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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 the state'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'

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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

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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 employer 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

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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.

In the case of Olmstead v. Shakespeare, 348 S.C. 436, 559 S.E.2d 370 (Ct. App. 2002) 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

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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

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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.

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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

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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 Schurlock 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

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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 life-time benefits under the South Carolina Workers’ Compensation Act.

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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

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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

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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.

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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

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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).

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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 scheduled loss pursuant to § 42-9-30.”

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



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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

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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 of a compensable injury, because the facts in Mauldin did not involve a repetitive trauma injury.

In 2007, the legislature amended the Workers' Compensation Act to provide that for repetitive trauma injuries occurring **on or after July 1, 2007**, the statute of limitations begins to run at the time the claimant knows or should know 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. The 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

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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

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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

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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 Ann. § 42-9-80.

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. §

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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.
- C. There must have been a causal connection between the false representation and the injury. Cooper v. McDevitt & Street Co., 260 S.C. 463, 196 S.E.2d 833 (1973). See also Ferguson v. R.F. Moore Constr. Co., 298 S.C. 457, 381 S.E.2d 496 (Ct. App. 1989); Givens v. Steel Structures, Inc., 279 S.C. 12, 301 S.E.2d 545 (1993); McCleod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984).

(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 vitiated 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'



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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.



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### 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?

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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).

## BENEFITS

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, where the time the employee worked is brief, the wages of a like employee should

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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

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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

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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

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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.

Effective Date	Maximum Compensation Rate
1/1/21	\$903.40
1/1/20	\$866.67
1/1/19	\$845.74
1/1/18	\$838.21
1/1/17	\$806.92
1/1/16	\$784.03
1/1/15	\$766.05
1/1/14	\$752.16
1/1/13	\$743.72
1/1/12	\$725.47
1/1/11	\$704.92
1/1/10	\$689.71
1/1/09	\$681.36

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1/1/08	\$661.29
1/1/07	\$645.94
1/1/06	\$616.48
1/1/05	\$592.56
1/1/04	\$577.73
1/1/03	\$563.55
1/1/02	\$549.42
1/1/01	\$532.77
1/1/00	\$507.34
1/1/99	\$483.47
1/1/98	\$465.18
1/1/97	\$450.62
1/1/96	\$437.79
1/1/95	\$422.48
1/1/94	\$410.26
1/1/93	\$393.06
1/1/92	\$379.82
1/1/91	\$364.37
1/1/90	\$350.19
1/1/89	\$334.87
1/1/88	\$319.20
1/1/87	\$308.24
1/1/86	\$294.95
1/1/85	\$287.02
1/1/84	\$268.99
1/1/83	\$254.38
1/1/82	\$235.00

**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.



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- 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 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 Manf. 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:

<u>Scheduled Members:</u>	<u>Maximum Weeks</u>
Thumb . . . . .	65

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1st Finger . . . . .	40
2nd Finger . . . . .	35
3rd Finger . . . . .	25
4th Finger . . . . .	20
Great Toe . . . . .	35
Another Toe . . . . .	10
Hand . . . . .	185
Shoulder (added July 1, 2007)	300
Arm . . . . .	220
Foot . . . . .	140
Leg . . . . .	195
Hip (added July 1, 2007)	280
Eye . . . . .	140
Hearing - one ear . . . . .	80
Hearing - both ears . . . . .	165
Back - up to 49% . . . . .	300
Back - 50% or greater . . . . .	500
Tooth . . . . .	2

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

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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 wage loss 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.

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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?**

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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. Tideland 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

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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 injury, the weekly compensation to be paid 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

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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 hereunder 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

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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.

## EXCLUSIVITY/TORT IMMUNITY

### 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

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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 curium 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

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Harrell went on to 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.

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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

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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

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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).



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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./Tennessee 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

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15 days after the examination, or 15 days after release for payment to be rendered. If the form utilized lists services 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.

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### 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.

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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

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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

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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

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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.”



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### 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.

## 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

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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

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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 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,

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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

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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.

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

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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

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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"?



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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

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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?

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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, 2021. 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.