TITLE

Winning Strategies and Tips in Workers' Compensation Practice/Selected Issues

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INTRODUCTION

Thomas Gagne has practiced workers's compensation and personal injury law in Greenville and Spartanburg South Carolina for seventeen years. He holds a B.A. from Cornell having studied literature and philosophy and is an alumnus of SUNY Buffalo Law School and Harvard Business School. He is a former JAG prosecutor and Special Assistant United States Attorney attached to Fort Jackson South Carolina. He also served as an assistant solicitor for Richland and York Counties. Tom was recently selected as a Top 100 Trial Attorney by the National Trial Lawyers as well as a Premier 100 attorney by the American Academy of Trial Lawyers.

OPENING

This section of the program concerns selected issues in worker's compensation law. I have attempted to touch on all these topics but within the framework of the life, if you will, of a typical workers' compensation claim, from intake to settlement. I have omitted for the sake of concision and time tips and strategies on hearings and appeals.

WHAT DO YOU GET OUT OF THIS?

I hope you take away from this little talk a few of the lessons I have learned in my twenty plus years of litigation and workers' compensation practice and spare you the headaches I have had to contend with. I have also included on my website at ***gagnelaw.com*** several forms that I have developed over the years to streamline the process and aid you in spotting issues before they blow up in your face. This lecture will also be posted on my website should you be interested.

Your duty as advocates begins and ends with what is in the best interests of the client, as positive law as well as common sense requires. However, I have included some strategies that will not only help you avoids problems with the opposing party but also problems with your client that could result in ethical violations or professional negligence claims. If you do not take care of yourself, you will do no one any good. Forewarned is forearmed.

I do not believe in reductive formulas for the practice of law, but if forced to choose I would say successful litigation is founded on four columns. Develop good legal and factual theories. From this develop a plan of attack. Communicate your strategy to your client and staff. Educate yourself and your client on the legal issues involved. Make certain your evidence in alignment. Anticipate where the fight

will be and attack your opponent by exploiting your points of leverage. These themes will become apparent as I proceed and will hopefully help guide you through litigation's labyrinths.

BODY

The intake questionnaire is your first opportunity to determine your client's needs and interests. It should also reveal to you the problems with your case as well if you have a case at all. Intake is a good time to explain to your client her basic rights: i.e., That she has a right to seek and receive the medical attention; that she has a right to have all her related medical bills paid, past and future, that she has the right, if warranted, to receive temporary compensation (TTD) and that she has the right to compensation for any permanent disability she may have suffered (indemnity).

Don't rely on a date of accident that states the accident occurred on a certain date or "thereabout". Your first inquiry should be exactly when did the accident happen? Getting the wrong accident date by taking your clients word for it can lead to many unpleasant consequences. What comes to mind immediately is that the client had experienced a preexisting or post - accident injury around the time of the alleged worker's compensation injury. This as you're well aware can severely impact your causation theory as some clients will not volunteer any accidents or injuries they may have suffered around the time of the putative worker's compensation accident.

Perhaps most embarrassing is the event in which the employee was not even working on the date in question. I learned the hard way in one case when it turned out the employer was not even open for business on the date the employee claimed to have been injured as it was Labor Day. If the claim has not already been accepted by the workers' compensation carrier, verify the date of accident with personnel attendance records you have subpoenaed or by deposing the employer or one of his representatives**. Use your subpoena power to discover information.** Don't be shy. It's one of the most powerful tools you have in your legal arsenal.

Another important piece of information you will receive is of course **the reporting requirement**. Don't leave it with "I told my coworker" or more frequently "my boss was there when I hurt myself". Spell it out for the client that she needed to report the injury verbally or in writing to her supervisor. Clients tend not to understand this. If she has not reported it by the time she sees you , tell her to report it as soon as possible. Do not depend on your filing to constitute notice. Stress the fact that notice must have been given to someone in a supervisory position. Make sure you get a name. It amazes me how many clients do not know their supervisors name just a nickname. Also get a complete schedule of eyewitnesses or other witnesses to the accident and educate your client as to the difference. You may have to subpoena them later on so make certain you get a proper name and address and phone number is possible. Subpoena the witness's records if you have to get the information. If all else fails hire an private investigator.

Determine if the employee has sought medical attention -- usually she has, if not on her own then by referral from the employer to an emergency room or a low-level medical aid practice. The diagnoses you receive from such places should be held suspect until you have received a definitive diagnosis by specialist, if the case warrants it. First responder medical professionals tend to treat via the triage method – that is, identify the major pathology or pathologies and stabilize it or them.

If the client has not received medical care and it otherwise looks like a good case, by all means refer her to a doctor pending appointment of an authorized doctor or a demurrer in the employer's Form 51 which is the defendants answer. **Exhibit 1.** But be careful to send the carrier a two-week demand for treatment. If no authorize treatment is forthcoming during that time and your client is still being treated by your, unauthorized doctor, you stand a better chance of getting your unauthorized doctor paid at a hearing.

Remember that if the client has been receiving treatment, this does not necessarily mean that the employer has accepted liability. On many occasions a carrier will conduct an investigation, issue a demurrer, and cease providing medical care. In that case of course you may have a fight on your hands. Therefore, file for hearing on the issue of **compensability.**

If the client is seeing a doctor, make certain that the doctor has issued a work status note – light-duty, full duty, or modified duty. Very likely the client will be in financial distress, thinking erroneously that her "boss" will take care of her she may not receiving any temporary compensation because the employer has failed to report the injury, or less egregiously, the employee has neglected to give her medical note to her employer. Remember that if the client does not have a note from an **authorized** doctor she cannot receive temporary compensation. So get the demand for an authorized MD out immediately, for the sake of both the client's treatment and source of income.

Critically, at this stage you will determine what body parts the client claims is injured. I insist the client circle a diagram of the human body because some clients will "snowball" their body parts once they figure out the basics of the damages game. **EXHIBIT 2.** Adding body parts later on can be a clear sign that your client is malingering or misleading you and everyone else.

On the other hand, some injuries take time to blossom, and the addition of symptoms and body parts is not at all atypical of the nature of the injury. For instance, I had a case involving a bilateral subdural hematoma – a serious bruising of the brain beneath the dense sheet of tissue surrounding the brain called the dura. It can take days or even weeks for the slow bleeding in the brain to manifest symptoms. In my case, my client blacked out while driving his car weeks post-incident. He also suffered headaches and vertigo even collapsing a few times weeks after the accident.

What was even more puzzling was the fact that the radiologist in the emergency room, after conducting a CT scan, failed to spot the hematoma. Lesson learned: diagnoses can be tricky business, depending on the

health of the client, her constitution, the nature of the injury and the evolution of the symptoms. So just because a client appears to be "snowballing", does not mean she is necessarily malingering. Careful analysis and investigation of the nature of the injury is required.

Having the client specify in the intake the body parts and symptoms involved also protects you later on if the client claims that you failed to address a specific injury. The intake also serves as a source of the client's prior statements concerning her medical history, pre- existing injuries, post existing injuries and any criminal record that will protect you later on should the client make inconsistent statements later in your case.

A few more words about the intake before I move on. As I touched on before briefly, doctors are usually concerned about the clients' chief symptoms, especially at his stage of the case, and especially considering the "triage" mentality of emergency room and initial care doctors who want to treat and stabilize the low hanging fruit – say, setting a fracture but failing to note that the patient may also be exhibiting or complaining about a symptom or symptoms in an entirely unrelated body part. So be sure to claim all the body parts your client claims on your Form 50, and let the client review for her approval. Also, remind the client to tell her doctor what ails her, not just the attorney. For some reason the client rarely speaks up at the doctor's examination, but let's you, the attorney, know her full spedctrum of complaints and symptoms.

Note this down in the log to protect yourself. If the body part claimed comes to nought then you can always ratchet back, but it is difficult to ratchet up. The intake will also tell you what stage the case is in: is the client at the beginning of the claim, i.e., closer in time to the actual date of accident? Or is she nearing maximum medical improvement? Has she already been released by the authorized doctor once she sees you and is only lacking her indemnity?

The intake should also give you a good picture of the overall health if the client including any past surgeries or treatment for the body parts involved, prior existing conditions, post existing accidents, and her history of workers' compensation claims, motor vehicle accidents, and slip and falls. Any prior impairment ratings of the same body part will also affect your theory of damages.

Your intake should also disclose if any multiple claims exist. For example, if the client was involved in a motor vehicle accident you may be able to make a claim against the tortfeasor's insurance. A couple of caveats. If the employee is a direct employee or a statutory employee of the employer, then she will be barred from making a claim against the employer in tort or contract pursuant to the statutory employer and exclusivity rule. **See S.C. Code Ann. Sec. 42-1-540**; *Carter vs. Florentine Corp*., 423 S.E.2d 112.13 (1992). If, however, the tortfeasor is a subcontractor, your client may be able to recover from that subcontractor. **See S.C. Code Ann. Sec. 42-1-560**. If you do proceed against a third party at law, remember to give the worker's compensation carrier notice of your action. This requirement, I would

argue, includes any claim including commencing litigation, although some may disagree. Notice is required because the workers' compensation carrier has a right of subrogation for any damages you may recover from the third-party tortfeasor.

In general, the best practice is for you to proceed yourself against the third party.

Also, if your client is an employee of a subcontractor, which is often the case, and is injured by another subcontractor working for a different company, then you may have a claim in tort against that subcontractor, if the employee/tortfeasor is not deemed a statutory employee. You can see how the various fact patterns can make this analysis quite complex rather quickly, so carefully analyze the legal status of all the players involved so as not miss a cause of action.

Be careful if the third-party claim involves another jurisdiction and/ or type of defendant. For example, an out-of-state defendant within the scope of his employment as a governmental or quasi - governmental entity should raise a red flag. These raise a host of sovereign immunity issues not the least of which notice provisions and/or statutes of limitations in other states maybe shorter. Tip: refer the case to a lawyer in that jurisdiction and sign the retainer agreement "**For Investigative Purposes Only."**

Spotting these and other issues upfront using a detailed intake is achieved through a thorough and systematic process of inquiry, which follows up and through itself, catching the significant issue or issues. This is why I never let the client fill out the intake herself. Because of his lay status, he will not understand the significance of some of the questions and may provide you with incomplete or even false information or perhaps no information at all regarding a particular issue.

Your first meeting with the client during intake is perhaps the most important one in the evolution of your discovery. This is where communication and education are paramount concerns. It is at this stage where the client learns of her rights, and where you plan the preliminarily theory and direction of the case. This is your chance to determine the body parts and diagnoses involved if possible, her current treatment history as well as medical and accident history, including any psychiatric history or drug and alcohol abuse, her family structure, criminal background if any, hobbies as well as her employability and what the client needs as soon as possible. It also establishes the client's story and will protect you later from claims of negligence or oversight.

Take this opportunity to get with your client on these and other issues from the very beginning so the both of you are "on the same sheet of music". Warn your client not to talk about the case facts to anyone especially the doctors, case management workers, or adjusters as these statements re-interpreted by professionals essentially in the employ of the opposing party can torpedo a case. I have included an intake form, an FAQ as well as a flash analysis on my website at gagnelaw.com for your use so you don't miss the major issues. **EXHIBIT 3**. But don't think it is perfectly exhaustive. Create your own checklist and

use it, modify it as you learn more. It can prove an invaluable aid to you and your staff and catch you up to date on a case very quickly.

AVERAGE WEEKLY WAGE

The average weekly wage determines the compensation rate. **See S.C. Code Ann. 42-9-10.** The parties calculate the total paid to the client within the last four quarters of the client's employment and then divide that number by the number of weeks the client worked during the four quarters. This figure is calculated before taxes and other deductions. If the client has not worker four quarters, then go back as far as possible in the client's history with the employer. Once this figure is determined divide by three and multiply by two, in other words, multiply by two thirds and you have your compensation rate.

This number is key because it will ultimately be used in calculating the amount of compensation your client is owed. The higher the average weekly wage the higher the compensation rate. The higher the compensation rate, the higher the compensation your client, both temporary total as well as disability she should receive.

Caveat: if the client is working more than one job you have a couple of problems. The problem with having more than one job is that the defense may claim that the client hurt himself or aggravated the injury at that job. This can severely impact the value of your case. If the defense is claiming that the client hurt himself on his "moonlighting job" then subpoena all medical records from the moonlighting job. This should tell you whether he has claimed injury to the specific body part in the recent past. The medical records themselves that you have already collected should also reveal this. Use your deposition power if necessary and if the facts fairly bear it out, include the other job as a defendant.

If your client has more than one job at the time of the injury, the law allows for inclusion of his compensation in determining the compensation rate. I had a case where the client had over $14,000.00 of unclaimed compensation from a second job which, after I claimed it, boosted his compensation rate considerably. The kick was that the client had reached maximum medical improvement and had been overpaid approximately $14,000.00 TTD, and therefore it was a wash. The form that reflects the computation of your client' s average weekly wage is the form 20**. EXHIBIT 4**. Demand this form as soon as possible from the opposing counsel or the adjuster as it can sometimes take some time receiving this. Sometimes opposing counsel cannot even get a copy of the form 20. This form is critical when you make your demand. Depending on the type of injury and the significance of the injury a few dollars' difference in the compensation rate can result in a significant loss or gain in the ultimate compensation your client receives.

The right to temporary compensation is predicated on her receiving a note from the authorized physician stating that she cannot work. One common problem you'll find at this stage, the pre-MMI stage, is when

the authorized doctor will write a note stating that the client can return to work either full-time or modified light-duty. The client usually calls you in a frantic mood claiming that she cannot fulfill the duties the note requires. In this scenario, tell your client that the law demands she returnto work in the modified status and that she needs to make a good faith effort to perform her duties. If she cannot perform these modified duties she should present herself to her employer and states she cannot perform the modified duty or full duty and that she needs to see the authorize physician again who, hopefully, will revert her status to temporary total disability.

DIAGNOSES

After you have made sure that your preliminary claim is accurate and exhaustive, your temporary compensation figure is accurate, and your client is receiving it, or, you have filed for compensability if the carrier has denied your claim, you have all the medical work excuses in order, and your client is receiving the proper medical care, your next pre-MMI task will help direct you to your proper case theory and theory of damages. Remember, differentiate between preliminary and definitive diagnoses. Understand that in some cases you may not receive a definite diagnosis, with the doctors disagreeing, but this is usually not the case. The doctor's usually disagree about the amount of permanent impairment a client has suffered.

From your definitive diagnosis you will be able to hone your theory of the case. If multiple body parts are involved, you may also have a claim for permanent and total disability. If only one body part is involved then your options include settling on a form 16, clinching the case, or proceeding to hearing. The diagnosis itself will determine your theory and damages sought. A sprain and strain usually gets a lot less than say a herniated disc or a torn rotator cuff. A form 16 settles the disability portion of your claim only leaving future medicals open as well as your client's right to claim a worsening of condition within one year of the commissioner's signing the order.

An award from a Commissioner essentially works the same way as a form 16. Whereas a clincher, as the name implies, settles not only the disability portion of the case, i.e. the indemnity portion of the case, but also all future medicals including a claim for worsening of condition.

The gravity of your case vis-à-vis the diagnosis will also be reflected by the amount of medical bills she has sustained. Demand a schedule of authorize medical bills, or subpoena them from opposing party. This will help you determine the value of your case and alert you to any authorized bills that the carrier has failed to pay. While you're at it, marshal a schedule of unpaid unauthorized medical bills to serve with your demand or present at a hearing.

The length of time a client is in primary treatment and therapy will also give you a clue as to the seriousness of the injury. The longer client stays pre-MMI in general the more serious the injury the greater chance is a worsening condition as well as future residuals.

Commissioners in general will initially tend to look at these elements to determine the value of your case – the number of body parts involved, the duration of treatment, the type of diagnosis, and the amount of medical bills. But the main indicator is the diagnosis. A fracture may not result in a slew of medicals as it's just set, depending on the complexity of the fracture, with perhaps some physical therapy follow-up, yet it may result in serious permanent impairment. **When evaluating a worker's compensation case, I always go to the putative diagnosis to orient my case theory. It follows that you have to be familiar with the various diagnoses a human is prone to, which means you have to take the study of medicine seriously if you want to be a successful worker's compensation attorney.**

So, at this stage we have a definitive diagnosis, and accurate knowledge of the body parts involved which are in alignment with the diagnoses and medical records of the authorized medical doctor, and the client is getting the type of treatment necessary to treat the condition or cure it altogether – – although there is usually some residual impairment even for mild soft tissue injury. Therefore, the remaining issue in the case is damages.

Problems arise if the cases been denied. **EXHIBIT 5**. You may have received a form 51 in the form of a demurrer. Don't let a demurrer throw you off. Eight or nine times out of 10 it just means that the carrier has not finished its investigation. It will in all likelihood admit the case at a later point. On the other hand, don't be fooled into thinking the case is accepted just because the client is receiving medical care or even temporary total. If the case is still within the proper time limit, it is easy for the carrier to suspend temporary compensation as well as medical treatment. Remember, if the carrier has been paying temporary total for more than 150 days it must, by law, seek a commissioners' order to terminate temporary total. **See S.C. Code Ann. Sec. 42-9-260; S.C. Code Regs. 67-504, 67-505 and 67-506 (Supp. 2008).**

In the case of an actual demurrer, you are in a bit of a quandary. The client needs both income and correct treatment. This can be solved if the client has third-party health insurance. Refer him to the appropriate doctor, send the denial to his health insurance carrier to get her treatment. Be prepared for a lien from a third-party carrier against whatever proceeds you may obtain later on in the case. Make sure you have sent the two-week demand letter we previously touched on. If you do receive a lien from a third party carrier, you can usually negotiate less than a dollar for dollar compensation. During negotiations, stress the expenses and time your client spent obtaining compensation from the worker's compensation carrier.

Weekly income is trickier. Demand, in writing, that the client receive temporary total. If absolutely necessary, there exist companies which will loan your client bridge money. And although they cannot

charge the outrageous fees they once did it is still very expensive money, and I therefore try to steer the client away from this option. If the client has a family, I suggest the client lean on them for support until the case is resolved.

If the client does not have insurance but is in need of treatment, you'll have to find a doctor willing to work on a risky case, hopefully on a contingency basis. This should not be a problem if you have cultivated your relationship with the various primary care doctors and specialists in your area and you have developed your "stable" of physicians, if you forgive the analogy.

If the case is truly contested, then you are up against the clock. Find the evidence which will resolve the issue or issues in your favor. Speed is of the essence. Sometimes, just the act of aggressive discovery by you will prompt the insurance carrier to initiate benefits, or even settle the case, even if it falls short of an ideal settlement, given the case's infirmities.

A couple more pre-MMI problems you may face. Delinquent payment of temporary total by the carrier. This will happen to your client and suddenly you have a scared and or irate client on your phone. Late TTD is usually a result of noncompliance or when the adjuster fails to renew "repetitive pay" or there is a lack of a work excuse.

Noncompliance is a serious issue. The carrier has the right to manage your client's health care. **See S.C. Code 42-15-60.** If the client fails to make his medical appointments, fails to follow the authorized doctor's orders, or is treated by a non-authorized doctor without the consent of the carrier or its representative, he's leaving himself open to a claim of noncompliance, which could result in the carrier suspending the client's benefits for good.

To avoid this, read your client the riot act up front. Impress upon him that medical care is singularly in the province of the workers' compensation carrier.

Repetitive pay problems arise when the adjuster simply fails to renew the payment of the client's temporary total. It's essentially a computer glitch. This is easily remedied by phone call. What is most common, however, is lack of an authorized work excuse either because the doctor has failed to provide one or the client has failed to remit the excuse to his employer or the carrier has failed to receive it from the employer. This is why I take the responsibility for the excuses, taking responsibility for them out of the client's hands. All she needs to do is provide us with the excuses. We will make certain that the carrier has the appropriate excuses ourselves, including making a demand from the authorized physician.

A few more words about pre-MMI problems before we move on to the MMI stage. I want to discuss filing the form 50. **EXHIBIT 5**. This is the initial claim form. Understand upfront it is a process, but even the form 50 can serve as evidence, especially if any statement you, as the attorney make in it contradicts

or is inconsistent with later claims. If anything needs be modified, added or subtracted from the 50 you have the right to reform it, but remember, too many modifications will make it look like you're not certain of your case theory, casting doubt on the credibility of you and your client.

Developing a strong case theory from the beginning is therefore essential. But do not stick to a theory contradicted by facts if you cannot otherwise reconcile the facts to the theory. Discovery often turns up new, even contradictory facts which negatively impact your initial theory. Better to modify your 50 rather than proceed with a broken one. And, if you estimate it will take longer than 60 days for your client to reach maximum medical improvement do not file for hearing. Unless you're able to persuade the opposing counsel to continue the case in a consent order you will have to withdraw your 50 if your client has not reached MMI by the hearing date. The good news is that most attorneys are willing to continue the case.

MMI

When your client has plateaued in her treatment, she has reached MMI. She is cured, or, she has reached the point in her treatment where she is as cured and she will be for the foreseeable future. For evidentiary purposes only a qualified doctor can determine him MMI.

Determining MMI can be tricky. If the client says she has not reached MMI, but is visiting the doctor on a sporadic basis just for a follow-up, in my opinion she has reached MMI and you can refer her to an IME doctor for verification she has reached MMI. Some clients, however, will refute the contention that she has reached MMI. This may be a function of their dependence on temporary total. They simply do not want to rock the boat. Explain to client that receiving TTD benefits after she has reached MMI, knowing t or should have known that she has reached MMI can leave a bad taste in the commissioner's mouth and prompt him to look negatively on the rest of the case.

You should have educated your client by this point to know that the law states she is not entitled to receive any more temporary total once she has reached MMI. Explain to her that any payments post MM will be deducted from her final award at the hearing. Practice tip: if your client has received excess temporary total, try to negotiate a waiver during the settlement phase of the case. I find you stand a good chance of getting one.

As noted, a carrier cannot terminate temporary total after 150 days of the employee's receipt of temporary total without a commission order. The only way to stop temporary total at this point is to have the client consent to termination by signing a form 17. **EXHIBIT 6.**

If the authorized doctor has not placed the client at MMI, it does not necessarily mean she is not at MMI. The opposing counsel or adjuster may have dropped the ball, or even the authorized doctor himself. In this case, proceed and refer your client to your doctor for an independent medical evaluation (IME). Make certain you refer her to the correct doctor, one who is a specialist in particular pathology, and, if possible, board-certified. I have seen cases where one party wins because his doctor was board certified in the opposing party's doctor was not.

Include a cover letter to your doctor explaining and educating him as to your legal and medical theory and what body parts you would like to have examined. Include a detailed medical questionnaire. Exhibit. Remember, doctors are not attorneys and will not necessarily include in the report language vital to your case. For example, doctors do not tend to talk in terms of "proximate" causation, or, to a "reasonable degree of medical certainty ".

Moreover, depending on the number and type of injuries you may have to refer your client to several doctors. Do not expect an ophthalmologist to rate a back injury. Another caveat pertaining to brain injury cases. For years attorneys have been able to refer brain injury clients to clinical psychologist. But caselaw regarding this issue is controversial now. See *Potter vs. Spartanburg School District 7, 716 S.E. 2d 123.* The best practice is to retain a neurologist or neurosurgeon for your IME doctor.

One other point about brain injuries and causation. If you're seeking permanent and total disability and a brain injury and is involved you must establish proximate causation between the brain injury and the disability. The brain injury does not have to be the proximate cause of the client’s permanent and total disability. However, it must at least be a cause of the disability.

Also, latest case law requires brain injury cases to be severe in origin in order to prevail on a permanent and total theory. See *Michael D. Crisp, Jr. vs. Southco., Inc., 738 S.E.2d 835*. Therefore, in your medical questionnaire ask your doctor if the brain injury can be classified as severe, moderate or mild.

Besides medical doctors, you may need other experts to prove your case depending on your legal and medical theories. The foregoing admonitions apply to other experts, for instance in a permanent and total disability case you'll need the services of a vocational expert as well as a life care planner. Again, educate your experts as to your specific needs, the date of accident, your legal theory and the language she needs to use in her report. Always include a questionnaire to distill the legal pre-requisites and the necessary legal language.

Now is a good time to review the status of your medical records. If you send an incomplete set of medical records to your IME doctor, you're leaving yourself open to attack by the defense with the single argument that, pursuant to the doctor's deposition, his opinion is flawed because he based it on an

incomplete set of medical records, especially if the missing record would have had a serious impact on his opinion. Procuring a complete set of medical records is not as easy as it sounds.

Here's a tip. Send a subpoena for all authorized medical records pertaining to your client's case to the OC or the carrier. This must be done prior to referring your client for an IME so the doctor has a complete set of records upon which to base his opinions. If the OC argues that the IME MD had an incomplete set of records, you have your subpoena as evidence that you attempted to secure all the records, and the burden of production has shifted to the employer. I say authorized MDs assuming you should not have any problems with any of your own referrals. But even that is not always the case. It is very difficult to work with a provider who is delinquent in sending you records.

Additionally, do not depend on your client giving you an accurate medical history. Nevertheless, prior to ordering the records meet with your client and review all the doctors he has seen. Have him sign a statement attesting to the completeness of the records in order to protect yourself later on. I refer to this as a verification letter. **EXHIBIT 6.**

With all the records and experts and statements and theories floating around, now it is a good time to start talking about alignment. Take a hard look at your case at this point. Do the client's symptoms and complaints synchronize with the body parts claimed? Do they synchronize with the diagnoses? Do diagnoses synchronize with the treatment? Do diagnoses synchronize with the degree of impairment and the mechanism of injury – for instance a high rating accompanying low impact MVA may not make sense. Does the pain level your client claims synchronize with the prescriptions?

A claimed pain level of eight accompanied by prescription for Tylenol may not hold water. Is the client's injury an aggravation of a pre-existing condition, a new traumatic injury, a repetitive injury, or is it an occupational disease? And if so does the client's medical history bear this out? Combing inconsistencies from all the various elements including the client's statements as well as his adopted ones (i.e. from statements made in the pleadings) is a defense attorney's bread-and-butter. Inconsistencies in statement, but even more compelling, inconsistencies in action. Pay close attention to your client's ***actus reus***.

Rarely will you have a perfectly aligned case, especially when you factor in the complexity of medicine any atypicality of symptoms. Not to mention disagreements among the experts.

Allow me to illustrate. I had a recent case where my medical theory was straightforward. My client had tripped and fallen at work injuring his cervical spine. A year before we had clinched a different case, same client, involving injury to his lumbar spine with complaints regarding his cervical spine. However, despite his cervical complaints from before no doctor diagnosed him with a cervical pathology. Rather, the cervical pain resulted from *referred* pain from the thoracic injury. Was his new cervical injury new or an aggravation of his previous thoracic pathology? And would a doctor necessarily make the distinction in

his examination? Would the law make the distinction considering the spine is listed as only one body part? It is incumbent upon you the lawyer to ask these and related questions in your medical questionnaire and elsewhere.

Questioning. Questioning. Questioning. This is the essence of good legal practice.

In another, unrelated case, a former client of mine complained of cervical pain and upon examination it was discovered this cervical pain was a product of a lumbar pathology. Therefore, you can understand the necessity of developing your preliminary case theory early and having an open and flexible mind to modify your legal and medical theories upon discovery of new evidence.

You can see how quickly the process can become complex. And the more evidence you have, in the form of a witnesses and expert witnesses the more complex it becomes-- the more likely you will have to face inconsistencies, contradictions and omissions.

EVIDENCE

Evidence in Worker's Compensation cases is not governed by the South Carolina Rules of Evidence. See *Hamilton vs, Bob Bennett Ford 518 S,E,2d 599*. In fact, the Commissioner may accept or ignore evidence, give it whatever weight she sees fit, as long as no abuse of discretion exists, a catch all term which legally bars the admissability of some evidence; in other words, she is given wide discretion. If you find yourself in a hearing place your objections on record nevertheless. Most Commissioners are reasonable and will give due weight to your evidentiary arguments, and you always want to preserve your objections on record. Just make sure your objection is for the correct reason. As far as medical experts are concerned, the law requires medical opinions from licensed medical doctors. However, the doctors do not need to be specialists the field or board certified. Nevertheless, it still is a good practice for your IME doctor to bear board certified credentials to counter any credibility attacks by opposing counsel. By the same token, argue that the authorized doctor is neither a specialist nor board certified in the area of medicine under consideration if that is the case.

Procedurally, file a for hearing as soon as your client has reached maximum medical improvement. The prospect of a hearing is one of your great leverage points in this process. The deadline gets lawyers and adjusters moving to make their case and hopefully begin negotiations in earnest to spare the expense and potential exposure of a hearing.

Get your medical ducks in a row. Hearing dates usually take from 60 to 120 days to get scheduled depending on how backed up the docket is. As far as your witnesses are concerned, get them into your office to review their testimony and prepare them for depositions by opposing counsel if you have not already done so. **EXHIBIT 7.** Unfortunately, you will not necessarily know all the witnesses opposing counsel will use until she files her brief. By that time the hearing is imminent and you may not have time

to depose all opposing witnesses, especially the doctors. In that case, you must either withdraw your 50, or better, enter a consent agreement with opposing counsel to continue the case. But take care, you can only withdraw your form 50 once.

One note about previous existing ratings to the same body part. If an employee receives an impairment rating in a previous accident with the same employer, and injures in a subsequent accident, then the rating you receive will be reduced by the rating he received in the previous case**. See S.C. Code Ann. Sec. 42-9-170.** The same credit appears to exist if the employee has a previous impairment to a body part that did not result from an on- the- job accident. *See Schwartz v. Vernon-Woodbury Mills, 33 S.E. 2d 517 and Hopper v. Firestone Stores, 72 S.E.2d 71.* Different rules apply if the employer is different.

LEGAL THEORIES

Now to get to the specific legal theories.

By this point your legal, medical, and factual theory should be well-developed. Remember, begin working on your theory as soon as the client retains you. As we have seen, some theories are apparent some not so much.

Permanent partial disability benefits for scheduled members are governed by **S.C.Code Ann. 42-9-30.** In a nutshell, it states that, unless another statute applies, or you apply a loss of earning capacity theory, if an employee injures himself out of and in the course of his employment, he may receive benefits based on a schedule of body parts delineating the number of weeks of compensation total loss of that body part engenders. For instance, total loss of use of the shoulder garners 300 weeks of compensation. If only one body part is involved, the law requires a scheduled analysis. See *Singleton v. Young Lumber Company, 114 S.E. 2d 145.*

Typically, when an injured employee reaches maximum medical improvement after the claim is admitted, the authorized physician rates the injured body part according to the AMA Guide to Permanent Impairment Ratings. These days, this is noted on a form 14 B along with an opinion from the authorized doctor as to whether the employee can return to work, modified duty, or full duty, and what future medications and or treatment the employee may need. **EXHIBIT 8.**

As noted, claimant's counsel should refer his client to an independent medical examiner who should document her opinion about the aforesaid issues.

If the client has suffered injury to two or more body parts, including psychological injury, she may be entitled to benefits under the permanent and total disability statute. *See Lee v. Harborside Café, 564 S.E. 2d 354*. In addition to the two body parts, you must present evidence that the client is unable to return to work, via a doctor's note or opinion, or answer to a medical query, along with the vocational report stating

he is permanently and totally disabled and that "no reasonable market for her services exist". *See Colvin v. E.I Dupont Denemours Companyy, 88 S.E.2d 581.* In this case the client is entitled to 500 weeks of compensation plus future medical care. You should also have evidence of what kind and the cost of the future medical care your client will need through the services of a life care planner and her written opinion.

The 500 weeks will be reduced by the number of weeks your client received temporary total. If your client wishes to be paid in a lump sum note it on your form 58 which accompanies your hearing brief. The remaining weeks will be discounted to present value using a 2% discount rate.

If the client has a large compensation rate you may want to consider benefits under the loss of earning capacity statute found at **S.C. Code Ann. Sec. 42-9-20.**

Here, the client may receive 300 weeks of a portion of his reduced average weekly wage based on vocational and medical evidence of a loss of earning capacity due to his work related injury.

Moreover your client may receive lifetime benefits for brain damage, both arms or legs at **S.C. Code Ann. Sec. 42-9-10 (C).**

The best legal theory for your case maximizes damages – past and future. It is of course case specific. Consider all your options and run all the numbers before deciding.

NEGOTIATIONS

I have always found it helpful to have filed for a hearing before beginning negotiations. Hearings are a natural point of leverage. Carriers do not want the added expenses or exposure of a hearing and defense attorneys, by and large would rather settle than face a big loss. So get those claimed filed for a hearing as soon as your client has reached MMI.

Now, whatever legal theory you choose to proceed with, when you're demanding an initial figure to settle the case anchor high. That is, make your initial offer high, but still within the realm of reason. If you begin negotiations with too high a figure, your opponent will not take you seriously at best and will not engage in serious negotiations with you at worst.

Know what your “scream point” is, that is, the least amount your client is willing to settle for her case short of litigation, either on a form 16 or clincher. Consider whether or not you're closing just the indemnity portion of your claim i.e. disability only, or disability plus residuals, i.e., future medical care included.

If you reduce your position, reduce it by small increments. Remember it's easy to go down, but it's difficult to go back up. Also, studies have shown that, psychologically, people do not differ in their feeling

an obligation to reciprocate an effort to compromise whether that effort is a small or a large departure from the previous position. The very act of compromise creates in your opponent the need to reciprocate.

And have your arguments at hand as to why your client should receive what you're demanding, especially your points of leverage. Attack the weakest points of the OC's case. Lay siege to these to keep your price up. Put the other side's feet to the fire as to why the price should be reduced. Moreover, the longer you're involved in negotiation the more likely you will settle as both parties feel that they have invested a significant amount of time and energy to get to where they are. Most people will sit through a bad movie instead of bailing out because they do not want to have wasted their time. Another psychological point -- people fear loss more than they desire gain. I have found this a powerful and reliable tool, especially in negotiation with your own client who is proving unreasonably intractable and is in danger of harming their own interests. You are there to protect the client, even from the client himself. To use a paternalistic metaphor – you would not let your child play in traffic.

A word about medicine. Worker's compensation is a branch of personal injury law. And personal injury law necessarily concerns itself with medical issues. As a personal injury lawyer you must familiarize yourself with the gross structures of the human body as well as the nature of the various pathologies which can afflict it. Each case you have is a potential learning opportunity regarding medicine. Take advantage of this. Keep a medical folder containing your research about the various maladies you encounter, its symptoms, the nature the malady, and the treatment protocols involved. Especially the rare cases. I felt guilty about using Wikipedia to research diagnoses I was unfamiliar with, until I read an article claiming that 90%of doctors use Wikipedia and their practice for just the same purpose.

Wikipedia is one option. Of course there are many others and many fine publications that are legally oriented that help the lawyer understand medical issues. Understanding medical issues is paramount ***because diagnosis is the lens through which you develop the other theories of your case legal, medical, and factual***.

For example, is the mechanism of the injury in line with the diagnosis. I worked with the attorney at one point who insisted that one his female clients suffered from a cervix strain. I was puzzled never having heard that condition before until I looked at the records myself and discovered she was suffering from a cervical strain. Your credibility as lawyers will depend largely on your understanding medical issues, especially when it comes to steering your client's towards the correct medical attention, treatment and tests for your client. Without supplanting the doctor's role, ask hard questions of all the doctor's concerning their management of the case. Doctors err as we all do.

DEFENSES

I have touched on a few defenses thus far, especially about maintaining the cohesion of your case. I would like to say a few words about intoxication and fraud in the application before I leave you.

In an intoxication defense, the opposing party will claim that your client was under the influence of drugs and alcohol which constituted the proximate case of his injury. In the years I have been in practice I have never seen this defense prevail. The defense must prove that the employee was intoxicated at the time of the injury. It will largely depend on a toxicology report where the employee registers "hot" for one or more drugs or alcohol. But unless they can show the employee was intoxicated ***at the time of the accident***, the defense will fail. Specifically, toxicology tests for metabolite -- chemicals in a person's blood as a byproduct of the drug. Because marijuana is fat soluable, it can stay in the body for up to a month after exposure. Cocaine and cocaine derivatives are not fat soluable and leave the body sooner through urine, say 24-48 hours.

Fraud in the application exists when the employee lies in his application for employment about his health, medical conditions and any prior injuries. *See Cooper v. McDevitt & Street Company, 196 S.E.2d. 833 (1973).* However, this defense requires that the employee lie about the health of the particular body part involved before it prevails. Again, I have seen very few of the defenses actually work, much less than the instances where the employee has failed to comply with the employer's managed health care provisions.

In conclusion, develop of good case theory, build a plan of attack, align your evidence if possible, concede points you will lose, communicate and educate your client and staff on your legal and factual theories, attack your opponent's weakest points, be smart in negotiations and you will have served your client well.

Greenville, South Carolina

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