Chapter 4

FILE WORK UP

§ 4.01 Notice.

Section 42-15-20 provides that notice of an accident must be given to the employer within 90 days of the accident. However, as a practical matter, lawyers should be wary of cases in which notice was not given immediately.

If the employer is not aware of an on-the-job injury, the employee or his attorney should send a written notice to the employer. Filing a claim and serving it on the employer/carrier can be sufficient notice.

The records of the first medical provider the claimant saw after his injury can be very important in proving notice. This is particularly true if the treatment was shortly after the accident AND the records indicate that the claimant was injured at work. This does not prove that the claimant got hurt at work, or that he gave notice of the injury. However, it does show that he told someone else about the accident long before he ever hired a lawyer and began

pursuing a claim for benefits. On the other hand, if the initial medical report contains no history of an on-the-job-injury, winning the claim will be an uphill battle.

If the employer claims to have no prior notice of the accident, it is often helpful to subpoena the employee's personnel file. (See § 4.12). Sometimes it will contain an accident report form. It may also be helpful to interview the injured employee's co-workers. The injured employee may have told his/her co-workers about the accident, or the other employees could have overheard the injured employee report the accident to a supervisor.

§4.02 Filing The Claim.

The injured employee has two years to file a claim after an accident. A claim may be filed by letter to the commission or Form 50. If a letter is used, it should contain essentially the same information contained in the Form 50. Section 42-15-40 provides that a filing may be made by registered mail and that proof of mailing within two years constitutes timely filing. The two year statute of limitations begins running on the date of discovery of the injury. Mauldin v. Dyna Color/Jack Rabbit, 308 S.C. 18, 416 S.E.2d 639 (1992); S.C. Code Ann. § 42-15-40. For occupational disease claims, the two-year period does not begin to run until the injured employee has been definitively diagnosed as having an occupational disease and has been notified of the diagnosis. Bailey v. Covil Corp., 291 S.C. 417, 354 S.E.2d 35 (1987). Arguably, either the date of disability or the date of last exposure can be used as the date to trigger the statute of limitations in a occupational disease claim.

Before the 1997 revisions to the Workers' Compensation Act, the payment of temporary total disability compensation pursuant to a signed Agreement As To Compensation (Form 15) tolled the statute of limitations. See Gold v. Moragne, 202 S.C. 281, 24 S.E.2d 491 (1943), and Halks v. Rust Engineering, 208 S.C. 39, 36 S.E.2d 852 (1946). McCreery v. Covenant Presbyterian Church, 303 S.C. 271, 400 S.E.2d 130 (1990) held that execution of a Form 15, approved by the commission, also equaled an admission of liability which could not later be disputed.

The commission regulations have adopted the intent of Halks and Gold and provide that payment of temporary total constitutes the filing of a claim. Regulation 67-503(A)(2). Since South Carolina is no longer an agreement state, payment of temporary total may no longer be the

equivalent of an admission of liability. However, it could be argued that if a carrier fails to stop payment of compensation and raise a legitimate ground for denying the claim within 150 days after notice of the injury, the claim is deemed admitted for liability purposes.

In some cases, the employer may be estopped from raising the statute of limitations as a defense if the injured employee justifiably relied upon the employer's representation that the claim is compensable and that it will be taken care of without its being filed with the commission within the two year period. Hucks v. Green's Fuel of South Carolina, 247 S.C. 457, 148 S.E.2d 149 (1966).

One of the first things an attorney should do in a workers' compensation case is to perfect the claim. See regulation 67-206. See also Appendix 4 for a sample letter to the commission with the necessary information and a request for the First Report of Injury and medical reports. A copy should be sent to the client and to the employer's insurance carrier, if known.

When filing a claim using a Form 50, do not check the box requesting a hearing unless you actually want to have the claim heard within three to four months. If you need additional time to develop your claim, the Form 50 should only be used to toll the statute.

It is easy to pinpoint the date of the accident in a single event case. However, there is generally no single date of accident in repetitive trauma and occupational disease cases. In these cases, what date do you put on the Form 50 as the "date of accident?" The date that the employee last engaged in the repetitive activity and/or became unable to work is often used. Sometimes the date he/she first sought medical treatment is used. Logically, since the accident truly did not occur on a single date, it would make more sense to use the period of time during which the claimant engaged in the repetitive activity. Unfortunately, the Claims and Judicial Departments at the commission sometimes have no taste for what is logical. They frequently reject Forms 50 that contain a range of time as the date of accident.

§ 4.03 Notice To The Commission & The Commission's File.

In most cases you will want to notify the commission as soon as you undertake representation of the injured employee. Sending the commission a claim letter or a Form 50 also serves to

notify the commission of your representation. At some point you will also want to request a copy of the commission's file. Most attorneys do this when they send in the original letter of representation/notice of claim. However, if the accident happened recently, there will often be very little in the commission's file. In such cases, it may be better to delay the request for a copy of the file or re-request the file at a later date. The commission charges a flat fee of $20.00 to cover copying charges.

The commission's file is often a valuable source of information. It will contain a copy of the Form 12-A, First Report of Injury, which may have important information about how the accident happened, when notice was given, etc. The file will often contain information about the amounts and periods of temporary total. It is also frequently a cheap source of medical records. And, it will sometimes contain records that the medical providers will never send you in response to a medical authorization. Company doctors have been known to report or testify that a certain condition is not work-related, yet the commission's file will contain documents indicating that they sought payment for their treatment from the employer's compensation carrier.

It is also a good idea to review the commission's file immediately before every hearing.

§4.04 Medical Reports.

In order to properly handle a file, you must have the claimant's medical records. As discussed above, the commission is often a cheap source of these records. Sometimes you can persuade the adjuster or rehabilitation nurse to send you copies of the medical records, but most of the time you must request them from the medical providers. Do not allow the medical provider to overcharge for medical records. Section 42-15-95 provides that the fee may not exceed $.65 per page for the first thirty pages and $.50 per page for each additional page. The provider may also charge a clerical fee for searching and handling, not to exceed $15 per request, plus actual postage costs and applicable sales tax.

If defense counsel sends a subpoena for medical records, make sure that you request a copy of all the records obtained pursuant to the subpoena. These records must be produced in accordance with SCRCP 45(c)(2)(A). The party requesting copies shall pay the reasonable costs of

reproduction. If defense counsel does not voluntarily provide copies as requested, either file a motion to compel with the commission or do not allow your client's deposition to be taken until all records are produced and you have had sufficient time to review them with your client. Otherwise, your client may be "ambushed" during his deposition by information contained in the medical records that he may have forgotten.

In some cases it is helpful to subpoena the treating physician's medical records. You may discover some interesting correspondence between defense counsel and the treating physician. Additionally, a subpoena will often prompt the production of medical records, including patient information forms, which are not always provided in response to a medical release form. The downside of sending a subpoena to a medical provider is that you are required to provide copies of the records to defense counsel upon request.

In some instances, the employer may have a plant nurse or a medical facility on site. In these cases, do not forget to send a subpoena to the plant for medical records. These records are particularly critical in repetitive trauma and occupational disease claims.

§ 4.05 Medical Ratings.

Assuming you have an impairment rating from the treating physician, you must next determine if you need a second opinion. If the treating physician gives a low to moderate impairment rating but imposes significant permanent limitations, you may not want to seek a second impairment rating. In theory at least, the commissioner should consider the limitations more than the numerical rating. You must weigh the cost of the second opinion against the likely benefit it will have on the probable award. It pays to know your commissioner. Some commissioners will not pay any attention to any evaluation paid for by the claimant's attorney.

It is very tempting to wait until the case is set for a hearing before seeking a second opinion. Why spend money on a second opinion until you know that the commissioner who will be hearing the case will pay attention to it? Whenever possible, you should make the decision to get a second opinion as soon as the treating physician gives the initial impairment rating. If you wait until you receive a hearing notice you may have problems in scheduling the exam,

getting the report, and making a timely submission of the report under the Administrative Procedures Act.

If you decide to obtain a second opinion, you should send the evaluating doctor copies of all prior medical records. You should also make sure the client takes his or her x-rays, MRI's and other test results to the examination. Some doctors appreciate a chronological medical summary.

You can sometimes decide whether to get a second opinion by reviewing the AMA Guides. Most physicians are conservative and give ratings at or below the levels specified in the AMA Guides. If the Guides yield a rating higher than that given by the treating physician, a second opinion might be a good idea. In theory, it may be possible for a commissioner to take judicial notice of the Guides, thus saving the cost of an evaluation. However, convincing the commission to take judicial notice of the Guides may be difficult.

If you do seek a second opinion evaluation, there is no affirmative duty to report this fact to the defense counsel. If the second opinion rating is higher than the initial rating, then submit it. If the rating is equal to or less than the initial rating, then keep it in your file and show it to your client so that he will have some insight into what his true rating of impairment is and he will probably have more realistic expectations at the time of settlement.

In seeking a second opinion evaluation, it should come as no surprise that some physicians are more liberal with their ratings than others. Some physicians are also more patient friendly. However, the second opinion should come from a competent physician who has some credibility with the commission. If you do not know who to refer the claimant to for a second opinion, check with your colleagues for recommendations.

When a claimant is on a running award and the carrier is anxious to settle the claim or wants to stop the payment of temporary total disability benefits, the adjuster is sometimes amenable to a second opinion evaluation. This is especially true if the first rating of impairment is obviously low or if it is apparent that the claimant needs additional medical treatment. This is an excellent opportunity to get the carrier to pay for the second opinion evaluation. Similarly, the adjuster in this situation may be more willing to approve a mutually agreeable physician.

§ 4.06 Medical Summary.

A chronological medical summary can be an important part of your file. It should be started as soon as you begin to acquire medical records on the claimant. It will save you many hours in handling the claim. It is virtually impossible to place actual medical records in chronological order. A medical summary gives you a nice straightforward chronology you can refer back to time and again. It will help you prepare the claimant for deposition or hearing. A medical summary can also be used as an attachment to your pre-hearing brief and/or APA submission.

It is a good practice to give the client a copy of the medical summary before preparation for the hearing. Much of what the doctor tells the client never reaches the medical report. With the medical summary, the client can see what the reports contain and also refresh his memory with regard to what he told the doctor at each office visit.

See Appendix 4 for a sample medical summary. This summary was prepared by a legal assistant. Usually, each entry is a synopsis of the actual report. If you have an uncommon term, you can define it in the summary.

§ 4.07 South Carolina Department of Vocational Rehabilitation.

In all cases of potential total disability, you should at least consider referring the client to the South Carolina Department of Vocational Rehabilitation (Voc Rehab). One reason is that many commissioners will ask if the claimant has gone and what the result was. But do not expect too much. Voc Rehab rarely gets anyone back to work. In fact, in many cases involving workers' compensation or social security disability they tell the employee they cannot help and send him away without even doing a workup.

In the rare case where Voc Rehab really tries, and fails, to help the employee, the vocational counselors can make excellent witnesses. They have credibility. After the employee completes the evaluation process, request the complete Voc Rehab file. See Authorization for Vocational Rehabilitation Records in Appendix 4. Go talk to the counselor if necessary.

In some instances, once the claim is settled Voc Rehab can be beneficial in providing medical benefits for the injured employee. Additionally, Voc Rehab may assist the injured employee in being retrained for light duty work. Some counselors can help the client obtain funding through grants and loans to provide financial assistance during the retraining period.

§ 4.08 Rehabilitation Nurses and Case Managers.

Most rehabilitation nurses (aka case managers) tend to be nothing more than investigators for the carrier. Their job is generally to get the claimant out of the doctor's office and off temporary total as soon as possible. Some attorneys will not allow rehabilitation nurses to deal directly with the claimant. The law does not require the claimant or his attorney to cooperate with a rehabilitation nurse. What rehabilitation nurses do is not considered medical treatment under the Act.

Whether to allow a rehabilitation nurse to become involved is a case-by-case call. There are a few good ones. And sometimes the nurse can arrange for additional medical treatment. This is particularly helpful in cases where the client is seriously injured and needs assistance to coordinate his medical treatment and to provide transportation. As long as the rehabilitation nurse is working for the client and providing assistance, his/her services may be utilized. But, when the nurse becomes too intrusive into the client's personal life and affairs, it is time to think about terminating these services. This is particularly true when the rehabilitation nurse's only goal is to get the client off temporary total.

If you do permit the nurse to assist the injured employee, make sure that the client goes into the physician's examination room alone. The nurse should never be allowed to be present during the examination. This is the claimant's opportunity to relate to the physician on a personal level. After the examination, if the nurse wants to discuss the medical treatment, the claimant should insist on being present when the nurse is speaking with the physician about the claimant's condition.

If you allow a rehabilitation nurse to become involved you should be sure to require, at a minimum, that as a condition of his/her involvement, he/she provide you with copies of all of reports, correspondence, etc.

Before agreeing to a rehabilitation nurse some attorneys require:

a. documentation of rehabilitation credentials;

b. a written plan detailing how the nurse intends to rehabilitate the claimant;

c. a guarantee of placement after rehabilitation; and,

d. a stipulation that the nurse will not testify against the claimant.

When faced with these requirements, most rehabilitation nurses tend to disappear.

In some instances, the rehabilitation nurse's records are actually helpful in confirming the fact that the employer refused to offer the injured employee alternative (light duty) work. Also, they will sometimes contain accounts of conversations with doctors that are substantially different from the doctor's records. When reviewing the nurse's records, if the nurse expresses any concern about the claimant's exaggerating his symptoms or malingering, terminate the nurse's involvement immediately.

§ 4.09 Mental Health Clinics.

Each county has a Mental Health Clinic. Treatment is usually performed by counselors with limited review/involvement by psychiatrists. The treatment may not be as good as what the claimant would get from a private practitioner. However, Mental Health is frequently the only source of care that an injured worker has. This is especially true when the treating physician cannot, or will not, acknowledge the existence of the claimant's mental/emotional problems. If the attorney sees signs of mental or emotional problems, he should consider referring the claimant to Mental Health.

§ 4.10 Psychological and Psychiatric Evaluations.

One shot psychological or psychiatric exams are generally of little value unless the claimant has documented mental or emotional problems in the prior medical records. This is one reason it is so important to refer the claimant to Mental Health if you begin to suspect problems. If you decide to refer the claimant for a one shot evaluation of mental or emotional disorders, it is generally better to use a psychiatrist than a psychologist.

On the other hand, psychologists can be very helpful in certain situations. It is often useful to have the claimant evaluated by a psychologist to determine whether he is functioning at a normal cognitive level. There are many psychologists who are well trained in performing intelligence testing at a reasonable cost. This information is particularly helpful when arguing that the claimant is disabled because of mental retardation, low intelligence, and limited reading, writing and mathematical skills. These are all impediments to return to work that may support the claim for disability and give credibility to the claim.

When the claimant exhibits signs of stress, depression, and emotional problems, it is often helpful to have the client go back to the authorized treating physician to request a referral to a psychiatrist. If the symptoms persist and are consistently related to the treating physician, most treating physicians will eventually concur in the need for a referral. If the carrier refuses such a referral, file a Form 50 and ask the commission to order that such an evaluation be authorized. In the alternative, you may want to send the claimant to a psychiatrist/psychologist of your choice, and argue that since the carrier refused authorization, the psychiatrist/psychologist of your choice is the treating physician, and that the carrier should be required to pay for this treatment.

§ 4.11 Social Security Disability.

If you believe the claimant is totally disabled, recommend that he/she file for Social Security Disability. At some point during the Social Security Disability claim process you will want to review the claimant's Social Security file. This file may contain medical records or other documents you do not have. There may also be information you can use to calculate the impact of a workers' compensation settlement on the claimant's future Social Security Disability benefits. See Chapter 6. To be allowed to review the claimant's file, send a letter requesting permission to do so and Social Security Form 1696, Appointment of Representative, to the local Social Security office. (See Appendix 4-3). But remember, once you send this form in you have committed to represent the claimant on his/her disability claim.

In order to be eligible for Social Security Disability benefits, the claimant must prove that he/she has been disabled, or will likely be disabled, for a period in excess of one year. It is not unusual for a Social Security Disability claim to take more than a year to reach the hearing stage. If it appears likely that the claimant will be disabled for a year or more, encourage him to file a claim for disability benefits immediately. If this claim is successful, the claimant may already be receiving Social Security benefits when he is released at maximum medical improvement on the workers' compensation claim. Do not forget that in certain instances, the claimant may be entitled to an award for a "closed period" of disability, instead of ongoing disability.

One major advantage in having the claimant awarded Social Security Disability benefits is that after twenty-nine months of disability he becomes entitled to Medicare benefits. At the time of clinchering the claim, the claimant is in a better position to settle and give up his potential right to future medical benefits if he is already eligible for Medicare. Remember to use the necessary Utica v. Mohawk language in preparing the clincher agreement if the claimant is receiving, or even remotely likely to receive, Social Security Disability benefits. As a result, the worker's compensation offset should be substantially reduced or eliminated. See Chapter 6. See also Appendix 4 for a letter to defense counsel asking that the Utica v. Mohawk provision be set forth in the clincher agreement.

Logically, the fact that a claimant has already been awarded Social Security Disability benefits should have some influence on a commissioner's decision. Try to submit the notice of award with your other APA submissions. If that fails, ask the claimant at the hearing if he is receiving any other income and have him say, "Yes, my Social Security Disability." Another way to get this evidence into the record is by referring to favorable medical and vocational reports that are part of the claimant's Social Security file. Although the order awarding disability benefits may not be admissible as an APA submission, the medical records and other documents from the Social Security claim should be admissible as APA submissions.

§ 4.12 Discovery.

Discovery in workers' compensation cases is limited. The Act provides for depositions and subpoenas in sections 42-3-160, 42-5-140 and 150. Under regulation 67-214, a subpoena may be served on a represented party via regular mail to the attorney of record. A subpoena may be served on an unrepresented party or witness via certified mail or personal service. Subpoenas may be served prior to requesting a hearing, provided that a claim has already been filed. Whether a claimant may be forced to undergo a discovery deposition is debatable. However, the commission's interpretation of the law is that these depositions are allowed.

As suggested in previous sections, the subpoena duces tecum is frequently the most powerful discovery tool available in a workers' compensation case. The attorney should seriously consider sending a subpoena to the employer in every case. See Appendix 4. Records of the rehabilitation nurse should also be subpoenaed if not provided voluntarily. Some attorneys also send subpoenas to the insurance adjuster and/or defense lawyer.

The pre-hearing brief, Form 58, also provides some limited discovery. Regulation 67-611.

§ 4.13 OSHA Demand for Employee Exposure and Medical Records.

The Occupational Safety and Health Act allows the employee to obtain certain records at no cost. See Appendix 4.

§ 4.14 Third Party Claims.

Every workers' compensation claim should be scrutinized for possible third party claims. Motor vehicle accidents are obvious, but products liability claims are easily overlooked. The Act provides that an injured worker can proceed against both the employer/carrier and the third party tortfeasor by complying with section 42-1-560. This section provides the mechanism for notifying the carrier of the worker's intention to file a third party claim.

Pending workers' compensation claims can be a very valuable tool in "financing" your third-party claim. It is a rare opportunity to have the leisure of having a client paid weekly

disability payments when he is injured by a tortfeasor. See Chapter 10 regarding proper handling of combined workers' compensation and third party claims.