, diabetes, congestive heart failure, hypertension, or prostate cancer. The Supreme Court of South Carolina, however, reversed that decision, holding that an injury to a single body part may result in an award of total disability if the injury combines with pre-existing conditions so as to render the claimant totally disabled.

The 2007 reform legislation added S.C. Code Ann. § 42-9-35 to the Workers’ Compensation Act. This provision effectively reverses the Ellison decision for claims with dates of accident on or after July 1, 2007. That statute requires claimants seeking permanent and total disability benefits to prove by a preponderance of the evidence that an injury to a single body part aggravates a separate preexisting condition or that a preexisting condition aggravates a subsequent injury. S.C. Code Ann. § 42-9-35(A) (Supp. 2007). Therefore, under this change in the law, unrelated medical conditions may not be combined with compensable injuries to render a claimant permanently and totally disabled. Claimants who cannot demonstrate that a subsequent injury has some direct impact on a preexisting condition, or vice versa, will be limited to an award for injury to a scheduled body part as set forth in § 42-9-30. Of course, this provision applies only to injuries occurring after July 1, 2007. Ellison remains the law applicable to injuries occurring prior to that date.

Additionally, as mentioned previously, in an instance where a claimant is found to have suffered 50% or more disability to his back, he is determined permanently and totally disabled. Again, this applies only to injuries occurring before July 1, 2007. The law applicable to claims with dates of injury after July 1, 2007 provides that 50% or greater impairment to the back merely creates a presumption of permanent and total disability that may be rebutted.

Notwithstanding the 500 week limitation prescribed in § 42-9-10, any person determined to be totally and permanently disabled who, as a result of a compensable injury, is a paraplegic, a quadriplegic, or who has suffered physical brain damage is not subject to the 500 week limitation and shall receive the benefits for life. In Cox v. Bellsouth, 356 S.C. 468, 589 S.E.2d 766 (Ct. App. 2003) the court held the Workers’ Compensation Commission is empowered to award a partial lump sum payment of claimant's lifetime benefits awarded for
a brain injury if in the best interest of the parties. Total lump sum awards, however, are prohibited in lifetime benefits cases pursuant to § 42-9-10.

**Potter v. Spartanburg School District 7** is a recent South Carolina Court of Appeals decision involving brain injury, in which the court addressed the Workers’ Compensation Commission’s ability to disregard certain medical evidence the Commission deems unreliable. The court affirmed the Workers’ Compensation Commission’s denial of the claimant’s alleged physical brain injury. The claimant fell approximately 12-14 feet onto asphalt and lost consciousness for a few minutes. He fractured his right femur and sustained a cut above his eye. CT scans of his head revealed some initial abnormalities that later resolved. The claimant underwent a neurological consultation with Dr. Thomas Collings about 11 months after his accident. Dr. Collings determined the claimant’s reported problems with disequilibrium were probably not related to his fall. The claimant later underwent a neuropsychological evaluation with Dr. Randolph Waid, a clinical psychologist. Dr. Waid determined the claimant had “cognitive disorder residuals of traumatic brain injury.” The claimant then returned to Dr. Collings, who stated that he did not believe the claimant had “significant ongoing neurologic difficulty” from the original accident.

The single commissioner awarded permanent partial disability benefits with regard to the claimant’s leg, but denied the claimant sustained physical brain injury. The single commissioner’s order stated that Dr. Waid is a clinical psychologist, and his opinion “concerning alleged brain damage is beyond [h]is area of expertise.” The commissioner stated that he gave greater weight to the opinion of the treating physician. The Court of Appeals affirmed, concluding that the Commission did not err in assigning less weight to Dr. Waid’s opinion than the treating physician.

25. **How are death benefits calculated, including the minimum and maximum rates:**

Death benefits under South Carolina Workers’ Compensation Act are set out in S.C. Code Ann. § 42-9-290. That section states that if death results proximately from an accident and within two years of the accident or while total disability still continues and within six years after the accident, the employer shall pay, or cause to be paid, in one of the methods provided in this Chapter to the dependant of the employee wholly dependent upon his earnings for support at the time of the accident, a weekly payment equal to 66-2/3% of his average weekly wages, but not less than $75.00 a week nor more than the average weekly wage in this state for the preceding fiscal year for a period of 500 weeks from the date of the injury. S.C. Code Ann. § 42-9-290 also provides that burial expenses of up to $2,500.00 are to be paid as well. If in a situation where the employee leaves dependents only partly dependent upon his earnings for support at the time of the accident, the weekly payment must equal the same proportion of the weekly payments for the benefit of persons wholly dependent as the amount contributed by the employee to such partial dependence bears to the annual earnings of the deceased at the time of his injury. When weekly compensation payments have been made to the employee prior to his death, the payments to his beneficiaries commence immediately after the date of the last payment to the employee, however, the 500 week cap commences from the date of the injury. These benefits can, of course, be paid out over a 500 week period or any benefits that have not yet been paid, can
be commuted to present value and paid in a lump sum.

The Supreme Court recently clarified the law regarding inheritability of workers’ compensation awards where a claimant dies from causes unrelated to a compensable work injury in Floyd v. Askins, 382 S.C. 84, 675 S.E.2d 450 (Ct. App. 2009). In such cases, beneficiaries are entitled to the remainder of a deceased claimant’s award that is based on scheduled disability under S.C. Code Ann. § 42-9-30, or wage loss under § 42-9-10(B). However, in cases where a claimant is awarded lifetime benefits under 42-9-10(C) as a result of brain injury, paraplegia, or quadriplegia, benefits terminate upon the claimant’s death from an unrelated cause, and beneficiaries are not entitled to the remainder. In the more recent case of McMahan v. SC Department of Education-Transportation, 417 S.C. 481, 790 S.E.2d 393 (Ct. App. 2016), the Court of Appeals held that the posthumous adjudication of permanent and total disability is permitted under the Act, where a claimant dies from a cause other than the injury for which he was entitled to compensation.

26. What is the criteria for establishing a "Second Injury" fund recovery?

The S.C. Code Ann. § 42-9-400 governs the manner in which the employer or insurance carrier shall be reimbursed by the Second Injury Fund. That section states that if an employee who has a permanent physical impairment from any cause or origin incurs a subsequent disability from injury by accident arising out of and in the course of his employment, resulting in compensation and medical payments, liability or either, for disability that is substantially greater, by reason of the combined effects of the pre-existing impairment and subsequent injury or by reason of the aggravation of the pre-existing impairment, than that which would have resulted from the subsequent injury alone, the employer or his insurance carrier shall in the first instance pay all awards of compensation and medical benefits but such employer or his insurance carrier shall be reimbursed by the Second Injury Fund.

In order to qualify under § 42-9-400 for reimbursement from the Second Injury Fund, the employer must establish when the claim is made for reimbursement thereunder, that the employer had knowledge of the permanent physical impairment at the time that the employee was hired or at the time that the employee was retained in employment after the employer acquired such knowledge. Provided, however, the employer may qualify for reimbursement thereunder upon proof that he did not have prior knowledge of the employee's pre-existing physical impairment because either the existence of such condition was concealed by the employee or was unknown to the employee.

Under amendments to the law taking effect July 1, 2007, the Second Injury Fund was dissolved as of July 1, 2013. Second Injury Fund claims are barred for injuries occurring after July 1, 2008, and no additional claims have been accepted after December 31, 2011. S.C. Code Ann. § 42-7-320 (Supp. 2007).
27. **What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?**

A change of condition claim is governed by S.C. Code Ann. § 42-17-90. That section states that upon its own motion or upon the application of any party in interest on the ground of a change in condition, the Commission may review any award and on such review they make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum or minimum provided in this title, and shall immediately send to the parties a copy of the order changing the award. No such review shall affect such award as regards any monies paid and no such review shall be made after twelve months from the date of the last payment of compensation pursuant to an award. Causby v. Rock Hill Printing and Finishing Co., 249 S.C. 225, 153 S.E.2d 697 (1967) states that a change in condition means a change in the physical condition of the claimant as a result of the original injury, occurring after the first award.

In the case of Owenby v. Owens Corning Fiberglass, 313 S.C. 181, 437 S.E.2d 130 (Ct. App. 1993), the Court of Appeals stated that a change of condition claim must be for a claim which was previously compensated. Where a single commissioner found insufficient evidence to support a psychological claim, that same claim cannot be raised on a later change of condition.

Effective July 1, 2007, the change of condition statute was amended to require that awards for a change of condition be based on “proof by a preponderance of the evidence that there has been a change of condition caused by the original injury, after the last payment of compensation.” S.C. Code Ann. § 42-17-90 (Supp. 2007).

In Tucker v. SCDOT, the South Carolina Supreme Court held that the claimant may toll the one year period for proving change of condition by filing a notice of claim, without requesting a hearing. 427 S.C. 299, 831 S.E.2d 426 (2019). However, the court also concluded that a claimant should not be permitted to “intentionally delay a hearing in the hope that evidence will later develop to support a change of condition claim.” If the employer suspects such an effort, it “may request a hearing or in some other fashion seek to protect its interests.”

28. **What situation would place responsibility on the employer to pay a claimant's attorney fees?**

The only applicable situation would be wherein the attorneys affecting the recovery from a liable third party and the extent of recovery shall be deemed to be for the benefit of the carrier, the employer/Carrier would be responsible to pay reasonable and necessary expenses, including attorney's fees incurred in effecting the recovery. This fee is usually one-third of the amount deemed to be for the benefit of the employer/Carrier.
29. **Is the compensation remedy exclusive?**

S.C. Code Ann. § 42-1-540. The rights and remedies granted by this title to an employee when he and his employer have accepted the provisions of this title, respectively, to pay and accept compensation on account of personal injury or death by accident, shall exclude all other rights and remedies of such employee, his personal representative, parents, dependents or next of kin as against his employer, at common law or otherwise, on account of such injury, loss of service or death.

The South Carolina Workers’ Compensation Act prohibits an employee from suing his or her employer at common law for personal injury, which is defined as injury by accident arising out of and in the course of employment. Decisions applying South Carolina law have strictly construed this definition. Our supreme court has held the intentional infliction of emotional distress constitutes a personal injury that falls within the scope of the act. Loges v. Mack Trucks, Inc., 308 S.C. 134, 137, 417 S.E.2d 538, 540 (1992). This was recently upheld in the case of McClain v. Pactiv Corp., 360 S.C. 480, 602 S.E.2d 87 (Ct. App. 2004). The McClain court noted that only when the tortfeasor/co-employee is the “alter ego” of the employer that the liability falls outside the scope of the Act, and that only “dominant corporate owners and officers” constitute “alter egos.” Otherwise, the claimant’s exclusive remedy is under Workers’ Compensation.

There has generally been strict adherence to the "exclusive remedy" doctrine in South Carolina, but there has also been "moderate" erosion by court rulings. The key to determining whether the exclusive remedy provision of the South Carolina Workers’ Compensation Act applies to exclude all other remedies is not whether the employer chooses to assert a claim for benefits under the Act, but whether both the employee and employer are subject to the Act, and actual coverage exists.

The Supreme Court addressed the “exclusive remedy doctrine” in Cason v. Duke Energy Corp., 348 S.C. 544, 560 S.E.2d 891 (2002). In Cason, the plaintiffs sustained injuries in the course and scope of their employment as the result of an accidental catastrophic event, and received workers’ compensation benefits from the defendant. The plaintiffs then filed a negligence action against the defendant/employer, and the defendant removed the case to federal court. Subsequently, the federal court judge certified to the South Carolina Supreme Court the question of whether § 42-5-250 permits employees, injured in explosions of boilers or flywheels or other single catastrophic explosions, to pursue litigation outside the exclusive remedy provisions of the Workers’ Compensation Act against their employers for damages to compensate them, for injuries received within the scope of their employment.

The South Carolina Supreme Court, in a per curiam opinion, held that § 42-5-250 neither creates an exception to the exclusivity provisions of the Workers’ Compensation Act, nor permit employees injured in a catastrophic explosion to pursue litigation against their employer outside the Workers’ Compensation Act. The Court concluded that § 42-5-250
was not “concerned with the relationship between employer and employee, but with the applicability of the Act to certain types of insurance policies.” In other words, § 42-5-250 was written to “ensure that catastrophic loss liability policies were not transmuted into Workers’ Compensation liability policies.”

In contrast, *Harrell v. Pineland Plantation Ltd.*, 377 S.C. 313, 523 S.E.2d 766 (1999), the South Carolina Supreme Court determined that nothing in the South Carolina Workers’ Compensation Act prohibits an employee from recovering both workers’ compensation from one employer and tort damages from an upstream employer who failed to secure compensation. The Court in *Harrell* went onto hold that a partnership that owned and operated a plantation, and that contracted with a management firm to run the plantation could not claim immunity from tort liability to an employee injured on partnership property under the exclusive remedy provision of the Act. The exclusive remedy provision was unavailable to the partnership because it did not secure payment of workers’ compensation for the employee. (See also *Glover v. U.S.*, 337 S.C. 307, 523 S.E.2d 763 (1999) holding that the federal government, as statutory employer of a subcontractor’s employees who were injured while working on an air force base renovation project, was not immune from tort liability for employees’ injuries under the exclusive remedy provision because the government did not purchase its own workers’ compensation insurance or qualify as a self-insurer under the Act).

In general, South Carolina courts and the Workers’ Compensation Commission have been liberal on finding an individual to be an “employee,” and covered under the Act. In light of the previous propensity, the courts in South Carolina strongly prevent direct suits by an employee against an employer.

A. **Scope of immunity.**

Provided, however, this limitation of action shall not apply to injuries resulting from acts of a subcontractor of the employer or his employees or bar actions by an employee of one subcontractor against another subcontractor or his employees when both subcontractors are hired by a common employer.

B. **Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

The South Carolina Supreme Court in *Dickert v. Metropolitan Life Insurance Company*, 311 S.C. 218, 428 S.E.2d 700 (1993), found that it is against public policy to extend immunity to the co-employee who inflicts an intentional tortious act upon another employee. The Act may not be used as a shield for a co-employee's intentional injurious conduct. This is consistent with our court's precedent that an employer, acting through an alter-ego, may not do so.

The Supreme Court addressed the dual persona doctrine in *Tatum v. Medical University of South Carolina*, 346 194, 552 S.E.2d 18 (2001) but chose not to apply the doctrine in that case. In *Tatum*, the plaintiff sustained a work-related injury in the course of her
employment with MUSC. Subsequently, a physician employed by MUSC performed surgeries on the plaintiff’s back. Soon thereafter, the plaintiff filed a medical malpractice action against MUSC alleging damages as a result of the physician’s negligence.

The Supreme Court held that an employee of a governmental entity/hospital, who sustains a compensable work-related injury, may not maintain a tort action against the governmental entity/hospital, for the negligence of the treating physician. The court concluded that the “provisions in both the Tort Claims Act and the Workers’ Compensation Act clearly establish the General Assembly did not intend to allow a government employee to maintain a tort action against her employer when workers’ compensation is applicable.”

The court cited S.C. Code Ann. § 15-78-6 (14), and held that the Tort Claims Act “specifically bars an action by an employee against her government employer when the claim is covered by workers’ compensation.” In addition, the court determined that the State and its employees are subject to the exclusivity provision of the Workers’ Compensation Act. Most importantly, however, the court concluded that S.C. Code Ann. § 42-15-70 was applicable in the present case, and that “[t]he original work-related injury is regarded as the proximate cause of the damage flowing from the subsequent negligent treatment.”

The court determined the “dual persona” doctrine did not apply because MUSC did not take on a legally distinct persona of the plaintiff’s treating hospital by referring her to a physician for treatment. The court held that MUSC was “only one legal entity even though it may act in many different capacities, including those of employer and medical provider.” More notably, the court concluded “even if we were to adopt the ‘dual persona’ doctrine, it is inapplicable in this situation.”

However, the court recently revisited this doctrine in Mendenall v. Anderson Hardwood Floors, Inc., 401 S.C. 558, 738 S.E.2d 251 (2013). In response to a certified question from the U.S. District Court, the Supreme Court stated that South Carolina does recognize the dual persona doctrine as an exception to the WC exclusivity provision. Walterboro Veneer was a predecessor company to Anderson. Walterboro designed a constructed cement vat for the purpose of soaking hardwood logs in a highly heated solution prior to milling. The decedent was hired by Anderson, and fell in the vat while attempting to access a steam leak for repairs. The vat was 193 degrees and burned 90 percent of his body, ultimately resulting in his death. The decedent’s heirs received workers’ compensation benefits from Anderson, and also sued Anderson for negligent manufacture, design, failure to warn, and negligent maintenance.

Although the court determined that South Carolina recognizes dual persona doctrine, the court did not conclude whether the doctrine should apply in this case. It did, however, state that the Tatum court’s application of the dual persona doctrine to the facts of that case was erroneous (see above). The court explained that the doctrine is a very narrow exception that permits a claimant to sue an employer in tort only when an employer “possesses a second persona so completely independent from and unrelated to its status as employer that by
established standards the law recognizes that persona as a separate legal person.” It is applicable only where the second set of obligations that forms the basis of the tort suit is entirely independent of the defendant’s obligations as an employer. The doctrine applies in only “truly exceptional situations” where it is possible to say that a duty arose solely from the non-employer persona.

30. **Are there any penalties against the employer for unsafe working conditions?**

S.C. Code Ann. § 42-9-70 allowed for an increase in compensation when injury or death was due to the fault of the employer, however, this was repealed effective June 27, 1988.

31. **What penalty, if any, for an injured minor?**

The Act specifically defines "employee" to include both legally and illegally employed minors. All contracts of employment executed between minors and employers are presumed to have been made subject to the Act unless the requisite notice is given by or to the parent or guardian of the minor. There is not a penalty or an increase in compensation for an injured minor.

32. **What is the potential exposure for "bad faith" or claims handling?**

Employees are barred from suing insurance carriers and employers at common law for "bad faith" refusal to pay statutory benefits. The South Carolina Court of Appeals reasoned that the exclusiveness of workers' compensation precluded any such action. The Court pointed out that the Act expressly covers the situation in which the employer or carrier refuses to pay benefits and provides a remedy, allowing the employee to petition the Commission for a hearing in such a situation. Failure to comply with the rules and regulations of the Act and failure to process claims on a timely basis and failure to file required forms with the Commission will result in fines being levied by the Commission. Therefore, no other remedy is available if the injury and claim is within the Act. See *Cook v. Mack's Transfer & Storage*, 291 S.C. 84, 352 S.E.2d 296 (Ct. App. 1986).

33. **What is the exposure for terminating an employee who has been injured?**

In 1986, the South Carolina legislature enacted a statute prohibiting an employer from retaliating against an employee because the employee had filed a workers' compensation claim. The burden of proof for proving a violation is upon the employee. The South Carolina Supreme Court adopted the determinative factor test which requires the employee to establish that he would not have been discharged but for the filing of the claim. In general, the South Carolina courts do not consider terminating an employee for inability to perform the duties for which he was hired to be retaliatory in nature. Any employer who violates this section is liable in a civil, equitable, non-jury action for the employee's lost wages, and the employee may be reinstated to his former position. This statute allows a wrongfully discharged employee to recover only lost wages and reinstatement. Lost wages consist of back pay, an equitable remedy in the nature of restitution, not legal damages.
CLAIMANTS are not entitled to either future earnings or punitive damages. S.C Code Ann. § 41-1-80.

THIRD-PARTY ACTIONS

34. Can third parties be sued by the Employee?

An injured employee, or his personal representative in the event of death, may recover damages from a third party tortfeasor in addition to workers' compensation benefits. The third party claim is a civil action brought in the Court of Common Pleas and governed by the South Carolina Rules of Civil Procedure. S.C. Code Ann. § 42-1-560.

35. Can co-employees be sued for work-related injuries?

S.C. Code Ann. § 42-1-150 provides that the South Carolina Workers' Compensation Act provides the exclusive remedy for employees who sustain work related injuries. The immunity is conferred not only on the direct employer, but also on co-employees, as demonstrated in the case of Strickland v. Galloway, 348 S.C. 644, 560 S.E.2d 448 (Ct. App. 2002). In that case, the plaintiff, a volunteer fireman, brought a civil action against a fellow volunteer fireman, seeking to recover damages for injuries sustained in an automobile accident. The accident occurred as both men were responding to a fire, and the defendant fireman’s vehicle struck the plaintiff as the defendant was pulling onto the shoulder of the road. The plaintiff received workers’ compensation benefits from the Anderson County Fire Department, and then brought a negligence action against the defendant. The court granted defendant’s motion for summary judgment on the basis that the plaintiff’s tort action was barred by the exclusive remedy doctrine.

Four exceptions to the exclusivity provision are recognized: (1) where the injury results from the act of a subcontractor who is not the injured person’s direct employer, as expressly stated by § 42-1-540; (2) where the injury is not accidental but rather results from the intentional act of the employer or its alter ego, Dickert v. Metro. Life Ins. Co., 311 S.C. 218, 428 S.E.2d 700 (1993); (3) where the tort is slander and the injury is to reputation, Loges v. Mack Trucks, Inc., 308 S.C. 134, 417 S.E.2d 538 (1992); or (4) where the Act specifically excludes certain occupations, as in S.C. Code Ann. §§ 42-1-350 through -375 (1985 and Supp. 2007).

As noted in Dickert, however, the Workers’ Compensation Act’s exclusivity provision may not be used as a shield for a co-employee's intentional injurious conduct.

36. Is subrogation available?

S.C. Code Ann. § 42-1-560 states the carrier shall have a lien on the proceeds of any recovery from the third party. If the employee does not institute a third party action within one year after the carrier accepts liability for the payment of compensation or within thirty
days prior to the expiration of the time in which such action may be brought, the right of the action of the injured employee shall pass by assignment to the carrier.

If the employee enters into a settlement for an amount less than the employee's estimated total cognizable damages, then the Commission may reduce the amount of the carrier's lien in the proportion that the settlement bears to the Commission's evaluation of the employee's total cognizable damages at law, if the Commission finds that a reduction is equitable to all parties and serves the interests of justice. § 42-1-560(f). Once the lien and other specified expenses are paid, any balance remaining is placed into a fund which shall be applied as a credit against future compensation benefits for the same injury or death and shall be distributed as provided in subsection (g). § 42-1-560(b). The Supreme Court of South Carolina clarified in Breeden v. TCW, Inc./Tennesse Exp., 355 S.C. 112, 584 S.E.2d 379 (2003) that future medicals are to be included in the future compensation fund under subsection (g), which is not subject to the lien reduction under subsection (f).

In both Breeden and Kirkland v. Allcraft Steel, 329 S.C. 389, 496 S.E.2d 624 (1998), the court set out examples of factors to be considered by the Commission when deciding whether or not it is "equitable to all parties concerned and serve[s] the interests of justice" to reduce the carrier's lien. These include: strength of the claimant's case, likelihood of third party liability, claimant's desire to settle, whether carrier is unreasonably refusing to consent to the settlement, the carrier's conduct in fulfilling its statutory obligations, and the extent of the claimant's injuries. (See also Question 46, infra, regarding settlement of third party claims where a lien exists.)

**MEDICALS**

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Payment of Medical Bills: S.C. Code Ann. Reg. 67-1303 provides that the treating physician or hospital shall send a Form 14A and attachments or Form UB-82 to the employer's representative or the insurance company. The particular form must be sent to the employer’s representative 15 days after the examination, or 15 days after release for payment to be rendered. If the form utilized lists servicess within the prescribed schedule of fees, the employer’s representative will simply pay the health care provider as requested, and file the form with the Commission. For contested bills, the employer’s representative will file the bill in question with the Commission's Medical Review Division for review under the schedule of fees.

Penalties: S.C. Code Ann. § 42-3-175 applies to injuries occurring on or after July 1, 2007, and specifically states that if a claimant brings a claim to enforce an order of the Commission and the Commission determines that the carrier had no good cause for failing to authorize medical treatment and/or pay benefits, the carrier must pay the claimant’s attorney’s fees and the costs of enforcing the order. Additionally, the Commission may impose sanctions for willful disobedience of an order, including a fine of up to $500 per day
for each day of the violation. While “benefits” is not a defined term, it is expected to include appropriate and timely payment of medical bills, as well as compensation benefits.

Additionally, in cases with a date of accident of July 1, 2007 or later, the Commission is required to notify the Department of Insurance of a carrier’s failure to authorize and pay benefits for medical treatment. If the Department of Insurance finds that there has been a violation of the laws regarding insurance, the Department may impose penalties for each violation, including administrative penalties, which include fines up to $30,000, revocation of licenses of the carrier and the adjuster, and imprisonment.

Finally, if the Commission discovers a “pattern” of failure to pay appropriate benefits without good cause, the Department of Insurance may revoke the carrier’s license to do business in South Carolina. A “pattern” is established when a carrier fails to pay an award at least three times within a two-year period.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The South Carolina Workers’ Compensation Act does not contain any formal procedures for motions to produce records. S.C. Code Ann. § 42-25-95 requires all existing information compiled by a health care facility or provider in a workers’ compensation case to be provided to the insurance carrier, employer, employee or their attorneys within fourteen days of a written request. Additionally, the common practice is for a subpoena to be issued when litigation is involved, as some providers are slow to respond to requests for medical records without a subpoena. As a general rule, treating medical providers tend to provide reports in a timely manner, as this is required for the Carrier to pay their bills for services.

39. **What is the rule on choice of physician?**

In South Carolina, the employer has the right to choose authorized treating physician. S.C. Code Ann. § 42-15-60 states that the employee must accept the treating physician appointed by the employer or the insurance carrier. Any refusal to accept such treatment provided by the employer will bar the employee from further compensation until the refusal ceases unless the circumstances are found to justify the refusal. The exception to this rule is in the case of a medical emergency. If an emergency arises and the employer fails to provide necessary medical care, the employer will be liable for treatment for an unauthorized treating physician. Reg. 67-509 specifically states that the employers' representative chooses an authorized health care provider and pays for authorized treatment.

In **Risinger v. Knight Textiles**, 353 S.C. 69, 577 S.E.2d 222 (Ct. App. 2002), the court held that an employer is not entitled to dictate the medical treatment of injured employees once the employees are awarded lifetime benefits by the Commission. In Risinger, the Commission awarded lifetime benefits to a claimant, finding the claimant permanently and totally disabled, and ordered the employer to pay lifetime benefits to the claimant.
Subsequently, Dr. Epstein referred the claimant to Dr. Steiner for treatment for chronic pain and depression. The employer refused to provide the recommended treatment and asked for an independent medical examination (IME). The Court of Appeals found that the employer was not entitled to an IME under § 42-15-80 because a final order had been issued and the employer was required to pay for all medical treatment under the order. The court reasoned that § 42-15-80 does not apply when a final order has been issued, that granting the employer’s request would effectively allow the employer to search for a third opinion, and that § 42-15-60 does not allow an employer to dictate the medical treatment of injured employees once they have been awarded lifetime benefits.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

Under S.C. Code Ann. § 42-15-60, medical care is to be provided for 10 weeks from the date of injury if the treatment will “effect a cure or give relief.” However, medical care must also be provided after that time as long as it will “tend to lessen the period of disability.” Indeed, medical treatment may be ordered by the Commission even after the claimant reaches maximum medical improvement, so long as it meets the standard set forth in Dodge v. Brucoli, Clark Layman, 334 SC 574, 514 S.E.2d 593 (Ct. App. 1999). In Dodge, the court held that to order an employer/carrier to continue providing medical benefits after maximum medical improvement, the Commission must make a factual determination addressing whether the medical treatment is either necessary to maintain maximum medical improvement or will otherwise tend to lessen the claimant’s period of disability.

In cases with dates of accident prior to July 1, 2007, the claimant’s testimony that he/she needs additional medical treatment may alone be sufficient to support the Commission’s findings on the necessity of future medical treatment. For dates of accident on or after July 1, 2007, a claimant must obtain a medical opinion stating to a reasonable degree of medical certainty that additional treatment is necessary to lessen the period of disability. The Court of Appeals recently denied medical treatment in Hartzell v. Palmetto Collision, where there was no medical evidence in the record stating that the claimant required additional treatment. (Opinion not yet published) (Ct. App. 2016).

41. Which prosthetic devices are covered, and for how long?

S.C. Code Ann. § 42-15-60 states that in cases of partial permanent disability, prosthetic devices will be furnished during the life of the injured employee or as long as they are necessary. In cases of permanent total disability, the claimant will be entitled to lifetime medical care, including prosthetic devices.

Prior to May 1992, work-related damage to prosthetic devices which did not result in personal injury was not compensable under the Act. S.C. Code Ann. § 42-15-65 now provides for compensation for damage to prosthetic devices, including eye glasses and hearing aids, when they are damaged as a result of an injury by accident which arises out of
and in the course of the employment.

42. Are vehicle and/or home modifications covered as medical expenses?

Again, S.C. Code Ann. § 42-15-70 provides for lifetime medical benefits in cases involving total disability. These benefits include reasonable and necessary nursing service, medicines, prosthetic devices, sick travel, medical, hospital and other treatment or care for the life of the injured employee.

Although not specifically addressed by the Act, the South Carolina Court of Appeals in Strickland v. Bowater, 322 SC 471, 472 S.E.2d 635 (Ct. App. 1996) addressed the issue of modifications. In Strickland, the claimant was rendered a quadriplegic. He purchased a modified van and was seeking the Commission to award not only the cost of modifying the van, but also the base cost of the unmodified van. The Court rejected the claimant's argument and found that the employer should bear only the cost of the modification and not the full cost of the van.

Similarly, in Pressley v. REA Const., 374 SC 283, 648 S.E.2d 301 (Ct. App. 2007), the claimant was rendered a paraplegic as a result of a compensable accident. He filed for a hearing requesting wheelchair accessible housing, and the Commission ordered the carrier to purchase a wheelchair accessible mobile home for the claimant. The employer/carrier appealed, arguing it should be responsible only for the costs of modifying a home purchased by the claimant and not also for the base price of the mobile home. The appellate court agreed and held that the “base cost of providing an injured employee housing is an ordinary necessity of life” for which temporary total disability benefits should be used, as temporary total disability is a substitute for wages.

Under the Act, the employer/carrier may evaluate the most cost-effective solution for the claimant. For example, in a case involving a paraplegic or quadriplegic, the carrier would probably prefer to modify the claimant's home rather than pay for round-the-clock nursing services or a nursing home if these were the only alternatives. Additionally, the Act requires that transportation to and from health care providers be covered. If the claimant is unable to travel in his family vehicle without modification, the employer/carrier would have the responsibility of providing such transportation as would be adequate to transport him to authorized health care providers. Again, vehicle modification may be a cost-effective alternative to providing transportation services.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Generally, S.C. Code Ann. § 42-15-60 provides medical, surgical, hospital and other treatment is limited to those charges that prevail in the community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person. S.C. Reg. 67-1304 details the procedure for using the schedule of fees for physicians and surgeons. Reg. 67-1305 details the procedure to establish hospitals' per diem rate. The Commission can approve payment of medical bills, which exceed the fee schedule
on a case-by-case basis. The Commission must approve all medical expenses. No hospital
is entitled to reimbursement by an employer until the medical provider has made all reports
required by the Commission.

44. **What, if any, provisions or requirements are there for "managed care"?**

Not applicable at this time under South Carolina Workers' Compensation Act.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Generally, a claim for benefits is initiated by filing a Form 50. Very often, this form is not
filed until there is a disputed issue. If the case is accepted in its entirety, the claimant is
provided such medical treatment and/or temporary total compensation as is deemed
necessary. Upon the claimant's reaching maximum medical improvement, the claim is
either resolved by way of settlement or is resolved at a hearing.

In a contested case, the claimant will typically file a Form 50 and the employer/carrier will
respond by filing a Form 51 (within 30 days as required by the Act). The employer/carrier is
free to deny all or any part of the claim. Typical issues include whether or not there was an
"accident," the choice of authorized treating physician, the degree of permanent partial
impairment, whether or not the claimant is permanently and totally disabled, whether or not
maximum medical improvement has been reached, and compensation rate. These issues
will be resolved at the hearing if not prior to the hearing upon agreement of the parties.

Furthermore, for dates of accident after June 18, 1996, when the employer-carrier stops
benefits in the first 150 days, the employee may in turn sign Section III of the Form 15
where he can contest the benefits being stopped. By doing so, he has requested a hearing by
way of Reg. 67-504 and a hearing will be set within sixty (60) days. See also Question 20,
supra.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

Once maximum medical improvement has been reached and an impairment rating is
assigned, the insurance carrier will very often request an informal conference before a
deputy commissioner. This is a very informal proceeding in which neither party is required
to be represented by counsel, although a representative of the carrier must be present, such
as an adjuster or third party administrator. The deputy commissioner will simply consider
the medical reports and, upon viewing the claimant, make a recommendation as to a
settlement amount. If this recommendation is not acceptable to either party, the case is
automatically set for a hearing. Parties will often by-pass this informal conference level and simply request a hearing before one of the seven workers' compensation commissioners.

The South Carolina legislature recently approved a regulation establishing mandatory mediation in certain types of cases. Reg. 67-1801 et. seq. provides that the parties must mediate claims in which the Claimant alleges permanent and total disability, occupational disease cases, third-party lien reduction claims, contested death claims, mental/mental injury claims, and cases of concurrent jurisdiction under the SC Workers’ Compensation Act and the Federal Longshore and Harbor Workers’ Compensation Act. Except for contested death claims, claims in which compensability is denied by the employer/carrier would not be subject to the mediation requirement. However, claims involving multiple employees arising out of employment with the same employer are subject to the requirement, regardless of whether the employer has admitted compensability. Furthermore, a Commission has the discretion to order mediation in any pending claim. The regulation also sets forth specific guidelines for requesting mediation, selecting a mediator, and paying mediation costs.

At the hearing before the jurisdictional commissioner, sworn testimony is taken and medical evidence is generally admitted under the Administrative Procedures Act, S.C. Code Ann. §§ 1-23-10 et. seq., in documentary form. The rules of evidence apply although they are somewhat relaxed. The claimant has the burden of proof by proving by a preponderance of the evidence his entitlement to the benefits he is seeking.

B. Appellate level.

Once the single commissioner has made the initial determination in the case, either party will have the opportunity to appeal the decision of the single commissioner to the full commission. The Commission is the ultimate fact finding body and any appeals from the full commission may only concern matters of law. Factual findings of the Commission will not be disturbed as long as there is substantial evidence in the record to support the findings. However, questions of law are proper grounds for appeal and will be ruled upon by the appellate tribunals.

For dates of accident prior to July 1, 2007, either of the parties may appeal the decisions of the full commission to the circuit court. At that point, the circuit court judge must affirm the findings of the Commission if there is substantial evidence to support their findings, although questions of law are given a de novo review. Any appeal from the circuit court is heard next by the Court of Appeals of South Carolina. Should appeals continue, the South Carolina Supreme Court can grant certiorari and issue a final judgment.

For dates of accident on or after July 1, 2007, appeals from the Commission proceed directly to the Court of Appeals of South Carolina. It is likely that this change in appeals process will decrease the number of appeals, as the Court of Appeals has much more stringent requirements with regard to briefs and oral arguments, and it is a costlier endeavor for all parties. Nevertheless, the standard of review remains the same; the Court of Appeals must affirm the factual findings of the full commission if there is substantial evidence to support
them, but questions of law are given de novo review.

47. **What are the requirements for stipulations or settlements?**

There are several ways in which claims can be resolved under the Act. Generally, an award made by the Commission is final unless the claimant can establish that he has sustained a physical change of condition, thereby entitling him to a review of the award pursuant to S.C. Code Ann. § 42-17-90. This change of condition must be filed within 12 months from the date of the last payment of compensation.

A claim can also be settled on a Form 16A, which has the same general effect as an award made by a commissioner in that the claimant has 12 months in which to file for additional benefits based upon a physical change of condition for the worse. He is not entitled to additional medical treatment for this period of time unless his medical treatment is rendered due to a physical change of condition for the worse. If the claimant alleges that he has sustained a change of condition for the worse and the employer/carrier denies this, the Claimant is entitled to file for a hearing for determination on this issue. (For claims with accident dates prior to July 1, 2007, the corresponding form is the Form 16.)

The parties can also resolve the matter on “clincher” agreement. This is a full and final settlement and will operate as bar to any future benefits which might otherwise be available to the claimant. If the claimant is not represented by counsel, he or she will be required to meet in person with the jurisdictional commissioner at a conference for the purpose of insuring that the claimant is fully advised of his rights, and the commissioner must approve the settlement. For dates of accident on or after July 1, 2007, the settlement is final once the jurisdictional commissioner has approved it. For dates of accident prior to July 1, 2007 the settlement agreement is not final until three additional commissioners have approved the clincher.

If the claimant is represented by counsel, a commissioner must approve the clincher if the date of accident is prior to July 1, 2007. For dates of accident on or after July 1, 2007, the clincher does not need to be approved by a commissioner and may simply be filed with the Commission. Either party may back out of a settlement agreement at any time before it is actually approved by the Commission. Therefore, oral settlements are not enforceable.

Additionally, Reg. 67-805, involving settlement of third party claims where a workers' compensation lien exists, requires that the distribution of third party settlement proceeds must be approved by the Commission unless otherwise directed by a court of competent jurisdiction. The Regulation exempts settlements of less than two thousand five hundred dollars, $2,500.00, which are deemed to be “approved automatically if the parties agree and do not need to be submitted to the Commission.”

48. **Are full and final settlements with closed medicals available?**

Yes. S.C. Code Ann. § 42-9-390 provides for full and final settlements as long as the
amount of compensation, the time and manner of payments provided for in the act are complied with.

Reg. 67-803 details the procedures for clinchers. A clincher agreement operates as a full and final release of all further benefits under the Workers' Compensation Act. A properly executed full and final settlement and release approved by the Commission has the same effect as a court order. However, the case of Spivey v. Carolina Crawler, 624 S.E.2d 435 (Ct. App. 2005) implies that the Commission may set aside a properly executed and approved clincher agreement on the basis of fraud, stating that “South Carolina tribunals have the inherent authority to reopen agreements and judgments procured by fraud.”

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. The settlement agreement is not complete unless there is a written agreement, signed by both parties in the form prescribed by the South Carolina Workers' Compensation Commission. For unrepresented claimants having dates of injury prior to July 1, 2007, four commissioners must approve a clincher agreement, and only one commissioner need approve a Form 16 agreement. For unrepresented Claimants having dates of injury on or after July 1, 2007, only one commissioner need approve clinchers and Forms 16A. The agreement is not binding on either party until approved by the Commission.

For represented Claimants with dates of injury prior to July 1, 2007, only one commissioner need approve a clincher or a Form 16 agreement. For represented claimants with dates of injury on or after July 1, 2007, clinchers and Form 16A settlements do not need approval by a commissioner and may simply be filed with the Commission. However, even when the claimant is represented by counsel, the agreement must be signed by the claimant himself.

Clincher settlements or Form 16/16A settlements with unrepresented claimants require in-person approval by a commissioner at a settlement conference, which is attended by the claimant and an attorney on behalf of the employer/carrier.

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**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required? What is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Generally speaking, any employer who regularly employs four or more employees in the same business within the state is required to maintain workers' compensation coverage. There are several exceptions to this rule, including casual employees and federal employees of the state, textile hall corporation, state and county fair associations, agricultural employees (S.C. Code Ann. § 42-1-360) and railroad employees, railway express companies or railway express company employees. (S.C. Code Ann. § 42-1-350)
Reg. 67-403 describes the procedure in which an employer not otherwise required to obtain workers' compensation coverage may elect to adopt the Act. These regulations must be complied with to the letter.

S.C. Code Ann. § 42-5-40 addresses the penalty for failure of an employer to have and maintain workers' compensation coverage when he is so required. The employer can be fined up to $50.00 for each day of refusal or neglect to obtain workers' compensation coverage. S.C. Code Ann. § 42-5-45 provides for fines of up to $1,000.00 and/or imprisonment of up to six months for willful failure to secure workers' compensation benefits. If an employer, otherwise required to obtain workers' compensation coverage, neglects to provide such coverage, he will be liable to an injured employee either for compensation under the Act or at law against such employer to recover damages for personal injury or death by accident. In any such action, the employer will not be permitted to defend himself upon any of the judicial common law defenses.

WHAT IS AVAILABLE?

Coverage by private carriers is available as long as they comply with the regulations promulgated by the Commission. Premiums established by the private carriers are generally based upon the nature of the business, the number of employees, the risk and hazards involved with the business, and the number of claims that are filed.

S.C. Code Ann. § 42-7-60 provides for the establishment of a State Workers' Compensation Fund ("State Fund") which covers all officers and employees of state and any county, municipality, or any other political sub-division thereof or any agency or institution of the state which has elected to participate in the fund. S.C. Code Ann. § 42-7-70 addresses rates and premiums in effect for the State Fund. The rates and premiums must not be "excessive, inadequate, or unfairly discriminatory."

Workers who perform duties for employers who do not have proper coverage are protected by the South Carolina Workers' Compensation Uninsured Employers Fund (UEF). The UEF arises out of S.C. Code Ann. § 42-7-200, which provides for an insolvency fund to be used in cases in which employers have failed to provide adequate coverage. The UEF is supported largely by taxes placed on carriers operating within the state and self-insured entities. The UEF is authorized to place liens on the assets of any employer if necessary; however, the law unquestionably prefers holding private carriers responsible for injuries on a statutory employee theory, thereby alleviating the UEF of liability. Specifically, S.C. Code Ann. § 42-1-400, provides that a higher tier contractor is considered the statutory-employer of an employee of a lower tier contractor, making the higher tier contractor liable to pay benefits to an employee if he sustains a compensable injury.

S.C. Code Ann. § 42-1-415(A) sets forth a narrow exception to the rule favoring the placement of liability on private carriers, providing that upon the submission of documentation to the Commission that a lower tier contractor has represented himself to a
higher tier contractor as having workers’ compensation insurance at the time the lower tier contractor was “engaged to perform work,” the higher tier contractor is relieved of liability for workers’ compensation benefits, and liability is transferred to the UEF.

A number of cases involving the transfer of liability of the UEF were decided in 2009. The case of Barton v. Higgs, 381 SC 367, 674 SE2d 145 (2009), is the first in a string of cases indicating that in order to transfer liability to the UEF, the requirements of § 42-1-415(A) must be followed to the letter. In Barton, a subcontractor purchased workers’ compensation coverage and provided an unsigned Certificate of Insurance to the general contractor. When the subcontractor’s employee was injured, it was revealed that the subcontractor’s policy was never bound due to fraud on the part of the insurance agency. Despite the subcontractor’s good faith effort in purchasing and providing documentation of insurance, and the contractor’s reasonable reliance thereof, the court held that the general contractor was on the hook for coverage as the statutory employer. The court relied on Reg. 67-415, which provides that a certificate of insurance "shall serve as documentation of insurance" and "must be dated, signed, and issued by an authorized representative of the insurance carrier for the insured," and therefore held that the subcontractor's unsigned Certificate of Insurance did not constitute proper documentation of workers’ compensation insurance so as to shift liability to the UEF under § 42-1-415(A). The court added that under its interpretation of Reg. 67-415, only a Certificate of Insurance -- and not the insurance industry’s standard ACORD 25-S form containing the designated information -- will constitute proper documentation of insurance under S.C. Code Ann. § 42-1-415. See also Hopper v. Terry Hunt Constr., 383 S.C. 310, 680 S.E.2d 1 (2009) (holding that an incomplete Certificate of Insurance does not constitute proper documentation of the subcontractor's workers' compensation insurance for purposes of transferring liability to the UEF under § 42-1-415).

In Hardee v. McDowell, 381 S.C. 445, 673 S.E.2d 813 (2009), the court held that because the general contractor did not obtain proof of insurance from a subcontractor at the time the sub was “engaged to perform work,” the general contractor could not transfer liability to the UEF when the policy – unbeknownst to either the general or the subcontractor – was cancelled just prior to the subcontractor’s employee’s work-related injury. Although the general contractor regularly contracted with this particular subcontractor, and retained his certificate of insurance in its files when the policy renewed each year, the court held that the requirement in § 42-1-415 that proof of insurance be shown at the time the subcontractor is “engaged to perform work” applied to each job performed by the subcontractor, and not at the beginning of each policy year. The court overruled South Carolina Uninsured Employer’s Fund v. House, 360 S.C. 468, 602 S.E.2d 81 (Ct. App. 2004), to the extent it is inconsistent with Hardee.

Previous to April 1, 2000, South Carolina operated an assigned risk pool as administered by NCCI for businesses that were considered high risk and therefore determined to be in ineligible for voluntary workers’ compensation coverage. All carriers prior to April 1, 2000, which did business in South Carolina, shared in the losses in the assigned risk pool. Effective April 1, 2000, Capital City Insurance Company and Companion Property and
Casualty Company voluntarily agreed to share equally with regard to coverage for employers which were refused voluntary coverage. These carriers paid first dollar premiums and did not therefore share their losses with other carriers who write business in the State of South Carolina.

51. **What are the provisions/requirements for self-insurance:**

**A. For individual entities.**

Chapter 5 of the Workers' Compensation Act. The specific procedures required for attaining a self-insurance status are addressed in S.C. Regulation 67-1501 through 67-1516. Basically, an employer must file an application for individual self-insurance along with evidence of solvency. If accepted, the self-insured must put up a bond as specified by the Commission.

**B. For groups or "pools" of private entities.**

Groups or "pools" of private entities are also free to join and obtain self-insurance status provided they comply with the same rules as listed above. Any individual desiring to be a part of a group or pool may apply as long as he can show that his company is in a similar business to other businesses in the fund, that he qualifies under the bylaws of the fund, and that he is financially sound and has a net worth of not less than $25,000.00. Reg. 67-1501(F).

A member of a self-insured insurance fund may withdraw from the fund, in writing, however, withdrawal is not effective until 30 days after the date the self-insurance division of the Workers' Compensation Act receives the written notice of intent to withdraw. S.C. Regulation 67-1512.

It should be noted that by way of statutory amendment on June 18, 1996, an employer may no longer opt-out of coverage under the Act. By July 1, 1997, all employers, with four or more employees, must be covered under the Workers' Compensation Act either through insurance or self-insurance.

52. **Are "illegal aliens" entitled to benefits of workers' compensation as The Immigration Control Act indicates that they cannot be employees although most state acts include them within the definition of “employee”?**

As the question indicates, there are two parallel legal doctrines applicable to this question. South Carolina law, § 42-1-130, specifically states that the term “employee” includes aliens, whether lawfully or unlawfully employed, but the IRCA states that illegal aliens cannot be employees. The Immigration Reform and Control Act of 1986 (IRCA) was designed to prohibit the lawful employment of unauthorized, or illegal, aliens in the United States. See 8 U.S.C. § 1324a. Violations of IRCA may result in either civil
and/or criminal penalties. Furthermore, IRCA specifically preempts any State law imposing “civil or criminal sanctions upon those who employ…unauthorized aliens.” Id.

However, the case of Curiel v. Environmental Management Services., 376 S.C. 23, 655 S.E.2d 482 (2007), outlines South Carolina’s position that those in this country illegally are nevertheless entitled to workers’ compensation benefits. The employer/carrier argued that the IRCA preempts state law with regards to this issue, and thus the claimant, who was admittedly illegal, was not entitled to benefits. The Supreme Court of South Carolina disagreed, noting a congressional report that indicated that the IRCA was not intended “to undermine or diminish in any way labor protections in existing law.” Thus, because the IRCA “does not expressly preclude an illegal alien from being considered an employee for workers’ compensation benefits,” it did not preempt state law. The court specifically considered the fact that disallowing workers’ compensation benefits to illegal workers “would mean unscrupulous employers could hire undocumented workers without the burden of insuring them” which would encourage, and not discourage, the hiring of illegal workers.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Currently under the South Carolina Workers’ Compensation Act, there is no specific exclusion excepting employers from coverage under the Act when an employee is injured by terrorist activities. In order to be covered by the Act, the employee’s activities must arise out of and be in the course of his employee at the time the injury occurs under S.C. Code Ann. § 42-1-160. Assuming that the injury resulting from terrorist activities arose out of and occurred in the course of employment, the injury would likely be covered under the Act. However, it should be noted that the South Carolina courts have not addressed this specific issue.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payor Act?

South Carolina does not have any state-specific requirements regarding the Medicare Secondary Payor (MSP statute). However, federal law does require compliance with this statute when settling workers’ compensation claims. Pursuant to the MSP statute, Medicare will only be the secondary payer when payment for medical treatment can reasonably be expected to be paid under workers’ compensation law or an automobile or liability insurance policy. As a result, Medicare will only pay those benefits that cannot reasonably be expected to be made under other primary coverage.

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If a medical treatment for an injury is protracted, then the parties must consider Medicare when (1) the claimant is already a Medicare beneficiary, regardless of the settlement amount, or (2) the claimant does not yet receive Medicare benefits, but has a reasonable expectation of Medicare enrollment within thirty months of the date of the settlement and the anticipated settlement amount after the duration of the agreement is greater than $250,000.

In these cases, the statute allows the carrier to set-aside an amount for payment of future medical expenses. If this amount is pre-approved by Medicare, Medicare will then pay for any medical expenses incurred once the set-aside is exhausted. The set-aside may be self-administered or may be administered through a vendor. The proposed settlement is submitted to the Medicare office for approval.

55. **How are subrogation items of Medicaid and health insurers treated under workers’ compensation?**

If compensation and medical bills are previously paid by Medicaid for a work-related injury, the employer must reimburse Medicaid. However, the employer may then subrogate those expenses against the workers’ compensation carrier. In general, assignments and liens are not allowed and are not adjudicated by the Workers’ Compensation Commission. As a result, claimant’s attorneys will normally negotiate these issues.

Under S.C. Code Ann. § 42-9-360, providers cannot “actively pursue collection procedures against a workers’ compensation claim prior to final adjudication of the claimant’s claim.” However, according to Baker Hospital v. Fireman’s Fund Ins. Co., 314 S.C. 98, 441 S.E.2d 822 (1994), a medical provider does have standing to sue the workers’ compensation carrier in a court of common pleas claim prior to the final adjudication of a claim so long as the complaint alleges causes of action that are not contingent on a decision the Workers’ Compensation Commission.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

Health care facilities and providers must provide medical information to the “insurance carrier, the employer, the employee, their attorneys, or the South Carolina Workers’ Compensation Commission, within fourteen days after receipt of written request” under S.C. Code Ann. § 42-15-95. Additionally, S.C. Code Ann. § 42-15-80 states “no fact communicated to a physician or otherwise learned by any physician or surgeon who may have attended or examined the employee…shall be privileged” to any employer against whom a claim has been brought.
In 1997, the Supreme Court of South Carolina addressed what physicians can ethically disclose about a patient’s confidences in S.C. Board of Medical Examiners v. Hedgepath, 325 SC 166, 480 S.E.2d 724 (1997). Under Hedgepath a physician may not voluntarily disclose non-privileged, discoverable information. In Hedgepath, a physician volunteered information about a patient to the attorney of an opposing party outside of a court proceeding. The Supreme Court held that the physician’s disclosure was unethical because it was offered outside of a court proceeding.

Thereafter, in Brown v. Bi-Lo, Inc., 341 S.C. 11, 535 S.E.2d 445 (Ct. App. 2000), the court determined that, while § 42-9-15 requires physicians to disclose written records upon the request of an attorney, it “does not authorize other ‘ex parte’ methods of communication between an insurance carrier, employer, or their representatives and the claimant’s health care provider.” Of course, this holding does not prevent insurance carriers and employers from deposing doctors. Additionally, employer representatives may speak with, or make a written inquiry to, health care providers provided they obtain the Claimant’s position.

For those claims with dates of accident on or after July 1, 2007, health care providers are permitted to communicate with employers, carriers, or their representatives without the claimant’s consent. However, the claimant must be notified of the discussion and be allowed to participate. Brown v. Bi-Lo remains applicable to claims with dates of accident prior to July 1, 2007.

Federal laws also have an impact on what physicians are able to disclose and to whom patient information may be disclosed. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created national standards for Federal privacy protections for an individual’s treatment information. HIPAA applies to protect health information in three covered entities: health plans, health care clearinghouses, and providers who transfer certain health care information electronically. The goal behind the enactment of HIPAA is to protect the misuse of health care information. Covered entities must implement standards to protect and guard against the “misuse of individually identifiable health information” and failure to meet these standards could result in criminal and civil fines for covered entities.

The Department of Health and Human Services (HHS) published the final regulation in the form of a “Privacy Rule in December 2000,” and the new rule commenced on April 14, 2001. The rule was modified in August 2002, “to improve the workability and avoid unintended consequences [of the rule] that could have impeded patient access to delivery of quality health care. The compliance date for the rule is April 2003, and small health plans have until April 14, 2004. See Office of Civil Rights (OCR) HIPAA Privacy, December 3, 2002 for a more detailed overview.

In addition to the responsibilities that covered entities incur as a result of HIPAA, patients have more clearly defined “rights” as a result of the Act. Patients are able to
obtain information about disclosures of their treatment information and how this information can be used. Disclosure of patient information is limited to a “minimum reasonably needed for the purpose of the disclosure.” Patients can obtain a copy of their own records and request corrections to these records. Finally, the patient is able to control certain uses and disclosures of their information.

The responsibility under HIPAA is on the health care provider, health care clearinghouses and health plans to monitor to whom patient information is released and for what purpose the information is to be utilized. However, a covered entity is provided with some flexibility as to how to meet these new standards. Employers and carriers should be aware that some of these changes might affect the procedures of release of information from covered entities. However, under the power of subpoena and the right to access a claimant’s medical records, the employer/carrier still has the right to ask for medical records.

The South Carolina courts have not addressed any potential conflicts between HIPAA and a state law. However, if HIPAA is raised as a defense against release of records, and state law allows the medical records to be released, HIPAA would preempt the state law. HIPAA privacy regulations contain provisions that address the preemption of state law by HIPAA, and these provisions are set forth in 45 U.S.C. §160.201 et seq.

57. **What are the provisions for “independent contractors”?**

Under the law, only an employee can seek workers’ compensation benefits, and an independent contractor is not an employee. However, employers are not able to disavow coverage for workers simply by calling them “independent contractors.” Rather, the courts consider whether the alleged employer has “the right and authority to control and direct the particular work or undertaking as to the manner or means of its accomplishment.” It is not the actual control that matters; rather, the issue is whether the alleged Employer had the authority to control. See Porter v. Labor Depot, 372 SC 560, 643 S.E.2d 96 (Ct. App. 2007). There are four factors to consider in this determination:

1. Direct evidence of the right to or exercise of control.
2. The method of payment.
3. The furnishing of equipment, and
4. The right to fire.

Of note, the court also stated that, while the employer/employee relationship is contractual in nature, no formality is required. If the acts of the parties suggest a recognition of the employer/employee relationship, then the courts will respect that relationship and find injuries to be compensable.

Recently, the Supreme Court of South Carolina stated in Wilkinson v. Palmetto State Transp. Co., 382 S.C. 295, 676 S.E.2d 700 (2009), that each of the four factors must be weighed “with equal force” in consideration of whether an employer/employee
relationship existed. (Previously, if a claimant were able to prove single factor, the existence of just one element was “not merely indicative of, but, in practice, virtually proof of, the employment relation.”)

58. **Are there any specific provisions for “independent contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

Employees of temporary agencies and the like are considered to be employees of the agency and not employees of the workplace to which they were assigned. However, should the staffing agency become insolvent or not have appropriate coverage, the employees may be considered “statutory employees” of the entity to which they were assigned. See #3 supra.

59. **Are there any specific provisions for “independent contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Historically, truck drivers fell under the standard test for independent contractors outlined above and generally were held to be employees covered under the Act. However, for injuries occurring on or after July 1, 2007, S.C. Code Ann. § 42-1-360 provides that

An individual who owns or holds under a bona fide lease-purchase or installment-purchase agreement a tractor trailer, tractor, or other vehicle and who, under a valid independent contractor contract, provides that vehicle and the individual’s services as a driver to a motor carrier.

The recent case of Wilkinson v. Palmetto State Transp. Co., 382 S.C. 295, 676 S.E.2d 700 (2009), specifically dealt with an owner/operator and the nature of his relationship with the trucking company which leased him the truck. The court outlined the four-factor test for analyzing whether an employer/employee relationship exists, and held that the test does apply to motor carriers and their owner/operators. The four factors to consider are: (1) direct evidence of the right to or exercise of control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Of interest is the court’s lengthy discussion on federal trucking regulations and their effect on the employer-employee analysis. With guidance from Pennsylvania case law in Universal Am-Can, Ltd. v. Workers’ Comp. Appeal Board, 762 A.2d 328 (Pa. 2000), the South Carolina supreme court clarified that a motor carrier’s requirement that its carrier lessee’s adhere to the federal trucking regulations, as well as the motor carrier’s own compliance with these regulations with regard to its relationship with a carrier lessee, should not affect a determination on employment status by a state court applying the common law test of control in a workers’ compensation claim.

60. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to**
medical treatment benefits under a claim?

The South Carolina Workers’ Compensation Act does not address Medicare liability in relation to settlement of future medical benefits. Therefore, there are no state-specific requirements that apply in these circumstances.

61. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

South Carolina does not permit medical marijuana.

62. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

South Carolina does not permit recreational marijuana.

**NOTICE**

This summary of South Carolina law is based upon existing case law and statutory authority which was in existence as of January 1, 2020. Please contact the ALFA contact partners listed at the top of this document for any changes that may have taken place since publication, or for more detailed information and case law regarding any specific area of the law.
1. Citation for the state's workers' compensation statute.

South Dakota Codified Laws ("SDCL"), Title 62.

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Generally, an employee is every person, including a minor, in the services of another under any contract of employment, express or implied with exceptions for elected officers of state or subdivision of government unless the governing body elects to treat these officials as employees, domestic servants working less than 20 hours in any calendar week and for more than six weeks in any thirteen week period and farm or agricultural laborers or workfare participants. Additionally country high superintendents, deputy sheriffs, constables, marshals, policemen, and firemen are all deemed employees. Other specific employees with varying degrees of coverage include vocational students, volunteers of the state or its subdivisions, volunteer firemen, conservation officers, and officers of corporations. Each can be considered an employee if certain statutory requirements are met. SDCL §§ 62-1-3, 62-1-4, 62-1-4.1, 62-1-5, 62-1-5.1, 62-1-6, 62-1-7, 62-1-8, 62-3-15.

A person who offers services voluntarily and gratuitously is acting outside the course of his employment, and injuries sustained in the course of such activity are not compensable. Woodcock v. City of Lake Preston, 2005 SD 95, 704 N.W. 2d 32.

3. Identify and describe any "statutory employer" provision.

Employer includes the state and any municipal corporation within the state or any political subdivision of this state, and any individual, firm, association, limited liability company, or corporation, or the receiver or trustee of the same, or the legal representative of a deceased employer, using the service of another for pay. SDCL § 62-1-2. A principal, intermediate, or subcontractor is liable for compensation for any employee of one of its subcontractors to the same extent as the immediate employer. If a principal or intermediate contractor carries
workers' compensation insurance for employees of subcontractors and, if the employee collects benefits from one of the employers, the employee is barred from recovering benefits from any other employers along the chain. SDCL § 62-3-10. The employers are further exempt from civil suit brought by that employee. See Metzger v. J.F. Brunten & Son, Inc., 84 S.D. 168, 169, 177 N.W.2d 261 (1969).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence".

South Dakota has eliminated the "by accident" requirement. The standard for injuries occurring prior to July 1, 1995, is whether the employment was a "contributing factor" to the condition or injury. Zacher v. Homestake Mining Co., 514 N.W.2d 394, 395 (S.D. 1994); Caldwell v. John Morrell & Co., 489 N.W.2d 353, 358 (S.D. 1992). Evidence of an unusual exertion was not required. Kirnan v. Dakota Midland Hospital, 331 N.W.2d 72, 74 (S.D. 1983).

South Dakota has a three pronged definition of injury: An injury is compensable when it is established by medical evidence that (1) the employment or employment related activities are a "major contributing cause" of the condition complained of; or (2) if the injury combines with a preexisting disease or condition to cause or prolong disability, impairment or need for treatment, the condition complained of is compensable if the employment or employment related injury is and remains a major contributing cause of the disability, impairment or need for treatment; or (3) if the injury combines with a preexisting work related compensable injury, disability or need for treatment, the subsequent injury is compensable if the subsequent employment or employment related activities contributed independently to the disability, impairment, or need for treatment. SDCL § 62-1-1(7)(a)(b)(c); Grauel v. South Dakota School of Mines & Technology, 2000 SD 145; Byrum v. Dakota Wellness Foundation, 2002 SD 141, 654 NW2d 215. Required proof is by a preponderance of the evidence. Gordon v. St. Mary’s Health Care Center, 617 N.W.2d 151 (S.D. 2000).

B. Occupational disease (including respiratory and repetitive use).

Repetitive use is not considered an occupational disease but an injury. Arends v. Dakotah Cement, 2002 S.D. 57, 645 NW2d 583. Occupational disease requires proof of total incapacity from performing work in the last occupation where the individual was injuriously exposed to the hazards of the disease. SDCL § 62-8-1(3), (6); Sauer v. Tiffany Laundry & Dry Cleaners, 2001 S.D. 24, 622 N.W.2d 741,743. To be an occupational disease the injury must be caused by a distinctive feature of the claimant’s occupation, not by an environmental condition of the claimant’s work place. Sauder v. Parkview Care Center, 2007 S.D. 103, 740 N.W.2d 878, 885.

For purposes of worker’s compensation, an injury, rather than occupational disease may occur when a pre-existing disease makes an employee more susceptible to a work related injury. St. Luke’s Midland Regional Medical Care v. Kennedy, 2002 S.D. 137, ¶ 17, 653 N.W.2d 880, 884-885. Unless a condition is intrinsic to an occupation, a worker’s
compensation claimant does not suffer from an occupational disease. SDCL § 62-8-1(6). Occupational disease must be attributable to conditions particular to an occupation rather than conditions coincidental to a work place. Id.

“Those seeking compensation for an occupational disease must prove: (1) they suffer from an occupational disease as defined by SDCL 62-8-1(6); (2) they are disabled from performing work in the last occupation in which they were injuriously to the hazard of such disease; and (3) the disease is ‘due to the nature of [the] occupation or process’ in which they were employed before their disablement.” Sauer v. Tiffany Laundry and Dry Cleaners, 2001 SD 24, ¶ 9, 622 N.W.2d 741, 744.

5. What, if any, injuries or claims are excluded?

Mental disabilities arising from emotional, mental or nonphysical stress or stimuli are not compensable. SDCL § 62-1-1(7)(c); Lather v. Huron College, 413 N.W.2d 369 (S.D. 1987).

Injury is defined as only injury arising out of and in the course of the employment, and does not include a disease in any form except as it shall result from the injury. SDCL § 62-1-1(7). A mental injury is compensable only if a compensable physical injury is and remains a major contributing cause of the mental injury, as shown by clear and convincing evidence. Id. at (c). See answer 9 for defenses.

South Dakota worker’s compensation law is remedial in nature and construed liberally to effectuate its purpose. Lather v. Huron College, 413 N.W.2d 369, 371 (SD 1987). Worker’s compensation is not intended to be health, accident, and old age insurance and spread general protection over risk, to all and arising out of and in the course of employment. Id. Only injuries arising out of and in the course of employment are compensable. Id.

6. What psychiatric claims or treatments are compensable?

Mental disabilities arising from emotional, mental or nonphysical stress or stimuli are not compensable. SDCL § 62-1-1(7); Lather v. Huron College, 413 N.W.2d 369 (S.D. 1987).

Psychiatric claims resulting from physical injury are compensable. Everingham v. Good Samaritan Center, 1996 SD 104, 522 N.W.2d 837, 838. As of July 1, 1999, mental injuries are compensable only if a compensable physical injury is and remains a major contributing cause of the mental injury, as shown by clear and convincing evidence. SDCL 62-1-1(7).

Mental and emotional claims that are a result of occurrences that are not within the scope of the stress or strain of daily living are compensable. Everingham v. Good Samaritan Center, 1996 SD 104, 522 N.W.2d 837, 842. When there has been a physical accident or trauma, and Claimant’s disability is increased or prolonged by traumatic neurosis, conversion hysteria, or hysterical paralysis, it is now uniformly held that the full disability including the effects of the neurosis is compensable. Gilchrist v. Trail King Industries, Inc., 2000 SD 68, 612 N.W.2d 1, 6.

South Dakota recognizes compensability for both mental-physical and physical-mental
injuries but does not allow compensation for injuries in the mental-mental category. *Benson v. Goble*, 1999 SD 38, 593 N.W.2d 402, 405. To be included in the physical-mental category there must have been a physical touching sufficient to become a physical trauma which caused the mental injury. It is not necessary that an organic injury resulted in order to find a compensable injury.

7. **What are the applicable statutes of limitations?**

For an injury, two years from the date the employer/insurer notifies the employee and the South Dakota Department of Labor, in writing, of the denial of a claim, in whole or in part. SDCL § 62-7-35. The right to compensation is also barred if no medical treatment has been obtained within seven years after the employee files the first report of injury. SDCL § 62-7-35.3. For an occupational disease, a claim must be filed with the South Dakota Department of Labor within two years from date of disability or death (SDCL § 62-8-11), and with the employer within 6 months after ceasing employment. §§ 62-8-13, 62-8-29 to 32. In any case in which benefits have been paid but no written denial issued, any claim for additional benefits must be filed within three years from the date of last payment of benefits. SDCL § 62-7-35.1.

8. **What are the reporting and notice requirements for those alleging an injury?**

An employee must provide written notice of an injury within three business days. Failure to give notice within that time prohibits a claim unless the employee can show: (1) the employer or the employer's representative had actual knowledge of the injury; or (2) the employer was given written notice after the injury and the employee had good cause for failing to give written notice within the three business days, which determination shall be liberally construed in favor of the employee. SDCL § 62-7-10; *Gordon v. St. Mary’s Healthcare Center*, 2000 SD 130, 617 N.W.2d 151, 157.

For an occupational disease, written notice of a claim must be provided within six months after the employment ceased in which it is claimed that the disease was contracted. SDCL § 62-8-29. Written notice is required of an occupational disease. Actual or constructive notice is not sufficient for occupational disease. *Heupel v. Imprimis Technology, Inc.*, 473 N.W.2d 464 (S.D. 1991).

9. **Describe available defenses based on employee's conduct:**

A. **Self-inflicted injury.**

No compensation is allowed for any injury or death due to the employee's willful misconduct, including intentional self-inflicted injury, intoxication, illegal use of any schedule I or schedule II drug, willful failure or refusal to use a safety appliance furnished by the employer, or perform a duty required by statute. SDCL § 62-4-37. The burden of proof is on the employer to prove such conduct was the proximate cause of the injury. *Driscoll v. Great Plains Marketing Corp.*, 322 N.W.2d 478, 479 (S.D. 1982).
“A four-part test is used to determine whether an employee’s violation of workplace safety rules constitutes willful misconduct.... The four-part test requires that:

1) the employee must have actual knowledge of the rule or appliance and its purpose;

2) the employee must have an actual understanding of the danger involved in the violation of the rule or failure to use the appliance;

3) the role or use of the appliance must be kept alive by bona fide enforcement by the employer; and,

4) the employee had no valid excuse for violating the rule or failing to use the appliance.”

Holscher v. Valley Queen Cheese Factory, 2006 SD 35, 713 N.W.2d 555, 568-569.

B. Willful misconduct, "horseplay," etc.

See answer 9A regarding willful misconduct. Horseplay requires a four factor analysis: (1) extent and seriousness of the deviation; (2) completeness of the deviation (i.e., whether it was commingled with the performance of duty or involved an abandonment of duty); (3) extent to which the practice of horseplay had become an accepted part of the employment; and (4) extent to which the nature of the employment may be expected to include some such horseplay. Phillips v. John Morrell & Company, 484 N.W.2d 527, 530 (S.D. 1992).

C. Injuries involving drugs and/or alcohol.

Employer must prove that the use of illegal drugs or alcohol was a substantial factor in causing the accident or injury. Goebel v. Warner Transportation, 2000 SD 79, 612 N.W.2d 18, 22.

10. What, if any, penalties or remedies are available in claims involving fraud?

Any person who knowingly files a fraudulent claim for workers' compensation benefits is guilty of a Class 1 misdemeanor. SDCL § 62-4-51.

An employer, insurer or fellow employee may submit a written request to the Department of Labor to terminate, modify or temporarily stop payments to a claimant because they have reason to believe the claim has been paid under fraudulent conditions or that the injury did not arise out of or in the course of employment. Upon receipt of the request, the Department shall order an investigation by the insurer, which is to be completed within ninety days after receipt of the order. After a contested case hearing conducted pursuant to S.D. Codified Laws chapter 1-26, the Department may order the claimant's payments continued, modified,
or terminated. If the Department has reason to believe criminal insurance fraud has been committed, it shall disclose its information to law enforcement. SDCL §§ 62-4-47, 62-4-48.

Additionally, in worker's compensation proceedings if the trier of fact believes any person testifying has knowingly sworn falsely to any material fact, the finder of fact may reject all of the testimony of that witness. SDCL § 62-7-40.

11. **Is there any defense for falsification of employment records regarding medical history?**

A false representation as to physical condition or health made by an employee in procuring employment precludes benefits for an otherwise compensable injury if it is shown that the employee intentionally and willfully made such a representation, the employer substantially and justifiably relied on it in hiring the employee, and a causal relationship existed between the representation and the injury. The burden is on the employer to prove each element. SDCL § 62-4-46.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Generally, yes if on the employer's premises. *Bender v. Dakota Resorts Management Group, Inc.*, 2005 SD 81, ¶ 14, 700 N.W.2d 739, 744. If off the employer's premises, factors to be considered include whether attendance is mandatory and what type of benefit the employer derives other than general employee morale.

13. **Are injuries by co-employees compensable?**

Generally, yes, assuming the injury arose out of and in the course of employment.

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**

Generally, when an injury occurs as the result of a private and personal matter in which the employment contributed nothing to the episode, the injury is noncompensable. Mere presence at one’s place of employment, isolating one from one’s family members and thus increasing the chances of injury does not constitute ‘contribution’ such to make the injury compensable. *Voeller v. HSBC Card Services, Inc.*, 2013 S.D. 50, ¶¶ 16, 21, 834 N.W.2d 839, 847-848. The injury may be compensable if employment contributed to assault. *Id.* An employer is considered to contribute to the assault when the employment engendered, exacerbated or facilitated the assault. *Id.*

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The method of calculation varies according to type of work and length of employment.
Generally, total earnings divided by 52, or total earnings divided by the number of weeks actually worked unless such calculation produces an unfair or inequitable result, then the average amount earned by employees in similar grade or occupation divided by 52. If neither of the above applies, multiply average day’s earnings by 300 and divide by 52. For seasonal employees: multiply average day’s earnings by the number of days it is customary to work, but not less than 200, and then divide by 52. SDCL §§ 62-4-24 through 62-4-28.

For a workers’ compensation claim arising before May 6, 2015, an employee’s earnings up to the claimed date of injury are calculated exclusively on the wages earned at the place of employment where the injury occurred. SDCL § 62-1-24. For claims arising after May 6, 2015 the average weekly wage is calculated by using the amount of compensation for the number of hours commonly regarded as a day’s work for each employer in which the person was concurrently employed” at the time of injury. SDCL § 62-1-25. Aggregation of wages is only permitted, however, where the employee was actively engaged in the concurrent employment and the injury affects the employee’s job duties at the concurrent employment. Id.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Sixty-six and two-thirds percent of the employee's earnings, but not more than the state maximum. If sixty-six and two-thirds percent is less than the state minimum, the minimum is paid. If the entire wage is less than the state minimum, the amount of compensation is the average weekly wage of the employee, less deductions for federal or state taxes or both, and for the FICA made from such employee’s total wages received during the period of calculation of the employee’s earnings. State maximums and minimums are revised each July 1 and are effective July 1 to June 30. SDCL § 62-4-3.

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

No compensation is due until the employee has been incapacitated for a period of at least seven consecutive days. If the incapacity extends beyond seven consecutive days, compensation is computed from the date of injury. SDCL 62-4-2. Failure to pay within 10 days on which payment is due shall result in an automatic penalty equal to 10 percent of the unpaid compensation. SDCL § 62-4-10.1.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out _______ day(s) before recovering benefits for the first _______ days)?**

See No. 17. The employee must be incapacitated for a period of seven consecutive days. If the waiting period is met, benefits are paid from the date of the injury. SDCL § 62-4-2.

19. **What is the standard/procedure for terminating temporary benefits?**
Temporary benefits are paid until the employee attains complete recovery or until a specific loss becomes ascertainable, whichever comes first. SDCL § 62-1-1(8). A loss becomes ascertainable when it becomes apparent that permanent disability and the extent thereof has resulted from an injury and that the injured area will get no better or no worse because of the injury. SDCL § 62-1-1(2). Generally speaking, entitlement to temporary benefits ceases when an impairment rating is given or when an employee returns to his usual and customary employment. At that time, the employee may be entitled to permanent partial disability benefits.

No specific form or request or permission is needed to terminate temporary disability benefits.

Temporary partial disability benefits are calculated as follows: If, after an injury, the employee as a result thereof becomes partially incapacitated from pursuing the employee’s usual and customary line of employment, or if released by a physician from temporary total disability and not yet been given an impairment rating, the employee shall receive compensation, subject to the maximum compensation rate, equal to one-half the difference between the average amount earned before the accident, and the average amount earned in some suitable employment or business after the accident. If the employee has not received a bona fide job offer that the employee is physically capable of performing, compensation shall be at the temporary total disability rate. However, in no event may the total amount received be less than the amount the employee was receiving for temporary total disability, unless the claimant refuses suitable employment. SDCL § 62-4-5.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No. See Answer 19, in which procedure for computing permanent partial disability is explained. SDCL §§ 62-4-6(24) and 62-1-1.2 do not provide that temporary total disability be credited toward amount to be paid for permanent partial disability. See Cantalope v. Veterans of Foreign Wars Club of Eureka, 2004 S.D. 4, 674 N.W.2d 329.

21. What disfigurement benefits are available and how are they calculated?

Benefits are payable equal to that portion of 312 weeks which is represented by the percentage such permanent disfigurement bears to the body as a whole. SDCL § 62-4-6(24). However, benefits are not payable for both disfigurement and a medical impairment rating to the same body part, only the medical impairment rating is paid.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

Permanent partial disability benefits vary in accord with the date of injury. However, every calculation includes consideration of an impairment rating. Impairment is determined by a medical impairment rating using the Guides to the Evaluation of Permanent Impairment
established by the American Medical Association. SDCL 62-1-1.2. The specific edition of the Guides to be used is stated in SDCL 62-1-1.2 and periodically changes when new additions are generated. However, as benefits in South Dakota are determined as of the date of injury, the applicable edition of the AMA Guides may not be the most recent version.

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Number of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Thumb</td>
<td>50</td>
</tr>
<tr>
<td>First Finger (Index)</td>
<td>35</td>
</tr>
<tr>
<td>Second Finger (Middle)</td>
<td>30</td>
</tr>
<tr>
<td>Third Finger (Ring)</td>
<td>20</td>
</tr>
<tr>
<td>Fourth Finger (Little)</td>
<td>15</td>
</tr>
<tr>
<td>Great Toe</td>
<td>30</td>
</tr>
<tr>
<td>Other Toes</td>
<td>10</td>
</tr>
<tr>
<td>Hand</td>
<td>150</td>
</tr>
<tr>
<td>Arm</td>
<td>200</td>
</tr>
</tbody>
</table>

(If arm is amputated below elbow, but a prosthesis can be utilized, then considered loss of a hand.)

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Number of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot</td>
<td>125</td>
</tr>
<tr>
<td>Leg</td>
<td>160</td>
</tr>
</tbody>
</table>

(If amputation is below the knee, but a prosthesis can be utilized, then considered loss of a foot.)

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Number of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye</td>
<td>150</td>
</tr>
<tr>
<td>One Ear</td>
<td>50</td>
</tr>
<tr>
<td>Both Ears</td>
<td>150</td>
</tr>
<tr>
<td>Back</td>
<td>312</td>
</tr>
</tbody>
</table>

Where the loss of use is partial and permanent, the compensation shall bear such relation to the maximum amount for complete and permanent loss of use as the partial loss of use bears to the complete loss of use. SDCL § 62-4-6.

B. Number of weeks for "whole person" and standard for recovery.

For permanent disfigurement or disability resulting from injury to any part of the body not listed, compensation for that portion of 312 weeks which is represented by the percentage that such permanent partial disability or permanent disfigurement bears to the body as a whole. SDCL § 62-4-6.
23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Five requirements must be met for rehabilitation benefits: (1) the employee must be unable to return to the usual and customary line of employment; (2) rehabilitation must be necessary to restore the employee to suitable, substantial and gainful employment; (3) the program of rehabilitation must be a reasonable means of restoring the employee to employment; (4) the employee must file a claim requesting the benefits; and (5) the employee must actually pursue the reasonable program of rehabilitation. SDCL § 62-4-5.1; Cozine v. Midwest Coast Transport Inc., 454 N.W.2d 548 (S.D. 1990). Benefits are paid at the temporary total rate during the program of rehabilitation and for up to sixty days prior to actually becoming involved in a program if and when the employee is actively preparing to engage in a program as shown by a certificate of enrollment. SDCL § 62-4-5.1. Certain relevant terms, such as "usual and customary line of employment" and "suitable, substantial and gainful employment" have been defined by statute. See SDCL §§ 62-4-54, 62-4-55.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

An employee is considered permanently and totally disabled, by statute and without regard for the physical ability to return to work, for loss of both hands or both arms, or both feet, or both legs, or both eyes or of any two thereof, or complete and permanent paralysis. SDCL § 62-4-6(23). An employee also may be permanently and totally disabled under the "odd-lot doctrine" if his physical condition, in combination with his age, training, and experience, and the type of work available in the community, cause him to be unable to secure anything more than sporadic employment resulting in an insubstantial income. SDCL § 62-4-53. The terms "community" and "sporadic employment resulting in an insubstantial income" are specifically defined by statute. SDCL § 62-4-52. The employee has the burden to make a prima facie case of total disability. The burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the claimant in the community. Other evidentiary requirements are also established by statute. SDCL § 62-4-53.

Permanent total disability benefits are paid for the life of the worker at the temporary total disability rate, with cost of living increases up to 3% per year for injuries occurring after July 1, 1988. For injuries occurring on or after July 1, 1993, there is an offset for social security retirement benefits as follows: 150% of the temporary total disability rate less the retirement benefits. In no event will the compensation benefits ever exceed the temporary total disability rate. SDCL § 62-4-7.

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.
The Employer must pay for burial expense and headstone up to $10,000.00. SDCL § 62-4-16. In addition, if death occurred outside the community where the employee lived, the employer is required to pay the cost of transportation of the body home. SDCL § 62-4-16.

B. Dependency claims.

Benefits are paid, at the temporary total disability rate, to the surviving spouse or dependents for the life of the spouse, unless the spouse remarries. Upon remarriage of the surviving spouse, payments to the eligible child or children may not commence until the expiration of two years from the date of remarriage. SDCL § 62-4-22.

26. What are the criteria for establishing a "second injury" fund recovery?

The Subsequent Injury Fund was abolished as of July 1, 1999. SDCL § 62-4-34.7 (1999 Supp.). However it was reenacted in 2001 to cover all injuries occurring prior to July 1, 2001. Id.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

Either party can request a review due to a change in condition by filing a written petition. The Department of Labor can then end, diminish, or increase amounts if it finds that a change in condition warrants such action. The "change of condition" must be physical; an economic change is insufficient. SDCL § 62-7-33. The change of condition must be causally connected to the original complaint of injury and must have been unforeseeable at the time of settlement. Kasuske v. Farwell, Ozmun, Kirk & Co., 2006 SD 14, 710 N.W.2d 451. In any case in which any benefits have been tendered pursuant to this title on account of an injury, any claim for additional compensation shall be barred, unless the claimant files a written petition for hearing pursuant to § 62-7-12 with the department within three years from the date of the last payment of benefits. SDCL § 62-7-35.1.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

The employer can be required to pay where it is found that the refusal to pay benefits was vexatious or unreasonable. SDCL § 58-12-3. This determination is made in a separate hearing after the issues have been decided by the Department of Labor. SDCL § 58-12-3.1.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Worker's compensation is the exclusive remedy for injury or death against the employer, or
any employee, partner, officer or director of such employer, except for rights and remedies arising from intentional tort. SDCL §§ 62-3-2, 62-3-3.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

The intentional tort exception is very difficult to prove. The worker must allege facts that plausibly demonstrate an actual intent by the employer to injure or a substantial certainty that injury will be the inevitable outcome of the employer's conduct. Substantial certainly is not to be equated with substantial likelihood, i.e., that an injury is probable. *Fryer v. Krantz*, 2000 SD 125, 616 N.W.2d 102, 109; *Harn v. Continental Lumber Co.*, 506 N.W.2d 91, 95-96 (S.D. 1993); *Jensen v. Sport Bowl, Inc.*, 469 N.W.2d 370, 372 (S.D. 1991). South Dakota has refused to allow a direct action against the employer under the dual capacity doctrine. *VerBouwens v. Hamm Wood Products*, 334 N.W.2d 874 (S.D. 1983), overruled by *Holscher v. Valley Queen Cheese Factory*, 2006 S.D. 35, 713 N.W.2d 66 on other grounds.

"[A] general contractor who is liable for worker’s compensation benefits is entitled to immunity but a subcontractor who is liable for the benefits is not entitled to such immunity." *Thompson v. Mehlhaff*, 2005 S.D. 69, ¶ 19, 698 N.W.2d 512, 519. SDCL 62-3-2 operates as an exclusionary provision which prevents claims against fellow employees for injuries obtained in the scope of employment even when the employer does not operate under South Dakota worker’s compensation law. *Canal Ins. Co. v. Abraham*, 1999 SD 90, ¶ 22, 598 N.W.2d 513, 518.

30. Are there any penalties against the employer for unsafe working conditions?

Allegations of an unsafe workplace are not sufficient to establish a claim for intentional tort. *Shearer v. Homestake Mining Co.*, 557 F.Supp. 549 (D.S.D. 1983), aff’d, 727 F.2d 707 (8th Cir. 1984); *McMillin v. Mueller*, 695 N.W.2d 217, 2005 SD 41; *Fryer v. Krantz*, 616 N.W.2d 102 (S.D. 2000); SDCL § 58-20-21. All insurers writing worker's compensation insurance shall offer to conduct, or contract for, annual workplace safety review services, including review reports with written recommendations for improved safety procedures if the premium is $5,000.00 or more. The insurer is not responsible for inspecting for compliance with federal or state safety laws or regulations. SDCL § 58-20-21. Employers are required to display informational postings promoting safety in the workplace in visible locations throughout the business premises. SDCL § 62-2-11.

31. What penalty, if any, for an injured minor?

No penalty provided for by statute. Law allows minor-employees to compensation under Title 62. SDCL § 62-1-3.

32. What is the potential exposure for "bad faith" claims handling?

South Dakota recognized a cause of action for bad faith in *Champion v. United States Fidelity & Guaranty Co.*, 399 N.W.2d 320 (S.D. 1987). The South Dakota Supreme Court
adopted a two-prong test: (1) there must be an absence of a reasonable basis for denial of benefits; and (2) knowledge or reckless disregard of a reasonable basis for denial. Implicit in that test is the conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurer where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured. Under these tests, an insurer may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to pay) a claim without a reasonable basis. This is a separate cause of action and the employer/insurer are not protected by exclusivity. Potential exposure includes punitive damages.

33. What is the exposure for terminating an employee who has been injured?

An employer may be civilly liable for wrongful discharge if it terminates an employee in retaliation for filing a lawful worker's compensation claim. SDCL § 62-1-16. A similar exception to the state's employment at will doctrine was recognized in Niesen v. Homestake Mining Co., 505 N.W.2d 781 (S.D. 1993).

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Subject to employer’s rights to subrogation and statute barring double recovery, an employee may choose to proceed against third party so long as employee can prove that third party caused additional injury. See Thompson v. Mehlhaff, 2005 S.D. 69, 698 N.W. 2d 512; National Farmers Union Property & Cas. Co. v. Bang, 516 N.W.2d 313 (S.D. 1994).

35. Can co-employees be sued for work-related injuries?

No, co-employees are protected by the exclusive remedy provision except with regard to intentional torts and negligence subject to the employers right to subrogation paid to the employee. SDCL § 62-3-2; Thompson v. Mehlhaff, 2005 SD 69, 698 N.W.2d 512. See answer 29A.

36. Is subrogation available?

If the employee has received compensation and then recovers from the third party, the insurer may recover from the employee all benefits paid less the necessary and reasonable expense of collecting the award, which expenses may include an attorney's fee not in excess of thirty-five percent of the compensation paid. SDCL §§ 62-4-38, 62-4-39. The employer has a first lien against the proceeds of a third-party recovery, subject to attorney fees. Zoss v. Dakota Truck Underwriters, 1998 S.D. 23, 575 N.W.2d 258; Liberty Mutual Insurance Co. v. Garry, 1998 SD 22, 574 N.W.2d 895. The lien applies to all damages awarded, including pain and suffering, but not for a spouse’s loss of consortium. See Zoss. If the employee elects not to proceed against the third party, the employer may do so either in the employee's name or its own. If a recovery is made in excess of the compensation paid, the excess shall be held for
the benefit of the employee, less a proportionate share of expenses, subject to the approval of the Department of Labor. SDCL § 62-4-40.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The employer is subject to interest charges incurred on unpaid medical bills. In addition, there is an automatic penalty of 10% of the unpaid amount if payment is not made within 10 days from date it is due. SDCL § 62-4-10.1.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

A medical practitioner treating an employee shall furnish a report of the injury and treatment to the employer and the Department of Labor within fourteen days following the first treatment. Thereafter, if the employee needs continued medical care or claims to be disabled from his employment, the medical practitioner shall provide status reports to the employer and the Department of Labor at no less than 30-day intervals. All medical and hospital information relevant to the particular injury shall, on demand, be made available to the employer, employee, insurer and the Department of Labor. No relevant information developed in connection with treatment or examination for which compensation is sought may be considered a privileged communication. If a medical practitioner willfully fails to make any report required of him, the Department of Labor may order the forfeiture of his right to all or part of payment due for services rendered. SDCL §§ 62-4-44, 62-4-45. The Department of Labor has, in contested cases, entered orders compelling a claimant to execute an authorization for release of medical records.

39. **What is the rule on (a) Claimant’s choice of physician; and (b) Employer’s right to a second opinion and/or Independent Medical Examination?**

A. **Claimant’s choice of physician.**

The initial choice of physician is the employee's. SDCL 62-4-43. The employee is required to advise the employer in writing, either prior to an injury or within a reasonable time thereafter, of the selected physician. If the employee later seeks to change the choice of physician, written approval must be obtained from the employer/insurer. However, SDCL 58-20-24 mandates that all worker’s compensation policies contain provisions to provide medical services and health care to injured workers for compensable injuries and diseases under a case management plan. The Department of Labor has issued administrative rules governing case management plans which address medical referrals and review of treatment. ARSD 47:03.

B. **Employer’s right to a second opinion and/or Independent Medical Examination.**
The insurer retains the right to have the employee examined by a physician of its choosing as soon as practicable after the injury, again one week later, and then not more often than once every four weeks. SDCL § 62-7-1.

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The employer is required to provide necessary first aid, medical, surgical and hospital services or other suitable care including medical and surgical supplies, apparatus, artificial members and body aids during the disability. SDCL § 62-4-1. Once the physician has been selected or acquiesced to, the employer has no authority to approve or disapprove the treatment rendered and if a disagreement arises it is the employer's burden to show the treatment was not necessary, suitable or proper. *Hanson v. Penrod Construction Co.*, 425 N.W.2d 396 (S.D. 1988). However, with the mandatory requirement of case management as referenced in No. 39(A), the case management plan will address treatment protocols and referrals.

41. **Which prosthetic devices are covered, and for how long?**

Prosthetic care is covered during the disability, for life. SDCL § 62-4-1.

42. **Are vehicle and/or home modifications covered as medical expenses?**

Yes, if they are considered medically necessary. *Howie v. Pennington County*, 1997 S.D. 45, 563 N.W.2d 116. The South Dakota Department of Labor has awarded home modifications and a vehicle when the facts support it.

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

The Department of Labor has, by administrative rule, adopted a medical fee schedule. SDCL § 62-7-8.

44. **What, if any, provisions or requirements are there for "managed care"?**

Both self-insured employers and worker's compensation insurers must provide medical services and health care to injured workers for compensable injuries under managed care plans certified by the Department of Labor. SDCL §§ 58-20-24, 62-5-21.

45. **What is the procedure for contesting all or part of a claim?**

If the parties are unable to reach an agreement, either may notify the Department of Labor in writing and request a hearing. SDCL § 62-7-12. Hearings are "contested case hearings" under South Dakota's Administrative Procedures Act (SDCL 1-26).
Every case management plan must contain a provision for dispute resolution. Parties dissatisfied with the result after completion of the dispute resolution procedure may file a Petition for Hearing with the Department of Labor. ARDS 47:03.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

If the employer and employee do not agree as to compensability, in whole or in part, either may request the Department to conduct a mediation in accordance with rules promulgated by the Department. SDCL 62-7-37.

If a Petition for Hearing is filed, the initial hearing and decision is governed by the Administrative Procedures Act (SDCL Ch 1-26) and an administrative law judge from the Department of Labor hears the case. Written decisions constitute the decision of the Department. A review of the decision by the Secretary of Labor can be requested within 10 days after receipt of the agency decision. SDCL §§ 62-7-12 through 62-7-16.

B. **Trial court.**

Decisions of the Department are appealable to the circuit court. The appeal must be filed within 30 days from receipt of the final agency decision. SDCL § 15-26A-6. The standard of review is "clearly erroneous" for questions of fact while questions of law are fully reviewable. *Thomas v. Custer State Hospital*, 511 N.W.2d 576 (S.D. 1994).

C. **Appellate.**

The final level of appeal is the South Dakota Supreme Court. SDCL § 1-26-37. The appeal must be filed within 30 days of the circuit court's order. SDCL § 15-26A-6. The standard of review remains "clearly erroneous" for questions of fact, and there is full review for questions of law with no deference given to the circuit court's determination. *Sopko v. C & R Transfer Co.*, 1998 SD 8, 575 N.W.2d 225.

47. **What are the requirements for stipulations or settlements?**

Agreements must be approved by the Department of Labor. If an employer and employee reach an agreement as to compensation, then a memorandum must be filed with the department. The Agreement is deemed approved and enforceable if the Department does not respond within twenty days of the memorandum’s filing. SDCL § 62-7-5.

48. **Are full and final settlements with closed medicals available?**

Yes, but only if compensability is at issue.

49. **Must stipulations and/or settlements be approved by the state administrative body?**
Yes. See answer 47.

RISK FINANCE FOR WORKERS' COMPENSATION

50. What insurance is required, and what is available (e.g. private carriers, state Fund, assigned risk pool, etc.)?

Employers must either be insured or self-insured in order to come under Title 62. SDCL ch. 62-5. An employer may secure the payment of compensation by insuring and keeping insured with any insurer or any mutual employer's liability association authorized to transact the business of worker's compensation insurance in the state or in an association authorized to exchange reciprocal or interinsurance contracts by individuals, partnerships or corporations. SDCL § 62-5-1. South Dakota also has an assigned risk pool through NCCI. Failure to be insured or self-insured exposes an employer in circuit court under the worker's compensation act for double worker's compensation benefits or to a tort action in which all tort defenses are available. SDCL § 62-3-11.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

Employers who seek to be self-insured must annually furnish satisfactory proof to the Department of Labor of their solvency and financial ability to pay claims. Upon receipt of satisfactory proof, the Department of labor issues a certificate of exemption relieving the employer of the obligation to purchase worker's compensation insurance. It is sufficient proof of solvency if the employer is a member of an association or reciprocal insurer. An application fee up to $2,500.00 is required with the application. The self-insured employer is required to provide a bond, or cash or certificate of deposit or approved governmental security in any combination in the total amount equal to the greater of: (1) $250,000.00, (2) twice the amount of compensation and medical claims paid during the preceding calendar year, or (3) the amount designated by the employer as a reserve for workers' compensation claims. SDCL § 62-5-5, 62-5-10.

B. For groups or "pools" of private entities.

The South Dakota Insurance Code allows for the creation of reciprocal insurers which may, among other things, provide worker's compensation insurance. SDCL ch. 58-34. Additionally, two or more electric utility employers or their trade associations may form a self-insurance association to protect members against losses arising from worker's compensation. SDCL §§ 58-20-25 through 58-20-40.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state
acts include them within the definition of “employee”?

No case law or statute in South Dakota specifically addresses the availability of worker’s compensation benefits for illegal aliens. But see Jensen v. Sport Bowl, Inc., 469 N.W.2d 370 (S.D. 1991) (holding that worker’s compensation provided the exclusive remedy for a minor even though the minor was illegally employed.) South Dakota law does prohibit illegal aliens from receiving unemployment benefits. SDCL61-6-34. In addition, South Dakota law defines covered employees under its Worker’s Compensation Act broadly, but does not specifically include ‘illegal aliens’ as covered employees. See Answer to Question # 1.

53. Are terrorist acts or injuries covered or excluded under the workers’ compensation law?

While there is no case on point in South Dakota, there does not appear to be any defense or exclusion that would preclude coverage if the injury arose out of and in the course of employment.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

No.

55. How are subrogation liens of Medicare and health insurers treated under workers’ compensation law?

If an employer denies coverage on the basis that the injury is not compensable as defined by SDCL 62-1-1(7)(a)(b) or (c), the injury is presumed to be non-work related for other insurance purposes and any other insurer shall pay according to their policy provisions. If it is later determined that the injury is compensable, the employer shall immediately reimburse the parties not liable for all payments made, including interest. SDCL 62-1-1.3.

56. What are the requirements of confidentiality and privacy of medical records under the workers’ compensation law and how are they affected by state and federal law (HIPAA)?

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462 went into effect on April 14, 2003. The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

No relevant information developed in connection with treatment or examination for which compensation is sought may be considered a privileged communication for purposes of a workers’ compensation claim. All medical and hospital information relevant to the particular injury shall, on demand, be made available to the employer, employee, insurer and the
department of labor. SDCL 62-4-45. Information obtained within the contemplation of the workers’ compensation laws shall be used for no other purpose than for the information of the department or insurance company with reference to the duties imposed upon such department. However, the department may release information to an injured employee or his attorney, to a social security or welfare office having a claim by the employee or to any state or federal agency which rehabilitates handicapped persons; and the department may issue statistical information where individual claimants are not identified. SDCL 62-6-5. There are, at present, no state regulations similar to HIPAA and HIPAA exempts workers’ compensation insurance. See 45 C.F.R. § 160.103. Additionally, entities to which the HIPAA privacy regulations apply “may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.” 45 C.F.R. § 164.512(l).

57. **What are the provisions for “Independent Contractors”?**

An independent contractor is an individual that has been and will continue to be free from control or discretion over the performance of the service, both under his contract of service and in fact and the individual is customarily engaged in an engaged in an independently established trade, occupation, profession or business. SDCL § 62-1-11.

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

No.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

An owner-operator who, as an individual or partner, or shareholder of a corporate owner-operator, owns a vehicle licensed and registered as a truck, road tractor, or truck tractor by a governmental agency, is an independent contractor while performing services in the operation of the owner-operator’s vehicle if the owner-operator has applied for and received a certification of independent contractor status from the Department of Labor. SDCL § 62-1-10. To obtain certification, the owner-operator and the carrier shall provide written documentation that the following are substantially present:

A. The owner-operator is responsible for the maintenance of the vehicle;

B. The owner-operator is responsible for the vehicle’s operating costs, including fuel, repairs, supplies, collision insurance, and personal expenses for the operator while on the road;
C. The owner-operator is responsible for supplying the necessary personnel to operate the vehicle, the personnel are considered the owner-operator's employees, and the owner-operator is responsible for providing proof of workers' compensation insurance for the employees;

D. The owner-operator's compensation is based on factors related to the work performed, including a percentage of any schedule of rates or lawfully published tariffs, and not on the basis of the hours or time expended;

E. The owner-operator determines the details and means of performing the services, in conformance with regulatory requirements, operating procedures of the commercial carrier, and specifications of the shipper; and

F. The owner-operator enters into a written contract which specifies the relationship to be that of an independent contractor and not that of an employee.

SDCL § 62-1-11.

An owner-operator, as an independent contractor, may elect to participate in this state's workers' compensation system as a sole proprietor. Alternatively, an owner-operator and the motor carrier to whom the owner-operator's vehicle is leased may mutually agree that the owner-operator will be covered under the motor carrier's workers' compensation insurance policy or authorized self-insurance, if the owner-operator agrees to pay the premiums requested by the motor carrier. An agreement by an owner-operator and a motor carrier to include the owner-operator under the motor carrier's workers' compensation coverage does not affect the independent contractor status of the owner-operator. If the owner-operator makes the election as set forth in this paragraph, the owner-operator will be deemed bound by the provisions of this title. SDCL § 62-1-13.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

Under Medicare regulations (42 CFR §411.20, 411.40), Medicare is secondary payer to
the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. 42 CFR § 411.32, 411.40, 411.46. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

(1) the employee is already a Medicare enrollee and the total settlement amount is greater than $25,000; or

(2) there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000. See Frazer v. CNA Ins. Co., 374 F.Supp.2d 1067, 1076 (N.D. Ala. 2005). If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Id.

Although there are no statutory or regulatory provisions that require parties to submit a Workers’ Compensation Medicare Set-Aside Agreement (“WCMSA”), allocating a portion of the settlement towards future medical expenses, parties may choose to submit a WCMSA to the Centers for Medicare and Medicaid services for review and approval so long as the above thresholds are satisfied. DEP’T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, May 11, 2011 Memorandum re: Medicare Secondary Payer-Workers’ Compensation, available at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/May-11-2011-Memorandum.pdf.

There are no special provisions in Title 62 regarding the protection of Medicare’s interests during settlement.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Currently medical use of marijuana is illegal under South Dakota and Federal law. See answer 9.

However, on February 14, 2017, the South Dakota Legislature passed Senate Bill 157 which created an exception for the possession of less than five grams of marijuana with a valid medical marijuana card from another state. On March 17, 2017 Senate bill 95 was signed by Governor Dennis Daugaard which added cannabidiol to the list of Schedule IV controlled substances and excluded it from the definition of marijuana as long as it is a drug product approved by the United States Food and Drug Administration. Measure 26, approving medical marijuana, will be voted on in South Dakota on November 3, 2020.

Currently, there is no case law regarding whether medical marijuana may be covered under Workers Compensation in South Dakota even if the employee falls within the exceptions above.
Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Currently recreational use of marijuana is illegal under South Dakota and Federal law. See answer 9. South Dakota will also vote on Constitutional Amendment A, approving the use of recreational marijuana, on November 3, 2020.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

Robert B. Stock, Esquire
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Tel: (701) 237-6983
1. **Citation for the state’s workers’ compensation statute.**
   

2. **Who are covered “employees” for purpose of workers’ compensation?**
   
   A covered employee is every person under contract of hire or apprenticeship, written or implied, including a paid corporate officer. T.C.A. § 50-6-102(12)(A). It also includes a sole proprietor or a partner, if he or she properly elects. T.C.A. § 50-6-102(12)(B). Please see #52 below for additional information regarding “illegal aliens.”

3. **Identify and describe any “statutory employer” provision.**
   
   T. C. A. § 50-6-113

   (a) A principal contractor, intermediate contractor or subcontractor shall be liable for compensation to any employee injured while in the employ of any of the subcontractors of the principal contractor, intermediate contractor or subcontractor and engaged upon the subject matter of the contract to the same extent as the immediate employer.
(b) Any principal contractor, intermediate contractor or subcontractor who pays compensation under subsection (a) may recover the amount paid from any person who, independently of this section, would have been liable to pay compensation to the injured employee, or from any intermediate contractor.

(c) Every claim for compensation under this section shall be in the first instance presented to and instituted against the immediate employer, but the proceedings shall not constitute a waiver of the employee's rights to recover compensation under this chapter from the principal contractor or intermediate contractor; provided, that the collection of full compensation from one (1) employer shall bar recovery by the employee against any others, nor shall the employee collect from all a total compensation in excess of the amount for which any of the contractors is liable.

(d) This section applies only in cases where the injury occurred on, in, or about the premises on which the principal contractor has undertaken to execute work or that are otherwise under the principal contractor's control or management.

(e) A subcontractor under contract to a general contractor may elect to be covered under any policy of workers' compensation insurance insuring the contractor upon written agreement of the contractor, by filing written notice of the election, on a form prescribed by the administrator, with the division. It is the responsibility of the general contractor to file the written notice with the division. Failure of the general contractor to file the written notice shall not operate to relieve or alter the obligation of an insurance company to provide coverage to a subcontractor when the subcontractor can produce evidence of payment of premiums to the insurance company for the coverage. The election shall in no way terminate or affect the independent contractor status of the subcontractor for any other purpose than to permit workers' compensation coverage. The election of coverage may be terminated by the subcontractor or general contractor by providing written notice of the termination to the division and to all other parties consenting to the prior election. The termination shall be effective thirty (30) days from the date of the notice to all other parties consenting to the prior election and to the division.

(f) This section shall not apply to a construction services provider, as defined by § 50-6-901.
4. **What types of injuries are covered and what is the standard of proof for each:**

Generally, the plaintiff in a workers’ compensation suit has the burden of proving his case by a preponderance of the evidence. *Owens Ill., Inc. v. Lane*, 576 S.W.2d 348 (Tenn. 1978). This is subject to the exception, herein, allowing for presumptions and requirement for clear and convincing evidence to overcome the drug free workplace presumption. T.C.A. § 50-6-110(c)(1).

A. (1) **Traumatic or “single occurrence” claims.**

An “injury” or “personal injury” is an injury by accident “arising[ing] primarily out of and in the course and scope of employment” that causes either disablement or death of the employee by a showing to “a reasonable degree of medical certainty that [the injury] contributed more than fifty percent (50%) in causing the disablement. In other words, the employee must be within the time and space boundaries of the employment, and he or she must be engaged in an activity that bears some reasonable relationship to the employment and be injured by a hazard or risk incident to the employment. An “injury” or “personal injury” also includes occupational diseases and mental injuries arising primarily out of and in the course of employment that cause either disablement or death of the employee. T.C.A. § 50-6-102(14). (The causation opinion of the panel physician shall be rebuttably presumed to be correct).

A. (2) **Repetitive (multiple) trauma (motion) claims.**

See the definition in 4.A.(1); however, conditions such as carpal tunnel syndrome, repetitive back motions, etc. may be covered, as well as hearing loss, as of 6/6/11 only if the condition arose primarily out of and in the course and scope of employment. See T.C.A. §50-6-301(b), noting that the causation opinion of the authorized treating physician will be entitled to presumption of correctness, rebuttable by a preponderance of the evidence effective 6/6/11.

B. **Occupational disease (including respiratory and repetitive use).**

As noted in 4.A.(1), an “injury” includes occupational diseases that arise primarily out of and in the course of employment and that cause either disablement or death of the employee. T.C.A. § 50-6-102(14). An occupational disease is deemed to have arisen out of the employment if: (1) it can be determined to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (2) it can be fairly traced to the employment as a proximate cause; (3) it has not originated from a hazard to which workers would have been equally exposed outside of the employment; (4) it is incidental to the character of the employment and not independent of the relation of employer and employee; (5) it originated from a risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected prior to its contraction; and (6) there is a direct causal connection between the conditions under which the work is performed and the occupational disease. Disease of the heart, lung, and hypertension arising out of and in the course of any type of employment shall be deemed to be occupational diseases. T.C.A. § 50-6-301, et seq.

5. **What, if any, injuries or claims are excluded?**

Compensation is not allowed for an employee’s injury or death when:

- the employee engaged in willful misconduct, such as deliberately violating safety rules or instructions, T.C.A. § 50-6-110(a)(1);
- the employee intentionally inflicted injury to him or herself, such as committing suicide, T.C.A. § 50-6-110(a)(2);
- the employee was intoxicated or used illegal drugs, T.C.A. § 50-6-110(a)(3);
• the employee deliberately failed or refused to use a safety appliance, T.C.A. § 50-6-110(a)(4);
• the employee deliberately failed to perform a duty required by law, T.C.A. § 50-6-110(a)(5); or
• with some exceptions, the employee was voluntarily participating in recreational, social, athletic or exercise activities, T.C.A. § 50-6-110(a)(6).

The burden of proof for this defense, including causation, is on the employer. T.C.A. § 50-6-110(b). However, if the employer has qualified as a “drug-free workplace,” then a rebuttable presumption is created that such drug or alcohol use was the proximate cause of the injury, unless waived by the employer’s prior actual notice and acquiescence of such activity. T.C.A. § 50-6-110(c)(1). As of 6/6/11, the presumption can only be rebutted by “clear and convincing evidence.”

Note also that compensation may be denied if an employee intentionally misrepresents his or her physical condition in an application for employment. Federal Copper & Aluminum Co. v. Dickey, 493 S.W.2d 463, 465 (Tenn. 1973). In addition, a number of statutory provisions allow employees who suffer from specific illnesses to waive their right to certain workers’ compensation benefits. See, e.g., T.C.A. §§ 50-6-213(a) (epileptics); 50-6-307(a) (occupational diseases); 50-6-307(b) (heart conditions).

6. **What psychiatric claims or treatments are compensable?**

Benefits may be awarded for a mental illness following a physical injury. This normally occurs when anxiety, depression or post-traumatic stress syndrome emerge after a work-related physical injury.

Courts have also awarded benefits for mental illnesses following mental stimuli. In these situations, the mental disorder must be caused by a sudden, acute or unexpected mental stimulus. If the mental condition is caused by general work-related stress, it will not be compensable.

Effective July 1, 2014, a “mental injury” is defined as a loss of mental faculties or a mental or behavioral disorder, arising primarily out of a compensable physical injury or an identifiable work related event resulting in a sudden or unusual stimulus, and shall not include a psychological or psychiatric response due to the loss of employment or employment opportunities. T.C.A. § 50-6-102(17).

The date of maximum medical improvement for mental injuries is conclusively presumed (1) at earlier of treating psychiatrist’s conclusion that MMI reached, or (2) 104 weeks after date of mental injury if no underlying physical injury. The opinion of a psychiatrist is necessary for the assignment of permanent impairment, which is unchanged from pre-July 2014 law.

Tennessee Courts have held that mental injuries could or may give rise to recovery in workers’ compensation. Jose v. Equifax, Inc., 556 S.W.2d 82, 84 (Tenn. 1977). In order to be compensable, a psychological injury must meet the traditional prerequisites of any workers' compensation claim: it must arise out of and be in the course of employment. T.C.A. § 50-6-103(a). With respect to mental injuries, the phrase “arising out of employment” has been construed to include only those injuries stemming from “an identifiable stressful, work-related event producing a sudden mental stimulus such as fright, shock, or excessive unexpected anxiety.” Goodloe v. State, 36 S.W.3d 62, 65 (Tenn. 2001) (citing Ivey v. Trans Global Gas & Oil, 3 S.W.3d 441, 446 n. 10 (Tenn. 1999)). This does not include every “undesirable experience” encountered in a job. Goodloe, 36 S.W.3d at 66 (quoting Jose, 556 S.W.2d at 84). It only includes traumatic experiences that are outside the normal bounds of the particular job in which the employee is engaged. Saylor v. Lakeway Trucking, Inc., 181 S.W.3d 314,
320 (Tenn. 2005); Gatlin v. Knoxville, 822 S.W.2d 587, 592 (Tenn. 1991). That is, the event “must be extraordinary and unusual in comparison to the stress ordinarily experienced by an employee in the same type duty.” Gatlin, 822 S.W.2d at 592. Loss of employment or employment opportunity does not qualify as a compensable mental injury.

7. **What are the applicable statutes of limitations?**

   **A. Injuries.**

   For injuries occurring on or after January 1, 2005, the limitations period for filing a workers' compensation claim is "one year after the accident resulting in injury." T.C.A. § 50-6-203(b). Unless there has been an approved settlement, and where the employer has not voluntarily paid workers' compensation benefits to the employee, the right to compensation is barred unless a mediation is properly requested within one (1) year after the accident resulting in the injury. T.C.A. § 50-6-203(b)(1).

   For injuries occurring after July 1 2014, if the employer has voluntarily paid workers' compensation benefits to the employee, unless a petition for benefit determination is filed with the bureau on a form prescribed by the administrator within one (1) year from the latter of the date of the last authorized treatment or the time the employer ceased to make payments of compensation to or on behalf of the employee. T.C.A. §§ 50-6-203(b)(2). If the parties are unable to settle all issues at the mediation, the mediator will prepare a Dispute Certification Notice listing all unresolved issues which may be heard by a workers’ compensation judge. If a party desires to have their claim decided by a workers’ compensation judge, he or she must file a request for hearing with the Division of Workers’ Compensation. This document must be submitted to the Clerk of the Court of Workers’ Compensation Claims within sixty (60) days after the issuance of the Dispute Certification Notice.

   A workers' compensation judge may hear and determine claims for compensation, approve settlements of claims for compensation, conduct hearings, and make orders, decisions, and determinations. Workers' compensation judges conduct such hearings in accordance with the Tennessee Rules of Civil Procedure, the Tennessee Rules of Evidence, and the rules adopted by the bureau. T.C.A. § 50-6-238.

   **B. Occupational diseases.**

   For occupational diseases occurring after January 1, 2005, a claim must be initiated within one year "of the date of the beginning of the incapacity for work." T.C.A. § 50-6-306(a). The "beginning of the incapacity for work" is the date when the employee knows, or in the exercise of reasonable care, should know, that he or she has an occupational disease and that it has substantially affected his or her capacity to work. Smith v. Asarco Inc., 627 S.W.2d 946 (Tenn. 1982). A claim for benefits due to coal workers' pneumoconiosis must be initiated within three years of discovery of total disability. T.C.A. § 50-6-306(b). For occupational diseases occurring before January 1, 2005, the suit must be initiated within one year “after the beginning of the incapacity for work resulting from an occupational disease.” T.C.A. § 50-6-306(a).

   **C. Deaths.**

   The payment of death benefits is governed by T.C.A. §§ 50-6-209 and 50-6-210. T.C.A. § 50-6-210(e)(10), states that “this compensation shall be paid during dependency not to exceed the maximum total benefit." Moreover, T.C.A. § 50-6-209(b)(3) states that "the total amount of compensation payable under this subsection (b) shall not exceed the maximum total benefit...."

   There are only two circumstances in which death benefits can be terminated: (1) the period of
dependency ends (e.g. the surviving spouse gets remarried, the minor child comes of age, the dependent dies); or (2) the "maximum total benefit" is reached. The maximum total benefit is not limited to 400 weeks. The Tennessee Supreme Court has stated that "[the statute] does not specifically limit death benefits to dependents for any set number of weeks." *Jones v. Gen. Acc. Ins. Co. of Am.*, 856 S.W.2d 133, 135 (Tenn. 1993). Although “death benefits to dependents are subject to the maximum and minimum weekly benefit and maximum total benefit, [the statute] does not place a limit on the number of weeks such benefits are to be paid." *Id.* Any award of death benefits should thus “continue to be paid beyond 400 weeks until the maximum total benefit is reached." *Id.*

As of July 1, 2014, in death claims, the dependent(s) shall file a petition for benefit determination on a form presented by the administrator within one year of the employee’s death. T.C.A. §50-6-203(e)(1)

*See* T.C.A. §§ 50-6-203 & 50-6-306 for more information on statutes of limitation.

8. **What are the reporting and notice requirements for those alleging an injury?**

An injured employee must immediately report the injury and provide written notice, unless such was not reasonable or practical at the time, within fifteen (15) days of date of the accident unless the employer had “actual notice.” T.C.A. § 50-6-201. The Notice must be signed by the claimant. The report must state in plain language the name and address of the employee, the time, place and nature and cause of the accident resulting in the injury to the employee. T.C.A. § 50-6-202(a)(2). Notice must be given personally to the employer, and in order to bar compensability, the employer must show prejudice. T.C.A. §50-6-201(a)(3).

An occupational disease must be reported to the employer within thirty (30) days after the first distinct manifestation of the disease. Written notice for an occupational disease should be given within (30) days after the first distinct manifestation in the same manner provided for an accidental injury. T.C.A. § 50-6-305(a). Somewhat later notice may be allowed if there is good cause for the delay and no prejudice exists as to the employer. Notice is not required until the condition is known to be disabling and related to a specific work accident or repetitive work activity. T.C.A. § 50-6-201(b).

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

An employer may use an employee’s self-inflicted injury as a defense. The employer has the burden of proof in showing that the employee’s actions constituted an intentional self-inflicted injury. T.C.A. § 50-6-110.

B. **Willful misconduct, “horseplay,” etc.**

The employer has the burden of proving that the employee was engaged in willful misconduct, “horseplay,” etc. The defense of willful misconduct requires (1) an intention to do the act; (2) a purposeful violation of orders; and (3) an element of perverseness. Willful failure or refusal to use a safety appliance is also a defense that the employer can use. The defense is predicated on a rule requiring the use of a safety appliance, and the employee must have had actual notice of the rule, which is routinely and systematically enforced. A willful failure or refusal to perform a duty required by law will also provide a defense for the employer. T.C.A. § 50-6-110; see *Stafford v. Sara Lee Corp.*, 2001 WL 65584 (Tenn. 2001) (claim non-compensable when employee failed to use safety device).
An employer is entitled to enforce workplace policies during the pendency of a workers’ compensation action. In fact, the Supreme Court of Tennessee explicitly stated this proposition in *Carter v. First Source Furniture Group* when the Court said that “an employer should be permitted to enforce workplace rules without being penalized in a workers’ compensation case.” *Carter v. First Source Furniture Grp.*, 92 S.W.3d 367, 371 (Tenn. 2002). That is, an employer may terminate an employee who violates an established company policy during the term of a workers’ compensation action.

C. **Injuries involving drugs and/or alcohol.**

A defense is available to the employer when the employee has been found to have been injured due to intoxication or illegal drugs. A blood alcohol level of .08 for non-safety sensitive positions and .04 for safety sensitive positions creates a presumption that the alcohol was a proximate cause of the injury. The employee then has the burden to prove that the alcohol or drugs was not the proximate cause of the injury, as long as the employer implements and follows the Drug-free Workplace Program set out in T.C.A. §§ 50-9-101 to 50-9-114. Otherwise, the employer has the burden of providing both level of intoxication and causation. T.C.A. § 50-6-110. If an injured worker refuses to submit to a drug test, then absent a preponderance of the evidence to the contrary, it shall be presumed that the accident was proximately caused by the use of drugs. T.C.A. § 50-6-110.

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Knowing, willing, and intentional switching of a work-related medical expense claim to group insurance or knowing failure to provide compensable medical treatment results in a $500 penalty and no offset of group payments made. T.C.A. § 50-6-128. Both the employee and the employer may be subject to civil and criminal penalties for violation of the applicable statutory fraud provisions, including knowingly making or causing to be made any false or fraudulent material statements or material representations to obtain or deny compensation benefits or expenses. A fraudulent insurance act is punishable as a criminal act under the statute. T.C.A. §§ 56-47-101 to 56-47-112.

11. **Is there any defense for falsification of employment records regarding medical history?**

Misrepresentation or falsification of employment records, which includes medical representations in a post-job offer, pre-employment physical exam medical questionnaire, may be a defense for an employer. However, the following elements must be met: (1) the employee must have knowingly and willfully made a false representation as to his physical condition; and (2) the employer must have relied upon the false representation, and the reliance must have been a substantial factor in the hiring; and (3) there must have been a causal connection between the false representation and the injury. See *Federal Copper & Aluminum Co. v. Dickey*, 493 S.W.2d 463, 465 (Tenn. 1973); see also *Quaker Oats Co. v. Smith*, 574 S.W.2d 45 (Tenn. 1978). For example, if an employee states on his employment application that he left his former job for “a better job,” when in fact he left due to his former employer’s inability to accommodate the employee’s medical restrictions, then workers’ compensation benefits may be barred because the employee made a “willful misrepresentation.” *Mark Allred v. Berkline*, LLC, 2010 WL 2612695 (Tenn. Workers Comp. Panel 2010).

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

No compensation is allowed for an injury caused by the employee's voluntary participation in recreational, social, athletic or exercise activities, including, but not limited to, athletic events, competitions, parties, picnics, or exercise programs, whether or not the employer pays some or all of
the costs of the activities unless (1) participation was expressly or impliedly required by the employer; (2) participation produced a direct benefit to the employer beyond improvement in employee health and morale; (3) participation was during employee's work hours and was part of the employee's work-related duties; or (4) the injury occurred due to an unsafe condition during voluntary participation using facilities designated by, furnished by or maintained by the employer on or off the employer's premises and the employer had actual knowledge of the unsafe condition and failed to curtail the activity or program or cure the unsafe condition. T.C.A. § 50-6-110.

13. Are injuries by co-employees compensable?

An injury resulting from an assault by a co-employee is compensable if the assault arose out of and within the course and scope of employment (e.g., if the assault followed from a dispute over some aspect of employment). See, e.g., Lewis v. Saturn Corp., 2000 WL 1262462 (Tenn. Workers’ Comp. Panel 2000). However, an injury resulting from an assault is not compensable if it followed from a dispute over a personal matter. As long as a work-related action may be established, then the injury is probably compensable. As noted herein, the common law aggressor defense has been abolished by case law.

14. Are acts by third parties unrelated to work, but committed on the premises, compensable?

Claims arising out of a purely personal altercation, even though on the premises, can be recoverable as long as the work-related action is satisfied. Also, simply because an employee is the “first aggressor,” is no longer an automatic bar to recovery. The “arising primarily out of” portion of the statute appears to take precedence, noting that workers’ compensation law is a “no fault concept.” See Woods v. Harry B. Woods Plumbing Co., 967 S.W.2d 768 (Tenn. 1998).
15. **What criterion is used for calculating the average weekly wage?**

Pursuant to T.C.A. § 50-6-102(3)(A) and subject to the limitations stated therein, the average weekly wage means the earnings of the injured employee in the employment in which the injured employee was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury divided by the number of weeks actually worked. Earnings generally include any benefits reported on W-2 form.

16. **How is the rate for temporary/lost time benefits calculated including minimum and maximum rates?**

The rate for temporary total benefits is calculated by multiplying the average weekly wage by 66 2/3%. T.C.A. § 50-6-207(1)(A). Benefits are paid subject to statutory maximum and minimum weekly amounts. The wage caps vary and are increased periodically up to 110% of the state’s average weekly wage as determined by the division. See T.C.A. § 50-6-102(16)(xi)(b). Likewise, the minimum weekly benefit is recalculated annually at the rate of 15% of the state’s average weekly wages. See T.C.A. § 50-6-102(18).

Temporary partial disability is calculated by taking 66 2/3% of the difference between the average weekly wage earnings of the worker at the time of the injury and the wage that the worker is able to earn in his disabled condition. This is subject to a 450-week cap. These benefits are also subject to the statutory maximum and minimum amounts. See T.C.A. § 50-6-207(2).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Compensation must be paid promptly and within fifteen (15) days after the employer has knowledge of any disability or death, and compensation must thereafter be paid semimonthly. T.C.A. § 50-6-205(b)(2). No benefits are payable for the first 7 days of disability; however, the disability will commence on the 8th day. See T.C.A. § 50-6-205(a).

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out 14 days before recovering benefits for the first day)?**

The first 7 days of disability are not initially recoverable; however, the benefit payment period becomes retroactive to the 1st day after the disability if the disability lasts for 14 days or more. T.C.A. § 50-6-205(a).

19. **What is the standard/procedure for terminating temporary benefits?**

The maximum medical improvement date or return to work, whichever first occurs, terminates temporary total disability. See Prince v. Sentry Ins. Co., 908 S.W.2d 937, 939 (Tenn. 1995). A notice of termination or change of benefits (Form C-26) must be filed with the state, as appropriate.

When an employer makes temporary total disability payments to an injured employee beyond the date that the employee reaches maximum medical recovery, the employer is entitled to deduct the amount of the overpayment from a subsequent award of permanent partial disability payments. See Mack v. Shelby County Government, 1992 Tenn. App. LEXIS 383, *9 (Tenn. Ct. App. May 5, 1992).

20. **Is the amount of temporary total disability paid toward the amount entitled for permanent partial disability?**

No credit is generally allowed for temporary total benefits paid on a permanent partial award,
21. What disfigurement benefits are available and how are they calculated?

Prior to July 1, 2014, serious disfigurement to the head, face or hands, and not resulting from the loss of a member or other specific injury already compensated, that so alters the personal appearance of the employee as to materially affect their employability in an employment that they were otherwise qualified to perform may entitle the employee to benefits. This employee would be eligible for permanent partial disability benefits, but not to exceed 200 weeks. T.C.A. § 50-6-207(3)(E).

However, as of July 1, 2014, T.C.A. § 50-6-207(3) no longer delineates benefits for disfigurement. These injuries are now apportioned to the body as a whole.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates? (See Response to No. 16. for minimum and maximum weekly benefits rates)

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

As of July 1, 2014, benefits are no longer calculated based on scheduled members/parts. All injuries are now apportioned to the body as a whole with a maximum value of 450 weeks, which was increased from 400 weeks as of July 1, 2014.

B. Number of weeks for “whole person” and standard for recovery.

1. Permanent Partial – Subject to the maximum weekly benefit and the minimum weekly benefit, employee shall receive 66 2/3% of the average weekly wages received for the 52-week period next preceding the injury for permanent partial for the applicable percentage of weeks assigned to the injury. T.C.A. § 50-6-207(3).

2. Permanent total disability benefits are payable until the employee is, by age, eligible for full benefits in the Old Age Insurance Benefit Program under the Social Security Act, except, see Response to No. 22(B)(3) below. T.C.A. § 50-6-207(4)(A). As of July 1, 2014, T.C.A. § 50-6-207(4) the capped 260-week compensation period for permanent total disability for employees injured after they are over the age of 60 is expanded to apply to an employee’s permanent total disability occurring less than 5 years before the date the employee is eligible for full benefits in the Old Age Insurance Benefit Program. By case law, this capped compensation period for permanent total disability applied to permanent partial disability and it is believed this amendment will likewise apply to permanent partial disability. See Smith v. U.S. Pipe and Boundary Co., 14 S.W.3d 739, 742 (Tenn. 2000); see also Vogel v. Wells Fargo Guard Serv., 937 S.W.2d 856, 862 (Tenn. 1996)).

3. If employee is over age 60 on the date of injury and is permanently and totally disabled, then the maximum benefit available is a cap of 260 weeks. T.C.A. § 50-6-207(4)(A)(i); Peace v. Easy Trucking Co., 38 S.W. 3d 526 (Tenn. 2001). By case law, this section also applies to permanent partial disability cases. The payments are offset by old age benefits attributable to employer contributions.

4. The current statutory framework for determining permanent partial disability benefits as provided in T.C.A. § 50-6-207(3) is as follows:

(3) Permanent Partial Disability.
(A) In case of disability partial in character but adjudged to be permanent, at the time the injured employee reaches maximum medical improvement the injured employee shall be paid sixty-six and two-thirds percent (66 2/3 %) of the employee's average weekly wages for the period of compensation, which shall be determined by multiplying the employee's impairment rating by four hundred fifty (450) weeks. The injured employee shall receive these benefits, in addition to the benefits provided in subdivisions (1) and (2) and those provided by § 50–6–204, whether the employee has returned to work or not; and

(B) If at the time the period of compensation provided by subdivision (3)(A) ends, the employee has not returned to work with any employer or has returned to work and is receiving wages or a salary that is less than one hundred percent (100%) of the wages or salary the employee received from his pre-injury employer on the date of injury, the injured employee may file a claim for increased benefits. If appropriate, the injured employee's award as determined under subdivision (3)(A) shall be increased by multiplying the award by a factor of one and thirty-five one hundredths (1.35); in addition, the injured employee's award shall be further increased by multiplying the award by the product of the following factors, if applicable:

1. Education: One and forty-five one hundredths (1.45), if the employee lacks a high school diploma or general equivalency diploma;
2. Age: One and two tenths (1.2), if the employee was more than forty (40) years of age at the time the period of compensation ends; and
3. Unemployment rate: One and three tenths (1.3), if the unemployment rate, in the Tennessee county where the employee was employed by the employer on the date of the workers' compensation injury, was at least two percentage (2%) points greater than the yearly average unemployment rate in Tennessee according to the yearly average unemployment rate compiled by the department for the year immediately prior to the expiration of the period of compensation.

(C) In determining the employee's increased award pursuant to subdivision (3)(B), the employer shall be given credit for payment of the original award of benefits as determined under subdivision (3)(A) against the increased award.

(D) Any employee may file a claim for increased benefits under subdivision (3)(B) by filing a new petition for benefit determination, on a form prescribed by the administrator, with the division no more than one (1) year after the period of compensation provided in section (3)(A) ends. Any claim for increased benefits under this subdivision (3)(D) shall be forever barred, unless the employee files a new petition for benefit determination with the division within one (1) year after the period of compensation for the subject injury ends. Under no circumstances shall an employee be entitled to additional benefits when:

1. The employee's loss of employment is due to the employee's voluntary resignation or retirement; provided, however, that the resignation or retirement does not result from the work-related disability;
2. The employee's loss of employment is due to the employee's misconduct connected with the employee's employment; or
3. The employee remains employed but received a reduction in salary, wages, or hours that is concurrent with a reduction in salary, wages or reduction in hours that affected at least fifty percent (50%) of all hourly employees operating at or out of the same location.
(E) Nothing in this subsection shall prohibit the employer and employee from settling the issue of additional benefits at any time after the employee reaches maximum medical improvement. Any settlement or award of additional permanent partial disability benefits pursuant to this subdivision shall give the employer credit for prior permanent partial disability benefits paid to the employee.

(F) Subdivision (3)(B) shall not apply to injuries sustained by an employee who is not eligible or authorized to work in the United States under federal immigration laws.

(G) The total amount of compensation payable in this subdivision 50–6–207(3) shall not exceed the maximum total benefit. The payment of temporary total disability benefits or temporary partial disability benefits shall not be included in calculating the maximum total benefit.

(H) All cases of permanent partial disability shall be apportioned to the body as a whole, which shall have a value of four hundred fifty (450) weeks, and there shall be paid compensation to the injured employee for the proportionate loss of use of the body as a whole resulting from the injury. If an employee has previously sustained an injury compensable under this section and has been awarded benefits for that injury, the injured employee shall be paid compensation for the period of temporary total disability or temporary partial disability and only for the degree of permanent disability that results from the subsequent injury.

5. The “Escape Clause”

For injuries occurring on or after July 1, 2014, in “extraordinary cases” where the Judge finds by clear and convincing evidence that limiting the employee’s recovery to the factors specified would be “inequitable in light of the totality of the circumstances,” the Judge may award any amount up to a maximum of 275 weeks if the Judge documents the following three facts:

1. The authorized treating physician has assigned a medical impairment rating of 10% to the body as a whole or greater;
2. The authorized treating physician has certified on a TDOL form that the employee’s injury has resulted in permanent restrictions which prevent the employee from returning to the “pre-injury occupation”; and
3. The employee is earning an average weekly wage less than 70% of the pre-injury “wage or salary.”

See T.C.A. § 50-6-242.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Vocational rehabilitation is not mandatory in Tennessee; however, pursuant to T.C.A. § 50-6-233(b), the administrator shall cause the division of workers’ compensation to refer all feasible cases for vocational rehabilitation to the department of education.

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

Permanent total benefits are paid at 66 2/3% of the employee’s average weekly wage, subject to the minimum and maximum rates applicable on the date of injury until the employee is eligible, by age, for full old age benefits under the Social Security Act, T.C.A. § 50-6-207(4)(A), with respect to
disabilities resulting from injuries that occur less than five (5) years before the date when the employee is eligible for full benefits in the Old Age Insurance Benefit Program or after the employee is eligible for full benefits, permanent total benefits are payable for a period of 260 weeks, subject to a reduction for old age insurance benefit payments attributable to employer contributions which may be received by the employee.

25. How are death benefits calculated, including the minimum and maximum rates?

   A. Funeral expenses.
   If death results from injury or occupational disease, the employer shall pay the burial expenses of the deceased employee, not exceeding seven thousand five hundred dollars ($7,500). T.C.A. § 50-6-204(c).

   B. Dependency claims.
   Death benefits for dependency claims are computed in T.C.A. § 50-6-210. In cases of death of an employee, sixty-six and two-thirds percent (662/3%) of the average weekly wages shall be paid in cases where the deceased employee leaves dependents, subject to the maximum weekly benefit. The total amount of compensation payable shall not exceed the maximum total benefit, exclusive of medical, hospital and funeral benefits. T.C.A. § 50-6-209.

   The compensation payable in case of death to persons wholly dependent shall be subject to the maximum weekly benefit and minimum weekly benefit; provided, that if at the time of injury the employee receives wages of less than the minimum weekly benefit, the compensation shall be the full amount of the wages a week, but in no event shall the compensation payable under this provision be less than the minimum weekly benefit. The maximum total benefit from death is the product of 450 times the state’s maximum weekly rate, increased from 400 as of July 1, 2014.

   Payment ceases to a dependent upon death, marriage, or achieving age 18 unless mentally incompetent or enrolled in a recognized educational institution until age 22. A surviving spouse can receive payments on behalf of dependent children.

   As of July 1, 2014, T.C.A. § 50-6-210 was amended by adding subsection (f), which applies to situations where compensation is payable due to the death of an employee where the decedent employee leaves an alien dependent or dependents residing outside of the United States.

   C. No dependents – estate claim.
   A lump sum benefit is payable to the decedent’s estate if there is no eligible dependent. As of 7/1/99, the lump sum payable was increased from $10,000.00 to $20,000.00. T.C.A. § 50-6-209(b)(2).

26. What are the criteria for establishing a “second injury” fund recovery?

   For injuries occurring on or after July 1, 2006, there is only one way to recover from the Second Injury Fund. To obtain a recovery, it must be shown that the employee previously sustained a permanent physical disability and has become permanently and totally disabled through a subsequent injury. In that event, the employee is entitled to payment from its employer or employer’s insurer for only the disability that would have resulted from the subsequent injury, and the employer or the employer’s insurer is not responsible for any payment attributable to the previous permanent physical disability. Any compensation that the employee is owed over and above the specific compensation for the subsequent injury is paid out of the Second Injury Fund. T.C.A. § 50-6-208(a)(1). However, for the Second Injury Fund to be responsible for any remainder of compensation, the previous physical disability must have been within the knowledge of the employer. T.C.A. § 50-6-208(a)(2).
27. **What are the provisions for reopening a claim for worsening of condition, including applicable limitations periods?**

**Lump sum** awards are no longer necessarily final thirty (30) days after receipt by the Division of Workers’ Compensation of settlement papers. Settlements, where the amount paid or to be paid in settlement or award does not exceed the compensation for six (6) months of disability are final and not subject to readjustment. T.C.A. § 50-6-230.

For body as a whole injuries occurring on or after July 1, 2004, if an injured employee received benefits for body as a whole and is subsequently no longer employed by the pre-injury employer at the same or greater wage within four hundred (400) weeks, the employee may seek reconsideration of the permanent partial disability benefits.

For scheduled member injuries occurring on or after July 1, 2004, if an injured employee is subsequently no longer employed by the pre-injury employer at the same or greater wage within the number of weeks for which the employee was eligible to receive benefits under T.C.A. 50-6-207, the employee may seek reconsideration of the permanent partial disability benefits.

**Effective July 1, 2010,** employees who continue in their employment after a reduction in pay or a reduction in hours due to economic conditions shall not be entitled to reconsideration of their claims if the reduction in pay or hours affected at least fifty percent (50%) of all hourly employees operating at or out of the same location. T.C.A.. This applies to both body as a whole and scheduled injuries.

For injuries occurring on or after July 1, 2009, where the pre-injury employer is sold or acquired after employee receives permanent partial disability benefits, then the injured employee shall not be entitled to seek reconsideration so long as (1) the injured employee continues to be employed by the successor employer at the same or higher pay; or (2) the employee declines an offer of employment with the successor employer at the same or higher pay. T.C.A. §50-6-241(d)(1)(C)(i). Credit will be given for the previous payments. T.C.A. § 50-6-241.

The provisions in T.C.A. §§ 50-6-241(d)(1)(A ), 50-6-241(d)(1)(C)(i), and 50-6-241 regarding the right of reconsideration are not applicable for injuries occurring on or after July 1, 2014. **For injuries occurring on or after July 1, 2014,** an Employee may petition the Court for increased benefits under certain circumstances. See Section 22.B.4, infra.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

For injuries occurring on or after July 1, 2014, statutory language applies to permit Workers’ Compensation Judges to award attorney’s fees following disputes regarding an employee’s entitlement to future medical benefits. In addition to any attorneys’ fees provided for in this section, the court of workers' compensation claims may award attorneys’ fees and reasonable costs, including reasonable and necessary court reporter expenses and expert witness fees for depositions and trials incurred when the employer fails to furnish appropriate medical, surgical and dental treatment or care, medicine, medical and surgical supplies, crutches, artificial members and other apparatus to an employee provided for in a settlement or judgment under this chapter. Tenn. Code Ann. § 50-6-226(d) (2015).

Additionally, for injuries that occur on or after July 1, 2016, the Court of Workers’ Compensation Claims is now permitted to award attorney’s fees to an employee if the Court determines at an expedited hearing or compensation hearing that the employer wrongfully denied a claim or failed to timely initiate medical or temporary/permanent disability benefits. See Public Chapter 1056 (SB2582/HB2416)
EXCLUSIVE/TORT LIABILITY

29. **Is the compensation remedy exclusive?**

   **A. Scope of immunity.**
   The compensation remedy is exclusive and protects employers maintaining proper coverage, co-employees for unintentional acts, and workers’ compensation insurers. T.C.A. § 50-6-108(a).

   **B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

   [Discrimination claims are intentional in nature and therefore not barred by the exclusive remedy provision. Although fraud is an intentional tort in Tennessee, a fraud claim is not necessarily an exception to the exclusive remedy provision. Third party indemnity actions against an employer are not precluded when an employer has expressly contracted to indemnify the third party. T.C.A. § 50-6-108(c). Exclusive remedy provision under Tenn. Code Ann. § 50-6-108(a) does not bar a claim for unemployment benefits. *See Bates v. Neeley*, 2007 WL 789519 (Tenn. Ct. App. 2007).]

   Tennessee at this time rejects the dual capacity doctrine, which is where an employer who is normally shielded from tort liability by the exclusive remedy principle may become liable in tort to his own employee if he occupies, in addition to his capacity as employer, a second capacity that confers upon him obligations independent of those imposed upon him as employer. *See Gonzalez v. Methodist Hosp. of Memphis*, 1993 Tenn. App. LEXIS 184, *8* (Tenn. Ct. App. Mar. 9, 1993).

   As of July 1, 2014, no employer who fails to secure compensation as required shall be permitted to defend a suit brought by a covered employee or the dependents of a covered employee to recover damages for personal injury or death on any of the following grounds:
   1) The employee was negligent;
   2) The injury was caused by the negligence of a fellow servant or fellow employee; or
   3) The employee had assumed the risk of the injury.

30. **Are there any penalties against the employer for unsafe working conditions?**

   Penalties for unsafe working conditions are administered under the Tennessee Occupational and Safety and Health Act and not under the Workers’ Compensation Act. However, certain employers with specified accident histories may be required to establish a safety committee.

   Every insurer writing workers’ compensation insurance must submit modification factors (or rates) for each insured to the Administrator of the Workers’ Compensation Division, if requested. Failure to do so can result in a monetary penalty. T.C.A. §§ 50-6-501 & 50-6-502.

31. **What is the penalty, if any, for an injured minor?**

   None is provided. A “minor” is expressly included under the definition of “employee,” whether “lawfully” or “unlawfully” employed. T.C.A. § 50-6-102(10)(A). Payment for injury to a minor must be made to the parent or other appointee of the guardian or Trustee, and any such settlement must be approved by the court. T.C.A. § 50-6-221. The maximum payment that may be made direct to the parent or guardian for the use and benefit of the minor cannot exceed $20,000.00,
32. **What is the potential exposure for “bad faith” claims handling?**

   Under the 2013 Workers’ Compensation Act, a medical payment committee hears disputes on medical bill payments between providers and insurers and has the authority to render decisions on the merits of a dispute. If it determines that a provider or insurer has acted in bad faith in refusing to provide payment for a medical bill or refusing to provide reimbursement for overpayment, the medical payment committee, upon a majority vote, shall refer the malfeasant provider or insurer to the division for consideration of assessment of a civil penalty of no more than one thousand dollars ($1,000) per occurrence. A provider or insurer aggrieved by the assessment of a penalty shall have the right to seek review in the manner provided by T.C.A. § 50-6-118(c). T.C.A. § 50-6-125(a)(1).

   In addition to the penalties described above, if an employer/insurer fails to make timely TTD payments within 20 days of knowledge of any qualified disability, a WC specialist can assess a penalty in the amount of 25% of any unpaid TTD payments. T.C.A. 50-6-205(b)(3)(A).

33. **What is the exposure for terminating an employee who has been injured?**

   Although Tennessee is an employment-at-will state, an employee-at-will who is discharged solely for filing a workers’ compensation claim may have a cause of action against the employer for retaliatory discharge, regardless of the eventual outcome of the workers’ compensation claim. Such claim may be subject to punitive damages. Additional exposure for termination of an employee who has a permanent impairment may be subject to a recovery under the Americans with Disabilities Act. *Leatherwood v. United Parcel Serv.*, 708 S.W.2d 396 (Tenn. Ct. App. 1985).

   Of course, if an employee is unable to return to work at the same or greater wage as a result of his injury, his benefits may be calculated as set forth in 22(B)(4), above.
THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

Third party actions are permissible under T.C.A. § 50-6-112. Failure of employee to file suit within one year operates as an assignment to the employer who then has an additional 6 months to file suit to avoid being time barred. § 50-6-112(d)(2).


35. Can co-employees be sued for work-related injuries?

Yes. Co-employees can be sued where the co-employee intentionally assaults the employee or if co-employee was acting outside the scope of his employment. Scott v. AMEC Kamtech, Inc., 583 F.Supp.2d 912 (E.D. Tenn. 2008).

36. Is subrogation available?

Yes. An employer “shall” have a subrogation lien against any recovery the worker obtains from a third party. Further, the employer may protect and enforce the lien by intervening in any action. T.C.A. § 50-6-112(c)(1).

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

A carrier is required to pay an undisputed and properly submitted medical bill from medical provider within thirty-one (31) calendar days of receipt of a properly submitted bill. A carrier not paying an undisputed part of the bill within the 31 calendar days is assessed a civil penalty of 2.08%, compounded monthly, (25% APR) on the undisputed portion of the bill. TN ADC 0800-2-17-.10. In addition to the civil penalty mentioned, a medical provider who does not receive timely payment of the undisputed portion of the bill may institute a collection action in court to obtain payment. If medical provider prevails, such provider shall also be entitled to reasonable costs and attorney fees to be paid by the carrier or self-insured employer. TN ADC 0800-2-17-.10

There is also a “medical payment committee” which will hear disputes between providers and insurers regarding the payment of medical bills. There are also penalties for bad faith denial of claims, and those penalties collected by the Department of Labor are paid into the Second Injury Fund. T.C.A. §§ 50-6-118(a), (b).

38. What, if any, mechanisms are available to compel the production of medical information reports and/or an authorization at the administrative level?

If the medical provider was authorized by the employer to provide medical care to the employee for treatment of the work-related injury, said medical provider must honor any request by the employer for medical information, medical records, professional opinions, or medical reports pertaining to the claimed work-related injury. There is no implied covenant of confidentiality, and the medical provider (authorized by the employer to provide treatment) must provide the records. T.C.A. § 50-6-204.

In order to obtain any other medical records, a doctor can be compelled through a court order or a subpoena to produce the records at a deposition or a HIPAA release.

All discovery disputes, including Motions to Compel and for Protective Order, shall be
adjudicated upon the review of written motions and affidavits. A workers’ compensation judge may, in the judge’s discretion, convene a hearing on a discovery dispute only upon a finding that good cause to convene a hearing exists.

39. What is the rule on: (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of physician.
For injuries occurring after July 1, 2014, T.C.A. § 50-6-204(a)(3)(A) provides that a claimant has the right to select from a panel of three (3) or more independent reputable physicians, surgeons, chiropractors or specialty groups if available in the employee’s community for the care the employee needs. If a panel of three cannot be compiled in the employee’s community, the employer may create a panel of physicians “within a one hundred (125) mile radius of the employee’s community of residence.” Once an authorized physician makes a referral to a specialist physician, “the employer shall be deemed to have accepted the referral unless the employer, within three (3) business days, provides the employee a panel” in that specialty. If a physician, surgeon or chiropractor on the panel of three (3) submitted by the employer declines to see the employee after the employee has chosen him/her from the panel, the employee may select from the remaining two (2) medical providers on the panel, or the employee may request the employer to replace the medical provider that declined treatment with another option. T.C.A. § 50-6-204(a)(3)(G)

B. Employer’s right to second opinion and/or Independent Medical Examination.
The injured employee must submit to an examination by a doctor chosen and paid by employer at all reasonable times. T.C.A. § 50-6-204(d)(1). While the injured employee has the right to have his own physician present at this exam, the injured employee will be responsible for such physician’s services. An independent medical examination may be ordered upon Motion of either party or the court when injury is disputed. The cost of the court appointed examination shall be divided equally between the parties. T.C.A. § 50-6-204(d)(9). The employee must submit to such examinations and must accept the required treatment by the authorized doctor; otherwise, upon refusal, the employer shall suspend compensation until the employee complies. T.C.A. § 50-6-204(d)(8).

A Medical Impairment Registry (MIR) is available through the Tennessee Department of Labor if the parties dispute an impairment rating received by the employee. An MIR request form may be completed by either party, but the employer bears the expense. The parties are permitted to mutually agree upon an examiner from the registry. However, if a dispute exists as to the appropriate examiner, the administrator will select 3 (three) names from the registry. The employer and the employee may then strike one of the names, leaving one physician. This physician’s opinion is presumed correct on the issue of impairment, subject to being overcome by clear and convincing evidence. T.C.A. § 50-6-204(d)(5).

40. What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?
The employer/insurer is responsible for payment of reasonable and necessary treatment, including chiropractic care, if it is provided through an approved panel selection or is judicially required. T.C.A. § 50-6-204.
41. Which prosthetic devices are covered, and for how long?

T.C.A. § 50-6-204(a)(1)(A) provides:

The employer or the employer's agent shall furnish, free of charge to the employee, such medical and surgical treatment, medicine, medical and surgical supplies, crutches, artificial members, and other reasonable and necessary apparatus, including prescription eyeglasses and eye wear, such nursing services or psychological services as ordered by the attending physician and hospitalization, including such dental work made reasonably necessary by accident as defined in this chapter.

42. Are vehicle and/or home modifications covered as medical expenses?

Yes, if they are reasonable and necessary for ongoing treatment. Dennis v. Erin Truckways, Ltd., 188 S.W.3d 578 (Tenn. 2006) (finding the term “apparatus” in statute includes medically necessary modifications to an injured worker’s house, but not the entire cost of housing).

In Calderon v. AutoOwners Ins. Co., the Special Workers’ Compensation Appeals Panel for the Supreme Court of Tennessee, citing Dennis, limited the employer’s requirement to pay for employee's housing to the costs directly attributable to modification of the housing to make it handicap accessible (but not the increase in rent between non-handicap accessible housing and handicap accessible housing), as well as affirming the lower court’s decision that the employer was not obligated to purchase a CCT Paratransit pass for the employee, so long as the employer ensures transportation to the employee’s injury-related appointments. Calderon v. AutoOwners Ins. Co., 2016 Tenn. LEXIS 813 at *9-10 (Tenn. Workers Comp. Panel Oct. 24, 2016).

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. Fee disputes are subject to review by the Medical Cost Containment Committee appointed by the administrator, which will have authority to render a decision on the merits of a dispute. T.C.A. § 50-6-125.

Tennessee’s Medical Fee Schedule (“MFS”) is made-up of three (3) “chapters” of administrative rules. These three (3) chapters are: Chapter 0800-2-17, 0800-2-18 and 0800-2-19. The current version of the MFS became effective on August 26, 2009. The first chapter, 0800-2-17, is called the Medical Cost Containment Program Rules and explains such things as the basis for the MFS, time-periods that payers have to timely reimburse providers for undisputed bills, what happens if payers do not comply, and appeal procedures, etc. Chapter 0800-2-18 is the actual MFS Rules and addresses such things as proper conversion factors to use for calculating the maximum allowable amounts for physicians’ professional services, medical devices, equipment, and penalties for violation of the MFS. Chapter 0800-2-19, the In-patient Hospital Fee Schedule, sets out how hospitals should be reimbursed.

44. What, if any provisions or requirements are there for “managed care”?

Employers are authorized, but not required, to use health maintenance organizations (HMO) and preferred provider organizations (PPO). T.C.A. § 50-6-122(a)(2). An employer or insurer is encouraged, but not required, to provide case management services if such services would prove to be beneficial. T.C.A. § 50-6-123 & TN ADC 0800-2-7-.03. If case management is undertaken, and if employee suffered a catastrophic injury, there must be a face-to-face meeting between case manager and employee within fourteen (14) calendar days after date of injury, and intermittently thereafter (every 3 months for the first year and every 6 months during the second year. If the employee’s suffering a catastrophic change experiences a significant change in medical condition, there must be a
face-to-face meeting within fourteen (14) days of that change. For non-catastrophic injury then there must be at least one face-to-face meeting within twelve (12) weeks of date of injury. TN ADC 0800-2-7-03.
PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

File Form C-23 (Notice of Denial of Claim) or Form C-27 (Notice of Controversy), the latter being required when payments have been made without an award, and the employer subsequently elects to controvert his liability. TN ADC 0800-2-1.07 & TN ADC 0800-2-1-.09. Forms are to be filed with the Tennessee Department of Labor with a copy provided to the employee or the employee’s attorney. Filing deadlines are strictly construed.

Either party may require a determination of compensability of all or part of a claim by a workers compensation specialist employed by the Tennessee Department of Labor by filing a Form C40A Request for Assistance. TN ADC 0800-2-5.02 & 5.03.

46. What is the method of claim adjudication?

A. Administrative level.

A “Petition for Benefit Determination” must be filed by the Employee within one year of the accident, or within one year of the date of the last voluntary payment by the employer/insurer (or date of last authorized treatment, whichever is later). T.C.A. § 50-6-203(b).

The mediation process is mandatory. Workers’ Compensation mediators shall “mediate all disputes,” “thoroughly inform all parties of their rights and responsibilities,” and “accept all documents and information presented to the division.” If the mediator succeeds in reaching a settlement agreement between the parties, the mediator “shall reduce the settlement to writing and each party shall sign.” Such settlements must be approved by a workers’ compensation judge. When mediation is held, “a person representing the employee and the employer, or the employer’s insurer, with authority to settle, must attend.” If no settlement is reached at mediation, then the mediator must prepare a “Dispute Certification Notice” specifying the issues which remain in dispute. T.C.A. § 50-6-236.

B. Trial level.

Workers’ compensation disputes are handled by the Court of Workers’ Compensation Claims, which has “original and exclusive jurisdiction over all contested claims for workers’ compensation benefits.” T.C.A. § 50-6-237.

A request for a hearing must be filed within sixty (60) days of the issuance of the dispute certification notice. Hearings in the court of workers’ compensation claims shall be conducted in accordance with the Tennessee Rules of Civil Procedure, the Tennessee Rules of Evidence, as well as any rules adopted by the division. The workers’ compensation judge need only address issues which are contained in the “Dispute Certification Notice.” The judge may grant permission for other issues to be raised only upon finding that: (1) the parties did not have knowledge of the issue prior to the issuance of the “Dispute Certification Notice and the parties could not have known of the issue despite reasonable investigation; and (2) prohibiting presentation of the issue would result in “substantial injustice.” Unless otherwise provided in the statute, the employee seeking benefits shall have the burden of proving each and every element of the claim by a preponderance of the evidence. All discovery disputes “shall be adjudicated upon the review of written motions and affidavits.” A judge may convene a hearing on a discovery dispute “only upon a finding that good cause exists to convene a hearing.” T.C.A. § 50-6-239.
C. Appellate Level.

The Workers’ Compensation Appeals Board hears appeals of Orders issued by the Court of Workers’ Compensation Claims. The Appeals Board is comprised of three judges who are appointed by the governor for 6 year terms. These judges are limited to two full terms. The workers’ compensation appeals board may review interlocutory and final orders of workers’ compensation judges. An order assessing a civil penalty under this chapter notwithstanding, no order issued by a workers’ compensation judge shall be subject to judicial review pursuant to the Uniform Administrative Procedures Act. A decision of the workers’ compensation appeals board shall not be subject to judicial review pursuant to the UAPA.

47. What are the requirements for stipulations or settlements?

The parties may settle the entire claim at any time after the employee reaches maximum medical improvement. The parties will have discretion to determine the proper impairment rating to apply when deciding upon the settlement terms.

The settlement conference will be held at the Workers’ Compensation office. All settlements will have to be approved by a workers’ compensation judge. T.C.A. § 50-6-240.

48. Are full and final settlements with closed medicals unavailable?

Tennessee law states that nothing “shall be construed to prohibit the parties from compromising and settling the issue of future medical benefits at any time,” so long as the employee has been informed of the potential consequences of the settlement. However, Tennessee law specifically prohibits the closing of medical benefits in the case of an employee who is permanently and totally disabled. T.C.A. § 50-6-240.

49. Must stipulations and/or settlements be approved by the state administrative body?

All settlements of injuries have to be approved by a workers’ compensation judge. T.C.A. § 50-6-240.
50. **What insurance is required; and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?**

An employer must obtain workers’ compensation insurance either through a private insurer or a self-insurance pool, unless otherwise qualified for self-insurance. T.C.A. § 50-6-405.

51. **What are the provisions/requirements for self-insurance?**

   A. **For individual entities.**
   An individual employer may self-insure by filing with the Department of Commerce and Insurance: (1) a deposit or bond for the negotiable securities totaling **not less than $500,000**; and (2) records, as required, to demonstrate the financial ability to pay all claims. T.C.A. § 50-6-405.

   B. **For groups or “pools” of private entities.**
   A group of ten or more employers in the same trade or professional association may self-insure as a pool, subject to the same types of requirements as individual employers. T.C.A. § 50-6-405(c).

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**


   However, “illegal alien” employee’s benefits are capped at 1.5x the medical impairment rating, provided, that the employer did not knowingly hire the employee at a time when the employee was not eligible or authorized to work in the United States under federal immigration laws. It shall be presumed the employer did not knowingly hire the employee at a time when the employee was not eligible or authorized to work in the United States under federal immigration laws if the employer can show, by a preponderance of the evidence, that the employer in good faith complied with the employment eligibility and identity verification requirements of federal law when the employee was hired. If it is shown by a preponderance of the evidence, that the employer had actual knowledge of the ineligible or unauthorized status of the employee at the time of hire or at the time of the injury, or both, then a sum of up to five (5) times the medical impairment rating determined by the authorized treating physician pursuant to § 50-6-204(d)(3) shall be paid in the following manner:

   (i) A sum up to one and one half (1 1/2) times the medical impairment rating shall be paid in a lump sum to the employee, the sum to be paid by the employer's insurer; and

   (ii) An additional sum up to three and one half (3 1/2) times the medical impairment rating shall be paid by the employer, in a lump sum into, and shall become a part of, the uninsured employers fund provided, that the sum shall not be paid by the employer's insurer.

   T.C.A. § 50-6-241(e).

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

   There is no Tennessee statute on point, so a court today would likely analyze the question by determining whether the injury “arises out of” the employment. In making its determination, the court...
would likely determine whether the injury arose from a risk peculiar to the employment. The location, timing and threat of the terrorist attack are also instructive. Apocalyptic weaponry, such as a nuclear bomb, that devastates employees and non-employees over a defined geographic area should not be covered. A terrorist attack that is pointed specifically toward a place of employment (e.g., a gun assault at a nuclear facility or biological laboratory) would likely arise out of the employee’s employment.

Analogous cases consider exposure to the elements and assaults by strangers. In other words, injury arising from a chemical or biological attack may be analogized to exposure to the outdoor elements. At least one Tennessee commentator has opined that “the opinions suggest that it is necessary to demonstrate that there was an increased risk, at least in the quantitative sense, from that to which the general public was exposed.” Workers’ Comp. Prac. & Proc., 4th Ed., Thomas A. Reynolds, § 10-4. Accordingly, the Supreme Court has upheld an award when an employee suffered an amputation caused by frostbite where the employee had worked for an extended period of time in the cold. Globe Co., Inc. v. Hughes, 442 S.W.2d 253 (Tenn. 1969). Cases considering assaults by strangers likewise considered the causal relation between the attack and the employment, but more recent cases seem to erode this doctrine. In the case of McCann v. Hatchet, 19 S.W.3d 218 (Tenn. 2000), the Tennessee Supreme Court upheld an award when an employee drowned in a hotel pool while traveling in connection with his employment. The Court held that the drowning was an “employment risk.” The case is instructive because the Court insinuated that it may be prepared to eventually overturn the earlier case of Thornton v. RCA Service, Co., 221 S.W.2d 954 (Tenn. 1949), in which the Court denied recovery to an employee who was shot by a “crazy, drunk or otherwise irresponsible stranger.” At the time of the assault, the employee in Thornton was eating dinner while traveling in his employment. Because the attack was fortuitous and unrelated to his employment – apart from the fact that he was traveling because of his work – the Court denied that the injury “arose out of” his employment.

The synthesis of these decisions is confusion. Because workers’ compensation law is liberally construed in favor of the employee, we may safely predict only that close calls will go to the employee.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?
No.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?
Hospital liens are specifically recognized in T.C.A. § 71-5-117. The General Assembly has created a specific framework placing the burden upon the plaintiff’s counsel to contact the State of Tennessee to determine whether there exist any subrogation interests, including child support, etc.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law, and how are they affected by state and federal law (HIPAA)?
Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprehensive legislation which sets standards for, among other things, privacy in communicating confidential medical information. HIPAA regulations specifically consider disclosure of protected health information arising from a workers’ compensation injury. In particular, 45 CFR § 164.512(1) states as follows:
Standard: Disclosures for workers’ compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Accordingly, care providers generally should be cooperative in providing health information related to workers’ compensation injury as permitted by T.C.A. § 50-6-204(a)(2)(A). This statute allows employers or case managers to communicate with the employee's authorized treating physician, orally or in writing, and each medical provider shall be required to release the records of any employee treated for a work-related injury to both the employer and the employee within thirty (30) days after admission or treatment. There shall be no implied covenant of confidentiality with respect to those records, which will include all written memoranda or visual or recorded materials, e-mails and any written materials provided to the employee's authorized treating physician, by case managers, employers, insurance companies, or their attorneys or received from the employee's authorized treating physician.

57. What are the provisions for “Independent Contractors”?

Independent contractors are excluded from coverage. See T.C.A. § 50-6-102(12)(A). However, the Tennessee Supreme Court has emphasized it is the Court’s duty to give the law a liberal construction in favor of employee status. See Wooten Transport, Inc. v. Hunter, 535 S.W.2d 858 (Tenn. 1976). The following relevant factors will be used to determine if an employee is an independent contractor: (1) the right to control conduct of the work; (2) the right of termination; (3) the method of payment; (4) the freedom to select and hire helpers; (5) the furnishing of tools and equipment; (6) self-scheduling of working hours; and (7) the freedom to offer services to other entities. See T.C.A. §50-6-102(12)(D). The right of the employer to control details of the work is the most important consideration and will be given the greatest weight. See Lindsey v. Smith & Johnson, Inc., 601 S.W.2d 923 (Tenn. 1980).

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

No. However, it has been held that a supplier of temporary manpower under contract obligating it to pay workers’ compensation benefits would retain that liability to pay workers’ compensation benefits for its loaned servant despite an absence of a right to control, although the special employer may also be liable. See Bennett v. Mid-South Terminals Corp., 660 S.W.2d 799 (Tenn. Ct. App. 1983). Also, joint employers may contract among themselves on a pro rata contribution for workers’ compensation benefits, or otherwise share liability in proportion to the wages paid. T.C.A. § 50-6-211.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

The workers’ compensation laws do not apply to common carriers engaged in interstate commerce. T.C.A. § 50-6-106(1)(A).

An owner-operator of a motor vehicle under contract to a common carrier may elect to be covered under any policy of workers’ compensation insurance. T.C.A. § 50-6-106(B).

There are no special provisions for owner-operators of trucks that deliver property or transport people.
60. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No.

In Tennessee it is appropriate to state that “the Medicare Set-Aside Allocation is based upon a good faith determination of the parties in order to resolve a questionable claim. The parties have attempted to resolve this matter in compliance with both State and Federal law and it is believed that the settlement terms adequately consider Medicare’s interest and do not reflect any attempt to shift responsibility of treatment to Medicare pursuant to 42 U.S.C. §1395y(b). The parties acknowledge and understand that any present or future action or decisions by CMS or Medicare on this MSA are on the Claimant’s eligibility or entitlement to Medicare or Medicare payments and will not render this release void or ineffective, or in any way affect the finality of this workers’ compensation settlement.”

61. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Not yet. Issues surrounding medical marijuana are in legislative and public discussions at present.

62. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No. Penalties for marijuana possession have been reduced in some circumstances but the substance is still illegal.
1. Citation for the state’s workers’ compensation statute.

Texas Labor Code Annotated § 401.001 et. seq. Note: The statute is broad and provides for additional rules prescribed by the Division of Workers’ Compensation, a part of the Texas Department of Insurance, to effectuate its goals. See TEX. LAB. CODE ANN. § 402.001. Additionally, with respect to employees leased pursuant to a staff leasing services agreement, see, TEX. LAB. CODE ANN. § 91.001 et. seq. and for employees retained through temporary agencies see, TEX. LAB. CODE ANN. § 92.001 et. seq.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

An employee is one in the service of another under a contract of hire. It includes one employed in the usual course and scope of the employer’s business who is temporarily asked to perform services outside the usual course and scope of the business. Also included are persons who are trainees under the Texans Work program established under Chapter 308 of the Labor Code. An independent contractor is not an employee under the Act. TEX. LAB. CODE ANN. § 401.012.

Workers covered by federal compensation statutes are excluded from coverage under the Texas worker’s compensation statute. TEX. LAB. CODE ANN. § 406.091(a)(2).

If one employer has the right to control the details of another employer’s employee at the time of the accident, the employer with the right of control may be considered to be the “employer” for worker’s compensation purposes under the “borrowed servant” doctrine. Dodd v. Twin City Fire Ins. Co., 545 S.W.2d 766 (Tex. 1977). An employee that is hired by a temporary employment agency, and is then assigned to perform work for a client of the agency, is an employee of both the agency and the client. For purposes of the Texas Workers Compensation Act, the temporary employment agency and the client of the agency are
employers of the employee. The Texas Supreme Court has recognized this as the “dual employer” doctrine. *Wingfoot Enterprises v Alvarado*, 111 S.W.3d 134 (Tex. 2003). If both the temporary agency and the client have workers compensation insurance coverage, the employee can not bring a common law claim for injury against either the agency or the client for any injury sustained while performing duties for either of them. *Garza v Exel Logistics, Inc.*, 161 S.W.3d 473 (Tex. 2005).

The Act applies to farm and ranch employees if they are migrant workers; seasonal workers who are employed on a truck farm, orchard, or vineyard or employed by a person with a gross annual payroll for the preceding year in an amount not less than the greater of the required payroll for the year preceding that year (adjusted for inflation) or $25,000.00; or are employed by a farmer, ranch operator, or labor agent who employs a migrant worker and are doing the same work at the same time and location as the migrant worker. **TEX. LAB. CODE ANN. § 406.162.**

In addition, for years prior to 1991, farm and ranch employees, other than migrant or seasonal workers, are covered if they were employed by a person with a gross annual payroll for the preceding year of at least $50,000.00. For 1991 and subsequent years, such employees are covered if they were employed by a person with gross annual payroll for the preceding year in an amount not less than the greater of the required payroll for the year preceding that year (adjusted for inflation) or $25,000.00, or by a person who employs three or more farm or ranch employees (other than migrant or seasonal workers). **TEX. LAB. CODE ANN. § 406.162.**

Professional athletes who are, by contract or labor agreement, entitled to benefits for medical care and weekly benefits that are equal to or greater than the benefits provided for under the Act may not receive both benefits under the Act and the equivalent benefits under the contract of hire or a collective bargaining agreement. The athlete must make an election as to the benefits he or she will receive. **TEX. LAB. CODE ANN. § 406.095.**

Resident or nonresident alien employees or legal beneficiaries are entitled to compensation under the Act. **TEX. LAB. CODE ANN. § 406.092.**

Minors and other legally incompetent employees may have guardians exercise on their behalf the rights and privileges granted to them under the Act. **TEX. LAB. CODE ANN. § 406.093.**

3. **Identify and describe any “statutory employer” provision.**

A general contractor and a subcontractor can enter into a written agreement whereby the general contractor provides workers’ compensation coverage to the employees of the subcontractor and the subcontractor. **TEX. LAB. CODE ANN. § 406.123(a).** If the general contractor has workers’ compensation, but its subcontractor does not and has no employees, the general contractor is treated as the employer of the subcontractor for workers’ compensation purposes. **TEX. LAB. CODE ANN. § 406.123(b).** The general contractor can deduct the premium from the contract proceeds. **TEX. LAB. CODE ANN. § 406.123(b), (d).** The employees of the subcontractor and the subcontractor become employees of the general contractor for purposes of Texas workers’ compensation law only. **TEX. LAB. CODE ANN.**
§ 406.123(e).

Additionally, if an employer contracts with a staff leasing services company and is assigned employees by that company under that contract, for worker’s compensation insurance purposes, the staff leasing services company and the employer shall be co-employers of the assigned employee. TEX. LAB. CODE ANN. § 91.042(c).

4. **What types of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or “single occurrence” claims.**

   An injury is any damage or harm to the body, including diseases or infections that naturally result from such damage or harm. The term also includes an occupational disease. TEX. LAB. CODE ANN. § 401.011(26). A compensable injury generally is an accidental injury, which is an injury that results from an “untoward event traceable to a definite time, place and cause.” *Olson v. Hartford Accident and Indemnity Company*, 477 S.W.2d 859 (Tex. 1972). An insurer is liable for compensation if the employee was subject to the Act and was acting within the course and scope of the employment at the time of injury. TEX. LAB. CODE ANN. § 401.011(10).

   B. **Occupational disease (including respiratory and repetitive use).**

   An “occupational disease” means a disease arising out of and in the course and scope of the employment that causes damage or harm to the physical structure of the body, including repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. It does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is incident to a compensable injury or occupational disease. TEX. LAB. CODE ANN. § 401.011(34).

5. **What, if any, injuries or claims are excluded?**

   Excluded claims include injuries where: (1) the employee was in a state of intoxication; (2) the injury was caused by the employee’s willful attempt to injure himself or to unlawfully injure another person; (3) the injury arose out of an act of a third person intended to injure the employee for a personal reason not related to employment; (4) the injury arose out of voluntary participation in an off-duty recreational, social, or athletic activity unless the activity is reasonably expected to be or is expressly or impliedly required by the employment; (5) the injury arose out of an Act of God unless the employment exposes the employee to a greater risk of harm than members of the general public; or (6) the injury was caused by the employee's horseplay. TEX. LAB. CODE ANN. § 406.032.

6. **What psychiatric claims or treatments are compensable?**

   Mental or emotional injuries that arise from legitimate personnel action, including transfers, promotions, demotions, or terminations are not compensable. TEX. LAB. CODE ANN. § 408.006. Any other psychiatric injury, which legitimately arises out of the employee’s job function and is incident to a traumatic work event is covered.
7. **What are the applicable statutes of limitations?**

An employee must notify the employer of an injury no later than 30 days after it occurs. In the case of an occupational disease, the employee must notify the employer no later than the 30th day after the date on which the employee knew or should have known that the injury may be related to the employment. **TEX. LAB. CODE ANN. § 409.001.** Failure to file this notice with the employer relieves the employer and the employer’s insurance carrier of liability unless (1) the employer or the insurance carrier have actual notice of the injury, (2) the division determines there is good cause for failure to report the injury, or (3) the claim is not contested by the employer or insurance carrier. **TEX. LAB. CODE ANN. § 409.002.** A claim for injury must be filed with the Texas Department of Insurance, Division of Workers’ Compensation, no later than one year after the injury. For occupational diseases, the claim must be filed no later than one year after the date on which the employee knew or should have known that the disease was related to the employment. **TEX. LAB. CODE ANN. § 409.003.** Failure to file a claim for compensation with the Division within this time period relieves the employer and the employer’s insurance carrier from liability unless (1) there is good cause for failure to file the claim, or (2) the employer or the insurance carrier do not contest the claim. **TEX. LAB. CODE ANN. § 409.004.**

8. **What are the reporting and notice requirements for those alleging an injury?**

An employee or a person acting on the employee’s behalf shall notify the employer or an employee who holds a supervisory or management position with the employer of an injury not later than the 30th day after the date the injury occurred; or if the injury is an occupational disease, the 30th day after the date the employee knew or should have known that the injury may be related to employment. **TEX. LAB. CODE ANN. § 409.001.**

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

A willful self-inflicted injury is not compensable. **TEX. LAB. CODE ANN. § 406.032(1)(B).**

B. **Willful misconduct, “horseplay,” etc.**

An injury due to horseplay or caused by an attempt to unlawfully injure another person is not compensable. **TEX. LAB. CODE ANN. §§ 406.032(1)(B), 406.032(2).**

C. **Injuries involving drugs and/or alcohol.**

An injury while the employee is in a state of intoxication is not compensable. **TEX. LAB. CODE ANN. § 406.032(1)(A).** Intoxication means having an alcohol concentration of 0.08 or more, or loss of the normal use of one’s mental or physical faculties resulting from the voluntary induction into the body of: (1) an alcoholic beverage; (2) a controlled substance; (3) a dangerous drug; (4) an abusable glue or aerosol paint; or (5) any other similar substance, the use of which is regulated under state law. **TEX. Penal Code § 49.01(2); TEX. LAB. CODE ANN. § 401.013(a).** Intoxication does not include the loss of use of mental or...
physical faculties resulting from the introduction of substances (1) taken under and in accordance with a prescription written by the employee’s doctor; or (2) inhaled or absorbed incidentally in the employee’s work. TEX. LAB. CODE ANN. § 401.013(b).

10. What, if any, penalties or remedies are available in claims involving fraud?

The Act provides that certain conduct is considered to be fraudulent if committed knowingly or intentionally in an effort to obtain or deny payment of a workers’ compensation benefit. Such conduct includes: (1) making a false or misleading statement; (2) misrepresenting or concealing a material fact; (3) fabricating, altering, concealing, or destroying a document; or (4) conspiring to commit such an act. One who fraudulently obtains a payment is liable for full repayment of the benefit plus interest. If the person is an employee or claiming death benefits, the repayment may be achieved through deduction from future payments if possible. An employer who commits such an act that results in the denial of benefits is liable for the past benefit payments plus interest. TEX. LAB. CODE ANN. § 415.008.

11. Is there any defense for falsification of employment records regarding medical history?

No. See Answer 10.

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

An injury sustained during activities paid for or supported by the employer is not compensable where the injury arises out of the voluntary participation in an off-duty recreational, social, or athletic activity not constituting a part of the work-related duties, unless the activity is a reasonable expectancy of or is expressly or impliedly required by the employment. TEX. LAB. CODE ANN. § 406.032(1)(D).

“...an injury is not “in the course and scope of employment” unless (1) participation in such activity is expressly or impliedly required by the employer; or, (2) the employer derives some benefit from the activity, other than the health and morale of the employee; or (3) where the injury takes place at the place or immediate vicinity of employment while the employee is required to hold himself or herself in readiness for work, and the activity takes place with the employers express or implied permission."

13. Are injuries by co-employees compensable?

Yes, unless it is an intentional injury for personal reasons. TEX. LAB. CODE ANN. § 406.032(1)(C).

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., “irate paramour” claims)?

No. Injuries that arise out of an act of a third person intended to injure the employee because of a personal reason and not directed at the employee as an employee or because of the
employment are not compensable. TEX. LAB. CODE ANN. §§ 406.032(1)(C).

BEFORE

15. What criterion is used for calculating the average weekly wage?

The average weekly wage is calculated according to the status of the employee and the length of employment preceding the injury. The basic distinction centers around whether the employee worked 13 consecutive weeks immediately preceding the injury: (1) if at least 13 weeks, the wage equals the sum of the wages paid in the 13 weeks immediately preceding the injury divided by 13; and (2) if less than 13 weeks or where the rate of pay is undetermined at the time of injury, the wage is equal to the normal wage the employer pays a similar employee for similar services. If no such similar employee exists, the average weekly wage equals the normal wage paid in the community for the same or similar services provided for pay. TEX. LAB. CODE ANN. § 408.041.

If neither established method can be applied reasonably because the employee’s employment has been irregular or because the employee has lost time from work during the 13-week period immediately preceding the injury because of illness, weather, or another cause beyond the control of the employee, the Division may determine the employee’s average weekly wage by any method that the Division considers fair, just and reasonable to all parties and consistent with the established methods. TEX. LAB. CODE ANN. §§ 408.041(c).

The average weekly wage of a part-time employee who limits the employee’s work to less than a full-time workweek as a regular course of that employee’s conduct is computed in a similar fashion. TEX. LAB. CODE ANN. §§ 408.042.

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

The Act does not refer to temporary total disability (“TTD”) benefits. Temporary Income Benefits have partially replaced TTD. When an employee has been under a disability for at least one week, temporary income benefits are then payable at the rate of 70% of the difference between an employee’s average weekly wage and the post-injury earnings, until the employee reaches maximum medical improvement. If the employee earns less than $8.50 an hour, for the first 26 weeks, the benefit is 75% of the amount computed by subtracting the employee’s weekly earnings after the injury from the employee’s average weekly wage. However, such benefits are not to exceed 100% of the state average weekly wage nor be less than 15% of the state average weekly wage. Such benefits may also not exceed the employee’s actual earnings for the previous year. TEX. LAB. CODE ANN. §§ 408.061, 408.062, 408.082, 408.101, 408.102, 408.103.

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

An insurer must begin payment of temporary income benefits no later than the seventh day after the date on which it receives written notice of the injury, provided the carrier does not
dispute the claim. TEX. ADMIN. CODE Tit. 28 §§ 124.7. [And, See answer 18.]

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out eight days before recovering benefits for the first seven days)?**

The employee must be out eight days before recovering benefits for the first seven days. In the case of injuries not producing immediate disability within the first eight days, benefits begin to accrue on the eighth day after disability begins. TEX. LAB. CODE ANN. § 408.082(b); TEX. ADMIN. CODE Tit. 28 § 124.7.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary income benefits terminate when the employee: (1) reaches maximum medical improvement; (2) dies; or (3) no longer suffers from a “disability” or an inability to obtain or retain employment. TEX. LAB. CODE ANN. §§ 408.102(a), 408.081(d), 408.101. Benefits also terminate at the expiration of 104 weeks from the date of accrual without consideration of the employee’s status as to disability. This result is reached by virtue of the definition of maximum medical improvement. Maximum medical improvement is reached at the earlier of: (1) the point at which no further material recovery from or lasting improvement to an injury can be reasonably anticipated in medical probability; or (2) the expiration of 104 weeks from the date benefits begin to accrue. TEX. LAB. CODE ANN. §§ 401.011(30), 408.102. The 104-week period for maximum medical improvement can be extended if the employee has undergone spinal surgery. TEX. LAB. CODE ANN. § 408.104.

Temporary income benefits may also be terminated if the employee, without good cause, fails or refuses to attend a scheduled Insurance Medical Exam (“IME”) required by the TWCC. TEX. LAB. CODE ANN § 408.004(e).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

See Answers 16 and 22.

21. **What disfigurement benefits are available and how are they calculated?**

The term “disfigurement” is not defined in the Act. However, the term “injury” includes any damage or harm to the physical structure of the body. TEX. LAB. CODE ANN. § 401.011(26). Disfigurement could be a basis for the recovery of benefits only where it results in a disability, *i.e.*, the inability because of a compensable injury to obtain or retain employment at a wage rate equivalent to the pre-injury wage. TEX. LAB. CODE ANN. §§ 401.011(16), 408.101.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rate and number of weeks?**

The Act does not provide for “permanent partial disability benefits.” Instead, in addition to Temporary Income Benefits, it provides for “impairment income benefits.” It defines
impairment as any anatomic or functional abnormality or loss resulting from a compensable injury, reasonably presumed to be permanent, and continuing to exist after maximum medical improvement. TEX. LAB. CODE ANN. § 401.011(23). An impairment rating is the percentage of permanent impairment of the whole body resulting from a compensable injury. TEX. LAB. CODE ANN. § 401.011(24). Impairment income benefits are calculated at 70% of the employee’s pre-injury average weekly wage; not to exceed 70% of the state average weekly wage, nor be less than 15% of the state average weekly wage. TEX. LAB. CODE ANN. §§ 408.126, 408.061(b), 408.062(a).

An employee is entitled to impairment income benefits if evidence of impairment exists based on an objective clinical or laboratory finding. If a doctor chosen by the claimant identifies an impairment and the finding is contested, a designated doctor or a doctor selected by the insurance carrier must be able to confirm the objective clinical or laboratory finding on which the impairment finding is based. TEX. LAB. CODE ANN. § 408.122. An award for an impairment income benefit must be based on an impairment rating using the AMA’s “Guides to the Evaluation of Permanent Impairment.” TEX. LAB. CODE ANN. § 408.124. An employee is entitled to impairment income benefits from the day after maximum medical improvement until the earlier of: (1) the expiration of a period computed at three weeks for each percentage point of claimant’s impairment rating; or (2) the employee’s death. In no event, however, are impairment income benefits to be paid for greater than 401 weeks from the date of the injury. TEX. LAB. CODE ANN. §§ 408.081(d), 408.083, 408.121.

Upon expiration of entitlement to impairment income benefits (see answer 22), an employee may be eligible for supplemental income benefits. In order to obtain such benefits, the employee must: (1) have an impairment rating of greater than 15% or greater due to the injury; (2) have remained unemployed or earning less than 80% of the average weekly wage due to the impairment; (3) not have chosen to commute a portion of the impairment income benefit under § 408.128; and (4) have complied with the Work Search Compliance Standards adopted under § 408.1415. TEX. LAB. CODE ANN. § 408.142(a).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

No. The Division shall analyze each report of injury received from an employer to determine whether the injured employee would be assisted by vocational rehabilitation. If the Division so finds, it will notify the employee in writing. The Division will also notify the affected insurance carrier and the Department of Assistive and Rehabilitative Services. TEX. LAB. CODE ANN. § 409.012.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

The Act does not provide for Permanent Total Disability Benefits. The employee may obtain temporary income benefits (see answers 16-19) until 104 weeks from the date the benefits accrued. If the disability still exists, the employee is entitled to impairment income benefits where the physician has assigned an impairment rating to the employee. (See answer 22)
Upon expiration of entitlement to impairment income benefits (see answer 22), an employee may be eligible for supplemental income benefits. In order to obtain such benefits, the employee must: (1) have an impairment rating of greater than 15% or greater due to the injury; (2) have remained unemployed or earning less than 80% of the average weekly wage due to the impairment; (3) not have chosen to commute a portion of the impairment income benefit under § 408.128; and (4) have complied with the Work Search Compliance Standards adopted under § 408.1415. TEX. LAB. CODE ANN. § 408.142(a).

An employee not entitled to supplemental income benefits upon expiration of entitlement to impairment income benefits may become entitled to supplemental income benefits at any time within one year after the date the impairment income benefit period ends provided the employee earns wages for at least 90 days that are less than 80% of the employee’s average weekly wage, the decrease in earnings is a direct result of the compensable injury, and the employee meets the other necessary requirements to receive supplemental income benefits. TEX. LAB. CODE ANN § 408.142(b).

Supplemental Income Benefits are paid monthly at the rate of 80% of the difference between 80% of the employee’s average weekly wage and the wages per week the employee has earned during the quarterly period of calculation, up to 70% of the state average weekly wage. TEX. LAB. CODE ANN. §§ 408.061(c), 408.144.

All income benefits, excluding lifetime and death benefits, terminate upon the expiration of 401 weeks from the date of injury. TEX. LAB. CODE ANN. § 408.083. An employee is entitled to lifetime income benefits until death only in limited circumstances, such as a head injury resulting in insanity or imbecility, an injury resulting in paralysis in two or more extremities, the loss of two or more feet or hands (in combination), or the loss of one’s sight, or third degree burns that cover at least 40 percent of the body and require grafting or third degree burns covering either both hands or one hand and the face, or whole body impairment that is rated 85 percent or greater based on “Guides to the Evaluation of Permanent Impairment” and is the result of a single accident. TEX. LAB. CODE ANN. § 408.161.

**25. How are death benefits calculated, including the maximum and minimum rates?**

**A. Death Benefits**

Death benefits are calculated as 75% of the employees average weekly wage. The weekly benefits payment is subject to the maximum allowable weekly benefit prescribed by statute. TEX. LAB. CODE ANN. § 408.181(b).

An insurance carrier may pay death benefits through an annuity if the annuity agreement meets the terms and conditions for annuity agreements adopted by the commissioner by
B. Dependency claims.

A workers compensation carrier is liable for death benefits when an injured employees compensable injury results in the death of the employee. Death benefits are paid to the legal beneficiaries of the deceased employee. A legal beneficiary may be a spouse, child, grandchild, or other dependent of the deceased employee, or eligible parent. If there are no legal beneficiaries or no timely claim has been filed, the carrier must pay the death benefits to the Division of Workers Compensation for deposit in the subsequent injury fund. Each beneficiary seeking to receive death benefits must file a separate claim for these benefits with the Division, unless the claim expressly includes orders made on behalf of another person. TEX. LABOR CODE ANN. § 408.182.

A dependent is one who receives a regular or recurring economic benefit that contributes substantially to the individual’s livelihood and welfare. To be a “dependent,” an individual must be entitled to receive a distribution of benefits under Ch. 408 of the Act relating to death and burial benefits. TEX. LAB. CODE ANN. § 401.011(14).

The Act defines an eligible spouse as a surviving spouse of the deceased employee unless the spouse had abandoned the deceased employee for more than one year immediately preceding the employee’s death without good cause. An eligible child is a child of the deceased employee who is: (1) a minor; (2) enrolled as a full-time student in an accredited educational institution and less than 25 years of age; or (3) a dependent of the deceased employee at the time of the employee’s death. An eligible grandchild is one whose parent is not an eligible child yet who is a dependent of the deceased employee. An eligible parent means the deceased employee’s mother or father, including an adoptive parent or a stepparent, who receives burial benefits under § 408.186. A mother or father whose parental rights have been terminated is not eligible. TEX. LAB. CODE ANN. § 408.182(f).

Where there are no eligible children or grandchildren, all benefits are paid to the eligible spouse. If eligible children and/or grandchildren exist, one-half of the benefits are paid to the eligible spouse and the other half are distributed equally to the eligible children (eligible grandchildren only receive distribution when their parent, who was an eligible child, is deceased). The spouse receives death benefits until death or remarriage. However, upon remarriage, the spouse receives a lump-sum payment of 104 weeks of death benefits. TEX. LAB. CODE ANN. § 408.183(b). Death benefits are paid at a rate of 75% of the employee’s average weekly wage, up to 100% of the state average weekly wage. TEX. LAB. CODE ANN. §§ 408.182, 408.181, 408.061(d).

26. What are the criteria for establishing a “second injury” fund recovery?

The Act provides for the payment of Subsequent Injury Fund benefits where an employee receives a subsequent compensable injury which, when coupled with the effects of a previous injury, results in a condition entitling the employee to lifetime income benefits. An employee
is entitled to such benefits only to the extent that the subsequent injury would have entitled the employee to benefits had the previous injury not existed. TEX. LAB. CODE ANN. § 408.162.

27. **What are the provisions for reopening a claim for worsening of condition, including applications periods?**

The statute does not contain any such provision. However, see Answer 18 providing for accrual of benefits on the eighth day after disability begins and Answer 22 regarding delayed eligibility for supplemental income benefits. Also, in judicial review actions, the Act allows consideration of new evidence if the court finds that there has been a substantial change of condition based on certain specified circumstances. TEX. LAB. CODE ANN. § 410.307.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

The Act does not provide for any situation when the employer must pay the employee’s attorney’s fees. However, in proceedings before the Division regarding supplemental income benefits, if an employee prevails on a disputed insurance claim with an insurance carrier following the Division’s determination that the employee is entitled to supplemental income benefits or the amount of supplemental income benefits due, the insurance carrier is liable for reasonable and necessary attorney’s fees incurred by the employee as a result of the dispute. TEX. LAB. CODE ANN. § 408.147(c); but see § 408.221 (attorney’s fees normally paid from claimant’s recovery).

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

A. **Scope of immunity.**

A recovery under the Act is the exclusive remedy for a work-related injury in lieu of a common law claim against the covered employer and/or co-workers. TEX. LAB. CODE ANN. § 408.001(a). If an employee works for a temporary employment agency and is assigned to work for a client of the agency, and both the agency and the client have workers compensation insurance coverage, the employee’s only remedy is workers compensation benefits under the coverage available to one or the other of the agency or the client. The employee can not bring a common law claim for injury against either the agency or the client for any injury sustained while performing duties for either of them. *Garza v Exel Logistics, Inc.*, 161 S.W.3d 473 (Tex. 2005)

B. **Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

Common law claims for intentional injuries are not precluded or covered by the Act. An employee may retain his common law right of action to recover damages for personal injury or death by written notification to the employer of the employee’s waiver of coverage under the Act and retention of his common law rights within five days of beginning employment
(or within five days of receipt of notice from the employer that the employer has obtained workers’ compensation coverage if the employer is not a covered employer at the time of the employee’s original employment). TEX. LAB. CODE ANN. § 406.034. Otherwise, an agreement by an employee to waive workers’ compensation benefits is void. TEX. LAB. CODE ANN. § 406.035.

Exemplary damages may be recovered from the employer by the surviving spouse or heirs of a deceased employee when the employee’s death was caused by the intentional act or omission or the gross negligence of the employer. TEX. LAB. CODE ANN. § 408.001(b). No exception to immunity is made for gross negligence when the injury does not result in the employee’s death. *Arnold v. Renken & Kuentz Trans. Co.*, 936 S.W.2d 57, 59 (Tex. App. – San Antonio 1996, no writ).

30. **Are there any penalties against the employer for unsafe working conditions?**

The former Texas Hazardous Employer Program, TEX. LAB. CODE ANN. § 41.041(b) that called for the designation of hazardous private employers was preempted by the federal Occupational Safety and Health Act (OSHA), 29 U.S.C.S. § 651 et. seq., because the Program implicitly regulated workplace safety issues, thereby subjecting employers to duplicative regulation. Because the Program effectively obligated private employers, under penalty of being publicly labeled as hazardous, to take action to reduce workplace injuries, it essentially regulated occupational safety and health issues addressed by federal law. *Skilled Craftmen of Tex., Inc. v. Tex. Workers’ Comp. Comm’n*, 158 S.W.3d 89 (Tex. App. – Austin 2005, writ dism’d).

31. **What is the penalty, if any, for an injured minor?**

None. A guardian of the minor may exercise the rights and privileges granted to the minor employee under the Act on his or her behalf. TEX. LAB. CODE ANN. § 406.093.

32. **What is the potential exposure for “bad faith” claims handling?**

Insurers’ actions taken pursuant to an order of the Division or recommendations of a benefit review officer are not subject to such claims. TEX. LAB. CODE ANN. § 416.001. The Texas Supreme Court has eliminated a cause of action based on the alleged breach of a worker’s compensation carrier’s common law duty of good faith and fair dealing owed to injured workers in handling their claims for benefits. *See Tex. Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430 (Tex. 2012). Texas Insurance Code Ch. 541 provides for recovery of actual damages caused by certain unfair acts or practices, including unfair claims handling, which damages may be trebled upon a finding of a knowing violation. The statute also provides for recovery of attorneys’ fees. TEX. INS. CODE ANN. §§ 541.060, 541.152. The Texas Supreme court also held in *Ruttiger* that a workers compensation claimant can not assert a cause of action against a workers compensation insurer under this statute.

33. **What is the exposure for terminating an employee who has been injured?**

No employee may be discharged or discriminated against because he or she has in good faith
filed a claim for workers’ compensation benefits, hired an attorney in such a claim, instituted or caused to be instituted any proceeding under the Act, or has testified or is about to testify in any proceeding under the Act. TEX. LAB. CODE ANN. § 451.001. An employer who wrongfully discriminates against an employee (including discharge) for filing a claim shall be liable for the reasonable damages suffered by the employee as a result of the discrimination. In addition, if the employee was discharged, he/she is entitled to be reinstated to his or her former position. TEX. LAB. CODE ANN. § 451.002. Punitive damages may be assessed for such wrongful discharge if the plaintiff can demonstrate “actual malice” by the employer. Cont’l Coffee Prods. v. Cazarez, 937 S.W.2d 444, 454 (Tex. 1996).

THIRD-PARTY ACTIONS

34. Can third parties be sued by the employee?

Yes. However, the insurance carrier that has paid benefits is granted a lien against any recovery of damages by the injured employee. TEX. LAB. CODE ANN. § 417.001.

35. Can co-employees be sued for work-related injuries?

No, except when the injury was intentional or in no way connected with an act performed or committed in the co-employee’s capacity of employer or servant. Medina v. Herrera, 927 S.W.2d 597 (Tex. 1996); Brown v. Hopkins, 921 S.W.2d 306 (Tex. App. – Corpus Christi 1996, no writ); Dickson v. Silva, 880 S.W.2d 785 (Tex. App. – Houston [1st Dist] 1993, writ denied); Ward v. Wright, 490 S.W.2d 223 (Tex. Civ. App. – Fort Worth 1973, no writ); Mobley v. Moulas, 468 S.W.2d 116 (Tex. Civ. App. – El Paso 1971, writ ref’d n.r.e.).

36. Is subrogation available?

The insurance carrier is subrogated to the rights of the injured employee and may enforce the liability of the third party in the name of the injured employee or the legal beneficiary. TEX. LAB. CODE ANN. § 417.001(b).

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Yes. An insurance carrier must take final action on a medical bill by the 45th day after receipt of the complete medical bill. Final action includes paying the bill, disputing a charge, requesting reimbursement for an overpayment, or any combination thereof. 28 TEX. ADMIN. CODE § 133.240. Interest accrues on unpaid medical bills from the 60th day after receipt of the bill. TEX. LAB. CODE ANN. § 413.019.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

A. Health Care Providers Reporting Requirements
The Rules of the Division mandate that healthcare providers shall prepare written reports and shall submit them to the carrier and the injured worker, or his/her representative. Tex. Adm. Code §§ 42.30, 42.33, 42.35, 42.40, 42.55, and 42.60

B. Pre-hearing conference.

Parties must exchange all available medical information promptly after the expiration of six weeks disability or earlier upon written request of either party. Thereafter, all medical information will be exchanged promptly upon receipt. If received less than seven days prior to a prehearing conference, it shall be brought to the prehearing conference for exchange. 28 Tex. Admin. Code § 61.35.

C. Benefit review conference/contested case hearing.

Parties must exchange all medical records and reports, witness statements, photographs or other pertinent evidence to be utilized at a benefit review conference or contested case hearing respectively, not later than 14 days before the conference, or not later than five days before an expedited conference. 28 Tex. Admin. Code §§ 141.4, 142.13; Tex. Lab. Code Ann. § 410.158. Pertinent information that becomes available thereafter shall be brought to the conference in sufficient copies for filing and exchange. The benefit review officer may reschedule a conference upon a determination that pertinent information has not been submitted or exchanged. No later than 15 days after the benefit review conference, parties shall exchange documentary evidence in their possession not previously exchanged, before requesting additional discovery by interrogatory or deposition. If the evidence is not produced voluntarily, the party may request a subpoena. 28 Tex. Admin. Code § 142.13. If a party fails to disclose the documents, information, or expert witness report known to the party or documents that are in the party’s possession, custody, or control within the prescribed time limits, the party may not introduce the evidence or expert testimony at any subsequent proceeding before the Division or in court on the claim unless good cause is shown. Tex. Lab. Code Ann. § 410.161.

D. Authorization.

The Texas Labor Code does not discuss the necessity to execute a medical authorization, but if a case is litigated, a claimant may provide an authorization in lieu of producing medical records and bills. Tex. R. Civ. P. § 194.2(j), (k). However, hearing officers may issue subpoenas. 28 Tex. Admin. Code §§ 142.2, 142.12.

39. What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Evaluation?

A. Claimant’s choice of a physician.

Except in an emergency, an injured employee, who lives in the network service area, may choose a treating doctor from the list of doctors maintained by the network. If an injured employee does not make an initial choice within 14 days, the network will assign a treating
An injured employee who does not live within the network’s service area would continue to choose a treating doctor from the Division’s Approved Doctor’s List (ADL). Tex. Ins. Code Ann. § 1305.103. If an injured employee is dissatisfied with his or her initial choice of a treating doctor, the injured employee is entitled to select another treating doctor from the network’s list of doctors. A network cannot deny an injured employee’s initial request to change treating doctors. However, any subsequent requests by an injured employee to change treating doctors are subject to network approval. If the employee becomes dissatisfied with a first choice, he or she may request authority to select an alternate. Tex. Ins. Code Ann. § 1305.104. The Division has prescribed certain criteria which govern whether the employee will be granted authority to select an alternate. A change of doctor may not be made to secure a new impairment rating or medical report. Tex. Lab. Code Ann. § 408.022.

An injured employee may request that his or her primary care provider under a group health HMO plan also serve as his treating doctor if the primary care provider agrees to abide by the network requirements. Tex. Ins. Code Ann. § 1305.105.

B. Employer’s right to a second opinion and/or Independent Medical Examination.

The Act does not expressly state whether an employer is entitled to a second opinion or an independent medical examination. However, an insurer is entitled to at least one IME every 180-day period to resolve any question about the appropriateness of health care received by the employee. Tex. Lab. Code Ann. § 408.004(b). A carrier may also request a medical examination when a certification of maximum medical improvement has not been made or an impairment rating has not been assigned. Additionally, if there is a dispute concerning an existing impairment rating, the Division shall direct the employee to be examined by a designated doctor. Tex. Lab. Code Ann. § 408.151. Further, the Division may contract with a health care provider for medical consulting services, including independent medical examinations. Tex. Lab. Code Ann. § 413.051(d).

40. What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?

Covered treatment includes all health care which is reasonably required by the nature of the compensable injury as and when needed. Tex. Lab. Code Ann. § 408.021. Health care which is reasonably required is health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices. Tex. Lab. Code Ann. § 401.011(22-a). Specifically, the employee is entitled to care that enhances the ability to return to or retain employment, promotes recovery, or cures or relieves the effects that naturally result from a compensable injury. Tex. Lab. Code Ann. § 408.021. “Health care” includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term includes medical, surgical, chiropractic, podiatric, optometric, dental, nursing, psychological, and physical and occupational therapy services. However, the term does not include vocational rehabilitation. Tex. Lab. Code Ann. § 401.011(19). An insurer’s liability for medical benefits may not be limited or terminated by agreement or
settlement. **TEX. LAB. CODE ANN. § 408.021(d).**

41. **Which prosthetic devices are covered, and for how long?**

Health care has been defined to include medical and surgical supplies, appliances, braces, artificial members, and prostheses, including training in their use. **TEX. LAB. CODE ANN. § 401.011(19)(F).** A prosthetic device is included in covered treatment where it cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. **TEX. LAB. CODE ANN. §§ 401.011, 408.021.**

42. **Are vehicle and/or home modifications covered as medical expenses?**

The Act does not expressly indicate whether vehicle and/or home modifications are covered medical expenses. However, the employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or enhances the ability of the employee to return to or retain employment. **TEX. LAB. CODE ANN. § 408.021(a).**

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

The Division is required to create guidelines for medical fees that are fair and reasonable and designed to ensure both quality medical care and effective cost control. In determining appropriate fees, the commissioner shall take into account economic indicators in health care. **TEX. LAB. CODE ANN. § 413.011(b).** The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. **TEX. LAB. CODE ANN. § 413.011(d).**

The commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols. Treatment guidelines and protocols must be evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines. **TEX. LAB. CODE ANN. § 413.011(e).** The commissioner may also adopt disability management rules, including the use of treatment plans, for non-network claims. **TEX. LAB. CODE ANN. § 413.011(g).** Additionally, the Division shall examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates or any other barriers exist that reduce the ability of an injured employee to access those medical needs. The Division shall also recommend to the legislature any statutory changes necessary to ensure appropriate access to those medical needs. **TEX. LAB. CODE ANN. § 413.011(i).** The Division also has the authority to identify areas of this state in which access to health care providers is less available and to adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. **TEX. LAB. CODE ANN. § 408.0252.**
Fee guidelines shall be reviewed and revised at least every two years to reflect medical treatment or ranges of treatment that are reasonable or necessary at the time the review and revision is conducted. TEX. LAB. CODE ANN. § 413.012. The Division must also create a division of medical review to monitor compliance with those rules and implement the policies adopted by it. TEX. LAB. CODE ANN. § 413.002.

44. What, if any, provisions or requirements are there for managed care?

Workers’ compensation insurance carriers, certified self-insurers, groups of self-insurers and governmental entities that self-insure may elect to contract with or establish health care networks certified by the Texas Department of Insurance in accordance with Chapter 1305 of the Texas Insurance Code. TEX. INS. CODE ANN. § 1305.005.

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

The insurer must contest compensability on or before the 60th day after the date on which it is notified of an injury by notifying the Division of its refusal to pay benefits, specifically stating the grounds for refusal. If the insurer fails to do so within the 60-day period, it waives its right to contest compensability. But, the initiation of payments by an insurance carrier does not affect the right of the insurance carrier to continue to investigate or deny the compensability of an injury during the 60-day period, and an insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier. Additionally, the insurer must advise the employee of his right to request a benefit review conference and the means to obtain additional information from the Division. Otherwise, the insurer commits an administrative violation. TEX. LAB. CODE ANN. §§ 409.021, 409.022.

46. What is the method of claim adjudication?

A. Administrative level – Division of Workers Compensation.

On receipt of a request from a party or on its own motion, the Division may direct the parties to a disputed workers' compensation claim to meet in a Benefit Review Conference to attempt to reach agreement on disputed issues involved in the claim. TEX. LAB. CODE ANN. § 410.023(a). The Division shall require the party requesting the benefit review conference to provide documentation of efforts made to resolve the disputed issues before the request was submitted. TEX. LAB. CODE ANN. § 410.023(b). During the Conference, the parties explain their positions, delineate the disputed issue(s), and resolve the disputed issue(s) by agreement, if possible. TEX. LAB. CODE ANN. § 410.021. Where the dispute is not resolved, the benefit review officer must prepare a report that enumerates each issue remaining to be resolved. TEX. LAB. CODE ANN. § 410.031. In the event the dispute is not completely resolved at the Conference, the parties must then go forward with a Contested Case Hearing no later than 60 days after the Benefit Review Conference or make an election to proceed with arbitration. TEX. LAB. CODE ANN. §§ 410.025(b), 410.104. The parties to a disputed
compensation claim are not entitled to a Contested Case Hearing or arbitration on the claim unless a Benefit Review Conference is conducted. TEX. LAB. CODE ANN. § 410.024.

Arbitration is chosen by mutual agreement, and such election cancels any scheduled Contested Case Hearing. The parties must file such election no later than the 20th day after the last day of the Conference. An election of arbitration is irrevocable and binding for the resolution of all disputes in the claim. TEX. LAB. CODE ANN. § 410.104.

If arbitration is not chosen, the parties proceed to a Contested Case Hearing. An issue that was not raised at a Benefit Review Conference or that was resolved at a Benefit Review Conference may not be considered, unless the parties consent or if the issue was not raised, the Division determines that good cause existed for not raising the issue at the conference. TEX. LAB. CODE ANN. § 410.151. At a Contested Case Hearing, the hearing officer acts as the sole judge of the relevance and materiality of the evidence offered and of the weight and credibility to be given to the evidence. TEX. LAB. CODE ANN. § 410.165. The proceedings must be recorded electronically. TEX. LAB. CODE ANN. § 410.164. Oral and written stipulations entered into the record are final and binding. TEX. LAB. CODE ANN. § 410.166. The decision includes findings of fact, conclusions of law, and an award of benefits, if due. TEX. LAB. CODE ANN. § 410.168. Conformity to the rules of evidence is not required. TEX. LAB. CODE ANN. § 410.165. A decision of a hearing officer regarding benefits is final in the absence of a timely appeal by a party and is binding during the pendency of an appeal to the appeals panel. TEX. LAB. CODE ANN. § 410.169.

An aggrieved party may file a written request for an appeal with the appeals panel no later than the 15 days after the decision of the hearing officer and must serve a copy of the request on the other party. The respondent party must file a written response with the panel within 15 days after the request for appeal is served. TEX. LAB. CODE ANN. § 410.202. In reviewing a Contested Case Hearing decision, the appeals panel must consider the record developed at the hearing and the written request for review and response thereto. Thereafter, the appeals panel either affirms the decision of the hearing officer, reverses the decision and renders a new decision, or reverses the decision and remands the case back to the hearing officer for further consideration and development of the evidence. An appeals panel may not remand a case more than once. TEX. LAB. CODE ANN. § 410.203. A decision of the appeals panel regarding benefits is final in the absence of a timely appeal for judicial review. TEX. LAB. CODE ANN. § 410.205. Upon judicial review, the record of the contested case hearing is admissible in accordance with the Texas Rules of Evidence. Nat’l Liability v. Allen, 15 S.W.3d 525, 529 (Tex. 2000).

B. Trial court.

After a party has exhausted all administrative remedies and remains aggrieved by a final decision of the appeals panel, that party may seek judicial review of the appeals panel decision. TEX. LAB. CODE ANN. § 410.251. Judicial review is obtained by filing suit in the district court no later than 40 days after the decision of the appeals panel was filed with the Division. TEX. LAB. CODE ANN. § 410.252. A trial will be limited to those issues decided by the Division appeals panel and upon which judicial review is sought. The pleadings must
specifically enumerate the determinations of the appeals panel by which the party is aggrieved. TEX. LAB. CODE ANN. § 410.302(b). The burden of proof is upon the party seeking judicial review of the particular issue. TEX. LAB. CODE ANN. § 410.303.

C. **Appellate.**

The parties may appeal the district court decision to the Texas Court of Appeals, as a matter of right, based on errors of law. Appeal of the decision of the Court of Appeals is only by discretionary petition for review to the Texas Supreme Court.

47. **What are the requirements for stipulations or settlements?**

Settlements may not provide for payment of benefits in a lump sum except as specifically provided within the Act. TEX. LAB. CODE ANN. §§ 408.005(a), 408.128. An employee’s right to medical benefits must not be limited or terminated. TEX. LAB. CODE ANN. §§ 408.005(b), 408.021. A settlement or agreement resolving an issue of impairment may not be made before the employee reaches maximum medical improvement and must adopt an impairment rating using the impairment rating guidelines described within the Act. TEX. LAB. CODE ANN. §§ 408.005(c), 408.124. All settlements must be signed by the commissioner and all parties to the dispute. TEX. LAB. CODE ANN. § 408.005(d). The commissioner shall approve a settlement if the commissioner is satisfied that it accurately reflects the agreement between the parties, it reflects adherence to all appropriate provisions of law and the policies of the division, and based on the law and facts, it is in the best interest of the claimant. TEX. LAB. CODE ANN. § 408.005(e).

If a settlement is reached at a Benefit Review Conference, the benefit review officer must reduce the settlement to writing. The settlement will not be effective unless it is approved by the commissioner. TEX. LAB. CODE ANN. §§ 408.005, 410.029. Those not approved or rejected before the 16th day after submission of the settlement to the commissioner are deemed approved. TEX. LAB. CODE ANN. § 408.005.

After a party has sought judicial review of an appeals panel decision, but before the entry of judgment by the trial court, a settlement may be reached, but such a settlement must be approved by the trial court. In order for the trial court to approve the settlement, it must find that the settlement: (1) accurately reflects the agreement between the parties; (2) is consistent with law; and (3) is in the employee's best interest. Further, a party proposing a settlement before judgment is entered by the trial court may petition the court orally or in writing for approval of the settlement. TEX LAB. CODE ANN. § 410.256.

48. **Are full and final settlements with closed medicals available?**

No. Settlements may only be reached regarding impairment income benefits, e.g. as to the employee’s degree of impairment and then only if (1) the employee has reached maximum medical improvement, and (2) the percentage of impairment agreed upon is one adopted using the impairment rating guidelines prescribed by statute. TEX. LAB. CODE ANN. § 408.005. See answer 47.
49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes, or by the court in the case of judicial review. See answer 47.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?**

An employer may elect whether or not to obtain workers’ compensation insurance coverage, except in the case of public employers and those otherwise provided by law. **TEX. LAB. CODE ANN. § 406.002.** The employer may obtain coverage through a licensed insurer or through self-insurance as provided under the Act. **TEX. LAB. CODE ANN. § 406.003.** An employer who does not obtain workers' compensation insurance coverage shall notify the Division in writing that the employer elects not to obtain coverage. **TEX. LAB. CODE ANN. § 406.004.** Also, the employer must notify each employee whether or not the employer has workers’ compensation insurance coverage. **TEX. LAB. CODE ANN. § 406.005.**

The insurer of last resort is the Texas Mutual Insurance Company. Specifically, if an applicant to the company would be rejected for workers’ compensation insurance under the company’s underwriting standards, the risk may not be rejected, but shall be insured at a higher premium as provided by the company's requirements. **TEX. INS. CODE ANN. § 2054.351.**

51. **What are the provisions/requirements for self-insurance?**

**A. For individual entities.**

In order to self insure, an employer must submit an application to the Division for a certificate of authority. The application must be submitted on a form adopted by the commissioner and accompanied by a $1,000.00 nonrefundable application fee. Within 60 days after the application is received, the commissioner shall approve or deny the application. **TEX. LAB. CODE ANN. § 407.041.** With the approval of the Texas Certified Self-Insurer Guaranty Association, the commissioner shall issue a certificate of authority to self-insure to an applicant who meets the certification requirements and pays the required fee. **TEX. LAB. CODE ANN. § 407.042.** A certificate of authority to self-insure is valid for one year after the date of issuance. **TEX. LAB. CODE ANN. § 407.044.**

To be eligible for a certificate of authority, the applicant must present evidence satisfactory to the commissioner and the association of sufficient financial strength and liquidity, under standards adopted by the commissioner, to ensure that all workers’ compensation obligations incurred by the applicant are met promptly. Specifically, the applicant must, among other things, present a plan for claim administration that is acceptable to the commissioner and that designates a qualified claims servicing contractor, demonstrate the existence of an effective safety program for each of its work locations, establish a minimum amount of total unmodified workers’ compensation insurance premiums for prior years, and meet extensive security requirements for incurred liabilities for compensation and for terminated surety.
bonds and excess policies. **TEX. LAB. CODE ANN. §§ 407.061-407.065.** Each applicant shall obtain excess insurance or reinsurance to cover liability for losses not paid by the self-insurer in an amount not less than the amount required by the commissioner. A certified self-insurer shall notify the Division not later than the 10th day after the date on which the certified self-insurer has notice of the cancellation or termination of excess insurance or reinsurance coverage required under this section. **TEX. LAB. CODE ANN. § 407.067.**

Each certified self-insurer shall file an annual report with the Division. The commissioner shall prescribe the form of the report and shall furnish blank forms for the preparation of the report to each certified self-insurer. The report must include, among other things, payroll information, the number of injuries sustained in the three preceding calendar years, and the amount paid during each year for income benefits, medical benefits, death benefits, burial benefits, and other proper expenses related to worker injuries. **TEX. LAB. CODE ANN. § 407.081.** Each certified self-insurer shall maintain the books, records, and payroll information necessary to compile the annual report and any other information reasonably required by the commissioner. **TEX. LAB. CODE ANN. § 407.082.**

Each certified self-insurer shall pay an annual fee to cover the administrative costs incurred by the Division and shall base its fee on the total amount of income benefit payments made in the preceding calendar year. The Division shall assess each certified self-insurer a pro rata share based on the ratio that the total amount of income benefit payments made by that certified self-insurer bears to the total amount of income benefit payments made by all certified self-insurers. **TEX. LAB. CODE ANN. § 407.102.** Each certified self-insurer shall also pay a self-insurer maintenance tax for the administration of the Division and the office of injured employee counsel and to support the prosecution of workers’ compensation insurance fraud in this state. Not more than two percent of the total tax base of all certified self-insurers may be assessed for a maintenance tax under this section. **TEX. LAB. CODE ANN. § 407.103.** These regulatory fees imposed are due on the 60th day after the issuance of a certificate of authority to self-insure and on the 60th day after each annual renewal date. **TEX. LAB. CODE ANN. § 407.104.**

A certified self-insurer may withdraw from self-insurance at any time with the approval of the commissioner. The commissioner shall approve the withdrawal if the certified self-insurer shows to the satisfaction of the commissioner that the certified self-insurer has established an adequate program to pay all incurred losses, including unreported losses, that arise out of accidents or occupational diseases first distinctly manifested during the period of operation as a certified self-insurer. **TEX. LAB. CODE ANN. § 407.045.**

### B. For groups or “pools” of private entities.

With the exception of public employees or governmental entities, an unincorporated association or business trust composed of five or more private employers may establish a workers’ compensation self-insurance group under this chapter if the employers are: (1) engaged in the same or a similar type of business; (2) are members of a **bona fide** trade or professional association that has been in existence in this state for purposes other than insurance for at least five years before the establishment of the group; and (3) enter into
agreements to pool their liabilities for workers’ compensation benefits and employers’ liability in this state. TEX. LAB. CODE ANN. § 407A.002. Subject to the approval of the commissioner, a group may merge with another group engaged in the same or a similar type of business if the resulting group assumes in full all obligations of the merging groups. The commissioner may conduct a hearing on a proposed merger and shall conduct a hearing if any party, including a member of either group, requests a hearing. TEX. LAB. CODE ANN. § 407A.003.

Each group shall be operated by a board of trustees composed of at least five persons whom the members of the group elect for stated terms of office. The trustees must be employees, officers, or directors of employers who are members of the group. Each board member shall be a resident of this state or an officer of a corporation authorized to do business in this state. An administrator or service company of the group, or owner, officer, employee of, or any other person affiliated with the administrator or service company, may not serve on the board of trustees. TEX. LAB. CODE ANN. § 407A.151.

An association of employers may not act as a workers’ compensation self-insurance group unless it has been issued a certificate of approval by the commissioner. TEX. LAB. CODE ANN. § 407A.005. A group that is issued a certificate of approval by the commissioner is not an insurer based on that certificate and is not subject to the insurance laws and rules of this state, except as otherwise provided. TEX. LAB. CODE ANN. § 407A.004. Each group shall be deemed to have appointed the commissioner as its attorney to receive service of legal process issued against the group in this state. The appointment of the commissioner is irrevocable, binds any successor in interest, and remains in effect as long as any obligation or liability of the group for workers’ compensation benefits exists in this state. TEX. LAB. CODE ANN. § 407A.006.

An association of employers that proposes to organize as a workers’ compensation self-insurance group shall file with the department an application for a certificate of approval. TEX. LAB. CODE ANN. § 407A.051(a). The application must include, among other things, the name of the group, the date of organization of the group, the name and address of each employer that is a member of the group, and any other information reasonably required by the commissioner. TEX. LAB. CODE ANN. § 407A.051(b). The application must be accompanied by, among other things, a $1,000.00 nonrefundable filing fee, and proof of compliance with the financial and excess insurance requirements. TEX. LAB. CODE ANN. § 407A.051(c). Additionally, a group shall notify the commissioner of any change in the abovementioned information not later than the 30th day after the effective date of the change. TEX. LAB. CODE ANN. § 407A.051(d). The commissioner shall evaluate the financial information provided with the application as necessary to ensure that the funding is sufficient to cover expected losses and expenses and that the funds necessary to pay workers' compensation benefits will be available on a timely basis. TEX. LAB. CODE ANN. § 407A.051(e). The commissioner shall act on a complete application for a certificate of approval not later than the 90th day after the date on which the application is filed with the department. If, because of the number of applications, the commissioner is unable to act on an application in a timely manner, the commissioner may extend the period for an additional 30 days. TEX. LAB. CODE ANN. § 407A.051(f).
Each group must have an estimated premium subject to experience modifier of at least $250,000.00 during the group’s first year of operation. Thereafter, the annual standard premium must be at least $500,000.00. TEX. LAB. CODE ANN. § 407A.055. An indemnity agreement must jointly and severally bind the group and each employer who is a member of the group to meet the workers’ compensation obligations of each member. The indemnity agreement must be in the form prescribed by the commissioner and must include minimum uniform substantive provisions as prescribed by the commissioner. Subject to the commissioner’s approval, a group may add other provisions necessary because of that group’s particular circumstances. TEX. LAB. CODE ANN. § 407A.056. The commissioner may also require a service company providing claim services to furnish a performance bond of $250,000.00 in the form prescribed by the commissioner. However, in lieu of a performance bond, a security deposit of cash or securities acceptable to the commissioner may be deposited with the commissioner to be held in the state treasury. TEX. LAB. CODE ANN. § 407A.057. Furthermore, each group shall pay a self-insurance group maintenance tax and a premium tax. TEX. LAB. CODE ANN. §§ 407A.301-407A.304.

A certificate of approval remains in effect until terminated at the request of the group or revoked by the commissioner. The commissioner may not grant the request of any group to terminate its certificate of approval unless the group has insured or reinsured all incurred workers’ compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the commissioner. Those obligations include known claims and expenses associated with those claims and incurred but not reported claims and expenses associated with those claims. TEX. LAB. CODE ANN. § 407A.101.

52. Are “illegal aliens” entitled to workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Yes. An alien is a person who is not a citizen of the United States. TEX. LAB. CODE ANN. § 401.011(4). A nonresident alien employee or legal beneficiary is entitled to compensation under the Act. A nonresident alien employee or legal beneficiary, at the election of the employee or legal beneficiary, may be represented officially by a consular officer of the country of which the employee or legal beneficiary is a citizen. That officer may receive benefit payments for distribution to the employee or legal beneficiary. The receipt of the payments constitutes full discharge of the insurance carrier’s liability for those payments. TEX. LAB. CODE ANN. § 406.092. A person residing in this State whose entry may be contrary to the immigration laws is not barred, by that reason alone, from receiving workmen’s compensation benefits. Commercial Standard Fire & Marine Co., v. Galindo, 484 S.W.2d 635, 637 (Tex. Civ. App. – El Paso 1972, writ ref. n.r.e.).

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

The Act does not specifically mention terrorist acts or injuries. Injuries caused by the actions of third parties, and intended to injure the employees because of personal reasons, are not
compensable. TEX. LAB. CODE ANN. § 406.032. However, injuries caused by criminal acts of third persons, where the employee is at risk because of his employment, are compensable. See Walls Reg’l Hosp. v. Bomar, 9 S.W.3d 805, 807 (Tex. 1999).

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Under Medicare regulations, Medicare is a secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. 42 C.F.R. §§ 411.40, 411.46; see 42 C.F.R. §§ 411.32, 411.33. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. 42 C.F.R. § 411.46.

Nothing in the Act relieves the carrier of its obligation to pay compensable medical expenses because of the potential availability of Medicare. Medicare payments made to or on behalf of injured workers are subject to Medicare’s superior lien. If the claimant receives a payment from a third party, Medicare must be reimbursed within 60 days. 42 U.S.C. § 1395y(b)(2)(A); 42 C.F.R § 411.24(h).

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party, and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

Nothing in the Act relieves the carrier of its obligation to pay compensable medical expenses because of the potential applicability of Medicare, Medicaid, or health insurance. Income or death benefits are subject to subrogation interests created under the Act after attorney’s fees and court-ordered child support has been paid. TEX. LAB. CODE ANN. § 408.203. If a benefit is claimed by an injured employee, the insurance carrier is subrogated to the rights of the employee. Upon recovery from a third party, the carrier must pay the injured employee after reimbursing itself and paying costs. TEX. LAB. CODE ANN. § 417.001.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?
HIPAA provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. § 164.512(l).

Information contained or derived from a worker’s compensation file is confidential and may not be disclosed by the Division, notwithstanding certain exceptions created under the Act. TEX. LAB. CODE ANN. § 402.083(a). Information concerning an employee who has been finally adjudicated of wrongfully obtaining payment is not confidential. TEX. LAB. CODE ANN. § 402.083(b). While a claim is either pending before the Division, being appealed, or is the subject of a subsequent suit, information may be released to the employee or the employee’s legal beneficiary, the employee’s or the legal beneficiary’s representative, the employer at the time of the injury, the insurance carrier, or third-party litigants in lawsuit arising out of the injury. TEX. LAB. CODE ANN. § 402.084. The Division is required to release claim information, in certain instances, to various government agencies, regulatory bodies, and public officials. In other situations, the release of this information is discretionary. TEX. LAB. CODE ANN. § 402.085.

Prospective employers may obtain information about prior injuries of an applicant for employment upon receipt of written authorization from the applicant. TEX. LAB. CODE ANN. § 402.087. However, employers are prohibited from making pre-offer inquiries about applicants’ workers’ compensation history. TEX. Att’y Gen. Op. No. DM-124 (June 9, 1992). Employers are not prohibited from providing prospective employers with information regarding a former employee, provided the information was obtained legally. TEX. LAB. CODE ANN. § 402.086.

The Act’s provisions regarding confidentiality of records does not currently mention HIPAA, but it is expected that to the extent of any conflict HIPAA, as the prevailing federal law, would control.

57. What are the provisions for “Independent Contractors”?

An independent contractor is not an employee under the Act. TEX. LAB. CODE ANN. § 401.012. An independent contractor is a person who contracts to perform work or provide a service for the benefit of another and who ordinarily: (1) acts as the employer of any employee of the contractor by paying wages, directing activities, and performing other similar functions characteristic of an employer-employee relationship; (2) is free to determine the manner in which the work or service is performed, including the hours of labor or method of payment to any employee; (3) is required to furnish or to have employees, if any, furnish necessary tools, supplies, or materials to perform the work or service; and (4) possesses the skills required for the specific work or service. TEX. LAB. CODE ANN. § 406.121(2).

The Act has specific provisions for building and construction independent contractors, TEX. LAB. CODE ANN. §§ 406.141-146, and farm and ranch employees, TEX. LAB. CODE ANN. § 406.165.
58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Professional employer services do not include independent contractors. TEX. LAB. CODE ANN. § 91.001(14). For purposes of the section on staff leasing services in the Texas Labor Code, an independent contractor is a person who contracts to perform work or provide a service for the benefit of another and who: (1) is paid by the job, not by a time-measured basis; (2) is free to hire as many helpers as the person desires and to determine what each helper will be paid; and (3) is free to work for other contractors, or to send helpers to work for other contractors, while under contract to the hiring employer. TEX. LAB. CODE ANN. § 91.001(10).

A certificate of insurance coverage showing that either a license holder or client maintains compensation insurance coverage constitutes proof of workers' compensation insurance coverage for the license holder and the client with respect to all covered employees of the license holder and to the client. TEX. LAB. CODE ANN. § 91.006(a).

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Under the Act, an owner operator is a person who provides transportation services under contract for a motor carrier. An owner operator is an independent contractor. TEX. LAB. CODE ANN. § 406.121(4). An owner operator and the owner operator's employees are not employees of a motor carrier under the Act if the owner operator has entered into a written agreement with the motor carrier that evidences a relationship in which the owner operator assumes the responsibilities of an employer for the performance of work. TEX. LAB. CODE ANN. § 406.122(c).

A motor carrier and an owner operator may enter into a written agreement under which the motor carrier provides workers' compensation insurance coverage to the owner operator and the employees of the owner operator. Such an agreement makes the general contractor the employer of the subcontractor and the subcontractor’s employees only for purposes of the workers’ compensation laws. If a general contractor or a motor carrier elects to provide coverage, then the actual premiums, based on payroll, that are paid or incurred by the general contractor or motor carrier for the coverage may be deducted from the contract price or other amount owed to the subcontractor or owner operator by the general contractor or motor carrier. TEX. LAB. CODE ANN. § 406.123.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.
Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

Nothing in the Act relieves the carrier of its obligation to pay compensable medical expenses because of the potential applicability of Medicare, Medicaid, or health insurance. Moreover, an insurance carrier in Texas can not settle an employee’s right to medical treatment. The carrier must pay for all medical expenses that are reasonable and necessary for the treatment of the injury. In the event an injured employee recovers damages from a third party as a result of the compensable injury, the carrier is entitled to reimbursement for the amounts it has paid for medical care received by the injured employee. In addition, the carrier is entitled to a credit for the medical expense and lost wage damages recovered from the third party.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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1. **Citation for the state's workers' compensation statute.**

Utah Code Annotated §34A-2-101, et seq. The Utah Occupational Disease Act is at §34A-3-101, et seq.

Helpful information regarding workers’ compensation in Utah, including answers to frequently asked questions, can be reviewed at the Labor Commission’s website: http://laborcommission.utah.gov.

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers' compensation?**

Employees include those engaged in government service, any express or implied contract of hire, lessees of mining property, and owners of a partnership or sole proprietorship if an election is made. §34A-2-104. Also, temporary employees qualify if the temporary staffing company which employs them secures compensation coverage. Utah Code Ann. §34A-2-105(3)(b). Officers and directors of the corporation if an election is made, or real estate agents or brokers, are not included. Utah Code Ann. §34A-2-104(5).

3. **Identify and describe any "statutory employer" provision.**

When an employer procures a contractor to do work and the employer retains supervision or control of the work, such work being a part or process in the trade or business of the employer, all employees of the contractor and all subcontractors under the contractor are considered employees of the original employer. Utah Code Ann. §34A-2-103(7)(b); See *Ghersi v. Salazar*, 883 P.2d 1352 (Utah 1994); *Bosch v. Busch Development, Inc.*, 777 P.2d 431 (Utah 1989); *Pate v. Marathon Steel Co.*, 777 P.2d 428 (Utah 1989).

4. **What types of injuries are covered and what is the standard of proof for each:**

   A. **Traumatic or "single occurrence" claims.**

   Accidents arising out of and in the course of employment, not purposely self-inflicted,
are compensable. Utah Code Ann. §34A-2-401. An accident is an unexpected or unintended occurrence that may be either the cause or the result of an injury. See _Allen v. Industrial Commission_, 729 P.2d 15 (Utah 1986).

B. **Occupational disease (including respiratory and repetitive use).**

Any disease or illness that arises out of and in the course of the employment and is medically caused or aggravated by that employment is compensable. Utah Code Ann. §34A-3-103.

5. **What, if any, injuries or claims are excluded?**

None, if they are caused by an industrial accident or occupational disease.

6. **What psychiatric claims or treatments are compensable?**

Physical, mental or emotional injuries related to mental stress arising out of and in the course of employment are compensable once the claimant proves “extraordinary” mental stress arising from employment, and establishes both legal and medical causation. The nature of the stress is judged according to an objective standard. Good faith employer personnel actions such as disciplinary actions, layoffs, demotions, promotions and terminations may not form the basis for a compensable mental stress claim. Utah Code Ann. §§ 34A-2-402, 34A-3-106.

7. **What are the applicable statutes of limitations?**

An employee must report the injury to the employer or the Commission within 180 days of the injury, or the claim is barred. Utah Code Ann. §34A-2-407(3). An employer or physician's injury report is sufficient evidence of notice.

Claims for occupational hearing loss must be filed in the time period specified in § 34A-2-506.

Except with respect to prosthetic devices, and in permanent total disability cases, medical treatment expenses must be covered so long as the expense is reasonable in amount, necessary to treat the injuries, and the expense is submitted for payment within the later of one year after the date of treatment, or the date on which the employee knew or should have known that the medical expense is related to the industrial accident. §34A-2-417(1).

As a general rule, benefits are barred if a claim is not filed within six years from the date of the accident. There is also a 12 year statute of limitations if the injured worker files an application for hearing within six years but is not able to meet his burden of proving that he is owed compensation within 12 years. An award of benefits may be made beyond 12 years in some instances where the injured worker is participating in a commission approved reemployment plan. §34A-2-417(2).
Death claims are subject to a one-year statute of limitation. §34A-2-417(3). Death benefits are only payable if the employee dies within six years from the date of first disability or first medical treatment following the industrial injury. §34A-2-903(2).

8. What are the reporting and notice requirements for those alleging an injury?

The employee, the employee’s next of kin, or the employee’s attorney must notify the employer of the injury. § 34A-2-407(2). Such notification can take the form of an employer’s or physician’s injury reported filed with the Labor Commission, the employer, or the employer’s workers’ compensation carrier, or payment of benefits by the employer or the employer’s carrier. § 34A-2-407(4). The employee must report an injury within 180 days. Utah Code Ann. §34A-2-407(3).

9. Describe available defenses based on employee's conduct:

A. Self-inflicted injury.

Self-inflicted injuries are not compensable. Utah Code Ann. §34A-2-401(1).

B. Willful misconduct, "horseplay," etc.

Injury from horseplay may not be in the course of employment, depending on how serious the deviation is. Prows v. The Industrial Commission, 610 P.2d 1362 (Utah 1980). Where an employee willfully fails to use a safety device or obey an order or rule, compensation is reduced 15%, except in case of injury resulting in death. Utah Code Ann. §34A-2-302.

C. Injuries involving drugs and/or alcohol.

No disability compensation is awarded to an employee when the major contributing cause of the injury is the employee's use of illegal substances, intentional abuse of drugs in excess of prescribed amounts, and intoxication from alcohol with blood alcohol concentration of .08% or greater. This does not apply if the employer permitted, encouraged, or had knowledge of the drug or alcohol use. Utah Code Ann. §34A-2-302. The workers compensation statute imposes a rebuttable presumption that the employee’s injury was caused by the employee’s conduct if a scientifically accepted chemical test establishes a blood alcohol concentration of .08 grams or greater, any amount of an illegal drug is found in the employee’s system, or the employee is found with improper amounts of prescription medication in his system. Id.

10. What, if any, penalties or remedies are available in claims involving fraud?

Any person convicted of workers compensation fraud is guilty of a crime, which can range from a class A misdemeanor to a second degree felony, depending on the amount of money that was involved. Utah Code Ann. §§ 76-10-1801, 34A-2-110.
11. **Is there any defense for falsification of employment records regarding medical history?**

There is no specific statutory defense for falsification of medical history, although such would fall under the fraud provisions of Utah Code Ann. § 34A-2-110.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**


13. **Are injuries by co-employees compensable?**

Yes, if all elements of a compensable accident are present. The co-employee is immune from suit for negligence. Utah Code Ann. §34A-2-105.

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g. "irate paramour" claims)?**

No known case, but they should not be compensable unless the injury arises out of and in the course of employment.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

An employee's average weekly wage is computed as follows: if wages are fixed by the year, the yearly wage is divided by 52. Utah Code Ann. § 34A-2-409(1)(a). If wages are fixed by the month, the monthly wage is divided by four and one-third. Utah Code Ann. § 34A-2-409(1)(b). If wages are fixed by the week, that is the average weekly wage. Utah Code Ann. § 34A-2-409(1)(c). If wages are fixed by the day, the wage is multiplied by the number of days the employee worked, or would have worked but for the accident. Utah Code Ann. § 34A-2-409(1)(d). If wages are fixed by the hour, the hourly rate is multiplied by the number of hours the employee would have worked for the week but for the accident (the multiplier must not be less than 20 hours). Utah Code Ann. § 34A-2-409(1)(e). If the wage was not fixed or cannot be ascertained, the average weekly wage is the usual wage for similar services. Utah Code Ann. § 34A-2-409(1)(f). If the employee is compensated by output, the employee’s average weekly wage is computed by taking the employee’s highest paying 13 week quarter from the previous four quarters, and dividing by 13. Utah Code Ann. § 34A-2-409(1)(g).

If none of the above methods fairly determine the average weekly wage in a case, the Commission is permitted to use any other method that will fairly determine the employee’s average weekly wage. Utah Code Ann. § 34A-2-409(2).

The state average weekly wage is determined by taking the total wages the state reported...
on contribution reports to the Department of Employment Security divided by the average monthly number of insured employees, determined by dividing the total insured employees reported for the preceding year by 12. Utah Code Ann. § 34A-2-410(3). It is calculated and published each year and becomes effective June 1.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The employee receives two-thirds of his or her average weekly wage at the time of the injury, but not more than 100% of the state average weekly wage and not less than $45 per week. Utah Code Ann. § 34A-2-410(1). The injured worker also receives an additional $20 per week for a dependent spouse and each dependent child under the age of 18, to a maximum of 4 children. Utah Code Ann. § 34A-2-410(1). In the event of light duty medical release where no such work is available, the employee will continue to receive temporary total disability benefits. Utah Code Ann. § 34A-2-410(2).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employer/insurer must promptly investigate a claim and pay within 21 days or send written notice that further investigation is needed. Labor Commission Rule R612-200-1-C. The claim must be paid or denied within 45 days.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

The employee must be out 14 days before recovering benefits for the first 3 days. Utah Code Ann. §34A-2-408.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary benefits are terminated when the health care provider or independent medical examiner renders an opinion that the condition has stabilized. Temporary benefits are not to exceed 312 weeks at the rage of 100% of the state average weekly wage over a period of 12 years from the injury. Utah Code Ann. § 34A-2-410(1)(b).

The Labor Commission may terminate temporary benefits upon motion from the employer for the reasons stated in Utah Code Ann. § 34A-2-410.5(2). These reasons include termination of the employee due to criminal conduct, violent conduct, or violation of reasonable written workplace safety rules; if the employee is incarcerated for an amount of time that would result in termination based on reasonable written policies; and if the employee is terminated for use of controlled substances or alcohol that results in a blood concentration of .08 grams or higher. Further, the Commission may terminate temporary benefits if the employee is terminated in accordance with a reasonable, written workplace rule that is applied in a manner that is reasonable and nondiscriminatory. Utah Code Ann. § 34A-2-410.5(2).
20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No, except that the total benefits may not exceed 66 2/3% of the state average weekly wage at the time of the injury for a total of 312 weeks. Any overpayment of this compensation may be recouped by the employer or its insurer by reasonably offsetting the overpayment against future permanent total disability benefits. Utah Code Ann. §34A-2-413(4).

21. **What disfigurement benefits are available and how are they calculated?**

A specific benefit schedule for impairment ratings to specific body parts is contained in Utah Code Ann. §34A-2-412(4). There is no entitlement for disfigurement benefits for scarring or similar disfigurement.

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

   **A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

   There is a listing of the number of weeks available for scheduled parts of the body. Utah Code Ann. §34A-2-412(4).

   **B. Number of weeks for "whole person" and standard for recovery.**

   If the permanent partial disability is based on an impairment rating, rather than a specifically scheduled injury, the permanent partial disability benefit is based on 312 weeks, multiplied by the applicable weekly compensation rate, multiplied by the impairment rating. As an example, if an employee’s compensation rate is $100, and his impairment rating is 10%, his permanent partial disability benefit is 312 X $100 X .10 = $3,120. Utah Code Ann. §34A-2-412(3).

   The maximum period of permanent partial disability compensation is 312 weeks, representing compensation for permanent total loss of bodily function. Utah Code Ann. §34A-2-412(6). "Disability means becoming medically impaired as to function," and "can be total or partial, temporary or permanent, industrial or nonindustrial." Utah Code Ann. §34A-2-102(6).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

If it appears that an injured worker is “disabled” as defined by statute (see Utah Code Ann. §34A-8a-102), the employer or its workers compensation carrier must file an initial written report with the Commission. The report must assess the injured worker’s need or
The employer must also provide the injured worker with information regarding re-employment. Utah Code Ann. §34A-8a-301.

Within 10 days of the written report, the employer must refer the disabled worker to the Utah State Office of Rehabilitation, or, at the employer’s option, to a private rehabilitation or re-employment service, to provide an evaluation and develop a re-employment plan. Utah Code Ann. §34A-8a-302.

Employers or their insurers that file initial “disabled injured worker” reports with the Commission, and who refer employees to the Utah State Office of Rehabilitation or to private services in accordance with this statute, are required to file quarterly reports with the Commission detailing rehabilitation activities. Utah Code Ann. §34A-8a-203. The purpose of the reports is to allow the state to monitor and evaluate the voluntary efforts of employers to assist injured workers in returning to the workforce. Utah Code Ann. §34A-8a-101(2).

An employer can offer reemployment after an industrial injury, which generally involves light duty or similar accommodation of the employee’s physical impairment and restrictions. If reemployment is justifiably terminated by the employer, the employer may petition the Labor Commission for reduction or cessation of disability payments. Termination of reemployment on the following grounds is deemed justifiable: criminal conduct, violent conduct, violation of certain workplace rules, incarceration in a correctional facility, or the inappropriate use of controlled substances or alcohol. Utah Code Ann. §34A-2-410.5(2). An employee’s right to medical benefits is not affected by this provision. §34A-2-410.5(3).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are two-thirds of the employee's average weekly wage at the time of the injury, but not more than 85% of the state average weekly wage, and not less than the sum of $45 per week, plus $20 for a dependent spouse and each dependent child. Utah Code Ann. §34A-2-413.

25. **How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

The employer pays all burial expenses. Utah Code Ann. §34A-2-401. The current cap on burial expenses is $8,000.

**B. Dependency claims.**

Death benefits are two-thirds of the decedent's average weekly wage at the time of the injury, but not more than 85% of the state average weekly wage at the time of the injury.
and not less than a minimum of $45 plus $20 for each dependent. Utah Code Ann. §34A-2-410.

26. What are the criteria for establishing a "second injury" fund recovery?

In Utah, the second injury fund is known as the Employer’s Reinsurance Fund. The Employers Reinsurance Fund is liable only if there is a 10% whole person permanent pre-existing impairment, the employee is permanently and totally disabled and the accident occurred between July 1, 1988 and June 30, 1994. The Fund pays half of all medicals over $20,000 and all permanent total disability benefits after the initial 3 year period. Utah Code Ann. § 34A-2-703. The employer receives a credit for all temporary and permanent disability benefits paid. Utah Code Ann. § 34A-2-703. The Fund has no liability for accidents or diseases occurring on or after July 1, 1994. Utah Code Ann. § 34A-2-702.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

If the employee's disability rating changes, he or she may reapply, subject to the statutes of limitation discussed above in conjunction with Question No. 7. Utah Code Ann. §34A-2-417.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

In most cases, the Act applies only to fixing the amount of attorney fees and provides no authority for assessing such fees against either party. Graham v. Industrial Comm’n, 495 P.2d 806 (Utah 1972). The attorney fees are set by Labor Commission rule, and are deducted from the applicant’s recovery. However, in a case where the only remedy sought is recovery of medical expenses, the Labor Commission rules provide for assessment of an “add on” attorney fee to compensate the applicant’s lawyer for assisting in getting the medical expenses paid. Also, a prevailing applicant’s attorney is entitled to recover reasonable and necessary costs incurred in prosecuting the claim. These fee issues are addressed in Utah Code Ann. § 34A-1-309 and Rule R602-200-2.

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Liabilities of the employer imposed by the Act are in place of "any and all other civil liability whatsoever." Utah Code Ann. §34A-2-105.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).
Exceptions include contractual waiver as set forth in *Freund v. Utah Power & Light Co.*, 793 P.2d 362 (Utah 1990), and when the employer or co-employee act with a specific intent to injure the employee. *Brian v. Utah International*, 533 P.2d 892 (Utah 1975); *Lantz v. National Semiconductor Corp.*, 775 P.2d 937 (Utah App. 1989).

30. **Are there any penalties against the employer for unsafe working conditions?**

Yes. If the employer willfully fails to provide necessary safety devices, the award can be increased 15%. Utah Code Ann. §34A-2-301. Any violation of any provision of the Act is a misdemeanor. Utah Code Ann. §34A-2-209.

31. **What is the penalty, if any, for an injured minor?**

The Utah labor statutes do not specify a penalty for an “injured” minor. However, Utah law prohibits minors from working in excess of certain hours, and from working in “hazardous” occupations. Utah Code Ann. §§34-23-201 and 202. It is a class B misdemeanor for an employer to “knowingly employ a minor or permit a minor to work in a repeated violation” of the child labor laws. Utah Code Ann. §34-23-402. Further, the Labor Commission may assess an administrative penalty of up to $500 per violation of the child labor requirements. Utah Code Ann. §34-23-401.

32. **What is the penalty if a court finds an employer has attempted to prevent an employee from making a claim?**

An employer may not knowingly or intentionally impede or diminish an employee’s efforts to make a claim or receive worker’s compensation benefits in any way, including intimidation, coercion, or harassment. Likewise, the code specifies that an employer may not suspend, discharge, discipline, or threaten an employee who has or is attempting to make a claim. If found guilty for such conduct, employers may be fined up to $5,000 for each violation. Utah Code Ann §34A-2-114.

33. **What is the potential exposure for "bad faith" claims handling?**

Under Utah law, a bad faith claim is contractual in nature, and the Utah Supreme Court has held that an injured employee cannot sue his employer's workers' compensation carrier because there is no privity of contract between the employee and the insurer. *Savage v. Educators Insurance Co.*, 908 P.2d 862 (Utah 1995). The courts have not foreclosed the possibility that a workers' compensation carrier could be sued for independent torts such as intentional infliction of emotional distress, *id.*, and the Utah Court of Appeals has implied that such claims would be permissible under Utah law. *Gunderson v. May Department Stores Co.*, 955 P.2d 346 (Utah Ct. App. 1998). Bad faith is not created because of a mere delay in payment to an injured employee. *Id.* The issue of whether an employee can sue his self-insured employer for bad faith has not been addressed by the Utah courts.

34. **What is the exposure for terminating an employee who has been injured?**
There is no exposure outlined in the statute for terminating an employee. Refer to employment and wrongful termination law. Note, however, that an employee’s right to receive workers’ compensation benefits is not affected by his or her termination from employment. Furthermore, it is frequently the case that the scope of a claim will expand after an employee has been terminated.

THIRD PARTY ACTIONS

35. Can third parties be sued by the employee?

36. Can co-employees be sued for work-related injuries?

37. Is subrogation available?

MEDICALS

38. Is there a time limit for medical bills to be paid, and are penalties available for late payment?
   Medical bills on an accepted liability claim are due and payable within 45 days of being billed. Also, any portion of a bill that is not in dispute is payable within 45 days. There is no specific penalty in the workers’ compensation statute for late payment of medical bills, other than imposition of 8 percent interest on unpaid benefit payments. See Utah Code Ann. § 34A-2-420(3) and Rule 612-2-13. The Utah Court of Appeals has held that an employer who fails to pay benefits after judgment has been entered by the Utah Labor Commission is subject to the 15 percent increase in benefits set forth in Utah Code Ann. §34A-2-302 for “willful failure of an employer to comply with the law or any lawful order of the industrial commission . . .” Gunderson v. May Department Stores Co., 955 P.2d 346, 351 (Utah Ct. App. 1998). Additionally, penalties can be imposed on employers for failure to properly administer claims. Such penalties include possible revocation of an employer’s certificate of self-insurance to prosecution for the misdemeanor of violating a Commission order. Id. Additionally, medical providers can file applications for hearing requesting payment of outstanding medical expenses for treatment related to workers’ compensation injuries.

39. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?
   The commissioners and the Secretary of the Commission may issue subpoenas to compel
the production of documents. Utah Code Ann. §34A-1-302. Generally, however, the employee executes a HIPAA-compliant authorization in order to release his or her records to the employer/insurer. An employer is entitled to such an authorization by Rule R612-2-22.

40. **What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

The employee is normally allowed to choose and is allowed to change physicians once without permission of the Labor Commission. Administrative Rule R612-300-2.

41. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

All medical, nurse and hospital services and medicines are covered. Utah Code Ann. §34A-2-401. This includes physical therapy and, in appropriate cases, chiropractic care is allowed.

42. **Which prosthetic devices are covered, and for how long?**


43. **Are vehicle and/or home modifications covered as medical expenses?**

Yes, if prescribed by a physician.

44. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes, in the regulations published by the Department. Administrative Rule R612-2-5.

45. **What, if any, provisions or requirements are there for “managed care”?**

In Utah, self-insured employers and workers compensation insurers may adopt a managed health program to provide employees with workers’ compensation benefits. The plan may include a preferred provider program so long as the employee is allowed a selection of more than one physician in the health care specialty required for treating his injury or condition. If an employer/insurer or self-insured entity develops an appropriate provider program, employees are required to utilize preferred provider physicians and medical care facilities. If an employee has been notified of the program, but chooses not to participate, the employee will be obligated to pay for any charges in excess of the preferred provider allowances.

Regardless of whether a preferred provider program is established, employers may have their own health care facilities on or near their work site, and may continue to contract with health care providers. The employer may also operate a health care facility and require employees to first seek treatment at the provided health care or contracted facility.
An employee is not required to seek treatment from a preferred provider in cases of emergency, when the employee believes in good faith that his condition is non-industrial, and when an employee living in a rural area would be unduly burdened by traveling to a preferred provider. See Utah Code Ann. §34A-2-111.

**PRACTICE / PROCEDURE**

46. **What is the procedure for contesting all or part of a claim?**

   After an employee reports a work injury, the claims representative can complete the Form 089 “Employee Notification Denial of Claim.” The claims representative can specify whether the claim is fully or partially denied and the basis for the denial. The form can be found at: https://laborcommission.utah.gov/wp-content/uploads/2019/11/Form-089-Revised-2-2019.pdf

   After the employee files an application for hearing, the employer/insurer files an answer, either admitting or denying each element of the claim.

47. **What is the method of claim adjudication?**

   **A. Administrative level.**

   The claim is filed before the Labor Commission, and is initially decided by an administrative law judge (“ALJ”). The decision of the ALJ may be appealed to the Commission.

   **B. Trial court.**

   Not applicable.

   **C. Appellate.**

   The decision of the Commission may be appealed to the Utah Court of Appeals.

48. **What are the requirements for stipulations or settlements?**

   Settlements are allowed only if there is a reasonable dispute or if the settlement is a reasonable commutation of future benefits. Utah Code Ann. §34A-2-420(4). No agreement by an employee to waive his or her right to compensation under the Act is valid. Utah Code Ann. §34A-2-108. See Labor Commission Rule R602-2-5 on settlement agreements.

49. **Are full and final settlements with closed medicals available?**
Such settlements are only available when compensability is disputed, or when the settlement is a commutation of reasonable future benefit entitlements. The Labor Commission’s approval is required for any such settlement. *Wilburn v. Interstate Electric*, 748 P.2d 582 (Utah Appeals 1988); Utah Code Ann. §34A-2-420(4); Labor Commission Rule R602-2-5. Otherwise, future medical expenses cannot be settled.

However, future medical expenses can be commuted, which amounts to paying the present day value of future anticipated medical expenses. For the Commission to grant a commutation, the parties will have to provide the judge with a doctor’s reasonable opinion regarding future treatment and the costs associated with such treatment.

50. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. Settlement agreement forms and information can be reviewed at https://laborcommission.utah.gov/divisions/adjudication/workers-compensation-settlement-agreements/.

**RISK FINANCE FOR WORKERS' COMPENSATION**

51. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

A private insurer, state fund or self-insurance are all options. Utah Code Ann. §34A-2-201.

52. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

Self-insurance is permitted if satisfactory proof of ability to pay is submitted annually to the Commission. Utah Code Ann. §34A-2-201(1). The self-insurer must also provide a knowledgeable contact within the state, maintain a toll free number for claims, and comply with all of the Commission's rules. Administration of such programs is discussed in Labor Commission Rule R612-3-5.

B. **For groups or "pools" of private entities.**

Risk pools are not mentioned in the statute.

53. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

Under Utah law, illegal aliens are specifically included in the statutory definitions of “employee,” “worker,” and “operative” under the Workers’ Compensation Act. Utah Code Ann. §34A-2-104(1)(b). Thus, such persons are entitled to workers’ compensation.
benefits.

54. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Utah workers’ compensation benefits are available because of injury or death “in any way contracted, sustained, aggravated, or incurred by the employee in the course of or because of or arising out of the employee’s employment.” Utah Code Ann. §34A-2-105(1). In light of this broad language, and the Act’s silence on the specific issue of terrorism, it is presumed that injuries caused by a terrorist act would be covered, so long as the employee is in the course of employment at the time of the injury.

55. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?**

There is nothing unique to Utah workers’ compensation law with regard to the federal Medicare program. As explained above in response to Question Nos. 48 and 49, full and final settlements can take place with the approval of the administrative law judge. It is not uncommon for the judge to require an explanation of how Medicare’s interest is being resolved in connection with her approval or disapproval of the settlement that is being proposed.

56. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

The State of Utah enjoys a statutory lien on all third party recoveries, including recoveries of workers’ compensation benefits. Utah Code Ann. §§26-19-2, 26-19-5. “This lien has priority over all other claims to the proceeds, except claims for attorney’s fees and costs . . .” Utah Code Ann. §26-19-5(1)(b). Health insurance subrogation is permissible in the workers’ compensation context. Absent a contractual provision to the contrary, Utah law does not allow subrogation until the injured worker has been made whole. *Hill v. State Farm Mutual Automobile Insurance Co.*, 765 P.2d 864 (Utah 1988.) However, Utah courts will enforce insurance policy provisions that allow for subrogation or reimbursement regardless of whether the injured worker was made whole as a result of the settlement. *Id*
57. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

At the present time, HIPAA, 45 CFR parts 160-164 and 65 FR 82462, is applicable in Utah, as in all other states. The HIPAA privacy rule recognizes the legitimate need of employers and workers’ compensation insurers to have access to applicants’ medical records to the extent authorized by state law. See 45 CFR 164.512(a).

Under Utah law, a medical provider is required, without authorization, to provide records necessary to substantiate the billing of medical services related to the workers’ compensation claim. Other relevant records must be disclosed pursuant to a Labor Commission records release form, or other HIPAA-compliant authorization form. Employers and insurers may not disclose medical information without authorization, and may only use the medical information to pay, assess or adjudicate the workers’ compensation claim.

Workers’ compensation applicants in Utah must provide the employer or workers’ compensation insurer with a signed medical records authorization when an action for benefits is filed with the Utah Labor Commission. Also, the Labor Commission will usually issue subpoenas upon request.

These medical records privacy and disclosure provisions are addressed in Rule R612-2-22.

58. **What are the provisions for “Independent Contractors”?**

The Utah Workers’ Compensation Act defines “independent contractors” as “any person engaged in the performance of work for another” who is (1) independent of the employer regarding execution of the work, (2) not subject to routine control of the employer, (3) engaged in only the performance of a definite job or piece of work, and (4) subordinate to the employer only regarding the result desired by the employer. Utah Code Ann. §34A-2-103(2).

The statute includes “independent contractors” as “employers” who are responsible to obtain workers’ compensation benefits for their employees. Utah Code Ann. §34A-2-201.

The employer of an independent contractor assumes workers’ compensation liability for his independent contractor’s employees if the employer “retains supervision or control, and this work is part or process of in the trade or business of the employer. Utah Code Ann. §34A-2-103(7)(a). However, this liability disappears if the employer of the subcontractor obtains and relies on a valid certification that the subcontractor had procured workers’ compensation benefits for his employees. Utah Code Ann. §34A-2-103(7)(e).
59. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

Under Utah law, the client company in an employee leasing arrangement is considered the employer of the leased employees, and is responsible to secure workers’ compensation benefits for them. However, the law does allow an insurer to issue a policy to the leasing company as the named insured, and its client companies as additional insureds through individual endorsements. Utah Code Ann. §34A-2-103(3).

60. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

No.

61. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state and you can contact ALFA at (312) 642-ALFA (3532).
1. Citation for the state's workers' compensation statute.

   Vermont Statutes Title 21, § 601 et seq.

**SCOPE OF COMPENSABILITY**

2. Who are covered "employees" for purposes of workers' compensation?

   The statute covers a person who has entered into the employment of or works under a contract of service or apprenticeship with an employer. The following are excluded: casual employees, persons engaged in amateur sports, persons engaged in farm or agricultural employment for an employer with an aggregate payroll of less than $10,000.00 per year, members of an employer's family dwelling in the employer's house, and persons engaged in any type of service in or about a private dwelling, sole proprietors or partners/owners of an unincorporated business provided they satisfy statutory requirements, under certain circumstances, an individual who performs services as a real estate broker or real estate salesperson, if approved by the commissioner certain members of a corporation or LLC, independent contractors, assistant judges and illegally hired minors. Persons falling under these exclusions may be covered at the employer's option. 21 V.S.A. § 601(12), 601(14); Falconer v. Cameron, 151 Vt. 530 (1989); Wolck v. Fort Drummer Mills, 98 Vt. 449 (1925).

3. Identify and describe any "statutory employer" provision.

   The statutory definition of employer includes the owner or lessee of premises or the operator of a business conducted on the premises who is not the direct employer of the employees employed there. 21 V.S.A. § 601(3). Vermont courts have determined that, for purposes of workers’ compensation, an employer includes anyone who is capable of supervising an employee and replacing him if the work performance is unsatisfactory, notwithstanding the absence of a monetary compensation exchange. Candido v. Polymers, Inc., 166 Vt. 15 (1996). In order to find a person an employer under this provision, the work being carried out by an independent contractor on the owner's or proprietor's premises must be of the type that could have been carried out by employees of the owner or proprietor in the course of his or her usual trade or business. King v. Snide, 144 Vt. 395 (1984).
4. **What types of injuries are covered and what is the standard of proof for each:**

The statute covers accidental personal injury arising out of and in the course of one's employment, including injury caused by the willful act of a third person. Personal injury includes: death resulting from an injury within two years, injury to and cost of acquiring and replacement of prosthetic devices, hearing aids and eye glasses. 21 V.S.A. § 601(7), 601(11)(A), 618.

To have a compensable injury, an employee must prove that: (1) the accident arose out of the employment; and (2) occurred in the course of the employment. Miller v. International Business Machines Corp., 161 Vt. 213 (1993). A personal injury occurs during the course of employment when it is within the period of time when the employee is on duty and in a location where he is expected to fulfill the obligations of his employment position. Id. As for the second element, “Arising out of” the Vermont Supreme Court has adopted a “but for” rationale. Shaw v. Dutton Berry Farm, 160 Vt. 594 (1993). Under this theory, also known as the “positional risk” doctrine, an injury arises out of the employment if the injury would not have occurred, but for the employment. Id.

A. **Traumatic or "single occurrence" claims.**

A personal injury by accident, arising out of and in the course of the employment, is compensable.

B. **Occupational disease (including respiratory and repetitive use).**

"Occupational disease" means a disease that results from causes and conditions characteristic of and peculiar to a particular trade, occupation, process or employment, and to which an employee is not ordinarily subjected or exposed outside or away from the employment and arises out of and in the course of the employment. 21 V.S.A. §601(23)

5. **What, if any, injuries or claims are excluded?**

Injuries caused: (1) by an employee's willful intention to injure himself or herself or another; (2) by or during intoxication; or (3) by an employee's failure to use a safety appliance for his or her use, are not compensable. 21 V.S.A. § 649. However, it should be noted that these defenses inject an analysis of fault into a no fault system. Because of that fact these are affirmative defenses and the burden of proof with regards to these defenses remains with the employer and the evidence supporting these defenses is scrutinized carefully by the Department of Labor.

6. **What psychiatric claims or treatments are compensable?**

“Mental-mental” claims are claims for workers’ compensation benefits for a mental condition that arose from a mental stimulus. Previously, the injured worker was required
to prove a causal connection between the stress and the injury, that the stresses encountered while working for the employer were significant and objectively real, that the job placed greater emotional strain and tension on him/her than other employees, and the stress could not be the result of bona fide personnel issues. However, an amendment to 21 V.S.A. §601(11)(J)(i), effective on July 1, 2017, provides that a mental condition resulting from a work-related event or stress shall be a compensable claim if it is demonstrated by the preponderance of the evidence that: “(i) the work-related event or work-related stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee across all occupations; and (ii) the work-related event or work-related stress, and not some other event or source of stress, was the predominant cause of the mental condition.” The section also provides that a mental condition is not compensable if it results from disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action taken in good faith by the employer. The employee still has the burden of proof to demonstrate that he/she can meet the standard by a preponderance of the evidence. Despite predictions of an expansion in the number of mental-mental claims as a result of this shift, we have seen no evidence of one so far. The Department of Labor has thus far provided no guidance as to what standard will be used when determining what constitutes the “pressures and tensions experienced by the average employee across all occupations.”

At the same time, 21 V.S.A. §601(11) was amended to state that “in the case of police officers, rescue or ambulance workers, or firefighters, post-traumatic stress disorder that is diagnosed by a mental health professional shall be presumed to have been incurred during service in the line of duty and shall be compensable, unless it is shown by a preponderance of the evidence that the post-traumatic stress disorder was caused by nonservice-connected risk factors or nonservice-connected exposure.” The amendment further states that a police officer, rescue or ambulance worker or firefighter who is diagnosed with post-traumatic stress disorder within three years of his/her last date of employment as a police officer, rescue or ambulance worker, or firefighter shall be eligible for workers’ compensation benefits under this section. The amendment creates a presumption that any emergency worker diagnosed with post-traumatic stress disorder has a compensable workers’ compensation claim for benefits. In order to deny the compensability of the claim, the carrier/employer will have to show by a preponderance of the evidence that the post-traumatic stress disorder was caused by something unrelated to the emergency service work.

7. **What are the applicable statutes of limitations?**

A claim for compensation must be made within 3 years after the injury or death. Any proceedings under the statute are contract claims, which must be commenced within six years of the injury. "Date of injury" for purposes of these provisions, means the point in time when the injury becomes reasonably discoverable and apparent. The limitations do not apply to any person who is mentally incompetent or a minor dependent so long as such person has no guardian. 21 V.S.A. § 656, 661; *Hartman v. Ovellette Plumbing & Heating Corp.*, 146 Vt. 443 (1985); *Hoisington v. Ingersoll Electric*, Op. No. 52-09WC (Dec. 28, 2009).
In occupational disease claims, the Vermont legislature repealed § 1006(a) and enacted 21 V.S.A. §660(b), which provides that a workers’ compensation claim for an occupational disease must be made within two years from the date on which the disease is reasonably discoverable and apparent. Murray v. Luzenac Corp, 2003 VT 37.

8. **What are the reporting and notice requirements for those alleging an injury?**

Notice must be given to the employer as soon as practicable after the injury and a claim for compensation must be made within six months of the injury. Notice must be in writing and provide the time, place, nature and cause of the injury, and must be signed by the employee. However, notice will not be held invalid or insufficient by reason of any inaccuracy in stating the time, place, nature or cause of the injury unless the employer was in fact misled as a result of such inaccuracy. 21 V.S.A. § 656, 658. Want of or delay in giving notice, or in making a claim, shall not be a bar to proceedings under the provisions of this chapter, if it is shown that the employer, the employer's agent or representative, had knowledge of the accident or that the employer has not been prejudiced by the delay or want of notice. 21 V.S.A. § 660.

9. **Describe available defenses based on employee conduct:**

   A. **Self-inflicted injury.**

      Willfully self-inflicted injuries are not compensable. This defense, however, is an affirmative one. 21 V.S.A. § 649.

   B. **Willful misconduct, "horseplay," etc.**

      Employees injured as a result of "horseplay" by fellow employees are covered if the commission of such an act was within the reasonable contemplation of the employer and the probability of its commission created an additional hazard incidental to the employment. Myott v. Vermont Plywood, Inc. 110 Vt. 131 (1938). Whether horseplay participant is entitled to recover workers' compensation benefits usually hinges on whether participant's injury occurred in course of employment, which, in turn, depends on extent of participant's deviation from work duties. Clodgo v. Rentavision, Inc., 166 Vt. 548 (1997). Also, compensation is not allowed for injuries caused by an employee's failure to use a safety appliance provided for his or her use. 21 V.S.A. § 649.

   C. **Injuries involving drugs and/or alcohol.**

      Injuries caused by or during an employee's intoxication are excluded. The burden of proof is on the employer/insurer in all of these defenses. 21 V.S.A. § 649. The Vermont Supreme Court held in 2010 that for the employer to successfully raise the employee’s intoxication as a defense to a claim, the employer must show that the intoxication played a role in causing the injury, either actively – “caused by” or passively – “caused during.” Cyr v., McDermott’s Inc., 187 Vt. 392 (2010).
10. **What, if any, penalties or remedies are available in claims involving fraud?**

The statute provides that a person who willfully makes a false statement or representation for the purpose of obtaining any benefit or payment under the workers' compensation statute on anyone's behalf will be fined up to $20,000.00 and forfeit all or a portion of any right to compensation as determined by the commissioner after the commissioner has determined the person willfully made a false statement or misrepresentation. An employer who willfully makes a false statement or report for the purpose of obtaining a lower workers' compensation premium may be assessed an administrative penalty up to $20,000 in addition to any other appropriate penalty. 21 V.S.A. § 708; 8 V.S.A. §3661(c). Either an employee or employer may be prosecuted for workers' compensation fraud under 13 V.S.A. § 2024.

11. **Is there any defense for falsification of employment records regarding medical history?**

Any person making such a falsification for the purpose of obtaining benefit or payment will be fined up to $20,000 and forfeits all or a portion of any right to compensation after a determination by the commissioner. 21 V.S.A. § 708.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

If an injury occurred while engaged off the premises of the employer in a recreational activity that is available to the employee as part of the employee's compensation package or as an inducement to attract employees, it shall not be considered to have occurred in the course of employment unless (A) the employer derived substantial benefit from the activity, beyond that of attracting labor or improving employee health and morale; (B) the activity was reasonably part of the employee's regular duties or undertaken to meet the expectations of the employer; or (C) the activity was undertaken at the request of the employer. 21 V.S.A. § 618. An injury arising from an on-premises recreational activity shall be presumed to be compensable if it occurred during a lunch or recreation period as a regular incident of employment. Grather v. The Gables Inn, 170 VT 377 (2000).

13. **Are injuries by co-employees compensable?**

Yes, so long as the injuries arise in the course of the employment. Shaw v. Dutton Berry Farm, 160 Vt. 594 (1993).

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?**

It depends on the facts and circumstances of the case. The Vermont Supreme Court has held that an injury, caused by the unprovoked stabbing by another employee in the employer-provided bunkhouse after work, arose from the employment as a matter of law.
The Court overruled a case in which an employee was denied benefits for injuries received in a fight in an employer-provided bunkhouse because, at the time of the fight, he was not engaged in any activity benefiting the employer. *Shaw v. Dutton Berry Farm*, 160 Vt. 594 (1993).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage must be computed in such a manner as is best calculated to give the average weekly earnings of the employee during the 26 weeks preceding the injury. 21 V.S.A. § 650(a). Weeks in which the injured employee worked less than half time are not included in the calculation. Bonuses, overtime, tips and second jobs are included in the calculation of the average weekly wage.

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Benefits are paid at two-thirds of the employee's average weekly wage during the 26 weeks preceding the injury. “Two-thirds” is determined by multiplying the average weekly wage by 0.667. For purposes of the statute, the Department of Labor establishes, on a yearly basis, the maximum and minimum weekly wages, which are presently set at $1,281.00 and $427.00 respectively. For purposes of determining temporary total or temporary partial disability compensation, the maximum and minimum compensation rates apply. Vt. Stat. Ann. tit. 21, § 650(a).

Effective July 1, 2013 if a claimant consents in writing, the carrier *may* pay the employee’s weekly temporary benefits by means of direct deposit or with an electronic prepaid benefit card account. 21 V.S.A. § 618(f)(1). These prepaid benefit card accounts shall not be used to pay permanent impairment benefits or lump sum benefits. 21 V.S.A. § 618(f)(1). The issuer of the card shall comply with consumer protection laws that apply to payroll account cards. 21 V.S.A. § 618(f)(1).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

The employer/insurer must begin paying such benefits after three days of the disability. 21 V.S.A. § 642.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g. must be out ___ days before recovering benefits for the first ___ days)?**

An employee must be out of work for three days to begin receiving benefits, the first three days are not compensated by the employer. 21 V.S.A. § 642. Once the employee has been out of work for ten consecutive days, the first three days are compensable. 21 V.S.A. §642.
19. What is the standard/procedure for terminating temporary benefits?

Unless an employee has returned to work, the employer must file a notice of intention to discontinue benefits indicating the date of and reasons for the proposed discontinuance. The discontinuance must also document that the claimant was referred for a vocational screening if the claimant was absent from work due to the work injury for 90 days and attach all the evidence that is relevant to the file. The Commissioner will review the notice to determine the sufficiency of the basis for the discontinuance. If the Commissioner finds that the discontinuance is supported by a preponderance of the evidence, the Commissioner may order that payments continue until a hearing is held and a decision is rendered. The employer/insurer may also terminate benefits when the employee has reached a "medical end result." 21 V.S.A. § 643a. In the case of termination on the basis of the claimant's failure or refusal to return to work, the notice must be accompanied by written documentation establishing the following: (A) that the claimant has been medically released to return to work, either with or without restrictions; AND (B) that the claimant has been notified both of the fact of his or her release and his or her obligation to conduct a good faith search for suitable work in writing; AND (C) that the claimant has either failed to conduct a good faith search for suitable work and/or has refused an offer of suitable available work once notified.

Payments must continue for seven days after notice is received by the commissioner and the employee. 21 V.S.A. § 643a.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No. Permanency benefits are not awarded until all the temporary benefits have ended, i.e., the employee has reached a medical end result and is back to work. Orvis v. Hutchins, 123 Vt. 18 (1962).

The payments are made during the seven days subsequent to the filing of notice of discontinuance are made without prejudice and may be deducted from any amount due for permanent partial disability benefits should the discontinuance be approved by the commissioner. 21 V.S.A. § 643a.

21. What disfigurement benefits are available and how are they calculated?

Only if allowed by the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.

22. How are the permanent partial disability benefits calculated, including the minimum and maximum rates?

The employee receives benefits based upon two-thirds (0.667) of the average weekly wage and receives a number of weeks of benefits based upon the percentage of
permanent impairment. The minimum and maximum average weekly wages are presently set at $427.00 and $1,281.00. The benefits paid are based on the employee’s compensation rate on the date of injury exclusive of dependents. COLA increases only apply if permanency benefits go through July 1. 21 V.S.A. § 650.

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

There is no longer a schedule of members/parts standard for recovery. The standard is now based on the percentage of whole body impairment according to the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. 21 V.S.A. §648(b). The percentage impairment for mental and behavioral disorders is calculated according to the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. 21 V.S.A. §648(b); Rule 10.1310.

B. Number of weeks for "whole person" and standard for recovery.

Whole person impairment is based upon percentage of impairment. For injuries occurring after April 5, 1995, impairment ratings will be calculated on a whole person basis with the applicable weekly benefit determined as a percentage of loss of the whole person multiplied by 550 weeks for a spine injury and 405 weeks for an injury to any other body part.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

An employee is entitled to vocational rehabilitation when, as a result of a work-related injury, the employee is unable to perform work for which he or she had previous training or experience. 21 V.S.A. § 641

24. How are permanent total disability benefits calculated, including the minimum and maximum rates?

In order to qualify for permanent total disability, the injury must result in: (1) the loss of actual earnings or earning capacity; and (2) the employee having no reasonable prospect of finding regular, gainful employment. 21 V.S.A. § 644. In order to determine permanent total disability, the commissioner shall consider other specific characteristics of the claimant, including the claimant's age, experience, training, education and mental capacity. Id. The employee receives a minimum of 330 weeks of benefits, and payments continue thereafter during such disability. 21 V.S.A. §645. Benefits are paid at two-thirds of the employee's average weekly wage, subject to the maximum and minimum weekly compensation rates. Id.

25. How are death benefits calculated, including the minimum and maximum rates?

A. Funeral expenses.
Burial expenses of up to $10,000.00 and expenses for out-of-state transportation of the decedent to the place of burial up to $5,000.00 are allowed. 21 V.S.A. § 632.

B. Dependency claims.

A spouse receives at minimum a sum equal to two thirds of the deceased employee's weekly wage until remarriage or until age 62 if the spouse is eligible for social security. 21 V.S.A. §635. In no event shall the spouse receive an amount less than 330 weeks at the maximum compensation rate unless the spouse dies. A spouse with one child receives 71\(\frac{2}{3}\)%%. A spouse with two dependent children receives 76 \(\frac{2}{3}\)%%. If there is no spouse, but there is one dependent child, the child receives 76\(\frac{2}{3}\)%%. If there is a child or children and no spouse then the amount payable to the spouse is divided equally among the children. If there is no spouse or children, then 30% is awarded to a dependent parent, or 20% to a partially dependent parent, or if no parent then the same percentages are awarded to a dependent grandparent. If there is none of the above, but there is a dependent grandchild, brother or sister then 15% is awarded for the first dependent and 5% for each additional grandchild, brother or sister up to 25% to be divided equally among the dependents. 21 V.S.A. § 632.

26. What are the criteria for establishing a "second injury" fund recovery?

The "Second Injury Fund" was repealed.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A claim may be re-opened by application of a party or the Commissioner by his or her own motion where there has been a change in condition if brought within six years of the award. The moving party must give the other parties or their attorneys six days’ notice of the re-opening. 21 V.S.A. § 668.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

An attorney fee may be awarded by the court if the employee prevails in an appeal to the Superior or Supreme Court. The Commissioner also may allow an attorney fee when the employee prevails at the Workers' Compensation Board. Vt. Stat. Ann. tit. 21, § 678; Hodgeman v. Jard Co., 157 Vt. 461 (1991); Coleman v. United Parcel Service, 155 Vt. 646 (1990). Absent a formal workers’ compensation hearing, the Commissioner may award fees to a claimant if: (1) the employer or insurance carrier is responsible for undue delay in adjusting the claim, or (2) the claim was denied without reasonable basis, or (3) the employer or insurance carrier engaged in misconduct or neglect AND the legal representation to resolve the issues was necessary, the representation provided was reasonable, and neither the claimant nor the claimant’s attorney has been responsible for any unreasonable delay in resolving the issues.
EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Compensation benefits are the employee's exclusive remedy. 21 V.S.A. § 622.

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

Nothing short of a specific intent to injure falls outside the scope of the Act. The wanton and willful acts of an employer will not take the injury outside the scope of the statute. Kittell v. Vermont Weatherboard, Inc., 138 Vt. 439 (1980). The standard pronounced in Kittell was reaffirmed as the applicable test in the recent decision of Mead v. Western Slate, Inc., 2004 VT 11. An illegally employed minor does have the right to a common law remedy for injuries sustained. Express indemnification agreements may also provide an exception. Vermont courts have not considered whether an employer possessing an independent "persona" is subject to a tort suit.

The injured employee or the employee's personal representative shall be prohibited from commencing a civil action to enforce liability against the workers' compensation insurance carrier for conducting workplace inspections, or an employer-employee safety committee except in the case of gross negligence or willful misconduct. 21 V.S.A. §624(h).

30. Are there any penalties against the employer for unsafe working conditions?

Vermont occupational safety and health law imposes penalties for unsafe working conditions. 21 V.S.A. § 210.

31. What is the penalty, if any, for an injured minor?

Where a minor is illegally employed under Vermont child labor law, the employer may be subject to a civil action. However, in Bruley v. Fonda Group, Inc., 157 Vt. 1 (1991), the Vermont Supreme Court barred a minor's civil action and held that the minor's remedy was workers' compensation despite the fact that he operated a lawn tractor which violated federal, but not state, law.

32. What is the potential exposure for "bad faith" claims handling?

Willful neglect of claims procedure can result in a requirement that the employer take out insurance independently. Depending on the circumstances, the Commissioner may order an insurer to pay benefits based on faulty claims handling or bad faith. 21 V.S.A. § 689.

33. What is the exposure for terminating an employee who has been injured?
The employer may be enjoined from terminating the employee on the basis of his/her filing of a workers’ compensation claim and may face civil penalties in accordance with the Vermont Consumer Fraud Act. 21 V.S.A. § 710. An employer is not required to employ a person who does not meet the qualifications of the position. Id. However, if the employee recovers within two years of the date of disability onset, the worker shall be offered the next available position if certain conditions are met.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. An employee may file a claim against a third party where the injury was caused under circumstances creating a legal liability in some party other than the employer. 21 V.S.A. § 624.

35. **Can co-employees be sued for work-related injuries?**

Yes, a co-employee is considered a third party for purposes of 21 V.S.A. § 624, and therefore can be sued. See Libercent v. Aldrich, 149 Vt. 76 (1987). In determining whether an individual is a co-employee, and therefore subject to suit, or an employer, and therefore immune from suit, the Vermont Supreme Court held that the critical factor is whether the injury occurred in the performance of a non-delegable duty of the employer, as opposed to arising out of an obligation owed to the injured employee. Gerrish v. Savard, 169 Vt. 468 (Vt. 1999).

36. **Is subrogation available?**

Yes. The employer/insurer must be reimbursed monies paid from any third party recovery. 21 V.S.A. § 624(e). Procedurally, the inured employee has the right to bring the claim for the first year. Thereafter, the employer/insurer may bring the claim in the name of the injured employee. 21 V.S.A. § 624(a).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The time limit to pay medical bills or deny them is 30 days and the Commissioner may suspend the license of an employer/insurer for refusing or neglecting to promptly pay medical bills. 21 V.S.A. § 688. The Commissioner can also compel an employer who neglects or refuses to pay medical bills promptly to obtain compensation insurance.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**
The filing of a claim constitutes a waiver of privilege between the parties. Therefore, upon request of the employer, the employee is obligated to execute a medical authorization, authorizing the release of all relevant medical records to the employer. If an employee fails or refuses to provide a medical authorization upon request, benefits may be suspended or the claim may be dismissed without prejudice. Rule 3.2130.

39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of a physician.

After the employer initially designates the treating health care provider, the employee may select another provider after giving the employer written notice of the reasons for the employee's dissatisfaction with the provider, as well as the name and address of his or her choice of provider. 21 V.S.A. § 640(b).

B. Employer’s right to second opinion and/or Independent Medical Examination.

An employer may designate the treating health care provider to initially treat an injured employee immediately following a compensable injury. 21 V.S.A. § 640(b). If the employee selects another provider, the employer shall have the right to require other medical examinations.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

Reasonable hospital, surgical, medical and nursing services and supplies are covered. 21 V.S.A. § 640(a). Chiropractic treatment and physical therapy are generally covered if shown to be reasonable and necessary. Palliative care may also be covered.

41. Which prosthetic devices are covered, and for how long?

Such issues are dealt with on a case-by-case basis, but generally, prosthetic devices are covered.

42. Are vehicle and/or home modifications covered as medical expenses?

Yes.

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. Medical services may not exceed the maximum fee for a particular service as provided by the Commissioner's schedule of fees and rates unless the employee demonstrates a need for reimbursement at a rate higher than the scheduled rate and the necessary treatment is not available at the scheduled rate. 21 V.S.A. § 640(d); Rule 40.
44. **What, if any, provisions or requirements are there for "managed care"?**

The Act does not have specific provisions addressing managed health care, and does not address specific medical issues other than the requirement that any medical care sought be reasonable, necessary and causally linked to the work injury. 21 V.S.A. § 640.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

If an agreement cannot be reached concerning compensation benefits, the employer/insurer must notify the Commissioner and the employee, in writing, within 21 days of notice to the employer of the injury, of the denial of the claim and the reasons for the denial. 21 V.S.A. § 662(b). Either party may apply to the Commissioner for a hearing concerning disputed issues. 21 V.S.A. § 663.

46. **What is the method of claim adjudication?**

A. **Administrative level.**

After at least one information conference, an aggrieved party may ask for a hearing before an administrative law judge at the Department of Labor and evidence is taken. The parties have an opportunity to examine witnesses and to submit memoranda on the legal and factual issues. Rule 17.0000.

B. **Trial court.**

A *de novo* trial takes place at the trial court level after an appeal has been made. Either party is entitled to a trial by jury. 21 V.S.A. § 670, 671.

C. **Appellate.**

Legal questions may be appealed to the Vermont Supreme Court. 21 V.S.A. § 672.

47. **What are the requirements for stipulations or settlements?**

Settlement agreements are filed with the Commissioner for his or her approval, which will only be given when the agreement conforms with the Act or, in the case of a compromise, the agreement is considered by the Commissioner to be in the employee's best interests. Once executed by the parties and approved by the Commissioner, settlement agreements shall become binding agreements and absent evidence of fraud or material mistake of fact, the parties shall be deemed to have waived their right to contest the material portions thereof.

48. **Are full and final settlements with closed medicals available?**
Yes, but only under limited circumstances.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. 21 V.S.A. § 662(a).

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Primary and direct coverage is required in full. 21 V.S.A. § 693. This may be done by means of a private insurer, guarantee insurance, self-insurance or non-profit self-insurance corporation.

51. **What are the provisions/requirements for self-insurance?**

   **A. For individual entities.**

   Self-insurance is available. Requirements for self-insurance are established pursuant to certain tests which take into account an employer's cash flow, working capital, liquidity, net worth to debt ratio, and profitability. Rule 26.0000.

   **B. For groups or "pools" of private entities.**

   Employers, with the approval of the Commissioner, may form corporations without capital stock for the purpose of establishing and maintaining Mutual Workers' Compensation Insurance Associations. 8 V.S.A. § 4361 et seq.

52. **Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

There are no cases addressing this issue in Vermont. As for the statutory construction, since the definition of “employee” under the Act is so broad (i.e. a person who has entered into the employment of or works under a contract of service or apprenticeship with an employer) and because there is no statutory exclusion for illegal aliens, it seems as though they would be entitled to workers’ compensation benefits.

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Neither the workers’ compensation statute, nor Vermont case law have addressed this issue. However, coverage will most likely be analyzed on a case-by-case basis to
determine if the injuries arose in the course of the employment.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers’ compensation by a workers’ compensation carrier or self-insured employer. The obligation to pay medical expenses for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter if at the time of the settlement the employee meets the following criteria:

- the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or

- there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC § 1395)

Claims for reimbursement of the costs of medical services rendered shall be approved by the commissioner. If so approved, they may be enforced against compensation awards in such manner as the commissioner may direct. 21 V.S.A. § 682.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. § 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. § 1396k(b).

Claims for reimbursement of the costs of medical services rendered shall be approved by the commissioner. If so approved, they may be enforced against compensation awards in such manner as the commissioner may direct. 21 V.S.A. § 682. With regard to Medicaid, the pertinent statute provides as follows: “To the extent that payment for
covered expenses has been made under the state Medicaid program or through any state agency administering health benefits or a health benefit plan for which Medicaid is a source of funding for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.” 33 V.S.A. § 1907, 1910.

Insurers shall take reasonable steps to discover whether the Department of Vermont Health Access has paid medical bills associated with workers’ compensation claims. 33 V.S.A. §1910 (b)(2). The legislation provides that the State of Vermont Human Service Agency has a lien against the insurer for monies paid for medical expenses on behalf of a person who has an injury, illness or disease and the person initiates a claim against an insurer for that injury, illness or disease. Additionally the legislation provides that “Payment to the recipient instead of the agency does not discharge the insurer from payment of the agency’s claim.” 33 V.S.A. §1910 (b)(2).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and are they affected by state and federal law (HIPAA)?**

At the present time, HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went into effect on April 14, 2003. The law provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

Vermont does not have any specific confidentiality/privacy requirements specific to workers’ compensation information. However, workers’ compensation Rule 3.2100 provides as follows: “the filing of a claim for workers' compensation shall be a waiver of all claims to privilege as between the parties regarding relevant medical records and reports. Therefore, upon request by the employer in the course of its investigation, the claimant shall execute a Workers' Compensation Medical Authorization (Form 7) for the release of all relevant medical records.” Employers must comply with any applicable state regarding the confidentiality and/or privacy of one medical information, i.e. (12 V.S.A. § 1612). In addition, the medical confidentiality requirements of the Americans with Disabilities Act are also essentially applicable to an employee who sustains a workers’ compensation injury. Similarly, employers must adhere to the privacy requirements of HIPAA if they submit first reports of injury electronically to either the workers’ compensation carrier or the Vermont Department of Labor.

57. **What are the provisions for “Independent Contractors”?**

The Vermont Statutes do not specifically define “independent contractors;” however, the case law imposes liability on business owners who utilize the services of independent contractors “to carry out some phase of their business.” *Frazier v. Preferred Operators Inc.*, 2004 VT 95 (2004). To determine whether an independent contractor is also deemed an employee for the purpose of workers’ compensation benefits the Court
evaluates “whether the type of work being carried out by the independent contractor is the type of work that could have been carried out by the owner's employees as part of the regular course of business.” *Edson v. State*, 2003 VT 32, ¶ 6 (2003).

The Vermont Supreme Court has addressed whether an Independent Contractor is subject to negligence actions when an employee of a hiring company is injured or whether the workers’ compensation statute protects the independent contractor by limiting the employee’s redress. Specifically the Court was presented with the issue of whether a company contracted to perform cleaning services for an electrical company was the co-employer of an employee of the electric company for the purpose of workers’ compensation benefits. *Smedburg v. Detlef’s Custodial Services, Inc.*, 2007 VT 99, at ¶ 25 (2007). In that case, the employee of the electric company slipped and fell and sued the cleaning company for negligence. *Id.* at ¶ 3. The Court found that the cleaning company was an independent contractor and not protected by the workers’ compensation laws, which would have limited Claimant’s redress to that set forth in 21 V.S.A. §601 et. seq. Ultimately, the Court denied a motion to dismiss as a matter of law and permitted an action of negligence against the cleaning company.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

No.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No.

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?
Yes. Vermont permits the use of medical marijuana, which is covered by Chapter 86 of Title 18 of the Vermont Statutes. However, 18 V.S.A. §4474c(b)(4) specifically states that the chapter shall not be construed to require that an employer [as defined in 21 V.S.A. §601(3)] provide coverage or reimbursement for the use of marijuana for symptom relief to be provided by, for purposes of workers’ compensation, an employer as defined in 21 V.S.A. §601(3). A person who uses medical marijuana is not exempt from arrest or prosecution for being under the influence of marijuana in a workplace or place of employment or smoking marijuana in any public place, including, but not limited to, a workplace. 18 V.S.A. §4474c(a)(1), (3).

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Yes, as of January 22, 2018 marijuana has been legalized to a limited degree. The law has decriminalized personal possession of no more than 1 ounce of Marijuana or 5 grams or less of hashish and two mature marijuana and four immature plants on private property [for individuals 21 or older]. This limit also applies per dwelling unit. Anything above these amounts is still a controlled substance and carries penalties of increasing severity based on the amount found in the possession of the individual. Additional restrictions of use include: no use in public places or while driving. Nothing in either the 2018 act or the current draft of the tax-and-regulate bill under consideration by the Legislature requires an employer to permit or accommodate the use, consumption, possession, transfer, display, transportation, sale or growing of marijuana in the workplace. Employers have the right to include prohibition of marijuana use in their policies and cannot be sued for discharging an employee who violates these policies.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation firm for your state, listed above.
1. Citation for the state’s workers’ compensation statute.

The Virginia Workers’ Compensation Act, Title 65.2 Code of Virginia 1950, as amended.

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

Effective January 1, 2004, an Employee is defined as “[e]very person, including aliens and minors, in the service of another under any contract of hire or apprenticeship, written or implied, whether lawfully or unlawfully employed, except one whose employment is not within the usual course of the trade, business, occupation or profession of the employer...” VA. CODE ANN. § 65.2-101.

3. Identify and describe any “statutory employer” provision.

“When any person...undertakes to perform or execute any work which is a part of his trade, business or occupation and contracts with any other person...for the execution or performance by or under such subcontractor of the whole or any part of the work undertaken [...], the [person] shall be liable to pay to any worker employed in the work any compensation under this title which he would have been liable to pay if the worker had been immediately employed by him.” VA. CODE ANN. § 65.2-302.

This section only applies in cases where there are at least “four persons in interest” – (1) an owner or other person who is having work executed for himself; (2) an independent contractor who has undertaken to execute the work for the person first mentioned; (3) a subcontractor, between whom and the independent contractor there is a contract for the execution by or under the subcontractor of the whole or some part of the work; and (4) a workman employed in the work. See Bamber v. City of Norfolk, 138 Va. 26, 121 S.E. 564 (1924).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.
An employee must prove by a preponderance of the evidence that the injury was caused by an identifiable incident, a single piece of work, or a sudden precipitating event that resulted in an obvious, sudden mechanical or structural change in the body. Injuries from repetitive trauma, continuing mental or physical stress, or other cumulative events, as well as most injuries sustained at an unknown time, do not satisfy this requirement. VA. CODE ANN. § 65.2-101.

B. Occupational disease (including respiratory and repetitive use).

An employee has a compensable occupational disease when he or she proves by a preponderance of the evidence that the disease arose out of the course of employment. A disease shall be deemed to arise out of the employment only if the following factors are present: (1) a direct causal connection between the conditions under which work is performed and the occupational disease; (2) it can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (3) it can be fairly traced to the employment as the proximate cause; (4) it is neither a disease to which an employee may have had substantial exposure outside of the employment, nor any condition of the neck, back or spinal column; (5) it is incidental to the character of the business and not independent of the relation of employer and employee; and (6) it had its origin in a risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction. VA. CODE ANN. § 65.2-400. Examples of diseases traditionally thought to be occupational diseases are: (1) asbestosis; (2) silicosis; (3) coal miner’s pneumoconiosis; and (4) mesothelioma.

For an ordinary disease of life to be compensable, the employee must prove by clear and convincing evidence, to a reasonable degree of medical certainty, that the disease: arose out of and in the course of the employment; and that one of the following exists: (1) it follows as an incident of occupational disease as defined in this title; or (2) it is an infectious or contagious disease contracted in the course of one’s employment in a hospital or sanitarium or laboratory or nursing home…or while otherwise engaged in the direct delivery of health care, or in the course of employment as emergency rescue personnel and those volunteer emergency rescue personnel referred to in VA. CODE ANN. § 65.2-101; or (3) it is characteristic of the employment and was caused by conditions peculiar to such employment. VA. CODE ANN. § 65.2-401. Examples of diseases traditionally thought to be ordinary diseases of life are: (1) hearing loss; (2) sight loss; (3) carpal tunnel syndrome; (4) tenosynovitis; and (5) ruptured heel cord.

In 1996, the Supreme Court of Virginia held that repetitive motion or cumulative trauma injuries were not compensable no matter how they are labeled or defined. The Stenrich Group v. Jemmott, 251 Va. 186, 467 S.E.2d 795 (1996). In 1997, the Virginia General Assembly responded by amending the occupational disease and ordinary disease of life statutes to expressly include hearing loss and carpal tunnel syndrome as compensable ordinary diseases of life, making them subject to the elevated burden of proof: by clear and convincing evidence. VA. CODE ANN. §§ 65.2-400(C), 65.2-401. Other conditions resulting from repetitive motion or cumulative trauma, such as tenosynovitis, trigger thumb, and even cubital tunnel syndrome, are not compensable in Virginia.
The Supreme Court of Virginia has further ruled that a floral designers’ allergic contact dermatitis, which developed from prolonged and repeated exposure to certain flowers, is compensable. *A New Leaf, Inc. v. Webb*, 257 Va. 190, 511 S.E.2d 102 (1999).

5. **What, if any, injuries or claims are excluded?**

See answers 4 and 9.

6. **What psychiatric claims or treatments are compensable?**

Psychiatric claims may be compensable (although this rarely occurs in practice) when the psychiatric or psychological injury occurred from an identifiable incident, occurring at a reasonably definite time, resulting in an injury. No physical injury is required. Absent a physiological structural change, a psychological injury will be recognized where the injury was precipitated by dramatic sudden shock or fright experienced by the employee apart from their ordinary course of business. The level of alarm or fright must rise to a level which would shock the conscience. *Teasley v. Montgomery Ward & Co., Inc.*, 14 Va. App. 45, 415 S.E.2d 596 (1992); *Hercules, Inc. v. Gunther*, 13 Va. App. 357, 412 S.E.2d 185 (1991). Psychiatric treatment can also be compensable under the Doctrine of Compensable Consequences, which provides that “where…the chain of causation from the original injury to the condition for which compensation is sought is direct, and not interrupted by an intervening cause attributable to the employee’s own intentional conduct, the subsequent condition should be compensable.” *Foods Distrub. v. Estate of Ball*, 24 Va. App. 692, 485 S.E.2d 155 (1997) (internal quotation marks omitted).

Post-traumatic stress disorder (PTSD) can, depending on the circumstances, be proven to be an injury by accident, an occupational disease or an ordinary disease of life. *Fairfax County Fire & Rescue Dep’t, et al. v. Mottram*, 263 Va. 365, 559 S.E.2d 698 (2002).

7. **What are the applicable statutes of limitations?**

There is a two year statute of limitations for the filing of claims for injury by accident from the date of the accident. VA. CODE ANN. § 65.2-601. The limitations periods for filing claims for occupational disease generally two years after a diagnosis of the disease is first communicated to the employee or within five years from the date of the last injurious exposure, whichever occurs first. There are different periods for certain specified diseases such as pneumoconiosis, byssinosis, asbestosis, and AIDS. VA. CODE ANN. § 65.2-406(A).

There are different limitation periods for claims involving death benefits. If the death results from an injury by accident, a claim for benefits must be filed within two years of the accident, and the death benefits claim must be filed within two years of the death. VA. CODE ANN. § 65.2-601. If the death results from an occupational disease within the applicable limitation period, a death benefits claim must be filed within three years of death. VA. CODE ANN. § 65.2-406(B).

A change in condition application must be filed twenty-four months from the last day for which compensation was paid pursuant to an award. VA. CODE ANN. § 65.2-708(A). If no award has been entered, this limitation does not apply. A change in condition
application based on the diseases set forth in §65.2-406 or on §65.2-503 (Permanent Loss) must be filed within thirty-six months from the last day for which compensation was paid. VA. CODE ANN. §65.2-708(A).

8. **What are the reporting and notice requirements for those alleging an injury?**

Typically, written notice is required (although in practical terms verbal notice is sufficient) within thirty days of the accident. No entitlement to medical or indemnity benefits accrues until notice is given unless reasonable excuse is made to the satisfaction of the Virginia Workers’ Compensation Commission and the employer has not been prejudiced by the delay. VA. CODE ANN. § 65.2-600(D). The notice shall state the name and address of the employee, the time and place of the accident, and the nature and cause of the accident and injury. VA. CODE ANN. §65.2-600(B). For claims involving occupational diseases, the written notice must be given within sixty days after the diagnosis is first communicated to the employee. VA. CODE ANN. § 65.2-405(A).

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

Intentionally self-inflicted injuries are not compensable. VA. CODE ANN. § 65.2-306(A).

B. **Willful misconduct, “horseplay,” etc.**

Injuries caused by the employee’s attempt to injure another, or by willful misconduct are barred. Claims are also barred for injury caused by an employee’s: (1) willful failure or refusal to use a safety appliance or perform a duty required by statute; or (2) willful breach of any reasonable rule or regulation adopted by the employer and brought, prior to the accident, to the knowledge of the employee. Id. See answer 13 regarding injuries due to “horseplay.”

C. **Injuries involving drugs and/or alcohol.**

No compensation is allowed for injury caused by the employee’s intoxication or use of a non-prescribed controlled substance. VA. CODE ANN. § 65.2-306(A).

D. **Injuries caused by the employee’s willful breach of any reasonable rule or regulation.**

No compensation is allowed when an employee’s injury is caused by his willful breach of any reasonable rule or regulation adopted by the employer and brought, prior to the accident, to the knowledge of the employee. VA. CODE ANN. § 65.2-306(A)(5).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Any person knowingly making, filing or using any writing or document known to be false, fictitious or fraudulent in connection with the entry of an award is guilty of a class 6 felony in the jurisdiction where the injury occurred. Doctors or lawyers convicted under this statute may have their licenses suspended or revoked. VA. CODE ANN. § 65.2-
312. Any payment to an employee pursuant to the Uninsured Employers’ Fund and later determined to have been procured by fraud, mistake or unreported change of condition shall be recovered from the employee and credited to the Uninsured Employers’ Fund. Payments to employees procured by fraud, misrepresentation, or failure to report any incarceration, return to employment, increase in earnings, remarriage or change in status as a full-time student, may be recovered from the employee either by way of credit against future compensation payments due or by action at law. VA. CODE ANN. § 65.2-712. Any payment to any employer/insurer from the Second Injury Fund later determined to have been procured by fraud or mistake shall be recovered from the employer/insurer and credited to the Fund. VA. CODE ANN. § 65.2-1105.

Effective January 1, 1999, insurance carriers who know or have reason to believe that an employee has procured benefits by fraud or misrepresentation, have a statutory obligation to furnish and disclose any information in his possession concerning the fraud to the Insurance Fraud Investigation Unit of the Department of State Police. Any insurer providing such information shall have immunity from any causation of action for defamation, invasion of privacy, or negligence. Virginia Fraud Reporting Immunity Act.

11. **Is there any defense for falsification of employment records regarding medical history?**

Benefits for an otherwise compensable accident will be denied if material misrepresentation as to physical condition is made by a prospective employee to the prospective employer and employment is offered on the basis of the misrepresentation to the employer’s detriment. Evidence must be clear that: (1) the misrepresentation was material; (2) it was made by the employee knowing it to be false; (3) the employer relied on the misrepresentation; and (4) that there was a causal connection between the misrepresentation and the injury.

12. **Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

Recreational activities on the premises at a time closely related to working hours and involving some concurrent benefit to the employer are incidents of employment, and injuries while engaged therein arise out of and in the course of the employment and are compensable. The activity itself must be an accepted and normal activity within the employment to be compensable. Such claims are evaluated on a case-by-case basis on their specific facts. Kum Ja Kim v. Sportswear, 10 Va. App. 460, 393 S.E.2d (1990).

13. **Are injuries by co-employees compensable?**

Injuries caused by co-employees are compensable if the assault was directed against the employee as an employee or because of the employment. Employees who are innocent bystanders and are injured as a result of horseplay, whether condoned by the employer or not, can recover. Injuries from condoned horseplay are compensable, while injuries from mutual horseplay are not. Dublin Garment Co., Inc. v. Jones, 2 Va. App. 165, 342 S.E.2d 638 (1986).

An employee who is sexually assaulted by a co-employee, employer or third-party, while in the course of their employment, may be entitled to workers’ compensation benefits.
The employee must promptly report the assault to the appropriate law enforcement agency. If the injured employee can establish that the nature of the employment substantially increased the risk of such assault, the employee shall be deemed to have sustained an injury arising out of the employment and shall have a valid claim for workers’ compensation benefits. VA. CODE ANN. § 65.2-301(A). The assault cannot be deemed to have been “personal” in nature and must have some direct relation to the nature of the employment.

14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., “irate paramour” claims)?

No. In order to be compensable, the acts of third parties must be related to the fact that the employee is an employee or because of the employment. Hopson v. Hungerford Coal Co., 187 Va. 299, 46 S.E.2d 392 (1948).

The provisions governing employee sexual assault described in Answer 13 extend to attacks perpetrated by third-parties. If the nature of the employment substantially increased the risk of sexual assault, then workers’ compensation benefits may be awarded. Merely because an assault occurs in the course of the employment does not necessarily mean that it arises out of the employment. The terms “arising out of” and “in the course of” are used conjunctively and both conditions must occur before compensation will be awarded. Dreyfus & Co. v. Meade, 142 Va. 567, 129 S.E. 336 (1925).

BENEFITS

15. What criterion is used for calculating the average weekly wage?

Use the past 52 weeks of employment wages. VA. CODE ANN. § 65.2-101(1)(a). For employees with less than 52-weeks employment with the employer, other calculations may be used so that the average is a fair replacement of wages lost as a result of the accidental injury. VA. CODE ANN. § 65.2-101(1)(b).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Temporary total disability is calculated by taking two-thirds of the average weekly wage. The maximum number of weeks of payment is 500. VA. CODE ANN. § 65.2-500. The minimum and maximum rates for the last five years are as follows:

<table>
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<th>Year</th>
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<th>Maximum</th>
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<tbody>
<tr>
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<tr>
<td>2008</td>
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<td>$955.00</td>
</tr>
<tr>
<td>2014</td>
<td>$241.75</td>
<td>$967.00</td>
</tr>
</tbody>
</table>
17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

An employer/insurer must pay temporary total disability benefits within fourteen days of the employee’s disability period once the employee’s award is established and final. An award is established when both parties execute an Agreement to Pay Benefits and submit the Agreement to the Virginia Workers’ Compensation Commission. An award shall also become established and final when, following a contested hearing, no party seeks appellate review from an Opinion authored by the Virginia Workers’ Compensation Commission. The fourteen day period in which the employer/insurer must supply benefits does not begin until the Award becomes final and a request for appellate review stays the fourteen day time period. VA. CODE ANN. §§ 65.2-524, 706. Once a final award has been established, a twenty percent penalty for payments made more than fourteen days after the award becomes final may be assessed. VA. CODE ANN. § 65.2-524.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out ___ days before recovering benefits for the first ___ days)?**

No compensation is allowed for the first seven days of incapacity because of an injury, but if the incapacity extends past that time, compensation commences with the eighth day. The employee must be out more than twenty-one days before recovering benefits for the first seven days. VA. CODE ANN. § 65.2-509.

19. **What is the standard/procedure for terminating temporary benefits?**

The standard procedure for terminating a temporary total award is execution by both parties of a Termination of Wage Loss Award detailing why the employee is no longer entitled to indemnity benefits. If the employee refuses to sign the Termination of Wage Loss Award the employer can file an Application for Hearing, and suspend payments until a Deputy Commissioner hears the case. Rule 1.4.

Compensation shall be paid through the date the Application for hearing was filed. If the application alleges the employee returned to work, then payment shall be made to the date of the employee’s return. If the application alleges a refusal of selective employment or refusal of medical attention or examination, then payment shall be made to the date of the refusal or 14 days before filing, whichever is later. Id. If the application alleges a failure to cooperate with vocational rehabilitation, then payment must be made through the date the application is filed. Id.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**
For accidents prior to 1991, the payment of permanency benefits cannot go beyond 500 weeks aggregate for temporary total, temporary partial and permanent partial benefits.

For accidents after 1991, the employee may be entitled to payment of permanent partial disability benefits after 500 weeks have been paid for temporary total and/or temporary partial if the total amount of all compensation including temporary total, temporary partial and permanent partial disability does not exceed the result obtained by multiplying the average weekly wage in effect at the time by 500. If the employee has been paid more than that amount, then he or she is not entitled to additional benefits. VA. CODE ANN §§ 65.2-503, 518.

21. **What disfigurement benefits are available and how are they calculated?**

Employees may receive permanent partial disability not exceeding sixty weeks for severely marked disfigurement of the body resulting from an injury not otherwise compensated. VA. CODE ANN. § 65.2-503(B)(16).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

**A. How many weeks are available for scheduled member/parts, and the standard for recovery?**

Loss of a member is compensated at the rate of two-thirds of the employee’s average weekly wage for the following periods:

- Thumb: 60 weeks
- Index Finger: 35 weeks
- Second Finger: 30 weeks
- Third Finger: 20 weeks
- Little Finger: 15 weeks
- Great Toe: 30 weeks
- Any other toe: 10 weeks
- Hand: 150 weeks
- Arm: 200 weeks
- Foot: 125 weeks
- Leg: 175 weeks

VA. CODE ANN. § 65.2-503(B).

For example, if an employee sustained a twenty percent loss of use of his or her arm, and the pre-injury wages resulted in a weekly compensation rate of $162.00, he or she would receive $162.00 per week for 40 weeks, *i.e.,* 20% x 200 weeks = 40 weeks.

**B. Number of weeks for “whole person” and standard for recovery.**

There is no recovery for whole person impairment in Virginia, unless the employee has qualified for permanent total disability or lifetime benefits. See answer to question 24.
23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Employers must furnish vocational rehabilitation services where reasonable and necessary. These may include vocational evaluation, counseling, job coaching, job development, job placement, on-the-job training, education and retraining, which is dependent upon the employee’s pre-injury job and wage classifications, age, aptitude and level of education, likelihood of success in a new vocation, and relative costs and benefits to be derived from such services. VA. CODE ANN. § 65.2-603(A)(3). Either the employer or employee may request vocational rehabilitation, and the Commission also has the authority to direct the employer to perform a vocational evaluation absent a request from either party. *Irwin v. Contemporary Woodcrafts, Inc.*, No. 0xxx-xx-4 (99-287).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Total and permanent incapacity is defined as the loss of “both hands, both arms, both feet, both legs, both eyes, or any two thereof in the same accident” or an injury that for all practical purposes results in total paralysis as determined by the Commission based on the medical evidence, or an injury to the brain which is so severe as to render the employee permanently unemployable in gainful employment. VA. CODE ANN. § 65.2-503(C). Benefits are paid at the rate of two-thirds of the employee’s average weekly wage and are subject to the maximum and minimum rates. VA. CODE ANN. § 65.2-503(E).

25. **How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

The employer shall pay funeral expenses up to $10,000.00 and reasonable transportation expenses of the deceased up to $1,000.00. VA. CODE ANN. § 65.2-512(B).

**B. Dependency claims.**

If death results from the compensable accident within nine years, the employer pays compensation in weekly payments equal to two-thirds of the employee’s average weekly wage, but not more than 100 percent nor less than twenty-five percent of the average weekly wage of the Commonwealth as defined in VA. CODE ANN. § 65.2-500. Payments are to be made: (1) to persons wholly dependent upon the deceased for 500 weeks from date of injury; (2) if there are no total dependents, to those presumed to be wholly dependent for a period of 400 weeks; or (3) if there are no total dependents, to partial dependents in fact for 400 weeks. VA. CODE ANN. § 65.2-512(A).

26. **What are the criteria for establishing a “second injury” fund recovery?**

The Commission enters awards against the Second Injury Fund in favor of an employer/insurer only upon finding that: (1) the employee has a prior loss or loss of use, supported by medical evidence, of not less than twenty percent or more of the arm, hand, leg, foot, eye, finger, toe or any combination of two or more thereof; (2) the employee
has suffered in an industrial accident an additional loss or loss of use of any of the members set forth above of not less than twenty percent; (3) the condition of both impairments rendered the employee totally or partially disabled; (4) the employer/insurer has paid temporary total/temporary partial disability compensation, permanent partial disability and medical treatment; and (5) the employee is entitled to further compensation for disability which has been paid by the employer/insurer. VA. CODE ANN. § 65.2-1103.

For purposes of § 65.2-1103, disability shall mean: (i) the partial or total loss or loss of use of an arm, hand, leg, foot, eye, finger, toe, or any combination of two or more thereof in an industrial accident and (ii) actual incapacity for work at the claimant’s average weekly wage. VA. CODE ANN. § 65.2-1102.

An employee has thirty-six months from receipt of the last payment of compensation to file a Change in Condition application seeking permanent partial disability benefits. VA. CODE ANN. § 65.2-708.

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

An employee has the greater of twenty-four months from the last day in which indemnity benefits were paid or thirty-six months from the day in which benefits were paid pursuant to a permanent partial disability to seek re-opening of a claim for worsening condition. After the lapse of the applicable twenty-four or thirty-six month time period, indemnity benefits shall be barred while lifetime medical benefits will continue. VA. CODE ANN. § 65.2-708.

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

An employer/insurer who unreasonably defends a claim may be subject to an assessment for attorney’s fees by the Commission. VA. CODE ANN. § 65.2-713(A).

EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

The employee’s rights under the Act preclude all other rights or remedies of such employee, his or her heirs and assigns, on account of the injury and/or death. VA. CODE ANN. § 65.2-307(A).

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

The Act is the exclusive remedy for occupational diseases even in the case of intentional torts. However, in a situation involving an accident, where the employer’s actions were committed with the intent to injure, there can be no accident and thus an employee’s
action for intentional infliction of emotional distress was not barred by the exclusivity provisions of the Act.

An executive officer may reject coverage for injury or death by accident, but not with respect to occupational diseases. If such rejection is elected, the executive officer may proceed at common law against the employer to recover damages for personal injury or death. VA. CODE ANN. § 65.2-300.

30. **Are there any penalties against the employer for unsafe working conditions?**

Not under the Workers’ Compensation Act, but OSHA may penalize an employer.

31. **What is the penalty, if any, for an injured minor?**

None.

32. **What is the potential exposure for “bad faith” claims handling?**

None aside from the remedies addressed in question 28 and VA. CODE ANN. § 65.2-713.

33. **What is the exposure for terminating an employee who has been injured?**

The discharge of an employee for exercising his or her rights under the Act is prohibited. VA. CODE ANN. § 65.2-308(A). Fraudulent claims by employees do not apply. The employee’s remedy is a suit in a circuit court having jurisdiction over the employer. Damages may include monetary awards, attorney’s fees, reinstatement and back pay plus interest. VA. CODE ANN. § 65.2-308(B).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes.

35. **Can co-employees be sued for work-related injuries?**

The exclusivity provisions of the Act prohibit suits against co-employees for work-related injuries, even in cases where an employee suffers a work-related injury due to the intentional tortious conduct of a fellow employee.

36. **Is subrogation available?**

Yes. An employer/insurer has the right to recover damages from a legally liable third party. VA. CODE ANN. § 65.2-309. The employer/insurer also has subrogation rights to recover uninsured and underinsured motorist benefits pursuant to insurance coverage carried by and at the expense of the employer. VA. CODE ANN. § 65.2-309.1.

**MEDICALS**
37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

Generally, itemized medical bills are to be paid within sixty days of receipt by the employer/carrier unless they are contested, denied, or incomplete. VA. CODE ANN. § 65.2-605.1. Denials, disputes, or requests for more complete information must be made within forty-five days of receipt of the bill. VA. CODE ANN. § 65.2-605.1. A failure to pay within the required time, requiring the employee to secure counsel to remedy the matter, may result in an assessment of attorney’s fees against the employer/insurer. VA. CODE ANN. § 65.2-714.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?

Any physician attending to an employee must, upon request of the employee, employer or insurer, furnish a copy of any medical report. VA. CODE ANN. § 65.2-604. No fact communicated through, or otherwise learned by, any physician or surgeon who attended or examined an employee or was present during an examination of an employee is privileged either in workers’ compensation hearings or in actions of law brought against the employer by the employee to recover damages. VA. CODE ANN. § 65.2-607.

39. What is the rule on choice (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Examination?

An employer/insurer is required to provide an employee with a panel of three physicians from which to choose a physician for treatment of the injury. The treatment is required to be paid and furnished by the employer/insurer for as long as it is medically necessary. VA. CODE ANN. § 65.2-603(A)(1). The employer’s failure to offer a panel of physicians or the employer’s denial of a claim allows the employee to select a physician of his or her own choosing.

The employer/insurer can require the injured employee to submit to one independent medical examination performed by a duly qualified physician. Additional independent medical examinations will not be allowed without authorization from the Virginia Workers’ Compensation Commission. VA. CODE ANN. § 65.2-607(A).

40. What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?

All medical care that is reasonable and necessary as a result of the injury is covered, including chiropractic care and physical therapy. VA. CODE ANN. § 65.2-603.

41. Which prosthetic devices are covered, and for how long?

An employer/insurer is required to provide and repair any prosthesis necessary as a result of an industrial accident, including special orthopedic shoes. This duty includes the proper fitting and training in the use of such devices and appliances. This applies to situations where the accident results in loss of an arm, hand, foot, leg or eye or loss of natural teeth or loss of hearing. VA. CODE ANN. § 65.2-603(A).
42. Are vehicle and/or home modifications covered as medical expenses?

Yes, provided that the aggregate cost of all such items and modifications required to be furnished on account of any one accident shall not exceed $42,000.00. VA. CODE ANN. § 65.2-603(A).

43. Is there a medical fee guide, schedule or other provision for cost containment?

Yes.

44. What, if any, provisions or requirements are there for “managed care”?

In addition to the requirement of providing a three physician panel to the employee, an employer/insurer is required to furnish any other necessary medical attention. VA. CODE ANN. § 65.2-603. For example, nursing care at home is owed, provided that the care is deemed to be both “medical attention” and “necessary.”

When an employer provides the employee with a three physician panel and also assumes all or part of the cost of providing health care coverage for that employee, either as a self-insured or under a group health insurance policy, the employer must inform the employee whether each physician named is eligible to receive payment under the employee’s health care coverage provided by the employer. VA. CODE ANN. § 65.2-603(E).

PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

Once an employee has filed his claim for benefits with the Commission, the Commission will send “20-Day Orders” to the employer/insurer, requesting them to advise, within 20 days, whether they will accept or deny the claim and the reasons for denial. If the claim is contested, it will be referred to a docket and scheduled for an evidentiary hearing before a Deputy Commissioner.

46. What is the method of claim adjudication?

A. Administrative level.

The Virginia Workers’ Compensation Commission has exclusive jurisdiction over workers’ compensation issues. All proceedings are administrative level proceedings.

B. Trial court.

There are no jury trials in Virginia on compensation issues.

C. Appellate.

Appeals are as a matter of right to the Full Commission (a three panel body) from Deputy Commissioner opinions (hearing level) and as a matter of right to the Virginia Court of
Appeals from the Full Commission. Appeals to the Supreme Court of Virginia from the Court of Appeals are by writ and are rarely granted unless an issue of precedential importance is raised. VA. CODE ANN. § 65.2-706.

47. **What are the requirements for stipulations or settlements?**

Parties may agree to lump sum settlements to fully and finally resolve disputes between them. VA. CODE ANN. § 65.2-701. Settlements are not binding unless and until they are approved by the Virginia Workers’ Compensation Commission. The parties may stipulate to compensability of a claim as well as periods of disability by signing and filing an Agreement to Pay Benefits or Supplemental Agreement to Pay Benefits. The parties may also stipulate to a change in the type or length of disability by signing and filing a Termination of Wage Loss Award.

48. **Are full and final settlements with closed medicals available?**

Yes.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

A settlement and/or memorandum of agreement must be filed with the Commission for approval. If approved, the agreement is binding, and an award of compensation entered on such an agreement is enforceable. An agreement will be approved only when the Commission is clearly of the opinion that the best interests of the employee or his or her dependents will be served by its entry. VA. CODE ANN. § 65.2-701.

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?**

Every employer with three or more employees is required to: (1) secure coverage with an insurer licensed to transact business in the Commonwealth; (2) receive a certificate from the Commission authorizing the employer to be an individual self-insured; or (3) be a member in good standing of a group self-insurance association licensed by the State Corporation Commission. An assigned risk pool is available for employers unable to secure coverage. An application to the State Corporation Commission is required to become a part of the assigned risk pool. VA. CODE ANN. § 65.2-800 et seq.

51. **What are the provisions/requirements for self-insurance?**

A. **For individual entities.**

To be an individual self-insured, an employer must prove solvency and financial ability to meet its obligations. The Commission shall establish reasonable requirements and standards for approval of an employer as a self-insured. VA. CODE ANN. § 65.2-801(B).

B. **For groups or “pools” or private entities.**
The State Corporation Commission has the same requirements for securing licensure by a group self-insurance association as apply to those seeking to qualify as individual self-insurers. VA. CODE ANN. § 65.2-802.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

Effective January 1, 2000, the Virginia General Assembly amended the term Employee as found in the Virginia Workers’ Compensation Act to embrace “every person, including aliens...whether lawfully or unlawfully employed.” VA. CODE ANN. § 65.2-101.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

Injuries sustained by an employee that result from terrorist attacks may be compensable under the Workers’ Compensation Act, if the acts were targeted at the employer or employee because of their employment or if the employment placed the employee at a higher risk of attack.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

There are no Virginia state specific rules on this issue. With respect to federal law, however, when settling a matter, if the claimant is currently entitled to Medicare or the settlement is over $250,000.00 and there is a reasonable expectation of Medicare entitlement within thirty months, then the parties must appropriately address the Medicare Secondary Payer Act, normally by a Medicare set-aside trust in an amount approved by the Centers for Medicare and Medicaid Services (CMS). If a Medicare set-aside trust is appropriate, documentation of approval by CMS may be required. CMS does not require a review of WCMSA proposals for Medicare beneficiaries where the total settlement amount is less than $25,000.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires states to include in their plan for medical assistance provisions (1) that the individual will assign to the state any rights to payment for medical care from any third party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The state is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).
The Virginia Workers’ Compensation Commission does not have jurisdiction over subrogation claims brought by Medicaid or other health insurers. However, liens or potential liens should always be taken into consideration when settling a workers’ compensation claim.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160-164 and 65 F.R. 82462, provides an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512(l). Therefore, your current practice of obtaining medical records could proceed under state law.

Any physician attending to an employee must, upon request of the employee, employer or insurer, furnish a copy of any medical report. VA. CODE ANN. § 65.2-604(A). No fact communicated through, or otherwise learned by, any physician or surgeon who attended or examined an employee or was present during an examination of an employee is privileged either in workers’ compensation hearings or in actions of law brought against the employer by the employee to recover damages. VA. CODE ANN. § 65.2-607(A). An employee may request a protective order from the Commission to seal medical records unrelated to the workers’ compensation claim.

57. **What are the provisions for “Independent Contractors”?**

Independent contractors are not considered employees under the Virginia Worker’s Compensation Act. However, an independent contractor of any employer may fall under the inclusion of the Act at the election of such employer provided (1) the independent contractor agrees to such inclusion and (2) unless the employer is self-insured, the employer’s insurer agrees in writing to such inclusion. All or part of the cost of the insurance coverage of the independent contractor may be borne by the independent contractor. VA. CODE ANN. § 65.2-101.

If an independent contractor undertakes to perform or execute any work which is part of his trade, business, or occupation and contracts with any other person for the execution or performance by or under such subcontractor of the whole or any part of the work undertaken by such owner, the owner shall be liable to pay to any worker employed in the work any compensation under this title which he would have been liable to pay if the worker had been immediately employed by him. The purpose of this provision is to expand the definition of employer in order to bring independent contractors and subcontractors who are engaged in work that is part of the trade, business, or occupation of the owner within the scope of the Act. Thus, the employees of independent contractors and subcontractors may fall within the scope of the Act and become statutory employees of the owner if the work being done is part of the owner’s general business. VA. CODE ANN. § 65.2-302.
A worker may recover compensation from a subcontractor or the principal contractor, but the worker may not collect from both. VA. CODE ANN. § 65.2-303. When sued by a worker of a subcontractor, a principal contractor shall have the right to join that subcontractor or any intermediate contractor as a party. VA. CODE ANN. § 65.2-304.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

No.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

No. However, a fairly recent Virginia Circuit Court case held that, because a grocery delivery truck driver was still in the process of completing a delivery at the time of his alleged injury and therefore still engaged in the trade, business, or occupation of the grocery store at the time of his accident, the exclusive remedy was under the Virginia Workers’ Compensation Act. Walls v. Food Lion, L.L.C., 66 Va. Cir. 26 (2004).

60. What are the “Best Practices” for defending workers’ compensation claims and controlling workers’ compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No, although the Virginia Workers’ Compensation Commission insists on an approved MSA for settlement of a claim that meets the CMS threshold for a required MSA.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Medical marijuana is only permitted to treat “intractable epilepsy” in Virginia, and its use for that treatment is tightly restricted. It is theoretically possible to be used for treatment in workers’ compensation in Virginia, but it would have to be under the tight restrictions established for treatment of “intractable epilepsy.”
63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Virginia does not permit the recreational use of marijuana. Intoxication by marijuana (usually referred to as “cannabis” in Virginia law) during an accident could qualify as willful misconduct. Please see answer to question 9B for more information on defending against willful misconduct, including intoxication by marijuana.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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1. **Citation for the state’s workers’ compensation statute.**

The Industrial Insurance Act of Washington (the “Act”) is in Title 51 of the Revised Code of Washington, from RCW 51.04.010 to 51.98.070. The Board of Industrial Insurance Appeals is governed by Washington Administrative Code 263-12.

**SCOPE OF COMPENSABILITY**

2. **Who are covered “employees” for purposes of workers’ compensation?**

The Act covers “workers” who are defined as 1) employees, and 2) independent contractors, the essence of whose contract is his or her personal labor. RCW 51.08.180; 51.08.185. Under RCW 51.08.185, "employee" has the same meaning as "worker" when the context would so indicate, and shall include all officers of the state, state agencies, counties, municipal corporations, or other public corporations, or political subdivisions. Case law has expansively interpreted that portion of RCW 51.08.180 extending coverage to independent contractors, the essence of whose contract is for personal labor. See, answers 57 through 59.

The Act specifically excludes particular workers and occupations. RCW 51.08.180; 51.12.020. Excluded workers include certain workers for businesses registered under chapter 18.27 RCW (Registration of Contractors) or licensed under chapter 19.28 RCW (Electricians and Electrical Installations). RCW 51.08.180; See, answers 57 through 59. Other excluded workers include domestic servants, home gardening and maintenance workers, employees not in the course of the trade, business, or profession of the employer, services performed in return for aid or sustenance, sole proprietors or partners, work of minor children employed by parents for agricultural activities on the family farm, jockeys, certain officers of a corporation, entertainers for specific performances, home newspaper delivery, services performed by an insurance producer, services performed by a booth renter, certain activities and situations for members of a limited liability company, a driver providing commercial transportation services, and for hire vehicle operators (e.g., chauffeurs). RCW 51.12.020(1)-(15).
In addition, an individual is not a “worker” if:

“(1) The individual has been and will continue to be free from control or direction over the performance of the service, both under the contract of service and in fact; and

(2) The service is either outside the usual course of business for which the service is performed, or the service is performed outside all of the places of business of the enterprise for which the service is performed, or the individual is responsible, both under the contract and in fact, for the costs of the principal place of business from which the service is performed; and

(3) The individual is customarily engaged in an independently established trade, occupation, profession, or business, of the same nature as that involved in the contract of service, or the individual has a principal place of business for the business the individual is conducting that is eligible for a business deduction for federal income tax purposes; and

(4) On the effective date of the contract of service, the individual is responsible for filing at the next applicable filing period, both under the contract of service and in fact, a schedule of expenses with the internal revenue service for the type of business the individual is conducting; and

(5) On the effective date of the contract of service, or within a reasonable period after the effective date of the contract, the individual has established an account with the Department of Revenue, and other state agencies as required by the particular case, for the business the individual is conducting for the payment of all state taxes normally paid by employers and businesses and has registered for and received a unified business identifier number from the state of Washington; and

(6) On the effective date of the contract of service, the individual is maintaining a separate set of books or records that reflect all items of income and expenses of the business which the individual is conducting.” RCW 51.08.195.

A son who was injured while being paid by the Department of Social and Health Services (“DSHS”) to provide in-home care for his disabled mother, was denied benefits under the Act because (1) he was not an employee of DSHS, and (2) he was nonetheless excluded from the Act because he was a domestic servant. Bennerstrom v. Dep’t of Labor & Industries, 120 Wn. App. 853, 86 P.3d 826 (2004).

A volunteer firefighter was not an "employee" or "worker" subject to the exclusive remedies provisions of the Act, where the town neither paid for nor compelled the volunteer's services and those services were freely given. Doty v. Town of South Prairie, 155 Wn.2d 527, 120 P.3d 941 (2005).
3. **Identify and describe any “statutory employer” provision.**

For purposes of the Act, “employer” is defined as “any person, body of persons, corporate or otherwise, and the legal representatives of a deceased employer, all while engaged in this state in any work covered by the provisions of this title, by way of trade or business, or who contracts with one or more workers, the essence of which is the personal labor of such worker or workers.” RCW 51.08.070.

“[A]s an exception to the definition of employer, persons or entities are not employers when they contract or agree to remunerate the services performed by an individual who meets the tests set forth in subsections (1) through (6) of RCW 51.08.195 or the separate tests set forth in section 5 of this act for work performed that requires registration under chapter 18.27 RCW or licensing under chapter 19.28 RCW.” Id.

4. **What types of injuries are covered and what is the standard of proof for each:**
   
   **A. Traumatic or “single occurrence” claims.**

   An industrial injury is defined as “a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.” RCW 51.08.100. The injury is compensable if it occurs in the course of employment. RCW 51.32.010. By judicial interpretation, compensation is payable for the aggravation or “lighting up” of pre-existing conditions and musculoskeletal injuries resulting from ordinary bodily movement. See, *Ruse v. Department of Labor & Industries*, 138 Wn.2d 1, 977 P.2d 570 (1999).

   The burden is on the employee to show that an injury occurred within the course of employment, and the statute is liberally construed in favor of the employee. See, *Clausen v. Department of Labor & Industries*, 15 Wn.2d 62, 129 P.2d 777 (1942).

   **B. Occupational disease (including respiratory and repetitive use).**

   “Occupational disease” is defined as “such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.” RCW 51.08.140. Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an “occupational disease” under this Act. RCW 51.08.142.

   The employee must prove by a preponderance of the evidence that the disease or disease-based disability came about as a matter of course as a natural consequence or incident of distinctive conditions of his or her particular employment, rather conditions coincidentally occurring in his or her workplace. *Dennis v. Department of Labor & Industries*, 109 Wn.2d 467, 745 P.2d 1295 (1987). A “disease-based disability” is the aggravation or “lighting up” of a pre-existing occupational or non-occupational disease and includes repetitive use.
In a claim for hearing loss, the Washington Supreme Court held that an employer could not use a median-based allocation method to reduce a worker’s hearing loss permanent partial disability award to compensate for age-related hearing loss. That would be contrary to the nature of workers’ compensation, which focuses on specific and individual employment-related injuries and diseases of claimants. Boeing Co. v. Heidy, 147 Wn.2d 78, 51 P.3d 793 (2002). For purposes of determining the appropriate rate of compensation, the court has held that occupational hearing loss is “partially disabling” as of the date a worker is last exposed to hazardous occupational noise. Harry v. Buse Timber & Sales, Inc., 166 Wn.2d 1, 201 P.3d 1011 (2009).

5. **What, if any, injuries or claims are excluded?**

Pursuant to statutory mandate, the Department of Labor and Industries (“Department”) has adopted a regulation which establishes that claims based on mental conditions or disabilities caused by stress do not fall within the definition of an occupational disease. RCW 51.08.142. Under WAC 296-14-300, examples of stressful conditions include conflicts with a supervisor, actual or perceived threat of termination, demotion, or disciplinary action, workload pressures, relationships with supervisors, co-employees or the public, fear of exposure to chemicals, radiation or other perceived hazards, personnel decisions, actual, perceived or anticipated financial reversals or difficulties occurring to the business of the self-employed individuals or corporate officers. See, RCW 51.08.142. Stress claims resulting from a single traumatic event are adjudicated with reference to RCW 51.08.100. WAC 296-14-300.

The Act excludes parking areas and disassociates them from the legislative definition of a jobsite for purposes of workers’ compensation. Puget Sound Energy, Inc. v. Adamo, 113 Wn. App. 166, 52 P.3d 560 (2002). However, this exclusion is not an absolute bar to compensation under the Act; the appropriate test is whether the worker’s injury occurred while acting in the course of employment. Id. If it did, then it does not matter whether the accident occurred in the parking lot or elsewhere. Id. Because the employer in Adamo required the worker to drive the company vehicle home, the worker’s accident was covered even though he was no longer working and was headed home for the day. Id. The parking lot exclusion is narrowly construed. In University of Washington, Harborview Medical Center v. Marengo, 122 Wn. App. 798, 95 P.3d 787 (2004), the exclusion did not preclude coverage for an employee who was injured when he slipped and fell in the stairwell of his employer’s parking garage on his way to work. The court held that the stairwell did not fall within the exclusion, because it was a means of getting to and leaving the parking area rather than a place where vehicles parked. The Court stated that such a narrow construction of this exception was consistent with the legislative intention to broadly construe the Act in favor of coverage.

The "dual purpose" exception to the "going and coming" rule under the Act may apply when an employee is injured in transit to or from a location off the employer's premises, when the employee's presence at that location served both a business and personal purpose and particularly where the making of the journey or the special urgency in which it is made is in itself a substantial part of the service for which the worker is employed.
Cochran Elec. Co. v. Mahoney, 129 Wn. App. 687, 121 P.3d 747 (2005). In Cochran, the exception applied to allow benefits to the survivor of an employee who was fatally injured on his bicycle while returning home after dropping off his employer-provided van for service, even though the injury occurred on the employee’s day off.

6. **What psychiatric claims or treatments are compensable?**

Mental conditions or disabilities caused by stress are excluded from the definition of “occupational disease.” See, answers to 4B and 5. Thus, “mental-mental” claims are not compensable. However, psychiatric conditions proximately caused by an otherwise compensable disease or injury are compensable (“physical-mental” cases). Mental health conditions that are the result of exposure to toxic chemicals and radiation can lead to an allowable claim if they are caused by exposure at work; in determining the existence of such conditions diagnosis by a psychologist can be considered. In re Dianna R. Gegg, BIIA Dckt. No. 08 16647 (April 16, 2010).

7. **What are the applicable statutes of limitations?**

Claims for injuries must be filed within one year after the date upon which the injury occurred or the rights of the dependents or beneficiaries accrued. RCW 51.28.050. Thus, injury claims must be filed within one year after the date of the occurrence, not the date of discovery of disability. Rector v. Department of Labor & Industries, 61 Wn. App. 385, 810 P.2d 1363 rev. denied, 117 Wn.2d 1004, 815 P.2d 266 (1991). Claims for occupational disease or infection must be filed within two years following the date the employee had written notice from a physician of the existence of the disease and that a claim for benefits may be filed. RCW 51.28.055.

8. **What are the reporting and notice requirements for those alleging an injury?**

The Act requires the employee or someone on the employee’s behalf to immediately report an industrial accident to the employer, superintendent or foreman in charge of the work. RCW 51.28.010. The employer must immediately report such an accident and the resulting injury to the Department if the employee received treatment, has been disabled or hospitalized, or has died as the apparent result of the accident or injury. Id. The Department has specific forms for reporting injuries or diseases, which satisfy the statutory requirements for content. See RCW 51.28.025.

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

If injury or death results from the deliberate intention of the employee to produce such injury or death, or while the employee is engaged in an attempt to commit or during the commission of a felony, neither the employee nor any dependent shall receive any payment under the Act. RCW 51.32.020.
B. Willful misconduct, “horseplay,” etc.

Workers’ compensation applies even where the injury or death occurs because of the employee’s horseplay. *Tilly v. Department of Labor & Industries*, 52 Wn.2d 148, 324 P.2d 432 (1958). In Tilly, the Washington Supreme Court held that a deceased employee was injured within the course of employment even though he died of a cerebral aneurysm shortly after horseplay with a co-employee near a drinking fountain adjacent to the men’s lavatory. However, the above general rule is limited. In evaluating whether or not an employee's "horseplay" while at work takes the employee out of the "course of employment," the Board of Industrial Insurance Appeals has applied the following test:

Whether the employee, by engaging in the horseplay or occasional foolery, unreasonably deviated from acting in furtherance of the employer's business to such an extent that the deviation could be said to constitute an abandonment (however temporary) of the employee's employment.


C. Injuries involving drugs and/or alcohol.

Coverage for these injuries depends on the circumstances. In *Flavorland Industries, Inc. v. Schumacker*, 32 Wn. App. 428, 647 P.2d 1062 (1982), the court held that the widow of an employee killed in an automobile accident was entitled to death benefits under the Act even though the decedent’s fatal accident occurred after working hours, off the employer’s premises, and after the employee had been drinking at a bar. The evidence indicated that the employee was driving a company car at the time, was reimbursed by his employer for entertainment expenses, and was required to socialize with clients and prospective clients as a part of his employment. The employee was socializing with clients and prospective clients at the bar before leaving for home. Thus, the employee was furthering the interests of his employer at the time he was drinking at the bar. *But see* *Superior Asphalt & Concrete Co. v. Department*, 19 Wn. App. 800, 578 P.2d 59 (1978), where the same court held that an intoxicated worker who was on his way home from a construction site was not in the course of his employment and, hence, benefits were properly denied because consumption of alcohol was not part of his job. In *In re Wesley H. Nicholas*, BIIA Dckt. No. 1015503 (October 11, 2011), the Board allowed benefits finding that a worker with trace amounts of marijuana and unprescribed methadone in his system was not so intoxicated that he could not perform his duties, and had not abandoned his employment.

10. What, if any, penalties or remedies are available in claims involving fraud?

At the administrative level, the Department can demand a refund of all benefits paid, plus a penalty of 50% of the total benefits paid whenever any payment of benefits under the Act has been induced by willful misrepresentation. RCW 51.32.240(5).

11. Is there any defense for falsification of employment records regarding medical
history?

It is a criminal felony or gross misdemeanor for theft under Washington’s criminal code (Title 9A RCW) for a claimant to knowingly provide false information required in a claim or application for workers’ compensation. RCW 51.48.020; See also, State v. Bodey, 44 Wn. App. 698, 723 P.2d 1148 (1986).

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

The Washington Workers’ Compensation Act provides benefits to “each worker receiving an injury,…during the course of his or her employment…." RCW 51.32.015. “Acting in the course of employment” means the worker acting at his or her employer’s direction or in the furtherance of his or her employer’s business. It is not necessary that at the time an injury is sustained by a worker he or she is doing the work on which his or her compensation is based. RCW 51.08.013(1). By statute, an employee is not acting in the course of his or her employment while participating in social activities, recreational or athletic activities, events or competitions, or parties or picnics, whether or not the employer pays some or all of the costs thereof, unless: (1) the participation is during the employee’s working hours, not including paid leave; (2) the employee was paid monetary compensation by the employer to participate; or (3) the employee was ordered or directed by the employer to participate or reasonably believed that he or she was ordered or directed to participate. RCW 51.08.013(2)(b).

Under the "traveling employee rule," when employees are required by their employers to travel to distant job sites, they are within the course of their employment throughout the trip for purposes of collecting benefits under the Act, unless they are pursuing a distinctly personal activity. RCW 51.08.013; Ball-Foster Glass Container Co. v. Giovanelli, 128 Wn. App. 846, 117 P.3d 365 (2005). "The rationale for this extended coverage is that when travel is an essential part of employment, the risks associated with the necessity of eating, sleeping, … are an incident of the employment even though the employee is not actually working at the time of the injury." Ball-Foster, 163 Wn.2d at 142, citing Buczynski v. Industrial Comm’n, 934 P.2d 1169, 1174-74 (Utah Ct. App. 1997). It follows then that the court's focus when evaluating the compensability of injuries occurring off duty during travel should be on whether the injury is fairly attributable to the increased risks of travel. Washington court's adopted this test stating "the injury must have its origin in a travel-related risk." Ball-Foster at 144. In Ball-Foster, an employee on paid business travel was eligible for benefits under the Act when he was injured while walking from his hotel to a musical performance because it was found that the employee was traveling at the direction of his employer and his travel was for a purpose benefitting the employer. An employee that is required to travel away from his permanent residence is considered a traveling employee even if he is required to stay at a fixed location for an extended period of time.

13. Are injuries by co-employees compensable?
Yes, this is true regardless of the co-employee’s negligence. RCW 51.24.030. Co-
employees are immune from lawsuits unless the injury was intentional, such as an

14. Are acts by third parties unrelated to work but committed on the premises,
compensable (e.g., “irate paramour” claims)?

Yes. Compensable injuries need not arise out of the employment; they need only occur
in the course of employment. RCW 51.24.030. The Act permits the injured worker or
beneficiary to elect to sue third parties (not co-workers) whose negligence caused the

BENEFITS

15. What criterion is used for calculating the average weekly wage?

Calculations are based on the wages the employee was receiving from all employment at
the time of the injury. RCW 51.08.178. Consideration is given to the seasonal, part-time
or intermittent nature of employment, as well as the employee’s pattern of employment.

Also, if an employer was supplying health care coverage (through health insurance or
otherwise) before the worker’s injury, but no longer supplies it after the worker’s injury,
the worker must replace it out of time-loss compensation, and it should be included in the
basis from which time-loss compensation is computed. Therefore, if the employer
discontinues payment of health insurance premiums for the injured worker during the
time period the employee is off work due to an industrial injury, the reasonable value of
health insurance must be included within “wages” when computing time-loss
compensation. Cockle v. Department of Labor & Industries, 142 Wn.2d 801, 16 P.3d
583 (2001).

16. How is the rate for temporary/lost time benefits calculated including minimum and
maximum rates?

The employee’s gross monthly wage multiplied by the entitlement percentage equals the
monthly time loss. RCW 51.32.090; 51.32.060. The payment is, based upon marital and
dependency status and the payments range from 60% to 75% of the worker’s monthly
wage. The maximum is 120% of the average state wage for injuries on and after June 30,
1996. Id. Benefits continue indefinitely, as long as the employee’s condition is not fixed
and stable. Id.

17. How long does the employer/insurer have to begin temporary benefits from the date
of disability?

Time loss compensation must commence within fourteen (14) days of the Department’s
receipt of the claim. RCW 51.32.210.
18. What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out ____ days before recovering benefits for the first _____ days)?

The employee must be unable to work for fourteen (14) days before recovering benefits for the first three (3) days. RCW 51.32.090(7). Time loss benefits are never provided for the date of injury. Id.

19. What is the standard/procedure for terminating temporary benefits?

Benefits may be terminated when: (1) an employee returns to work; (2) the attending physician releases the employee to return to work; or (3) the employee’s medical condition is fixed and stable. RCW 51.32.090.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

No.

21. What disfigurement benefits are available and how are they calculated?

There is no provision for disfigurement benefits. Such injuries would be considered in calculating permanent partial disability.

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

Unlike many states, permanent partial disability awards are not payable in terms of weeks of disability payments. Schedule awards for actual amputations are set by statute in fixed dollar amounts and adjusted each July by reference to the consumer price index. RCW 51.32.080. Unspecified permanent partial disability awards are based on the extent of total bodily impairment. Id. Most unspecified awards are the subject of “categories” of impairment administratively adopted by rule. Id. The categories carry varying percentages of the maximum allowable for unspecified disabilities. Id. The maximum allowed for unspecified disabilities is adjusted each July 1 by reference to the consumer price index. Id. The standard for recovery is decided by medical opinion based on objective medical findings after a worker’s condition becomes fixed and stable. RCW 51.32.055.

B. Number of weeks for “whole person” and standard for recovery.

See, answer to 22A.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the
standard for recovery?

Vocational services are discretionary with the supervisor or supervisor’s designee of the Department of Labor and Industries. RCW 51.32.095. When the Department has approved a vocational plan before December 31, 2007, benefits may include the cost of books, tuition, fees, supplies, equipment, transportation, child or dependent care, and other necessary expenses. Id. The amount of benefits may not exceed $4,000 ($3,000 in all other cases) in any fifty-two (52) week period and, in the discretion of the supervisor, may be extended for an additional fifty-two (52) week period. Id.

For vocational plans approved for a worker between January 1, 2008 through July 31, 2015, total vocational costs allowed by the supervisor or supervisor's designee are limited to those provided under the pilot program established in RCW 51.32.099.

Furthermore, In 2011 Washington created a Stay-At-Work Program codified at RCW 51.32.090. With limitations detailed in the statute, employers who provide employees receiving temporary total disability with light duty or transitional work allowed by the worker's physician are eligible to receive wage subsidies and other incentives from the Department. For sixty six (66) days the employer can receive a wage subsidy of fifty percent (50%) of the employee’s basic, gross wage paid for light duty or transitional work. Additional incentives include up to one thousand dollars ($1,000.00) in reimbursement for training, up to four hundred dollars ($400.00) for necessary clothing and up to two thousand five hundred dollars ($2,500.00) for tools or equipment.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Benefits are calculated in the same manner as time loss benefits. See, answer to 16.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Burial expenses are paid where death results from the injury. The maximum payment is 200% of the average monthly wage in the state. RCW 51.32.050.

B. **Dependency claims.**

The amount payable for dependents is based upon whether there is a surviving spouse, children or other dependents. See, RCW 51.32.050. The amounts vary from 60 to 70% of the worker’s wages. Id. The maximum benefit is 120% of the average wage in Washington as determined each July 1. Id. If there are surviving children but no eligible spouse, a monthly benefit of 35% of the employee’s wages are paid to the guardian of the minor dependent. Id. An additional 15% of the wage is paid for each additional child, up to a maximum benefit of 65% of the wage. Id. If there is more than one child, benefits are divided equally among them. Id. Other qualified dependents are eligible for benefits.
Id. The benefit limit is 65% of the employee’s wage, or 120% of the average wage in the state, whichever is less. Id.

26. What are the criteria for establishing a “second injury” fund recovery?

The Second Injury Fund applies to permanent total disability which results from the combined effects of pre-existing disabling conditions and the industrial injury/occupational disease. RCW 51.44.040. The employer bears the burden of establishing that the employee had a "previous bodily disability" which objectively impaired the ability to perform his or her work duties at the time of hiring or materially diminished the employee's ability to perform the activities of daily living. Crown, Cork & Seal v. Smith, 171 Wn.2d 866, 259 P.3d 151 (2011).

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

An employee can apply for reopening of the claim for additional compensation within seven years (ten years for eye injuries) from the date the first closing order based on medical advice, recommendation or examination becomes final. RCW 51.32.160. In every case the employee must show, by a comparison of objective medical findings, that his or her causally-related condition worsened between the time of last closure and date the application is acted upon. Loushin v. ITT Rayonier, 84 Wn. App. 113, 924 P.2d 953 (1996). The Director, on his or her own motion and in his or her discretion, may reopen a claim for all benefits at any time. RCW 51.32.160.

In Energy Northwest v. Hartje, 148 Wn. App. 454, 199 P.3d 1043 (2009), the Board of Industrial Insurance Appeals (“the Board”) reopened a workers' compensation claim and awarded the worker additional time loss compensation due to aggravation of her industrial injury. The employer appealed the decision, and the Washington Court of Appeal reversed. The court of appeals held that the worker voluntarily retired prior to reopening her claim and that since her injury did not cause her failure to return to the work force, she was not entitled to additional compensation.

In In re Stephen R. Everhart, BIIA Dckt. No. 09 14820 (March 3, 2010), the Department reopened a claim for aggravation at the request of the claimant but then decreased the finding of the claimant's wage at the time of injury from $2,200.00 to $440.00. The claimant appealed to the Board requesting that the first wage order be used, but the Board held that the most recent wage order was final and determinative.

28. What situation would place responsibility on the employer to pay an employee’s attorney fees?

Employees aggrieved by orders issued by the Department or self-insured employers may appeal to the Board. There is no provision for payment of attorney’s fees incurred by the employee in proceedings before the Board.
Appeals may be taken from the Board to Washington Superior Court for a trial de novo, with or without a jury. A reasonable attorney fee is payable by the Department or self-insurer for the services of the employee’s attorney in both the superior court and the appellate courts, if the order of the Board is reversed or modified and either the accident fund or medical aid fund is affected. RCW 51.52.120. Courts have interpreted the attorney fee's statute liberally to "ensure adequate representation for injured workers who were denied justice by the Department." *Guillen v. Contreras*, 169 Wn.2d 769, 238 P.3d 1168 (2010) (quoting *Brand v. Dept. of Labor*, 139 Wn.2d 659, 667, 989 P.2d 1111 (1999). Attorney fees are also payable by the Department or self-insurer if an appeal is pursued by “a party other than the worker or beneficiary” and the right to entitlement is affirmed by the board.

In an appeal by an employee to superior court involving a state fund employer with 25 employees or less, if the Department does not appear and the Board’s order in favor of the employer is sustained, the Department must pay a reasonable fee and costs. RCW 51.52.130.

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   **A. Scope of immunity.**

   Each employee injured in the course of employment, or his or her family or dependents in the case of death, shall receive benefits. Except as otherwise provided in the Act, those benefits are in lieu of any and all rights of action whatsoever against any person. RCW 51.32.010.

   **B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

   If injury results from the “deliberate intention” of the employer to produce such injury, the employee receives compensation benefits and may sue the employer. RCW 51.24.020. The phrase “deliberate intention” means the employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge. *Birklid v. Boeing, Co.*, 127 Wn.2d 853, 904 P.2d 278 (1995). This exception has consistently been interpreted narrowly, and requires more than gross negligence or failure to observe safety laws or procedures. See, e.g., *Vallandigham v. Clover Park School Dist. No. 400*, 154 Wn.2d 16, 109 P.3d 805 (2005). An employer was immune from liability under the Act for the wrongful death of an employee who died from dehydration on a long-haul driving trip, because causation was not established, the employer did not have actual knowledge that the employee would die or willfully disregard that knowledge, and the employer did not engage in any practices that denied the employee proper hydration. *Byrd v. System Transport, Inc.*, 124 Wn. App. 196, 99 P.3d 394 (2004).

   An employee may also sue the employer if the condition complained of is a “non-occupational disease,” i.e., a disease which is not covered under “the basic provisions of

Neither an employee nor an employer can exempt itself from, or waive the benefits of, the Act. Any attempt to do so, by contract or otherwise, is void. RCW 51.04.060.


30. **Are there any penalties against the employer for unsafe working conditions?**

Yes. The state has adopted the Washington Industrial Safety & Health Act (WISHA), a counterpart to the Occupational Safety and Health Act (OSHA), which imposes safety and health standards on industry and sets penalties for violations of those standards. See, Chapter 49.17 RCW. The authority to assess penalties under WISHA lies exclusively with the Department of Labor and Industries, and the Board's authority regarding a WISHA citation is appellate only. In re Bergen Brunswig Drug Co. dba Amerisource Bergen Corp., BIIA Dckt. No. 08 W1080 (February 11, 2010). The Board lacks the authority to increase the penalty on its own motion. Id.

31. **What is the penalty, if any, for an injured minor?**

A minor shall be deemed “sui juris” under this Act and a claim by an injured minor worker will be treated the same as other workers’ claims, except to the extent that payments may be made to the minor’s parent or guardian until age of majority. RCW 51.04.070.

32. **What is the potential exposure for “bad faith” claims handling?**

The Washington Supreme Court has specifically rejected a cause of action for wrongful delay or termination of benefits, i.e., “bad faith.” Wolf v. Scott Wetzel Services, 113 Wn.2d 665, 782 P.2d 203 (1989). However, the exclusive remedy provisions of the Act do not protect an employer from a civil action when the employer or an agent hired by the employer to administer a claim wrongfully delays or terminates benefits through conduct which constitutes the tort of outrage. Mere allegation of “bad faith” conduct is insufficient. Outrageous conduct must go beyond all possible bounds of decency and be regarded as atrocious and utterly intolerable in a civilized community. 113 Wn.2d at 667. A self-insurer’s delays in payment or refusals to pay benefits as they come due trigger penalties under the Act in the amount of $500, or 25% of the amount then due, whichever
is greater. The penalties are paid to the employee. RCW 51.48.017. This is the sole remedy unless the conduct is outrageous.

33. **What is the exposure for terminating an employee who has been injured?**

An employee who is terminated in retaliation for a compensation claim has statutory and common law remedies. Discharge or discrimination against any employee because he or she has filed or expressed an intention to file a claim for compensation is prohibited. RCW 51.48.025(1). An employer was held to be in violation of this anti-retaliation provision where its worker, after injuring her back and filing a workers’ compensation claim, was harassed and verbally and non-verbally abused by co-workers who called her names and accused her of lying about her injury. Robel v. Roundup Corp., 148 Wn.2d 35, 59 P.3d 611 (2002).

However, an employer may still take action against an employee for other reasons, including failure to observe health or safety standards adopted by the employer, or the frequency or nature of job-related accidents. RCW 51.48.025(1).

Any employee discharged or subjected to discrimination in violation of the statute may file a complaint with the Department, which must investigate the complaint. RCW 51.48.025(2). If a violation is found, the Director is obligated to bring an action in the superior court of the county in which the violation is alleged to have occurred. Id. The employee has the right to institute the action on his or her own if the Director determines that the section has not been violated. Id. The superior court has authority, for cause shown, to restrain violations of this action and to order all appropriate relief including reinstatement with back pay. Id. In Wilmot v. Kaiser Aluminum and Chemical Corporation, 118 Wn.2d 46, 921 P.2d 18 (1991), the Washington Supreme Court held that this statute is not a condition precedent to a common law action against an employer for retaliatory discharge for filing a claim; nor does the statute prohibit a suit for the tort of outrage.

Terminating an injured employee may also invoke claims under the Family Medical Leave Act of 1993, the Americans with Disabilities Act of 1990, and the Washington Law Against Discrimination codified under Chapter 49.60 RCW.

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. RCW 51.24.030. See also, answer to 14.

35. **Can co-employees be sued for work-related injuries?**

Usually a co-employee who causes an injury cannot be sued. The statute authorizing third-party actions (RCW 51.24.035) has been construed as an extension of the exclusive remedy rule to co-employees so long as the injury is not intentional. See also, answer to
36. **Is subrogation available?**

Yes. The Act authorizes a lien in favor of the Department or a self-insurer, as well as formulas to determine an amount which must be repaid from a third-party action. RCW 51.24.060. Any recovery by an employee from a third party relating to an injury in which the employee received workers' compensation benefits "shall be distributed" according to the statute's distribution formula. Id. The formula requires payment in the following order: (1) attorney fees and costs, (2) 25% to the injured worker free of any claim by the Department, (3) to the Department "the balance of the recovery made, but only to the extent necessary to reimburse for benefits paid," and (4) to the injured worker. Id. The amount of a third party settlement or judgment that relates to loss of consortium or pain and suffering cannot be distributed to the Department as a reimbursement because the Department does not provide funds for noneconomic damages when distributing workers' compensation benefits. Flanigan v. Dept. of Labor & Industries, 123 Wn.2d 418, 869 P.2d 14 (1994)(loss of consortium); Tobin v. Dept. of Labor & Industries, 81946-7 (Wash. 8-12-2010)(pain and suffering). In Tobin a worker who was totally and permanently disabled by a crane boom settled with a third party for $1.4 million, $793, 086.16 of which was attributable to pain and suffering; the Department was overruled by the Washington Supreme Court when it attempted to include the entire $1.4 million in its reimbursement calculation.

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Medical bills must be paid within 60 days of receipt of proper billing in the form prescribed by the Department. RCW 51.36.080.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The physician-patient privilege is abolished in workers’ compensation proceedings. RCW 51.04.050. The statute specifically provides that all medical information in the possession or control of any person and relevant to the injury in question in the opinion of the Department, shall be made available, upon request, to the employer, the employee’s representative, and the Department. No person shall incur any legal liability for releasing that information. RCW 51.36.060.

39. **What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?**

A. **Claimant’s choice of physician.**
The claimant may choose his or her physician as long as the physician is part of the approved health care provider network established by the Department. RCW 51.36.010; WAC 296-20-01010.

B. Employer’s right to second opinion and/or Independent Medical Examination.

Any worker entitled to receive, or who claims, benefits under the Act shall, if requested by the Department or self-insurer, submit himself or herself for medical examination, at a time and from time to time, at a place reasonably convenient for the worker. RCW 51.32.110; 51.36.070.

40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?

Only treatment which is “proper and necessary” is authorized by statute. RCW 51.36.010. Proper and necessary chiropractic care and evaluation is allowed. RCW 51.36.015. By rule, the Department has established guidelines for approval and the duration of many treatment procedures.

41. Which prosthetic devices are covered, and for how long?

The Act provides proper prosthetic devices for workers whose injury results in the loss of an eye or a limb. RCW 51.36.020(2). These devices are provided and replaced for the worker without regard to the date of injury or treatment. RCW 51.36.020(5). The Department has authority to rent or purchase prosthetic devices, depending on the length of time the employee will require them. The Department or self-insurer will repair or replace originally-provided prosthetics that are damaged, broken or worn out, upon documentation from the attending doctor. WAC 296-20-1102. Replacement of prosthetics or special equipment can be provided on closed claims after prior authorization. WAC 296-20-124(4).

42. Are vehicle and/or home modifications covered as medical expenses?

Yes. RCW 51.36.020(7) to (9).

43. Is there a medical fee guide or schedule, or other provisions for cost containment?

Yes. The director publishes a maximum fee schedule. RCW 51.04.030.

44. What, if any, provisions or requirements are there for “managed care”?

None.

PRACTICE/PROCEDURE
45. **What is the procedure for contesting all or part of a claim?**

Within 60 days of an order, decision, or award by the Department, a request for reconsideration may be filed with the Department, or an appeal may be filed with the Board. RCW 51.52.050. The 60 day time period begins when the order, decision, or award is "communicated" to the worker. Id. The Board determined that an order was not "communicated" to a worker until the worker returned from vacation where the order was mailed to the worker prior to her leaving for vacation, but did not arrive at her residence until after she left. In re Dorena R. Hirschman, BIIA Dckt. No. 09 17130 (May 7, 2010). However, the Board does consider an electronic "secure message" which denies a worker's request as a written final determination on the issue which could be appealed. In re Colleen M. Aldridge, BIIA Dckt. No. 1015903 (February 16, 2011).

46. **What is the method of claim adjudication?**

**A. Administrative level.**

State fund claims are adjudicated by the Department, and interlocutory and final decisions are made in orders which may be protested or appealed. Self-insured claims are self-adjudicated or managed by third-party administrators, but in either case the Department retains oversight authority. See, Chapter 51.32 RCW. Self-insured employers may issue orders closing claims in limited circumstances, but the Department must review and issue a final order in most cases. Id. Adjudications at the Department level, including both state fund and self-insured claims, may be appealed to the Board which is a quasi-judicial agency designated by statute as the exclusive forum for hearing appeals in workers’ compensation cases. See, Chapter 51.52 RCW.

**B. Trial court.**

Decisions of the Board may be appealed to Superior Court within 30 days of the date of communication of the order. RCW 51.52.110. Review in the Superior Court is de novo, but no new evidence is admissible. RCW 51.52.115. Trial may be by jury, upon demand as in any other civil case. Id. Decisions of the Board are prima facie correct and the appealing party has burden of proof to overcome that presumption. Id. If an employer is appealing the Board's decision regarding an assessment of unpaid industrial insurance premiums stemming from a Department audit, the employer must first pay the full amount of the assessment (including the unpaid tax, penalties and interest) before it can bring an action in Superior Court, unless the employer obtains a court order showing undue hardship. RCW 51.52.112; Arredondo v. Dept. of Labor & Industries, 155 Wn. App. 1031 (2010); Probst v. Dept. of Labor, 155 Wn. App. 908 (2010).

**C. Appellate.**

After workers’ compensation claims enter the trial court system, the cases follow standard judicial procedure and decisions of the Superior Court may be appealed to the Washington Court of Appeals, and then the Washington Supreme Court.
Furthermore, a Limited English Proficiency (LEP) individual's statutory right to government paid interpreter services is triggered when a government agency initiates a legal proceeding involving the individual. RCW 2.43.010 et al. "[N]either the Department nor the Board initiate[s] a legal proceeding" when it analyzes and reviews a claim for workers compensation. Kustura v. Dept. of Labor & Industries, 169 Wn.2d 81, 233 P.3d 853 (2010). If the Board in its discretion appoints an interpreter to assist an LEP party, current regulations require the Board to pay for the interpreter's services, and once appointed the Board is required to permit the interpreter to translate whenever necessary at the hearing. Id. at 85.

47. **What are the requirements for stipulations or settlements?**

All claim resolution structured settlement agreements must be approved by the board of industrial insurance appeals. RCW 51.04.063. An application for approval of claim resolution structured settlement must be filed electronically. WAC 263-12-01501. Structured settlement agreements must conform to the multiple statutory requirements detailed in RCW 51.04.063 to receive approval, including age limitations. Attorney fees for claim resolution structured settlement agreements are limited to fifteen percent (15%) of the total amount to be paid to the worker. RCW 51.52.120.

The above laws regarding structured settlements were recently enacted and will likely evolve as they are interpreted. It is recommended that anyone consult local employment counsel regarding new and recent developments in this area.

48. **Are full and final settlements with closed medicals available?**

No.

49. **Must stipulations and/or settlements be approved by the state administrative body?**

Yes. RCW 51.04.063(2)(a).

**RISK FINANCE FOR WORKERS’ COMPENSATION**

50. **What insurance is required, and what is available (e.g., private carries, state fund, assigned risk pool, etc.)?**

The Act does not contemplate the participation of private insurers. Premiums are paid to the state treasury for the accident fund, the medical aid fund, the supplemental pension fund, or any other fund created by the Act. RCW 51.08.015. Certain state fund employers qualify for participation in the retrospective rating program which rewards low claims experience with a premium refund. RCW 51.18.010.
Self-insured employers do not contribute to the state fund and may reinsure up to 80% of their liability. But the reinsurer has no voice in claim adjudication. RCW 51.14.020.

51. **What are the provisions/requirements for self-insurance?**

**A. For individual entities.**

An employer qualifies as a self-insurer by establishing to the satisfaction of the Director of the Department that it has sufficient financial ability to ensure the prompt payment of all compensation due. RCW 51.14.020. The Director may require self-insurers to (1) supplement existing financial ability by depositing into an escrow account, in a depository designated by the Director, money and/or corporate or governmental securities; or (2) procure a surety bond written by any company admitted to transact surety business in the state. Id. A letter of credit is acceptable in lieu of money and/or corporate or governmental securities, but only if the self-insurer has a net worth of not less than $500,000,000 as evidenced in an annual financial statement prepared by a qualified, independent auditor using generally accepted accounting principles. Id.

The money, securities or bond must be in an amount reasonably sufficient in the Director’s discretion to ensure payment of reasonably foreseeable compensation and assessments, but not less than the employer’s normal expected annual claim liabilities and in no event less than $100,000. Id. A self-insurer may reinsure a portion of its liability with any reinsurer authorized in the state, but the reinsurer may not participate in the administration of the responsibilities of the self-insurer. Id. The reinsurance may not exceed 80% of the liabilities under the Act. Id.

**B. For groups or “pools” of private entities.**

School districts, educational service districts, private hospitals, and member managed LLC's are authorized to form a self-insured group, which is deemed to be a single employer for purposes of the Act. RCW 51.14.150; In re J D I, LLC, BIIA Dckt. No. 09 18829 (June 15, 2010).

52. **Are “illegal aliens” entitled to benefits of worker’s compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?**

Yes. A “worker” is defined as any person in the state who is engaged in covered employment or who is engaged in the employment of or who is working under an independent contract, the essence of which is for personal labor. RCW 51.08.180.

53. **Are terrorist acts or injuries covered or excluded under workers’ compensation law?**

Neither the Act nor Washington case law addresses this question.
54. Are there state specific requirements that must be satisfied in light of the obligation of parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

The Act does not include any state specific provisions regarding reimbursing Medicare.

A structured settlement can resolve all benefits and "[b]ind the parties with regard to all aspects of a claim except medical benefits." RCW 51.04.063(2)(c)(i)(emphasis added). Therefore, most structured settlements will not need to consider Medicare's interests since medical is not compromised. In unique situations the potential for defining the nature and extent of the injuries and disability may require the consideration of Medicare's interest in the structured settlement. See, WAC 263-12-052(6); See also, answers to 37 and 49.

The above laws regarding structured settlements, and Medicare's involvement, were recently enacted and will likely evolve as they are interpreted. It is recommended that anyone consult local employment counsel regarding new and recent developments in this area.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation laws?

The Federal Medicaid statute requires states to include in their plan for medical assistance provisions (1) that the individual will assign to the state any rights to payment for medical care from any third-party and (2) that the individual will cooperate with the state in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The state is authorized to retain such amount as is necessary to reimburse it (and the federal government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

The Act does not address the question. The Department retains the right of subrogation, i.e., off-set, against social benefits received by the injured worker from the Department of Social and Health Services. RCW 43.20B.720.

56. What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?

The Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. parts 160-164 and 65 F.R. 82462-01, went into effect on April 14, 2003. It provides an exception for workers’ compensation claims to allow the collection of medical records by employers and insurers. 45 C.F.R. 164.512. Employers must nonetheless treat these medical records confidentially, as they would under any other circumstance.
The Act does not specifically address the confidentiality and privacy of medical records in light of state and federal regulations. However, under the Act, the Department has the authority to conduct audits and investigations of health care providers who provide care to industrially injured workers pursuant to the Act, including medical records that may be deemed privileged or confidential under other statutes. RCW 51.36.110. The auditor/investigator cannot remove original patient records, or disclose any records or information, unless directly related to the official duties of the Department. Additionally, the auditor/investigator must destroy all copies of medical records in their possession upon completion of the audit, investigation or proceeding. Id. The health care provider shall not be liable for breach of any confidential relationships based on the disclosure of such medical records. Id.

57. What are the provisions for “Independent Contractors”?

The Act covers “workers.” See, RCW 51.32.010. Independent contractors are considered “workers” if the essence of their contract is for their personal labor. RCW 51.08.180. Case law has expansively interpreted workers’ compensation laws to extend coverage to independent contractors. However, independent contractors are not considered “workers” if the essence of their contract is not for their personal labor, or as a separate alternative, if the independent contractor meets the test set forth in RCW 51.08.195:

“As an exception to the definition of ‘employer’ under RCW 51.08.070 and the definition of ‘worker’ under RCW 51.08.180, services performed by an individual for remuneration shall not constitute employment subject to this title if it is shown that:

(1) The individual has been and will continue to be free from control or direction over the performance of the service, both under the contract of service and in fact; and

(2) The service is either outside the usual course of business for which the service is performed, or the service is performed outside all of the places of business of the enterprise for which the service is performed, or the individual is responsible, both under the contract and in fact, for the costs of the principal place of business from which the service is performed; and

(3) The individual is customarily engaged in an independently established trade, occupation, profession, or business, of the same nature as that involved in the contract of service, or the individual has a principal place of business for the business the individual is conducting that is eligible for a business deduction for federal income tax purposes; and [See, In re GT Drywall, Inc., BIIA Dckt. No. 10 11537 (January 3, 2011) discussing this factor in depth]

(4) On the effective date of the contract of service, the individual is responsible for filing at the next applicable filing period, both under the contract of service and in fact, a schedule of expenses with the internal revenue service for
the type of business the individual is conducting; and

(5) On the effective date of the contract of service, or within a reasonable period after the effective date of the contract, the individual has established an account with the Department of Revenue, and other state agencies as required by the particular case, for the business the individual is conducting for the payment of all state taxes normally paid by employers and businesses and has registered for and received a unified business identifier number from the state of Washington; and

(6) On the effective date of the contract of service, the individual is maintaining a separate set of books or records that reflect all items of income and expenses of the business which the individual is conducting.”

In addition, workers for either independent contractors registered under Chapter 18.27 RCW or electricians licensed under Chapter 19.28 RCW are not considered “workers” covered under the Act. RCW 51.08.180. There are additional categories of workers who are excluded. See, Chapter 51.12 RCW and answer to 2.

Under RCW 51.12.070:

“The provisions of this title apply to all work done by contract; the person, firm, or corporation who lets a contract for such work is responsible primarily and directly for all premiums upon the work. The contractor and any subcontractor are subject to the provisions of this title and the person, firm, or corporation letting the contract is entitled to collect from the contractor the full amount payable in premiums and the contractor in turn is entitled to collect from the subcontractor his or her proportionate amount of the payment.”

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Yes. RCW 51.16.060 requires temporary staffing service providers to pay the required premiums for temporary employees assigned to a client customer. The rule applies to any temporary staffing business providing temporary employees to a client customer. WAC 296-17-31027. If the temporary staffing service provider fails to pay the required premium to the Department, the client customer is responsible for the unpaid premium. Id.

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

Yes. Under RCW 51.08.180, a person is not a “worker” under the Act with respect to his or her activities attendant to operating a truck which he or she owns, and which is leased
60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?

No, there are not any state specific requirements as it relates to protecting Medicare’s interests when settling a claim. However, the Washington Department of Labor and Industries has a duty to notify Medicare when a claim is settled. Medicare will then pursue any funds it previously paid, which it believes should have been satisfied by L&I.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

In 1998, Washington State’s Initiative I-692 went into effect, Washington’s Medical Use of Marijuana Act (MUMA)(codified at RCW 69.51A et. seq., permitting patients with certain debilitating conditions to use medical marijuana. However, I-692 did not legalize marijuana use in the workplace and is silent on how the workplace may be impacted. In that regard, employers retain authority to enact drug policies prohibiting marijuana use both in and outside the workplace. Private sector employers may require that their employees consent to drug testing as a condition of employment. Public employers may also require drug testing subject to the same Constitutional requirements that impacted them prior to the enactment of I-692.

Qualified patients who are entered into the medical marijuana database may legally purchase sales-tax free any combination of the following:
- Three (3) ounces of usable marijuana
- Forty-eight (48) ounces of marijuana-infused product in solid form
- Two hundred sixteen ounces (216) of marijuana-infused product in liquid form or
- Twenty-one (21) grams of marijuana concentrate

Current medical aid rules, WAC 296-20-03010, provides that L&I considers payment for drugs when approved by the FDA for the condition prescribed or is prescribed for off-label use for a drug supported by published scientific evidence of safety and effectiveness. Since the FDA has not approved medical marijuana for any disease or
condition, coverage decisions will be dependent upon L&I’s and the courts’ interpretation of WAC 296-20-02704 which is the directors criteria used to make a medical coverage decisions. There is room here for good law to be made by administrative regulation, or through the court system.

Worker’s compensation claims are subject to denial, but not automatically denied when an injured worker tests positive for THC; and it is unlikely to make any difference in the analysis when medical vs recreational use is considered. However, there is one theory that will support claim rejection however, and that is excess intoxication, where the level of intoxication is so great the workers have effectively removed themselves from the course and scope of their employment.

Note that while MUMA permits the use of medical marijuana, the Act holds no job protections. See, e.g., Roe v. TeleTech Customer Care Mgmt, 171 Wn.2d 736 (2011) (plaintiff authorized to use marijuana medicinally under MUMA had her job offer rescinded after testing positive for marijuana; court held MUMA did not protect employees from discharge for medicinal use.)

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

In 2012, Washington State’s Initiative I-502 went into effect, decriminalizing certain cultivation, sale, possession and use of marijuana. RCW 69.50 et. seq. However, I-502 did not legalize marijuana use in the workplace and is silent on how the workplace may be impacted. In that regard, employers retain authority to enact drug policies prohibiting marijuana use both in and outside the workplace. Private sector employers may require that their employees consent to drug testing as a condition of employment. Public employers may also require drug testing subject to the same Constitutional requirements that impacted them prior to the enactment of I-502.

Any adult aged 21 or older may purchase any combination of the following from a licensed retail marijuana store:
- One (1) ounce of usable marijuana
- Sixteen (16) ounces of marijuana-infused product in solid form
- Seventy-two (72) ounces of marijuana-infused product in liquid form, or
- Seven (7) grams of marijuana concentrate

For any further questions, concerns or advice, please contact your local ALFA counsel contact:

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**Introductory Note:** West Virginia's workers’ compensation system has long been burdened by substantial debt. For decades, the Legislature has attempted to remedy this situation by reforming and changing the workers’ compensation system. Amendments passed in 2005 set in motion the most drastic change: privatization. Pursuant to these amendments, the Workers’ Compensation Commission was terminated on December 31, 2005, and a single private insurance company was given a monopoly on the workers’ compensation market from January 1, 2006 to June 30, 2008. The monopoly ended on July 1, 2008, when other carriers were authorized to enter the market. Notwithstanding privatization, employers were always permitted to self-insure their risk, provided they meet the applicable criteria.

The Legislature separated the state’s obligations from those of the new private system by creating two classes of claims. Claims with a date of injury or last exposure before July 1, 2005 (known as Old Fund claims) remained the responsibility of the state. On the other hand, claims with a date of injury or last exposure on or after July 1, 2005 (known as New Fund claims) would comprise the private market. Self-insured employers continue to be responsible for their own claims regardless of the date of injury or last exposure.

The Insurance Commissioner is responsible for regulating the workers’ compensation market, for enforcing the workers’ compensation laws and regulations, and for administering the Old Fund claims.

1. **Citation for the state workers' compensation statute.**

SCOPE OF COMPENSABILITY

2. Who are covered “employees” for purposes of workers’ compensation?

“Employees” for the purposes of workers’ compensation are defined as “all persons in the service of employers and employed by them for the purpose of carrying on the industry, business, service or work in which they are engaged . . . .” W. Va. Code § 23-2-1a(a). As the quoted language indicates, “employee” is very broadly defined. Notably, the right to receive workers’ compensation is not affected by the fact that a minor was or is employed in violation of state laws regarding the employment of minors, even where the minor obtained employment by misrepresenting his or her age. W. Va. Code § 23-2-1a(b).

3. Identify and describe any “statutory employer” provision.

Employers within the meaning of West Virginia’s workers’ compensation statute include “all persons, firms, associations and corporations regularly employing another person or persons” for the purpose of conducting any form of industry, service or business in the state. W. Va. Code § 23-2-1(a). As with the term “employee,” “employer” is broadly defined. The state of West Virginia, state governmental agencies, volunteer fire departments or companies, and certain emergency service organizations are specifically deemed to be employers. Id.

Certain employers are not required to maintain workers’ compensation insurance for their employees, but may elect to do so. W. Va. Code § 23-2-1(b). These exempt employers include:

A. Employers of employees engaged in domestic services.

B. Employers of five or fewer full-time employees engaged in agricultural service.

C. Employers of employees while the employees are employed out of state, unless such out of state employment is temporary.

D. Churches.

E. Casual employers, meaning an employer who employs no more than three persons on a temporary, sporadic and intermittent basis for no longer than ten calendar days in any calendar quarter.

F. Employers engaged in organized professional sports activities, including employers of trainers and jockeys engaged in thoroughbred horse racing; however, any employees who do not participate in sports activities must be covered by workers’ compensation insurance. For example, a driver who transports equipment, but who does not participate in any sports activities, would have to be covered.
G. Volunteer rescue squads or volunteer police auxiliary units organized under the auspices of the government, or volunteer organizations created or sponsored by government entities or an area or regional emergency medical service board of directors in furtherance of the purposes of the Emergency Medical Services Act (W. Va. Code § 16-4C-1 et seq.). However, any paid employees of these volunteer organizations must be covered by workers’ compensation insurance.

H. Any employer whose employees are eligible to receive benefits under the federal Longshore and Harbor Workers’ Compensation Act, but only with respect to such employees.

I. Taxicab drivers of taxicab companies operating under W. Va. Code § 24A-2-1 et seq., who provide taxicab services pursuant to a written or electronic agreement that identifies the driver as an independent contractor consistent with the requirements of the U.S. Internal Revenue Code.


The definitions of “domestic services,” “temporary,” or “temporary, intermittent and sporadic” are set forth in Title 85, Series 8 of the West Virginia Code of State Rules. “Domestic services” are services of a household nature performed by an employee in or about a private home of the person by whom he or she is employed. W. Va. Code St. R. § 85-8-3.3. Such services generally include the services performed by cooks, butlers, maids, housekeepers, baby sitters, care givers, medical providers, handymen, gardeners, and the like. Id. at § 85-8-3.3.a “Temporary” employment, as used in the context of temporary employment outside the state, means a period not exceeding thirty calendar days within any 365 day period. Id. at § 85-8-3.17. Finally, “temporary, intermittent and sporadic” employment means a period not exceeding ten working days in any ninety day period. Id. at § 85-8-3.19.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or “single occurrence” claims.

Injuries sustained “in the course of” and “resulting from” covered employment are compensable. W. Va. Code § 23-4-1(a). All three elements must be present or the claim is not compensable. Barnett v. State Workmen’s Compensation Commissioner, 172 S.E.2d 63 (W. Va. 1996). For example, if an employee sustains an injury in the course of employment, but not as a result of that employment, the claim would not be compensable.

Generally, an employee must establish by positive evidence, or by evidence from which the inference can fairly and reasonably be drawn, that he or she sustained an injury in the course of and resulting from his or her covered employment. Emmel v. State Workers’ Compensation Director, 145 S.E.2d 29 (W. Va. 1965); Deverick v. State Workmen’s Compensation Director, 144 S.E.2d 498 (W. Va. 1964); Hayes v. State Workmen’s Compensation Director, 140 S.E.2d 443 (W. Va. 1963).
Pursuant to W. Va. Code § 23-4-1g(a), the resolution of any issue, including compensability of a claim, must be based on a weighing of the evidence and a finding that a preponderance of the evidence supports the particular resolution of that issue. The process of weighing the evidence includes, without limitation, assessing the reliability, relevance, materiality, and credibility of the evidence in the context of the issue presented. *Id.* Where the evidence on opposing sides of an issue is found to be equal in weight, the resolution most consistent with the employee’s position is adopted. *Id.* Except in this limited circumstance, all claims for compensation must be decided according to their merit and not according to any principle of law requiring the liberal construction or application of workers’ compensation legislation. W. Va. Code § 23-4-1g(b). It should be noted, however, that claim decisions made by the Insurance Commissioner, an insurance carrier, a self-insured employer, or a third party administrator of any of the foregoing entities, (all generally referred to as “claims administrators”) prior to July 1, 2003, were governed by the so-called “Rule of Liberality” which required that evidence be liberally construed in favor of the employee.

B. Occupational disease (including respiratory and repetitive use).

As with traumatic or single occurrence claims, occupational diseases that are sustained “in the course of” and “resulting from” covered employment are compensable. W. Va. Code §§ 23-4-1(a) and (b). Occupational disease claims may be filed for occupational hearing loss, repetitive motion conditions, and “each new occupational disease as medical science verifies it and establishes it as such . . . .” *Powell v. State Workmen’s Compensation Commissioner*, 273 S.E.2d 832 (W. Va. 1980).

No employee, however, may receive compensation for an “ordinary disease of life to which the general public is exposed outside of employment . . . except when it follows as an incident of an occupational disease. . . .” W. Va. Code § 23-4-1(f).

Pursuant to W. Va. Code § 23-4-1(f), an occupational disease, excluding occupational pneumoconiosis, occurs in the course of and as a result of covered employment, where it appears to the “rational mind,” based upon consideration of all the circumstances, that:

1. There is a direct causal connection between work conditions and the occupational disease;
2. The disease can be seen to have followed as a natural incident of work as a result of the exposure occasioned by the nature of the employment;
3. The employment is the proximate cause of the disease;
4. The disease did not result from a hazard to which the employee is equally exposed outside of employment;
5. The disease is incidental to the character of the employment, and not independent of the employer-employee relationship; and
(6) The disease appears to have originated from a risk connected with employment and to have flowed as a natural consequence from that risk.

A claim for occupational pneumoconiosis must satisfy the nonmedical criteria in order to be accepted. The nonmedical criteria consist of the following:

(1) The claimant must have been exposed to minute particles of dust in abnormal quantities for a continuous period of at least sixty days while in the employ of the employer against whom the claim is asserted;

(2) The claim must be filed within three years from the last day of a continuous period of sixty days’ exposure to the hazards of occupational pneumoconiosis or within three years from the date the claimant was advised by a physician of a diagnosed impairment due to occupational pneumoconiosis, whichever is later;

(3) The claimant must have been exposed to the hazards of occupational pneumoconiosis in West Virginia for a continuous period of at least two years during the ten years immediately preceding the date of last exposure, or for any five of the fifteen years immediately preceding the date of last exposure; and

(4) Whether the claimant has been exposed to the hazards of occupational pneumoconiosis for a period of at least ten years during the fifteen years preceding the date of last exposure and whether the claimant has sustained a chronic respiratory disability, in which event the claimant will be entitled to a rebuttable presumption that he or she is suffering from occupational pneumoconiosis.

W. Va. Code §§ 23-4-1(b), 23-4-8c(b), 23-4-15(b), and 23-4-15b.

Occupational pneumoconiosis is defined as a lung disease “caused by the inhalation of minute particles of dust over a period of time due to causes and conditions arising out of and in the course of employment.” W. Va. Code § 23-4-1(d). It includes, but is not limited to, silicosis, anthracosilicosis, coal workers’ pneumoconiosis, silico-tuberculosis, asbestosis, siderosis, anthrax, and any and all other dust diseases of the lungs. Id.

Once an occupational pneumoconiosis claim is accepted on a nonmedical basis, the claimant is referred to the Occupational Pneumoconiosis Board (a panel of physicians specializing in occupational lung disease) for a medical diagnosis of occupational pneumoconiosis and a determination of the extent, if any, of the claimant’s impairment. W. Va. Code §§ 23-4-8b and 23-4-8c.

The evidentiary standard and burden of proof in occupational disease and occupational pneumoconiosis claims is the same as the standard and proof required in occupational injury claims. W. Va. Code § 23-4-1g; see also answer to No. 4A.
5. **What, if any, injuries or claims are excluded?**

Claims involving injuries or diseases not sustained “in the course of,” or “resulting from” employment, or both, are not compensable. See answer to No. 4. A pre-existing condition is not considered a compensable component of a workers’ compensation claim merely because the pre-existing condition may have been aggravated by a compensable injury. Syl. Pt. 3, *Gill v. City of Charleston*, 236 W. Va. 737, 783 S.E.2d 857 (2016). Instead, the aggravation of a noncompensable pre-existing condition is compensable if it results in a discrete new injury. *Id.* Additionally, claims involving psychiatric conditions, without associated physical injuries, are excluded. W. Va. Code § 23-4-1f; *Bias v. Eastern Associated Coal Corporation*, 640 S.E.2d 540 (W. Va. 2006); *see also State ex rel. Darling v. McGraw*, 647 S.E.2d 758 (W. Va. 2007); see also answer to No. 6. Finally, self-inflicted injuries, or injuries caused by the employee’s willful misconduct (provided such misconduct resulted in a self-inflicted or intentional injury), horseplay or intoxication are not compensable. W. Va. Code § 23-4-2(a); see also answer to No. 9.

6. **What psychiatric claims or treatments are compensable?**

So-called “mental-mental” claims are not compensable. W. Va. Code § 23-4-1f; *Bias v. Eastern Associated Coal Corporation*, 640 S.E.2d 540 (W. Va. 2006); *see also State ex rel. Darling v. McGraw*, 647 S.E.2d 758 (W. Va. 2007). In other words, any alleged psychiatric condition caused solely by nonphysical means and which does not result in physical injury or disease is not compensable. *Id.* If the psychiatric condition is otherwise compensable, most forms of psychiatric treatment will be authorized, provided the treatment is reasonably required. W. Va. Code § 23-4-3(a)(1). In certain cases, treatment for psychiatric conditions not causally related to a compensable injury or disease may be authorized for a limited period of time to maximize recovery from the compensable injury or disease. W. Va. Code St. R. § 85-20-12.6. The treatment, compensability, and evaluation of psychiatric conditions is governed further by the provisions of W. Va. Code St. R. § 85-20-12. However, the requirement of § 85-20-12.2.a that a psychiatric diagnosis be made within six months of a work-related injury, or a significant complication thereof, in order to be ruled compensable is invalid. *Bowers v. W. Va. Office of the Ins. Comm’r*, 686 S.E.2d 49 (W. Va. 2009). The requirement of § 85-20-12.5.a that a claimant must obtain prior authorization of an initial psychiatric consultation is also invalid. Syl. Pt. 1, *Hale v. W. Va. Office of the Ins. Comm’r*, 724 S.E.2d 752 (W. Va. 2012). In addition, a claimant must follow a specific three-step process when attempting to add a psychiatric condition as a compensable component of his or her workers’ compensation claim. *Id.* at Syl. Pt. 2. This three-step process consists of the following: (1) the claimant’s treating physician refers the claimant to a psychiatrist for an initial consultation; (2) following the initial psychiatric consultation, the psychiatrist is to make a detailed report consistent with the procedure described in West Virginia Code of State Rules § 85-20-12.4; and (3) the claims administrator, aided by the psychiatrist’s report, is to determine whether the psychiatric condition should be added as a compensable injury in the claim. *Hale, supra* at Syl. Pt. 2; W. Va. Code St. R. § 85-20-12.4.
7. What are the applicable statutes of limitations?

The statute of limitations varies depending on whether the claim is for an occupational injury, an occupational disease, or occupational pneumoconiosis.

For occupational injury claims, including claims for dependent’s benefits, the statute of limitations is six months from the date of injury or death, whichever is applicable. W. Va. Code § 23-4-15(a). Despite this statute of limitations being jurisdictional (meaning the failure to file timely “forever bar[s]” the claimant’s right to compensation), the West Virginia Supreme Court of Appeals carved out an exception to the statute of limitations that applies in a limited context. This exception, as declared by the Court, applies where the claimant in a dependent’s death benefits claim based on a traumatic injury “delays filing a claim because the claimant was unaware, and could not have learned through reasonable diligence, that the decedent’s cause of death was workrelated, and the delay was due to the medical examiner completing and making available an autopsy report . . . .” Syl. Pt. 5, Sheena H. v. Amfire, LLC, 772 S.E.2d 317 (W. Va. 2015). Under these circumstances, the six month deadline for filing a dependent’s benefits claim is “tolled until the claimant, through reasonable diligence, could have learned of the autopsy report finding that the decedent’s death was, in any material degree, contributed to by an injury or disease that arose in the course of and resulting from the decedent’s employment.” Id. According to the Court, its decision to create an exception to the statute of limitations of W. Va. Code § 23-4-15(a) is a “narrow ruling” that applies only to death benefit claims. Id. at 323 n.4. The ruling also only applies where the delay in filing was attributable to a delay in the medical examiner providing the autopsy report. Id. at 323.

For occupational disease claims, other than occupational pneumoconiosis, an application for benefits must be filed within the later of: (a) three years from the last day the employee was exposed to the occupational hazard; or (b) the date the employee’s occupational disease was made known to him or her by a physician, or the date the employee reasonably should have known of the existence of the occupational disease, whichever occurs earlier. W. Va. Code § 23-4-15(c); Holdren v. Workers’ Compensation Commissioner, 382 S.E.2d 531 (W. Va. 1989). In the case of death due to occupational disease, the application for benefits must be filed within one year from the employee’s death. W. Va. Code § 23-4-15(c). As a practical matter, occupational disease claims generally are not burdened by the statute of limitations because of testimony by the claimant that he or she did not know of the condition and was not told of the condition by a physician until a time that is within the three year limitations period.

For occupational pneumoconiosis claims, an application for benefits must be filed within three years from the last day of a continuous period of at least 60 days during which the employee was exposed to the hazards of occupational pneumoconiosis, or within three years from when a diagnosed impairment due to occupational pneumoconiosis was made known to the employee by a physician. W. Va. Code § 23-4-15(b). In the case of death due to occupational pneumoconiosis, the application for benefits must be filed within two years from the employee’s death. Id.
8. What are the reporting and notice requirements for those alleging an injury?

An employee who sustains an occupational injury must immediately, or as soon as practical, give or cause to be given written notice to the employer. A copy of the notice must also be given to the employer’s third party administrator and/or insurance carrier, or if the claim involves the state Old Fund, the Insurance Commissioner. See W. Va. Code § 23-4-1a. Notice given within two working days of an injury is deemed to be immediate notice. W. Va. Code St. R. § 85-1-3.1. The failure to give immediate notice of an injury weighs against a finding of compensability, and dilutes the credibility and reliability of the claim, although such failure may not be the only reason for denying a claim. Id. This rule has been interpreted by the Insurance Commissioner as being limited to traumatic injury claims, and as such, is not applicable to occupational disease or occupational pneumoconiosis claims.

The written notice must include: the name and address of the employer; the name and address of the employee; the time, place, nature and cause of the injury; and whether temporary total disability has resulted from the injury. W. Va. Code § 23-4-1a. Examples of forms for reporting injuries or diseases which incorporate these requirements, and which the Insurance Commissioner has approved for general use are available on the Insurance Commissioner’s website, www.wvinsurance.gov. The forms may be modified by a claims administrator with regard to trade dress and other related information, such as name and mailing address. However, a claims administrator may not modify, add or remove information fields from the forms without prior approval of the Insurance Commissioner. The written notice to the employer must be given personally by the employee or sent by certified mail. Id. This requirement is rarely observed in practice. The written notice to the employer’s administrator or insurance carrier may be sent by regular mail. Id.

9. Describe available defenses based on employee conduct:

A. Self-inflicted injury.

Claims involving self-inflicted injuries are not compensable. W. Va. Code § 23-4-2(a). Nonetheless, an employee’s suicide is compensable and dependent’s benefits are payable for such suicide if: (1) the employee sustained an injury or disease arising out of the course of and result of covered employment; (2) without that injury or disease the employee would not have developed a mental disorder that impairs his or her rational judgment; and (3) without that mental disorder the employee would not have committed suicide. Syl. Pt. 1, Hall v. State Workmen’s Compensation Commissioner, 303 S.E.2d 726 (W. Va. 1983)

B. Willful misconduct, “horseplay,” etc.

Willful misconduct or disobedience of a statute or rule legally promulgated for an employee’s protection will bar recovery for that employee if his injury is strictly a result of his misconduct or disobedience. See Chiericozzi v. Compensation Commissioner, 19
S.E.2d 590 (W. Va. 1942). Before an employee’s violation can work to bar compensation, however, it must be shown that the employee’s misconduct or disobedience resulted in a self-inflicted or intentional injury. *See Roberts v. Consolidated Coal Co.*, 539 S.E.2d (W. Va. 2000). Compensation is not barred if the employer acquiesces in the conduct. *Chiericozzi*, 19 S.E.2d 590. Moreover, bad judgment and negligence is not willful misconduct. *Thompson*, 54 S.E.2d 13.

An employee who is injured as a result of “horseplay” or a quarrel which is a purely personal matter and unrelated to covered employment does not sustain an injury as a result of employment and is not entitled to workers’ compensation benefits. *Claytor v. State Compensation Commissioner*, 106 S.E.2d 920 (W. Va. 1959), overruled on other grounds by, *Geeslin v. Workmen’s Compensation Commissioner*, 294 S.E.2d 150 (W. Va. 1982). However, an employee who is the innocent victim of the horseplay of other workers and is thus injured during the course of employment is entitled to workers’ compensation benefits for the injury. *Sizemore v. State Workmen’s Compensation Commissioner*, 435 S.E.2d 473 (W. Va. 1977).

If an altercation “arises out of the employment, the fact that claimant was the aggressor does not, standing alone, bar compensation under the West Virginia Workers’ Compensation Act . . . for injuries sustained in the altercation.” Syl. Pt. 1, *Geeslin v. Workmen’s Comp. Com’r*, 170 W. Va. 347, 294 S.E.2d 150 (1982).

**C. Injuries involving drugs and/or alcohol.**

If an employee’s injury was caused by his or her intoxication, the employee is not entitled to receive any benefits. W. Va. Code § 23-4-2(a). “Intoxication” is not specifically defined by statute or regulation, nor is it expressly limited to drugs or alcohol. Thus, one could argue that an employee is not entitled to compensation where the employee’s injury resulted from ingestion of any substance that results in “intoxication.”

Under the Workers’ Compensation Act, an employer may require an employee to undergo a blood test after an injury for the purposes of determining whether the employee is intoxicated, as long as the employer has a reasonable and objective good faith suspicion of the employee’s intoxication. *Id.* Legislative amendments to W. Va. Code § 23-4-2(a) in 2015 created a presumption that an employee was intoxicated and the employee’s injury was caused by intoxication. *Id.* The presumption is invoked under two circumstances: (1) where a blood test is administered within two hours of the injury and the test shows more than five hundredths of one percent, by weight, of blood alcohol content; or (2) where, at the time of blood test, there is evidence of on or off the job use of non-prescribed controlled substances. *Id.*

10. **What, if any, penalties or remedies are available in claims involving fraud?**

Pursuant to W. Va. Code § 61-3-24f(1), any person who fraudulently obtains, or attempts to obtain, workers’ compensation benefits to which he or she is not entitled, or greater than he or she is entitled, or for a period longer than he or she is entitled, is guilty of
felony larceny if the amount in question is $1,000 or more, and guilty of misdemeanor
larceny if the amount is less than $1,000. Id. A person convicted of a felony shall be
confined in a state penitentiary for one to ten years, or confined in a county or regional
jail for not longer than one year and fined up to $2,500. Id. A person convicted of a
misdemeanor, shall be confined in a county or regional jail for not longer than one year
or fined up to $2,500, or both. Id.

W. Va. Code §§ 61-3-24f(2) and 61-3-24e(5) make it a felony for any person to
knowingly and willfully make false reports or statements under oath, affidavit,
certification, or by any other means regarding information required to be provided under
the workers’ compensation statutes in a workers’ compensation matter. The penalty for
this offense is one to three years imprisonment and/or fines of $1,000 to $10,000. Id.
Any person convicted under the provisions of W. Va. Code §§ 61-3-24f or 61-3-24e(5)
shall also be required to make full restitution of all monies paid, regardless of whether the
person was convicted of a felony or misdemeanor. W. Va. Code §§ 61-3-24f(3) and 61-
3-24e(5). Moreover, where the person convicted is an employee receiving workers’
compensation, the employee shall, from and after conviction, cease to receive such
person convicted is a responsible person of an employer, the person or entity also shall
forfeit any property that constitutes, or is directly or indirectly derived from, proceeds of

In addition to the above, there are numerous other criminal penalties defined by statute.
These penalties apply to employers, responsible persons of employers, health care
providers, employees, and other persons. It is beyond the scope of this document to
describe them all. For further information, see W. Va. Code §§ 61-2-24e, 61-3-24g, and
61-3-24h.

On the administrative side, the workers’ compensation insurance provider, whether it be
the Insurance Commissioner, a self-insured employer, or an insurance company, may set
aside, amend, or correct any decision it made which is discovered to be the result of
fraud. W. Va. Code § 23-5-1(e). This corrective action can be taken at any time,
regardless of whether the order may otherwise be considered final. Id.

11. **Is there any defense for falsification of employment records regarding medical
history?**

Yes. See answer to No. 10.

12. **Are injuries during recreational and other non-work activities paid for or supported
by the employer compensable?**

There are no specific statutory provisions with respect to this area of law. As stated
above, an injury is compensable if it is sustained “in the course of” and “resulting from”
employment. Generally, recreational and social activities are deemed to be in the course
of employment when the employer derives a substantial and direct benefit from the
activity. However, the employer’s benefit must be something more than the intangible
value of improving the health and morale of one’s employees. *See Emmel v. State*
13. **Are injuries by co-employees compensable?**

Yes, if they are sustained “in the course of” and “resulting from” covered employment.

14. **Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., “irate paramour” claims)?**

Yes, provided that the employee establishes that he or she sustained the injury “in the course of” and “resulting from” covered employment.

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The average weekly wage is the daily rate of pay at the time of the injury or the weekly average of the employee’s best quarter of wages out of the preceding four quarters of wages, whichever is greater. W. Va. Code § 23-4-14(b)(2). However, for purposes of determining temporary total disability benefits payable to part-time employees, the average weekly wage is generally based upon the best average weekly gross pay received during the best quarter of wages in the preceding four quarters of wages. W. Va. Code § 23-4-6d(b). Part-time employees are those employees who are customarily and regularly employed twenty five hours or less per week, and are classified as part-time by the employer. W. Va. Code § 23-4-6d(a).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

The maximum weekly rate for temporary total disability benefits is 66⅔% of the average weekly wage earnings at the date of the injury, not to exceed the state average weekly wage. W. Va. Code § 23-4-6(b). The minimum weekly benefit may not be less than 33⅓% of the state average weekly wage, except in the case of part time employees or temporary partial rehabilitation benefits. *Id.* Under no circumstances may the minimum weekly benefit rate exceed the level of benefits determined by using the applicable federal minimum wage. *Id.*

The Insurance Commissioner publishes a chart of the maximum and minimum benefit rates on its website, www.wvinsurance.gov. For fiscal year 2020 (July 1, 2019 to June 30, 2020), the maximum weekly temporary total disability rate is $865.11, and the minimum weekly rate is $193.33.

Aggregate awards of temporary total disability benefits resulting from a single injury may not exceed 104 weeks. W. Va. Code § 23-4-6(c).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**
Upon finding the claim compensable, a self-insured employer must immediately pay the amounts due the employee for temporary total disability benefits. W. Va. Code § 23-4-1c(g). In any event, payment of temporary total disability benefits by any claims administrator must begin no later than fifteen working days from receipt of the employee’s or employer’s report of injury, whichever is received sooner, and a proper physician’s report or any other information necessary for determining whether an injury will result in disability exceeding three days. See W. Va. Code § 23-4-1c(b). Notwithstanding the above, temporary total disability benefits may be immediately paid where it appears from the employer’s report of injury or proper medical evidence that the injury will result in disability greater than three days. Id.

18. **What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out _____ days before recovering benefits for the first _____ days)?**

The employee must be unable to work due to the compensable injury for more than seven consecutive calendar days before recovering benefits for the first three days. W. Va. Code § 23-4-5; W. Va. Code St. R. § 85-1-5.1. In order to qualify for temporary total disability benefits, the employee must be unable to work due to the compensability injury for three consecutive calendar days. Id.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary total disability benefits are suspended when: (1) the physician selected by the workers’ compensation provider finds that the employee has reached maximum degree of improvement; (2) the authorized treating physician finds that the employee has reached maximum degree of improvement, or that the employee is ready for a permanent disability evaluation and the treating physician has not made a recommendation regarding permanent disability; (3) the evidence otherwise justifies a finding that the employee has reached maximum degree of improvement; or (4) the evidence justifies a finding that the employee has engaged, or is engaging, in abuse including, but not limited to, physical activities inconsistent with the compensable injury. W. Va. Code § 23-4-7a(e). When benefits are suspended for any of these reasons, the employee is permitted a reasonable period of time (usually 30 days) to submit evidence justifying the continued payment of temporary total disability benefits. Id. If no evidence is submitted or the evidence that is submitted is insufficient, a protestable order is entered closing the claim for temporary total disability benefits.

Temporary total disability benefits terminate when: (1) the claimant returns to work; or (2) the authorized treating physician concludes that the claimant has reached his or her maximum degree of improvement and recommends a permanent partial disability award of fifteen percent or less. W. Va. Code §§ 23-4-7a(c) and 23-4-7a(e). Under these circumstances, the suspension procedure described above is not applicable. Benefits cease immediately upon the occurrence of either of these events.

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**
21. **What disfigurement benefits are available and how are they calculated?**

If disfigurement causes permanent disability less than total disability, permanent partial disability benefits are available. The method for calculating these benefits is explained below in the answer to No. 22. Disfigurement is not taken into consideration in awarding permanent total disability benefits, except to the extent that it affects the claimant’s ability to engage in substantial gainful activity requiring skills that can be acquired or skills which are comparable to those of any gainful activity in which the claimant has engaged with some regularity over a substantial period of time. See W. Va. Code § 23-4-6(n)(2).

22. **How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

Permanent partial disability benefits are calculated by first determining the percentage of disability to total disability. W. Va. Code § 23-4-6(e)(1). Each percent of disability is generally equal to four weeks of benefits. **Id.** However, if the claimant is released by the authorized treating physician to return to the pre-injury job without restrictions, but the employer does not offer the pre-injury job or a comparable job when a position is available, each percent of disability equals six weeks of benefits. **Id.** at § 23-4-6(e)(2). The maximum benefit rate for permanent partial disability awards is 66⅔% of the average weekly wage earnings at the date of the injury, not to exceed 70% of the state average weekly wage. **Id.** at § 23-4-6(e)(1). The minimum weekly benefit is the same as the minimum rate for temporary total disability. **Id.**

The Insurance Commissioner publishes a chart of the maximum and minimum benefit rates on its website, www.wvinsurance.gov. For fiscal year 2020 (July 1, 2019 to June 30, 2020), the maximum weekly permanent partial disability rate is $605.58, and the minimum weekly rate is $193.33.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

W. Va. Code § 23-4-6(f) sets forth a table which provides the percentage of disability for injuries resulting in the total loss by severance of any of the members named therein. For example, the loss of a thumb is considered to be 20% disability. In addition, the loss of both eyes or the sight thereof, the loss of both hands or the use thereof, the loss of both feet or the use thereof, and the loss of one hand and one foot or the use thereof are conclusively presumed to be permanent total disabilities. W. Va. Code § 23-4-6(m).

B. **Number of weeks for “whole person” and standard for recovery.**

The Workers’ Compensation regulations require the use of the AMA *Guides to the
**Evaluation of Permanent Impairment, 4th Edition** in determining whole-person impairment for most injuries. W. Va. Code St. R. § 85-20-65.1. The AMA *Guides* do not apply to disability resulting from occupational pneumoconiosis, occupational hearing loss, psychiatric conditions, or claims involving the provisions of W. Va. Code § 23-4-6(f) (relating to loss of certain body parts) or W. Va. Code § 23-4-6(m) (relating to certain injuries conclusively presumed to be permanent total disabilities). W. Va. Code St. R. § 85-20-67. The Workers’ Compensation Act equates the terms whole-person impairment and permanent disability. W. Va. Code § 23-4-6(i). Generally, each percent of disability equals four weeks of benefits. *Id.* at § 23-4-6(e)(1). If, however, the claimant is released by the treating physician to return to the pre-injury job without any restrictions, but the employer does not offer the pre-injury job or a comparable job when a position is available, each percent of disability equals six weeks of benefits. *Id.* at § 23-4-6(e)(2); *Janet L. Richardson v. Speedway, LLC*, No. 14-0106 (W. Va. Mar. 27, 2015) (Memorandum Decision) (unpublished).

The evaluation and rating of permanent partial disability resulting from lumbar, thoracic, and cervical spine injuries is further subject to the ranges of permanent partial disability set forth in Tables 85-20-C, 85-20-D, and 85-20-E of Title 85, Series 20 of the Workers’ Compensation Rules. W. Va. Code St. R. § 85-20-64.1-64.4; *Simpson v. W. Va. Office of the Ins. Comm’r*, 678 S.E.2d 1 (W. Va. 2009). Additionally, awards for permanent partial disability due to carpal tunnel syndrome are capped at six percent for each injured hand. W. Va. Code St. R. § 85-20-64.5. However, the Supreme Court of Appeals of West Virginia has held that the impairment cap for carpal tunnel syndrome in W. Va. Code § 85-20-64.5 is invalid and cannot be applied to carpal tunnel impairment ratings assessed under Table 16 of the AMA *Guides*. *Syl. Pt. 3, Davies v. W. Va. Office of the Ins. Comm’r*, 708 S.E.2d 524 (W. Va. 2011). The Court’s decision in *Davies* did not address application of the carpal tunnel impairment cap to impairment ratings determined under Table 15 of the AMA *Guides*. *Id.* at 527 n.2.

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Employees who have sustained a permanent disability or injuries likely to result in temporary total disability may qualify for vocational rehabilitation benefits. W. Va. Code § 23-4-9(b). The workers’ compensation claims administrator must, at the earliest possible time, determine whether the employee is a suitable candidate for vocational rehabilitation. *Id.* With limited exception, vocational rehabilitation benefits must be authorized by the workers’ compensation claims administrator prior to rendering the rehabilitation services. *Id.* The expenditure for any one employee’s vocational rehabilitation shall not exceed $20,000.00. *Id.*

Where vocational rehabilitation is authorized, the employee is entitled to receive temporary total disability benefits during vocational rehabilitation or rehabilitative treatment, if such vocational rehabilitation or rehabilitative treatment renders the employee temporarily totally disabled. W. Va. Code § 23-4-9(c). If an employee returns to gainful employment as a part of a rehabilitation plan, but the employee’s average
weekly wage earnings are less than those earned at the time of the injury, the employee is entitled to receive temporary partial rehabilitation benefits. W. Va. Code § 23-4-9(d). However, temporary partial rehabilitation benefits are not paid where the difference between the pre-injury average weekly wage and the post injury average weekly wage is five percent or less. W. Va. Code St. R. § 85-15-7.6.

The rate of temporary partial rehabilitation benefits is 70% of the difference between the average weekly wage at the time of the injury and the average weekly wage at the new employment, but in any event, cannot exceed the employee’s temporary total disability rate. W. Va. Code § 23-4-9(d). There is no minimum benefit rate for temporary partial rehabilitation benefits. Id.

The aggregate award of any temporary total rehabilitation benefits or temporary partial rehabilitation benefits for a single injury may not be for a period exceeding 52 weeks, unless the payment of temporary total rehabilitation benefits is made in connection with an approved vocational rehabilitation plan for retraining. Id. In such a case, temporary total rehabilitation benefits may be provided for 104 weeks. Id.

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

For all permanent total disability awards granted on or after July 1, 2003, irrespective of date of injury or last exposure, benefits are payable until the employee reaches age 70, at a rate of 66⅔% of the employee’s earnings, not to exceed the state average weekly wage. W. Va. Code §§ 23-4-6(d) and 23-4-6(n)(2). For permanent total disability awards granted before July 1, 2003 in claims with a date of injury or last exposure prior to May 12, 1995, benefits are payable until the employee reaches the age necessary to receive federal old age retirement benefits under the version of the Social Security Act in effect on May 12, 1995 (typically age 65), at a rate of 66⅔% of the employee’s earnings, not to exceed the state average weekly wage. W. Va. Code § 23-4-6(d). For permanent total disability awards granted before July 1, 2003 in claims with a date of injury or last exposure before May 12, 1995, benefits are payable for life at a rate of 70% of the employee’s average weekly wage on the date of injury, not to exceed the state average weekly wage. W. Va. Code § 23-4-6(d) (1994). Generally speaking, the minimum rate for any PTD award is 33⅓% of the state average weekly wage. W. Va. Code §§ 23-4-6(d) and 23-4-6(b).

The Insurance Commissioner publishes a chart of the maximum and minimum benefit rates on its website, www.wvinsurance.gov. For fiscal year 2020 (July 1, 2019 to June 30, 2020), the maximum weekly permanent total disability rate is $865.11, and the minimum weekly rate is $193.33.

25. **How are death benefits calculated, including the minimum and maximum rates?**

A. **Funeral expenses.**

Reasonable funeral expenses may be paid as deemed proper, and in an amount fixed by

B. Dependency claims.

When a compensable traumatic injury causes death, and disability is continuous from the date of the injury until death, or if death results from occupational disease or occupational pneumoconiosis, dependents are entitled to receive benefits for as long as their dependency shall continue, in the same amount as was paid or would have been paid to the employee for total disability. W. Va. Code 23-4-10; see also Crist v. Cline, 632 S.E.2d 358 (W. Va. 2006). The persons that are considered dependents and the length of dependency for each type of person is set forth in W. Va. Code §§ 23-4-10(b) and (d). The standard for compensability in dependents’ benefits claims is whether the compensable injury or disease was a material contributing factor to the employee’s death. *Bradford v. Workers’ Compensation Commissioner*, 408 S.E.2d 13 (W. Va. 1991).

If an employee receiving permanent total disability benefits dies from a cause other than a compensable injury or disease, the employee’s statutorily defined dependents are entitled to an award equal to 104 times the weekly benefit amount the employee was receiving at the time of death. W. Va. Code § 23-4-10(e). This amount may be paid in either a lump sum or in periodic payments, at the option of the dependents. *Id.*

26. What are the criteria for establishing a “second injury” fund recovery?

The Second Injury Reserve fund has been eliminated with respect to all awards made by a claims administrator on or after July 1, 2003. W. Va. Code § 23-3-1(d)(1).

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

A claimant may seek further benefits in a claim that has been closed, but which is not time barred, by submitting a written request to reopen. To obtain a reopening, the claimant must demonstrate that there has been an aggravation or progression of his or her condition, or the existence of a previously unconsidered material fact. W. Va. Code §§ 23-5-2 and 23-5-3. Moreover, the West Virginia Supreme Court of Appeals held that for purposes of obtaining a reopening, the claimant must show a *prima facie* cause, which is nothing more than any evidence which would tend to justify, but not compel, the inference that there has been a progression or aggravation of the compensable injury. *Harper v. State Workmen’s Comp. Comm’r*, 234 S.E.2d 779 (W. Va. 1977).

In a claim closed without entry of a permanent partial disability award or in which no award was made, a request for reopening must be made within five years of the date of closure. W. Va. Code § 23-4-16(a)(1).

In a claim in which an award of permanent partial disability was made, the reopening request must be made within five years of the date of the initial permanent partial
disability award. W. Va. Code § 23-4-16(a)(2). Under limited circumstances, this five year deadline may be excused or extended. All of the following circumstances must be present to excuse or extend the reopening deadline: (1) the claimant must have received an initial permanent partial disability award; (2) the claimant must file a timely request to add a condition to his or her claim; (3) the additional condition is found to be compensable; and (4) the claims administrator failed to refer the claimant for the permanent partial disability evaluation mandated by W. Va. Code § 23-4-7a(f). Syl. Pt. 5, Hammons v. W. Va. Office of the Ins. Comm'r, 775 S.E.2d 458 (W. Va. 2015). The mandatory examination cited by the Court in Hammons refers to the claims administrator’s obligation in most claims to refer the claimant for an independent medical examination whenever temporary total disability exceeds 120 days from the date of injury, or from the date of the last examination. W. Va. Code § 23-4-7a(f).

In a fatal claim, any further award must be made within two years after the employee’s death. W. Va. Code § 23-4-16(a)(3).

Except with regard to occupational pneumoconiosis claims, further medical treatment or rehabilitation services may not be authorized in any claim in which “significant treatment” has not been rendered for five years. W. Va. Code § 23-4-16(a)(4). (Exactly what constitutes “significant treatment” is not defined by statute, regulation or court decision). Occupational pneumoconiosis claims, however, are never closed for medical benefits. W. Va. Code § 23-4-8d. Additionally, the limitation on medical or rehabilitation services does not apply to the replacement of artificial limbs, crutches, hearing aids, eyeglasses, or other mechanical appliances that wear out, need to be refitted due to a progression of the compensable injury, or are broken in the course of and as a result of employment. W. Va. Code §§ 23-4-16(a)(4) and 23-4-3(d).

A claimant may only make two requests to reopen a claim for permanent benefits in the applicable five year period; except that for occupational disease and occupational pneumoconiosis claims, a new five year period begins after each subsequent award. W. Va. Code §§ 23-4-16(a)(1) and (2). There is also a limited exception to the reopening deadline of W. Va. Code § 23-4-16(a)(2), as discussed above. The number of times the claimant may attempt to reopen a claim for temporary total disability benefits is unlimited. See W. Va. Code §§ 23-4-16(a)(1) and (2); W. Va. Insurance Commissioner Informational Letter No. 164.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

When the Workers’ Compensation Office of Judges (an administrative adjudicatory body that reviews and decides protests to claim decisions made by a claims administrator) determines that a denial of compensability, temporary total disability benefits, or an authorization of medical benefits was unreasonable, the employee is entitled to receive reasonable attorneys’ fees and costs incurred in obtaining a reversal of the unreasonable denial. W. Va. Code § 23-2C-21(c). This provision applies only to self-insured employers and insurance companies; it is not applicable to claim decisions made by the
Insurance Commissioner or its third party administrator. *Id.* A denial is unreasonable if, after the employee submits evidence of the compensability of the claim, the entitlement to temporary total disability benefits or medical benefits, the insurance company or self-insured employer cannot demonstrate that it had, at the time of denial, evidence or a legal basis which supported the denial. *Id.* Payment of the attorney fees and associated costs is not made until conclusion of the litigation, including all appeals. *Id.*

To initiate the unreasonable denial and attorney fee process, the claimant must submit a written allegation to the Office of Judges. W. Va. Code St. R. § 93-1-19.2. The written allegation must be copied to the employer and filed with the Office of Judges within ninety days of the final decision or final appeal outcome. *Id.*

A claimant who prevails in any proceeding relating to the denial of medical benefits by a private carrier or a self-insured employer may be awarded reasonable costs and reasonable attorney’s fees incurred in reversing the denial, as long as the final order resolving the denial in the claimant’s favor was entered after July 12, 2013. W. Va. Code § 23-5-16(c)(1); Syl. Pt. 4, *Cassella v. Mylan Pharmaceuticals, Inc.*, 766 S.E.2d 432 (W. Va. 2014). The maximum hourly attorney rate is $125. *Id.* The maximum attorney fee award is $500 per litigated medical benefits denial, up to $2,500 per claim. W. Va. Code § 23-5-16(c)(2). A claimant may not receive an award of attorney’s fees and costs under W. Va. Code § 23-5-16(c)(1) and the unreasonable denial process of W. Va. Code § 23-2C-21(c) for the same litigated issue. W. Va. Code § 23-5-16(c). To proceed under § 23-5-16(c)(1), the claimant’s attorney must file a fee petition with the adjudicatory body, or arbitrator or mediator that entered a final decision on the issue within thirty days after the decision becomes final. W. Va. Code § 23-5-16(c)(1). The attorney’s experience, the complexity of the issue, the hours expended, and the contingent nature of the fee must be considered when determining whether a requested attorney fee award is reasonable. W. Va. Code § 23-5-16(c)(3).

Additionally, in certain cases permanent total disability awards may be reopened and re-evaluated by a self-insured employer, the Insurance Commissioner, or an insurance carrier, whichever is responsible for the claim, in order to assess whether the employee continues to be totally disabled. W. Va. Code § 23-4-16(d)(1); *See Justice v. W. Va. Office of the Ins. Comm’n*, 736 S.E.2d 80 (W. Va. 2012). The employee is entitled to reasonable attorneys’ fees and costs incurred in defending the award, if the award is retained. W. Va. Code § 23-4-16(d)(2). Pursuant to W. Va. Code St. R. § 85-5-5.7, the employee’s attorney may charge up to a maximum of $5,000 ($3,500 through final decision by Office of Judges and $1,500 for appeals), although this maximum fee may be waived in extraordinary cases.

**EXCLUSIVITY/TORT IMMUNITY**

29. Is the compensation remedy exclusive?

A. Scope of immunity.
Yes, unless the employer has engaged in “deliberate intention” pursuant to W. Va. Code § 23-4-2(d)(2), has defaulted on premium payments or other obligations of the Workers’ Compensation Act, or in other circumstances where the Legislature specifically provides a private remedy outside the workers’ compensation system. W. Va. Code § 23-2-6; Bias v. Eastern Associated Coal Corporation, 640 S.E.2d 540 (W. Va. 2006). Absent these circumstances, the immunity is absolute and precludes any tort action against an employer. Id.

B. Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).

The statutory immunity may be lost if the employer acted with “deliberate intention.” This exception may be established in one of two statutory ways. Regardless of the type of deliberate intent claim pursued by the plaintiff, the employee, the employee’s representative, or the employee’s dependent must file a workers’ compensation claim as a prerequisite to filing a civil action for “deliberate intention”, unless he or she can establish good cause for not filing the workers’ compensation claim. W. Va. Code § 23-4-2(c).

The first way in which “deliberate intention” may be established requires proof that the employer acted with a conscious, subjective, and deliberate intent to produce the specific result of injury or death to an employee. W. Va. Code § 23-4-2(d)(2)(A). This standard requires a showing of actual, specific intent and is not satisfied by an allegation or proof of: (1) conduct which produces a result that was not specifically intended; (2) conduct which constitutes negligence, regardless of how gross or aggravated; or (3) willful, wanton or reckless misconduct. Id.

“Deliberate intention” may also be found if the trier of fact determines, either through specific findings of fact made by the court or jury, that five specific elements are proven: (1) the existence of a specific unsafe working condition which presents a high degree of risk and a strong probability of serious injury or death; (2) that the employer, prior to the injury, had actual knowledge of the specific unsafe working condition and the high degree of risk and strong probability of serious injury or death presented by such condition; (3) that the unsafe working condition was a violation of a law, regulation, rule, or commonly accepted and well known safety standard within the employer’s industry or business; (4) that notwithstanding the existence of the facts as set forth above, the person or persons alleged to have actual knowledge of the specific unsafe working condition nevertheless intentionally exposed the employee to such specific unsafe working condition; and (5) the employee so exposed suffered serious compensable injury or death as a direct and proximate result of such condition. W. Va. Code § 23-4-2(d)(2)(B)(i) – (v). See generally Mayles v. Shoney’s, Inc., 405 S.E.2d 15 (W. Va. 1990); Mandolidis v. Elkins Industries, Inc., 246 S.E.2d 907 (W. Va. 1978).

Actual knowledge must be specifically proven, and cannot be “deemed” or presumed to exist. W. Va. Code § 23-4-2(d)(2)(B)(ii)(I). The plaintiff/employee also cannot establish actual knowledge by showing what the employee’s immediate supervisor or manager should have known had he or she exercised reasonable care or been more diligent. Id. at
§ 23-4-2(d)(2)(B)(ii)(II). In addition, to prove that the employee’s immediate supervisor or that management knew of prior accidents, near misses, safety complaints, or citations, the plaintiff must present “documentary or other credible evidence.” Id. at § 23-4-2(d)(2)(B)(ii)(III).

The safety standard on which the “deliberate intent” claim is based must be a “consensus written rule or standard promulgated by the industry or business of the employer.” Id. at § 23-4-2(d)(2)(B)(iii)(I). The state or federal statute, rule or regulation at issue in the claim must be specifically applicable to the work or working condition involved; must be intended to specifically address the alleged hazard involved; and the determination whether the statute, rule or regulation is applicable is a legal issue to be decided by the Judge. Id. at § 23-4-2(d)(2)(B)(iii)(II)(a)-(c).

To constitute a “serious compensable injury” for purposes of the five factor test for a “deliberate intent” claim, the plaintiff must prove that the injury meets one of four specific definitions:

(1) The injury results in at least 13% whole person impairment granted as a final award in a workers’ compensation claim; causes permanent serious disfigurement, permanent loss or significant impairment of function of any bodily organ or system, or objectively verifiable bilateral or multilateral radiculopathy; and is not a physical injury that has no objective medical evidence to support the diagnosis;

(2) The plaintiff provides written certification by physician that the injury is caused by the unsafe working condition and is likely to cause death within 18 months or less of filing the civil action;

(3) If the injury is one for which impairment cannot be determined under applicable impairment rules, the injury causes permanent serious disfigurement, permanent loss or significant impairment of bodily organ or system function, or objectively verified bilateral or multilateral radiculopathy; and is not a physical injury that has no objective medical evidence to support the diagnosis; or

(4) If the condition is occupational pneumoconiosis, the plaintiff provides written certification from a pulmonologist that the injured employee has complicated pneumoconiosis or pulmonary massive fibrosis that has caused at least 15% impairment as confirmed by reproducible ventilatory testing, and the cause of action is filed within one year of the date the employee meets the requirements of this definition.


No punitive or exemplary damages may be awarded in a deliberate intent action that is based on the five factor test. W. Va. Code § 23-4-2(d)(2)(C)(ii). The court is required to dismiss an action for deliberate intent on a motion for summary judgment if the plaintiff has failed to prove all five of the factors in this test. Id. at § 23-4-2(d)(2)(C)(iii).

Any employer who is required to obtain and maintain workers’ compensation insurance,
but who fails to do so, loses immunity from civil actions by an employee, and may not raise the following common law defenses: (1) the fellow-servant rule; (2) assumption of risk; (3) contributory negligence; and (4) that the negligence in question stemmed from the actions of someone whose duties are prescribed by statute. W. Va. Code § 23-2-8.

30. **Are there any penalties against the employer for unsafe working conditions?**

No, other than unsafe working conditions that would constitute acts committed with “deliberate intention” as set forth in W. Va. Code § 23-4-2.

31. **What is the penalty, if any, for an injured minor?**


32. **What is the potential exposure for "bad faith" claims handling?**

Pursuant to W. Va. Code § 23-2C-21(a), an employee may not bring or maintain a cause of action for violation of the provisions of the Workers’ Compensation Act or the provisions of Chapter 33 of the West Virginia Code (relating to insurance in general) against an insurance carrier or third party administrator, or any employees or agents of the same. The exclusive civil remedy for such a violation is the administrative fines or remedies provided by statute or regulation. W. Va. Code § 23-2C-21(b). An employee, however, may maintain an action for reasonable attorney’s fees and expenses where it is determined that a denial of compensability, temporary total disability benefits, or an authorization of medical benefits was unreasonable. W. Va. Code § 23-2C-21(c); see also answer to No. 28. Additionally, an employer may be sued by an employee for intentionally providing information it knows to be false for the purpose of depriving the employee of workers’ compensation benefits. *Persinger v. Peabody Coal Company*, 474 S.E.2d 887 (W. Va. 1996).

33. **What is the exposure for terminating an employee who has been injured?**

An employer shall not discriminate in any manner against present or former employees due to actual or attempted receipt of workers’ compensation benefits. W. Va. Code § 23-5A-1. Moreover, it is a discriminatory practice to terminate an employee who is receiving, or is eligible to receive, temporary total disability benefits while he or she is off work due to a compensable injury, unless the employee committed a separate dischargeable offense. W. Va. Code § 23-5A-3(a). It is also a discriminatory practice for an employer to fail to reinstate an employee who has sustained a compensable injury to his or her former position upon demand, provided that the position is available and the employee is not disabled from performing the duties. W. Va. Code § 23-5A-3(b). An employee may bring a cause of action for discrimination, and recover those damages typically available in a civil action, including punitive damages.

**THIRD PARTY ACTIONS**
34. **Can third parties be sued by the employee?**

Yes. An employee is not precluded from asserting claims against a third party whose act or omission causes, in whole or in part, the employee’s injury, even if he or she has received workers’ compensation benefits for the same injury. W. Va. Code § 23-2A-1(a). (If the third party’s act or omission causes, in whole or part, the employee’s death, a cause of action against that party could be maintained by the employee’s dependents or personal representative. Id.) However, subrogation applies to amounts recovered through any third party actions. See answer to No. 36.

35. **Can co-employees be sued for work-related injuries?**

No. The immunity from liability extends to every officer, manager, agent, representative or employee of an employer, as long as such person is acting in furtherance of the employer’s business and does not inflict an injury with deliberate intention. W. Va. Code § 23-2-6a.

36. **Is subrogation available?**

Yes. For all third party causes of action arising or accruing on and after January 1, 2006, subrogation is allowed with regard to all medical and indemnity benefits paid as of the date of the recovery. W. Va. Code § 23-2A-1(b)(1). For causes of action arising or accruing prior to January 1, 2006, subrogation is allowed with regard to all medical benefits paid as of the date of recovery, except that with respect to any cause of action arising or accruing prior to January 1, 2003, the amount received in subrogation may not exceed fifty percent of the amount recovered from the third party. W. Va. Code § 23-2A-1(b)(2). In addition, the Insurance Commissioner is allowed subrogation with regard to all medical and indemnity benefits paid, and which are to be paid, from the Uninsured Employer Fund, regardless of the date on which the cause of action arose or accrued. W. Va. Code § 23-2A-1(b)(3) Reasonable attorneys’ fees and costs are deducted from any amount subject to subrogation. W. Va. Code § 23-2A-1(c).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

There is no law specifying a time limit within which medical bills or invoices must be paid.

38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

In claims in litigation before the Office of Judges, the parties are required, upon request, to promptly exchange reports rendered in conjunction with evaluations. W. Va. Code St. R. § 93-1-7.4B. The Office of Judges may enter an order compelling production if a
motion to compel is filed. A party to a workers’ compensation matter may also utilize a subpoena *duces tecum* in order to compel the production of documents. W. Va. Code St. R. § 93-1-8.4A.

An employee, by filing an application for workers’ compensation benefits, irrevocably agrees that any physician may release and/or orally discuss medical reports pertaining to the employee’s medical history, condition, treatment, prognosis, and anticipated period of disability. W. Va. Code § 23-4-7(b). Despite this, some health care providers may still insist on receiving a specific, Health Insurance Portability and Accountability Act (HIPAA) compliant release before providing medical records. Such releases usually are not difficult to obtain. Moreover, the claimant must sign all medical releases that are necessary for the self-insured employer or insurance company to obtain information and records concerning a pre-existing medical condition that is reasonably related to the compensable injury in order to determine the nature and amount of workers’ compensation benefits to which the claimant is entitled. W. Va. Code § 23-2C-17(f). Furthermore, in claims in litigation, the Office of Judges will compel a claimant to sign a medical release upon a showing of an unjustified failure of the claimant to cooperate. W. Va. Code St. R. § 93-1-7.2.B.3.

Whenever a private carrier, a claims administrator, a self-insured employer, or the Insurance Commissioner refer a claimant for an independent medical examination in connection with the entity’s claims administration functions, the claimant and employer (if applicable) must be provided with a copy of the examination report. W. Va. Code § 23-4-8(a).

### 39. What is the rule on (a) Claimant’s choice of a physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

**A. Claimant’s choice of physician.**

The employee chooses his or her treating physician. W. Va. Code St. R. § 85-20-6.1 However, an employee may be required to choose a physician within a managed health care plan, such as a preferred provider organization or health maintenance organization, established by the employer or insurance carrier and approved by the Insurance Commissioner. W. Va. Code § 23-4-3(b)(2); W. Va. Code St. R. § 85-20-6.1. The Insurance Commissioner, self-insured employer, or insurance company has the right to choose the physician for an independent medical evaluation.

**B. Employer’s right to second opinion and/or Independent Medical Examination.**

The employee and employer each are entitled to have the physician of their choosing attend the examination of the employee performed by the physician selected by the Insurance Commissioner, self-insured employer, or insurance carrier. W. Va. Code § 23-4-8(a). The physician selected by the employee and/or employer has the right to concur in
the resulting report, or may prepare his or her own report of the examination. *Id.* In addition, for claims in litigation, all parties are entitled to “a reasonable number of relevant medical examinations or vocational evaluations,” meaning no more than two per specialty or discipline involved in the litigated issue. W. Va. Code St. R. § 93-1-7.4.A. This limitation may be exceeded upon a showing of necessity. *Id.*

40. **What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?**

Any treatment that is “reasonably required” as a result of the compensable injury is covered. W. Va. Code § 23-4-3(a)(1). Additionally, W. Va. Code St. R. § 85-20-1 *et seq.* sets forth specific and extensive treatment guidelines for a wide range of injuries and diseases. The treatment guidelines further define and clarify what treatments are reasonably required for a given injury or disease. It is noted, however, that the West Virginia Supreme Court of Appeals has invalidated or modified certain guidelines or requirements for treatment. See, *e.g.*, Moore v. K-Mart Corp., 769 S.E.2d 35 (W. Va. 2015).

41. **What prosthetic devices are covered, and for how long?**

Any prosthetic device that is “reasonably required” as a result of the compensable injury is covered until no longer reasonably required. W. Va. Code § 23-4-3(a)(1).

42. **Are vehicle and/or home modifications covered as medical expenses?**

Yes. Such medical goods and supplies “as may be reasonably required” are covered as medical expenses. W. Va. Code §23-4-3(a)(1). The West Virginia Supreme Court has specifically interpreted this language to include automobile modifications. *Crouch v. Commissioner*, 403 S.E.2d 747 (W. Va. 1991).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

The Insurance Commissioner is authorized to establish and amend, from time to time, a schedule of the maximum reasonable amounts to be paid to those rendering treatment or services to employees. W. Va. Code § 23-4-3(a). The fee schedule does not apply to managed care programs. A copy of the fee schedule can be obtained from the Insurance Commissioner’s website (www.wvinsurance.gov).

44. **What, if any, provisions or requirements are there for “managed care”?**

The Workers’ Compensation Act specifically prohibits employers from entering into “contracts with any hospital, its physicians, officers, agents or employees to render medical, mental or hospital service to or give medical or surgical attention therein to any employee . . .” for a compensable workers’ compensation injury. W. Va. Code § 23-4-3(b)(1). This provision, however, does not prevent employers from participating in a managed health care plan, including but not limited to, a preferred provider organization
PRACTICE/PROCEDURE

45. What is the procedure for contesting all or part of a claim?

The claimant, or his or her dependents, may protest (contest) any final decision of the Insurance Commissioner, insurance carrier, or self-insured employer, whichever is applicable. W. Va. Code § 23-5-1(b)(1). “An employer may protest decisions incorporating findings made by the Occupational Pneumoconiosis Board, decisions made by the Insurance Commissioner . . . or decisions entered pursuant to . . . [§ 23-4-7a(c)(1) (relating to permanent partial disability recommendations by treating physician)].” W. Va. Code § 23-5-1(b)(1). This language has been interpreted as limiting the employer’s right to protest to these three categories of decisions. Lowe’s Home Centers, Inc. v. Gregory Gwinn, No. 13-1291 (W. Va. June 1, 2015) (Memorandum Decision) (unpublished). Moreover, the insurance carrier has “sole authority to act on behalf of the employer in the claim,” in all aspects related to litigation, including hiring anddesignating lead counsel. W. Va. Code St. R. § 85-1-7.3; see also W. Va. Code St. R. § 85-8.4.

A written protest must be filed with the Office of Judges within sixty days of receipt of the decision, or the decision becomes final. W. Va. Code § 23-5-1(b)(1). The written protest must include a copy of the decision protested, W. Va. Code St. R. § 93-1-6.1, and must be copied to all parties to the claim. W. Va. Code § 23-5-1(b)(1). The sixty day time limit for filing a protest may be extended by an additional sixty days, for a total of 120 days, upon a showing of good cause or excusable neglect. W. Va. Code § 23-5-6.

46. What is the method of claim adjudication?

A. Administrative level.

A protest to a final decision of the Insurance Commissioner, an insurance carrier, or a self-insured employer must be properly and timely filed with the Office of Judges. W. Va. Code § 23-5-1(b)(1). Thereafter, the Office of Judges will enter a time frame order setting forth the sequence in which evidence is presented. W. Va. Code St. R. §§ 93-1-6.3 and 6.4. During this time frame, the Office of Judges receives evidence and/or argument, and holds hearings. At the conclusion of the time frame, the Office of Judges will issue a written decision affirming, reversing or modifying the protested claim decision. W. Va. Code § 23-5-9(d). The Office of Judges may instead remand a claim for further development if necessary for a full and complete disposition of a protest. W. Va. Code § 23-5-9(e). An appeal from a final decision of the Office of Judges is filed with the Workers’ Compensation Board of Review. W. Va. Code §§ 23-5-10 and 23-5-
In deciding a given protest, the Office of Judges is not bound by the usual common law or statutory rules of evidence. W. Va. Code § 23-5-9(c). The Office of Judges, however, does have its own rules of practice and procedure which govern the litigation of protests before it. These rules are set forth at W. Va. Code St. R. § 93-1-1 et seq.

B. **Trial court.**

Not applicable. The litigation of a workers’ compensation claim is purely administrative.

C. **Appellate.**

As stated above, appeals from any final decision made by the Office of Judges are taken to the Board of Review. The appeal must be filed within 30 days of receipt of notice of the Office of Judges’ final decision, or in any event and regardless of notice, no later than 60 days from the date the final decision. W. Va. Code §§ 23-5-10 and 23-5-12(a). The Board of Review will issue a written order reversing, affirming, or modifying the Office of Judges’ determination. W. Va. Code § 23-5-12(b). Upon motion of any party or upon its own motion, and for good cause shown, the Board of Review may instead remand the claim for additional development. W. Va. Code § 23-5-12(d).

Appeals from any final order of the Board of Review are taken directly to the West Virginia Supreme Court of Appeals. W. Va. Code § 23-5-15(a). The appeal must be filed within 30 days from the date of the final order. Id. All appeals to the Supreme Court are discretionary.

The record considered on appeal from a final decision of the Office of Judges or the Board of Review generally is confined to the record developed before the Office of Judges. According to the procedural rules of the Board of Review, however, evidence not considered by the Office of Judges may be considered by the Board of Review in support of a motion to remand. W. Va. Code St. R. §§ 102-1-4.3 and 102-1-8.2.

In addition to the above, an employer, an insurance carrier, or the Insurance Commissioner may petition for stay of an adverse Office of Judges’ decision. W. Va. Code § 23-5-9(f). Any decision that requires payment of indemnity benefits, or necessarily requires or will result in payment of such benefits, may be the subject of a petition for stay. Id.; W. Va. Code St. R. § 85-1-18.1. No stay may be granted from a decision awarding medical, rehabilitation, or permanent total disability benefits. W. Va. Code St. R. §§ 85-1-18.4. (A certain amount of back permanent total disability benefits may be withheld pending appeal, however. W. Va. Code § 23-4-1d(b)).

A written petition for stay must be filed either with the administrative law judge who authored the decision granting the benefits or with the Board of Review. W. Va. Code § 23-5-9(f). The petition must be filed with the Office of Judges within ten calendar days of the date of the decision, or if filed with the Board of Review, within the deadline to file
an appeal and contemporaneously with that appeal. W. Va. Code St. R. § 85-1-18.2. In either case, the claimant may file a written response to the petition for stay within ten calendar days of the date on which the petition was filed. Id. Every petition must state the reasons why stay is being sought and the grounds for the underlying appeal. W. Va. Code St. R. § 85-1-18.3. Stays are granted only in cases involving extraordinary or exceptional circumstances. Any stay granted lasts until expiration of the deadline to appeal the adverse Office of Judges’ decision, or until the Board of Review resolves the appeal, if an appeal is filed. W. Va. Code St. R. § 85-1-18.5. However, if the Board of Review remands the claim to the Office of Judges, the stay remains in effect until the Office of Judges enters a new decision on the issue. Id.

47. **What are the requirements for stipulations or settlements?**

There are no statutory requirements for stipulations. However, the rules of the Office of Judges govern stipulations made during the litigation of a claim. Stipulations must be written or made orally on the record, and may relate to a question of fact, the contents of a document, or expected testimony of a witness. W. Va. Code St. R. § 93-1-7.3.D.1. Stipulations must be written or stated in clear and unambiguous terms, relevant to an issue in litigation, supported by a factual basis, and understood and agreed to by all parties. W. Va. Code St. R. § 93-1-7.3.D.2. A stipulation of fact accepted by the Office of Judges is binding upon, and may not be contradicted by, the parties. W. Va. Code St. R. § 93-1-7.3.D.3. However, a stipulation pertaining to the contents of a document or expected testimony may be attacked, contradicted, or explained as if the document had actually been submitted into evidence or the witness had actually testified. Id. No stipulation, regardless of type, is binding on the Office of Judges. Id.

The parties to a claim may negotiate a full and final settlement of any and all issues in a claim, including medical benefits, wherever the claim may then be in the administrative or appellate process. W. Va. Code § 23-5-7(a). Medical benefits previously could not be settled in nonorthopedic occupational disease claims. The settlement of medical benefits in these claims was made possible by legislation passed in 2015 and which became effective on June 8, 2015. The claimant must be represented by counsel in order to settle medical benefits in a nonorthopedic occupational disease claim. Id. An orthopedic occupational disease is an occupational disease that involves the musculoskeletal system (bone, muscles, ligaments, tendons, and nerves) as it functions for the purposes of mobility; a nonorthopedic occupational disease is an occupational disease that is not an orthopedic occupational disease. W. Va. Code St. R. §§ 85-12-3.3 and 85-12-3.4. Moreover, hearing loss or hearing impairment claims were expressly excluded from the definition of nonorthopedic occupations disease by legislation that became effective on June 4 2019. W. Va. Code § 23-5-7(a).

Insured employers may participate in settlement only to the extent permitted under the terms of its insurance policy. W. Va. Code St. R. § 85-12-4. Moreover, if a non self-insured employer is inactive in a claim, the Insurance Commissioner, an insurance carrier, or self-insured employer, whichever is responsible for the claim, may negotiate a settlement on its behalf. W. Va. Code § 23-5-7(a). If a self-insured employer defaults in
payment of the settlement, the Insurance Commissioner must assume responsibility for payment and then recover the amount paid from the employer. \textit{Id.}

Every settlement agreement must include the toll free number of the West Virginia State Bar and provide the employee with five business days from the date of execution in which to revoke the agreement. W. Va. Code § 23-5-7(b). The settlement agreement is to be made a part of the claim record for settlements involving all employers other than self-insured employers. W. Va. Code § 23-5-7(a); W. Va. Code St. R. § 85-12-3.10. Any issue that is the subject of a properly executed settlement agreement may not be reopened by any party, except in the case of fraud. W. Va. Code § 23-5-7(a). However, the Insurance Commissioner may void settlement agreements entered into by unrepresented claimants that are found to be unconscionable. W. Va. Code § 23-5-7(b). A settlement is unconscionable if it constitutes a “gross miscarriage of justice or if the terms shock the conscience.” W. Va. Code St. R. § 85-12-14.2. The criteria to be considered in determining whether a settlement is unconscionable includes, but is not limited to: each party’s bargaining position; whether any material terms of settlement were not conspicuous; meaningful alternatives available to the claimant at the time of settlement; whether the claimant had adequate time to read and review the settlement agreement; and whether the claimant was advised of his or her right to obtain a lawyer. \textit{Id.} The claimant bears the burden of proving a settlement is unconscionable, and all settlements are presumed not to be unconscionable. W. Va. Code St. R. § 85-12-14.3.

48. Are full and final settlements with closed medicals available?

Yes. The parties are permitted to settle medical benefits in all claims. W. Va. Code § 23-5-7(a). See answer to No. 47.

49. Must stipulations and/or settlements be approved by the state administrative body?


**RISK FINANCE FOR WORKERS' COMPENSATION**

50. What insurance is required, and what is available (e.g., private carriers, state fund, assigned risk pool, etc.)?

Generally, all employers must have workers’ compensation coverage for their employees. W. Va. Code §§ 23-2-1(a) and 23-2-9. Previously, such coverage was offered exclusively through the State Workers’ Compensation Commission. In 2005, the Workers’ Compensation Commission was terminated and the market was privatized. A single insurance company was given the exclusive right to provide workers’ compensation insurance until July 1, 2008. W. Va. Code § 23-2C-15(a) and (b). The market was fully opened on July 1, 2008, and other insurance companies entered the market. An employer must maintain workers’ compensation insurance through a private carrier or self-insure its risk. W. Va. Code § 23-2C-15(b).
Many State funds were created as a result of the privatization of the workers’ compensation system. These include, among others, the Workers’ Compensation Uninsured Employers’ Fund, Assigned Risk Fund, Self-Insured Employer Guaranty Risk Pool, and Self-Insured Employer Security Risk Pool. W. Va. Code § 23-2C-6(a). Although the 2005 amendments formally created the Self-Insured Employer Guaranty Risk Pool and Self-Insured Employer Security Risk Pool, these funds, having been previously established by the Commission, were in existence prior to 2005.

In addition, political subdivisions, as defined by W. Va. Code St. R. § 114-65-2.9, are permitted to join together to purchase group insurance or to establish and maintain a self-insurance risk pool to provide coverage for their workers’ compensation insurance risks (as well as civil liability risks). Id. at § 114-65-3.1.

Insurance companies pay a fee into the Workers’ Compensation Uninsured Employers’ Fund. W. Va. Code § 23-2C-8(a)(3). Self-insured employers may also be assessed a fee for this fund. Id. Coverage provided by the Assigned Risk Fund is pursuant to a pooling arrangement managed by the Insurance Commissioner, and is intended to be self-sustaining. W. Va. Code § 23-2C-10(c). Assessments may be made on all insurance companies providing workers’ compensation insurance in the event of a deficit in the Assigned Risk Fund. W. Va. Code § 23-2C-10(e). The Self-Insured Employer Security Risk Pool is funded by proceeds received from the draw-down on surety documents in the event of a self-insured employer’s default, graduated premium taxes made by participating self-insured employers for periods through the quarter ending June 30, 2004, certain statutory assessments on self-insured employers, and any other funds made available through legislative grant. W. Va. Code St. R. § 85-19-7.1. The Self-Insured Employer Guaranty risk pool is funded by an annual assessment of 5% of the preceding fiscal year’s premium payments or $5,000, whichever is greater, for the first three years after an employer become self-insured, and thereafter an annual assessment of 2% of the self-insured employer’s preceding fiscal year’s indemnity payments, (excluding payments to fully and finally settle claims) or $5,000, whichever is greater. W. Va. Code St. R. § 85-19-9.1. The Insurance Commissioner may change the assessment methodology or minimum level of funding if necessary to maintain the solvency of the Self-Insured Employer Guaranty Risk Pool. W. Va. Code St. R. § 85-19-9.3. All insurance companies and self-insured employers are assessed amounts for regulatory surcharges, and until January 2019, for debt reduction surcharges. W. Va. Code § 23-2C-3(f). The debt reduction surcharge was eliminated on January 1, 2019. W. Va. Code 23-2C-3(h). The regulatory surcharge is charged to policyholders and remitted to the Insurance Commissioner. W. Va. Code § 23-2C-3(f)(3)(A); W. Va. Code St. R. § 85-6-4.1. Self-insured employers are assessed a certain percentage of their payroll for the regulatory surcharge. W. Va. Code §§ 23-2C-3(f)(2) and (3)(B); W. Va. Code St. R. § 85-6-5.1. The amount of each surcharge is generally determined by the Insurance Commissioner every fiscal year. Id. However, the Insurance Commissioner has set the regulatory surcharge for insurance companies for January 1, 2019 to December 31, 2022, at the rate of 5%. The self-insured regulatory surcharge is .14% for January 1, 2019 through June 30, 2020.
51. What are the provisions/requirements for self-insurance?

A. For individual entities.

There are express requirements for being self-insured, most of them concerning financial responsibility and capability. These requirements are set forth at W. Va. Code § 23-2-9 and W. Va. Code St. R. § 85-18-1 et seq. Employers qualifying for and electing self-insurance must furnish a bond or other security to insure payments, in addition to other requirements. Id.

B. For groups or "pools" of private entities.

The Insurance Commissioner is authorized to create and administer a perpetual self-insurance security risk pool of funds, sureties, securities, and insurance provided by private insurers to secure payment of obligations of self-insured employers. W. Va. Code § 23-2-9(e). An example of such security risk pools are the self-insured employer guaranty risk pool and self-insured employer security risk pool, which were discussed above in the answer to No. 50.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

“Nonresident alien beneficiaries” are entitled to the same benefits as United States citizens. W. Va. Code § 23-4-15a. The Legislature has not addressed illegal aliens specifically, and the issue has not arisen before the West Virginia Supreme Court of Appeals.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

There is no statutory provision specific to terrorist acts and the issue has not otherwise arisen. Presumably, any injury or disease to an employee caused by a terrorist act would be compensable if it otherwise meets the criteria for a compensable injury.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

There are no requirements specific to West Virginia that must be observed. However, the parties must ensure that federal law is observed.

Under 42 U.S.C. § 1395y(b)(2) and Medicare regulations (42 C.F.R. § 411.46), Medicare payments may not be made for items or services to the extent that payment for the same has been, or can be, made under a workers’ compensation law or plan. Moreover, Medicare will not pay for an employee’s medical services related to a compensable...
workers’ compensation injury when the individual receives a settlement, judgment, or award that includes funds for future medical expenses, until such funds are expended. In other words, Medicare is a secondary payer of medical expenses related to a workers’ compensation injury. The obligation to pay medical benefits for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers’ compensation matter which involve a commutation of medical expenses, i.e. the settlement includes an amount for future medical benefits or releases the workers’ compensation carrier from responsibility for future medical benefits. Medicare approval of a settlement, particularly the amount set aside for future medical treatment, is strongly recommended if at the time of the settlement:

A. The employee is a Medicare beneficiary and the settlement amount is greater than $25,000; or

B. There is a reasonable expectation that the employee will become a Medicare beneficiary within 30 months of the settlement and the settlement amount is greater than $250,000.

In either case, Medicare should be notified in the event of a settlement. Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set-aside trust for large settlements, or it may require merely a custodial self-administered trust account. 42 C.F.R §§ 404 and 411; 42 U.S.C. § 1395.

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

West Virginia workers’ compensation law permits settlement of future medical benefits in all claims. Accordingly, when settling future medical expenses related to a compensable injury, the parties must consider the interests of Medicare if the claimant is a Medicare beneficiary, or there is a reasonable expectation that the claimant will enroll in Medicare within 30 months of the settlement, regardless of the settlement amount. If the amount of the settlement meets the applicable Centers for Medicaid & Medicare Services review threshold criteria discussed above, the parties are strongly advised to submit the settlement to Medicare for approval. If the settlement amount is less than the applicable dollar amount threshold, but the settlement otherwise meets the applicable Centers for Medicaid & Medicare Services review criteria, the parties should consider whether it is necessary to include a Medicare set-aside arrangement as part of the settlement or an allocation for future medical expenses within the settlement agreement.

When submitting a request for review and approval of the set-aside arrangement to Medicare, include a cover letter which contains:

A. The employee’s name, date of birth, address, phone number, and Health Insurance Number or Social Security Number if the employee is not yet entitled to Medicare;

B. The name, address, and phone number of the employer;
C. The name, address, and phone number of the workers’ compensation insurer;

D. The date(s) of injury or last exposure;

E. A brief description of the compensable injuries, including the ICD-9 diagnosis codes, if available;

F. Information regarding the employee’s entitlement to Medicare;

G. The total settlement amount;

H. The proposed Medicare set-aside amount;

I. The name of the attorneys representing the employee, employer, and workers’ compensation insurer;

J. The state where the workers’ compensation matter is being litigated; and

K. A medical release.

In addition, the request for approval must include, among other things, the actual settlement agreement, and documentation regarding: the employee’s life expectancy; a life care plan if the injury is serious or extensive; current and future treatment; expected medical recovery; the person responsible for control and documentation of expenditures from the Medicare set-aside account; and the details of the Medicare set-aside account.

55. How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions: (1) that the individual will assign to the State any rights to payment for medical care from any third party; and (2) that the individual will cooperate with the State in identifying or pursuing any third party who may be liable to pay for care and services available under the Medicaid plan, unless good cause for refusing to cooperate is shown. 42 U.S.C. § 1396k(a)(1). State plans for medical assistance must also provide for entering into cooperative arrangements with any appropriate state agency, court or law enforcement officials to assist the state agency administering the state plan with enforcement and collection of rights to support or payment and any other matter of common concern. 42 U.S.C. § 1396k(a)(2). A state is authorized to retain such amount as is necessary to reimburse it (and the Federal Government where appropriate) for medical assistance payments, with the remainder of any such amount retained being paid to the individual. 42 U.S.C. § 1396k(b).

The Workers’ Compensation Act does not contain any statutory provisions specific to this question, and the issue has not otherwise arisen. Subrogation generally is considered in the answer to No. 36.
56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

The HIPAA regulations, at 45 C.F.R 164.512(1)(a), provide an exception for workers’ compensation claims so as to allow the collection of medical records by employers and insurers. Therefore, your current practice of obtaining medical records could proceed under state law. See answer to No. 38 for a discussion of the relevant state law. Issues related to HIPAA have not otherwise arisen.

57. **What are the provisions for “Independent Contractors”?**

The Workers’ Compensation Act contains no provisions regarding independent contractors, nor does it explicitly provide that independent contractors are not employees for workers’ compensation purposes. However, it is clear from the purpose of the Act and case law that independent contractors are not employees for workers’ compensation purposes. *Walls v. McKinney*, 85 S.E.2d 901 (W. Va. 1954). The criteria for determining whether one is an independent contractor for workers’ compensation purposes differs based on whether the worker is engaged in a hazardous or nonhazardous industry. W. Va. Code St. R. § 85-8-6.2. A hazardous industry is one that involves: (1) construction; (2) carriage by land, water, or air; (3) extraction of natural resources; and (4) the manufacture, handling, storage, use, generation or conveyance of molten metal, explosive or injurious gases, chemicals, inflammable vapors, dusts or fluids, corrosive acids, or atomic radiation. W. Va. Code St. R. § 85-8-3.8.

An individual engaged in a hazardous industry is an independent contractor if they meet all of the following criteria:

A. The individual must hold himself or herself out to be in business for himself or herself;

B. The individual generally has control over the time when work is being performed, and his or her work schedule is not dictated by the person or entity for whom the work is performed;

C. The individual has control and discretion over the means and manner of the work, and in achieving the result of the work;

D. Unless expressly required by law, the individual is not required to work exclusively for the person or entity for whom the work is performed; and

E. The individual provides the most significant equipment required to perform the work, if equipment is required to perform the work.

On the other hand, an individual engaged in a nonhazardous industry is an independent contractor if they meet all of the following criteria:

A. The individual possesses any license, permit, or other certification required by federal, state, or local authorities of businesses or individuals engaged in the type of work being performed by the individual;

B. The individual and the person or entity for whom the individual performs services have entered into a written contract that clearly establishes the individual is an independent contract for whom workers’ compensation insurance will not be provided; and

C. The individual maintains primary control over the time, manner, and means of the work performed.


As seen from the criteria above, the test for those engaged in a hazardous industry is more stringent than the test for those who are not. Regardless of the type of industry involved, any individual who performs services for compensation paid by an employer is presumed to be an employee until it is proven that the individual is an independent contractor. *Id.* at § 85-8-6.2. The burden of proving independent contractor status is on the party who asserts it. *Id.*

58. **Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific statutory or regulatory provisions applicable to independent contractors with regard to professional employment organizations, temporary service companies, or leasing companies. W. Va. Code § 33-46A-1 *et seq.* generally governs professional employer organizations, as does W. Va. Code St. R. § 85-31-1 *et seq.*

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

Yes, such independent contractors would be engaged in a hazardous industry and would be subject to the more stringent criteria for determining independent contractor status. W. Va. Code St. R. §§ 85-8-3.8 and 6.2a. See answer to No. 57.

60. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

West Virginia does not have any specific requirements that must be satisfied with respect to the obligation of the parties to protect Medicare’s interests when settling medical benefits. See answer to No. 54.
61. What are the “Best Practices” for defending workers’ compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized “Best Practices” plan.

62. Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

Medical marijuana is permitted in West Virginia. However, the use, dispensing, and prescription of medical marijuana may not begin until July 1, 2019. Medical marijuana may be dispensed to patients and caregivers. A patient may receive medical marijuana only if they have a certification from a medical practitioner registered with and approved by the Bureau of Public Health, and a valid medical marijuana identification card from the Bureau of Public Health. W. Va. Code § 16A-3-2(a)(1)(A). Medical marijuana may be dispensed to caregivers only if they meet the requirements of the West Virginia Medical Cannabis Act, and have a valid medical marijuana identification card from the Bureau of Public Health. W. Va. Code § 16A-3-2(a)(1)(B). Medical marijuana may only be dispensed in the following forms: pill; oil; topical; a medically appropriate form for vaporization or nebulization (excluding dry leaf or plant form unless leaf or plant forms become acceptable under applicable rules); tincture; liquid; and dermal patch. W. Va. Code § 16A-3-2(a)(2).

The West Virginia Medical Cannabis Act contains a number of provisions relating to employment issues that may arise with respect to an employee’s use of medical marijuana. An employer may not discharge, threaten, refuse to hire, or otherwise discriminate or retaliate against an employee solely because of the employee’s status as an individual who is certified to use medical marijuana. W. Va. Code § 16A-15-4(b)(1). However, the employer is not required by the Medical Cannabis Act to make any accommodation for the use of medical marijuana on the employer’s property or premises. W. Va. Code § 16A-15-4(b)(2). The Medical Cannabis Act further permits an employer to discipline an employee for being under the influence of medical marijuana in the workplace or for working while under the influence of medical marijuana when the employee’s conduct falls below the standard of care normally accepted for that position. Id. An employer may also prohibit an employee from performing any duty or task that the employer deems life-threatening to the employee or other employees, while the employee is under the influence of medical marijuana. W. Va. Code § 16A-5-10(3). Lastly, employers are not required to commit any act that would put the employer or any person acting on its behalf in violation of federal law. W. Va. Code § 16A-15-4(b)(3).

In addition, the Medical Cannabis Act generally prohibits anyone from performing any task under the influence of medical marijuana when doing so would constitute negligence, professional malpractice, or professional misconduct. W. Va. Code § 16A-
12-9(1). This general prohibition would apply to employment and non-employment settings.

63. Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?

No, recreational use of marijuana is not permitted.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a “Best Practices” plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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Mark J. Grigoraci, Esquire
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1. **Citation for the State's workers’ compensation statute.**

   Wis. Stat. §102.01-.89 (2011) with April 17, 2012 Amendments

**SCOPE OF COMPENSABILITY**

2. **Who are covered "employees" for purposes of workers’ compensation?**

   a. Every person, including elected officials, in the service of the state or any of its municipalities, regardless of whether the person is a resident or is employed or injured inside or outside of the state;

   b. Peace officers engaged in the enforcement of the peace or the pursuit and capture of those charged with crime;

   c. Every person in the service of another under any contact of hire, express or implied, and all helpers, assistants or employees if employed with the employer’s actual or constructive knowledge, including minors, but excluding domestic servants and other persons whose employment is not in the course of any trade or business unless the employer elects to include them;

   d. Every person selling or distributing newspapers or magazines on the street or from house to house;

   e. Members of volunteer fire companies or of any legally organized rescue squad;

   f. Certain independent contractors and employees of contractors;

   g. National Guard members or active-duty state guard members (provided that equivalent federal benefits are not available);

   h. A participant in a community work experience program;

   i. Students in vocational, technical, and adult education districts who, as part of their program, perform services or manufacture goods sold by the school;

   j. A child performing uncompensated community service as a result of an informal disposition, consent decree, or order;

   k. An adult performing uncompensated community service under a deferred prosecution program;
l. Inmates of state penal institutions if performing assigned work, or working in a work-release or transitional employment program;

m. Certain public or private school students under a work training, work experience, or work study program.

n. An employee, volunteer, member of an emergency management unit or a member of a regional emergency response team.

Note: Domestic servants and true volunteers are not included. Wis. Stat §102.07. Coverage can be obtained for volunteers.

3. Identify and describe any "statutory employer" provision.

An employee of an uninsured subcontractor under an insured general contractor may claim compensation from the general contractor for injuries sustained. Wis. Stat. §102.06 ("Contractor Under" provision). Practically, the State Uninsured Employers Fund would pick up any such claims so long as it is solvent which has essentially suspended the application of claims under Wis. Stat. §102.06. In Acuity v. Olivas, 2007 WI 12, 298 Wis. 2d 640, 726 N.W.2d 258, a general contractor hired a subcontractor to assist with drywall installation projects. The subcontractor recruited persons to assist him with the projects. The Wisconsin Supreme Court concluded that the persons the subcontractor recruited were employees under the Act but not employees of the subcontractor.

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

The employee must establish that the single traumatic incident was a direct cause of injury, a temporary aggravation of a pre-existing condition, or that the traumatic event was a precipitation, aggravation and acceleration of a pre-existing condition. Lewellyn v. Industrial Comm., 38 Wis. 2d 43, 155 N.W.2d 678 (1968).

B. Occupational disease (including respiratory and repetitive use).

An employee must establish that the employment was either the sole cause of a condition or at least a material contributory causative factor in the condition's onset or progression. Universal Foundry Co. v. DILHR, 82 Wis. 2d 479, 263 N.W.2d 172 (1978). An employee's permanent sensitization to cigarette smoke as a result of workplace exposure has been held to be a compensable occupational disease. Kufahl v. Wisconsin Bell, LIRC Dec. No. 88-000676 (12/11/90). The injury date for occupational disease is the date of disability, which in turn has been defined as "the first date of wage loss through lost work time attributable to the effects of the occupational disease." General Cas. Co. v. LIRC, 165 Wis. 2d 174, 180, 477 N.W.2d 422 (Ct. App. 1991) If there was no prior lost time, the date of loss is the last date of employment for the employer whose work was a
material and significant causative factor in the onset and progression of the condition.

5. **What, if any, injuries or claims are excluded?**

Injuries that did not arise out of and while the employee was in the course of the employment are not covered.

6. **What psychiatric claims or treatments are compensable?**

Psychiatric injuries which are a direct consequence of a physically traumatic injury are compensable. The employee only needs to prove that the psychological injury was a direct result of the physical injury. *Johnson v. Industrial Comm.*, 5 Wis. 2d 584, 93 N.W.2d 439 (1958). However, in a claim where the psychiatric injury is not the result of a physical injury, the employee must establish that he or she was exposed to extraordinary emotional stress beyond that experienced by all similarly situated employees. *School District No. 1 v. DILHR*, 62 Wis. 2d 370, 215 N.W.2d 373 (1974); *Swiss Colony v. DILHR*, 72 Wis. 2d 46, 240 N.W.2d 128 (1976); *Probst v. LIRC*, 153 Wis. 2d 185, 450 N.W.2d 478 (Ct. App. 1989).

7. **What are the applicable statutes of limitations?**

The statute of limitations is 12 years from the date of injury or death, or 12 years after the date that compensation, other than treatment or burial expenses, was last paid. Wis. Stat. §102.17(4). However, in the case of an occupational disease or a traumatic injury resulting in the loss or total impairment of a hand or any part of the rest of the arm proximal to the hand, or of a foot or any part of the rest of the leg proximal to the foot, any loss of vision, any permanent brain injury, or any injury causing the need for an artificial spinal disc or a total or partial knee or hip replacement, there shall be no statute of limitations. Benefits or treatment expenses for an occupational disease becoming due after 12 years from the date of injury or death or last payment of compensation, other than for treatment or burial expenses, shall be paid from the work injury supplemental benefit fund under §102.65, and in the manner provided in §102.66. Benefits or treatment expenses for such a traumatic injury becoming due after 12 years after that date shall be paid from that fund and in that manner if the date of injury or death or last payment of compensation, other than for treatment or burial expenses, is before April 1, 2006. Wis. Stat. §§102.17(4) and 102.66(1) & (2).

8. **What are the reporting and notice requirements for those alleging an injury?**

An employee alleging injury must report the incident within 30 days of its occurrence or the date the employee knew or should have known of the injury and its relationship to the employment. However, absence of notice will not bar recovery if it is found that the employer was not misled thereby. There is a laches provision in the statute extinguishing the claim after two years for failure to report. Wis. Stat §102.12. However, the laches provision does not apply if the employer knew or should have known, within the two year period, that the employee had sustained the injury upon which the claim is based.
9. **Describe available defenses based on employee conduct:**

**A. Self-inflicted injury.**

Self-inflicted intentional injuries are not compensable. Wis. Stat. §102.03(1)(d). For purposes of this section, however, negligent acts (such as driving while intoxicated) that result in personal injury will reduce but not necessarily bar a claim for benefits. *Dibble v. DILHR*, 40 Wis. 2d 341, 161 N.W.2d 913 (1968). (A 15% reduction, up to $15,000, is possible if at a hearing the employer proves that the injury was caused by intoxication. Wis. Stat. §102.58). Death by suicide will be compensable if the claimant establishes any substantial evidence that a chain of causation exists linking the suicide to a compensable industrial injury. *Brenne v. DILHR*, 38 Wis. 2d 84, 156 N.W.2d 497 (1968).

**B. Willful misconduct, "horseplay," etc.**

Employees participating in horseplay and receiving injuries will not be compensable if the act was a deviation sufficient to remove the employee from the course of employment. Factors used to determine whether given horseplay was such a deviation includes: (1) the extent and seriousness of the deviation; (2) the completeness of the deviation (i.e., abandonment of duty); (3) the extent to which horseplay had become an accepted part of the employment; and (4) the extent to which the nature of employment may be expected to include horseplay. *Nigbor v. DILHR*, 120 Wis. 2d 375, 355 N.W.2d 532 (1984). A nonparticipating victim of horseplay is entitled to benefits. *Badger Furniture Co. v. Industrial Comm.*, 195 Wis. 134, 217 N.W. 734 (1928).

Willful misconduct can be a complete bar, provided the misconduct constitutes a complete deviation from the scope of employment. *Vollmer v. Industrial Comm.*, 254 Wis. 162, 35 N.W.2d 304 (1948). The following events result in a reduction of compensation by 15% (not to exceed $15,000): (1) employee's failure to use safety devices; (2) employee's failure to obey safety rules; and (3) when the injury is due to the intoxication of the employee or use by the employee of a controlled substance. Wis. Stat. §102.58.

**C. Injuries involving drugs and/or alcohol.**

Where the employer proves the injury was caused by intoxication, compensation is reduced by 15% with a maximum reduction of $15,000. Wis. Stat. §102.58; *Haller Beverage Corp. v. DILHR*, 49 Wis. 2d 233, 181 N.W. 2d 418 (1970). Wis. Stat. §102.58 has been amended to include use of a controlled substance or its analog as set forth in Wis. Stat. §961.01(4m).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

In 1971, Wisconsin enacted a statute specifically designed to deal with fraud in insurance and employee benefit claims. A knowingly false or fraudulent representation, benefit application, account, certificate or proof of loss, to support a claim for payment under a policy of insurance or employee benefit program, to an employer, insurer or agency
charged with administering an employee benefit program, is a violation of criminal law. Wis. Stat. §943.395. Fraud not exceeding $2,500 is a Class A misdemeanor, punishable by a fine of $10,000 or imprisonment not to exceed 9 months, or both, while fraud exceeding $2,500 is a Class I felony, punishable by a fine of $10,000 or imprisonment not to exceed three and one half (3 ½) years, or both.

Prior to January 1, 1994, fraudulent claims for worker's compensation benefits could permissibly be referred to a county district attorney or the Wisconsin Attorney General for prosecution. Effective January 1, 1994, employers/insurers are required to report fraudulent claims to the Department of Workforce Development if the employer/insurer is satisfied that reporting the claim will not impede the ability to defend it. Wis. Stat. §102.125. DWD is mandated to "refer credible cases" to the appropriate district attorney for prosecution. Wis. Stat. §943.395.

11. Is there any defense for falsification of employment records regarding medical history?

Unfortunately, falsification of information on employment records is not a bar to worker's compensation benefits. Tews Lime and Cement Co. v. DILHR, 38 Wis. 2d 665, 158 N.W.2d 377 (1968).

12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?

Vendors' recreational activities with their customers, such as fishing or hunting trips, are not deviations from employment if authorized or directed by the employer. Continental Casualty Co. v. Industrial Comm., 26 Wis. 2d 470, 132 N.W.2d 584 (1965); Schwab v. DILHR, 40 Wis. 2d 686, 162 N.W.2d 548 (1968).

One court used the following factors to hold that a baseball game was within the course of employment whether: (1) the employee was subject to the employer's rules of conduct while at the event; (2) participation was part of job description and performance reviews; (3) participation benefited the employer; and (4) the employer actively solicited employee participation. Wunsch v. City of Fond du Lac Fire Dept., LIRC Dec. No. 93-040966 (December 21, 1994).

A softball game played during a paid 20 minute break was deemed a momentary and insubstantial deviation from employment and hence the injury an employee sustained during the game was found to be compensable where the activity had gone on long enough for the employer to be aware of the activity and to become an incident of employment. E.C. Styberg Engineering Co., Inc. v. LIRC, 2005 WI App. 20, 278 Wis. 2d 540, 692 N.W.2d 322.

With regard to wellness programs, there is a statutory exception precluding liability for injuries occurring while the employee is "engaging in a program designed to improve the physical well-being of the employee, whether or not the program is located on the employer's premises, if participation in the program is voluntary and the employee
receives no compensation for participation." Wis. Stat. §102.03(1)(c)(3).

13. **Are injuries by co-employees compensable?**

Wisconsin generally follows the rule of innocence. If the employee was an innocent bystander to a fight or was not the aggressor, the claim is compensable. Where the employee was the aggressor, the administrative law judges have generally determined that the injuries are not compensable. No state appellate court has commented on these cases.

14. **Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g., "irate paramour" claims)?**

Injuries caused by workplace violence may be compensable if the employment places the employee in a "zone of special danger". This is referred to as the "positional risk" doctrine.

There will be liability where the circumstances of employment put the employee at the time and place where he or she was injured by a force not solely personal to him or her. *Allied Mfg. Ins. v. DILHR*, 45 Wis. 2d 563, 173 N.W.2d 690 (1970); *Cutler-Hammer, Inc. v. Industrial Commission*, 5 Wis. 2d 247, 253-54, 92 N.W.2d 824 (1958).

Personally motivated assaults may invoke the positional risk doctrine if a condition of employment facilitates the injury. *Weiss v. City of Milwaukee*, 208 Wis. 2d 95, 559 N.W.2d 588 (1997).

**BENEFITS**

15. **What criterion is used for calculating the average weekly wage?**

The "average weekly wage" is the greater of two factors: (1) the hourly wage rate multiplied by the number of hours normally scheduled to work (usually 40 hours per week); and (2) the average of the total gross wages earned in the 52 weeks preceding the injury. The employee must have been employed for 90 days to use the average gross wage. There are special rules for seasonal and part-time employees. Wis. Stat. §102.11. It is presumed, unless rebutted by reasonably clear and complete documentation, that the normal full-time workweek established by the employer is 24 hours for a flight attendant, 56 hours for a firefighter, and not less than 40 hours for any other employee. Wis. Stat. §102.11(4).

16. **How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?**

Temporary total disability benefits are paid at the rate of two-thirds of the average weekly wage. The maximum rate varies depending on the year in which the injury occurred. For 2015 injuries, the maximum temporary total disability rate is $911 per week. Average weekly earnings for temporary disability, permanent total disability or death benefits for
injury after January 1, 1982, shall not be less than $30. Wis. Stat. § 102.11(1).

17. **How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

There is no specific statutory requirement for “prompt payment” of disability benefits, but the Department of Workforce Development generally requires an employer/insurer to pay 80% of all indemnity claims within 14 days of the injury.

18. **What is the “waiting” or “retroactive” period for temporary benefits (e.g., must be out _____ days before recovering benefits for the first _____ days)?**

If an employee is off less than 8 days, there is a 3 day waiting period. If the employee is disabled on the 8th day there is no waiting period. Wis. Stat. §102.43.

19. **What is the standard/procedure for terminating temporary benefits?**

Temporary disability must be paid when two things occur at the same time: (1) a wage loss; and (2) a healing period is not yet reached. Temporary disability may be terminated when the employee returns to work during the healing period. You may owe temporary partial benefits if there is a partial wage loss. Benefits are also terminated when a medical practitioner indicates that maximum medical improvement has been reached. See also, Wis. Admin. Code §DWD 80.47. Larsen Co. v. Industrial Comm., 9 Wis. 2d 386, 101 N.W.2d 129 (1960); Knobbe v. Industrial Comm., 208 Wis. 185, 242 N.W. 501 (1932). An employer/insurer must advise the employee and Department of Workforce Development that benefits are being terminated and that, if the employee disagrees, he or she has a right to a hearing on the issue. However, if an employee who has sustained a compensable injury undertakes in good faith invasive treatment that is generally medically acceptable, but that is unnecessary, the employer shall pay disability indemnity for all disability incurred as a result of that treatment. An employer is not liable for disability indemnity for any disability incurred as a result of any unnecessary treatment undertaken in good faith that is noninvasive or not medically acceptable. Wis. Stat. §102.42 (1m).

Wis. Stat. §102.43(9) allows for the suspension of temporary total disability payments when an employee is able to return to restricted work during the healing period, if any of the following apply: (1) the employee is offered suitable employment within his or her physical and mental limitations; (2) the employee has been suspended or terminated due to the employee’s alleged commission of a crime substantially related to the employment AND the employee has been formally charged (If the employee is found not guilty, temporary total disability is due); or (3) the employee has been suspended or terminated due to the employee’s violation of the employer’s drug policy during the period when the employee could return to a restricted type of work during the healing period (The drug policy must have been established in writing and regularly enforced prior to the date of injury).
Compensation for temporary disability will be suspended for an employee who has been convicted of a crime, is incarcerated, and not available to return to work during the healing period. Wis. Stat. §102.43 (9)(d).

20. **Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

You are only entitled to a credit if there has been an overpayment of temporary total disability benefits.

21. **What disfigurement benefits are available and how are they calculated?**

Benefits are awarded where the disfigurement is: (1) permanent; (2) visible in the ordinary course of employment; and (3) likely to occasion a potential wage loss. Wis. Stat. §102.56. As of April 17, 2012, Wis. Stat. §102.56(1) & (2) is amended. Now, disfigurement will not be allowed for an employee who returns to work for the employer at the time of injury or who is offered employment by that employer at the same or higher wage, unless employee has an actual wage loss. The maximum benefit is the average annual earnings, or 50 times the average weekly wage at the time of injury. In addition to the appearance and location of the disfigurement, factors considered in determining the award include the employee’s age, education, training, previous experience and earnings, current occupation and earnings, and likelihood of future suitable occupational change.

22. **How are permanent partial disability benefits calculated including the minimum and maximum rate?**

Benefits are two-thirds of the average weekly earnings at the time of injury, but not less than $30. The average weekly earnings for permanent partial disability for injuries occurring on or after January 1, 2010, and before May 1, 2010, with wages of at least $423, resulting in a maximum compensation rate of $282, and, for injuries occurring on or after May 1, 2010, earning at least $438, resulting in a maximum compensation rate of $292. For injuries occurring on or after January 1, 2011, and after January 1, 2012, the rate is $302. For injuries occurring on or after April 17, 2012, the rate is increased to $312. For injuries occurring on or after January 1, 2013, January 1, 2014, or January 1, 2015, the maximum rate remains at $322.

A. **How many weeks are available for scheduled members/parts, and the standard for recovery?**

Over two dozen named injuries subject to the schedule are set forth in Wis. Stat. §102.52. Medical doctors determine “relative disabilities” to scheduled parts of the body. There is a guideline for determining relative disabilities in Wis. Admin. Code §DWD 80.32. An example of the calculation of a relative disability is as follows. Assume a permanent disability of 10% at the hip joint. Total disability at the hip joint is 500 weeks of permanent disability. A 10% disability in this case is 50 weeks of permanent partial disability. The benefits are paid on a weekly or monthly basis after the healing plateau is
reached and temporary disability benefits have been terminated. Benefits are increased by 25% if the employee sustains an injury to the hand listed in the schedule and the injured hand is the employee’s dominant hand. Wis. Stat. §102.54.

B. Number of weeks for “whole person” and standard for recovery.

Those injuries not specifically set forth in Wis. Stat. §102.52 are considered “unscheduled” and available for a “whole person” rating. Such injuries include a disability affecting the torso, head, and mental faculties other than hearing or sight. The maximum number of weeks for a whole person permanent disability is 1,000. Wis. Stat. §102.44(3). This is a medical rating subject to certain guidelines. However, “unscheduled” functional permanency cases are also available for an assessment of lost earning capacity by a vocational expert. Northern States Power Co. v. Industrial Comm., 252 Wis. 70, 30 N.W.2d 217 (1947). Wisconsin is an “earning capacity” state, so the vocational experts determine what percentage the pre-injury earning capacity has been diminished by the physical residuals of an injury. Comparison between pre- and post-injury wages is relevant but not dispositive. Any functional permanency that has been paid for an unscheduled injury is deducted from the loss of earning capacity assessment.

23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?

Vocational rehabilitation retraining maintenance benefits (temporary total disability during a school program) are available. Wis. Stat. §102.61. The employee can work part-time, or 24 hours per week, and still be entitled to the full temporary total disability benefit for that week. Wis. Stat. §102.43(5), effective April 17, 2012. An employee must have sustained permanent disability as the result of a compensable injury. If an employee is not able to return to suitable employment with the employer, he or she is to be evaluated by the state Division of Vocational Rehabilitation. Johnson v. LIRC, 177 Wis. 2d 736, 503 N.W.2d 1 (Ct. App. 1993). Suitable employment means employment that is within an employee’s permanent work restrictions, that the employee has the physical capacity, knowledge, transferable skills, and ability to perform, and pays not less than 90% of the employee’s pre-injury average weekly wage. Wis. Stat §102.61(1g)(a). If the employee cannot receive retraining through the DVR, the suitable employment wage requirement is decreased to 85% of the employee’s pre-injury average weekly wage. Wis. Admin. Code §DWD 80.49(4) and (5).

The DVR counselor’s decision regarding retraining may not be challenged unless there is a showing of fraud or a flagrant abuse of discretion. Massachusetts Bonding & Ins. Co. v. Industrial Comm., 275 Wis. 505, 82 N.W.2d 191 (1957).

Based on the April 17, 2012 amendments, the insurance carriers and self-insured employers will be liable for reasonable costs of a retraining program including the cost of tuition, fees, and books in cases where the Division of Vocational Rehabilitation provides services for the rehabilitative training program. Wis. Stat. §102.61(1), (1g) (b), (1m) (d) & (1r) (c).
24. **How are permanent total disability benefits calculated, including the minimum rates?**

Permanent total disability can be awarded under two sets of circumstances. There are certain “scheduled permanent total disabilities” that warrant the automatic award of permanent total disability. Wis. Stat. §102.44(2). There are also “vocational permanent total disabilities” arising out of an assessment of 100% vocational disability by a vocational expert. See answer 23. In either case, benefits are paid at the applicable temporary total disability rate (two-thirds of the average weekly wage) for as long as the employee lives. You may be entitled to take a social security disability offset against these payments.

25. **How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

In all cases where death of an employee proximately results from the injury, the employer/insurer shall pay the reasonable expense for burial. As of May 1, 2010, the maximum burial expense was increased to $10,000, and as of 2015 it remains at that amount. (Wis. Stat. § 102.50.)

**B. Dependency claims.**

Dependents, usually the spouse or minor child of the deceased, are entitled to four times the employee’s annual earnings (200 times the average weekly wage) at the time of injury as a death benefit. Such benefits are paid in four yearly installments starting on the date of death. The maximum death benefit for a 2015 injury is $273,300. Wis. Stat. §§102.46-.50; Wis. Stat. §102.11(1).

26. **What is the criteria for establishing a “second injury” fund recovery?**

An employee must establish permanent disability from a compensable injury equal to 200 weeks of compensation and permanent disability from a non-work condition of 200 weeks permanent disability. Benefits are then available for the second non-work permanency at the termination of all work-related disability payments. Wis. Stat. §102.59(1). (April 17, 2012 amendment clarifies that an employee will only be limited to one (1) claim from the Second Injury Fund.)

27. **What are the provisions for reopening a claim for worsening of condition, including applicable limitation periods?**

All claims are open, unless specifically closed by compromise, for the length of the applicable limitation period. Wis. Stat. §102.17(4). In those cases where a “final order” has been obtained after a hearing, only medical expense claims remain open. Administrative law judges are permitted to issue “interlocutory orders,” reserving jurisdiction on any or all issues. There is some controversy over whether an interlocutory order as to one issue leaves open all issues. There is a strong policy coming from the
administrative agency, the DWD, to leave cases open.

28. **What situation would place responsibility on the employer to pay an employee’s attorney fees?**

   All attorney fees are paid directly to the attorney from the employee’s award. Wis. Stat. §102.26(3)(b).

**EXCLUSIVITY/TORT IMMUNITY**

29. **Is the compensation remedy exclusive?**

   A. **Scope of immunity.**

   The exclusive remedy provision protects the employer, co-employees and the worker’s compensation insurer from third party suit. Wis. Stat. §102.03(2).

   B. **Exceptions (intentional acts, contractual waiver, “dual capacity,” etc.).**

   There are two statutory exceptions: (1) an assault intended to cause bodily harm by a co-employee; and (2) suit against a co-employee for negligent operation of a motor vehicle not owned or leased by the employer. Wis. Stat. §102.03(2). There are also several limited exceptions recognized by appellate court decision: (1) implied waiver of the immunity by endorsement to an auto liability policy, *Backhaus v. Krueger*, 126 Wis. 2d 178, 376 N.W.2d 377 (Ct. App. 1985); (2) where the employer acted in a persona distinct from its status as an employer, *Henning v. General Motors Assembly Div.*, 143 Wis. 2d 1, 419 N.W.2d 551 (1988); and (3) where the employer expressly accepted responsibility for injuries to persons on a job site, *Schaub v. West Bend Mutual*, 195 Wis. 2d 181, 536 N.W.2d 123 (Ct. App. 1995).

30. **Are there any penalties against the employer for unsafe working conditions?**

   An employer can be compelled to pay an additional 15% of compensation, up to $15,000, where the injury was caused by the failure to follow Occupational Safety and Health Administration regulations or where the employer failed to provide a safe place of employment. Wis. Stat. §102.57; Wis. Stat. §101.11 (“Safe Place Statute”).

31. **What is the penalty, if any, for an injured minor?**

   When the injury is sustained by a minor illegally employed, compensation shall be doubled, up to a maximum of $7,500, if the employee does not have a written work permit; triple the compensation, up to a maximum of $15,000, is paid if the minor is working at prohibited employment. The penalty is not paid to the minor but rather is paid into the state Supplemental Benefit Fund. Wis. Stat. §102.60.

32. **What is the potential exposure for “bad faith” claims handling?**
The bad faith penalty is 200% of compensation, including medical expenses, up to a maximum of $30,000 for each act of bad faith. Wis. Stat. §102.18(1)(bp). Where the employer/insurer “inexcusably” fails to pay, a penalty of 10% of the delayed compensation can be awarded. Wis. Stat. §102.22(1). The two penalties may not be awarded concurrently.

33. **What is the exposure for terminating an employee who has been injured?**

An employer can be fined up to a year’s wages for unreasonable refusal to rehire the employee. Wis. Stat. §102.35(3). The employer must prove the termination was: (1) “fit, fair and just under the circumstances”; (2) the result of an inability to provide work suited to the employee’s physical and mental limitations; or (3) the result of a seniority provision in a collective bargaining agreement. *West Bend Co. v. LIRC*, 149 Wis. 2d 110, 438 N.W.2d 823 (1989); *West Allis School District v. DILHR*, 116 Wis. 2d 410, 342 N.W.2d 415 (1984).

**THIRD PARTY ACTIONS**

34. **Can third parties be sued by the employee?**

Yes. The employer, insured, or the Department (State Fund), if the Department pays or is obligated to pay a claim under Wis. Stat. §§102.18(1) or 102.66(1), shall have the right to share in any settlement based on a statutory right. Wis. Stat. §102.29(1)(a). (Statute renumbered and changed effective April 17, 2012.)

35. **Can co-employees be sued for work-related injuries?**

A co-employee cannot be sued, unless the injury resulted from an intentional assault, or the co-employee operated a motor vehicle not owned or leased by the employer. Wis. Stat. §102.03(2).

36. **Is subrogation available?**

The employer/insurer/the Department (State Fund) enjoys the same right to sue the third party as the employee. The award is distributed in accordance with the schedule set forth in Wis. Stat. §102.29(1)(a).

**MEDICALS**

37. **Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

The Act does not contain a provision for penalizing an employer/insurer for late payment of a medical bill, although the state Office of Commissioner of Insurance generally holds that such bills should be paid or denied within 30 days of their receipt and accompanying proof of their alleged relationship to the injury.
38. **What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

The Department of Workforce Development (formerly DILHR) may, after a prehearing conference, “issue an order requiring disclosure or exchange of any information or written material which it considers material to the timely and orderly disposition of the dispute or controversy.” Wis. Stat. §102.17(1)(b). A failure to comply with the terms of such an order may result in a dismissal of a pending claim without prejudice or an order excluding evidence relating to the information at hearing. The DWD will order production of reports upon written request by a party to do so, even without a prehearing conference, as a matter of DWD policy.

To be admissible at hearing, medical reports must be filed and served on a form WKC-16-B at least 15 days in advance of the hearing. Wis. Stat. §102.17(1)(d); Wis. Admin. Code §DWD 80.22. Unless good cause is shown, a failure to meet these preconditions will result in exclusion of non-conforming medical reports at the hearing.

There is technically a waiver of the physician-patient privilege as to “reasonably related” medical records which occur as a matter of law when the employee reports an industrial injury, or makes a claim for benefits. Wis. Stat. §102.13(2). However, many medical records custodians will not disclose any records without a signed authorization. Records custodians also frequently misconstrue the term “reasonably related” so that relevant medical records are not disclosed. Complete medical records may be subpoenaed to hearing, but in such cases, the records are not available to the independent medical examiner or defense attorney in advance of the hearing and a concluding hearing may be necessary to protect the due process rights of the employer/insurer.

39. **What is the rule on choice (a) Claimant’s choice of physician; (b) Employer’s right to a second opinion and/or Independent Medical Evaluation?**

Where the employer has notice of an injury and its relationship to the employment, the employer shall offer to the employee its choice of practitioner. Practitioners include physicians, chiropractors, psychologists, and podiatrists. The employee has a right to a second choice of attending practitioner on notice to the employer/insurer. Partners and clinics count as one practitioner, and treatment by one practitioner on referral from another is deemed to be treatment by one practitioner. Wis. Stat. §102.42(2).

An employee who claims compensation must submit to one or more reasonable examinations by a practitioner selected by the employer if the employer so requests in writing. Wis. Stat. §102.13(1). Claimant may not be required more than 100 miles to participate in the examination except in special circumstances. Expenses must be tendered in advance. Wis. Stat. §102.13(1)(b). By department policy, expenses include wages lost as a result of the examination and mileage. The notice of the examination must include the date, time and place of the exam and the procedure for changing them, as well as the examiner’s area of specialty. The notice must also explain the employee’s rights to have a personal physician present at the exam, right to receive copies of all reports generated from the exam, and to have a translator present if the employee has
difficulty communicating in English.

40. **What is the standard for covered treatment (e.g., chiropractic care, physical therapy, etc.)?**

Wisconsin adopted treatment guidelines effective for treatment received on or after November 1, 2007. Wis. Admin. Code Ch. DWD 81. The guidelines only apply to conceded claims. Wis. Admin. Code §DWD 81.01(2). For treatment not specifically covered in §§DWD 81.04 to 81.13, the code allows treatment reasonable and necessary for the diagnosis and to cure or relieve a condition consistent with the current accepted standards of practice within the scope of the provider’s license or certification. Wis. Admin. Code §DWD 81.03(10).

In general, the guidelines require medical providers to evaluate the medical necessity of all treatment on an ongoing basis to determine if there is progressive improvement. If the provider determines there is not progressive improvement in two of the following categories - subjective reports of improving pain, progressively improving objective clinical signs, or progressively improving functional status – the modality shall be discontinued or significantly modified or the provider shall reconsider the diagnosis. Wis. Admin. Code §DWD 81.04(c). Providers may depart from the guidelines if there is a documented medical complication, previous treatment did not meet the accepted standard of practice, the treatment is necessary to assist the patient in the initial return to work where the work activities place stress on the body part affected by the workplace injury, the treatment continues to cause progressive improvement in the patient’s condition, or there is an incapacitating exacerbation of the patient’s condition. The guidelines have specific provisions covering medical imaging studies and the treatment of low back pain, neck pain, thoracic back pain, upper extremity disorders, complex regional pain syndrome of the upper and lower extremities, inpatient hospitalizations, surgical procedures, and chronic management.

Covered treatment includes medical, surgical, chiropractic, psychological, podiatric, dental and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances, and training in the use of artificial members and appliances. Wis. Stat. §102.42(1). A procedure has been established to resolve disputes concerning the reasonableness of fees and the necessity of treatment. The guidelines in Wis. Admin. Code Ch. 81 are factors for an impartial health care services review organization and a member from an independent panel of experts established by the department to consider in rendering opinions to resolve necessity of treatment disputes arising under Wis. Stat. § 102.16(2m) and Wis. Admin. Code § 80.73. With regard to reasonableness of fees, bills are subject to reduction if they exceed a fixed amount and set forth in a certified database. There is an appeal process for the medical provider to challenge the decision. The employee is not responsible to pay the difference between the allowed amount and the amount charged. Wis. Admin. Code §DWD 80.72. The DWD will have a third “independent” medical practitioner review disputes on necessity of treatment and that practitioner’s finding binds the parties. Wis. Admin. Code §DWD 80.73.
41. **Which prosthetic devices are covered, and for how long?**

Prosthetic appliances are subject to the same standard as all other medical treatment (see answer 40). Liability for repair and replacement of prosthetic devices is limited to the effects of normal wear and tear. Artificial members furnished at the end of the healing period for cosmetic purposes only need not be duplicated. Wis. Stat. § 102.42(5).

42. **Are vehicle and/or home modifications covered as medical expenses?**

The Commission has held that a van is not a medical supply and thus the employer/insurer was not required to purchase a vehicle for an employee who became a paraplegic after an injury. However, the employer/insurer was required to pay for modifications to the vehicle to accommodate the individual’s handicap. *Flynn v. Allen Roofing & Construction Co.*, WC Claim No. 87-048518 (LIRC June 13, 1990).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. Wis. Stat. §102.16(2), (2m), Wis. Admin. Code Chapter DWD 80.

44. **What, if any, provisions or requirements are there for “managed care”?**

None. A review of medical bills to determine whether they are reasonable is permitted under certain guidelines. See answer 40.

**PRACTICE/PROCEDURE**

45. **What is the procedure for contesting all or part of a claim?**

Claims for indemnity and medical expense are contested by filing an application for hearing which the DWD. The respondents (employer/insurer) must answer within 20 days on forms provided by the DWD. If the employee is not represented or if there are multiple issues a prehearing conference may be held. A 30 minute discussion between the parties prior to trial, may be held. The Department has also recently enacted settlement conferences, prior to hearing on some cases. A formal hearing, usually limited between two and four hours, will be scheduled within approximately two months of the filing of the Certification of Readiness form, which notifies the Department that the Applicant is ready to proceed with a Hearing. An administrative law judge finds facts and renders conclusions of law in a written decision following the hearing. The written decision should be issued within ninety days of the hearing and close of the record. Wis. Stat. §§102.17 and 102.18.

46. **What is the procedure for contesting all or a part of a claim?**

**A. Administrative level.**

Initial determinations are made by an administrative law judge employed by the Department of Workforce Development’s Worker’s Compensation Division. The case
can then be appealed to the Labor and Industry Review Commission, a three-person politically appointed panel which acts on cases where petitions for review have been filled.

B. Trial court.

Circuit court appeals are permitted. A Labor and Industry Review Commission (LIRC) award may be set aside because: (1) LIRC acted without authority or in excess of its powers; (2) the order was procured by fraud; or (3) LIRC’s findings of fact do not support the order or award. Wis. Stat. §102.23.

C. Appellate.

The Wisconsin Court of Appeals and Supreme Court are subject to the same jurisdictional requirements as the circuit court.

47. What are the requirements for stipulations or settlements?

Stipulation and compromise agreements are permitted, both subject to review by the DWD. In order to obtain a full and final compromise on a particular claim, the DWD must find there is a “valid dispute” between the parties. No compromise is enforceable unless it is reviewed and approved by the DWD. Wis. Stat. §102.16(1); Wis. Admin. Code §DWD 80.03.

48. Are full and final settlements with closed medical available?

Yes. Yet, you also need to address Medicare Set-Aside issues.

49. Must stipulations and/or settlements be approved by the state administrative body?

Yes. Wis. Stat. §102.16(1). See answer 47.

RISK FINANCE FOR WORKERS’ COMPENSATION

50. What insurance is required, and that is available (e.g., private carriers, State Fund, assigned risk pool, etc.)?

All “employers” within the meaning of Wis. Stat. §102.04(1) must be insured for worker’s compensation or receive permission from the DWD to be self-insured. Wis. Stat. §102.28. Private insurers service the majority of employers. There is an “assigned risk pool” for those employers who are not able to obtain private insurance or permission to be self-insured.

51. What are the provisions/requirements for self-insurance?

A. For individual entities.

The requirements for self-insurance by an individual entity are set forth in Wis. Stat.
§102.28(2) and Wis. Admin. Code Chapter DWD 80. Essentially, a determination is made as to whether the applicant for self-insurance status is financially solvent and able to meet its expected obligations, given past injury and claim history.

B. For groups or “pools” of private entities.

Insurance pools are permitted. “Safety group dividends” may be formed among employers with similar classes, industries, trades or professions, so long as they agree to a special loss control program. Wis. Stat. §631.51. It is also possible for a group of employers to form a “mutual insurance company.” Wis. Stat. §611. Risk sharing pools are also permitted. Wis. Stat. §619. Risk sharing pools are groups of private employers who contract with a single insurer to insure each member of the group. This is a highly regulated area and contact should be made with the DWD and Office of Commissioner of Insurance before taking such action.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?


53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

A terrorist act would be subject to the same principles applicable to injuries by other third parties. See answer 14.

54. Are there any state specific requirements which must be satisfied in light of the obligation of the parties to satisfy Medicare’s interests pursuant to the Medicare Secondary Payer Act?

Wisconsin does not have any formal requirements that must be satisfied when Medicare’s interests are implicated in a worker’s compensation claim. Yet, we advise clients to take Medicare’s interests into consideration in all settlements, and to follow all policies adopted by the Centers for Medicare and Medicaid Services (“CMS”). Some judges in the Worker’s Compensation Division will require the parties to address Medicare’s interests by either providing for a Medicare Set-Aside Agreement, leaving future medical expenses open, or agreeing to pay future medical expenses in the compromise agreement before a settlement will be approved.

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of worker’s compensation by a worker’s compensation carrier or self-insured
employer. The obligation to pay for medical expenses for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a worker’s compensation matter, when the settlement closes out future medicals. CMS currently imposes the following review thresholds:

- The employee is already a Medicare beneficiary and the total settlement amount is greater than $25,000; or
- There is a reasonable expectation that the employee will be a Medicare beneficiary within 30 months of the settlement and the settlement amount is greater than $250,000.

Note that these requirements are subject to change. CMS does not issue review letters for claims that do not meet their review thresholds. The recommended method to protect Medicare’s interests is to consider and, if necessary, include a WCMSA as part of the worker’s compensation settlement.

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights for payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b). The duty to reimburse for payments is set forth in Wis. Stat. § 102.27(2)(b).

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

Although state and federal law generally treat medical records as confidential, and these records may not be disclosed without the consent of the patient, HIPAA and state law permit disclosure of medical records to employers and insurers, for worker’s compensation purposes, without an authorization. [45 C.F.R. 164.512(l), and Wis. Stats. §§102.13(1)(a), (2)(a), and 146.81(4), 146.82(1)]. Even though there is this exception, the HIPAA regulations are adhered to when disclosing information to third parties. Also, the healthcare providers are concerned with the HIPAA regulations. In all practical purposes, an authorization is required to obtain complete medical records.

57. **What are the provisions for “Independent Contractors”?**
Wis. Stat. § 102.07(8)(b) provides a 9-part test to determine who is an independent contractor. All 9 elements must be met in order for a person to be deemed an independent contractor and not an employee. In practice, it is often difficult to establish that all 9 elements have been met.

An independent contractor will not be an employee of an employer for whom the independent contractor performs work or services if the independent contractor meets all of the following conditions:

1. Maintains a separate business with his or her own office, equipment, materials and other facilities.

2. Holds or has applied for a federal employer identification number with the federal internal revenue service or has filed business or self-employment income tax returns with the federal internal revenue service based on that work or service in the previous year.

3. Operates under contracts to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work.

4. Incurs the main expenses related to the service or work that he or she performs under contract.

5. Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or service.

6. Receives compensation for work or service performed under a contract on a commission or per job or competitive bid basis and not on any other basis.

7. May realize a profit or suffer a loss under contracts to perform work or service.

8. Has continuing or recurring business liabilities or obligations.

9. The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

Employers in the construction, painting, and drywall trades are subjected to a $25,000 penalty, per occurrence, for misclassifying employees as independent contractors.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?
Professional employment organizations, temporary service companies, and leasing companies are considered “temporary help agencies.” "Temporary help agency" means an employer who places its employee with or leases its employees to another employer who controls the employee's work activities and compensates the first employer for the employee's services, regardless of the duration of the services. Wis. Stat. 102.01(2)(f).

A temporary help agency is the employer of an employee whom the temporary help agency has placed with or leased to another employer that compensates the temporary help agency for the employee's services. A temporary help agency is liable under Wis. Stat. § 102.03 for all compensation and other payments payable under this chapter to or with respect to that employee, including any payments required under Wis. Stats. §§ 102.16(3), 102.18(1)(b) or (bp), 102.22(1), 102.35(3), 102.57, or 102.60. Except as permitted under Wis. Stat. § 102.29, a temporary help agency may not seek or receive reimbursement from another employer for any payments made as a result of that liability. Wis. Stat. § 102.04(2m).

59. Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?

The 9-part test in Wis. Stat. § 102.07(8)(b) is used to determine whether an owner/operators of trucks or other vehicles for driving or delivery of people or property is an independent contractor is governed. Jarrett v. LIRC, 2000 WI App. 46, 233 Wis. 2d 174, 607 N.W.2d 326.

In C.W. Transport, Inc. v. LIRC, 128 Wis. 2d 520, 383 N.W.2d 921 (Ct. App. 1986), an owner/operator delivered a load for C.W. and entered a trip lease with another common carrier for the return trip. The court of appeals found that the owner/operator was an employee of C.W. and not the common carrier with whom the trip lease was signed because C.W. “reserved a modicum of direction and control during the trip lease.” The modicum of direction and control consisted of the requirement that C.W. approve the trip lease, be apprised of the owner/operator’s schedule, and retain 7% of the trip lease payment for administrative expenses (the trip lease carrier issued payment to C.W. who would remit payment to the owner/operator less the 7%).

60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?

Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.
The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state by contacting ALFA at (312) 642-ALFA (2532).
1. Citation for the state's workers' compensation statute.

Wyoming Statutes § 27-14-101, et seq., proscribes the Wyoming Workers’ Compensation Act (hereinafter, “the Act.”).

SCOPE OF COMPENSABILITY

2. Who are covered "employees" for purposes of workers' compensation?

Under the Act, covered employees are “any person engaged in any extrahazardous employment under any appointment, contract of hire or apprenticeship, express or implied, oral or written, and includes legally employed minors, aliens authorized to work by the United States department of justice, office of citizenship and immigration services, and aliens whom the employer reasonably believes, at the date of hire and the date of injury based upon documentation in the employer’s possession, to be authorized to work by the United States department of justice, office of citizenship and immigration services.” Wyo. Stat. § 27-14-102(a)(vii).

The Act specifically excludes from the definition of employee: 1) any individual whose employment is determined to be causal labor; 2) sole proprietors or partners of business partnerships (unless coverage is elected); 3) an officer of a corporation (unless coverage is elected); 4) independent contractors; 5) a spouse or dependent of an employer living in the employer’s household; 6) a professional athlete1; 7) an employee of a private household; 8) a private duty nurse engaged by a private party; 9) an employee of the federal government; 10) any volunteer2; 11) any adult or juvenile prisoner or probationer; 12) any elected or appointed public official of any governmental board or commission, except for a duly elected or appointed county officer; 13) any owner and operator of a motor vehicle which is leased or contracted with driver to a for-hire common or contract carrier; 14) any member of a limited liability company (unless coverage is elected); 15) any foster parent providing foster care services for the department of family services or for a certified child placement agency; 16) any individual providing child day care or

1 Team owners are required to obtain coverage for professional athletes under a different section of the act. Wyo. Stat. §§ 27-14-102(a)(xxix) and 27-14-108(q).
2 Unless covered pursuant to Wyo. Stat. § 27-14-108(e), which covers an enumerated number of volunteers, including but not limited to firefighters, search and rescue personnel, search pilots, law enforcement personnel, etc.
babysitting services, whose wages are subsidized or paid in whole or in part by the Wyoming department of family services; and 17) any responsible broker, associate broker or salesperson licensed under the Real Estate License Act, who receives compensation for their services. Wyo. Stat. § 27-14-102(a)(vii)(A)-(S).

Those working in extrahazardous industries must be covered by workers’ compensation insurance. Wyo. Stat. § 27-14-108(a). The “extra hazardous” industrial occupations enumerated by the Act include: agriculture, mining, utilities, construction, manufacturing, wholesale trade, retail trade, transportation and warehousing, information, real estate (including rental and leasing), administrative and support and waste management and remediation services, educational services, health care and social services, arts entertainment and recreation, accommodation and food services, other services (including repair and maintenance, personal and laundry services, dry-cleaning, and pet care), and public administration, including human resource and environmental quality programs. Wyo. Stat. § 27-14-108(a)(ii)(A)-(S).

The Act also specifically enumerates the instances in which governmental employees are covered by the Act. Wyo. Stat. § 27-14-108(d).

Further, any employer can elect to cover all of its employees, regardless of industrial classification, and any corporation or limited liability company may elect to obtain coverage for its corporate officers or limited liability company members. Wyo. Stat. § 27-14-108(j)-(k).

3. Identify and describe any "statutory employer" provision.

A statutory employer is any person or entity that employs an employee engaged in any extrahazardous occupation enumerated in the Act, or electing to cover an employee under Wyo. Stat. § 27-14-108(j) or (k), and at least one of whose employees is described in Wyo. Stat. § 27-14-301. See Wyo. Stat. § 27-14-102(a)(viii).

4. What types of injuries are covered and what is the standard of proof for each:

A. Traumatic or "single occurrence" claims.

Any injury arising out of and in the scope of employment is compensable. “Injury” “means any harmful change in the human organism other than normal aging and includes damage to or loss of any artificial replacement and death, arising out of and in the course of employment while at work in or about the premises occupied, used or controlled by the employer and incurred while at work in places where the employer’s business requires an employee’s presence and which subjects the employee to extrahazardous duties incident to the business.” Wyo. Stat. § 27-14-102(a)(xi).

The employee has the burden of establishing all essential elements of the claim by a preponderance of the evidence. Coronary conditions and hernias have specific burden of proof requirements. Wyo. Stat. § 27-14-603(b). Mental injury claims are also subject to
special evidentiary requirements, including proof that the mental injury was caused by, and occurred simultaneously with or subsequent to, a compensable physical injury. See Wyo. Stat. § 27-14-102(a)(xi)(J).

B. Occupational disease (including respiratory and repetitive use).

The employee has a greater burden of proof in proving compensability of "injuries which occur over a substantial period of time." Wyo. Stat. § 27-14-603(a). The employee must prove by competent medical authority that the claim arose out of and in the course of the employment. Additionally, the employee must prove by a preponderance of the evidence that there is a causal connection between the employment and the injury, that the injury followed as a natural incidence of the work as a result of the employment, that the injury can be fairly traced to the employment as a proximate cause, that the injury does not come from a hazard to which the employee was equally exposed outside of the employment, and that the injury is incidental to the character of the business and not independent of the relation of employer and employee. Wyo. Stat. § 27-14-603(a)(i)-(v).

5. What, if any, injuries or claims are excluded?

Excluded claims include claims involving: (1) any illness or communicable disease unless the risk of contracting the illness or disease is increased by the nature of the employment; (2) injuries due to intoxication; (3) the employee's willful intention to injure or kill himself or herself or another; (4) injuries due solely to the "culpable negligence" of the employee; (5) injuries sustained in travel to or from the employment unless the employee is reimbursed for travel expenses or is transported by the employer's vehicle; (6) injuries sustained by a prisoner during or any harm resulting from any illegal activity engaged in by prisoners held under custody; (7) any pre-existing injury or condition; (8) any injury related to the natural aging process or from the normal activities of day-to-day living; (9) injuries sustained while engaged in recreational or social events under circumstances where the employee was under no duty to attend and where the injury did not result from the performance of tasks related to the employee's normal job duties or as specifically instructed to be performed by the employer; and (10) any mental injury, unless it is caused by a compensable physical injury, it occurs subsequent to or simultaneously with the physical injury, and it is proved by clear and convincing evidence. Wyo. Stat. § 27-14-102(a)(xi)(A)-(J).

6. What psychiatric claims or treatments are compensable?

The definition of "injury" under the Wyoming Workers’ Compensation Act excludes mental injuries, unless the mental injury is caused by a compensable physical injury, it occurs subsequent to or simultaneously with the physical injury, it is diagnosed by a licensed psychiatrist or licensed clinical psychologist meeting criteria established in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association, and meets certain other specified requirements. Wyo. Stat. § 27-14-102(a)(xi)(J). In no event may benefits for compensable mental injuries be paid for more than six months after the injured employee’s physical injury has
healed to the point that it is not reasonably expected to substantially improve. *Id.*

7. **What are the applicable statutes of limitations?**

For an injury that is the result of a single occurrence, an application for benefits must be made within one year after the accident occurs. Wyo. Stat. § 27-14-503(a). For injuries not readily apparent, the claim must be filed within one year after the employee discovers the injury. *Id.* For an injury which occurs over a substantial period of time, the claim must be filed within one year after the diagnosis of injury is first indicated to the employee, or within three years from the last date of injurious exposure, whichever occurs last. Wyo. Stat. § 27-14-503(b). However, the three-year statute of limitations does not apply to injuries that result from exposure to ionizing radiation. *Id.*

The statutes of limitation may be tolled if the injured employee is mentally incompetent or a minor, or where death results from the injury and any of his dependents are mentally incompetent or minors. Wyo. Stat. Ann. § 27-14-505.

A claim for increase or modification of benefits must be made within four years from the date of the last payment of benefits. Wyo. Stat. § 27-14-605.

8. **What are the reporting and notice requirements for those alleging an injury?**

An employee must notify the employer of the occurrence and general nature of the accident as soon as is practicable, but no later than 72 hours after the injury becomes apparent. Wyo. Stat. § 27-14-502(a). In addition, the injured employee is obligated to, within ten days after the injury becomes apparent, file an injury report with his or her employer as well as the Division of Workers' Safety and Compensation. *Id.*

Failure to file such reports creates a rebuttable presumption that the claim shall be denied. Wyo. Stat. § 27-14-502(c). However, “[t]he presumption may be rebutted if the employee establishes by clear and convincing evidence a lack of prejudice to the employer or division in investigating the injury and in monitoring medical treatment.” *Id.*

9. **Describe available defenses based on employee conduct:**

A. **Self-inflicted injury.**

Recovery under workers' compensation is barred if the injury arose from the "employee's willful intention to injure or kill himself." Wyo. Stat. § 27-14-102(a)(xi)(B)(II).

B. **Willful misconduct, "horseplay," etc.**

Recovery is barred if the injury resulted from the "employee's willful intention to injure or kill himself or another," or was "due solely to the culpable negligence of the injured employee." *Id.; See, e.g., Shepherd of Valley Care Center, v. Fulmer, 269 P.3d 432 (Wyo. 2012). “Culpable negligence” means “willful and serious misconduct.” *Id.* at 438. To be culpable negligence, “an act must be intentional, unreasonable and taken in
disregard of a known or obvious risk so great as to make it probable injury will follow.” *Id.* It requires “an extreme departure from ordinary care in a situation where a high degree of danger is apparent.” *Id.*

Additionally, if an employee knowingly engages or persists in an unsanitary or injurious practice which tends to imperil or retard his recovery, or if the employee refuses to submit to medical or surgical treatment reasonably essential to promote recovery, then the employee forfeits all right to compensation. Wyo. Stat. § 27-14-407.

Any injury sustained by a prisoner during or any harm resulting from any illegal activity engaged in by the prisoner held under custody is not compensable. Wyo. Stat. Ann. § 27-14-102(a)(xi)(E).

C. **Injuries involving drugs and/or alcohol.**

Recovery is barred if the injury was caused by the employee being "intoxicated or under the influence of a controlled substance, or both, except any prescribed drug taken as direct by an authorized health care provider." Wyo. Stat. § 27-14-102(a)(xi)(B)(I).

10. **What, if any, penalties or remedies are available in claims involving fraud?**

A misrepresentation or false statement made for the purpose of receiving a workers' compensation payment is a criminal offense. Wyo. Stat. § 27-14-510(a)(i)-(ii). Specifically, this applies to “any person who knowingly makes, authorizes or permits any misrepresentation or false statement to be made for the purpose of him or another person receiving payment of any kind under this act.” *Id.* Additionally, employers are subject to criminal penalties for “mak[ing] a false statement in a payroll report or reports resulting in the avoidance of or reduction in the employer's premium obligation,” or “mak[ing] a false statement in an injury report with the intention of denying a worker benefits due.” Wyo. Stat. § 27-14-510(b)-(c). An employer, employee, or other person making a false statement as set forth in the statute is guilty of “(i) A misdemeanor punishable by a fine of not more than seven hundred fifty dollars ($750.00), imprisonment for not more than six (6) months, or both, if the value of the payment is less than five hundred dollars ($500.00) (ii) A felony punishable by a fine of not more than ten thousand dollars ($10,000.00), imprisonment for not more than ten (10) years, or both, if the value of the payment is five hundred dollars ($500.00) or more. *Id.* Additionally, the Wyoming Attorney General can bring a civil action to recover benefits paid due to mistake, misrepresentation, or fraud. Wyo. Stat. § 27-14-511.

11. **Is there any defense for falsification of employment records regarding medical history?**

No section of the Act specifically addresses falsification of employment records regarding medical history. However, a misrepresentation or false statement made for the purpose of receiving a workers' compensation payment is a criminal offense. See Answer to No. 10, *supra.*

12. **Are injuries during recreational and other non-work activities paid for or supported**
by the employer compensable?

An employee cannot recover for injuries sustained while engaged in recreational or social events under circumstances where the employee was under no duty to attend the recreational or social event, and where the injury did not result from the performance of tasks related to the employee's normal job duties or as specifically instructed to be performed. Wyo. Stat. § 27-14-102(a)(xi)(H). The Wyoming Supreme Court has used the theory of the “second compensable injury” to make adverse findings to this particular exception. See, e.g., Alvarez v. State ex rel. Wyoming Workers' Safety & Comp. Div., 164 P.3d 548 (Wyo. 2007).

13. Are injuries by co-employees compensable?

Injuries incurred as a result of actions by co-employees are compensable if they arise out of and in the course of employment. However, the exclusive remedy provision of the Wyoming Workers’ Compensation Act does include immunity for co-employees who “intentionally act to cause physical harm or injury to the injured employee.” See Wyo. Stat. § 27-14-104(a) and Wyo. Stat. § 27-14-105(a). The Wyoming Supreme Court has interpreted “intentionally act” to mean willful and wanton misconduct. Vandre v. Kuznia, 297 P.3d 768, 774 (Wyo. 2013). “Willful and wanted misconduct is the intentional doing of an act, or an intentional failure to do an act, in reckless disregard of the consequences and under circumstances and conditions that a reasonable person would know, or have reason to know, that such conduct would, in a high degree of probability, result in harm to another.” Id. It essentially means that co-employee “acted with a state of mind approaching intent to do harm or committed an act of unreasonable character in disregard of known or obvious risks so great as to make it highly probable that harm would follow.” Id.

14. Are acts by third parties unrelated to work, but committed on the premises, compensable (e.g. "irate paramour" claims)?

Unclear. Recovery is allowed for any injury "arising out of and in the course of employment while at work in or about the premises occupied, used or controlled by the employer and incurred while at work in places where the employer's business requires an employee's presence...." Wyo. Stat. § 27-14-102(a)(xi). An employee covered by the act and injured while engaged in his work is not deprived of coverage if the injury was sustained under circumstances creating a legal liability in some person other than the employer. Wyo. Stat. § 27-14-105(a). If the employee recovers from a liable third party, then the state is to be reimbursed for all payments made, or to be made, on behalf of the employee but not to exceed one-third of the total proceeds of recovery alleged in the third-party action. Id. The state’s recovery is also reduced pro rata for attorney fees and costs. Id.

BENEFITS
15. What criterion is used for calculating the average weekly wage?

The Act does not contemplate an average weekly wage. Rather, the Act provides that benefits are paid pursuant to the injured worker’s actual monthly earnings at the time of injury. See Wyo. Stat. § 27-14-403. The Act’s implementing Rules and Regulations define actual monthly earnings as the “[i]ncome the employee was receiving from all employment and which is lost due to the injury.” Average monthly earnings includes 1) actual value of board, lodging, rent or housing and per diem expenses; 2) commissions and bonuses; 3) average amount of overtime received in the six months prior to the injury; 4) gratuities received in the course of employment; 5) wages earned from employment at more than one occupation; and 6) unemployment insurance benefits. Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division, Chapter 1 (4)(d)(i)(A)-(F).

Average monthly wage does not include severance pay, the cash value of health, medical, life or other insurance benefits, social security benefits, passive investment income, any adjustments to the employee’s income made after the date of injury, or the amounts reimbursed to the employee for any special expenses incurred by the employee in the nature of the employment. Id.

The state determines the statewide monthly wage, based on unemployment insurance commission information and other available statistics. Wyo. Stat. § 27-14-802(b).

16. How is the rate for temporary/lost time benefits calculated, including minimum and maximum rates?

Temporary total disability benefits are paid monthly and are calculated at either “thirty percent (30%) of the statewide average monthly wage or two-thirds (2/3) of the injured employee's actual monthly earnings at the time of injury, whichever is greater,” but not to exceed “the lesser of one hundred percent (100%) of the injured employee's actual monthly earnings at the time of the injury or the statewide average monthly wage for the twelve (12) month period immediately preceding the quarterly period in which the injury occurred.” Wyo. Stat. § 27-14-403(c); See also, Chapter 7, Section 1(a)(i), Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division.

17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?

Wyoming's workers compensation system is a state-run system and benefits are paid as they are processed. Thus, there is no statutory guideline for payment within a certain period of time, because the state fund is the payor. However, the Division has 15 days to review an employee’s entitlement to benefits once an injury report or claim for compensation is filed. Following this initial review, the Division must issue a final determination approving or denying the claim. Wyo. Stat. § 27-14-601(k)(i). If the claim
is approved, the Division must determine the amount of the compensation award and then notify the employee. Wyo. Stat. § 27-14-601(d). If the Division’s determination of compensability cannot be approved without additional information, the Division has 45 days to issue its final determination from the date it issues its request for additional information. Wyo. Stat. § 27-14-601(k)(ii).

18. What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out ___ days before recovering benefits for the first ___ days)?

The employee must be out eight days before recovering benefits for the first three days. Wyo. Stat. §27-14-404(d).

19. What is the standard/procedure for terminating temporary benefits?

Temporary total disability benefits cease when the employee's recovery is complete, to the extent that his or her earning capacity is substantially restored, or the employee has an ascertainable loss and qualifies for permanent disability. Wyo. Stat. § 27-14-404(c). Additionally, temporary total disability benefits will not be paid if, inter alia, an employee or his personal representative fails to file a claim for benefits within thirty 30 days after the first day immediately succeeding the first 30 days of any “certified” period of temporary total disability. Wyo. Stat. § 27-14-404(d)(i). Only a health care provider may “certify” temporary total disability, and the employer, employee and division may request recertification of the period of total temporary disability at interval of not less than sixty (60) days, except in extraordinary circumstances in which case the division may reconsider recertification at any time. Wyo. Stat. § 27-14-404(g). Temporary total disability benefits can also be suspended if the employee fails to appear and cooperate at an appointment with the employee's health care provider, or one scheduled by the Division. Chapter 7, Section 2(a), Wyoming Workers' Safety and Compensation Rules, Regulations and Fee Schedules.

The period for receiving a total temporary disability award for injuries resulting from any one (1) incident or accident shall not exceed a cumulative period of twenty-four (24) months. Wyo. Stat. § 27-14-404(a). The Division may award additional benefits beyond this limitation pursuant to its rules and regulations and its discretion “in the event of extraordinary circumstances.” Id. An additional award of total temporary disability benefits in an extraordinary circumstance shall not exceed 12 cumulative calendar months. Chapter 7, Section 2(b)(ii), Wyoming Workers' Safety and Compensation Rules, Regulations and Fee Schedules.

20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?

There are no provisions in the Statute or Rules of Procedure providing for crediting the amount of temporary total disability paid toward the amount of entitled permanent partial disability benefits.
21. What disfigurement benefits are available and how are they calculated?

An employee incurring permanent disfigurement to the face or head that affects earning capacity or the ability to secure gainful employment receives an additional award, to not exceed six (6) months of compensation payable as provided in Wyo. Stat. § 27-14-403(c). See Wyo. Stat. § 27-14-405(k).

22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?

A. How many weeks are available for scheduled members/parts, and the standard for recovery?

Permanent partial disability benefits are calculated on the basis of two-thirds of a state-wide average monthly wage for the 12 month period immediately preceding the quarterly period in which the injury occurred. Partial disability benefits are calculated as a portion of the injured worker's permanent total disability rating would be. See Answer to 22B. See also Chapter 7, Section 1 of the Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division.

B. Number of weeks for "whole person" and standard for recovery.

The Act recognizes two types of permanent partial awards, and specifies formulas for these awards. The amendments passed in 1994 replaced what was formerly a permanent partial disability award that had both a physical component as well as a vocational or loss of earnings component. Different benefit schedules are applicable for injuries occurring, or benefits awarded, prior to July 1, 1994.

Permanent Partial Impairment

The permanent partial impairment award is calculated by a licensed physician. Wyo. Stat. § 27-14-405(g). The physician uses the most recent edition of the AMA Guide to the Evaluation of Permanent Impairment to rate the injury. Id. The award is to be paid monthly at two-thirds (2/3) of the state average monthly wage for the twelve month period immediately preceding the quarterly period in which the injury occurred. Wyo. Stat. § 27-14-403(c). The award is paid for the number of months determined by multiplying the percentage of impairment by sixty (60) months. Wyo. Stat. § 27-14-405(g). There is no longer a lengthy list of body parts with a corresponding schedule.

Permanent Partial Disability

An employee awarded permanent partial impairment benefits may also apply for either permanent partial disability benefits or vocational rehabilitation. Permanent partial disability benefits appear to be the legislature's response to the previous award for loss of earnings. See Mahaffey v. State ex rel. Wyoming Workers’ Safety and Compensation Division, 249 P.3d 234, 237-38 (Wyo. 2011). The formula for the award is based in part
upon factors that the Wyoming Supreme Court had stated should be considered in the former loss of earnings component of a permanent partial disability award. *Id.* To qualify for permanent partial disability benefits, an employee must be, because of the injury, unable to return to employment at a wage that is at least ninety-five percent (95) of the monthly gross earnings the employee was earning at the time of injury, and must have actively sought suitable work, considering the employee's health, education, training and experience. Wyo. Stat. § 27-14-405(h)(i)-(iii). Permanent partial disability benefits depend upon what percentage of the state average monthly wage the employee's actual monthly earnings are. The award is then based on either a percentage of the employee's actual monthly earnings or the state average monthly wage. *See* Wyo. Stat. § 27-14-403(c). The number of months available for permanent partial disability benefits depends on factors such as age, education, and the number of occupations previously worked. Wyo. Stat. § 27-14-403(c); Wyo. Stat. § 27-14-405(j)(i)-(v).

23. **Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

An employee may apply to the division to participate in a vocational rehabilitation program if a permanent partial impairment award has been made, or is at least reasonably expected to be made, and the compensable injury will prevent the employee from returning to any occupation for which he or she had previous training or experience and in which the employee was gainfully employed at any time during the three-year period before the injury. *See* Wyo. Stat. § 27-14-408. An individual rehabilitation plan must not exceed five years or a total cost of $30,000, absent extenuating circumstances. *See generally* Wyo. Stat. § 27-14-408(e)(ii).

24. **How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are calculated as provided in Wyo. Stat. § 27-14-403(c). Employees are classified by what percentage of the statewide average monthly wage their actual monthly earnings are. The award is paid for 80 months and is a percentage of either the employee's actual monthly earnings or the statewide average monthly wage. Wyo. Stat. § 27-14-406(a). The maximum rate is the statewide average monthly wage. The minimum depends on the employee's actual earnings. The permanent total disability award constitutes the exclusive benefit for both the physical impairment and the economic loss resulting from an injury, including loss of earnings, extra expenses associated with the injury and vocational rehabilitation. *Id.*

25. **How are death benefits calculated, including the minimum and maximum rates?**

    **A. Funeral expenses.**

The expenses must be paid up to $5,000, with an additional $5,000 to cover related expenses. Wyo. Stat. § 27-14-403(e)(ii).
B. Dependency claims.

Dependent children are entitled to $250.00 per month “until the child dies or reaches the age of twenty-one (21), whichever occurs first, or if the child is physically or mentally incapacitated until the child dies unless qualified for and receiving benefits under the Medicaid home and community based waiver program.” Wyo. Stat. § 27-14-403(b). If “the child is enrolled or preregistered in a post secondary educational institution including a four-year college, community college or private trade school,” the child shall receive the amount until age 25. *Id.* This amount is to be adjusted annually for inflation by the Division. *Id.*

A surviving spouse is entitled to receive monthly payments for 100 months on the same basis that the employee would have had for permanent disability. *See* Wyo. Stat. § 27-14-403(e)(iii). If the surviving spouse dies before the award is entirely paid or if there is no surviving spouse, then the unpaid balance is paid to surviving dependent children of the employee. *Id.*

Surviving parents (or a parent) are entitled to receive payments for 60 months on the same basis that the employee would have for permanent disability if the employee died with no surviving spouse or dependent children and the parent or parents received one-half of their financial support from the employee at the time of the injury. Wyo. Stat. § 27-14-403(e)(v).

26. What are the criteria for establishing a "second injury" fund recovery?

The Division may apportion the benefit charge to the employer's general industrial classification when an employee has suffered successive compensable injuries, but no single employer can be determined to be singularly chargeable. Wyo. Stat. § 27-14-603(e). *See also* Wyo. Stat. § 27-14-201(d).

27. What are the provisions for re-opening a claim for worsening of condition, including applicable limitations periods?

An application can be made within four years from the date of the last payment for additional medical and disability benefits on the ground of increase or decrease of incapacity due solely to the injury, or for mistake or fraud. *See* Wyo. Stat. § 27-14-605.

28. What situation would place responsibility on the employer to pay an employee's attorney fees?

Hearing examiners may appoint attorneys to injured employees in contested cases, whose attorney fees are paid by the state. Depending upon the merits of the claim, the hearing examiner will designate whether attorneys' fees should be charged against the employer's experience rating in the State Fund, or whether payment or the attorney's fees will come out of a general fund. Wyo. Stat. § 27-14-602(d).
EXCLUSIVITY/TORT IMMUNITY

29. Is the compensation remedy exclusive?

A. Scope of immunity.

Employers and joint employers who contribute to the state fund and who remain current in their premium payments possess immunity from civil actions. See Wyo. Stat. § 27-14-104. Currently, co-employees also enjoy immunity unless their conduct causing injury is intentional (see answer 13). For a discussion of the standards for co-employee suits, see Vandre v. Kuznia, 310 P.3d 919 (Wyo. 2013). Additionally, the Director and the Attorney General must be served by certified mail return receipt requested with a copy of the complaint in any suit against a third party. Wyo. Stat. § 27-14-105(b).

B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).

Co-employees do not enjoy immunity, and can be sued if they intentionally act to cause physical harm or injury. Wyo. Stat. § 27-14-104(a). See Section 13, supra.

30. Are there any penalties against the employer for unsafe working conditions?

There is no statutory provision proscribing penalties against an employer for unsafe working conditions. However, in McKenman v. Wyoming Sawmills, Inc., 816 P.2d 1303 (Wyo. 1991), the Court held that OSHA violations do not remove the protection afforded employers under the Act.

31. What is the penalty, if any, for an injured minor?

There are no special or additional penalties for injuries to a legally employed minor. Wyo. Stat. § 27-14-102(a)(vii). A minor is deemed to be free of any legal disability for purposes of the Act. Wyo. Stat. § 27-14-106.

32. What is the potential exposure for "bad faith" claims handling?

There is no such exposure, because the state is the only insurer.

33. What is the exposure for terminating an employee who has been injured?

In Griess v. Consolidated Freightways Corp., 776 P.2d 752, 754 (Wyo. 1989), the Wyoming Supreme Court held that firing an employee for filing a workers' compensation claim violated public policy and was actionable. However, the Wyoming Supreme Court has affirmed a dismissal of a plaintiff’s claim for wrongful termination, where the only evidence the plaintiff presented in support of her claim that she was wrongfully discharged as a result of filing a workers’ compensation claim was the temporal

THIRD PARTY ACTIONS

34. Can third parties be sued by the employee?

An employee may bring an action against a third person for causing an injury, however, the Workers' Compensation Fund “is entitled to be reimbursed for all payments made, or to be made, to or on behalf of the employee under th[e] act but not to exceed one-third (1/3) of the total proceeds of the recovery[.]” Wyo. Stat. § 27-14-105(a).

35. Can co-employees be sued for work-related injuries?

Co-employees can be sued if they intentionally act to cause physical harm or injury. Wyo. Stat. § 27-14-104(a). See Section 13, supra.

36. Is subrogation available?

Subrogation rights and further rights to reimbursement have been limited. If an employee recovers from a third party, the State is entitled to be reimbursed for all payments it has made, but its reimbursement must not exceed one-third of the employee's total recovery. Wyo. Stat. § 27-14-105.

MEDICALS

37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?

There are no time limit provisions in the Statute or Rules of Procedure for payment of medical bills. Additionally, because Wyoming utilizes a state fund for payment of workers’ compensation benefits, there are no penalties for late payment of medical bills. However, reimbursements for medical services must be deemed reasonable, necessary and directly related to the work-related injury. See, Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division, Chapter 7, Section 3.

38. What, if any, mechanisms are available to compel the production of medical information (reports and/or authorization) at the administrative level?

An employee's health care provider may be required to testify before a hearing examiner or court, and provide written reports and attend depositions in his or her professional capacity. Failure to comply will forfeit his or her remuneration for services rendered. The law of privileged communication between health care provider and patient does not apply. Wyo. Stat. § 27-14-610.
An employee's filing of a report of accident is considered a release of information pertaining to the injury. Upon notice to the employee, a medical care provider is authorized to release medical records pertaining to the injury to the clerk of court, the division, or the employer. Wyo. Stat. § 27-14-502(d).

If the Administrator has reason to believe that an employee, employer, health care provider or any representative thereof has engaged in any activity in violation of the Act, the Administrator can conduct an investigation to determine if the Act has been violated and can conduct discovery pursuant to the Wyoming Rules of Civil Procedure. The administrator may examine the books, accounts, payrolls or business operations of any employer to secure any information necessary for the investigation and administration of the Act at any reasonable time on twenty-four (24) hours notice but excluding Sundays and holidays unless waived by the employer, either in person or through any authorized inspector, agent or deputy. See Wyo. Stat. § 27-14-803.

If the employer, employee, health care provider or any representative thereof refuses to cooperate and assist discovery by the Administrator, the Attorney General may, at the request of the Administrator and upon reasonable notice to all parties, apply to the district court for a subpoena or for an order compelling compliance. Id.

Finally, The Wyoming Rules of Civil Procedure shall apply and be followed in hearings before the Division, to the extent not inconsistent with these rules. Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division, Chapter 1, Section 5(k). This allows parties typical discovery tools to gain access to medical records.

39. What is the rule on (a) Claimant’s choice of physician; (b) Employer’s right to second opinion and/or Independent Medical Examination?

A. Claimant’s choice of physician.

An employer or the Division may designate health care providers to provide non-emergency medical attention. Wyo. Stat. § 27-14-401(f). However, an employee may select any other health care provider. Id. An employee wishing to change a treating health care provider while under treatment must file a written request with the Division stating all reasons for the change and the intended new health care provider. See, Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division, Chapter 7, Section 3(a)(ii).

B. Employer’s right to second opinion and/or Independent Medical Examination.

If the employee selects a health care provider other than the one selected by the employer or the Division, the employer or the Division may require a second opinion by the health care provider of their choice. Wyo. Stat. § 27-14-401(f). “The second opinion may include an independent medical evaluation, a functional capacity exam or a review of the diagnosis, prognosis, treatment and fees of the employee’s health care provider. The
independent medical evaluation, a functional capacity exam or the review by the employer’s health care provider shall be paid for by the employer and the evaluation, a functional capacity exam or review by the division’s health care provider shall be paid from the worker’s compensation account.” *Id.*

In addition, in any contested case proceeding, the hearing examiner may a duly qualified impartial health care provider to examine the employee and give testimony. Wyo. Stat. 27-14-604(a). The employer or employee may, at his own expense, also designate a qualified health care provider who may be present at the examination of the employee and give testimony at later hearings. *Id.*

40. **What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

The standard generally is that reasonable and necessary health care, which is required as a result of compensable injuries, must be provided. *See* Wyo. Stat. § 27-14-401(a); Wyo. Stat. § 27-14-102(a)(xii); *Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division*, Chapter 7, Section 3(a)(i). In addition, reimbursements for travel in obtaining medical and hospital care will not be paid for travel to a location within 10 miles except by ambulance, or for travel other than that necessary to obtain the closest available medical or hospital care needed by the employee. Wyo. Stat. § 27-14-401(d).

41. **Which prosthetic devices are covered, and for how long?**


42. **Are vehicle and/or home modifications covered as medical expenses?**

Only one automobile at a time may be remodeled and certain modifications may be made to the employee’s primary residence. Wyo. Stat. § 27-14-102(a)(i)(A)-(B).

43. **Is there a medical fee guide or schedule, or other provisions for cost containment?**


44. **What, if any, provisions or requirements are there for "managed care"?**

The Division of Workers' Safety and Compensation assigns "case analysts" to oversee cases. The case analyst may, in essence, coordinate managed care.

**PRACTICE/PROCEDURE**
45. **What is the procedure for contesting all or part of a claim?**

An initial review of entitlement to benefits will be made by the Division within fifteen (15) days after the accident report or claim is filed. The Division issues a final determination or a request for additional information at that time. Wyo. Stat. § 27-14-601(k)(i). Any interested party may request a hearing before a hearing examiner on the Division's final determination by filing a written request for hearing with the Division within fifteen (15) days after the final determination notice is mailed. Wyo. Stat. § 27-14-601(k)(iv).

Upon receipt of a request for hearing, the Division will refer the matter to the appropriate hearing authority. A hearing examiner designated by the Office of Administrative Hearings conducts contested cases. See generally Wyo. Stat. §§ 27-14-601, 27-14-602. Medically contested cases may be referred to a medical hearing panel, or, by agreement of the parties, the hearing examiner may transfer a medically contested case to a medical hearing panel or seek the advice of the medical commission. Wyo. Stat. § 27-14-616(e).

For a list of claims procedures see the *Rules, Regulations, and Fee Schedules of the Wyoming Workers’ Safety and Compensation Division*, Chapter 5, Section 4.

46. **What is the method of claim adjudication?**

   **A. Administrative level.**

   Administrative determinations are made by the Division of Workers' Compensation, as outlined in answer 45.

   **B. Trial court.**

   The initial objection or “appeal” of the Division’s Final Determination is made to The Office of Administrative Hearings or the Medical Commission, depending on the case. Either way, a formal hearing will be conducted for contested cases. Wyo. Stat. § 27-14-602(a). The hearings are in accordance with the law in effect at the time of the injury, as a small claims hearing or as a contested case hearing, subject to certain statutory criteria. Wyo. Stat. § 27-14-602(b).

   **C. Appellate.**

   Decisions of the administrative law judges can be appealed first to the district court, and then directly to the Wyoming Supreme Court, as provided by the Wyoming Administrative Procedure Act. Wyo. Stat. § 27-14-602(b)(iii).

47. **What are the requirements for stipulations or settlements?**

The Act specifically states that there is no prohibition against the employer or Division
from reaching a settlement of up to $2,500 in any one case without an admission of compensability or that the injury was work-related. Wyo. Stat. § 27-14-601(e).

The Act also sets forth procedures for settlements in third party actions, requiring that before offering settlement to an employee, a third party or its insurer must notify the State of the proposed settlement and give the State the opportunity to object within fifteen (15) days of receipt of the notice. Wyo. Stat. § 27-14-105(b). “If notice of proposed settlement is not provided, the state is entitled to initiate an independent action against the third party or its insurer for all payments made to and any amount reserved for or on behalf of the employee under th[e] act.” Id. Failure of the attorney for the third party to give notice could result in being reported to the Grievance Committee of the Wyoming State Bar. Wyo. Stat. § 27-14-105(d).

48. **Are full and final settlements with closed medicals available?**

Yes. It is considered the better practice to have such closed medical settlements approved by an administrative law judge. However, this subject is not specifically contemplated or proscribed by statute, rule or regulation. It is also noteworthy that the Division is often wary of entering into such settlement, as they may cause future issues (such as potential Medicare complications).

49. **Must stipulations and/or settlements be approved by the state administrative body?**

As stated in answer 48, this is the best practice. Cases do arise where the state approves a claim which an employer contests. In those cases, it would not seem necessary to have the approval of the state. This area is also not specifically contemplated or proscribed by statute, rule, or regulation.

**RISK FINANCE FOR WORKERS' COMPENSATION**

50. **What insurance is required, and what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

Wyoming has a state fund as the sole system available to all employers. Employers should be aware that taking part in the state system may be the only method of gaining immunity from suit. Some employers have mistakenly relied upon a private insurance policy that guarantees to employees the same benefits as required under state law. Such a private policy may not grant immunity to the employer.

51. **What are the provisions/requirements for self-insurance?**

   A. **For individual entities.**

   See answer 50.

   B. **For groups or "pools" of private entities.**
See answer 50.

52. Are “illegal aliens” entitled to benefits of workers’ compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of “employee”?

An “employee” covered by the act includes legally employed “aliens authorized to work by the United States department of justice, office of citizenship and immigration services, and aliens whom the employer reasonably believes, at the date of hire and the date of injury based upon documentation in the employer’s possession, to be authorized to work by the United States department of justice, office of citizenship and immigration services.” Wyo. Stat. § 27-14-102(a)(vii); See, e.g., Felix v. State ex rel. Wyoming Workers’ Safety & Comp. Div., 986 P.2d 161 (Wyo. 1999).

“Illegal aliens” may be entitled to benefits of the Act, if the employer has documentation and a reasonable belief that the employee is authorized to work in the United States, but in fact is not. See, e.g., Gonzalez v. Reiman Corp., 357 P.3d 1157 (Wyo. 2015). However, employers who knowingly hire “illegal aliens” potentially expose themselves to personal liability for work-related injuries and may not be able to claim immunity under the Act.

53. Are terrorist acts or injuries covered or excluded under workers’ compensation law?

This is unknown; however, it is possible that terrorist acts are covered under the Act as there are no provisions under the Act specifically precluding terrorist acts from coverage.

54. How are workers’ compensation settlements affected by Medicare trusts and liens?

Under Medicare regulations (42 C.F.R. 411.46), Medicare is secondary payer to the payment of workers compensation by a workers compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers compensation matter if at the time of the settlement the employee meets the following criteria:

- The claimant is currently a Medicare beneficiary and the amount is greater than $25,000; or

- The claimant has reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement and the anticipated settlement amount is greater than $250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account.
Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

Medicare is requiring Medicare set-aside trusts to be established for settlements in which the employee is likely to be qualified for or is receiving Medicare and faces significant medical costs related to the employee’s industrial injury in the future. If the trust is not established, Medicare reserves the right to file a claim in the future against all parties involved in the settlement, including the lawyers representing both parties, and the insurance company.

55. **How are subrogation liens of Medicaid and health insurers treated under workers’ compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. See 42 U.S.C. §1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

Medicaid and health insurers have a right to file a claim in civil court against any parties involved in a workers’ compensation matter for medical bills which should have been covered under a workers’ compensation case.

56. **What are the requirements for confidentiality and privacy of medical records under workers’ compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA, 45 C.F.R. parts 160-164 and 65 F.R. 82462, went into effect on April 14, 2003. The law provides an exception for workers compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(l)] Therefore, your current practice of obtaining medical records could proceed under state law.

HIPAA will apply to workers’ compensation cases. Therefore, all parties need to be careful in dealing with medical records in worker’s compensation matters.

57. **What are the provisions for “Independent Contractors”?**

Independent Contractors are expressly excluded from the definition of “employee.” Wyo. Stat. § 27-14-102(a)(vii)(D). "Independent contractor" is defined as an individual
who performs services for another individual or entity and (1) is free from control or direction over the details of the performance of services by contract and by fact; (2) represents his services to the public as a self-employed individual or an independent contractor; and (3) may substitute another person to perform his services. Wyo. Stat. § 27-14-102(a)(xxiii).

In *Diamond B Services, Inc.* 120 P.3d 1031 (Wyo. 2005), the Wyoming Supreme Court, citing *Combined Insurance Company of America v. Sinclair*, 584 P.2d 1034, 1043 (Wyo. 1978) and quoting *Lichty v. Model Homes*, 211 P.2d 958, 967 (Wyo. 1949), has held that an independent contractor “is one who, exercising an independent employment, contracts to do a piece of work according to his own methods and without being subject to the control of his employer except as to the result of the work.”


When an express contract exists between the parties, it is important evidence in defining the relationship, although it is not conclusive of the issue. Other factors which are important to the determination include: the method of payment, the right to terminate the relationship without incurring liability, the furnishing of tools and equipment, the scope of the work, and the control of the premises where the work is to be done. *Singer*, 227 P.3d at 309; *Stratman*, 760 P.2d at 980. Another factor to be considered is whether the worker devotes all of his efforts to the position or if he also performs work for others. *Id.*

With regard to the “method of payment” criterion, an independent contractor usually determines the price of his services and bills for his services on a regular basis. *Singer*, 227 P.3d at 309; *Noonan*, 713 P.2d at 166. On the other hand, when the employer determines the worker’s rate of pay and takes deductions out of his paychecks for federal income taxes, Social Security, and Medicare then a master-servant relationship is indicated. *Id.* Payment of workers’ compensation and unemployment insurance premiums by an employer suggests that the worker is an employee rather than an independent contractor. *See In re: Claims of Naylor*, 723 P.2d 1237, 1240-41 (Wyo. 1986); *In re Reed*, 444 P.2d 329, 330 (Wyo. 1968). Similarly, when a worker is eligible to participate in benefit programs such as retirement or insurance plans, as a result of his association with the employer, it suggests a master-servant relationship exists. *Combined Insurance*, 584 P.2d at 1043.

58. Are there any specific provisions for “Independent Contractors” pertaining to professional employment organizations/temporary service companies/leasing companies?

Wyo. Stat. §27-14-102(a)(xxiv) defines "casual labor" as service of less than two (2)
consecutive weeks and not within the normal course of business. Further, § 27-14-102(a)(xxv) defines "temporary service contractor" to be any person, firm, association or corporation conducting a business that employs individuals directly for the purpose of furnishing services of the employed individuals on a temporary basis to others. Wyo. Stat. §27-14-102(a)(xxvi) defines a "temporary worker" to be a worker whose services are furnished to another employer on a temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

59. **Are there any specific provisions for “Independent Contractors” pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

   No. However, Wyo. Stat. § 27-14-102 (a)(xi)(D) provides that injury does not include any injury sustained during travel to or from employment unless the employee is reimbursed for travel expenses or is transported by a vehicle of the employer.

60. **What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

   Financial exposure to workers’ compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized “Best Practices” plan.

   Every business must deal with the expense of workers’ compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.

61. **Are there any state specific requirements which must be satisfied in light of the obligation of the parties to protect Medicare’s interests when settling the right to medical treatment benefits under a claim?**

   There are no state specific statutory requirements which must be satisfied in order to protect Medicare’s interest when settling the right to medical treatment benefits under a claim. See also, Response 54 supra.

62. **Does your state permit medical marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

   Wyoming does appear to permit medical marijuana as contemplated by Wyo. Stat. § 35-7-1901 et seq. (Supervised Medical Use of Hemp Extracts). However, the Wyoming Workers’ Compensation Division issued a Provider Bulletin on December 18, 2013 noting the denial of Marinol for non-malignant pain.

   Additionally, there is at least one district court case which has found the use of medical marijuana is not permitted under Wyoming Workers’ Compensation. See, e.g., Tarraferro v. State of Wyoming, ex. rel., Doc. No. 176-631, filed in the First Judicial
District, County of Laramie, *Opinion and Order on Petition for Review*, filed March 25, 2011. In *Terraferro*, the court concluded “[t]he Wyoming Supreme Court has recently addressed the issue of medical marijuana and its status in the stat of Wyoming. They have said that marijuana is illegal even for medical purposes and that it would be illegal for a physician to prescribe it, even in Colorado.” *Id* (citing *Burns v. State*, 246 P.3d 283, 286 (Wyo. 2011)).

63. **Does your state permit the recreational use of marijuana and what are the restrictions for use and for work activity in your state Workers’ Compensation law?**

Wyoming does not permit the recreational use of marijuana. See Wyo. Stat. § 35-7-1014(d)(xiii), List of Controlled Substances. As discussed in response to Questions 62, the state of Wyoming still considers marijuana illegal.

The ALFA affiliated counsel who compiled this State compendium offers an expert, experienced and business-friendly resource for review of an existing plan or to help write a "Best Practices" plan to guide your workers’ compensation preparation and response. No one can predict when the need will arise, so ALFA counsels that you make it a priority to review your plan with the ALFA Workers’ Compensation attorney for your state, listed below:

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