The Defense Attorneys' Perspective on a Successful Mediation.

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The Defense Attorney's Perspective on a Successful Mediation

Tips on claim management, following the rules/statute, documenting the file, and preparing for mediation.

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Goals

- Cover documents and paperwork that the rules and statute require be filed, regardless of claim compensability.
- Address substantive topics: What is an injury? Do any affirmative defenses apply? What do I need to look for in my initial claim investigation?
- Recommend best practices for preparing claims for mediations.
- How to ensure a productive and fruitful mediation.
- Provide recommendations and tips from an insider’s point-of-view.
- Give a recap of recent updates.

When in doubt, reach out.

Feel free to ask any question you'd like during the presentation or after.

You can text (865) 309-4059 during the presentation if you have a question, but don't want to raise your hand (or if we've moved on to the next topic). We'll have someone who will respond.

In practice, if you have any questions or concerns, please feel free to contact one of us.

Mr. Mayton Panning

Mayton Panning (“EE”)

The Employer, Vawltech, on 9/4 sends you the below information:

- Injured 9/1.
- EE told ER supervisor on 9/3.
- 45 years old.
- Back hurt after lifting a pallet of drinks.
- ER tells you he has only been working there a couple months.
- No problems with him, but he has complained about back before.
- He also may have had a prior surgery to his back according to another coworker. Word on the street is he played some college ball too.
- According to that same co-worker, EE was not using his back brace.
- Went to see on-site provider on 9/3, diagnosed with back strain. Says he couldn’t work after. Received restrictions taking him completely out of work. Referred to ortho.

The Employer’s Obligations

There are a few things the ER **must** immediately do:

- The ER must accept any notice, whether from the employee or employee's representative.
  - ❖ That means from the EE, or from EE’s attorney.
- The ER must report "all known or reported accidents or injuries" to the insurer within 1 business day of knowledge of the injury.
  - ❖ Can’t report to the insurer what isn’t known.

Here, Vawltech reported the injury on 9/4, within one day of receiving notice from the EE on 9/3.

While there may be some initial compensability concerns or possible defenses, again, the rules and statute require certain documents be sent to the employee and certain forms be submitted to the Bureau.

What has to immediately be sent to the Employee?

- Within **two** (2) business days, send Mr. Panning:
  1. Notice of a Reported Injury (https://www.tn.gov/content/dam/tn/workforce/documents/injuries/bureau-services-forms/NoticeofReportedWorkInjury.pdf)
  2. A copy of the Beginner's Guide to Tennessee Workers' Compensation (ttps://www.tn.gov/workforce/injuries-at-work/available-resources/redirecr-available-resources/a-beginner-s-guide-to-tn-workers--comp.html)

Do I have to contact Mr. Panning? Yes!

- Within **two** (2) business days, you must "make verbal or written contact" with Mr. Panning.
  - ❖ If it's **medical only**, the Notice of Reported Injury from the last slide will satisfy this requirement.
  - ❖ However, if it's a **lost-time claim**, then separate verbal or written contact must be made that contains:
    1. adjuster's name and contact information, which shall include the adjuster's direct phone number, fax number, email address, and mailing address and
    2. An attempt to investigate the facts of the claim and obtain a history of prior claims, including work history, wages, and job duties.
- A good rule of thumb: Lost time = personal contact.
- First ask whether the employee is only seeking treatment, or are they claiming they can't return to work?

From our example, what contact has to be made with Mr. Penning?

- He is requesting medical treatment, and he is saying he is in too much pain to go into work.
- Consequently, this is a lost-time claim.
- The “Notice of a Reported Injury” and “Beginner’s Guide to Tennessee Workers’ Compensation” have to be sent.
- What else?
- A separate verbal or written contact must be made with the adjuster’s contact information + investigate current and prior claims.

Tips

- We'd recommend an initial investigation regardless of whether it's a medical only or lost-time claim.
- If possible, take a recorded statement or have a third-party vendor do one. The facts matter, and headaches on the back-end can oftentimes be avoided on the front end. An ounce of prevention is worth a pound of the cure.
- Make sure you ask about "who, what, where, when, how, why, and witnesses." Ask about prior injuries, treatment, surgeries, or MVAs.
- Injured employees do not have to be a perfect recorder, but they must at least identify an "incident" or "set of incidents" "identifiable by time and place of occurrence."

The Panning Call

You send the required information and call Mr. Panning. He states:

- Confirms he injured himself 9/1 while lifting a pallet of Bepsi.
- He “felt a twinge, then his back was sore.” Didn’t think much of it, but it got worse as time went on.
- Admits he wasn’t wearing his back brace, but “no one does.”
- Worked through the pain until it got so bad he formally reported it.
- Says he needs to see a doctor.

Afterward, call the Employer

- Adjusters “shall make personal, written or telephone contact with the employer within two (2) business days of the notice of the injury to verify details regarding the claim.”
- Use this as an opportunity to corroborate the employee’s story.
- Also conduct further investigation as to any potential defenses.
- Identify witnesses.
- Shore up times and dates.

Call with Vawltech Rep

- Confirms a coworker saw the incident. No dispute as to the incident.
- Employee was not wearing harness.
- They train employees on it and have a safety manual.
- However, they don’t regularly enforce it.
- Employee said he was fine, then on 9/4 requested treatment.
- Rep said, “We’ve seen people not wearing it. We don’t tell them to put it on. People rarely wear one frankly.”
- “I heard he played some college ball back in the day. He’s complained about his back once or twice before.”

Issues?

- There are a few worth investigating, and it would be a good idea to touch base with an attorney to get their thoughts.
- However, the rules and statute still require certain documents be filed, regardless of compensability (and even if a claim is ultimately denied).
- This does not mean you are taking a position regarding compensability, only that you are satisfying certain obligations outlined within the statute and the administrative rules.

C-20 First Report of Injury

- If it's just a minor scrape, scrap, paper cut, and can be treated with minor first aid, then no need to complete a C-20. More serious bruises, strains, and sprains require one.
- A good test comes from the rule itself. Does the injury require a) a need for treatment, b) restricted work, c) an inability to work, or d) death, then a C-20 is needed.
- Must be filed **14** days after ER's report of injury if the injury causes death or the employee cannot return to work within 7 calendar days.
- If the employee returns within 7 or fewer days, then you have until the **15th** of the following month.
- If not filed within 60 days, then it could lead to a penalty.
- We'd recommend filing it as quickly as possible.

Mr. Panning's Case

- He was injured on 9/1
- But didn't receive restrictions until 9/3, which took him out of work.
- ER reported to you on 9/4
- Go ahead and complete the FROI within 14 days, or by 9/29 by the latest.

9/4 Note from On-Site Nurse

After sending the FROI, you receive the on-site nurse from 9/4.

- X-rays negative for fracture
- EE reported 8 out of 10 pain
- Taken completely out of work until follow-up.
- Recommended follow-up with urgent care, but no formal referral.

Panels

- The rules require a panel of physicians be provided to the claimant in certain circumstances.
- The follow slides address those situations.
- A general rule of thumb is that you should provide a panel within 3 business days of the date of injury, but that does not necessarily mean care is being authorized.
- Remember as well that direct referrals can be a basis for the insurer to provide a panel at the insurer's discretion.
- Before we address Mr. Panning's panel, we'll go over the rules.

C-42 Panel of Physicians

- Within three (3) business days of a **notice of injury** and **the employee expressing a need for treatment**, provide a C-42 Panel of Physicians.
- Providers "must be qualified, willing, and able to treat in a timely manner."
- Each provider must be independent, unassociated in practice, and within the employee's community.
  - ❖Community is undefined in the statute, but generally the closer to where the employee lives, the better.
- Can list physician names or you can list the specialty practice group. The employee can then choose the physician with that group.
- https://www.tn.gov/content/dam/tn/workforce/documents/Forms/c42.pdf

What if there aren’t any providers nearby?

- There is a “safety-valve” provision allowing a panel to be prepared with providers within 125 miles of the employee’s “community of residence.”
- Again, undefined. However, only 1 physician has to be unassociated with the other two, so it's a bit easier.
- The statute doesn't specifically state whose burden it is to establish the absence of qualified, independent providers, but to ensure no disputes arise later, it's recommended to record attempts to find doctors or come to an agreement with the injured employee or their representative.

Traumatic Injuries and Immediate Care

Provide immediate emergency services. Once the claimant has stabilized, then you have 3 business days to provide a panel. 0800-02-01-.06(3).

- Essentially, injuries requiring immediate medical treatment.
- OK to prepare a panel and include one of the treating physicians.

Additional Panel Tips

On-Site Providers

- You can have employees evaluated by an on-site or in-house providers, but that does not replace the panel requirement. These providers can be included on a panel, though. 0800-02-01-.06(4).

Walk-Ins/Urgent Cares

- These can be included as long as they're staffed by at least one physician and that physician is identified on the panel.
- You can use multiple ones of the same name, but different locations, provided each has a different staff physician or medical director.
  - ❖ For example, a Concentra in Murfreesboro and one in Nashville are both fine as long as they have different staff physicians or medical directors.
- If you have further questions about panels, contact an attorney.

Mr. Panning's Panel

- Didn't request treatment until 9/4.
- Was there any obligation to provide a panel prior to 9/4?
- No. There must be 1) notice of an injury and 2) an expressed need for treatment.
- We had notice, but not an expressed need for treatment. It wasn't until 9/4 he said he needed to treat.
- Does the in-house provider count? No.
- In sum, a panel must be provided to Mr. Panning by 9/7.

Compensability

- It might feel like we're doing things in reverse by not addressing compensability first, but keep in mind in Tennessee the obligations and filings referenced above must technically be done irrespective of compensability decisions.

- Regardless, within **15** calendar days of verbal or written notice of an injury, you must make a decision on compensability. During that time, you may conduct a "reasonable investigation."
- Compensability decisions can be reversed later as additional investigation warrants.

For Mr. Panning's case…

- He provided notice on 9/3.
- That means we have until 9/18 to make a decision.
- We're still waiting on the 9/8 note though.
- Nonetheless, under the rules we are still obligated to decide within 15 calendar days.

- For purposes of this example, your counsel decides that there's not quite enough for this denial just yet.

Preliminaries:

- Is there a need for treatment?
- Is there an injury or incident primarily caused by the employment and within the course and scope of employment?
- Is notice proper? Does the statute of limitations apply?
- Are any defenses available?
  - ❖Willful misconduct, self-injury, horseplay, failure to follow a safety rule, intoxication, employee vs. independent contractor, etc?

Mr. Panning's Case

- If we find out additional information, like maybe an earlier injury occurred, then we could explore further.
- Good examples would be a prior unreported injury or a prior reported injury for which Mr. Panning didn't seek treatment.
- E.g., an incident over a year ago involving the back, and while treating for this injury, the ATP indicates this actually dates to that prior injury.
- For right now, neither one seems to apply.

- So what about affirmative defenses?

Affirmative Defenses

No compensation is awardable if injury was due to:

- Willful misconduct (e.g., horseplay)
- Intentional, self-inflicted injury (e.g., injuring oneself)
- Intoxication or illegal drug use (separate slide)
- Willful failure or refusal to use a safety device
- Willful failure to perform a duty by law
- Voluntary participation in recreational activities, unless required by employer, among other factors.

Affirmative Defenses

In general, the burden is on the Employer to establish the defense. This means proving that the injury resulted from and/or was proximately caused by the prescribed activity.

Safety violations normally have a bit of a higher burden. There must be *bona fide* enforcement of a safety rule, and the Employee had to have been trained on the rule. The key cases on this, *Mitchell v. Fayetteville Public Utilities*, created a four-part test.

Addendum *Ernstes v. Printpack, Inc.*

- Creates a new, five-standard test for evaluating notice defenses.

1. Did the employee provide written notice within 15 days?
2. If no timely written notice, did the employer have actual notice?
3. If neither, did the employee provide a “reasonable excuse.”
4. If none of the above, then the claim should be denied and dismissed.
5. If there was written notice, and employer alleges a defect in it, *then* employer must establish prejudice.

“Reasonable Excuse"

- Courts look at:

1. the employer’s actual knowledge of the employee’s injury,
2. lack of prejudice to the employer by an excusal of the notice requirement, and
3. the excuse or inability of the employee to timely notify the employer.

Impact of *Ernstes*

- The impact of this case strengthens the viability of a notice defense.
- Previously, courts were requiring employers to establish prejudice *as a result of the lack of timely written notice*.
- This meant even if there was no notice within 15 days, employers additionally had the burden to show prejudice. This was very circumstantial and fact-based.
- Now, the burden to establish prejudice is limited only to where the employer alleges a defect in the written notice provided.
- Hot off the presses—just came out Monday, so more cases may further develop this new test.

You’ve investigated the claim, and you and counsel agree to proceed with accepting…

If you decide to deny…

- You have **5** business days from when you reached that decision to file a C-23 Notice of Denial with the Bureau and simultaneously send copies to the employee, his/her representative, the treating physician, and the insured.
- https://www.tn.gov/content/dam/tn/workforce/documents/injuries/bureau-services-forms/c23.pdf
- If you decide to **change** benefits after paying them, you have **5** business days in which to file a C-26 Notice of Change or Termination of benefits.
- https://www.tn.gov/content/dam/tn/workforce/documents/injuries/bureau-services-forms/c26.pdf
- The magic number for denying or changing is **5**.

Denial

- Make sure you submit your filings to the Bureau, the employee, his/her attorney, the treating physician, and the employer.
- Expect the employee to file a Petition, with or without assistance of counsel.
- You will likely have to proceed to mediation. For right now, we'll skip that and jump into claims that are accepted.

Claim Acceptance

- Once you've accepted a claim, you need to determine what kind of claim it is: Medical only or lost time.
- **Medical Only:** As name suggests, is a claim where there's only treatment and the employee has not lost any time.
- **Lost Time:** Where the employee needs treatment *and* has missed work.

Medical Benefits

- Treatment must be reasonable, appropriate, and medically necessary.
- A panel-selected physician has a rebuttable presumption of correctness.
- If you disagree on treatment, you may have the employee submit to an independent medical examination.
- You may also submit a treatment recommendation to Utilization Review to certify/non-certify based on medical necessity determined by the Official Disability Guidelines (“ODG”). Not dispositive.

- Medical benefits are paid out according to the TN WC fee schedule.
  - ❖Can be waived (for example, out-of-state providers)
- Employee **must** accept medical treatment as provided for under the statute and rules.
- Employee is entitled to a mileage reimbursement if the physician is outside a 15 mile radius of the employee's residence or workplace.

- If medical benefits aren’t provided timely, it potentially opens up a can of worms.

- Injured employees can seek treatment on their own, and a judge could deem the provider they seek treatment from as an authorized treating physician and order authorization of treatment with that physician.

- This is a case-by-case situation, but in addition to potential penalties, if you do not provide a panel, you could lose control over the employee's treatment and be obligated to pay for treatment from a provider unfamiliar with workers’ compensation. If you think this may happen, talk to an attorney.

9/8 CareCentral Note

You receive the note by fax on 9/15.

- Diagnosed with a back strain.
- Physical exam reveals tenderness in the lumbar region.
- X-ray returned negative for any fractures.
- Still off work.
- Urgent care refers the claimant to Dr. James Noonelikes, a lumbar orthopedist that no one likes.
- You really don’t want Mr. Panning to see this guy.

Referrals for Specialized Treatment

Limited, and only in certain circumstances.

- If a provider refers the employee to a specialized provider, you have **3** business days from receipt of the referral (by fax, e-mail, hand-delivery) to provide a panel of three providers within that specialty, otherwise you accept the referral.
  - ❖Essentially, if you want to exercise control over the referral or are worried about the provider the physician is referring the employee to.
  - ❖Discretionary. No obligation to provide the panel. Can simply accept the referral.
- After the specialized treatment is finished, generally released to MMI or referred back to original ATP.

Referrals for Surgery

- If the ATP recommends surgery, the employee can request a second opinion from a panel of 2 physicians in the same specialty. If there has already been a specialty panel provided, then the employee can select one of the two remaining physicians.
- The option to have a second opinion does not alter the previous selection of the ATP.
- What if the employee wants a second opinion as to rating? Treatment purposes?
- Purely discretionary, no obligation to under the statute unless it's for "surgery and diagnosis."

Non-compliance

- What if the employee is refusing treatment, no-shows for multiple appointments, or refuses an IME?
- Best practice is to put them on notice that the refusal may impact benefits and give them a chance to remedy. Otherwise, the employee's "right to compensation shall be suspended and no compensation shall be due and payable while the injured employee continues to refuse." 50-6-204(d)(8).
- When the employee becomes compliant any unpaid temporary benefits for the period of non-compliance are due.

Lost-Time Claims

- With these claims, in addition to the medical benefits above, the employee is entitled to indemnity: Temporary disability for being out of work prior to maximum medical improvement (“MMI”) and permanent disability after they reach MMI.

- To pay out these benefits, you calculate the average weekly wage (“AWW”) and multiply by 66 2/3 to find out the compensation rate (“CR”), then plug that information into a wage statement.

- Confirm with the employer the employee's wages for the 52-week period prior to the injury. Then, use that information to complete a wage statement to certify the average weekly wage and compensation rate.

Wage Statement

- First, ask the ER for the injured employee’s payroll for the 52 week period prior to the date of injury.
- If there is only a partial year (e.g., 30 weeks), then request that.
- If neither is available, you can use a similarly situated employee in the same grade, same work, whether employed or in the same district. "Earnings" are gross wages.
- Then simply divide by the amount of weeks. A full 52 weeks will be divided by 52, and 30 by 30. After dividing, multiple by 66 2/3.
- Make sure you are calculating based on gross wages and include overtime.
- There are minimum and maximum compensation rates.

When to Pay

- Nothing for the first seven days, not including DOI. Then daily benefits from days 8 through 13. Once you hit day 14, then it dates back to the first day after the DOI.
- You must start paying TTD/TPD no later than **15** calendar days after the date of the disability begins. Subsequent payments are to be made every 15 days

How Much Do I Pay Based On Restrictions

- If employees are totally out of work, they get the full CR, or TTD.
- If they go back to work, but not fully and are making less than before, then 66 2/3rd the difference between what they're making and their CR, or TPD.
- If they refuse accommodated work, then temporary disability is suspended.
- If they are terminated for cause, then temporary disability is suspended if the ER could have accommodated the restrictions.

Snapshot of Mr. Panning's Case and TTD as of 9/8

- Taken off work on 9/4.
- So he must receive temporary disability 15 days later at the latest, or 9/19.
- Since he's completely out of work, he's entitled to TTD.
- You've calculated the similarly situated AWW to be $417.38. His CR is then $278.25.
- Still off work as of 9/8.
- Yet to schedule with Dr. Best.
- From 9/4 to 9/11, **no benefits**. From 9/12 through 9/17, **daily rate**. Once 9/18 hits, then you would retroactively pay out the 9/4-9/11 period and begin weekly payments.

Mr. Panning's Treatment

- The Claimant finally sees Dr. Best on 9/20.
- He has been out of work this entire time, so you've started TTD.
- Claimant reported 10-out-of-10 pain.
- Said, "I played a bit of college ball and took a big hit to my back. Had to see a doctor. No surgery."
- Dr. Best does an MRI, which reveals 1) Disc herniation without radiculopathy at L4-5 and 2) disc herniation without radiculopathy as L5-6 with significant degenerative disc disease and chronic foraminal stenosis.
- "The L4-5 disc herniation appears related to the date of injury. The L5-6 is less clear."
- Recommendations for injections to L4-5 and physical therapy.

What's the compensable injury as of 9/20?

- Technically, only that which is primarily (greater than 50%) related to the alleged work injury.
- Is the L4-5 disc herniation that "appears related" compensable?
  - ❖Technically, it is not—*yet*.
- In these situations, it's generally advisable to follow up with the treating physician with a medical questionnaire.
- If the provider certifies that the diagnosis *is not* primarily related to the work incident, then it's not compensable.
- If they certify *it is*, then it is compensable.

Should I Send a Questionnaire?

- It depends and is circumstantial to each case.
- On the one hand, you don't want to do the "other side's" work for them.
- On the other hand, you don't want to proceed with a dispute arising from a provider's transcription error.
- Court's don't require the provider to use the *exact* language of the statute; e.g., "primarily (greater than 50%) related."
- Synonyms work: Directly, more likely than not, predominantly, etc.
- Delaying could also worsen the condition and increase exposure.

Mr. Panning's Medical Questionnaire

- You decide to send a medical questionnaire to the treating physician.
- Dr. Best responds, "I think the L4-5 is acute and directly due to the incident patient alleged."
- "The L5-6 is less clear. It appears degenerative from MRI but he states it was asymptomatic. Possibly aggravation."
- Dr. Best recommends a discectomy at both levels.

Mr. Panning's 11/25 Appointment

- You find out from the provider that Mr. Panning missed his 10/25 appointment as he was unwell.
- It's rescheduled to 11/25.
- He again reports 10/10 pain.
- Dr. Best recommends a discectomy to not only the L4-5 but also L5-6.

Medical Hypotheticals

- At this juncture, if Mr. Manning disagreed with surgery, he could request a second opinion, which we would be obligated to provide.
- Conversely, if the insured were concerned about the surgery given the nature of the injury, it can be submitted to UR.
- Remember, treatment must be reasonable, appropriate, and medically necessary.
- UR addresses medical necessity only under the ODG.
- While Dr. Best's opinion has a presumption of correctness, it is rebuttable.
- In practice, courts will often defer to the ATP's opinion.
- To successfully rebut, treatment recommendations must clearly fall short of the ODG, but it's sometimes advisable to pair it with a second opinion.

Medical Disputes

- Disputes concerning treatment often involve second opinions or UR.
- ATP recommendations are presumed to be medically necessary and are “rebuttable only by clear and convincing evidence demonstrating that the recommended treatment substantially deviates from, or presents an unreasonable interpretation of, the treatment guidelines [ODG].”
- For rating disputes (e.g., from an ATP and an IME), either party can seek an MIRR, which the employer pays for. The MIRR doctor's opinion is presumed to be the accurate impairment rating, but may be rebutted by clear and convincing evidence.

The IME

- You manage to fit in an IME with Dr. Gooder before the claimant's surgery now scheduled for 1/1.
- Dr. Gooder says, "The L4-5 disc herniation is not inconsistent with the reported injury. I agree with Dr. Best's opinions and treatment recommendations."
- "But the L5-6 is degenerative. Moreover, during our intake, the patient reported a prior injury he had while playing football. He didn't have surgery, but he did say he had pain off-and-on for years after."

Now what?

- Best practice would be to inform Dr. Best's office that the L5-6 discectomy is not authorized.
- You could also follow-up with Dr. Best's office with another medical questionnaire to see if he agrees with Dr. Gooder.

The Second Questionnaire

- You send another questionnaire to Dr. Best with Dr. Gooder's opinion enclosed.
- Dr. Best responds: "I was not aware of the prior injury. He also informed me he had been asymptomatic, If he had symptoms prior to the work injury, then I would say the L5-6 is not primarily related."

Medical Miscellany

- Medicine is as much an art as it is a science.
- Providers are supposed to rely largely on objective findings.
- In cases of degenerative findings where employees state they were asymptomatic before, providers will occasionally relate a diagnosis to a work injury.
- Providers base their opinions on the information they have available at the time.
- New or different information—such as surveillance, pre-injury treatment records—can lead to a changed opinion.

Due Diligence

- In these situations, it is worthwhile to investigate further.
- A medical canvass can be used for nearby hospitals or providers.
  - ❖No implied or express confidentiality for workers' compensation records.
  - ❖But it's a good idea to have a release executed to expedite.
  - ❖You will need the release for any pre-DOI records.
  - ❖If the employee refuses, the records can be sought via subpoena, or the employee can be compelled to execute the release by motion.
- Following up with the employer can also be helpful.
- They may be able to say if the employee previously complained of pain.
- If so, have affidavits prepared.
- Also review the records to see if the employee reported one thing to a provider and another to a different provider.

Mr. Panning's Surgery and Post-Surgery

- He undergoes surgery scheduled on 1/1.
- One month later he reports tremendous relief.
- He is 2/10.
- In the months following, he has some physical therapy.
- On 5/1, Dr. Best says he has no more treatment to offer.
- In his note, he writes, "He can go back to work. He cannot lift more than 50 pounds though. Maximum medical improvement."

Maximum Medical Improvement

- Monitor treatment to ensure the employee timely reaches MMI within the extent of his injury.
- Good idea to assign a nurse case manager if assistance is needed.
- Once employees have “plateaued,” or need no further active treatment, then they’re at MMI.
- Only treating physicians or chiropractors can assign an impairment rating. 50-6-204(k)(1). They have to use the Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment. (k)(2)(A). They have to be to the body as a whole. This rating is presumed accurate, but may be rebutted by a preponderance of the evidence. 50-6-204(k)(7).

Dr. Best's Final Medical Report

- You receive Dr. Best's Final Medical Report and an impairment rating addendum 5 days later.
- He assigned a 15% whole-body impairment rating.
- He states, "I think based on his overall condition and all diagnoses he has a 15% whole-body impairment rating."
- States he used Table 17-4, Class 3.

Rating Issues

- There are a few steps you can take.
- We know that Mr. Panning has a single-level disc herniation primarily related to the work injury.
- However, he was rated for a multi-level disc herniation.
- Likely Dr. Best may have simply rated out Mr. Panning's total condition, without apportioning between pre-existing and work.
- Two main options: Submit a questionnaire to the ATP or seek an IME.
- Each has its own pros and cons. The questionnaire is cheaper and quicker, the IME on average will be more helpful if there is a genuine dispute.
- If the medical director is taking too long to complete the FMR, then the Bureau's medical director can help out.

Pain Management Agreements

- As a condition of receiving controlled substance narcotics, the employee may sign a formal written agreement with the physician. If they violate this agreement more than once, then the employee's right to pain management through controlled substances is suspended. This will also be deemed "misconduct connected with the employee's employment for purposes of § 50-6-207(3)."

Mr. Panning’s Offer

- Once the FMR is received, then an offer of settlement has to be made within 30 calendar days, if there is no dispute. If settlement is not agreed upon, then proceed to mediation.
- If the employee skips out on an evaluation for rating assignment purposes, "without justifiable cause," then the employee is subject to sanctions up to a dismissal of his claim.

- You call Mr. Panning to offer a settlement based on the 10%, but he disagrees “since the doctor gave him a 15%.” He doesn’t budge.

Mediation

- This process starts when one of the parties files a Petition for Benefit Determination (“PBD”).
- To make the most out of mediation, make sure you have identified the pertinent issues and provided the necessary materials to the assigned mediator.
- Make sure to keep an open line of communication with the mediator. They may request documents, and you are obligated and have a time period in which to produce them.
  The PBD is the “functional equivalent” of a Complaint.
- At this point, you will need to retain counsel.

PBD

- PBD must include:

1. Identifying information of the employee and employee's attorney, if applicable;
2. The name of the employer;
3. The date of the alleged injury or accident;
4. A short plain statement describing the alleged injury or accident; and
5. The signature of the employee or employee's attorney.

After the PBD is Filed

- Once the PBD has been formally filed and a mediator is identified, we'd recommend immediately sending over the FROI, wage statement, and any denial/termination/change of benefits forms. We'd also recommend having the claims assistant send over the most pertinent records. When in doubt, don't hesitate to ask the mediator specifically what they need.

PBD Deadlines

- Once referred to a mediator, the parties have **14** days to exchange medical records. As further medicals are received, then they have to be sent within 14 days.
- A wage statement has to be sent to the mediator within 7 business days of a request or 15 calendar days of filing of a Dispute Certification Notice (occurs after a mediation impasse).
- Parties to a scheduled alternative dispute resolution proceeding must cooperate with scheduling, produce documents requested in writing or orally by a mediator, provide a representative authorized to settle the matter, be prepared to mediate all disputed issues at the time of the scheduled alternative dispute resolution proceeding, and mediate all issues in good faith.

Mediation Scheduling and Deadlines

- The mediator will generally work with you and your schedule to set up a mediation.
- Prior to Covid-19, the majority of the mediations would be in-person for all the parties.
- Since Covid-19, it is at the discretion of the parties.
- Generally will default to telephonic or videoconference mediations.
- Either party can request an in-person mediation.

Mediations

- Not every mediation is concluded on the day of the mediation.
- Sometimes more information is needed by the parties.
- Mediators can grant a continuance or leave mediation “open” for a scheduled period of time (e.g., 30 days or 60 days).
- During this time, the parties then conduct additional fact finding (e.g., written discovery, subpoenas, depositions, medical records requests).
- Occasionally the parties are waiting on a third party, such as a provider completing an FMR or an IME providing a written opinion.

Litigation Update Snapshot (Unpaid Medicals)

- Bad faith penalties under 50-6-118(d) previously required:

1) a final judgment and 2) an ER who wrongfully failed to reimburse an EE who paid for medical expenses within 60 days of that judgment

OR

3) the ER failed to provide reasonable and medical medical treatment if 4) a court thought that failure was in **bad faith**.

- Now, replace “bad faith” inquiry with whether ER “unreasonably” failed to pay medical expenses.
- Undefined, but presumably a lower bar.
- 60-day safe harbor if paid within “carrier's receipt of information and documentation reasonably necessary to issue payment of the subject medical expense or to determine liability for reasonable and necessary medical treatment.”
- Becomes effective **July 1, 2023**.

Litigation Update Snapshot (Attorney's Fees)

- Currently, potentially liable for employee's attorney's fees if the employer "wrongfully" denies the claim or "wrongfully" fails to timely initiate medical or disability benefits.
- The "wrongfully" standard is to be replaced by "**unreasonably**."
- Undefined, likely lower burden though.
- Became effective April 13, 2023.

Conclusion

- Once a claim is formally reported, remember to make your filings and reach out to the employee.
- Once an injury + request for treatment occurs, provide a panel.
- Make a compensability decision within 15 calendar days.
- Acceptance of a claim or payment of benefits does not prejudice any defenses.
- Can accept claim, then controvert benefits as new information comes to light.
- Even if claim is denied or disputed, still file what must be filed.

Conclusion

- Timely authorize reasonable, appropriate, and medically necessary treatment.
- If dispute, there are options. IME can address everything above plus causation. UR can address medical necessity.
- Can rebut ATP's presumption. In-person IME evaluation is better than records review or UR.
- Rating disputes follow similarly, but parties have option of MIRR.

We hope you enjoyed your second day of our conference. We will see you tomorrow morning for breakfast at 7 AM.

Agenda

BWC Bureau of WORKERS' COMPENSATION & INTERNATIONAL WORKERS' COMPENSATION FOUNDATION IWCF

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