



The Top 10 Questions or Issues With Workers' Compensation

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TOP TEN QUESTIONS OR ISSUES WITH TENNESSEE WORKERS' COMPENSATION



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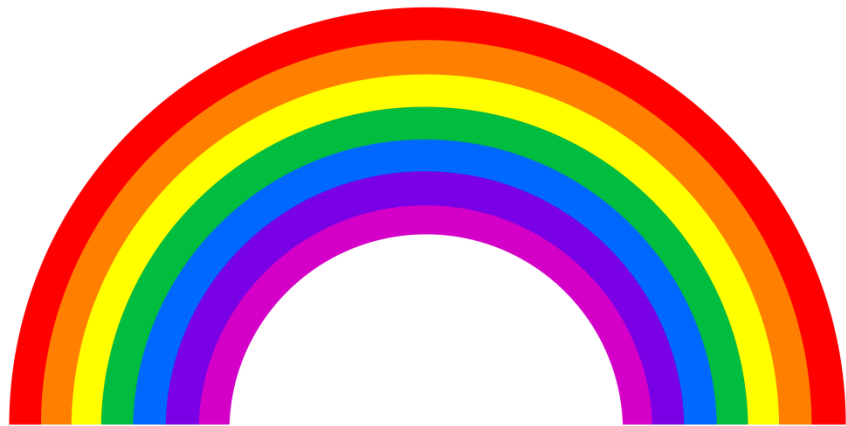
ALABAMA, GEORGIA, KENTUCKY, MISSISSIPPI, NEW JERSEY, NEW YORK, PENNSYLVANIA & TENNESSEE





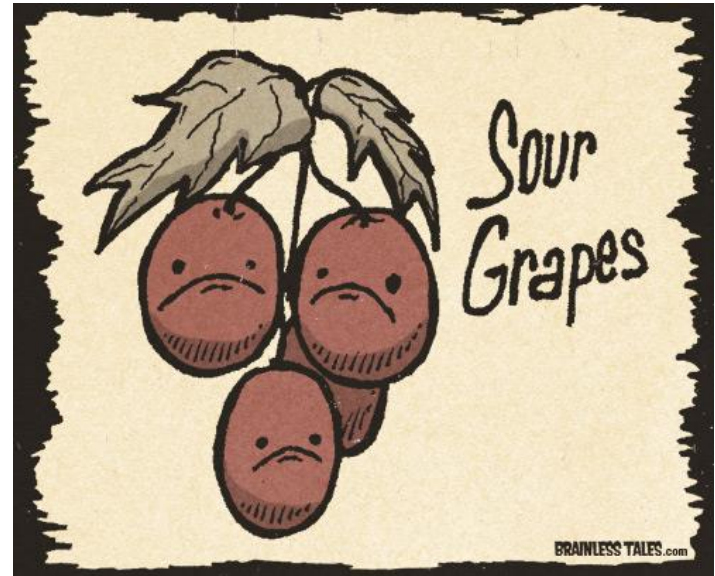
DREAM IT.
BELIEVE IT.
ACHIEVE IT.

SOME INITIAL OBSERVATIONS



SOME INITIAL OBSERVATIONS

- Costs are down
- Claims are resolved for reduced amounts
- Claims are expedited more than under old law
- Administrative system provides more stability in process



SO WHAT IS THE GOAL?



- 
- I TOTALLY WOULD HAVE SOLD THEM OUT. **BIG TIME.**

GENERAL INFORMATION: REFORM ACT

- For dates of injury on or after July 1, 2014
- Created a new, separate administrative system
- Bureau of Workers' Compensation

GENERAL INFORMATION: GOALS OF REFORM

- To make the claim process more efficient for injured workers
- Change in construction of law, intended to put all parties on a level playing field
- Provide uniform standards in benefits and recoveries

GENERAL INFORMATION: IMPARTIAL CONSTRUCTION

- No longer liberally construed in favor of the employee
- Impartial, in accordance with basic principles of statutory construction



RIGHT OFF THE BAT: NOTICE

- Employee required to provide employer with written notice within 15 days of occurrence, or if gradual 15 days after employee knows or should know of injury, or is rendered unable to work.
 - Name/address of employee
 - Time/place/nature/cause of incident
- Failure to provide adequate notice will not result in a bar of compensation
 - Except to the extent the employer is prejudiced by the inadequate notice, and then only to the extent of the prejudice
 - Very liberal standard, rarely a successful defense

NOTICE/DRUG FREE WORKPLACE

- Intoxication must be the proximate cause of the injury
- If employer is a certified member of the TN Drug free workplace and if employee is confirmed positive for a drug, or have alcohol level at .08% for non safety positions (.04 for safety positions), *it is presumed the drug or alcohol is proximate cause of the injury*, and employee is denied benefits.
- Can be rebutted by employee by clear and convincing evidence.
- But still 15 day notice requirement

NOTICE/DRUG FREE WORKPLACE

- NOT AN EXPERT
- 1000 ng/ml is max out for THC saturation in fat.
- Decreases at average of 10% per day.
- So day 1 900, day 2 810, day 3 729, day 4 656.1, day 5 590.5...day 10 348.7...day 15 205.9.
- But average case, a joint gets you to 50-70 nl/mg.
- One test tried to get the subjects really “up there.” and that came out to 230. which, by the way, is a negative test if you give notice on the 15th day.
- One study in 1989 showed only one positive test (at 20 ng/ml) after 14 days, and on average undetectable in subjects after 9.8 days.
- Cocaine is generally completely out of system in 144 hours (6 days). But most out in 4 hours.

NOTICE

- So what can be done:
 - Hard and fast rule. Presumed prejudice, no exceptions, DFWP 5 day notice requirement
 - Since that is not happening any time soon...witnesses, documentation, waiver—but overall, notice is not going to carry the day in most cases.

CLAIMS HANDLING – FIRST REPORT (FROI)

- A FROI must be submitted to BWC as soon as possible in all cases where the reported injury results in a need for medical treatment
 - If the injury resulted in 7 calendar days or fewer of disability, it must be submitted before the 15th day of the month following the month in which it occurred.
 - If the injury resulted in death or more than 7 calendar days of disability, it must be submitted no later than 14 calendar days after the report by the employer of the injury.
 - Minor injuries treated by first aid (such as cuts and scrapes) need not be reported to the Bureau
- The adjusting entity must send a Notice of a Reported Injury and a copy of the Beginner's Guide to Tennessee Workers' Compensation to the employee's last known address via first class mail within two business days of receiving a verbal or written notice of any injury from an employer (send it certified, or track it)

CLAIMS HANDLING: CONTACT WITH EMPLOYEE/EMPLOYER

- The adjuster shall make verbal or written contact with the employee within 2 business days of receiving a verbal or written notice of any injury
 - For medical only claims, this contact is satisfied by the mailing of the Notice of Reported Injury
 - Provides each employee with the adjuster's name and contact information, including direct phone number, fax number, email address, and mailing address
 - Helps to investigate the facts of the claim and obtain a history of prior claims, including work history, wages, and job duties
- Adjusters shall make personal, written, or telephone contact with the employer within 2 business days of the notice of the injury to verify the details regarding the claim
 - An adjuster assigned to a claim which had previously been assigned to a different adjuster shall make written contact with the employee within 2 business days of the assignment and must provide that adjuster's direct phone number, fax number, email, and mailing address

CLAIMS HANDLING - COMPENSABILITY

- Adjusting entity must decide on compensability within 15 calendar days of the verbal or written notice of injury
 - If, after reasonable investigation, a claim is denied, the adjusting entity must notify the BWC within 5 business days of reaching that decision
 - In cases where compensability is questioned, adjusters should contact all authorized medical providers who have rendered medical services to an employee within 3 business days of an initial office visit to investigate details concerning the injury and treatment and make a preliminary compensability determination
 - Must file the Notice of Denial of Claim for Compensation and provide the employee or their representative, the treating physician, and the insured, a non-EDI version of the Notice of Denial
 - Must include the basis for the denial – and it better be supportable. Opinions don't count!

OMBUDSMAN PROGRAM

- Established by BWC
- Providing assistance to unrepresented employees
 - Protecting employee's rights
 - Assisting in dispute resolution
 - Obtaining information for employees available under workers' compensation laws
- If either party obtains an attorney, the ombudsman program may not be utilized by that party

PETITION FOR BENEFIT DETERMINATION

- Mediation will be scheduled at the time a party files a Petition for Benefit Determination (“PBD”) with BWC
- Parties must exchange all medical records at time PBD is filed
- Employer must file a wage statement within seven business days of request from mediating specialist or within 15 business days after dispute certification notice filed
- PBD must be filed within one year of injury or last voluntary benefit payment in conjunction with the statute of limitations provided by T.C.A. § 50-6-203

PETITION FOR BENEFIT DETERMINATION

- Documents issued by a mediator do not dismiss the PBD. Once filed, it tolls until:
 - Adjudication by judge
 - Settlement of the claim approved by a judge
 - Nonsuit or voluntary dismissal of a claim
 - Involuntary dismissal of claim

MEDIATION

- Mediations may be in person, telephonically, or by video conference. In person if you are local, by internal regulation.
- If unable to settle, Mediator issues Dispute Certification Notice (“DCN”) certifying disputed issues for trial
- If pro se at mediation, it is the same tight rope for the mediator

A FEW “SPECIAL” INJURIES

- Gradually occurring injuries – still must establish that employment was the primary cause of the condition
 - Last Day Worked rule
 - “New injury” every day
- Heart attacks and strokes
 - Caused by physical exertion or strain
 - Stress of emotional experience as work-related event – abnormal or unusual stressor
- Hernias – specific factors must be established
 - Injury resulting in hernia or rupture
 - Appearing suddenly
 - Accompanied by pain
 - Immediately following the accident
 - Did not exist prior to the date of incident

EXPEDITED HEARING – LOWER BURDEN OF PROOF

- Employee need not prove every element of his or her claim by a preponderance of the evidence in order to obtain relief at an expedited hearing. Instead, s/he must come forward with sufficient evidence from which this Court might determine s/he is likely to prevail at a hearing on the merits. See Tenn. Code Ann. § 50-6-239(d)(1) (2017); McCord v. Advantage Human Resourcing, 2015 TN Wrk. Comp. App. Bd. LEXIS 6, at *7-8, 9 (Mar. 27, 2015).
- For a lower standard of proof, employee must do less to prove case, employer must do more.
- The standard by appellate court in reviewing a trial court's decision presumes that the court's factual findings are correct unless the preponderance of the evidence is otherwise. See Tenn. Code Ann. § 50-6-239(c)(7) (2018).

EXPEDITED HEARING — LOWER BURDEN OF PROOF

- Employer - You have to try your case in full at the expedited hearing level.
- Full proof, depositions, affidavits, exhibits, live witnesses.
- But if you win at expedited hearing level, you have a good chance of not having to try the case twice.

PRO SE EMPLOYEES



PRO SE EMPLOYEES

- Judges and your attorney know rules of evidence and rules of civil procedure. Pro se does not.
- They will ramble, and ramble, and ramble. And gossip. And get mad. And....
- Judge has to walk that fine line between getting the pro se to the point, and offering advice. It's tricky
- In expedited hearing, that lower standard may help pro se.
- In full hearing, they will have to prove their case in its entirety.

PRO SE EMPLOYEES

- What can you do?
 - Be mindful—object, keep them on point, keep hearsay and unfounded evidence out of the case.
 - Watch your deadlines. Comply with yours, and object and move to exclude when they do not. They are held to the same standards as everyone else. If the judge would not do it for represented party, then judge will likely not do it for pro se.
 - Focus the issue(s) as much as possible.
 - The pro se will be given leeway. The goal is to get them their day in court. But they will not be given free rein.
 - Continuances, show cause hearings, extensions. Time will likely be given to a pro se (and to represented parties). Don't let that change your approach.

PRO SE EMPLOYEES

- Don't get discouraged.
 - Judges cite to this precedent all the time
- As stated by the Tennessee Supreme Court, “[i]t is not the role of the courts, trial or appellate, to research or construct a litigant’s case or arguments for him or her.” *Sneed v. Bd. of Prof’l Responsibility of the Sup. Ct. of Tenn.*, 301 S.W.3d 603, 615 (Tenn. 2010).

DOUBTFUL AND DISPUTED AWARDS

- This is Tennessee’s “Nuisance Value” settlement. At any point, a claim can be settled under a doubtful and disputed basis.
- Employer does not have to admit compensability.
- Medical benefits are closed.
- No limit on settlement.
- But you need a reason—judge still has to find settlement is in best interest of employee

SETTLEMENT

- Parties may settle the claim in full at any time after the date of MMI
- Parties will be able to settle the issue of additional benefits before additional multipliers are determined (i.e. before the end of the compensation period)
- Parties may continue to settle with closed future medical benefits

FUTURE MEDICALS

- Parties can close medical benefits on any claim as long as:
 - The settlement agreement contains a provision confirming that the Employee has been advised on the consequences of the settlement, if any, with respect to Medicare and TennCare benefits and liabilities.
- Future medical benefits may not be closed on Permanent and Total Disability Cases T.C.A. § 50-6-240



NEW ADMINISTRATIVE SYSTEM: DUTIES OF WORKERS' COMPENSATION JUDGES

- Conduct hearings
- Provide rulings
- Approve settlements
- Issue subpoenas
- Settle discovery disputes

JUDGES

- Keep in mind:
 - Old law – 95 counties. At least one circuit judge. One chancery. Could in most cases go to either. Some send you to general sessions judge. Bigger counties have 2, much bigger counties have 9 or more. So in general—that is around 200 different judges with 200 different opinions of the law and 200 temperaments
 - Now you have 12. Still different opinions, but a lot more consistency.

JUDGES

Old law, each court had it's own system.

Each court here does as well.

You cannot forum shop anymore

So just know your jurisdictions and your judges, and act accordingly.

JUDGES



- And no sneaking around. Paying out a settlement will not get rid of the case, unless approved by a judge. If you settle, and don't get it approved, the statute of limitations is extended for two years from the date the last payment of PPD benefits was made to employee.

PENALTY PROGRAM: EMPLOYER-SPECIFIC PENALTIES

- BWC may penalize employers for:
 - Failing to timely provide a panel of physicians
 - Wrongful failure to pay TTDs
 - Wrongful failure to satisfy terms of an approved settlement

PENALTY PROGRAM: UNIVERSAL PENALTIES

- BWC may penalize either party for:
 - Failure to appear or to mediate in good faith
 - Failure to comply within the designated timeframe of any order or judgment issued by a WCJ
 - A party's misbehavior within the CWCC

PENALTY PROGRAM: BAD FAITH PENALTIES

- BWC may issue bad faith penalties for:
 - An employer's bad faith failure to reimburse medical expenses paid by the employee
 - An employer's bad faith failure to provide reasonable and necessary expenses and treatment
 - A party's failure to produce documents, cooperate in scheduling, or provide a representative to attend a settlement conference could result in attorneys fees and costs if party acted in bad faith or lacked good cause

OTHER ISSUES I HAVE HEARD THROUGHOUT THE AGES



TRAVELING EMPLOYEE

- If travel is part of the job, they are covered.
 - Traveling employees are covered during entire travel, while regular employees are only covered on the employer's premises (includes parking lot).
- Frolic or detour:
 - If they go on distinctly personal errand/departure from work while on their travels, not compensable.
 - High burden to make it personal
- Going and Coming Rule:
 - Accidents (MVAs) on the way to or from work are generally not compensable.

WILLFUL MISCONDUCT

- Willful misconduct (or willful failure to use a safety device) must meet all four elements:
 - 1) actual notice of the safety rule
 - 2) employee's understanding of the danger involved in violating rule
 - 3) bona fide strict continuous enforcement of rule
 - 4) no reasonable excuse for violating rule
- See Mitchell v. FPU, 368 SW3d 442 (2012)

IDIOPATHIC INJURIES

- Idiopathic injuries are those that have “an unexplained origin or cause, and generally does not arise out of employment unless ‘some condition of employment presents a peculiar or additional hazard.’”

CAN I TALK TO THE DOCTORS?

- Yes, that is 100% allowed in Tennessee! Both oral and written communications are permissible with the ATP. However:
 - If ATP is deposed, all communications must be disclosed to opposing party at least 10 days prior to the deposition.
 - In order to communicate with non-ATPs, you still need a separate and broader signed HIPAA-compliant release and doctor-patient confidentiality still applies.

WHY DO WE ALWAYS PAY?

- Said by Employers only. Why?
 - Filing fee: \$150, paid for by employer every time, unless the employee voluntarily nonsuits.
 - Medical Impairment Registry: no matter who requests it, employer pays the \$1500 fee
 - Penalties: do employees get penalized?
 - Frivolous lawsuit: Employees do it, to date, no penalties, even when frivolous is found. Employers, from my review penalized every time found frivolous.
 - Medical provider does not get fee for missed appointment, unless employer or insurer made appointment and failed to cancel it.
 - C30A – Impairment rating = \$250 paid by employer, even if it is a zero.

THE PAIN MANAGEMENT CONUNDRUM

- T.C.A. §50-6-204
- Pain management physicians can be located within 175 miles of employee's residence.
- Narcotics Agreement
 - As a condition to receiving pain management, the Employee may sign a formal written agreement with the physician prescribing controlled substances, which acknowledges the conditions under which the injured or disabled employee may continue to be prescribed such controlled substances and agreeing to comply with such conditions.

THE PAIN MANAGEMENT CONUNDRUM

- Violations of the Narcotics Agreement:

If the injured or disabled employee violates any of the conditions of the agreement **on more than one occasion**, then:

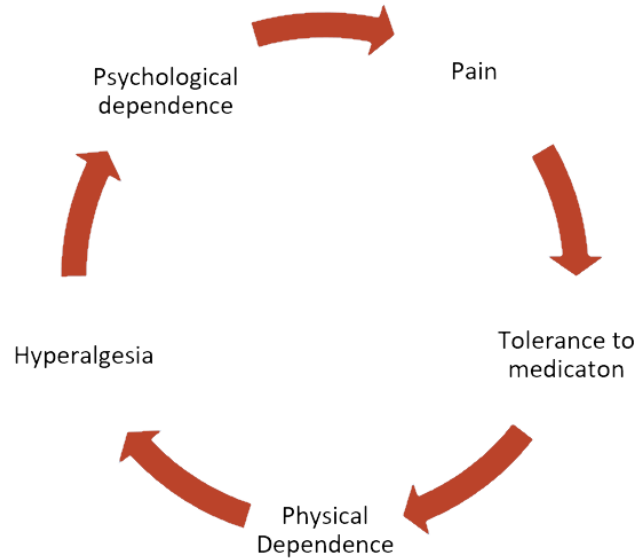
(1) The employee's right to pain management through the prescription of Schedule II, III, or IV controlled substances under this amendment **would be terminated** and the injured or disabled employee would no longer be entitled under this amendment to the prescription of such substances for the management of pain;

(2) For injuries occurring on or after July 1, 2012, the violation would be **deemed to be misconduct connected with the employee's employment**

THE PAIN MANAGEMENT CONUNDRUM

- A physician may disclose the employee's violation of the agreement on the physician's own initiative, and **upon request of the employer, a physician must disclose any such violation.**
- If an employer terminates an injured or disabled employee's right under this amendment to pain management, then the employee may file a PBD with the BWC to request further pain management treatment.
- If an employer or insurer alleges that an injured or disabled employee is not entitled to reconsideration or permanent disability benefits as described above because of the employee's alleged violations of the formal agreement, an ALJ would determine whether such violations occurred.

SO HOW DO YOU STOP IT?



TENNESSEE UTILIZATION REVIEW

- RULES FOR UTILIZATION REVIEW

1. Applies to all recommended treatments
2. Employers/Insurers shall have a system for UR
3. UR providers shall be licensed and registered
4. All reviews shall be objective
5. UR is applicable to the necessity, appropriateness, efficiency, and quality of recommended treatment
6. Upon initiation of UR, the Insurer and/or ATP shall submit the entire medical file to the UR agent

TENNESSEE UTILIZATION REVIEW: STEP BY STEP

- STEP 1:
 - Authorized treating physician (ATP) recommends treatment
- STEP 2:
 - Within 3 business days of receipt of the referral/recommendation, the insurer shall determine whether to send the proposal to UR
 - If no referral within 3 days, the treatment shall be authorized

TENNESSEE UTILIZATION REVIEW: STEP BY STEP

■ STEP 3:

- If Referred to UR, the insurer shall notify all parties and, if already assigned to the claim, the Bureau
 - When referring to UR, the insurer shall provide a copy of the entire medical file. If the insurer does not have the entire medical file, then it shall immediately make a written request to the ATP for the file. The ATP then has five business days to respond to this request. Time requirements are tolled until this time period passes at which point if the ATP has not complied, the UR moves forward and the UR agent makes a decision based upon the contents of the file.
- The UR agent shall render the determination and communicate the decision in writing to the ATP, the insurer, employee, and opposing counsel within seven (7) business days of receipt of case from employer
 - If UR approves treatment, that decision is binding on the parties for administrative purposes.
 - If UR denies treatment, the UR physician shall (1) list all records and material reviewed in support of the decision and (2) identify the reason why treatment is not necessary. **UR denials are good for six (6) months unless there is a material change.

TENNESSEE UTILIZATION REVIEW: STEP BY STEP

■ STEP 4:

- Within 3 business days of receiving the UR denial, the insurer shall notify the ATP, employee, and OC of the denial or if they will approve the treatment along with a copy of the form for an appeal.

■ STEP 5: Appeal of UR

- Within 30 calendar days of receipt of the denial, the ATP, employee, or opposing counsel shall file an appeal with the Bureau. The Bureau will issue a decision as soon as practicable.
 - If the Bureau affirms the denial of benefits, it shall not constitute an exhaustion of the administrative process. If the employee wants to pursue further remedies, the Employee may file a Petition for Benefit Determination (PBD) within seven (7) business days of receipt of the denial from the Bureau.
 - If the Bureau disagrees with the UR denial, the insurer then has seven (7) calendar days to inform provider of approval OR seven (7) business days from receipt of the denial to file a Petition for Benefit Determination (PBD).

AND NOW.....

TOP
10

QUESTIONS?





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