MANIER & HEROD

Tennessee Workers' Compensation

The Ultimate Guide

Fifth Edition

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By

MANIER & HEROD

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FOREWORD

This book is designed to describe, in ordinary terms, the underlying principles of workers' compensation law in Tennessee. It is intended to serve as a reference book for those who do not necessarily claim expertise in this area. It was created to help virtually any reader gain basic knowledge of the existence and importance of various aspects of the Tennessee Workers' Compensation Law in this state. While each of the individual chapters of this book could easily comprise a full book by itself, every attempt has been made to condense the contents while still striving to adequately cover the subject matter.

On July 1, 2014, the Tennessee legislature passed the most extensive statutory reform since 2011. The 2014 statutory reform dramatically affects the administration and adjudication of claims in Tennessee through revised rules promulgated by the newly created Bureau of Workers' Compensation and the formation of the Court of Workers' Compensation Claims. This book encompasses those changes. Decisions from the Court of Workers' Compensation Claims and the Appeals Board are molding case law in light of these changes. It is anticipated that there will also be regulations formulated beyond the date of the printing of this book to further delineate and explain the changes. We also anticipate the possibility of further statutory changes. We send email updates to address these continuing changes.

We hope this guide will prove useful to you. Of course, it is not intended as a substitute for professional advice, and specific legal problems should be addressed with legal counsel. For additional information and updates on developments in the law, please visit our website at www.manierherod.com. You can also access the forms discussed in this book at https://www.tn.gov/content/tn/workforce/injuries-at-work/bureau-services/bureau-services/workers--comp-forms.html

Reliance on precedent from the Tennessee Supreme Court is appropriate unless it is evident that the Supreme Court's decision or rationale relied on a remedial interpretation of pre-July 1, 2014 statutes, that it relied on specific statutory language no longer contained in the Workers' Compensation Law, and/or that it relied on an analysis that has since been addressed by the general assembly through statutory amendments. See McCord v. Advantage Human Resourcing, No. 2014-06-0063, 2015 TN Wrk. Comp. App. Bd. LEXIS 6, at *13 (Tenn. Workers' Comp. App. Bd. Mar. 27, 2015).

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I.

REQUIREMENTS FOR FILING A CLAIM FOR WORKERS' COMPENSATION BENEFITS

A. Initiation of the Claim

A claim is initiated when the employee either gives notice of a claim or the employer has actual knowledge of the claim. If conflicts arise concerning compensability or entitlement to benefits, either party may file a Petition for Benefit Determination with the Tennessee Bureau of Workers' Compensation. The current Petition for Benefit Determination requires identification of the employee, employer, and insurer.

B. Notice Must be Given to the Employer

1. The Fifteen (15) Day Requirement. The Tennessee Workers' Compensation Law requires an employee to comply with certain procedural requirements in filing his/her claim in order to obtain benefits. The first requirement is that the employee must notify the employer that he/she is making a claim for an injury:

> Every injured employee or such injured employee's representative shall, immediately upon the occurrence of an injury, or as soon thereafter as is reasonable and practicable, give or cause to be given to the employer who has no actual notice, written notice of the injury . . . No compensation shall be payable under this chapter, unless the written notice is given to the employer within fifteen (15) days after the occurrence of the accident, unless reasonable excuse for failure to give the notice is made to the satisfaction [of the court].[1]

Generally, the employee's notice of injury to the employer is sufficient if it is reasonably calculated to convey the message that the employee suffered an injury arising out of and in the course of the employment.[2] Significantly, in circumstances where an employer alleges defective or inaccurate notice, the employer has the burden of proving the extent of any prejudice resulting from the employee's defective notice before any relief can be granted.[3]

Notice can come from either the injured employee or what the law calls "the injured employer's representative."[4] This representative could be a family member, co-worker, or attorney. Although the Act states that the employee should provide written notice of the injury "immediately upon the occurrence of an injury," cases regarding the notice requirement soften the strictness of the rule.[5] Notice must only

be given when the employer does not have actual notice of the injury. An employer has actual notice, when it witnessed the employee's injury, arranged for an ambulance to transport the injured employee to the hospital for treatment of the work-related injury, or drove the injured employee to a doctor's office for examination after an injury on the job site. However, a co-worker's knowledge of an employee's compensable injury is not sufficient notice to the employer for workers' compensation purposes when the co-worker is not in a position of authority over the employee.[6]

An employee, or his representative, does not have to provide written notice in every case. The fifteen (15) day notice requirement is not a strict one. When notice is given more than fifteen (15) days after an injury occurs, the cases in Tennessee provide that the judge deciding these issues is to examine the facts and determine when an employee should be reasonably aware that the employee sustained a compensable work-related injury. Only when the employee acquires that knowledge does the fifteen (15) day period begin.

2. Failure to Give Timely Notice. In the event an employee fails to provide the required notice, the employee cannot receive benefits under the Act. However, courts are extremely reluctant to deny a claim for benefits on a technicality. For this reason, employers should consult with their insurance carriers and attorneys before deciding to deny a claim for failure to give proper notice. The courts will generally give the employee the benefit of the doubt in these situations.[7] For example, the Tennessee Supreme Court excused an employee from giving timely notice from the date of his accident when there was a gradual progression of symptoms several months before the employee was finally advised by his physician of the connection between his back problems and his on-the-job accident.[8] The Court recognized that the employee had a limited understanding of his condition and of his rights under the Act. Other cases have made it clear that if the employee provides a "reasonable excuse for the failure to give notice," the time period does not start until the employee no longer has that excuse.[9]

3. Company Policy Notice Requirements. The Act's notice requirements alone govern the burden placed on the employee to notify the employer that a work-related injury has occurred. Some employers have specific requirements written into their employee handbooks stating that notice of an accident must be given within a specified time period (for example: within forty-eight (48) hours of an accident). Although such policies are allowed and can be used to encourage immediate reporting of workplace injuries, employers cannot successfully defend a workers' compensation lawsuit based on the employee's failure to comply with the company's notice requirements. The fifteen (15) day provision set out in the statute is the time period the courts will use. It would be a good idea to have a written policy regarding giving notice of any accident or injury and to have the employees sign a form or the policy manual acknowledging that the employee is aware of the employer's notice policy, especially if the employer's policy is different from the notice provision in the statute. This will help defend against the employee's claim that the employee did not know he was required to give notice of a work injury.

4. Purpose of the Notice Requirement. The notice requirement serves several purposes. First, if the employee provides the employer with proper notice, then the employer has the opportunity to investigate the injury before the passage of time fades memories and clouds judgment. Second, if the employee actually suffered a work-related injury, with proper notice the employer can then provide the employee with the appropriate medical treatment under workers' compensation. Finally, the notice requirement helps put both the employer and the employee on alert as to potential safety hazards in the workplace, so the employer can correct them and work to prevent similar injuries in the future.

Before an employer can defend a case based on lack of proper notice, the employer must be able to show that it was in some way prejudiced by the failure of the employee to give notice.[10] In order to satisfy this provision, employers generally try to show the lack of notice prejudiced their timely investigation of the claim or prejudiced their right to provide authorized medical care. The requirement that the employer prove that it was in some way harmed by the lack of timely notice makes the notice defense even more difficult for the employer to successfully assert. Other than the disappearance or death of a critical witness or the other problems caused by a lengthy delay such as the inability of the employer to control medical treatment, proving prejudice to the employer based on a lack of notice is difficult, but not impossible.[11]

5. Gradual Injuries. Generally, an employer will not succeed with a notice defense when the injury begins as a small problem and gradually progresses to a point where it becomes disabling and treatment is required. The date of injury in these cases is deemed to be the date the employee's condition is sufficiently severe to prevent him from working, rather than the date on which the condition was diagnosed.[12] This law is commonly referred to as the Last Day Worked Rule.

The Tennessee Supreme Court Workers' Compensation Appeals Panel clarified the rule and applied it to situations in which an employee is terminated prior to reporting a work-related injury. The Appeals Panel held that even if the termination of the employee's employment is completely unrelated to the employee's injury, the employee's date of injury is the last day worked for the employer.[13] Employers should be on notice, especially in cases of large-scale plant layoffs, that terminated employees can now claim their last day worked for their employer as their date of gradual injury for notice and statute of limitations purposes.

C. Statute of Limitations

1. The One (1) Year Requirement. For injuries occurring on or after July 1, 2014, the Tennessee Workers' Compensation Law provides that the right to compensation for a work-related injury is barred unless notice is given to the employer and a Petition for Benefit Determination is filed with the Bureau of Workers' Compensation within one year after the accident resulting in injury.[14]

2. Tolling the Statute. In Tennessee, the statute of limitations is tolled (stops running) while an employer pays benefits to or on behalf of an employee. If an employer has voluntarily paid benefits within one year following the date of injury, then an employee's right to compensation is forever barred unless the employee has filed a Petition for Benefit Determination within one year of the date of the last authorized treatment or the last payment of benefits, whichever is later. Thus, the employee has one year from the date the last payment of benefits is issued within which to file suit seeking further workers' compensation benefits. However, to toll the statute, the employee must know the source of the payments, and that the payments are being stopped. While payments made under workers' compensation insurance toll the statute, payments of medical bills by private health insurance do not. Additionally, payments of disability benefits or medical bills by the Veterans' Administration, Medicaid, or a state government plan also do not extend the statute. Additionally, the statute is tolled, or extended, while the physical or mental incapacity of the injured person or the injured person's dependents prevent them from performing any act required by the statute.[15]

3. Courts are Flexible. As with the provisions on providing notice of an injury, the statute of limitations provision contains some flexibility designed to benefit the employee. Recent cases reaffirm the principle that the one (1) year period of time for seeking workers' compensation benefits does not begin to run until the employee's disability would be known by a person of reasonable intelligence or when an employee discovers the permanent nature of the injury.[16] Adjudicators look to the date the employee was unable to work for purposes of determining both notice and statute of limitations questions.[17]

D. Occupational Disease Cases

There is a one (1) year statute of limitations for filing a compensation claim related to an occupational disease.[18] The provision applies to the employees and their dependents (should the employee die as a result of the occupational disease). Usually, a one (1) year statute will begin to run upon the date of diagnosis of the condition. However, the Tennessee Supreme Court held that lawsuits in occupational disease cases do not have to be filed until the employee is disabled from the disease.[19] Therefore, the one (1) year statute of limitations in occupational disease cases does not begin to run until the employee can no longer work, even if this condition was diagnosed several years prior to the date the employee stopped working.[20] Further, the Tennessee Supreme Court Workers' Compensation Panel went a step further and held that the date of injury for an employee with an occupational disease was the last date worked for the employer, even though the employee's termination had nothing to do with her injury.[21] Thus, employers should be on notice, especially in the case of large layoffs, that the termination date of employment may be the date of injury for gradually-occurring injuries for both notice and statute of limitations purposes.

In many instances, an employee is unaware of the diagnosis or the "work-relatedness" of the occupational disease, but when the employee learns of such connection, the statute begins to run.[22] Claims for occupational disease or death benefits must be initiated in the same manner as an acute injury, i.e. by filing a Petition for Benefit Determination. As set forth above, the applicable time limitation commences on either the first day the employee is unable to work due to the occupational disease or the date of the employee's death. In black lung cases, a claim for benefits or death resulting from pneumoconiosis must be filed within three (3) years of either discovery of total disability or the date of the employee's death.[23]

Endnotes to Chapter I

1 Tenn. Code Ann. § 50-6-201(a)(1).
2 Jones v. Helena Truck Lines, Inc., 833 S.W.2d 62 (Tenn. 1992); Tenn. Code Ann. § 50-6-201(a)(2).
3 Simmons v. RHA/ Trenton, Inc., No. 2016-07-0249 (Tenn. Wrk. Comp. Panel Feb. 1, 2017).
4 Tenn. Code Ann. § 50-6-201(a)(1).
5 *Id*.
6 Jones v. Helena Truck Lines, Inc., 833 S.W.2d 62 (Tenn. 1992).
7 *But see* Wausau Insurance Co. v. Richardson, No. E2010-00356-WC-R3-WC (Tenn. Wrk. Comp. Panel Feb. 16, 2011) (upholding a trial court's verdict based on the employee's failure to give notice).
8 Buckner v. Eaton Corp., No. 2016-01-0303, (Tenn. Workers' Comp. App. Bd. Nov. 9, 2016).
9 *Id*.
10 Tenn. Code Ann. § 50-6-201(a)(3).
11 *See* Buckner at *4-5.
12 Tenn. Code Ann. § 50-6-201(b); Maples v. Federal-Mogul Corporation, No. 2015-04 0039, 2016 TN Wrk. Comp. App. Bd. LEXIS 8 (Tenn. Workers' Comp. App. Bd. Feb. 17, 2016).
13 Little v. Aerospace Center Support, 2007 WL 1385959 (Tenn. Wrk. Comp. Panel May 10 2007).
14 Tenn. Code Ann. § 50-6-203.
15 Tenn. Code Ann. § 50-6-203(d).
16 Shuler v. Eastman Chemical Company et al., No. E2016-02292-SC-R3-WC (Tenn. Wrk. Comp. App. Nov. 17, 2017).
17 Maples v. Federal-Mogul Corporation, No. 2015-04-0039, (Tenn. Workers' Comp. App. Bd. Feb. 17, 2016); *see* also Shuler, No. E2016-02292-SC-R3-WC (Tenn. Wrk. Comp. App. Nov. 17, 2017).
18 Tenn. Code Ann. § 50-6-306(a).
19 Shuler v. Eastman Chemical Company et al., No. E2016-02292-SC-R3-WC (Tenn. Wrk. Comp. App. Nov. 17, 2017).
20 *Id*.
21 *Id*.
22 *Id*.
23 Tenn. Code Ann. § 50-6-306(b).

II.

IS IT A WORKERS' COMPENSATION INJURY?

A. Does an Employer/Employee Relationship Exist?

1. Requirements to be an Employer Subject to Workers' Compensation Law. In order for an employer to be subject to the provisions of the Tennessee Workers' Compensation Law, the employer must employ five (5) or more employees.[1] This number includes part-time and full-time employees.[2] There is an exception to the five (5) employee rule for employers in two (2) industries. An entity engaged in the construction industry must carry workers' compensation insurance, and an entity engaged in mining and production of coal must carry workers' compensation insurance if it has one (1) or more employees.[3]

Other special rules apply to construction service providers, which are defined as "engaged in the construction industry."[4] The phrase "engaged in the construction industry" is defined by the classifications of the rate service organization designated by the Tennessee Commissioner of Commerce and Insurance.[5] If an employer is found to be engaged in the construction industry, then its employee may seek workers' compensation benefits from his or her initial employer as well as the principal or intermediate contractor.[6] In other words, by pursuing relief from his or her immediate employer, the construction employee does not waive his or her right to seek compensation from the principal or intermediate contractor.[7] In fact, the employee may join all contractors in a single lawsuit.[8] However, if an employee of a subcontractor is successful in his or her workers' compensation claim against the principal contractor, then the exclusive remedy doctrine applies to the principal contractor as the employee's employer.[9] Thus, an injured employee may move up the construction hierarchy ladder until that employee is able to find an entity that is able to pay his or her workers' compensation claim.

A subcontractor may elect to be covered under the general contractor's policy of workers' compensation coverage with the written agreement of the contractor. The general contractor must file written notice of the election with the Bureau of Workers' Compensation.[10] However, if the general contractor fails to do so the subcontractor will still be covered by the general contractor's insurance policy if the subcontractor can show payment of premiums to the insurance company for that coverage.[11] Any person, including sole proprietors and partners, principal contractor, intermediate contractor or subcontractor engaged in the construction industry must carry workers' compensation insurance.[12] This law does not apply to people working on their own property for their own use for which they receive no compensation.[13]

2. Definition of Employee. A worker is only eligible for benefits under the Tennessee Workers' Compensation Law if he or she meets the law's definition of an employee. Under the law, an employee is generally defined as every person in the service of an employer, under any written or implied contract of hire or apprentice-

ship.[14] Courts have found that the employment contract must include an express or implied agreement for payment of some type for the employee to be eligible for benefits.[15]

a. Employees vs. Independent Contractors and Subcontractors. The law distinguishes employees from independent contractors and subcontractors. An independent contractor or subcontractor is not an employee under the Workers' Compensation Act, and thus is ineligible to receive workers' compensation benefits if injured on the job.[16] In a work relationship, in order to determine whether an individual is categorized as an "employee," a "subcontractor" or an "independent contractor" the following factors shall be considered:

1) The right to control the conduct of the work;
2) The right of termination;
3) The method of payment;
4) The freedom to select and hire helpers;
5) The furnishing of tools and equipment;
6) The scheduling of working hours; and
7) The freedom to offer services to other entities.[17]

The most significant factor in determining whether a person is an employee is the employer's right of control.[18] Generally, the court has found that, "Whether a claimant is an employee or an independent contractor depends upon the nature of the business of the alleged employer, the way the business is conducted, and the claimant's relationship to that business.[19] Where there is a contract of employment, either express or implied, the burden is on the employer to show the employee is an independent contractor, rather than an employee.[20] While no single factor is determinative when deciding whether a worker is an employee or an independent contractor, the Supreme Court has "repeatedly emphasized the importance of the right to control the work when distinguishing employees and independent contractors, the relevant inquiry being whether the right existed, not whether it was exercised."[21] If the employer controls both the method and the result of the work, then that worker is generally considered an employee. However, if the employer controls only the result of the work and the worker can choose the manner in which it is accomplished, then that worker is an independent contractor or subcontractor.[22] Generally, courts have been liberal in finding workers to be employees. If the employer retains any control over the way the duties of the workers are performed, then that worker is usually found by the court to be an employee.[23]

b. Borrowed Employees. Generally, the original employer retains responsibility for an employee's injuries even though that employee may be loaned to another person.[24] The borrowing, or special, employer may be liable if the following three (3) conditions are met:

1) The employee must have made a contract of hire, express or implied, with the special employer;
2) The work being done must be essentially that of the special employer; and
3) The special employer must have the right to control the details of the work.[25]

A borrowed employee is prohibited from suing the borrowing employer. He or she is only entitled to workers' compensation benefits from the original employer.[26]

c. Volunteers. In order for a worker to be considered an employee for purposes of the Tennessee Workers' Compensation Law, there must be a contract for hire.[27] Because the word hire indicates payment of some kind, workers who "neither receive nor expect to receive any kind of pay for their service" are not employees.[28]

A good illustration of this concept is the 1983 case of *Hill v. King*.[29] In this case, damages were sought by the family of Mr. Hill, who was killed while riding in an airplane being used by the sheriff of Robertson County to transport a prisoner.[30] At issue was whether Mr. Hill could sue Robertson County for workers' compensation benefits.[31] Though Mr. Hill was retired, he offered to help the sheriff as a volunteer without pay.[32] The sheriff accepted Mr. Hill's offer and supplied him with a pistol, uniform and badge.[33] Mr. Hill worked whenever he wanted and was needed but never received a salary.[34] The court held that Mr. Hill was not an employee as defined by the Tennessee Workers' Compensation Law because he did not receive valuable consideration for his services.[35]

The Tennessee Supreme Court has held that an employee is someone who receives payment.[36] The Court has given a number of examples of what suffices as payment for purposes of workers' compensation: payment includes board, room and training furnished to a student nurse or hospital intern, food and lodging provided to a college football player or county prisoner, and even refreshments given to a casual porter.[37]

The Court held that mere gratuities or gifts, including discounts, are not considered payments unless there is an understanding by the parties that these gifts or discounts are intended to constitute wages.[38]

d. Illegal Immigrants. Illegal immigrants can be employees and recover some but not all benefits under the Tennessee workers' compensation law. Tenn. Code Ann. § 50-6-207(3)(F) states that for injuries sustained on or after July 1, 2014, individuals who are not eligible or authorized to work in the United States under federal immigration law are not entitled to increased benefits ("resulting award") regardless of the employee's work status.[39] The statute caps the permanent partial disability award for undocumented employees and remains at one times

the anatomic impairment rating. In *Sandoval v. Mark Williamson d/b/a Tennessee Steel Structures*, the employee was not eligible or authorized to work in the United States under federal immigration law, so the employer accordingly refused to pay benefits beyond the anatomic impairment rating.[40] The employee claimed entitlement to additional benefits and challenged the constitutionality of Tenn. Code Ann. § 50-6-207(3)(F) on the basis that it was an anti-immigration statute that was preempted by federal immigration laws.

The employee relied on the Tennessee Supreme Court's prior decision in *Martinez v. Lawhon*, in which the Court declared unconstitutional a previous statute that precluded undocumented workers from receiving more than 1.5 times the anatomic impairment rating in cases governed by the pre-July 1, 2014 law.[41] The Court determined that the holding in *Martinez* did not control the current immigration statute because of material differences between the current statute and the pre-July 1, 2014 version at issue in *Martinez*. The Court went on to conclude that Tenn. Code Ann. § 50-6-207(3)(F) is constitutional, as it is not preempted by federal immigration laws.

Specifically, the Tennessee Workers' Compensation Law provides all benefits except enhanced disability benefits to undocumented workers who suffer injuries that arise primarily out of and in the course and scope of employment.[42]

e. Minors. Minors can be employees and receive workers' compensation benefits.[43]

B. Definition of Injury

The definitions of "personal injury" and "injury" were significantly changed in the 2013 Workers' Compensation Reform Act. The new definitions apply to injuries occurring after July 1, 2014. Specifically, as part of the most recent Workers' Compensation Reform Act, the general assembly again amended the definition of "injury" and "personal injury" to mean an injury by accident, a mental injury, occupational disease including diseases of the heart, lung and hypertension, or cumulative trauma conditions including hearing loss, carpal tunnel syndrome or any other repetitive motion conditions, arising primarily out of and in the course and scope of employment, that causes death, disablement or the need for medical treatment of the employee.[44] The statute now requires proof, by a "reasonable degree of medical certainty," that the work accident "contributed more than fifty percent (50%) in causing the death, disablement or need for medical treatment, considering all causes."[45] Furthermore,"'shown to a reasonable degree of medical certainty' means that, in the opinion of the physician, it is more likely than not considering all causes, as opposed to speculation or possibility."[46] Under the post-Reform definition, an injury is considered accidental only if it is primarily caused by a specific incident (or incidents) arising out of and in the course of employment and is identifiable by time and place of occurrence. A mental injury or disease is not considered a workers' compensation injury unless it arises out of and in the course and scope of employment. The new law also requires that cumulative trauma conditions, hearing loss, carpal tun-

nel syndrome, and all other repetitive motion conditions are not considered a workers' compensation injury unless the condition arose primarily out of the course and scope of employment.

A "mental injury" is defined as "a loss of mental faculties or a mental or behavioral disorder." To qualify as compensable, a mental injury must arise "primarily out of a compensable physical injury or an identifiable work-related event resulting in a sudden or unusual mental stimulus."[47] Cases focusing on the latter category make clear that (1) the injury must stem from an identifiable stressful, work-related event producing a sudden mental stimulus, and (2) the event must be unusual compared to the ordinary stress of the worker's job.

Not all mental injuries are compensable. For example, a psychological or psychiatric response due to the loss of employment or employment opportunities is not compensable. Similarly, the aggravation of a preexisting mental condition is not compensable "unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment."[48] At the same time, however, "an employer takes an employee with all preexisting conditions and cannot escape liability when the employee, upon suffering a work-related injury, incurs a disability far greater than if she had not had a preexisting condition."[49]

C. Did the Injury Arise Out of and in the Course and Scope of Employment?

After the statutory amendments from the Workers' Compensation Reform Act of 2013, for an injury to be compensable under the Act, it must both arise primarily out of and be in the course of employment.[50] Generally, the phrase "arising primarily out of" refers to the cause of the injury, while the phrase "in the course of employment" refers to the time, place or circumstance in which the injury occurred.

It is in the context of these most recent statutory amendments that relevant case law must be considered. As the Workers' Compensation Appeals Board has indicated, "reliance on precedent from the Tennessee Supreme Court is appropriate unless it is evident that the Supreme Court's decision or rationale relied on a remedial interpretation of pre-July 1, 2014 statutes, that it relied on specific statutory language no longer contained in the Workers' Compensation Law, and/or that it relied on an analysis that has since been addressed by the general assembly through statutory amendments."[51]

With that caveat in mind, the Tennessee Supreme Court has examined the following specific scenarios regarding whether they satisfy the "arising out of" and "in the course of employment" requirements.

1. Injuries Going to and Coming From Work. A worker who is injured on the employer's premises, coming to or going from the actual workplace, is injured in the course of employment.[52] This case also held that a parking lot provided by the employer for its employees is part of the employer's premises, regardless of whether the lot is also available to customers or the general public.[53] The phrase "course of employment" has been interpreted to mean not only the time that the employee

is actually paid, but also a reasonable time during which the employee is necessarily on the employer's premises while going to or from the actual work station.[54] The Tennessee Supreme Court has extended the definition of "course of employment" to include an employee who is injured on a public street while crossing that street to get to the employer-provided parking lot.[55]

Except for employees injured on the employer's premises, the general rule in Tennessee is that injuries occurring on the way to or from work are not compensable.[56] However, as with many areas of the Act, this general rule is subject to some exceptions.

In considering exceptions to the general rule, Tennessee courts analyze what benefit the employer is receiving as a result of the employee's actions. If the employee's duties require travel, injuries the employee receives because of the hazards of travel are compensable. Therefore, where a traveling salesman on a sales trip died in a fire at a hotel where he customarily stopped on his sales trips, the death arose out of and in the course of his employment.[57] If the employee takes time off from the employment duties to embark on a personal errand, then the personal errand acts as an intervening cause and any injury that results during the time of the personal errand is generally not compensable.

The use of a company car may make a difference in whether the travel is within the course and scope of employment. For example, in one case an employee was killed in an accident while driving a company car. Even though the employee was resumably on his way home and on a personal errand, his death was considered to arise out of and in the course of his employment.[58] In another case, an employee was reimbursed for his travel expenses incurred while driving his personal car. He was killed when crossing a street to look at a fishing reel while traveling to perform inspections for his employer. His death was not considered to be compensable.[59] Additionally, an employee who was killed during her lunch break while traveling to her house to pick up a company document was not entitled to benefits because the employer did not specifically instruct the employee to retrieve the document during the lunch break.[60]

2. Traveling Employees. Injuries that occur during a traveling employee's recreational activity may be covered if it is reasonable activity that would not be considered a personal errand. The Tennessee Supreme Court has ruled that the employee is in the course of his employment continuously during a trip and that the employer's reasonable recreational activities are rationally connected to the employment.[61] The general rule is that an employee whose work entails traveling away from the employer's normal job site is considered to be in the course of employment during the whole trip, except when there is a distinct departure on a personal errand.[62] In *McCann v. Hatchett*, the employee was a carpet layer who had traveled to Vermont with several other employees to lay carpet at a motel.[63] The employee drowned while swimming in the pool of the motel where he was lodged while off-duty. The Court ruled that the employee swimming in the pool was a reasonable recreational activity and therefore found the injury arose out of and in the course and scope of employment and therefore was compensable.[64] It would appear that this ruling may be limited to employees whose travel required an overnight stay.

Similarly, a Chattanooga employee who was instructed by her employer to attend a one day seminar in Atlanta invited two friends (who were not co-employees) to join her for the trip.[65] Because of car trouble, the employee was unable to arrive in Atlanta before the seminar started.[66] She and her friends ate and shopped in Atlanta and checked into a hotel. They decided to drive back to Chattanooga at 3:00 a.m. and at 4:36 a.m., an eighteen-wheeler collided with the employee's vehicle.[67] The Tennessee Workers' Compensation Panel found that the employee was injured in the course and scope of the employment because she was engaged in a "special errand" for her employer at the time of the accident, and it was not her fault that she could not attend the seminar.[68]

The casual relationship between an injury sustained by a traveling employee and his employment must be determined based upon the facts of each individual case.[69] A traveling employee must still demonstrate that the employees injury arose from the employment.[70] An injury caused by an idiopathic condition does not become compensable solely because the employee is traveling on employer business.[71]

3. Workers on Lunch Break. Although employee lunches are frequently off the clock and unpaid, the national trend of workers' compensation jurisprudence has been toward recognizing lunch breaks as part of an employee's work day. In determining the compensability of an injury sustained by an employee during a lunch break, courts focus on the place selected by the employee for his lunch. In the seminal lunch break case, *Johnson Coffee Company v. McDonald,* the Court held compensable the death of an employee who fell down an elevator shaft during her lunch break.[72] In *Johnson,* the deceased employee had left the company premises to purchase her lunch and was killed when she was returning to the building.[73] The Court adopted the general rule followed by workers' compensation treatises:

> "Where an employer provides a place for his employees to eat, or directs or permits them to go to a place for that purpose, he owes to them the same duty of protection from danger there that he does at the place where such employees work."[74]

Injuries suffered by employees on the employment premises during lunch breaks generally are held to be compensable.[75] The rationale for this general rule appears to be that the employee who eats on the premises remains available to the employer and subject to the employer's control. In addition, employers often provide break rooms for their own convenience, as well as for the benefit of employees.[76]

Lunch breaks taken off the premises are generally not compensable, however, if, the employee leaving the employer's premises during a lunch break benefits the employer, the injuries sustained have been considered compensable.[77] If an employee departs from the employer's premises with the announced intention of eating her lunch at home, then the employee cannot recover workers' compensation benefits, even if the employee advises the employer that she also plans to pick up a survey form which she has prepared at the request of the company's human resources group.[78] This decision was influenced by the fact that the employee made an off-premises journey and had not been specifically instructed to retrieve the document.[79]

In another case, the Court ruled that the drowning of a sixteen year-old employee during an unpaid lunch break at a lake approximately one-half mile from the work site did not arise out of and in the course and scope of employment because the place where the injury occurred was not the actual work site and the employees were engaged in independent recreational activity.[80] Finally, the Court has rejected an employee's argument that his claim was compensable when he was assaulted immediately after lunch and was facilitating his employer's business by eating lunch on a client's property, but was injured only after leaving the premises in search of his assailant.[81] Unfortunately, the courts have not established a hard and fast rule to follow in this area of the law, and the judges appear to decide each situation on a case-by-case basis.

Generally, a parking lot provided by an employer for its employees is considered the employer's premises regardless of whether the lot is also available to customers or the general public.[82] In fact, courts have even extended this premises rule to include area necessary for access to the land owned or controlled by the employer.[83] The Tennessee Supreme Court ruled that a public street located between the employer's plant and a designated employee parking lot directly across from the plant should be treated as if it were part of the employer's premises because the journey across the public street is a necessary route between the two (2) portions of the employer's premises.[84] However, once an employee has exited the parking area and begins traveling on his or her own personal time, he or she is no longer on the employer's premises or in the course of his or her employment.[85] If the employee is leaving the plant in his or her automobile, but still inside an access gate, and is injured, the appellate courts have held the injury compensable.[86]

4. Practical Joking. In order to be covered by workers' compensation, an injury must arise out of and occur in the course of employment.[87] The Tennessee Supreme Court has addressed whether or not an injury is in the course of employment when it is caused by the practical joking of a fellow employee. In one case, the Court categorized the employee's practical joking as willful misconduct and held that he was not injured in the course of his employment.[88] However, in another case, the Court distinguished injuries that resulted from practical joking during the employee's idle or down time from injuries accruing from practical joking while performing job duties. The Court held that when the injury from practical joking occurred during time when the employer allowed the employees extensive idle time, practical joking is to be expected and therefore it is covered.[89] In this case, the Court stated "it is common knowledge, embodied in more than one old law that idleness breeds mischief, so that if idleness is a fixture of the employment, its handmade mischief is also."[90] Thus, the Court held the injury that occurred because of practical joking during idle time was compensable.[91]

5. Sexual Harassment. The Tennessee Supreme Court has ruled that sexual harassment is not ordinarily covered by workers' compensation law, because it does not usually relate to the business of the employer.[92] The Court left the door open to the possibility of a claim under workers' compensation if the sexual harassment is integral to the employee's employment. Such an instance might occur when the employer requires or encourages the employee to engage in any practice that would likely invite sexual advances. However, absent that unlikely circumstance, workers' compensation is not the proper avenue for the employee to pursue a claim for sexual harassment. Under Tennessee law, the proper avenue for the employee to pursue a claim for sexual harassment in the workplace is the Tennessee Human Rights Act.[93]

6. Injuries Sustained in a Telecommuter's Home. The Tennessee Supreme Court addressed a case of first impression in *Wait v. Travelers Indem. Co. of Illinois*.[94] In the case, a telecommuter was making lunch at home when she answered a knock on the door and let her neighbor in her home.[95] The neighbor assaulted her in her kitchen.[96] The Court found that the injuries were sustained in the course and scope of her employment because she was in a location the employer could reasonably expect her to be, and she was not violating a policy by eating lunch or letting someone into her home.[97] However, the injuries did not arise out of her employment, because there was no causal connection between the assault and employment; the assault did not emanate from a risk inherent to her employment. Therefore, the Court dismissed her Complaint.[98]

As more employers allow employees to work from home, inevitably more claims will be filed. Additional decisions are likely forthcoming, as these cases and resulting determinations will be very fact-specific.

Endnotes for Chapter II

1 Tenn. Code Ann. § 50-6-102(1).
2 *Id*.
3 Tenn. Code Ann. § 50-6-902.
4 *Id*.
5 *Id*.
6 *Id*.
7 *Id*.
8 *Id*.
9 Tenn. Code Ann. § 50-6-113.
10 *Id*.
11 *Id*.
12 *Id*.
13 *Id*.
14 Tenn. Code Ann. § 50-6-102(10).
15 *Id.*
16 Tenn. Code Ann. § 50-6-102(11)(D).
17 *Id*.
18 *See* Seals v. Zollo, 327 S.W.2d 41, 44 (Tenn. 1959).
19 Galloway v. Memphis Drum Service, 822 S.W.2d 584, 586 (Tenn. 1991); *see also* Jewell v. Cobble Construction and Arcus Restoration, No. 2014-05-0003 (Tenn. Workers' Comp. App. Bd. Jan. 12, 2015).
20 Butler v. Johnson, 426 S.W.2d 515, 519 (Tenn. 1968).
21 *Id.*
22 *Id.*
23 *Id*.
24 *See* Welch v. Reiling, 99 S.W.2d 216 (1936).
25 *Id*.
26 *See* Carpenter v. Hooker Chem. & Classics Corp., 553 S.W.2d 356 (Tenn. Ct. App. 1977).
27 *Id*. at 701 (citing Arthur Larson, Workmen's Compensation Law, § 47.10 (1993)).
28 *Id*.
29 Hill v. King, 663 S.W.2d 435, 436 (Tenn. Ct. App. 1983).
30 *Id*.
31 *Id*. at 437.
32 *Id*.
33 *Id*.
34 *Id*. at 445.
35 *Id*.
36 *See* Garner v. Reed, 856 S.W.2d 698 (Tenn. 1993).
37 *Id*.
38 *Id*.
39 Tenn. Code Ann. § 50-6-207(3)(F)
40 Sandoval v. Williamson, No. M2018-001148-SC-R3-WC (Tenn. Workers' Comp. Panel Mar. 28, 2019).
41 Martinez v. Lawhon, No. M2015-00635-SC-R3-WC (Tenn. Workers' Comp. Panel Nov. 21, 2016).
42 *Id*.
43 American Sur. Co. of NY v. City of Clarksville 315 S.W.2d 509 (Tenn. 1958).
44 Tenn. Code Ann., § 50-6-102(12).
45 *Id*.
46 *Id*.

47 Tenn. Code Ann. § 50-6-102(12)(B).
48 Tenn. Code Ann. § 50-6-102(14)(A).
49 Kellerman v. Food Lion, Inc., 929 S.W.2d 333, 335 (Tenn. 1996).
50 *See* Orman v. Williams Sonoma, Inc., 803 S.W.2d 672 (Tenn. 1991); Brimhall v. Home Ins. Co., 694 S.W.2d 931 (Tenn. 1985).
51 McCord v. Advantage Human Resourcing, No. 2014-06-0063, 2015 TN Wrk. Comp. App. Bd. LEXIS 6, at *13 n.4 (Tenn. Workers' Comp. App. Bd. Mar. 27, 2015)
52 *See* Lollar v. WalMart Stores, Inc., 767 S.W.2d 143 (Tenn. 1989).
53 *Id*.
54 *Id.* at 150.
55 Copeland v. Leaf, Inc., 829 S.W.2d 140 (Tenn. 1992).
56 Frazier v. Normak International, 572 S.W.2d 650, 651 (Tenn. 1978).
57 Carter v. Hodges, 132 S.W.2d 211 (Tenn. 1939); *see also*, Hudson v. Thurston Motor Lines, Inc., 583 S.W.2d 597 (Tenn. 1979).
58 Gregory v. Porter, 322 S.W.2d 591 (1959).
59 Lumbermen's Mutual Casualty Co. v. Dedmon, 264 S.W.2d 567 (1951).
60 Stephens v. Maxima Corp., 774 S.W.2d 931 (Tenn. 1989).
61 Arthur Larson & Les K. Larson, Workmen's Compensation Law, §25.00 (1998).
62 *Id*.
63 McCann v. Hatchett, 19 S.W.3d 218 (Tenn. 2000) (finding employee's drowning in swimming pool at motel where workers were lodged constituted a compensable death).
64 *Id*.
65 Carter v. Utica Mutual Insurance Company, 2003 WL 22080788 (Tenn. Aug. 23, 2007).
66 *Id*.
67 *Id*.
68 *Id*.
69 McDonnell v. Continental Machine Movers, 2009 WL 3029625 (Tenn. Sept. 23, 2009).
70 *Id*.
71 *Id*.
72 Johnson Coffee Company v. McDonald, 226 S.W. 215, 216 (Tenn. 1920).
73 *Id*. at 216.
74 *Id*. at 215.
75 *See* Drew v. Tappan Co., 630 S.W.2d 624 (Tenn. 1982); *see also* Carter v. Volunteer Apparel, Inc., 833 S.W.2d 492 (Tenn. 1992).
76 McCormick v. Aabakus, 2000 W.L. 1473915 (Tenn. Workers' Comp. Panel Oct. 5, 2000) (holding an employee who clocked out for lunch, walked to a nearby sandwich shop, purchased her meal and returned to the employee break room to eat her lunch but did not clock back in sustained a compensable injury when she choked on a portion of her sandwich resulting in her death.).
77 Stephens v. Maxima Corp., 774 S.W.2d 931 (Tenn. 1989); Jordan v. United Methodist Urban Ministries, Inc., 740 S.W.2d 411 (Tenn. 1987).
78 Stephens v. Maxima Corp., 774 S.W.2d 931 (Tenn. 1989).
79 *Id*.; *See also* Hudson v. Thurston Motor Lines, Inc., 583 S.W.2d 597, 599 (Tenn. 1979) (holding that "injuries that occur while an employee is furthering or facilitating his employer's business are included in the course of his employment.").
80 Jordan v. United Methodist Urban Ministries, Inc., 740 S.W.2d 411 (Tenn. 1987).
81 Alder v. Mid-South Beverages, Inc., 783 S.W.2d 544 (Tenn. 1990).
82 *See* Lollar v. WalMart Stores, Inc., 767 S.W.2d 143 (Tenn. 1989).
83 *Id*.
84 Copeland v. Leaf, Inc., 829 S.W.2d 140 (Tenn. 1992).
85 McCurry v. Container Corp. of America, 982 S.W.2d 841 (Tenn. 1998).

86 Durant v. Saturn Corp., 2004 WL 941012 (Tenn. Workers' Comp. Panel, Apr. 30, 2004).
87 Tenn. Code Ann. § 50-6-102(14).
88 Hogsett v. Insurance Co. of America, 486 S.W.2d 730 (Tenn. 1972).
89 Ransom v. H.G. Hill Co., 326 S.W.2d 659 (Tenn. 1959).
90 *Id*.
91 *Id*.
92 Anderson v. Save-A-Lot, LTD, 989 S.W.2d 277 (Tenn. 1999).
93 Id. at 289.
94 Wait v. Travelers Indem. Co. of Illinois, 240 S.W.3d 220 (Tenn. 2007); *Id*. at 223.
95 *Id*.
96 *Id*. at 227.
97 *Id*. at 228-29.
98 *Id*.

III.

DEFENSES TO A WORKERS' COMPENSATION LAWSUIT

A. Defenses Listed in the Statute

TENN. CODE ANN. § 50-6-110(a) states:

> No compensation shall be allowed for an injury or death due to:
>
> 1) The employee's willful misconduct;
> 2) The employee's intentional self-inflicted injury;
> 3) The employee's to intoxication or illegal drug usage;
> 4) The employee's willful failure or refusal to use a safety device;
> 5) The employee's willful failure to perform a duty required by law;
> 6) The employee's voluntary participation in recreations, social, athletic or exercise activities...

The employer has burden of proof to establish these defenses. The following is a discussion of these defenses.

1. Willful Misconduct. Under TENN. CODE ANN. § 50-6-110 (a), an employee cannot recover benefits for an injury incurred as a result of willful misconduct. "Willful misconduct" involves conduct arising from intention to do an act that amounts to a purposeful violation of orders or workplace rules and conduct containing an element of perverseness.[1] This defense usually requires proof of a deliberate and intentional violation of a known regulation designed to protect the employee from serious bodily harm. To qualify as "willful," the employee has to have intended to do the act, but it does not require a finding the employee intended both the act and the result.[2] Here, "willful" is best understood as an act that was no accident.

For example, in *Wright v. Gunther*, the worker was injured while sliding down an elevator cable four hundred eighty-five (485) feet to his work station on the ground below.[3] The employee had done this before but was never warned not to use this method of transportation. The employer had no rules against such conduct. The Court found that the action by the employee was not "willful misconduct" and awarded benefits. The act was willful, but it was not misconduct.

Even when an employer maintains rules and regulations prohibiting certain conduct, if the employer disregards the rule or allows employees to habitually violate the rule, the employer is not allowed to invoke this defense in a claim for benefits.[4] This is also true under the "safety defenses" discussed below regarding the use of safety devices such as a harness. Employers should have safety rules and make their employees aware of those rules, then enforce those rules consistently with specific penalties. Even when this is done, the defense may not succeed. Before

2012, a successful willful misconduct defense required the employer to prove the conduct contained an element of "perverseness" and employers were only successful when the violation or misconduct was involved. The Courts have limited this defense to "the most extreme situations and has for all practical purposes limited its application to willful disobedience to known and understood prohibitions."[5]

In 2012, the Tennessee Supreme Court removed the requirement of "perverseness" from the requirements and announced a clear test which followed the traditional analysis.[6] To deny a claim, the court required (1) the employee have actual notice of the rule which was violated, (2) the employee understand the danger in violating the rule, (3) the employer not tolerate violations of the rule by enforcing and correcting prior violations, and (4) the employee lack a reasonable excuse for violating the rule. The violation of the rule must be the cause of the injury. A judge has discretion about whether the employee's excuse for violating the rule was reasonable. To deny benefits, the employee's violation must be willful, not just negligent or needless. In *Mitchell*, the employee worked as a lineman and was injured while contacting a live electrical wire. He disregarded safety rules the employer strictly enforced. The Court found the danger was obvious and the employee had no valid excuse so benefits were denied.[7]

When evaluating on the merits of this defense, all four elements must be present. Most attempts to successfully assert this defense fail due to a lack of evidence showing the employer consistently enforced the safety rule at issue. If a co-worker or supervisor testifies the rule was violated and not corrected previously, the defense is likely to fail.

2. Intentional Self-Inflicted Injuries. The Tennessee Workers' Compensation Law also prohibits awards of compensation where the employee suffers an injury from intentional self-inflicted conduct.[8]

Consider the case of an employee who died from alcoholism during the time he was being treated for a separate compensable injury. The employer argued the claim should be rejected because of his drinking. The Tennessee Supreme Court disagreed and found that such conduct did not rise to the level necessary to fulfill the intentional self-infliction of injury requirement.[9] Even where the employee had been warned that heavy drinking could cause his death, and where the evidence was that the employee drank heavily because of his "pain, despair, and idleness resulting from his injury," benefits were still awarded.[10]

This defense is often mixed with the willful misconduct defense. In *State ex rel. Flowers/Newman v. Tennessee Trucking Ass'n Self Ins. Group Trust*, an over the road truck driver was killed when she leapt from her tractor-trailer on a mountainous stretch of a highway.[11] The Supreme Court Workers' Compensation Special Panel excused the employee's conduct, finding she attempted to flee her truck due to failing brakes on a downhill stretch of a highway. The Court believed that an employee should not be found to have intentionally injured herself in an emergency situation.

There are few cases in Tennessee involving this defense. This defense is good only where an employee consciously and intentionally inflicts bodily harm to himself. Remember, the employer carries this burden, which is especially difficult to prove.[12]

It can be difficult for a court to believe the injury the employee suffers from was done intentionally. You should be sure you have strong evidence before addressing this defense. Many times, a different variation of this defense will be appropriate.

3. Intoxication. The statute states "No compensation shall be allowed for an injury or death due to the employee's intoxication or illegal drug usage ..."[13]

An intoxicated employee has a blood alcohol content of 0.04% in safety-sensitive jobs and 0.08% everywhere else. This must be tested in blood sample or breath testing. Alleged drug usage requires a positive test typically administered in a hospital or medical office.

A safety sensitive job is "a position in which a drug or alcohol impairment constitutes an immediate and direct threat to public health or safety."[14] There is no definitive list of such jobs, but the broadest statutory definition is a job "in which a momentary lapse in attention could result in injury or death to another person."[15]

Intoxication must be the reason the injury occurred for the defense to apply. Employers which qualify as a Certified Drug-Free Workplace enjoy automatic presumption that intoxication was the proximate cause of the accident. Once presumed, the burden shifts from the employer to the employee to show the intoxication was not the proximate cause.

To become a certified drug free workplace (CDFW), an employer applies then, after acceptance, renews its application annually to prevent gaps in participation. Participating employers must administer pre-employment tests after a conditional job offer is made, provide testing after an injury, and furnish explanation in writing to employees detailing the reason for the test not later than seven days after the test. Employers qualifying as a CDFW enjoy a presumption the injury was caused by the intoxication and provide a basis to determine whether the employee violated any internal policies regarding drug use. This may form the basis to deny an employee's claim that he is entitled to an increased benefit if the employer terminates the employee for failing his drug test. Further, refusal to submit to a drug or alcohol test creates a presumption the proximate cause of the injury was the intoxication, unless there is clear and convincing evidence otherwise. This refusal may also qualify as a violation of company policy and as the basis of termination.

It should be noted that even if the employer is certified, a successful defense requires a causal relationship between the intoxication and the injury regardless of the burden shift to the employee. As an example, an intoxicated construction worker who falls from a beam is more likely to lose his case than is the intoxicated construction worker he lands on. To assist with the defense, employers should be sure the testing facility preserves the sample, especially blood samples, to the extent possible. If there is a challenge to the test, another expert may want to run an independent battery of tests, and there should be no failure to preserve a sample capable of preservation.

Additionally, it is also very important to interview witnesses and co-workers and record their statements about employee's erratic or impaired conditions. Workers are more likely to forget or cover for a co-worker when in the context of litigation. A statement taken shortly after the accident is more likely to be true, and when recorded or written, the statement cannot later be changed. Significantly, if

the employer knew the employee was intoxicated before the accident and "acquiesced in the employee's presence at the workplace," then no presumption in the employer's favor applies.[16] The employer can still argue the defense but carries the burden to prove the intoxication caused the accident.

The nature of marijuana poses specific considerations. If a drug test is positive for THC, it does not mean the employee was intoxicated because those metabolites can remain in one's system for several days or more. These defenses are hard to win, and usually require witness testimony that the employee appeared intoxicated shortly before the injury.

4. Willful Failure or Refusal to Use a Safety Device. Tenn. Code Ann. § 50-6-110 prohibits an award of benefits to an employee injured because of his willful failure or refusal to use a safety appliance.[17] This defense dates all the way back to 1938. In *Cordell*, the employer instructed the employee in the use of safety appliances.[18] The proof showed the employer repeatedly instructed the employee to use these safety devices. The employee died when he came into contact with an electrical wire and was not using the required safety appliances. The Court denied benefits, stating as with the defenses discussed above, the employer has the burden of proving the employee's willful failure to use a safety device.

Although this remains in the statute as a separate defense, it is analyzed the same way as the worker misconduct defense described earlier. Employers have successfully asserted this defense for an employee's failure to wear safety gloves as in the *Mitchell* case and for an employee failing to wear safety glasses to prevent metal shavings from entering his eyes while drilling directly overhead. In *Seville - Palma*, the employee was told to wear glasses to protect his eyes with the glasses furnished by the employer.[19] When employee was injured due to his failure to wear the glasses, the employer denied compensation.[20] The Court found the employee expressed no reasonable excuse for his failure to wear glasses, and found him unlikely to prevail, thereby upholding the denial.[21]

Some employers mistakenly believe that a violation of an OSHA or TOSHA rule is all that is required. They reason that everyone knows TOSHA and OSHA rules and this knowledge proves all elements of the defense. This is not true. Employees can still win if they show a reasonable excuse for violating a rule. Keep in mind the defense requires an employer to have a rule regarding the safe use of the device, to show the employee had knowledge of the rule and understanding of the danger in breaking the rule, to consistently enforce the rule, and to show the employee had no reasonable excuse for breaking the rule.

5. Failure to Perform a Duty Required by Law. The analysis of this defense is often mingled with that of the willful misconduct defense discussed above. There are no modern reported cases adding elements to this specific defense which are not already present in the willful misconduct body of law. Although employers may be able to argue the mere violation of a law's statutory duty should establish a good defense, a court will excuse a violation of a law if the employer had knowledge

of the violation and ignored it, or if an employee had a reasonable excuse for his or her failing to perform the legal duty. This defense would be analyzed the same way as the safety defense cases described above.

6. Recreational Activities. In 2007, the Tennessee Supreme Court awarded workers' compensation death benefits to the widow of a worker suffering from occlusive coronary artery disease who died during his voluntary participation in a recreational basketball game during work hours and on the employer's premises.[22] This 2007 case caused controversy because two (2) years earlier, the Tennessee Supreme Court held that an employee's voluntary recreational activities during work hours were not compensable.[23]

The Tennessee legislature resolved the confusion, excluding injuries sustained during recreational activities from compensation. The law now states that when an employee's injury results from "voluntary participation in recreational, social, athletic or exercise activities, including, but not limited to, athletic events, competitions, parties, picnics, or exercise programs, whether or not the employer pays some or all of the costs of the activities," the injury is not compensable unless:

A) Participation was expressly or impliedly required by the employer;
B) Participation produced a direct benefit to the employer beyond the improvement in employee health and morale;
C) Participation was during the employee's work hours and was part of the employee's work-related duties; or
D) The injury occurred due to an unsafe condition during the voluntary participation using facilities designated by, furnished by, or maintained by the employer on or off the employer's premises and the employer had actual knowledge of the unsafe condition and failed to curtail the activity or program or cure the unsafe condition.[24]

In *Pope v. NEBCO of Cleveland, INC.,* the Tennessee's Supreme Court's Special Workers' Compensation Appeals Panel decided a 2016 case involving a 2014 knee injury of a car dealership employee.[25] In 2010, employer began its participation in the Chattanooga Mud Run as one of its sponsors. The Mud Run raised money for Habitat for Humanity. The employer, an auto dealership received a promotional benefit on printed materials and displayed its vehicles at the event. The employer was given three team entries as part of its sponsorhip. The general manager of the dealership delegated the task of filling the teams to a subordinate. He recognized there would be some peer pressure to join a team, but joining was voluntary and there was no requirement any participants would have to sell cars or promote the dealership during the run.

The injured worker was initially reluctant to join a team preferring instead to work that Saturday and pursue sales commissions. After refusing more than a few efforts to recruit him, he reluctantly agreed to join. During the run, he injured his knee and the dealership contested compensability.

On appeal, the Panel considered when a recreational activity is implicitly required by examining three factors:

1) The relationship between the employee and the person pressuring the employee. If the supervisor exerted the pressure, it is more likely the claim would be compensable. In this case, pressure was exerted by a co-worker without supervisory authority.
2) Would an employee refusing to participate suffer an adverse employment action? If so, the activity is likely implicitly required. The court found no evidence of that in this case.
3) Rewards to the employee do not constitute "implicit requirement." An employer's reward of "aerobic bucks" or a "nominal cash prize" is not enough to prove an "implicit requirements" exists. No such reward was offered to the employee in this case.[26]

The Panel held that a feeling of peer pressure to join was a subjective feeling insufficient to prove the employee was implicitly required to participate. This is true even though he felt a responsibility to not be the reason the team could not run.

The Court found no direct benefit of employee's participation in the run, which occurred outside the employee's work hours, was unpaid during the event, and required no advertisement by the employee for the dealership during the event, and did not participate in a representative capacity by not wearing clothing identifying the dealership. Thus, the Panel agreed that the employer met its burden to prove that the injury was not work-related compensable.

The key to this defense is always in the details. Had any of the facts changed, the result could have been different. Those considering this defense need a heavy investment into the facts and a thorough legal analysis before confidently issuing a denial. Some injuries at softball games and company picnics may be compensable. Others may not.

B. Other Defenses Recognized by the Courts

1. Injuries from Fights or Physical Attacks by Co-Workers. The analysis as to the compensability of a claim does not change when the employee's injury arises from a fight with or an attack by a co-worker within the course of employment. The rule that the employee must prove that the injury arose out of and in the course of his or her employment still applies in these situations. Unfortunately, the variety of court decisions in this type of injury situation make it difficult, if not impossible, to successfully predict the outcome of a case. Normally, the courts look closely at the facts of each case to determine the compensability of an injury sustained because of a co-employee's assault, rather than relying on a general rule of law. Most cases turn on the credibility of witnesses and the reliability of any evidence.

There are, however, some general principles that can be taken from the case law that will give guidance to those trying to decide if a particular situation is compensable. The Court has set forth general rules governing compensability of injuries from attacks by co-workers[27]:

1) If an assault occurs from an argument over the performance of work or the possession of tools or equipment used in the work, then the assault is compensable.
2) If an assault arises out of a purely personal matter and is solely to gratify feelings of anger or hatred, then the assault does not arise directly out of the employment and is not compensable.
3) Benefits are recoverable even when the injured employee is the aggressor in a fight.
4) Where the assault has a rational causal connection to the work and occurs while the injured employee was engaged in the performance of work duties, the assault is compensable.
5) A cooling off period may indicate that the fight was more personal than work related.

Many problems arise in situations that are not clearly either purely personal or purely over the performance of work. For instance, in several of the cases decided by the Tennessee courts, the argument between employees starts with a casual comment about the work habits of a co-employee then escalates into personal name calling. In other cases, the argument begins with a personal comment and ends with statements involving the work situation. The compensability of the claim depends on whether the fight was about something work-related or was purely one to satisfy the personal anger or insult between the combatants. In 2007, the Tennessee Supreme Court grouped assault cases into three categories: (1) assaults with an "inherent connection" to employment such as disputes over performance, pay or termination; (2) assaults stemming from "inherently private" disputes imported into the employment setting from the employee's domestic or private life and not exacerbated by the employment; and (3) assaults resulting from a "neutral force," such as random assaults on employees by individuals outside the employment relationship.[28] Other fact situations arise that create philosophical questions. For example, when one employee brings a bar of soap to work, and a fight erupts over the use of the soap, the adjudicator must look to the ownership of the soap (personal) and the fact that the job situation required employees to wash their hands (work related) in determining compensability. For these reasons, courts have struggled to reach a fair result in each case while applying the above guidelines. It is equally difficult for those handling claims to predict the outcome of fact situations that do not clearly fall under one of the above rules. It is best to look objectively at the situation and reasonably apply the guidelines.

Since the courts appear to look at the cause of a fight in deciding whether it is work-related, it is extremely important for an employer to perform a thorough investigation of the situation as soon as possible. Written statements of all parties and witnesses to a fight should be taken immediately after the altercation. If the employee seeks legal advice and the lawyer explains to the employee that he cannot recover workers'

compensation benefits if the fight is purely personal in nature, then the employee's story regarding the fight will often change. A written statement from the employee shortly after the fight can raise an issue as to the employee's credibility should the employee's story change after talking to a lawyer.

2. Injuries from Assaults by Third Parties who are not Co-Workers. The Tennessee courts have set forth the following general guidelines to determine whether assaults by non-employee third parties are compensable:

1) If the motive of the assailant is employment related, then the worker's injuries are covered by workers' compensation;
2) If the motive of the assailant is purely personal, then the worker's injuries are not covered by workers' compensation; or
3) If the motives of the assailant are both personal and employment related, then the worker's injuries may be covered by workers' compensation.[29]

The compensability of an assault against an employee turns on the "facts and circumstances of the plaintiff's employment."

Every compensable claim must (1) occur in the course and scope of employment, and (2) arise out of employment. When evaluating assault claims, do not forget to first determine whether the employee was actually at work. Usually the answer is yes, and you move on to the "arising out of" analysis below. But sometimes the assaulted employee was attacked while off work or having deviated from work.

Determining whether the injury *arose out of* the employment is often more difficult to determine. "Arising out of" refers to the cause or origin of the injury. Not all assault cases are treated the same.

As stated previously, the courts have recognized the following three categories for assaults that occur at the workplace:

1) assaults with an "inherent connection" to employment such as disputes over performance, pay or termination;
2) assaults stemming from "inherently private" disputes imported into the employment setting from the claimant's domestic or private life and not exacerbated by the employment; and
3) assaults resulting from a "neutral force" such as random assaults on employees by individuals outside the employment relationship.[30]

The first category generally refers to assaults by employees and are compensable. The second category concerns personal disputes between an employee and assailant and are not compensable. Most assaults falling into categories one and two are straightforward. Most litigation concerns the third category of neutral force assaults. When the "undisputed facts clearly show that the assault had neither an inherent connection with the employment, nor did it stem from a personal

dispute between [the assailant] and the [employee]…we must focus our attention on the facts and circumstances of the [employee's] employment and its relationship to the injuries sustained by the [employee]."[31]

Generally, for an injury to "arise out of" employment, it must emanate from a peculiar danger or risk inherent to the nature of the employment. Thus, "an injury purely coincidental, or contemporaneous, or collateral, with the employment ... will not cause the injury ... to be considered as arising out of the employment."[32] However, in limited circumstances, where the employment involves "indiscriminate exposure to the general public," the "street risk" doctrine may supply the required causal connection between the employment and the injury.[33]

The Court has explained the Street Risk Doctrine as follows:

> We first adopted the "street risk" doctrine in 1979 to offer guidance in an otherwise murky area of the law. In a case involving a truck driver who was shot by two assailants while entering his truck after lunch, we held that "the risks of the street are the risks of the employment, if the employment requires the employee's use of the street." *Hudson v. Thurston Motor Lines, Inc.,* 583 S.W.2d 597, 602 (Tenn.1979). Thus, the purpose of the "street risk" doctrine is to "provide the necessary causal connection between the employment and the injury" when "the employment exposes the employee to the hazards of the street." *Hudson v. Thurston Motor Lines, Inc.,* 583 S.W.2d at 602.
>
> The application of the "street risk" doctrine has now expanded to include employees whose work exposes them to the public. In a case involving an employee whose employer permitted her to work from a home office, we held:
> When an employee suffers a "neutral assault" within the confines of her employer's premises—whether the premises be a home office or a corporate office—the "street risk" doctrine will not provide the required causal connection between the injury and the employment unless the proof fairly suggests either that the attacker singled out the employee because of his or her association with the employer or that the employment indiscriminately exposed the employee to dangers from the public.[34]

One of the most recently available decisions came from the Appeals Board.[35] In this case, the employee worked as a groundskeeper for an ungated apartment community. One summer day, while mowing grounds adjacent to a public road, an assailant approached the employee from behind, and dragged him into nearby woods. As the employee fled, he was shot twice in the leg. The assailant was not apprehended and there was no known motive for the assault. The employee filed a workers' compensation claim and the issue on appeal was whether the Street Risk Doctrine applied. The trial court essentially found that the assault was random and the employee's work did not place him in any more danger than the general

public. The employee appealed, and won, largely because the Appeals Board thought the apartment community invited and solicited the community at large. The Board found the employment exposed the employee to the dangers of the street because his job required he pick up trash, move furniture to dumpsters, and mow lawns adjacent to streets where the public enjoyed "unfettered access."[36]

It is often difficult for employers to decide whether or not to afford coverage to an employee assaulted by a non-employee. These guidelines should be instructive, however, even though the Tennessee Supreme Court has recognized that:

> "Injuries that result from a willful assault upon an employee present one of the most difficult cases for determination whether such injuries arise out of and in the course of the employment."[37]

In addition, the courts have held that the Tennessee Workers' Compensation Law covers situations where the assailant shows clear animosity toward the workplace or employer and that animosity appears to be the motivation behind the attack.[38] Under this theory, coverage has even been extended to an employee stabbed by her non-employee boyfriend who was tired of his girlfriend socializing with colleagues from the office. The Court held the assault was motivated by the conditions of the work and arose out of the nature of the work.

In 2007, the Tennessee Supreme Court held the Street Risk Doctrine is not a limitless means of allowing recovery for every situation.[39] When an employee suffers a neutral assault within the confines of her employer's premises, or whether the premises is a home office or a corporate office, the Street Risk doctrine will not provide the required causal connection between the injury and the employment unless the proof fairly suggests either that the attacker singled out the employee because of his or her association with the employer or that the employment indiscriminately exposed the employee to dangers from the public.[40]

3. Misrepresentation. Although severely limited by the Americans with Disabilities Act (ADA), misrepresentation is still a viable defense in a workers' compensation case. In order to establish the affirmative defense of misrepresentation, an employer must prove three (3) elements:

1) The employee knowingly and willfully made a false representation of his or her physical condition;
2) The employer relied upon that misrepresentation in making the decision to hire the employee; and
3) There was a causal relationship between the false representation and the work-related injury sustained by the employee.[41]

In *Beasley v. U.S. Fidelity & Guaranty Co.,* the Employee was asked in his job application if he had history of back injury or pain.[42] He marked "no." He was hired to do a job involving bending, lifting and twisting. Employee hid from his Employer his fall of 10 -12 feet five years before, causing lumbar spine damage resulting in a medical discharge to himself. Employee then fell on ice, injuring his back, then suffered

a recurrence of low back pain while sweeping a few weeks later. His pain escalated to the point he was unable to work, so he sued his employer for permanent and total disability benefits. Employer defended by alleging misrepresentation.

Benefits were denied. Employee's "no" on his job application was a knowing and intentional lie which induced the Employer to hire him. Employer proved it would not have hired him with a history of back injury due to the nature of work. His representing no history of low back injury was a substantial factor in his hiring. Employer offered compelling proof the injury he sustained with his current employer was something his history predispositioned him to suffer. The claim was denied.

In *Allred v. Berkline, LLC*, the employee was terminated by his first employer because it could not accommodate his medical restrictions.[43] When the employee applied for a job with the subsequent employer, omitted the real reason for leaving his first employer and instead claims he said he left his prior employer for a better job.[44] The Panel concluded the employee willfully misrepresented the circumstances of his prior termination. Had his second employer known the truth, he would not have been hired. Finally, the Panel found a causal connection between the prior injury which was the subject of the false representation and the work injury. Benefits were denied.

The ADA, which was signed into law on July 26, 1990, prohibits covered entities from conducting pre-employment medical examinations or inquiries of a job applicant as to whether he or she is an individual with a disability or as to the nature or severity of such disability.[45] An Employer could run into ADA trouble if it seeks a disclosure of a medical condition in the employment process. An employer should stay informed on developments in ADA law to be sure physical fitness questions are not in violation of the law.

When misrepresentation defenses fail, it is usually because an employee never made a knowingly affirmative misstatement. Perhaps the employee was never asked about his condition. Without a knowingly false statement, there can be no defense.

C. The Exclusive Remedy Doctrine

Tennessee Workers' Compensation Law is a compromise: an employer enjoys lower liability under the workers' compensation law than it would under a tort system, but all causally related claims are compensable.

The Exclusive Remedy Doctrine enforces this compromise by preventing an employee from suing his or her employer for negligence. Injured workers and their attorneys frequently challenge exclusive remedy so they can escape the workers' compensation system and pursue negligence claims worth substantially more money.

There are exceptions to the Exclusive Remedy Doctrine. If a co-employee intentionally injures an employee, the employee can sue the co-employee and still pursue workers' compensation benefits against the employer.[46] The co-worker who assaulted the employee is not protected by the exclusive remedy rule. Only the employer is protected.

The Exclusive Remedy Doctrine also does not prevent tort claims against a "third person" (i.e. any person or entity that is not the injured employee's employer, the employer's workers' compensation insurer, or a co-employee).[47] Therefore, the doctrine neither immunizes employers from lawsuits brought by persons not designated as "employees" under the Act, nor does it protect employers from tort suits brought by employees based on "injuries or accidents" not covered by the Act.[48]

Additionally, an exception to the Exclusive Remedy Doctrine exists when an employee proves that the employer had an actual intent to injure the employee. However, proving actual intent to injure is very difficult. For example, in one case, an employee was injured due to his employer's failure to use safe blasting procedures when working with explosives.[49] The court held that proof of willful safety violations does not provide a sufficient basis for inferring actual intent to injure on behalf of the employer.[50]

Similarly, an employer's actions in knowingly permitting hazardous work conditions, knowingly ordering an employee to perform a hazardous task, and willfully or knowingly violating a state safety statute do not rise to the level of intent to injure an employee.[51] For instance, several employees were killed in an explosion that resulted from the employer's failure to take certain precautions in violation of the Tennessee Occupational Safety and Health Act.[52] The wrongful death actions against the employer were dismissed upon the finding that the tort claims were barred by the Exclusive Remedy Doctrine.[53] The Tennessee Court of Appeals held that an employer knowingly violating safety regulations and permitting dangerous working conditions to exist, even in violation of state regulations, does not rise to the level of actual intent to injure.[54] The court stated that there is a difference between gross and criminal negligence and actual intent to injure.[55]

Endnotes to Chapter III

1 Tenn. Code Ann. § 50-6-110(a).
2 Ins. Co. of Am. v. Hogsett, 486 S.W.2d 730, 733 (Tenn. 1970).
3 Wright v. Gunther Nash Mining Construction Co., 614 S.W.2d 796, 799 (Tenn. 1981).
4 Bryan v. Paramount Packaging Corp., 677 S.W.2d 453, 455 (Tenn. 1984).
5 Wright, 614 S.W.2d at 798(Tenn. 1981).
6 Mitchell v. Fayetteville Pub. Utils., 368 S.W.3d 442 (Tenn. 2012)
7 *Id*.
8 Tenn. Code Ann. § 50-6-110(a)
9 *See* Wheeler v. Glens Falls Ins. Co., 513 S.W.2d 179 (Tenn. 1974).
10 *Id*.
11 State ex rel. Flowers/Newmann v. Tennessee Trucking Ass'n Self Ins. Group Trust, 2008 WL 2510577 (Tenn. Workers' Comp. Panel 2008).
12 *Id*. at *7.
13 Tenn. Code Ann. § 50-6-110 (a)(3).
14 Tenn. Code Ann. § 50–9–103(16)(B).
15 *Id*.
16 Tenn. Code Ann. § 50-6-110(c)(1).
17 Tenn. Code Ann. § 50-6-110(a)(4).
18 Cordell v. Kentucky-Tennessee Light & Power Co., 121 S.W.2d 970 (Tenn. 1938).
19 Sevilla-Palma v. Wauford Air Conditioning, Inc., No. 2016-05-0242 2016 WL 39112 38, at *2 (Tenn. Court of Workers' Comp. Claims July 19, 2016) aff.'d No. 2016-05-0242, 2016 WL 459468 (Tenn. Workers' Comp. App. Bd Aug. 30, 2016).
20 *Id*. at *1.
21 *Id*. at *5-6.
22 Gooden v. Coors Technical Ceramic Co., 236 S.W.3d 151 (Tenn. 2007).
23 Young v. Taylor-White, LLC, 181 S.W.3d 324 (Tenn. 2005).
24 Tenn. Code Ann. § 50-6-110 (a)(6).
25 Pope v. NEBCO of Cleveland, Inc., 585 S.W.3d. 874 (Tenn. Ct. App. 2018).
26 *Id*.
27 Jesse v. Savings Prods., 772 S.W.2d 425 (Tenn. 1989); see also Woods v. Harry B. Woods Plumbing Co., 967 S.W.2d 768 (Tenn. 1998).
28 Wait v. Travelers Indemnity Co. of Illinois, 240 S.W.3d 220 (Tenn. 2007).
29 *Id*.
30 *Id*.
31 *Id*.
32 Morales v. Boshwit Brothers Inc., et. al., 2017 WC 1135131 (TN WC App., 2017).
33 Jesse v. Savings Prods., 772 S.W.2d 425 (Tenn. 1989).
34 Padilla v. Twin City Fire Ins. Co. 324 S.W.3d 507 (Tenn. 2010).
35 *Id*.
36 DeBow v. First Inv. Prop., Inc. 623 S.W.2d 273 (Tenn. 1981).
37 Bell v. Kelso Oil Co. 597 S.W.2d 731 (Tenn. 1980).
38 Wait v. Travelers Indemnity Co. of Illinois, 240 S.W.3d 220 (Tenn. 2007).
39 *Id*.
40 *Id*.
41 Beasley v. U.S. Fidelity and Guarantee Co., 699 S.W.2d143 (Tenn. 1985).
42 *Id*.
43 Allred v. Berkline, LLC , 2010 WL 2612695 (Tenn. W.C. Panel June 30, 2010).
44 *Id*.
45 42 U.S.C § 12101.
46 Tenn. Code Ann. § 50-6-112.

47 *Id*.
48 *Id*.
49 Bell v. Kelso Oil Co. 597 S.W.2d 731 (Tenn. 1980).
50 *Id*.
51 Mize v. Conagra, Inc., 734 S.W.2d 334 (Tenn. Ct. App. 1987).
52 *Id*.
53 *Id*.
54 *Id*.
55 *Id*.

IV.

EMPLOYMENTS NOT COVERED

The following employments are exempt from the Tennessee Workers' Compensation Law:[1]

A. Common Carriers

Common carriers doing interstate (crossing state lines) business and are covered under Federal Workers' Compensation Law are exempt from coverage under the Tennessee Act.[2] This provision requires that the carrier be a common (not a private) carrier. Further, the common carrier must be operating under a certificate of public convenience and necessity (issued formerly by the ICC, now by the NSTA). The Act further provides that a leased operator and/or leased owner/operator of a motor vehicle under contract to a common carrier may elect to be covered by filing Form I-14 with the Commission of Labor.[3]

B. Casual Employees

The Tennessee Workers' Compensation Law specifically provides that it does not apply to casual employees.[4] Casual employees are not the same as part-time employees or independent contractors. The Act defines a casual employee as "one who is not employed in the usual course of trade, business, profession or occupation of the employer."[5] For example, a person hired to clean snow from a retail grocery store's parking lot might be considered a casual employee.

C. Domestic Servants, Farm and Agricultural Laborers

The same provision of the Act exempts domestic servants and employers thereof, in addition to farm and agricultural laborers and their employers.[6]

D. Employers with Fewer Than Five (5) Employees

The Tennessee Workers' Compensation Law applies to employers who have five (5) or more full-time and/or part-time employees.[7] Employers with less than five (5) employees may elect to be covered by the Act by filing written notice of intent to be covered at least thirty (30) days before the happening of the accident intended to be covered by filing Form I-8. Employers engaged in mining the production of coal and anyone engaged in the construction industry must carry workers' compensation insurance, even if the employer has as few as one (1) employee.

E. Government Employees

The State of Tennessee, its counties, and its municipal corporations are exempt from the Tennessee Workers' Compensation Law unless they accept the provisions of the Act by filing written notice on Form I-8 with the Division of Workers' Compensation.[8]

F. Ski Patrolmen

Finally, persons performing voluntary service as ski patrolmen and receiving no compensation other than meals or lodging or the use of ski tow or ski lift facilities are exempt from the Act.[9]

Endnotes to Chapter IV

1 Tenn. Code Ann. § 50-6-106.
2 Tenn. Code Ann. § 50-6-106(1)(A).
3 Tenn. Code Ann. § 50-6-106(1) (B).
4 Tenn. Code Ann. § 50-6-106(2).
5 *Id.*
6 Tenn. Code Ann. § 50-6-106(3)–(4).
7 Tenn. Code Ann. § 50-6-106(5).
8 Tenn. Code Ann. § 50-6-106(6).
9 Tenn. Code Ann. § 50-6-106(7).

V.

DISABILITY BENEFITS DUE TO THE EMPLOYEE

A. How to Calculate the Weekly Compensation Rate.

1. In General. The law governing the computation of the average weekly wage and compensation rate for injured workers has remained largely unchanged as a result of the 2013 Reform Act. A summary of how to calculate the benefits is below, and any changes under the new law are noted accordingly.

a. When the Employee has Worked for the Employer for the Prior 52-Week Period. Tennessee law provides that when an employee is injured in a work-related accident, the employee is entitled to weekly workers' compensation benefits. Weekly benefits for lost time are calculated based on two-thirds of the employee's "average weekly wage." The employee's average weekly wage is calculated by averaging the employee's wages over the 52 weeks immediately preceding the date of the injury.[1] The calculation is made in this manner regardless of whether or not the employee received a raise or cut in pay during that time period. If the employee has worked for the employer for the entire 52 weeks prior to the injury, it is very important that the employer calculate the weekly average wage by using the employee's actual gross pay. More often than not, an inaccurate number is obtained when the employer simply multiplies the hourly wage by 40 hours per week instead of obtaining the actual wages paid. Performing the proper wage calculation can result in a substantial savings to the employer. Additionally, there are maximum and minimum limits on weekly benefits (discussed in section 3 of this chapter).

In using the 52 week average, if the employee loses more than 7 days of work during that time then the earnings for the remainder of the 52 weeks are divided by the number of weeks remaining after the time lost is deducted.[2] Circumstances are determined on a case-by-case basis, but generally those over which the employee has no control, such as plant closings for repairs, suspension of operations due to shortage of materials, or weather, should not be deducted if the employee was a regular employee.

b. When the Employee has Worked for the Employer for Less Than 52 Weeks. If the employee has worked less than one year, then the employee's average weekly wage is calculated by dividing the total wages worked by the number of weeks worked, as long as the calculation is fair to both sides.[3] If it is not practical to compute the wages by dividing by the number of weeks worked because the employee has worked for the employer for a short time, then the wages of a similarly situated employee should be used. Similarly situated employees are those paid for work in the same grade, and who are employed by the same employer to do the same work.[4] If this is not practical or fair, then the statute directs the employer to use the average weekly wage of a person in the same type of employment in the same area who is employed by a different employer.[5]

For purposes of calculating the average weekly wage of an employee, use the employment in which the employee was working at the time of the injury. Therefore, if an employee is working multiple jobs and is hurt on his part-time job, his workers' compensation rate is calculated only based on his average weekly wage in his part-time job.

In attempting to determine what would constitute earnings, the Tennessee Supreme Court has held that any type of economic gain to the employee can be used to calculate earnings. Earnings may include stock increases when paid in lieu of direct monetary compensation. Tips may be considered in calculating the average weekly wage if those tips are considered by the employee and the employer to be part of the employee's wages. The value of room, board, or other employee benefits may also be included in computing an employee's average weekly wage, depending on the circumstances of each particular situation.

2. Seasonal Employees. When the work schedule of the employee varies during the year because of the nature of the employment, such as seasonal employment, the Tennessee Supreme Court has held that the average weekly wage is determined without deduction for the lost days caused by "circumstances incident to [the] employment."[6] In doing so, the Court noted the amount of work for the employees varied during the year and the employees were aware of this variation at the time they accepted their jobs. The Court contrasted this scenario from one in which the lost days are a result of illness or unexpected plant shutdown for repairs.[7] Thus, the general rule is, when an employee takes a job knowing that the work is seasonal, the employer can use the wage history for the entire prior 52 weeks in computing the average weekly wage even though there were weeks in which the employee earned no wages due to the seasonal layoff. Under the 2014 reform, there have been no revisions to the computation of benefits for seasonal workers.

3. Maximum and Minimum Benefits. The calculation of the workers' compensation rate to be due an employee is subject to minimum and maximum limits.[8] The minimum and maximum workers' compensation rate is calculated based on a percentage of the State's average weekly wage.

For injuries sustained on or after July 1, 2005, the maximum weekly temporary total disability benefit is defined as 66 2/3% of the employee's average weekly wage, so long as that amount does not exceed one hundred ten percent (110%) of the state's average weekly wage.[9] The maximum weekly benefit for permanent disability benefits for injuries occurring on or after July 1, 2004, is defined as 66 2/3% of the employee's average weekly wage up to one hundred percent (100%) of the state's average weekly wage.[10]

The Tennessee Workers' Compensation Law also sets the minimum amount that can be paid to an employee for weekly benefits. If 2/3 of an employee's average weekly wage computes to less than the statutory minimum weekly benefit, then the employee will receive the minimum set by statute. The minimum weekly benefit an employee may receive is fifteen percent (15%) of the state's average weekly wage.[11]

Beginning with the Reform Act of 2004 and continuing through the current 2014 revisions, the Bureau of Workers' Compensation publishes two separate maximum rates for temporary total disability benefits and permanent partial disability benefits. Thus, a precise date of injury is needed because the date of injury will affect the

compensation rate. A historical and current chart showing the maximum and minimum compensation rates in Tennessee by date of injury can be found at: https://www.tn.gov/content/dam/tn/workforce/documents/max_and_min_comp_rates.pdf

B. Notice of Denial.

Under Tenn. Code Ann. § 50-6-205(c)(1), if the employer disputes a claim then it must notify the Tennessee Bureau of Workers' Compensation. When an employer stops benefits for any reason other than final settlement or denial of a claim after investigation, the workers' compensation carrier or the employer (if self-insured) is required to notify the Tennessee Bureau of Workers' Compensation.[12] Previously, where an employer made payments and later chose to deny liability, filing a Form C-27 was required. The Bureau of Workers' Compensation no longer requires the filing of the Form C-27 Notice of Controversy. Instead, the Notice of Denial, Form C-23 is now required when any aspect of the claim is denied. While it remains to be seen if the prior deadlines apply, we can assume that the employer still has fifteen (15) days of the due date of the first omitted payment or denied treatment to file the C-23.[13] The prior payment of benefits does not stop the employer from later asserting any defenses in the claim.[14]

A 1988 Tennessee Supreme Court decision concluded that the failure to file the required notice of controversy form precluded the employer from denying liability of the injury.[15] However, a decision subsequent to that case sets forth the principle that an employer or its carrier may make a "reasonable investigation" of a claim and then deny a claim through the filing of a notice of controversy.[16] Thus, an employer or carrier may begin making payments of benefits and later, after investigation reveals that the claim is not compensable, suspend payments, but must file a notice of controversy within 15 days of the last payment in order to rely on this defense at trial. There is no case law on the revised filing requirements and elimination of the C-27; however, as with other areas of the law, we are instructed to rely on precedent when no contrary opinion is available.

In addition, it should be noted that failure to timely file the required forms and notices with the Bureau of Workers' Compensation subjects employers and their insurers to harsh penalties under the law.

C. Weekly Benefits Paid While Healing.

1. Temporary Total Disability Benefits. For injuries that produce temporary total disability ("TTD"), the worker is paid his weekly workers' compensation rate as calculated above during this healing process. These benefits terminate when the employee reaches his/her maximum medical improvement ("MMI"). Maximum medical improvement means a physician has opined the employee has healed to the greatest

extent expected.[17] Temporary total disability benefits can also be terminated when the employee becomes able to return to work at any employment.[18] Payment of temporary total disability benefits can be terminated when:

1. The employee returns to work;
2. A physician advises that the employee has reached maximum medical improvement;
3. A physician releases the employee to return to work without restrictions;
4. The employee refuses medical treatment.

If an employee misses a portion of a week, his workers' compensation benefits shall be calculated on the basis of one-seventh (1/7) of his workers' compensation rate for each day missed.[19] In other words, divide the weekly workers' compensation rate by 7 to determine the daily workers' compensation rate.

Temporary total disability benefits begin on the eighth day after the disability resulting from the employee's injury.[20] The statute provides that if the disability extends for 14 days or more, then the compensation shall begin with the first day of disability after the injury.[21] Payments are then due twice monthly to the employee during the period of temporary total disability.[22]

The general assembly has established time deadlines that create a presumption that the employee has reached MMI in psychological and pain management cases. For mental injuries with an underlying physical injury, the employee is presumed to be at MMI upon the earliest occurrence of the psychiatrist placing the employee at maximum medical improvement, or when the treating physician ends all active medical treatment for the physical injury.[23] For mental injuries with no related physical injury, MMI is presumed 104 weeks after the date of injury.[24]

Additionally, for claims in which pain management persists after active treatment ends, the employee is presumed to be at MMI.[25] These presumptions do not limit the right to continued medical treatment, but do allow the parties to proceed toward a resolution of permanent disability benefits.

The court has also held that an injured worker is entitled to temporary total disability benefits for the time period the worker is incapacitated due to surgery despite not knowing during his temporary period of disability that the injury was work-related.[26] However, an employee cannot recover temporary disability benefits during the time the employee is engaged in alternate employment.[27]

a. Disputes Regarding Temporary Total Disability Benefits. Disputes often arise in workers' compensation cases regarding payment of temporary total disability benefits. The Reform Act of 2013 created the Bureau of Workers' Compensation and moved the adjudication of workers' compensation claims to an administrative system, out of the court system. All workers' compensation cases in which the date of injury is on or after July 1, 2014 are heard by the Court of Workers' Compensation Claims. The Reform Act of 2013 mandates that the parties engage in informal mediation before their dispute is heard by the court. Either party may now submit a Petition for Benefit Determination, which initiates the process. The parties then attend mediation and at-

tempt to resolve their issues in good faith. If no resolution occurs, the mediator will issue a Dispute Certification Notice (DCN), and the case will be placed on the docket. The employee then will have sixty (60) days to request either a Scheduling Hearing or an Expedited Hearing.[28] At the Expedited Hearing, the court will determine whether the claimant is likely to prevail on his claim for temporary benefits if the case proceeded to a full Compensation Hearing.[29] Only the issues addressed stated on the DCN can be adjudicated at the Expedited Hearing.

In addition to the court's determination on benefits, the court is empowered to assess a penalty against an employer or insurer who fails to pay, or untimely pays, temporary disability benefits within twenty (20) days after the employer has knowledge of any disability that would qualify for benefits. The penalty is up to the discretion of the court and shall be an amount equal to 25% of the amount of unpaid benefits. If such a penalty is assessed on temporary benefits, then it is paid directly to the employee.[30]

Prior to assessing a penalty, the court must issue a request to the employer or insurer to provide documentation as to why the penalty should not be assessed.[31] Should the court determine that the employer or insurer failed to pay temporary benefits as required, the court must issue an order that assesses the penalty in a specific dollar amount to be paid directly to the employee. If the employer or insurer fails to comply with that Order within fifteen (15), then the employer or insurer will be subject to additional severe penalties.

The 25% penalty is in addition to other penalties that may be assessed for failure to pay temporary disability benefits. The employer or insurer may be referred for additional penalties up to $5,000.00, which are assessed by the Bureau of Workers' Compensation. The additional penalties are paid to the Bureau to offset the costs of administering the workers' compensation law.

b. Filing Requirements. It is important for the employer and the insurer to be familiar with the various forms and filings they are required to file with the Bureau of Workers' Compensation with regard to payment of benefits after a work injury has been reported. The employer must first file a Form C-20, Tennessee Employer's First Report of Work Injury with the Bureau after an accident has occurred. Such wage statement shall be accompanied by either (1) Form C-22, Notice of First Payment of Compensation, or (2) Form C-23, Notice of Denial of Benefits. If the employer is denying the claim, the Notice of Denial must be filed with the Bureau within five (5) days of the denial, and a copy of the Form C-23 shall be provided to the employee within the same time period.

Employers or insurers that fail to file the required form face a penalty of $50 to $5,000 at the discretion of the Bureau's penalty division. If an employer or insurer has good cause for the failure to timely file these notices with the Bureau of Workers' Compensation, then they may be able to avoid or reduce their penalties by responding accordingly during the investigation process.

An employer or insurer must also file a Notice of Change or Termination of Compensation Benefits with the Bureau of Workers' Compensation when the rate of TTD benefits change or stop. Should the employer or insurer fail to meet these requirements, they may be assessed the same penalty noted above for failure to file

the Form C-22 or Form C-23. As noted above, Form C-23 must now be submitted to the Bureau of Workers' Compensation by the employer if any aspect of the case is or becomes contested.[32]

2. Temporary Partial Disability. Temporary partial disability applies to an employee who has returned to work part-time and/or at a lower rate during the healing process. These benefits accrue before the employee reaches his date of maximum medical improvement. Temporary partial disability benefits are calculated by taking two-thirds of the difference between the wage earned at the time of the injury and the wage the employee earns in his partially disabled condition.[33]

The total amount of temporary partial disability payments is subject to a maximum cap of 450 weeks of benefits.[34] Therefore, if an employee is receiving temporary partial disability, meaning that he is working making less than he made at the time of the injury and has not yet been placed MMI, then the employer does not have to pay temporary partial disability benefits longer than 450 weeks.

D. After the Doctor Releases the Employee.

1. Permanent Partial Disability Benefits. Once an employee either reaches maximum medical improvement, or returns to work, the employer is entitled to terminate the payment of temporary total or temporary partial disability benefits. If the employee is given an impairment rating by the treating physician on a compensable claim, then employer owes the employee permanent disability benefits.[35]

If the employer or insurer settle an employee's claim, then the settlement must be approved by a judge at the Court of Workers' Compensation Claims. If a settlement is not reached then the parties may participate in a full Compensation Hearing to determine the amount of permanent partial disability benefits owed to the employee. The authorized treating physician's impairment rating is given a presumption of correctness that must be overcome in order for the court to find that a different impairment rating is correct.[36]

For injuries on or after July 1, 2014, all permanent impairment is to be apportioned to the body as a whole, which has the value of four hundred fifty (450) weeks of workers' compensation benefits.[37] The law no longer has a schedule for determining the value of individual body parts. All injuries are rated to the body and the impairment rating is determined through application of the AMA Guides. The general assembly determines the effective date of the most recent edition of the AMA Guides. Tenn. Code Ann. §50-6-102 currently defines AMA Guides as the 6th edition until a new edition is designated by the general assembly. The edition in effect on the date of injury is the applicable edition for each claim. For injuries occurring on or after January 1, 2008, the applicable edition is the Sixth Edition.[38]

a. Determining the Initial Benefit. The most recent revisions to the Tennessee Workers' Compensation Law eliminated the multipliers for awards and instead created the initial benefit. For injuries on or after July 1, 2014, the law now provides that initial benefits are owed in compensable cases that result in an impairment rating. These

benefits are paid without regard to whether or not the employee returns to work. The initial benefits are equal to the percentage of impairment multiplied by 450 weeks and then by the employee's weekly compensation rate.[39]

> Example: Employee received 7% BAW impairment from the authorized physician. Employee has a weekly compensation rate of $500.
> 7% x 450 = 31.5 weeks
> 31.5 x $500 = $15,750.00
> The Employee is entitled to initial benefits in the amount of $15,750.00, or 31.5 weeks.

The initial award of benefits is referred to as the "original award."[40]

b. Determining Whether Increased Benefits are Owed. If the employee does not return to work or does so but receives less than her pre-injury wage with any employer then she may apply for increased benefits at the end of her initial compensation period.[41] For injuries between July 1, 2014 and June 21, 2020, this period of time is equal to the number of weeks of initial benefits paid beginning with the MMI date. In the example above, the employee's initial compensation period expires 31.5 weeks from her date of MMI.

For injuries on or after June 22, 2020, the legislature established a minimum initial compensation period of 180 days from the date of MMI. Thus, for injuries that warrant 6% BAW permanent partial impairment or less, the initial compensation period is extended to 180 days.

If the employee is entitled to increased benefits, then those benefits are calculated by multiplying the original award by the following applicable factors at the expiration of the initial compensation period:

- 1.35 if the employee does not return to work, or does so but receives less than her pre-injury wage;
- 1.45 if the employee does not have a high school diploma or equivalent GED;
- 1.2 if the employee is greater than 40 years old at the expiration of the initial compensation period; and
- 1.3 if the unemployment rate in the county of employment is greater than 2 points above the state average for the year prior to the expiration of the initial compensation period of compensation.[42]

These factors should be multiplied not added together. If all factors apply then the most an employee can receive for increased benefits is 3.05 times the original award of initial benefits. The employee has one (1) year from the expiration of the initial compensation period to file a Petition for Benefit Determination requesting increased benefits.[43] If such a request is not filed then the statute of limitations runs on the increased benefits. The employer is given a credit for the initial benefits originally paid.[44]

As with the old law, the employee is not entitled to increased benefits if her loss of employment is the result of

- Voluntary resignation or retirement unrelated to the work injury;
- Misconduct; or
- A reduction in salary, wages, or hours that affected at least 50% of all hourly employees working at the same location.[45]

In a compensable case resulting in impairment, permanent partial disability benefits may be settled, including comprising increased benefits, at any time after MMI is reached.[46]

c. Permanent Partial Disability in Excess of Increased Benefits. For injuries on or after July 1, 2014, there are certain cases in which permanent partial disability benefits can be awarded over and above the calculation of increased benefits. Under the old law, this was commonly referred to as a case that would "bust the caps." The law now states that in "extraordinary cases where the employee is eligible for increased benefits," the employee may receive benefits up to two hundred seventy-five (275) weeks.[47] The employer is still given credit for any initial benefits already paid and these extraordinary benefits are paid in lieu of increased benefits. In order to receive these benefits, "a workers' compensation judge must make specific, documented findings" that as of the date of the award or settlement all of the following are true:

- The authorized physician has assigned the employee an impairment rating of at least ten percent (10%) to the body as a whole;
- The authorized physician has certified on the Bureau of Workers' Compensation form that the employee may no longer perform the employee's pre-injury occupation; and
- The employee is not earning an average weekly wage or salary that is equal to or greater than seventy percent (70%) of her pre-injury wage or salary.[48]

As with other benefits, parties are allowed to reach a compromised settlement of these benefits; however, it should be made clear that the law requires that a judge make specific findings that these benefits are warranted. It is also important to note that it is the authorized physician's rating, not that of an independent medical physician, that is used to determine whether benefits are owed.

E. Permanent Total Disability

For injuries occurring on or after July 1, 2014, any employee who is permanently and totally disabled by a job-related injury is entitled to payment of his weekly benefits during the entire period of the permanent total disability until the employee is eligible for full Social Security Retirement benefits.[49] However, if the injury occurs within five (5) years of the employee's eligibility for full Social Security Retirement benefits, or after the employee is so eligible, then permanent total disability benefits are payable for a period of two hundred sixty (260) weeks.[50] Permanent total disability benefits are also subject to an offset equal to the amount of any old age insurance benefits payments attributable to employer contributions.[51]

In no event should the lump sum portion awarded to an employee for permanent total disability exceed one hundred (100) weeks plus any accrued benefits. A judge can award a lump sum of up to one hundred (100) weeks to pay legal fees and to pay pre-injury obligations of the employee which are in arrears. Employee's attorney's fees in contested cases of permanent total are calculated only upon the first four hundred fifty (450) weeks of the employee's disability.[52] For instance, if an employee is twenty-five (25) years old and permanently disabled, he may be entitled to forty years of benefits. The attorney representing him would only be allowed a fee based on the first four hundred fifty (450) weeks of that time period. The lump sum portion of that award could not exceed one hundred (100) weeks plus any accrued benefits. After one hundred (100) weeks of the employee's permanent total disability benefits are paid in lump sum, the remaining weekly disability benefits still owed to the employee is reduced to take into account the weeks of benefits already paid.[53] This recalculation of weekly benefits shall result in the payment of equal weekly installments starting on the date the court orders payments to begin and ending when the employee's benefits are to terminate.[54]

After a case has been tried, an employer or its insurer has the right to have a permanently and totally disabled employee medically reexamined once every two (2) years[55] The purpose of this reexamination is to determine if the employee is still permanently and totally disabled.[56] If the employee is found to no longer be permanently and totally disabled, then the employer or its insurer can petition the court to reduce the remaining amount of benefits owed to the employee.[57] An employer or insurer wishing to reexamine a permanently and totally disabled employee must first call or send a letter to the employee requesting the employee see a physician.[58] If the employer or the insurer cannot come to an agreement with the employee regarding reexamination within thirty (30) days, then the employer or insurer must send the employee written notice of a demand for examination by certified mail, return receipt requested, on a form provided by the Bureau of Workers' Compensation.[59] The employee then has thirty (30) days to submit to the appointment scheduled on the form or schedule the appointment for a different time not to exceed ninety (90) days.[60] Failure of the employee to abide by these requirements will result in a suspension of periodic disability benefits.[61] Suspended benefits are reinstated only after the employee submits to an examination.[62]

Even if an employee is able to work, in some limited circumstances the court may still find the employee is permanently and totally disabled. If an employee receives an award of permanent total disability benefits and is later found to be working, then the employer can return to court and ask the judge to modify the award based on that fact. Therefore, when an employee is being paid permanent total benefits, best practices require a periodic activity check on the employee to see if he is working. The employer must wait more than two (2) years after the award before it seek modification. Any amounts paid in lump sum are final.[63] Also, all payments, including settlements and awards of compensation, totaling less than six (6) months of disability are final and cannot be reopened.[64]

Endnotes for Chapter V

1 Tenn. Code Ann. § 50-6-102(3)(A).
2 *Id*.
3 Tenn. Code Ann. § 50-6-102(3)(B).
4 Tenn. Code Ann. § 50-6-102(3)(C).
5 *Id*.
6 Russell v. Genesco, 651 S.W.2d 206 (Tenn. 1983).
7 *Id*. at 209-10.
8 *See* Tenn. Code Ann. § 50-6-102(16).
9 Id.
10 Id.
11 Tenn. Code Ann. § 50-6-102(18)
12 Tenn. Code Ann. § 50-6-205(d)(1).
13 Id.
14 Tenn. Code Ann. § 50-6-205(d)(3).
15 Goins v. Kayser/Roth Hosiery, Inc., 751 S.W.2d 423, 424 (Tenn. 1988).
16 Dobbs v. Liberty Mut. Ins. Co., 811 S.W.2d 75 (Tenn. 1991).
17 *See* Gluck Bros. v. Coffey, 431 S.W.2d 756 (Tenn. 1968).
18 *See* A.C. Lawrence Leather Co. v. Loveday, 455 S.W.2d 141 (Tenn. 1970).
19 Tenn. Code Ann. § 50-6-207(1)(A).
20 Tenn. Code Ann. § 50-6-205(a).
21 *Id*.
22 Tenn. Code Ann. § 50-3-205(b)(2).
23 Tenn. Code Ann. § 50-3-207(1)(D)-(E).
24 Tenn. Code Ann. § 50-3-207(1)(D)(iii).
25 Tenn. Code Ann. § 50-6-207(1)(E).
26 Banks v. United Parcel Service, Inc., 170 S.W.3d 556 (Tenn. Special Workers' Compensation Panel 2005).
27 Gray v. Cullom Machine, Tool & Die, Inc., 152 S.W.3d 439 (Tenn. 2004).
28 Tenn. Code Ann. § 50-6-239(a).
29 *Id*.
30 Tenn. Code Ann. § 50-6-118.
31 *Id*.
32 Tenn. Code Ann. § 50-6-205(d)(1).
33 Tenn. Code Ann. § 50-6-207(2).
34 *Id*.
35 Tenn. Code Ann. § 50-6-207(3).
36 Tenn. Code Ann. § 50-6-102(14).
37 Tenn. Code Ann. § 50-6-207(3)(H).
38 Tenn. Code Ann. § 50-6-204(k)(1).
39 Tenn. Code Ann. § 50-6-207(3)(A).
40 *Id*.
41 Tenn. Code Ann. § 50-6-207(3)(B).
42 *Id*.
43 Tenn. Code Ann. § 50-6-207(3)(D).
44 Tenn. Code Ann. § 50-6-207(3)(C).
45 Tenn. Code Ann. § 50-6-207(3)(D).
46 Tenn. Code Ann. § 50-6-207(3)(E).
47 Tenn. Code Ann. § 50-6-242(a)(2).
48 *Id*.
49 Tenn. Code Ann. § 50-6-207(4)(C)(i)-(iii).
50 *Id*.

51 *Id*.
52 *Id*.
53 *Id*.
54 *Id*.
55 *Id*.
56 *Id*.
57 *Id*.
58 *Id*.
59 *Id*.
60 TENN. CODE ANN. § 50-6-207(4)(C)(iii).
61 *Id*.
62 *Id*.
63 TENN. CODE ANN. § 50-6-231 (repealed under new law and new case law has not addressed this issue).
64 TENN. CODE ANN. § 50-6-230 (repealed by new law).

VI.

MEDICAL AND OTHER BENEFITS DUE TO THE EMPLOYEE

A. Scope of Medical Care

The law provides that the employer or insurance company shall furnish free of charge to the employee the medical and surgical treatment, medicine, medical and surgical supplies, crutches, artificial members, and other apparatus, including prescription eyeglasses and eyewear, such nursing services or psychological services as ordered by the attending physician, and hospitalization, including such dental work made reasonably necessary by the accident, as may be required.[1] The statute contains no limit on the time these benefits are payable or on the amount of money that can be payable by the employer/carrier. If the authorized treating doctor recommends specific medical treatment, there is a great likelihood that the Judge will require that the treatment be approved.

In addition, an employer and/or insurer has a duty to pay the medical expenses that are clearly the employer's obligation in a prompt and timely manner under the statute.[2] The employer or the employer's workers' compensation insurance carrier must pay an undisputed properly submitted bill for medical services within thirty (30) calendar days of receipt.[3]

The employee's doctor is required to furnish, upon request, a report within thirty (30) days concerning the claimed injury, its effect upon the employee, the medical treatment prescribed, an estimate of the duration of required hospitalization, if any, and an itemized statement of charges.[4] The information provided by the treating doctor and hospital regarding the subject injury is not privileged; consent by the employee is not required to get that information from the health care provider.[5] However, most providers required a signed medical authorization by the employee prior to releasing medical records.

Whether or not treatment is reasonable, necessary, and required will depend primarily on the medical testimony.[6] It should be noted that chiropractic treatment expenses, when reasonable and necessary, are "medical expenses" within the meaning of the statute.[7]

B. Medical Benefits - Reasonable and Necessary

The employer or the employer's insurance carrier is required to furnish free of charge to the employee medical and surgical treatment, medical and surgical supplies, crutches, artificial members, eyeglasses, nursing services, psychological services, dental work, etc. The employer and insurance carrier will only be liable for these bills if they are reasonable and necessary.[8]

Under the 2013 Act, the parties are free to negotiate to close the employee's right to future medical care. The 2004 Reform Act prohibited closing medicals until three (3) years after the settlement or trial. Only in cases settled on a doubtful and disputed basis for a maximum of fifty (50) times the minimum compensation rate were parties allowed to close an employee's right to future medical benefits.

In 2011, Section 50-6-204 of the Tennessee Code Annotated was amended to revive the parties' rights to negotiate closure of the right to future medical care for claims with dates of injury on or after June 6, 2011. Parties may agree to settle the employee's right to future medical treatment in cases of permanent partial disability without regard to the amount of the settlement. Parties are not allowed to close the future medical benefits of an employee who is permanently and totally disabled.

For injuries on or after July 1, 2014, the parties are free to negotiate the closure of medical benefits in any permanent, partial disability case or in contested claims. Parties are still not allowed to close medical benefits in permanent total disability cases.[9] Additionally, while it is not part of the statute, it is the position of the current judiciary that parties may not close medical benefits in any claim in which the employee retains hardware as a result of the treatment.

C. Panel of Medical Providers

One of the most important advantages available to the employer under the Tennessee Workers' Compensation Law is the right to control the employee's choice of a treating doctor. The employer preserves this right by providing the employee a list of at least three (3) physicians from the employee's "community" (if available) on form C-42.[10] Neither the statute nor the case law provides a definition of what community means. However, if three (3) or more physicians or specialists are not available in the community, an employee may provide a doctor for the panel who is within a one hundred twenty-five (125) mile radius of the employee's community.[11] As long as the employer provides the required list of three (3) physicians, the employee must accept the offered treatment or benefits may be suspended.[12] When an emergency situation exists, Section 50-6-204(g) of the Tennessee Code Annotated allows the employee to seek medical treatment on his own and establishes the employer's liability thereof not to exceed $300.00.

The employer must provide a panel of physicians to the employee (1) in writing and (2) on a form created by the Bureau.[13] The employee is then required to document on the Form C-42, in writing, the physician of his choice. The employee is required to sign and date the form. After completion, the employer is required to give a copy of the completed form to the employee. The employer is also required to maintain a copy of the completed form in its records.

Failure to provide a list of three (3) physicians can result in the employee or his attorney choosing the physician, which can lead to prolonged treatment and inflated impairment assessments. The panel of three (3) physicians should be provided as soon as possible. The employer should contact the insurer's representative to determine which local doctors should be considered for a panel well in advance of an injury being reported. It is recommended that the employer post a list of authorized doctors in a prominent place or to include this information in the employee manual. However, the C-42 must always be provided to an injured employee. After an injury to an employee, an employer should make certain the list of authorized doctors is given to the employee in writing to prevent the employee from later claiming this information was never provided. The wise employer checks with its insurance carrier or defense attorney for the names of doctors they would recommend for treatment in workers' compensation cases.

The choice of panel physicians is critical. Thus, when selecting a physician, the employer must consider a network of specialists who will provide appropriate medical treatment and help the employer access information, exercise control and return an employee to work, even if in a modified or light duty program. It is beneficial to provide physicians with adequate and accurate job descriptions so the physician can provide information about the employee's work status and give opinions about the employee's ability to perform the essential duties of his employment.

The panel of doctors provided by the employer must consist of three (3) doctors who are in the employee's community. If the panel doctor makes a referral to a specialist, under the 2013 Act the employer must provide that new panel within three (3) business days.[14] Otherwise, if a referral was made to a specific doctor by the panel doctor, this new referral doctor will be an authorized physician.

When an employer has complied with the statute by providing a panel of three physicians at an early date, the employer is generally not liable for any treatment from an unauthorized doctor. Such treatment from a doctor not on the panel is considered unauthorized and becomes the employee's responsibility.[15] Of course, when the authorized doctor refers the employee to another physician, both are considered authorized medical providers. With the passage of the 2013 Act, the Courts and Appeals Board are actively reviewing cases to make sure that proper panels were provided to the employee. If panels were not given but the employer directed care to a physician, then the court will routinely order employers to provide panels to employees despite treatment being already authorized and provided. Additonally, they are making referrals to the Bureau's Penalty Division for investigation and possible penalties.

The Tennessee Supreme Court previously set forth the following options for an employee who is dissatisfied with the designated physician's findings:

1) The employee may request that the judge appoint a neutral physician;
2) The employee may consult with the employer prior to making other arrangements for treatment; or
3) The employee may choose his own physician and be personally liable for all related expenses.[16]

In addition, the law provides very limited circumstances for a second opinion. When the treating physician refers the employee, a second opinion shall be given to address only the issues of surgery or diagnosis. The second opinion physician is chosen from the remaining two (2) physicians on the panel. This choice does not change the original panel physician's designation as the authorized provider.

The employer's liability for medical expenses extends only to those expenses which are reasonable and necessary.[17] However, when treatment is given by an authorized physician, that physician's charges are governed by the fee schedule (discussed in Section H herein). Where an employee seeks treatment on his own and the court finds that the employee was justified in doing so, the employee still must prove the reasonableness and necessity of those expenses. The employee is also entitled to recover any reasonable and necessary future medical expenses incurred as a result of the compensable injury.[18]

The law contains additional provisions that protect an employer from liability for excessive medical expenses. For example, a utilization review system has been established which provides three (3) separate penalties for health care providers found to have rendered excessive or inappropriate services.[19] Under this statute, the Administrator of the State of Tennessee's Bureau of Workers' Compensation is authorized to contract with an independent organization to provide utilization review of selected outpatient and inpatient health care providers to workers' compensation claimants. When a health care provider is found to have rendered excessive or inappropriate services, the Commissioner of Labor can invoke any of the following penalties:

1) A forfeiture of the provider's right to payment for services that are found to be excessive or inappropriate;
2) A civil penalty between $100 and $1,000; or
3) A temporary or permanent suspension of the right to provide medical care services for workers' compensation claims if the provider has engaged in repeated violations.[20]

Of course, in an emergency situation the employee may be taken to an emergency room or other available physician and the employer will be liable for that initial emergency treatment. However, the employer reserves the right to provide the employee with the panel of physicians following that emergency room visit.

D. Medical Impairment Registry

Under the Worker's Compensation Reform Act of 2013, the legislature retained a method by which parties may handle a dispute over the employee's permanent impairment. The Medical Impairment Registry Program is specifically set out in Chapter 0800-2-20 of the State's administrative rules. The sole purpose of the Medical Impairment Registry (hereafter referred to as the "MIR") is to establish a resource to resolve disputes as to the degree of permanent medical impairment ratings given for injuries or occupational diseases.

Either party may request a MIR evaluation if such party disputes an impairment rating assigned by a physician.[21] The request is limited to only the issue of the impairment rating. Issues such as causation, medical treatment, work restrictions, job modifications or apportionment cannot be addressed under this program. Requests for the evaluation must be written, and they can be submitted by paper or electronic application to the Program Coordinator in compliance with the rules. The MIR applies to injuries or occupational diseases that occurred on or after July 1, 2005.

Section 50-6-204(d)(5) of the Tennessee Code Annotated specifically provides: "When a dispute as to the degree of medical impairment exists, either party may request an independent medical examiner from the commissioner's registry…."[22] It further sets out the procedures for obtaining an evaluation subject to the commissioner's rules.[23] It is important to note that the rules for the new registry only apply to a dispute between the parties to the degree of the impairment.[24] Disagreements over any issues other than the permanent impairment rating would not be subject to these provisions. In those cases, the employer may seek an independent medical evaluation of the employee to address causation, restrictions, or other issues in dispute.

The main purpose of the MIR is to offer a physician who agrees to provide evaluations in a manner consistent with the standard of care in his or her community and in compliance with the MIR Program Rules. Basically, this program will allow the registry physician to render an opinion regarding the impairment of the injured employee, in an effort to resolve a conflict between the ratings of each party's respective expert medical opinions.

Significantly, the opinion of the MIR physician shall be presumed to be accurate and may be rebutted only by clear and convincing evidence.[25] The opinions of any other physician rendered after the MIR selection and evaluation will not be legally presumed to be accurate and will carry no additional evidentiary weight in further proceedings by the parties. The Bureau does not intend to permit the MIR rating to be attacked by any party waiting to depose its expert until after the MIR evaluation and MIR report have been rendered. No party may seek a second MIR registry opinion for the same injury.

1. Process for Obtaining the Medical Impairment Rating. The parties may attempt to negotiate selection of a physician to conduct a medical impairment rating evaluation prior to requesting assistance from the Bureau. However, physicians whose names appear on the MIR Registry, but are selected by means other than those set out in the administrative rules, shall have no greater presumption of correctness given to their opinions than any other provider's impairment rating when the physician was not selected in accordance with the rules.[26]

2. Application of the Registry. If the parties are unable to agree on a physician to conduct an evaluation, or if an agreement between the parties fails, either party may request the MIR Registry Three-Physician list. The written opinion of the MIR physician shall be presumed to be correct subject only to rebuttal by clear and convincing evidence.[27]

3. Form Required. The Application for a Medical Impairment Rating form is available upon request from the Bureau MIR Program Coordinator, or online at https://www.tn.gov/content/tn/workforce/injuries-at-work/bureau-services/bureau-services/workers--comp-forms.html. The application:

1) Must be in writing;
2) Must include all body part(s) or medical condition(s) to be evaluated, including whether mental impairment shall be evaluated;
3) Must include the names of all physicians that have previously evaluated, treated, or are currently evaluating or treating the employee for the work-related injury at the employer and/or employee expense;
4) Must include the names of all physicians made available to the employee at the time of the injury on the Form C-42; and
5) Must include the state file number assigned to the claim and a certificate that all parties including the Program Coordinator have been sent a copy of the request at the same time.[28]

The application will not be processed by the Program Coordinator until all required information has been provided.

4. Selecting the Registry Physician. Within five (5) days of the receipt of the completed Application, the Program Coordinator will produce a listing of three (3) qualified physicians from the MIR Registry, from which one (1) physician shall be designated to perform the evaluation. Upon receipt of the physician list, the employer has three (3) business days to strike one (1) name from the list and inform the other party and the Program Coordinator of that name. The employee will then have three (3) business days to strike one of the two (2) remaining names, and to inform the employer and Program Coordinator of the name of the remaining physician, who will conduct the evaluation.[29]

If the Program Coordinator is not notified of the selected physician within ten (10) calendar days of the date the Program Coordinator issued the three (3) physician listing, the Program Coordinator may select a physician at random from the list. Furthermore, if either party fails to timely strike a name from the listing, the other party may notify the Program Coordinator of the name it wishes to strike. Then the Program Coordinator will randomly select a physician from the remaining two (2) names, and that physician shall perform the evaluation. The Program Coordinator shall notify the parties of the selected physician in writing.

Should a physician be unable to perform an evaluation, the Program Coordinator shall provide the parties with one replacement name, and parties shall again strike a name from the list in accordance with the above-mentioned procedure.[30]

5. Setting the Appointment for the Evaluation. Within three (3) business days of receiving notice of the physician selection, the Program Coordinator shall call the MIR physician to schedule the evaluation, and shall immediately notify both parties, and the Workers' Compensation Specialist (if assigned) of the date and time of the evaluation. Only after this notification may the employer or insurance carrier contact the MIR physician to arrange for payment and submission of medical records.[31]

6. Submitting Copies of Medical Records. The employer shall submit copies of all pertinent medical records to the physician, the Program Coordinator and the employee at least ten (10) days prior to the evaluation. ALL MEDICAL RECORDS MUST BE SENT AT THE SAME TIME (CONCURRENTLY).[32]

If deemed necessary by the Program Coordinator, then the employee shall promptly sign a MIR Waiver and Consent form permitting the release of information to the MIR physician. The employer is responsible for forwarding a copy of the consent form to all treating and evaluating physicians and providers. Failure to do so will permit the employee to submit all medical records in his or her possession to be used in the evaluation not later than five (5) days before the examination. If medical records are not timely submitted, the Program Coordinator may reschedule the examination or permit the MIR Report to be rendered with the information that was properly made available.

7. Content of Medical File. The medical file shall include a dated cover sheet listing the employee's name, MIR Registry physician's name, MIR Registry case number, date and time of the appointment, and the state file number. The medical file shall be in chronological order, by provider, and tabbed by year. The medical file shall also include a written summary with range of treatment dates by the treating physician. The medical file SHOULD NOT include medical bills, adjustor notes, surveillance tapes, denials, vocational rehabilitation reports, non-treating case manager notes. Medical depositions may only be submitted to the MIR physician by written agreement of the parties.

The employee may be accompanied by an adult friend or family member; however, the companion may be asked to leave the evaluation at the request of the MIR Registry physician. It is important to note that the companion may not be the employee's attorney, paralegal or other legal representative or any other personnel employed by the employee's attorney or legal representative. The employee shall be reimbursed for reasonable travel expenses should the employee be required to travel outside a fifteen (15) mile radius from his residence or workplace.[33]

8. Payment of Fees. Physicians performing an evaluation in accordance with the Program Rules shall be prepaid a total evaluation fee by the employer. The evaluation fee includes normal record review, the evaluation, and a production of the standard "MIR Impairment Rating Report." Completed reports received and accepted by the Program Coordinator within thirty (30) calendar days of completing the examination are billed at $1,500.00.[34]

9. Multiple Impairment Rating Disputes and Evaluations. In instances of more than one (1) impairment being disputed in more than one (1) medical specialty, and there is an insufficient number of physicians on the registry who are qualified to perform all aspects of the evaluations, separate evaluations may be required, each requiring a separate application and physician-selection processes and fees.[35]

10. Requirements for the Evaluation and Report. Prior to the evaluation, the MIR physician is required to review all materials provided by the parties in accordance with the rules, and review the purpose of the evaluation and the impairment questions to be answered in the evaluation report.[36]

Following the evaluation, the MIR physician should consider all medical evidence obtained during the evaluation and provided by the parties in accordance with the Rules, complete an "MIR Impairment Rating Report," notify the Program Coordinator of the completion of the Report, and send the completed report via overnight delivery, electronic mail or U.S. Mail to the Program Coordinator.[37] It is important to note that NO physician-patient relationship is established between the MIR physician and the employee during the MIR Registry evaluation. The sole purpose of the evaluation is to establish an impairment rating, not to recommend future medical treatment, provide a diagnosis, or render medical advice.[38] After completing an evaluation, the MIR physician shall render the "MIR Impairment Rating Report." If the MIR physician agrees with the treating physician's determination of MMI, the report must include:

1) A brief description and overview of the employee's medical history;
2) A statement of concurrence with the treating physician's date of maximum medical improvement;
3) Pertinent details of the physical and/or mental evaluation;
4) Results of any diagnostic tests with copies of those tests attached;
5) An impairment rating consistent with the AMA Guides;

6) A rationale for the impairment rating based upon medical certainty, with references to clinical findings, objective findings and supporting documentation to clearly show how the rating was derived; and
7) A true or electronic signature of the physician and date with a certification set out in the Rules and Regulations.[39]

If the MIR physician does not agree with the treating physician's date of MMI, a report similar to the one referenced above shall be completed, as well as the rationale for disagreeing and, if possible, a determination as to the expected date of full or partial recovery. In either case, the physician is entitled to collect or retain the appropriate MIR fee.[40]

The services of the MIR physician conclude upon the Program Coordinator's acceptance of the final MIR Impairment Rating Report. Once the report has been accepted, the Program Coordinator will distribute copies of the report to the parties and the Workers' Compensation Specialist, if assigned.[41] Complaints regarding any MIR physician shall be submitted, in writing, to the Program Coordinator. The Commissioner may remove a physician from the MIR Registry permanently or temporarily based upon the grounds of misrepresentation, failure to timely report a conflict of interest, failure to comply with the requirements of the Rules, failure to correctly apply the AMA Guides, or any other reason for the good of the Registry as determined by the Commissioner.[42]

11. Overturning an MIR Physician's Report. Parties are prohibited from seeking a second MIR Registry impairment rating for the same injury if an impairment rating was issued after the first MIR Registry evaluation.[43] The permanent impairment rating given by the MIR physician in accordance with the rules and regulations of the Program shall be the opinion presumed to be correct and accurate. The presumption may only be rebutted by clear and convincing evidence. Opinions reached by any physicians utilized after mutually agreed upon selections not involving the issuance of an MIR Registry three (3) physician listing are not legally presumed to be accurate and shall carry no additional evidentiary weight in any proceedings, even in cases where the physician selected may also serve on the MIR Registry.[44]

E. Travel Expenses

Travel expenses are recoverable by the injured employee if it is shown that the travel is reasonably required in order to receive reasonably required treatment. When the employee is required to travel to an authorized medical provider located outside a radius of fifteen (15) miles (one way) from the worker's residence or workplace, then the employee shall, upon request, be reimbursed for his travel expenses.[45] Rules of the Bureau of Workers' Compensation set the mileage reimbursement at the amount of money per mile paid to state employees for their travel. This amount is periodically adjusted by the state.

F. Funeral Benefits

If the work injury or occupational disease results in death of the employee, then the employer shall owe, in addition to medical services, the payment of burial expenses of the deceased employee.[46] For injuries occurring prior to May 18, 2017 that result in death, the employer shall not owe more than $7,500.00 toward the employee's burial expenses.[47] This maximum amount was increased to $10,000 for injuries on or after May 18, 2017.[48]

G. Death Benefits

When the work injury or occupational disease results in the death of the employee, benefits are paid to the employee's dependents.[49] If the employee leaves no dependents, the employee's estate collects a lump sum payment of $20,000.00.[50] The employer must pay the deceased employee's medical, hospital and funeral bills in addition to the death benefits.[51] Section 50-6-210 of the Tennessee Code Annotated gives specific, yet very complicated, guidelines as to who is a dependent and who is not.[52] The most any dependents can collect in death benefits is four hundred fifty (450) weeks of benefits at the maximum compensation rate specified in the table below.

The benefits payable to a dependent over this four hundred fifty (450) week period can be at a rate less than 66⅔% of the employee's average weekly wage. The following chart summarizes the different compensation rates payable to certain kinds of dependents:

PERCENTAGE OF AVERAGE WEEKLY WAGE

	Type of Dependent(s)	% of AWW
1)	Surviving Spouse and no Dependent Child[53]	50%
2)	Surviving Spouse and Child[54]	66-2/3%
3)	Surviving Spouse and Children[55] (Judge decides how to apportion)	66-2/3%
4)	Dependent Orphan[56]	50%
5)	Dependent Orphans[57]	66-2/3%
6)	Dependent Parent[58] (If deceased employee leaves no Surviving Spouse or Child entitled to payment)	25%

7)	Dependent Parents[59]	35%
8)	One Dependent Brother, Sister, Mother-in-Law, Father-in-Law or Grandparent[60] (If deceased employee leaves no Surviving Spouse, Child or Parent entitled to payment.)	20%
9)	More than one Dependent Brother, Sister, Mother-in-Law, Father-in-Law or Grandparent[61] (divided equally)	25%

Benefits paid to a surviving spouse terminate upon remarriage or death.[62] However, courts may award benefits to sole surviving spouse in lump sum under exceptional circumstances and not as a matter of course.[63] If the remarried spouse has a child entitled to receive benefits at the time of remarriage, that child is treated as an orphan for purposes of collecting death benefits.[64] Children of deceased employees lose their weekly benefit in accord with various disqualifying circumstances listed in Section 50-6-210(d)(8) and (11) of the Tennessee Code Annotated. Children of deceased employees who are under eighteen (18) years of age receive compensation until they turn eighteen (18).[65] Dependents of deceased employees who are over eighteen (18) years of age and are mentally or physically incapacitated from earning receive benefits during the period of their incapacity.[66] Any dependent attending a recognized coeducational institution receives benefits until age twenty-two (22).[67] A dependent's marriage or death also terminates benefits.[68]

Section 50-6-210(e) of the Tennessee Code Annotated states that death compensation is paid during dependency not to exceed the maximum total benefit. Maximum total benefit, defend by Section 50-6-102(14) of the Tennessee Code Annotated, is four hundred fifty(450) weeks times the maximum weekly benefit (except for injuries before July 1, 1992).

Section 50-6-102(15) of the Tennessee Code Annotated says maximum weekly benefit is sixty-six and two thirds percent (66⅔%) of the employee's average weekly wage (subject to a percentage of the state's average weekly wage, depending on the date of injury). To summarize: Maximum exposure is the same for every claimant injured between July 1st and June 30th. Only the rate of payment varies and is based on the decedent's average weekly wage.

If an employee dies as the result of a work-related injury and leaves behind dependents residing outside the United States, then a Workers' Compensation Mediator may hold a mediation, as long as a representative from the employer and a representative from the dependents' country are present.[69] The Administrator may approve a settlement, or if none is reached, either representative party may file suit in the Court of Workers' Compensation Claims. Any payments due to the foreign

beneficiaries shall be paid to the consulate of the country in which they are citizens for distribution to those beneficiaries.[70] A judge or the Administrator must order that payment be made to the consulate, who must execute a bond. The bond will not be discharged until an accounting of the distribution of the benefits is filed with the Commissioner or court where the bond was issued.[71]

H. Medical Fee Schedule

1. General Information. Tennessee's Medical Fee Schedule became effective July 1, 2005, pursuant to a mandate from the Tennessee General Assembly as part of the Tennessee Workers' Compensation Reform Act of 2004.[72] It does not set an absolute fee for services, but instead, sets a maximum amount that may be paid. Negotiation between payers and providers is encouraged but payers will not be required to pay more than the fee schedule allows.

Reimbursement to all providers shall be based on the total bill or amount due and shall be the lesser of: (1) the provider's usual charge, (2) the maximum fee schedule set forth in the Bureau's Rules, or (3) the MCO/PPO or any other negotiated and contracted amount.[73] When no specific methodology for reimbursement is listed in the fee schedule, the maximum reimbursement is one hundred percent (100%) of Medicare. If no Medicare methodology is available, then the maximum reimbursement is the usual & customary reimbursement (eighty percent (80%) of billed charges).[74] Exceptions for certain extended ICU stays for serious injuries may be allowed.

2. Purpose. In consultation with the Advisory Council on Workers' Compensation and the Medical Care and Cost Containment Committee, the Commissioner is authorized to promulgate rules pursuant to the Uniform Administrative Procedures Act (UAPA) to establish a medical fee schedule.[75] These rules may include implementation of a system that includes procedures for review of medical charges, enforcement of the medical fee schedule and a method of appeal.[76] The goal of the medical fee schedule is to provide injured workers with quality medical care while controlling prices and system costs.[77]

3. Application. The Tennessee medical fee schedule applies to all injured employees claiming workers' compensation benefits in Tennessee. The date of reference is the date medical service is received, not the date of the employee's injury.

4. Coverage. The medical fee schedule covers fees of physicians and surgeons, hospitals, prescription drugs and ancillary services provided by other healthcare facilities and providers.[78] The fee schedule is not intended to prohibit an employer, trust or pool, or insurer from negotiating lower fees in its own medical fee contracts.[79] Specifically, the medical fee schedule covers the following services:

1) Anesthesia Services
2) Injections
3) Home Healthcare
4) Skilled Nursing Facility Charges
5) Outpatient Services (Including Emergency Room Care if Patient is not Admitted)
6) Pathology Services
7) Radiology Services
8) Chiropractic Services
9) Physical Therapy/Occupational Therapy (PT/OT)
10) Speech Therapy
11) Durable Medical Equipment and Implant Reimbursement
12) Medical Supplies
13) Orthotics and Prosthetics
14) Pharmacy
15) Ambulance Services
16) Clinical Psychological Services
17) Surgery, Surgical Assistants and Modifiers
18) Professional Services
19) Dentistry
20) Physician's Assistants and Certified Nurse Practitioners Maximum Reimbursement[80]
21) Inpatient hospital services[81]

The Medical Fee Schedule is a Medicare-based system, but with multiple conversion factors. The Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Law. The Medical Fee Schedule provides the maximum amount a provider may charge for services, including fees of physicians, surgeons, hospitals, prescription drugs, and additional services provided by other health care facilities. These amounts are calculated for services specified by the American Medical Association CPT codes by using appropriate conversion factors to account for geographic and national standards.

5. Penalties. A payer paying in excess of the Fee Schedules and a provider retaining excessive reimbursement over ninety (90) days is a violation of the Fee Schedule Rules and may result in penalties up to a $10,000.00 civil penalty against both payer and provider. Penalties are assessed at the Commissioner's discretion.[82] This section of the fee schedule did not become effective until January 1, 2006 and does not apply to violations prior to that time.

6. Appeals Procedure. When a payer and provider disagree as to payment under the fee schedule, either party may send a request to the Medical Care and Cost Containment Committee seeking administrative review and a recommendation regarding the issue. Disputes as to the application or interpretation of the fee schedule rules may also be submitted to the Medical Care and Cost Containment Committee for review.[83]

To submit an appeal or request for review of a dispute, parties should send the request to:

Medical Director of the Division of Workers' Compensation
Bureau of Workers' Compensation
220 French Landing Drive
Nashville, Tennessee 37243

A complete set of the medical fee schedule rules are available on the Tennessee Secretary of State website:
https://www.tn.gov/workforce/injuries-at-work/bureau-services/bureau-services/medical-fee-schedule.html

Additional information about the medical fee schedule and its application may also be found on the Tennessee Department of Labor website:
https://www.tn.gov/workforce/injuries-at-work/bureau-services/bureau-services/medical-fee-schedule.html

Endnotes for Chapter VI

1 Tenn. Code Ann. § 50-6-204(a)(1)(A).
2 Tenn. Code Ann. § 50-6-204(a).
3 Tenn. Dept. Lab. R. 0800-2-17-.10.
4 Tenn. Code Ann. § 50-6-204(a)(2)(A).
5 Tenn. Code Ann. § 50-6-204(a)(2)(D).
6 Tenn. Code Ann. § 50-6-204.
7 Humphrey v. David Witherspoon, Inc., 734 S.W.2d 315 (Tenn. 1987).
8 Tenn. Code Ann. § 50-6-204(a)(1).
9 Tenn. Code Ann. § 50-6-240.
10 Tenn. Code Ann. § 50-6-204(a)(3)(A).
11 *See* Tenn. Code Ann. § 50-6-204(a)(3)(B).
12 Tenn. Code Ann. § 50-6-204(d)(8).
13 Tenn. Code Ann. § 50-6-204(a)(3)(D)(i).
14 Tenn. Code Ann. § 50-6-204(a)(3)(A)(ii).
15 Tenn. Code Ann. § 50-6-204(a)(3)(A).
16 *Id. See also* Consolidation Coal Co. v. Pride, 452 S.W.2d 349, 354 (1970).
17 Tenn. Code Ann. § 50-6-204(a).
18 *Id.*
19 Tenn. Code Ann. § 50-6-124.
20 Tenn. Code Ann. § 50-6-124(e).
21 Tenn. Dept. Lab. R. 0800-2-20.02.
22 Tenn. Code Ann. § 50-6-204(d)(5).
23 Tenn. Dept. Lab. R. 0800-2-20-.06.
24 *Id.*
25 *Id.*
26 *Id.*
27 *Id.*
28 *Id.*
29 *Id.*
30 *Id.*
31 *Id.*
32 Tenn. Dept. Lab. R. 0800-2-20-.06.
33 Tenn. Code Ann. § 50-6-204(a)(6)(A).
34 Tenn. Dept. Lab. R. 0800-2-20-.10.
35 Tenn. Dept. Lab. R. 0800-2-20-.12
36 Tenn. Dept. Lab. R. 0800-2-20-.11.
37 *Id.*
38 *Id.*
39 *Id.*
40 *Id.*
41 *Id.*
42 *Id.*
43 *Id.*
44 *Id.*
45 Tenn. Code Ann. § 50-6-204(a)(6)(A).
46 Tenn. Code Ann. § 50-6-204(c)
47 *Id.*
48 *Id.*
49 Tenn. Code Ann. § 50-6-210.
50 *Id.*
51 *Id.*

52 *Id.*
53 *Id.*
54 *Id.*
55 *Id.*
56 *Id.*
57 *Id.*
58 *Id.*
59 *Id.*
60 *Id.*
61 *Id.*
62 *Id.*
63 *Id.*
64 *Id.*
65 *Id.*
66 *Id.*
67 *Id.*
68 *Id.*
69 *Id.*
70 *Id.*
71 *Id.*
72 Tenn. Code Ann. § 50-6-204(i)(1).
73 Tenn. Dep't Lab. R. 800-2-18-.02(2).
74 *Id.*
75 Tenn. Code Ann. § 50-6-204(i)(1).
76 *Id.*
77 *Id.*
78 *Id.*
79 Tenn. Code Ann. § 50-6-204(i)(4).
80 Tenn. Dep't Lab. R. 0800-2-18-.04.
81 Tenn. Dep't Lab. R. 0800-2-19-.03.
82 Tenn. Dep't Lab. R. 0800-2-18-.15.
83 Tenn. Dep't Lab. R. 0800-2-17-.21.

VII.

SPECIFIC INJURIES

The Workers' Compensation Law defines "injury" and "personal injury" to mean "an injury by accident, a mental injury, occupational disease including diseases of the heart, lung and hypertension, or cumulative trauma conditions, including hearing loss, carpal tunnel syndrome, or any other repetitive motion conditions arising primarily out of and in the course and scope of employment, that cause accidental death, disablement, or the need for medical treatment of the employee."[1] To be compensable under the workers' compensation statute, an injury must arise primarily out of and in the course and scope of employment. An injury arises primarily out of and in the course and scope of employment "only if it has been shown by a preponderance of the evidence that the employment contributed more than fifty percent (50%) in causing the injury, considering all causes."[2] Further "an injury causes death, disablement or the need for medical treatment only if it has been shown to a reasonable degree of medical certainty that it contributed more than fifty percent (50%) in causing the death, disablement or need for medical treatment, considering all causes."[3] The phrase "reasonable degree of medical certainty" means that, "in the opinion of the physician, it more likely than not considering all causes, as opposed to speculation or possibility.[4] The opinion of the treating physician, selected by the Employee from the Employer's designated panel of physicians…shall be presumed correct on the issue of causation but this presumption shall be rebuttable by a preponderance of evidence."[5]

A. **Hernias**

The Tennessee Code has an entire section devoted exclusively to hernias. Section 50-6-212(a) of the Tennessee Code Annotated sets out five (5) specific requirements to recover for a hernia or rupture, resulting from an injury by accident, arising primarily out of and in the course and scope of the Employee's employment, which must be "definitely proven" by the employee to the satisfaction of the court. These requirements include:

1) There was an injury resulting in hernia or rupture;
2) The hernia or rupture appeared suddenly;
3) It was accompanied by pain;
4) The hernia or rupture immediately followed the accident; and
5) The hernia or rupture did not exist prior to the accident for which compensation is claimed.

This last subsection applies to situations in which an employee has either a congenital or a pre-existing hernia which was not occupationally caused or related. Thus, if the employee sustains an accidental injury at work that aggravated the prior non-compensable hernia, recovery is not permitted.[6] If an injury did not primarily cause the hernia, then the injury is not compensable.

In order for a hernia to be found compensable, it must be proved that it "appeared suddenly" or "immediately followed the accident," such that it must have developed "without warning or without previous notice."[7] For a hernia to be determined to be immediate, it must appear so soon after the injury that it cannot be attributed to any other cause. Should the Employee fail to establish that he suffered a compensable injury, as required by statute, benefits will be denied.

Along with the broad changes to the Tennessee Workers' Compensation Law that the General Assembly made in 2013, the Assembly also made minor changes to Tenn. Code Ann. § 50-6-212, hernia or rupture. While the current version of section 50-6-212(a) is substantially similar to the previous, the current version of subsection 50-6-212(a) added the terms "primarily" and "scope" to subsection (a). The addition of these terms altered the proof requirements for establishing a compensable hernia claim so that an employee must prove that the hernia resulted "…from an injury by accident arising primarily out of an in the course and scope of the employee's employment…" "An injury "arises primarily out of and in the course and scope of employment" only if it has been shown by a preponderance of the evidence that the employment contributed more than fifty percent (50%) in causing the injury, considering all causes." The definition of this phrase directly impacts the employee's burden under section 50-6-212(a)(1) by requiring the injured employee to prove that the employee's workplace activities contributed more than fifty percent (50%) in causing "…the injury resulting in the hernia or rupture."

The statute further provides that should the hernia be found compensable, it shall be treated in a surgical manner by a radical operation.[8] Should any such operation result in death, the death will be considered compensable as well, and benefits shall be paid accordingly. Should the employee refuse to undergo the radical operation, to cure the hernia or rupture, no compensation will be allowed during the time the refusal continues.[9] However, if the employee proves to have some chronic disease or condition which the court could find unsafe for the employee to undergo surgery, the employee shall be paid benefits according to the statute.[10]

In the past, most hernia cases did not involve permanent disability. However, an employee may be awarded permanent partial disability benefits if an impairment rating has been assigned.[11]

B. **Heart Attacks**

A heart attack is compensable if it arises primarily out of and in the course and scope of employment, considering all causes. A heart attack may be compensable, even though the employee suffered from preexisting heart disease, if the heart attack arose primarily out of employment. This is because an aggravation of a preexisting condition may be compensable if the aggravation arose primarily out of and in the course and scope of employment. Tennessee's heart attack cases fall into two (2) categories. The first category consists of those cases precipitated by physical exertion or strain; the second category consists of those cases resulting from mental or emotional stress.[12] If the heart attack results from physical exertion or strain, it is unnecessary that there be extraordinary exertion or unusual physical strain.[13] In order to recover when there is no physical exertion, but rather emotional stress, worry, shock, or tension, the heart attack must be immediately precipitated by a specific acute or sudden stressful event. Stress or worry of generalized employment conditions are not compensable. Therefore, if a worker's heart attack is caused by a mental or emotional stimulus, rather than physical exertion or strain, there must be a climactic event, or series of incidents of an unusual or abnormal nature for recovery to be permitted.[14]

Of the two (2) groups, employees claiming that their heart attack arose because of physical exertion have a slightly easier time proving that their injury was causally related to their work.

1. Heart Attacks Caused by Physical Exertion. The compensability of an employee's heart attack caused by physical exertion depends upon the precipitating factors involved.[15] No unusual exertion or physical strain must be proven prior to recovery.[16]

The outcome of these cases frequently depends upon the reliability and certainty of the medical proof as to whether or not the physical exertion caused the heart attack or aggravated a pre-existing heart problem. The Tennessee Supreme Court summarized its approach regarding medical proof of causation as follows:

> Our approach has been to recognize the imprecision of medical proof of causation and hold that medical testimony that normal physical exertion of employment could have or might have caused the acceleration or aggravation of a pre-existing heart condition is sufficient to make out a prima facia case that the injury or death arise out of employment. If the employer introduces no evidence to the contrary, the preponderance of evidence supports an award of workers' compensation benefits.[17]

With regard to heart attack cases, there is no certain rule which permits for benefits to an employee who is disabled from a heart attack while on the employer's premises, or for a denial of benefits to an employee who is disabled from a heart attack that occurs while the employee is on the way home from work.[18]

Prior case law establishes that the issue surrounding heart attack cases is whether the evidence links the physical activities of the employment with the heart attack, not whether there is proof of physical exertion at the moment the heart attack occurred.

2. Heart Attacks Caused by Stress. The second category of heart attacks suffered by employees includes those precipitated by emotional stress, worry, or tension, unaccompanied by physical strain or exertion. It is generally well-settled in Tennessee that to recover for a heart attack in the absence of physical exertion, the heart attack must be "immediately precipitated by a specific acute or sudden stressful event, rather than a general employment condition."[19] Common causes of this category of heart attacks include specific incidents involving sudden stress, fright, tension, shock, anxiety, or worry. Employees have a more difficult time recovering benefits for heart attacks caused by emotional or mental stress because courts require proof of a "specific, climactic event or series of incidents of an abnormal or unusual nature."[20]

In situations involving stress related heart attacks, the courts try to separate the natural progression of a disease and the stressors of everyday life, from the acute incidents that can trigger a heart attack prematurely.[21] Normal stressors that an employee might encounter are not sufficient to satisfy the causation element of a workers' compensation claim. In essence, courts do not allow recovery for normal stressors because "emotional stress, to some degree, accompanies the performance of any contract of employment. When this is within the normal bounds of the ups and downs of normal human experience, courts frequently decline to impose liability."[22] An employee's long hours and general work-related stress are insufficient to constitute an "accident" under the Act.[23]

3. Presumption for Law Enforcement Officers. The Tennessee legislature created a specific presumption that any impairment of the health of a law enforcement officer caused by hypertension or heart disease shall be presumed to be an accidental injury suffered in the course of employment.[24] For this presumption to apply, the law enforcement officer must have had a physical examination before the disability that showed no evidence of hypertension or heart disease.[25] The employer can, however, rebut the presumption by presenting medical testimony which establishes that there is no causal relationship between the employee's work and his or her claim for benefits.[26]

4. Waivers for Pre-Existing Heart Conditions and Epilepsy. When an employee has a prior history of heart disease, heart attack, coronary failure or occlusion, he may be permitted to waive in writing any compensation from the employer for claims growing out of an aggravation or repetition of such condition. The waiver must be filed with the Administrator, and must include a copy of the medical statement giving the prior history of that condition.[27]

Employees may also choose to waive workers' compensation benefits for injuries resulting from epilepsy.[28] The election shall be made by giving notice to the Employer in writing on a form to be furnished by the Bureau of Workers' Compensation and filing a copy of the notice with the Bureau.

C. **Psychological Injuries**

The Tennessee Workers' Compensation Law provides compensation for two types of mental injuries. The first type of mental injury comes from a compensable physical injury that results in permanent disability. The second type of mental injury is caused by a work related event that results in sudden or unusual mental stimulus. An employee does not have to be exposed to physical danger in order to recover for a purely psychological injury. However, worry, anxiety, or emotional stress of a general nature is not compensable, because the workers' compensation system "does not embrace every stress or strain of daily living or every undesirable experience encountered in carrying out duties of a contract of employment." Mental injuries are generally compensable when they are precipitated by physical exertion or strain or specific incident or series of incidents involving mental or emotional stress of unusual or abnormal nature.

A "mental injury" is defined as a "loss of mental faculties or a mental or behavioral disorder, arising primarily out of a compensable physical injury or an identifiable work-related event resulting in a sudden or unusual stimulus." "Mental injury" shall not include a psychological or psychiatric response due to the loss of employment or employment opportunities. PTSD can also be a compensable claim.

For a mental injury by accident to "arise primarily out of employment, it must be caused by an identifiable, stressful, work-related event causing or producing a sudden mental stimulus, such as fright, shock, or unexpected anxiety, and it may not be gradual employment" stress that builds up over time. In addition, the stress produced may not be usual stress, but must be extraordinary and unusual in comparison to the stress ordinarily produced by an employee in the same type of duty.

Not all mental injuries give rise to recovery in workers' compensation cases. For example, a "psychological or psychiatric response due to the loss of employment or employment opportunities" is not compensable. Similarly, the aggravation of a preexisting mental conditional is not compensable "unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment." At the same time, however, "an employer takes an employee with all preexisting conditions, and cannot escape liability when the employer takes an employee, upon suffering a work-related injury, who incurs a disability far greater than if she had not had a preexisting condition."

The legislature has established limits on the temporary total disability benefits that can be claimed for a psychiatric injury. The statute now provides that an employee claiming a mental injury as defined by Tenn. Code Ann. § 50-6-102(17), occurring on or after July 1, 2009, shall be conclusively presumed to be a maximum medial improvement upon the earliest occurrence of the following:

i. At the time the treating psychiatrist concludes the employee has reached maximum medical improvement; or
ii. One hundred four (104) weeks after the date of injury in the case of mental injuries where there is no underlying physical injury.

Evidence of medical impairment may only be given by psychiatric testimony, not that of a psychologist. You must have medical testimony to support and award of permanency of the disease or the aggravation of a nervous condition. In regard to mental and nervous disorder claims, the testimony of a psychiatrist (M.D.) is required. Testimony from a psychologist (not an M.D.) is insufficient to establish causation and permanency of a claim for mental disorder.[29]

1. Psychological Injuries Caused By Physical Injuries. Compensation has traditionally been allowed for psychological disorders that develop after the employee first sustains a compensable work-related physical injury. For the psychological injury to be compensable, the employee must prove that the mental or behavioral disorder arose primarily out of a compensable physical injury.[30]

These cases typically hinge upon whether the psychological condition is causally related to the work-related injury. Thus, the certainty of the medical proof regarding the origin of the psychological injury is critical when building a case for or against compensability.

2. Psychological Injuries Caused by Sudden or Unusual Mental Stimulus. The second type of mental injury does not involve a work-related physical injury. Instead, this class of mental injuries concerns work-related events involving fright, shock, or excessive, unexpected anxiety which cause a mental injury. To be compensable, the injury must stem from an identifiable stressful work related event producing a sudden mental stimulus, and the event must be unusual compared to the ordinary stress of the worker's job. The psychiatric injury must be the result of a specific work related incident. Mental injuries from the everyday stress or tension of one's job are not compensable. The law specifically states that an employee's psychological response due to the loss of employment or employment opportunities is not compensable.[31]

D. **Stroke Cases**

Stroke cases are very similar to heart attack cases. There are strokes that are brought on by physical exertion, and there are strokes that are caused by unusual stress or an abnormal nature. Like heart attacks, strokes are generally compensable as accidental injuries when they are precipitated by (1) physical exertion or strain, or a (2) specific incident or series of incidents involving mental or emotional stress of an unusual stress or abnormal nature. For a stroke precipitated by stress to be compensable, the stress has to be unusual or abnormal. Ordinary stress of one's occupation does not meet this standard.

The seminal case dealing with strokes is *Reeser v. Yellow Freight Sys., Inc*.[32] In *Reeser*, the employee was a truck driver who was driving a truck through one of the largest ice storms ever to hit Tennessee. The employee had to navigate his truck through downed trees and around abandoned vehicles. This trip was also made largely in the dark because of broken electrical lines to the street lights. The employee had a stroke in the cab of his truck and had a major accident. The Tennessee Supreme Court held that this type of injury is generally compensable when the stroke is "precipitated by . . . a specific incident or series of incidents involving mental or emotional stress of an unusual or abnormal nature. In other words, excessive and unexpected mental anxiety, stress, tension or worry attributable to the employment can cause injuries sufficient to justify an award of benefits."[33]

E. **Gradual Injuries**

The legislature has made changes regarding what constitutes gradual injuries and the causation of such injuries. Gradual injuries still present problems with regard to the statute of limitations and notice because there is not a clear cut traumatic accident date upon which one can rely. Through an amendment to the definition of "injury," the new legislation significantly limits the scope of what constitutes a compensable injury, especially gradual injuries. Thus, the new statute narrows the definition of "injury" to a "specific incident or incidents arising primarily out of and in the course of employment, and is identifiable by time and occurrence."[34]

Hearing loss, carpal tunnel syndrome, and all repetitive motion conditions are not considered occupational diseases, but are compensable if the condition arose primarily out of and in the course and scope of employment. There must be evidence of medical testimony that the employment contributed more than fifty percent (50%) in causing the injury, considering all causes. The opinion of the treating physician shall be presumed correct on the issue of causation, but this presumption shall be rebuttable by a preponderance of the evidence.

Endnotes for Chapter VII

1 Tenn. Code Ann. § 50-6-102(14).
2 *Id*.
3 *Id*.
4 *Id*.
5 *Id*.
6 *Id*.
7 Capps v. Goodlark Medical Center 804 S.W.2d 887 (Tenn. 1991).
8 Etter v. Blue Diamond Coal Co., 215 S.W.2d 803, (Tenn. 1948).
9 Tenn. Code Ann. § 50-6-212(b).
10 Tenn. Code Ann. § 50-6-212(c)(1).
11 Tenn. Code Ann. § 50-6-212(c)(2).
12 *See* Corcoran v. Foster Auto G.M.C., Inc., 746 S.W.2d 452 (Tenn. 1988).
13 Clark v. Nashville Machine Elevator Company, 129 S.W.3d 42 (Tenn. 2004).
14 *Id*.
15 *Id*.
16 Bacon v. Sevier County, 808 S.W.2d 46, 47 (Tenn. 1991); Shelby Mut. Ins. Co. v. Dudley, 574 S.W.2d 43, 44 (Tenn. 1978).
17 Bacon, 808 S.W.2d at 47; *see also* Flowers v. South Central Bell Telephone Co., 672 S.W.2d 769, 770 (Tenn. 1984).
18 King v. Jones Truck Lines, 814 S.W.2d 23, 29 (Tenn. 1991).
19 Clark v. Nashville Machine Elevator Company, 129 S.W.3d 42 (Tenn. 2004).
20 *Id*.
21 Cunningham v. Shelton Sec. Service, Inc. 46 S.W.3d 131 (Tenn. 2001).
22 *Id*.
23 *Id*.
24 Bacon v. Sevier County, 808 S.W. 2d 46 (Tenn. 1991).
25 Tenn. Code Ann. § 7-51-201.
26 *Id*.
27 Tenn. Code Ann. § 50-6-102(17).
28 Tenn. Code Ann. § 50-6-213(a).
29 *See* R.E. Butts Co. v. Powell, 463 S.W.2d 707,709 (Tenn. 1971).
30 Tenn. Code Ann. § 50-6-102(17).
31 *Id*.
32 Reeser v. Yellow Freight Systems Inc., No.-1S01-9603-CV-00042 (Tenn. Feb. 24, 1997).
33 *Id*.
34 Tenn. Code Ann. § 50-6-102(14).

VIII.

TENNESSEE BUREAU OF WORKERS' COMPENSATION

The Tennessee Bureau of Workers' Compensation oversees numerous programs relating to workers' compensation. The programs include: Mediation and Ombudsman Services of Tennessee (MOST); Court of Workers' Compensation Claims; Appeals Board; Medical Impairment Registry; Utilization Review; Case Management; Medical Fee Schedule; Penalty Program; and Drug Free Workplace. The Bureau of Workers' Compensation has eight regional offices throughout the state.

The Bureau of Workers' Compensation maintains an extensive website that includes all notices and forms necessary for employees and employers during the process of a workers' compensation case, as well as other helpful workplace injury information. The website can be accessed at https://www.tn.gov/workforce/injuries-at-work/injured-workers.html.

A. Mediation and Ombudsman Services of Tennessee (MOST)

The Mediation and Ombudsman Services of Tennessee (MOST) program attempts to resolve disputes between injured employees and an insurance adjuster or employer in a workers' compensation claim. The goal of this program is to resolve disputes that involve compensability, medical treatment including future medical benefits, and/or temporary disability benefits.

Mediation, or alternative dispute resolution, can help resolve disputes between employees and an insurance adjuster or employer in a workers' compensation claim. Mediation is conducted privately between the parties with the assistance of a Mediation Specialist from the Tennessee Bureau of Workers' Compensation. When received, the matter will be assigned to a Mediating Specialist. The assigned Mediating Specialist is not a legal representative for the employee or employer. The Mediating Specialist is neutral and will attempt to reach a voluntary agreement of the disputed issues between the parties.

1. Ombudsman

The Bureau has an ombudsman program to assist self-represented parties with workers' compensation claims. The ombudsman program provides assistance to employees, employers or any other party or participant in a workers' compensation claim who is not represented by legal counsel. Any party who is not represented by counsel may request the services of a workers' compensation ombudsman by contacting the Bureau.

Pursuant to the rules, an ombudsman shall have authority including, but not limited to:

a) Meeting with and providing information to unrepresented parties about their rights and responsibilities under the law;
b) Investigating claims and attempting to resolve disputes without resort to alternative dispute resolution and court proceedings;
c) Communicating with all parties and providers in the claim;
d) Assisting the parties in the completion of forms; and facilitating the exchange of medical records.[1]

An ombudsman cannot provide legal advice. Further, an ombudsman cannot be called to testify in any proceeding, and no statement or representation made to an ombudsman shall be considered by a workers' compensation judge for any purpose.[2]

2. Petition for Benefit Determination

Under the 2013 Reform Act, a Petition for Benefit Determination (PBD) effectively replaced the Request for Assistance process utilized under the old law. When a dispute arises over payment of benefits, either party may file a PBD on the Bureau's form. If a petition for benefit determination is not filed within one year of the date of injury or last date of payment on the claim, then the right to compensation under the Workers' Compensation Law relating to the dispute shall be forever barred.[3]

After a PBD is filed, each party shall exchange medical records related to the injury in dispute. The Rules require that any additional records received during litigation be provided to the other party within 14 days of receipt.[4] The mediator may refer any party that does not comply with the requirements of this rule for the assessment of a civil penalty.[5]

Within seven (7) business days after the request of the mediating specialist or within fifteen (15) business days after a Dispute Certification Notice is filed with the clerk, whichever is sooner, the employer shall provide a wage statement on form C42 detailing the employee's wages over the fifty-two (52) week period preceding the injury.[6] If the Dispute Certification Notice has been filed with the clerk, the employer shall file the wage statement with the clerk. Under either circumstance, the employer shall serve a copy of the wage statement upon the employee. Any employer who does not file a wage statement within the timeframe provided may be assessed a civil penalty.[7]

3. Alternative Dispute Resolution (Mediation)[8]

Once a case has been assigned to a mediator, the mediator shall schedule alternative dispute resolution (ADR). ADR may take place in-person, telephonically or even through emails depending on the preference of the mediator and filing party.

If the parties reach an agreement through this process, then the mediator will issue a Dispute Resolution Statement and will close its file. If the parties are not able to reach a settlement then the mediator will issue a Dispute Certification Notice.

4. Dispute Certification Notice.[9] If the parties are unable to reach a resolution of all disputed issues, the mediator shall issue a Dispute Certification Notice (DCN) to the parties. The mediator shall note any issues that the parties have agreed upon in the Notice as well as the remaining issues that are still in dispute including all defenses to the claim that were raised during the mediation. The parties have five (5) days to review the DCN and request revisions prior to the mediator filing the DCN with the Court of Workers' Compensation Claims. Upon completion of the amended DCN, the mediator will file it with the Court of Workers' Compensation Claims.

B. Court of Workers' Compensation Claims

1. Request for Hearing.[10] Once the DCN is filed with the Court, a request for hearing must be filed within 60 days in order to keep the case on the court's docket. A party may request a Scheduling Hearing, which keeps the case on the court's docket for status conferences, or an Expedited Hearing, which will bring the disputed issues in the DCN to the judge for adjudication. If neither hearing request is filed, then the court clerk will place the case on a separate dismissal calendar for a show cause hearing, in which the judge will ask the parties to appear and inform the court why the case should remain on the docket when no hearing was timely requested.

2. Scheduling Hearing.[11] If a Request for Scheduling Hearing is filed, then the judge will hold a hearing to determine the status of the claimant's treatment and litigation. When the claimant has reached MMI, if the parties are still unable to reach a resolution of the claim then the judge will enter a Scheduling Order for discovery deadlines, post-discovery ADR and final Compensation Hearing date. Once the date of the compensation hearing has been set, the parties will not be allowed to modify it without permission from the presiding judge based on a finding of good cause.

3. Expedited Hearing.[12] If there is a dispute over temporary disability and/or medical benefits, either party may file a request for expedited hearing. This interlocutory process has replaced the former request for assistance (RFA) procedure. A request for Expedited Hearing must be accompanied by an affidavit from the filing party containing a plain and concise statement of the facts upon which the request is based and any other documents demonstrating the party is entitled to the requested relief. The party requesting an Expedited Hearing shall list any witnesses it intends to introduce at the hearing. This hearing may take place in-person or the judge may agree to render a decision based on the record without the need for an in-person hearing. Evidentiary rules for an Expedited Hearing are more lenient than those required at the final Compensation Hearing.

For example, as long as medical records are signed by the physician or custodian of records, those records may be entered into evidence without the need for taking the physician's deposition or filing a C32.

Remember, this is an interlocutory proceeding, meaning it is not the final determination of the case. If the Expedited Hearing results in a denial of benefits, then the claim shall continue and/or the aggrieved party may file an appeal with the Workers' Compensation Appeals Board within 7 days after the Order is entered.

4. Post-Discovery Mediation.[13] After all hearings have taken place and discovery has been completed, the new law requires the parties to participate in additional alternative dispute resolution proceedings with a workers' compensation mediator. If the parties do not reach settlement of all issues at ADR, then the mediator must file a new Dispute Certification Notice listing all agreed upon issues, as well as those that remain disputed. Only issues listed in the final DCN will be heard at the Compensation Hearing.

5. Compensation Hearing.[14] The Compensation Hearing serves as the trial for the case. The Rules of Evidence and Civil Procedure apply, so that all testimony must come in the form of deposition, C32, or live testimony at the hearing. While rare, the case may be decided on the record in lieu of an in-person hearing. Once the final order is entered by the presiding judge following the Compensation Hearing, the aggrieved party shall have 30 days to file a Notice of Appeal with the Workers' Compensation Appeals Board. If no such appeal is filed then the Order becomes final and the parties must timely comply.

6. Settlement Approval.[15] In any case where the parties reach a full and final settlement, the settlement must be approved by a workers' compensation judge. The parties are free to settle a disputed claim at any time and there is no maximum or minimum constraint on the monetary amount of settlement. For approval of compensable claims, the judge must find that the employee is receiving, substantially, the benefits provided by the Tennessee Workers' Compensation Law. The parties are also free to settle a disputed claim at any time and there is no maximum or minimum constraint on the monetary amount of settlement. If the settlement is of a disputed case pursuant to Tenn. Code Ann. § 50-6-240(e), then the judge must find the settlement is in the best interest of the employee. The parties may also close the right to future medical benefits as long as the employee is advised of the consequences of the settlement, if any, with respect to Medicare and TennCare benefits and liabilities. Further, the authorized treating physician must opine that no additional treatment is anticipated for the injury or that the amount being paid to close medical benefits will adequately cover the cost of any anticipated treatment. It should be noted that the court almost never allows closure of medical benefits when hardware has been used to treat a work injury.

C. Case Management.[16] In Tennessee, only licensed physicians or registered nurses may conduct case management in a workers' compensation claim. Case management services are voluntary at the option and expense of the employer or insurance carrier. However, if utilized, the employee must cooperate. Pursuant to the rules, nurses who are not licensed (i.e. case manager assistants) may be used as long as they work under the direct supervision of a case manager and meet certain certification requirements. Recent changes to these rules have set out very specific tasks a case manager may and may not do. Pursuant to the rules, case managers are required to:

1) Develop a treatment plan to provide appropriate medical care services to an injured or disabled employee;
2) Systematically monitor the treatment provided and the medical progress of the injured or disabled employee;
3) Assess whether alternative medical care services are appropriate and delivered in a cost effective manner according to acceptable medical standards;
4) Ensure that the employee follows up on the prescribed medical plan; and
5) Formulate a plan for the employee to return to work while with due regard for the employee's recovery and restrictions and limitations, if any.

A case manager shall not:

1) Prepare the panel of physicians or influence the employee's choice of physician;
2) Determine whether the case is work related;
3) Question the physician or employee regarding issues of compensability;
4) Conduct or assist any party in claims negotiation, investigation, or any other non-rehabilitative activity;
5) Advise the employee as to any legal matter including settlement options or procedures, monetary recovery, claims evaluation, or the applicability of the workers' compensation law to the employee's claim;
6) Accept any compensation or reward from any source as the result of settlement;
7) Discuss with the employee or physician what the impairment rating should be;
8) Reschedule medical appointments without first discussing the scheduling change with the employee;
9) Refuse to provide case management reports to parties to the claim;

10) Assist in any way in recording the employee's activity for the purposes of disproving the employee's claim; or
11) Deny or authorize treatment for the purpose of guaranteeing prepayment or precertification.[17]

An employer or insurer is free to provide case management services on its own or through a third-party as long as it does so in compliance with these rules. It is important to note that even the case manager is paid by the employer, those communications are not confidential and may be discoverable in litigation.

D. Utilization Review

Utilization review means the evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee. Utilization Review (UR) applies to all recommended treatments for work-related injuries or conditions. The parties are required to participate in utilization review whenever a dispute arises as to the medical necessity of a recommended treatment. Employers are required to establish and maintain a system of utilization review. An employer may choose to provide utilization review services itself, through its insurer or through a third party administrator. Whenever utilization review is conducted, whether mandatory or not, such utilization review must be conducted in complete conformity with the Bureau's regulations. Failure to comply with the regulations in any way may subject the employer and utilization review agent to sanctions and/or civil penalties. The Medical Director may determine whether a utilization review was conducted in conformity with the regulations and may determine that a utilization review is void.[18]

1. Utilization Review Requirements

In any case in which utilization review is undertaken, the utilization review agent shall make an objective evaluation of the recommended treatment as it relates to the employee's condition and render a determination concerning the medical necessity of the recommended treatment. A utilization review agent is allowed to contact the authorized treating physician with regard to the recommended treatment. All denials must be issued by a licensed physician, who is required to notify the parties of the denial in writing.

2. Applicability

Diagnostic procedures ordered by an authorized physician in accordance with treatment guidelines in the first thirty (30) days after the date of injury are not subject to utilization review.

3. Time Requirements

If an employer wishes to submit a treatment recommendation to utilization review, then an employer must do so within three (3) business days of the authorized treating physician's notification of the recommended treatment. The treatment request must be in writing from the authorized physician.

An approval of a recommended treatment by the employer's utilization review agent is final and binding on the parties for administrative purposes. If a denial of the recommended treatment is appealed, then the utilization review agent shall send a copy of the denial to all parties and the Bureau within five (5) business days of a request. The appealing party has 30 days to do so. If the Medical Director approves the recommended treatment, then the employer or carries has seven (7) calendar days after receipt of the determination letter to notify the Bureau and the provider of compliance and authorization of the recommended treatment. The employer is required to pay the cost of the appeal. If an employer wishes to override a denial prior to the cost of an appeal being incurred then it must do so within three (3) business days after receiving the decision. An employee may still file a petition for benefits or request for a hearing to seek approval of treatment ordered by the authorized physician but denied by UR.

Utilization review decision to deny recommended treatment is effective for 6 months from the date of the decision.[19] Thus, as long as the request is for the same treatment, unless there is a material change documented by the treating physician then an employer is not required to resubmit the treatment recommendation to utilization review for denial.[20]

Endnotes for Chapter VIII

1 Rules of TN Dept. of Labor and Workforce 0800-02-21-.09; Tenn. Code Ann. § 50-6-216 (E)(2).
2 Rules of TN Dept. of Labor and Workforce 0800-02-21-.04.
3 Tenn. Code Ann. § 50-6-203.
4 Rules of TN Dept. of Labor and Workforce 0800-02-21-.10(2).
5 *Id*.
6 Rules of TN Dept. of Labor and Workforce 0800-02-21-.10(3).
7 *Id*.
8 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.10(4).
9 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.11.
10 *Id*.
11 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.14.
12 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.15.
13 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.21.
14 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.22.
15 Rules of TN Dep't. of Labor and Workforce 0800-02-21-.23.
16 Rules of TN Dep't. of Labor and Workforce 0800-02-07.
17 Rules of TN Dep't. of Labor and Workforce 0800- 02-07-.04-.02.
18 Rules of TN Dep't. of Labor and Workforce 0800- 02-06-.06(7)(a).
19 TN Rules and Regs. 0800-02-06-.06 (7)(a)
20 *Id*.

IX.

THE EFFECT OF PRIOR MEDICAL PROBLEMS ON THE CLAIM

A. Aggravation of Pre-existing Condition

An employer assumes the risk that an employee with a pre-existing condition will have that condition aggravated by a subsequent on-the-job injury. Generally, it is well established in Tennessee that an employer takes his employee as he finds him, which includes any pre-existing afflictions.[1] However, if work activities aggravate a pre-existing condition merely by increasing pain without enhancing the severity of the condition, there is no compensable injury.[2]

In the particular instance of a pre-existing heart condition, an aggravation of that condition arising out of physical activity, exertion, or strain of the employee's work is compensable.[3] It has also been held that medical expenses not caused by an injury itself but from the stress from undergoing operations necessitated by the heart condition/injury are properly awarded under the Tennessee Workers' Compensation Law.[4]

In addition, if a work-related injury aggravates or contributes to an idiopathic condition (a condition without documented cause), it may be a compensable claim.[5] This contributing cause of death standard may be satisfied and the claim found compensable even though the injured employee was suffering from some prior disability of a serious nature. In one extreme case, an employee suffered a cut on the back of his hand while at work and shortly thereafter died from blood poisoning which developed from the cut. The Tennessee Supreme Court found that the death of the employee arose out of his employment and was, therefore, compensable, even though he suffered from leukemia and would have eventually died from that condition.[6]

When a health care provider who is treating a work-related injury causes that injury to be worse or causes a completely new injury by the treatment that he or she renders, the result will be found to be compensable under Tennessee law. The courts have ruled that the original injury is the proximate cause of the damage flowing from the subsequent, negligent treatment by a physician. Where the aggravation of the injury by a physician rises to the level of improper treatment, the injured employee can bring a malpractice action against the physician even after workers' compensation benefits have been received by the employee.

Determining the compensability of an alleged work-related aggravation of a preexisting, degenerative medical condition has long been a source of difficulty under Tennessee's Workers' Compensation Law. The general assembly has, in recent years, sought to clarify this issue through statutory amendments. In 2011, the definition of "injury" was amended to provide that work-related injuries "do not include . . . cumulative trauma conditions ... unless such conditions arose primarily out of and in the course and scope of employment."[7]

Two years later, as part of the 2013 Workers' Compensation Reform Act, the general assembly again amended the definition of "injury": "Injury" and "personal injury" mean an injury by accident, . . . or cumulative trauma conditions ... arising primarily out of and in the course and scope of employment, that causes death, disablement, or the need for medical treatment of the employee; provided that:

> (A) An injury . . . shall not include the aggravation of a preexisting disease, condition or ailment unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment.[8]

Moreover, for injuries occurring on or after July 1, 2014, the general assembly made clear that "this chapter shall not be remedially or liberally construed but shall be construed fairly, impartially, and in accordance with basic principles of statutory construction and this chapter shall not be construed in a manner favoring either the employee or the employer."[9] The pertinent statute makes clear that an aggravation of a preexisting condition is a compensable injury when "it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment."[10] Thus, an employee can satisfy the burden of proving a compensable aggravation if: (1) there is expert medical proof that the work accident "contributed more than fifty percent (50%)" in causing the aggravation, and (2) the work accident was the cause of the aggravation "more likely than not considering all causes."[11] Finally, the Workers' Compensation Appeals Board has opined that an aggravation or exacerbation need not be permanent for an injured worker to quality for medical treatment reasonably necessitated by the aggravation.[12]

B. The Last Injurious Exposure Rule

Tennessee Code Annotated Section 50-6-304 (2017) states, "when an employee has an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the disease, and the employer's insurance carrier, if any, at the time of the exposure, shall alone be liable, for the occupational disease, without right to contribution from any prior employer or insurance carrier."

The workers' compensation law prior to the Reform Act of 2013 included a statutory component of liberal construction, which does not exist for injuries after July 1, 2014.[13] Under the Reform Act of 2013, an employer is liable only to the extent that the employee's injury arose primarily out of and in the course of employment.[14] Moreover, an "injury" shall not include the aggravation of a preexisting disease, condition, or ailment unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment.[15]

Those benefits due an employee in such a case are, therefore, not apportioned between multiple employers, but rather the total liability falls on the last employer. The last successive employer or insurance carrier, again taking the employee as he is found at the time of the accident, will be liable for all medical expenses, regardless of any preexisting condition.

Tennessee law does not provide for the apportionment of liability between successive employers or their insurance companies.[16] It is sufficient in Tennessee that the last injury be merely the straw that broke the camel's back in order to make the last employer liable for all benefits. If this was not the rule, then courts would be asked to undertake the burdensome task of speculating upon the amount of contribution or apportionment of each injury sustained by the employee. This is the problem that the Court sought to avoid with the imposition of the last injurious injury rule.[17]

The Tennessee Supreme Court has noted the futility of the task of apportionment of liability between separate injuries and observed that such an undertaking by the Court would result in mere speculation. In the case of the mistaken payment of benefits of a non-last employer insurance carrier, the Court has found that those benefits may be recovered from the last carrier. The Court reasoned that otherwise the later insurer, who is liable for benefits because of the last injurious exposure rule, would be unjustly enriched by the former insurer's payments.

The last employer or insurance carrier is liable in full for any permanent disability resulting from each of the successive injuries, whether the subsequent injury aggravates a preexisting condition or merely combines with the prior injury contributing to the total disability. It is important to note that there is a distinction between actually aggravating a previous condition and merely causing an increase in pain when applying the last injurious exposure rule. Thus, a subsequent employer will only be held liable under the rule if the employee actually suffers an injury to a preexisting condition. A mere increase in pain is not sufficient to establish that the employee suffered an injury while employed by the subsequent employer. Case law supports the position that a subsequent employer will not be held liable for the progression of an injury that occurred while in the employ of the previous employer. The court held that there must be a compensable progression, aggravation or acceleration of an injury to shift liability to the subsequent employer.[18]

When an employee has an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the disease, and the employer's insurance carrier (if any) at the time of that exposure, shall solely be liable for the entire injury without right of contribution from any prior employer or insurer.[19] Tennessee case law has strictly upheld this provision and would include any exposure which "augments the disease to any extent, however slight."[20] This rule can create hardship, but was set up by the legislature so that employees would not wind up fighting against two different employers. It is clear by the statute which employer is liable. **Example:** "An employee may work for a particular employer for twenty (25) years, lose his job, and work for another employer for five (5) hours. If the last employer for five (5) hours created an exposure to the occupational disease, then it would

be liable for the entire disability to the employee. One possible caveat to this liability analysis is that per statutory change in 2011, the opinion of the treating physician is presumed to be correct on the issue of causation.[21] While this statutory change only applies to injuries occurring after June 6, 2011, it has the potential to trump the last injurious injury/exposure rule. Should the treating physician opine an alleged injury after June 6, 2011 is caused solely by prior employment, and not aggravated by current employment, it is possible liability could rest with the prior employer."

C. Does the Employer Receive Credit for Prior Injuries?

With the bar against apportionment between employers or insurance carriers for successive injuries, it cannot be said the law provides any true credit for prior injuries. It remains, however, essential during the course of the claim or lawsuit to investigate the extent to which the employee has suffered from prior injuries and disabilities. Although the employer is still held liable for the entire disability caused by the on-the-job injury, proof of pre-existing health problems should be taken into consideration in the context of causation. Additionally, investigation into preexisting conditions can also lead to the identification of credibility problems on the part of an employee who seeks to deny and/or minimize a preexisting condition. The legislature created the Subsequent Injury Fund (formerly known as the Second Injury Fund) as the primary statutory mechanism to address the needs of employers regarding credit for prior injuries.

D. Subsequent Injury Fund

The Second Injury Fund, now Subsequent Injury and Vocational Recovery Fund, is still found at Tenn. Code Ann. §50-6-208. The Fund was created in an effort to encourage employers to hire workers who have handicaps or other disabilities which effectively impair their competitive position in the labor market. The fund is state-run and managed by the Administrator of the Bureau of Workers' Compensation. It is funded each fiscal year by a portion of the premium tax paid by insurance companies to the State. The law allows employees or employers to bring the Subsequent Injury Fund into a lawsuit, to potentially augment or offset any recovery, respectively.

An injured employee who has previously sustained a permanent physical disability from any cause or origin and thereafter becomes permanently and totally disabled through a subsequent injury may be compensated by the Subsequent Injury Fund for the difference in the amount received for the subsequent injury and the amount to which he would be entitled in order to be compensated for total disability. The employer or the employer's insurance carrier is only required to pay for the disability that would have resulted from the subsequent disability.[22]

Since the physical disability may result from any cause or origin, the prior disability need not have resulted from a prior work injury. Instead, it may have resulted from a congenital condition or an accident unrelated to employment.[23] Recovery under part (a) of the Subsequent Injury Fund statute also requires that the court deem the employee "permanently and totally disabled" by the subsequent injury. Put another way, there is no recovery from the Subsequent Injury Fund under part (a) for cases resulting in permanent partial disability. Thus, where an employee with a preexisting permanent physical impairment is thereafter rendered permanently and totally disabled in a compensable accident, the employer is liable only for the disability that would have resulted from the subsequent injury, without consideration of the first. The Subsequent Injury Fund pays the difference between the amount received by the injured employee from the employer for the second injury and the amount to which he would be entitled in order to be compensated for the permanent total disability. For example, if an employer hires an employee who suffered a back injury in a prior car accident and the employee suffers a work-related injury in which she becomes one hundred percent (100%) disabled, the employer must pay only for the portion of the one hundred percent (100%) disability caused by the compensable injury. The Subsequent Injury Fund would pay the rest. It is up to the trial court to determine the amount of disability caused by the first and second injuries.

The Tennessee Supreme Court has held that it is possible for an employee to be permanently and totally disabled by the combined effects of multiple injuries whose individual disability percentages do not add up to one hundred percent (100%), even if prior injuries have not been aggravated by later injuries.[24] The Court's rationale was that the cumulative effect of the disability caused by multiple injuries may exceed that which would have been caused by either injury independently.

Part (a) also says that the Subsequent Injury Fund does not have to pay anything unless the employer had actual knowledge of the preexisting permanent physical disability prior to the subsequent injury. The reasoning behind this requirement is to encourage employers to hire people with existing disabilities and to give those employers the benefit of reducing their liability by accessing the Second Injury Fund. The Americans with Disabilities Act (ADA) covers employers with more than fifteen (15) employees and affects how the employer may obtain the necessary information with respect to preexisting disabilities. The ADA does not prohibit employers from obtaining information regarding preexisting injuries; however, it does govern when and how the employer may obtain such information. No questions regarding disabilities may be asked on the employment application. However, such inquiries may be made after a conditional offer of employment has been made to the potential employee, contingent upon satisfactory completion by the employee of a medical examination if all employees in the same job category are required to take the same medical examination. While, pursuant to the ADA, this information must be kept confidential, the ADA does not prevent the use of information gained on the post-conditional offer medical examination with respect to the Subsequent Injury Fund.

The knowledge required under this section may be obtained after the initial employment, but prior to the subsequent injury, as long as the employee is retained in employment after the employer's procurement of such information. The employer is not required to be fully aware of all underlying medical causes of the disability, but must at least be aware that the disability exists.

If the disability is not one that a layman would label as obvious (for example, where an individual is missing a limb), the presumption is the employer was unaware of the preexisting disability when hiring the employee. As such, the employer bears the burden of proving knowledge of the condition before the employee sustained the subsequent injury in order for the Second Injury Fund to be liable for the employee's compensable injury.

Case law further indicates that the Tennessee Supreme Court will place a greater burden on employers to prove that they had actual knowledge of a previous disability. Section 50-6-208(a)(2) of the Tennessee Code Annotated states that "the employer must establish that the employer had actual knowledge of the permanent and preexisting disability at the time that the employee was hired or at the time that the employee was retained in employment after the employer acquired such knowledge, but in all cases prior to the subsequent injury." However, the Supreme Court continues to hold to the premise that "the purpose behind the creation of the Second Injury Fund was to encourage employers to hire individuals with permanent physical disabilities by limiting the employer's liability in the event of a second injury."[25] Accordingly, in most cases the Court has found for the employer on the question of prior actual knowledge.

To give an example of a part (a) claim, an employee with two (2) prior workers' compensation injuries was rendered permanently and totally disabled under Section 50- 6-208(a) of the Tennessee Code Annotated by a third, progressive injury to her shoulder and arm. Additionally, employee suffered from high blood pressure and cervical arthritis. The employee was found permanently and totally disabled. Due to the sum of her prior conditions, the Chancellor properly allocated ten percent (10%) permanent total disability to the employer and the remaining ninety percent (90%) to the Second Injury Fund.[26]

In summary, to recover from the Subsequent Injury Fund under Section 50-6-208(a) of the Tennessee Code Annotated, the employer must prove that:

1) The employee had a previous permanent disability from any cause;
2) The employee is presently permanently and totally disabled; and
3) The employer had actual knowledge of the preexisting disability at the time the employee was hired or that the employee was retained in employment after the employer found out about the prior disability.

Additionally, pursuant to a new program, an employee may request vocational recovery assistance from the Subsequent Injury and Vocational Recovery Fund. An employee is eligible for the program if at the time the initial compensation period ends the employee did not return to work with any employer because of a work injury or has returned to work at a wage or salary that is less than the pre-injury wage or salary. The employee may apply for the program by filing a request for vocational recovery assistance within ninety (90) days of the date of final payment of compensation. Vocational recovery assistance includes vocational assessment, employment training, GED classes, and education through a public Tennessee community college, university or college. The total amount that can be paid on behalf of an eligible employee is $5,000.00 per year and up to $20,000.00 for all years combined. The new program is available to employees injured on or after July 1, 2017.

Endnotes for Chapter IX

1 Trosper v. Armstrong Wood Products, 273 S.W.3d 598,604 (Tenn. 2008).
2 Townsend v. State, 826 S.W.2d 434, 436 (Tenn. 1992).
3 Thomas v. Aetna Life & Casualty Co., 812 S.W.2d 278, 284 (Tenn. 1991).
4 Arnold v. Firestone Tire and Rubber Co., 686 S.W.2d 65, 67 (Tenn. 1984).
5 Clark v. Nashville Machine Elevator Co. Inc., 129 S.W.3d 42 (Tenn. 2004).
6 Williams v. Delvan Delta, Inc., 753 S.W.2d 344 (Tenn. 1988).
7 Phillips v. A&H Const. Co., Inc., 134 S.W.3d 145 (Tenn. 2004).
8 McCann Steel Co. v. Carney, 237 S.W.2d 942 (Tenn. 1951).
9 Tenn. Code Ann. § 50-6-102(12) (2011).
10 Tenn. Code Ann. § 50-6-102(14)(A) (2013).
11 Tenn. Code Ann. § 50-6-116.
12 Tenn. Code Ann. § 50-6-102(14)(A).
13 Tenn. Code Ann. § 50-6-102(14)(C)-(D).
14 Miller v Lowes Home Center, Inc., 2015 WC 6446638 (Tenn. Workers' Comp. Appeals Bd. 2015).
15 *See* Tenn. Code Ann. § 50-6-116.
16 Tenn. Code Ann. § 50-6-102(14).
17 *Id*. at (14)(A).
18 McCormick v. Snappy Car Rentals, Inc., 806 S.W.2d 527, 529 (Tenn. 1991).
19 *Id*.
20 Crew v. First Source Furniture Group, 259 S.W.3d 656 (Tenn. 2008).
21 Tenn. Code Ann. § 50-6-304.
22 Oman Construction Co. Inc. v. Bray, 583 S.W.2d 303, 306 (Tenn. 1979).
23 Tenn. Code Ann. § 50-6-102(14)(E).
24 Tenn. Code Ann. § 50-6-208(a)(1).
25 *See, e.g.* Bomely v. Mid-America Corp., 970 S.W.2d 929 (Tenn. 1998).
26 Watt v. Lumberman's Mut. Ins. Co., 62 S.W.3d 123 (Tenn. 2001).

X.

OCCUPATIONAL DISEASES

In Tennessee, occupational diseases are all diseases, including diseases of the heart, lung, and hypertension, arising primarily out of and in the course of employment that causes death, disablement, or the need for medical treatment of the employee.[1] The term disease is not defined in the statute. One should look to the diagnosis of the particular doctor to determine whether or not the condition is, in fact, a disease. As with all injuries, an occupational disease shall be deemed to arise primarily out of the employment only if shown by a preponderance of the evidence that the employment contributed more than fifty percent (50%) in causing the disease, considering all causes.[2]

Black lung disease (coal miner's pneumoconiosis) does not qualify as an occupational disease under the Tennessee Workers' Compensation Law, but Tennessee has adopted the standards and criteria in the Federal Coal Miners' Health & Safety Act of 1969 and the Black Lung Benefits Act of 1972.[3] Generally, all of the criteria for entitlement and the available benefits under the Black Lung Benefits Act have been incorporated by reference into the Tennessee Workers' Compenation Law. However, the process for seeking benefits remains governed by the Tennessee Workers' Compensation Law and the Tennessee Bureau of Workers' Compensation's rules.

A. Notice

The notice requirement does not apply to claims for total disability or death due to asbestos related diseases or claims for black lung benefits.[4]

B. Statute of Limitations

A Petition for Benefit Determination alleging an occupational disease claim must be filed with the Tennessee Bureau of Workers' Compensation within one (1) year of the incapacity for work or death resulting from an occupational disease.[5] If the employee's claim for benefits is barred by the statute of limitations, then the death claim is also barred even if it is filed within one (1) year of the date of death. A claim for benefits related to coal workers' pneumoconiosis must be filed within three (3) years of the discovery of total disability or date of death.[6]

The beginning of the incapacity for work period is what would be construed as the happening of the injury. Most cases go further and hold that simple incapacity for work is not enough to start the beginning of the running of the statute of limitations. In these cases, the employee must also have knowledge of a disabling work related disease. Consequently, although an employee may know about a particular disease, the one (1) year statute of limitations to file a Petition for Benefit Determination does

not start until the employee becomes disabled from that disease and the employee knows or reasonably should know that the disease is work related.[7] Therefore, if an x-ray shows a small amount of asbestosis in the employee's lungs, the employee is not required to file a Petition for Benefit Determination until the employee becomes disabled from that asbestosis, which could be many years later.[8]

C. Waivers

When an employee is found to be affected by or susceptible to a specific occupational disease, the employee may, subject to the Tennessee Bureau of Workers' Compensation, be permitted to waive in writing compensation for any aggravation of the employee's condition that may result from the employee's working or continuing to work in the same or similar occupation for the same employer or for another employer.[9] Furthermore, when an employee has a prior history of heart disease, heart attack, or coronary failure or occlusion, the employee may be permitted to waive in writing compensation from the employer for claims growing out of an aggravation or repetition of the condition.[10] In that case, the waiver must be evidenced by filing with the Bureau of Workers' Compensation a written document with an attached copy of a medical statement giving the prior history of the condition. Once the waiver has been filed and accepted by the Bureau, all claims for workers' compensation benefits growing out of an aggravation or repetition of the condition by the employee or the employee's dependents shall be barred.

D. Which employer is liable?

As in gradual injury cases, when an employee has an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the disease shall alone be liable for workers' compensation benefits.[11] If the employer is insured, then the insurance carrier at the time of the last injurious exposure will solely be liable for benefits. There is no right of contribution from any prior employer or insurance carrier.

Endnotes for Chapter X

1 Tenn. Code Ann. § 50-6-102(14).
2 Tenn. Code Ann. § 50-6-102(B).
3 Tenn. Code Ann. § 50-6-302.
4 Tenn. Code Ann. § 50-6-305(b).
5 Tenn. Code Ann. § 50-6-203, § 50-6-306.
6 Tenn. Code Ann. § 50-6-306(b).
7 Tenn. Code Ann. § 50-6-302.
8 Tenn. Code Ann. § 50-6-305. This provision does not apply to claims for total disability or death resulting from an asbestos-related disease or Black Lung Disease.
9 Tenn. Code Ann. § 50-6-307 (a)(1).
10 Tenn. Code Ann. § 50-6-307(b).
11 Tenn. Code Ann. § 50-6-304.

XI.

LAWYER INVOLVEMENT

A. Communication with Defense Counsel

While the employee's attorney may be involved early in a workers' compensation claim, counsel for the employer is often not retained until the request for a Petition for Benefits (PBD) or the Dispute Certification Notice has been filed. Therefore, the employee's attorney has the opportunity to talk with a client concerning the client's activities and medical complaints so as to maximize the value of the claim. The employee may decide not to work and to return frequently to the doctor with numerous complaints. The principle defense an employer has against such employees and their attorneys is to communicate fully with defense counsel and the medical providers.

Employers should encourage their employees to utilize the services of the Tennessee Bureau of Workers' Compensation Ombudsman Program. The Ombudsman can answer questions the employee has and the employee can thereby avoid the fee associated with hiring an attorney to answer the same questions. Employers can also use this toll free service for assistance in handling workers' compensation injury claims.

The first contact between the employer and defense counsel usually comes when the Petition for Benefit Determination (PBD) has been filed. Defense counsel notifies the employer of its representation and discusses the factual circumstances surrounding the injury. It is essential that the employer give its attorney the complete personnel record concerning the employee, including the employee's work history, medical history, payroll history, disciplinary record, special skills and vocational training, and all other pertinent information.

After gathering all claim and employment information, defense counsel prepares a response to the employee's PBD based upon the information provided and sends the response to the Bureau of Workers' Compensation mediator assigned to the case. The PBD may request the Bureau order benefits, or it may simply ask for a mediation to discuss settlement of the claim. If the PBD is requesting a mediation, the defense attorney will provide available dates to the Bureau.

If the issues in the PBD are not completely resolved, then the PBD is filed in Court. After the claim is filed in Court, defense counsel may also contact the employer to assist in responding to Interrogatories and Request for Production of Documents. Both Interrogatories and Requests for Production of Documents are legally permissible means by which either party can obtain information from the other. While providing this information is usually a difficult and tedious task for the employer, it is much less expensive than alternative means. Communication with defense counsel is essential in preparing and finalizing the employer's responses. If critical information is left out at this stage, then the employer may be precluded from using that information later at trial.

At some point in the proceedings, it may become necessary for an employer's representative to appear live to answer, under oath, a series of questions from the employee's attorney. This process is known as a deposition and defense counsel will typically meet with the employer's representative in advance to explain the process more fully. In addition, an employer's representative will certainly be asked to attend an Expedited Hearing and a Final Compensation Hearing and to be prepared to testify at that time. Keep in mind that the need for complete communication between the employer and defense counsel continues throughout litigation and up to the time of any hearings. Defense counsel should be notified immediately if the employer finds that the employee has returned to work elsewhere, been injured in another accident or a fight, been arrested, or has been seen engaged in vigorous physical activities which exceed permanent work restrictions.

B. Surveillance

An important resource for defending a workers' compensation case is simple word-of-mouth communication regarding the employee's activities. If an injured employee is off work and the employer receives information that the employee is working or physically active, the employer should relay this information to its attorney as soon as possible. Depending on the situation, the insurance company may hire an investigator to conduct surveillance on the employee. Surveillance can be expensive, and certainly should not be used in every case. However, under certain circumstances, testimony from an investigator or even videotape of the employee's physical activities (such as waterskiing, moving furniture, or working at another job) can ruin the credibility of an employee who testifies that the injury has caused a sedentary lifestyle.

There is some uncertainty with regard to a statutory privilege called the attorney-private investigator privilege.[1] This privilege allows the attorney to withhold information regarding surveillance if the attorney is the one who hired the private investigator. This privilege has not been addressed by the courts; however, it is clear that a court may force the employer to produce the results of surveillance under the theory that the person doing the surveillance is a fact witness. This is true even if the surveillance substantiates or verifies the employee's claimed injury. For this reason, it is suggested that you consult your attorney before performing surveillance.

C. Where a Workers' Compensation Claim may be Filed.

1. Courts With Jurisdiction. By statute in Tennessee, the employee or the employer may file a PBD with the Bureau. The PBD is filed with any Bureau office in Tennessee and can be assigned to any Mediating Specialist throughout Tennessee. However, if a DCN is issued and filed in Court, then it is assigned to a judge responsible for hearing claims for the county where the employee lived at the time of the accident.

To reopen a claim to seek the increased benefits, the employee must first file a PBD within one (1) year of the date on which the Initial Compensation Period expired.[2] If the parties cannot reach an agreement regarding additional permanent partial disability benefits a mediation, then the PBD will be filed in Court for a hearing with a judge.

2. Settlement. When the parties agree to a settlement, the settlement hearing occurs in the Court where the PBD was filed or in the Court responsible for hearing claims for the county where the employee lived when the work accident occurred if a PBD was not previously filed. The Court strongly prefers in person attendance by the employee at the settlement hearing except in very rare circumstances. For example, when an employee lives outside of Tennessee or where an employee travels with their job, a judge could allow the employee to attend a settlement hearing by phone.

If the employee is permanently and totally disabled, future medical benefits may not be settled or compromised at any time.[3] For injuries on or after July 1, 2014 the parties free to compromise and settle the right to future medical benefits. The parties are still prohibited from compromising and settling future medical benefits in cases where the employee is determined to be permanently totally disabled.

Whenever there is a dispute between the parties as to whether or not the claim is compensable, the parties may settle the disputed claim without regard to whether the employee is receiving substantially the benefits provided by the Workers' Compensation Law. There is not a minimum or maximum amount allowed for settlement of claims in this manner.

Once approved, settlements are filed with the Court Clerk. Settlements must be accompanied by a Workers' Compensation Statistical Data Form (SD- 2). It is important that the SD-2 be fully completed.[4]

An employer/insurer should consult an attorney to discuss and protect Medicare's interests when settling any workers' compensation case involving Medicare set aside agreements/submissions. A critical issue for settlement of cases involving Medicare will be the issue of future medical benefits. It may be difficult under the 2013 Act to close future medicals on certain types of injuries. However, there is a possibility that the parties could settle future medical benefits if a set aside for Medicare is agreed on by the parties since technically this would not close the medicals, but would set money aside to cover future medical bills. Once that money is exhausted, Medicare would be liable for all future medical bills.

D. Appeals

Appeals of orders issued by the Court of Workers' Compensation Claims are made directly to the Workers' Compensation Appeals Board and, in some instances, to the Tennessee Supreme Court. If appealing an expedited hearing order, the appeal must be filed within seven business days after the filing of the order.[5] In this instance, appeal is exclusively to the Appeals Board. After a ruling by the Appeals Board in an expedited hearing appeal, there is not another appeal available.

A party may appeal a compensation hearing order to the Appeals Board or directly to the Tennessee Supreme Court. If the appeal is initially filed with the Appeals Board, the Appeals Board's decision may be appealed to the Tennessee Supreme Court. An appeal of a compensation hearing order to the Appeals Board must be filed within thirty calendar days after the issuance of the order. An appeal to the Tennessee Supreme Court must be filed within thirty days of the order's becoming final, which is typically either thirty days after the issuance of the Appeals Board's decision or, if an appeal was not made to the Appeal Board, within sixty days of the issuance of the compensation hearing order.[6]

The Tennessee Supreme Court may refer workers' compensation appeals to a special appellate panel consisting of three judges designated by the Chief Justice of the Tennessee Supreme Court. At least two of the three judges shall be members of the Supreme Court or retired judges. Cases referred to this special panel are prepared and argued as if being heard by the full Supreme Court. This panel's findings are final within thirty (30) days unless any member of the Supreme Court files a request that the entire Supreme Court hear the case or any party files a similar motion within fifteen (15) days of the panel's decision. In the event a party files a motion requesting the entire Supreme Court to hear an appeal, the judgment is not final until the full Supreme Court denies the motion or issues an opinion. The full Supreme Court will only review the trial record and briefs filed with the workers' compensation appeals panel except when the full Supreme Court decides to order further briefing and/or order the parties to appear at oral argument.

Endnotes for Chapter XI

1 Tenn. Code Ann. § 24-1-209.
2 Tenn. Code Ann. § 50-6-207(3)(D).
3 Tenn. Code Ann. § 50-6-240(d).
4 Tenn. Code Ann. § 50-6-217(2)(A).
5 Tenn. Code Ann. § 50-6-225, 50-6-217(2)(B).
6 Tenn. Code Ann. § 50-6-225(c).

XII.

EMPLOYMENT, EMPLOYEE BENEFITS, AND SUBROGATION ISSUES RESULTING FROM INJURY

A. Deciding Whether or Not to Return an Injured Employee to Work

Tennessee has long been an employment at will state. Employees in Tennessee working without an employment contract generally have been subject to termination "for good cause, for no cause, or even for cause morally wrong."[1] Exceptions to the employment at will doctrine include statutes limiting an employer's right to discharge employees due to race, religion, sex, age, physical or mental condition, because they report safety violations, because they miss work to perform jury duty, or for refusal to acquiesce to illegal activity in the workplace.[2]

The court has also limited the employment at will doctrine in several areas, one of which is the area of workers' compensation. The Tennessee Supreme Court has specifically held that an employer cannot discharge an employee solely because the employee seeks workers' compensation benefits.[3] The Court held that discharging an employee merely because that employee sought workers' compensation benefits was a device intended to relieve employers of their obligation to pay workers' compensation benefits and was in violation of Section 50-1-304 of the Tennessee Code Annotated. That statute states that if an employee is wrongfully terminated, the employee may bring an action for retaliatory discharge.[4]

The Tennessee Supreme Court has held that to successfully maintain a retaliatory discharge cause of action for filing a workers' compensation claim, an employee must prove the following four (4) elements:

1) The worker's status as an employee of the defendant;
2) The worker's request for workers' compensation benefits;
3) The employer's discharge of the worker; and
4) Whether the request for workers' compensation benefits is a substantial factor in motivating the employee's discharge.[5]

Once the employee proves a link between the claim for benefits and the employee's discharge, the burden shifts to the employer to show a legitimate non-retaliatory reason for the discharge. Legitimate reasons might include a showing of the employee's shortcomings, such as excessive tardiness or absenteeism, lying, stealing, or even general business conditions, such as layoffs involving other employees. The Court has held that an employee discharged "pursuant to a neutral policy of the [employer] to terminate employees who have been absent for an extended period of time, regardless of the reason" is a legitimate reason for termination.[6]

An employer may be liable to an employee for other acts or events that are outside the area of workers' compensation, including those under the ADA. The employer may also be liable to an employee for other forms of invidious discrimination, such as race, sex, religion, and age. The forms of discrimination are governed by Title VII of the Civil Rights Act of 1983 and the Civil Rights Act of 1991.

An employer may also be liable to an employee for its intentional acts committed against that employee. Tennessee has recognized a common law cause of action against an employer for intentional acts committed by that employer. A common law cause of action is not subject to any caps on dollar liability and the employer retains its normal defenses in tort, unlike in claims made under the Tennessee Workers' Compensation Law. Intentional acts include assault, battery, false imprisonment, defamation, and intentional infliction of emotional distress. The Tennessee Supreme Court, however, has stressed that the employer must have actual intent in order to be liable for these torts.

The employer should consult a labor and employment attorney for advice on particular fact situations involving these return to work considerations.

B. What Happens When Major Medical Benefits or Disability Benefits Were Paid Under a Separate Policy? In some cases, employers are unaware that the employee is making a claim for workers' compensation benefits until months after the accident took place. In those situations, the employer will generally file the employee's claim with the major medical carrier and with any short-term disability benefits carrier available to the employee. The employer may also simply continue paying the employee's wages or salary. Once payments are made, the question arises as to whether or not the workers' compensation carrier can take credit for those payments.

An employer may choose to compensate an injured employee at the employee's regular wages or salary during the period of temporary disability. In such a case, the payments shall not result in an employee's receiving less than the employee would otherwise receive for temporary disability benefits. When an employer voluntarily pays an employee's regular wages or salary during the period of temporary total disability and the employee is later awarded temporary total disability benefits for that time period, the carrier is entitled to a credit against the temporary total disability award for the regular wages.[7] However, if the credit is more than the temporary total disability award, the remainder cannot be credited against the permanent disability award.

Employers and insurance carriers can also take a credit against workers' compensation benefits owed to an injured employee for prior payments made to or on behalf of the injured employee by other parties. These credits are circumstance specific and include the following: payments made under an employer funded disability plan, recoveries against liable third parties, old age social security benefits, and agreements with employees to provide payments greater than the schedule provides.

1. Employer Funded Disability Plan. Tennessee Workers' Compensation Law allows employers to take a credit against workers' compensation disability benefits for any payments made to an employee under an employer-funded disability plan for the same injury, provided that the disability plan permits such an offset.[8] The employer's disability plan must explicitly provide for an offset of such payments against workers' compensation liability and be entirely funded by the employer.[9] Tennessee courts have also allowed this offset to extend to major medical payments as well, even though the statutory language addresses only disability plans.[10]

The offset is allowed against temporary partial, temporary total disability, permanent partial, and permanent total disability benefits. The offset cannot result in an employee's receiving less than what the total amount of workers' compensation benefits the employee would otherwise receive. An employer may lose the ability to offset disability payments against a temporary total disability award if it knowingly, willfully, and intentionally causes a medical or wage loss claim to be paid under a health or disability plan knowing that the claim arose out of a compensable work-related injury and should have been submitted under its workers' compensation insurance carrier.[11]

2. The Subrogation Lien. In cases where a person other than the employer is the cause of the employee's work place injury, the employee has a right to seek damages from the liable third party, in addition to collecting his workers' compensation benefits. However, the Tennessee Workers' Compensation Law also grants employers a subrogation lien against any recovery the employee obtains from the third party, up to the amount of workers' compensation benefits the employer has paid to the injured employee.[12]

The employer's subrogation lien arises automatically. The lien does not depend on any involvement of the employer in any manner. Nor does the lien depend on the employee's being made whole in the third party action.[13] Tennessee courts have prevented employees from circumventing an employer's subrogation lien by ensuring that it does not matter whether the third party action is settled in or out of court, or whether the employer's rights are purportedly preserved by the employee's settlement agreement with the third party.

Employers should be aware of a few potential pitfalls. First, an employer may lose any potential credit for future medical payments paid after the employee settles the tort case if these expenses are unknown or incalculable at the time of settlement. [14] The employee is not required to hold the settlement proceeds from the tort case in order to reimburse the employer for future medical payments. The same may hold true for indemnity benefits, such as permanent total disability benefits, paid after the tort case is settled. Thus, the best practice may be settling the workers' compensation case prior to the employee's settling the tort case.

Another pitfall for employers is the issue of attorney's fees in the third party action. Essentially, employers must pay a pro rata share of the employee's attorney's fees in the employee's third party action, unless employers provide their own legal assistance to the employee, regardless of whether the employer actually participates in

the third party lawsuit.[15] The employee's attorney has a duty to protect the subrogation interest of the employer, which is why the employer is required to pay for that portion of the attorney fees.

When the employer does not hire an attorney for the lawsuit against the third party action and does not voluntarily pay the employee's attorney, the employer will likely be required by the court to pay the same fee as called for in the employee's contract with the attorney, assuming the fee is reasonable.[16] If the employer disagrees with the reasonableness of the fee, a hearing should be requested.[17] The attorney seeking the fee will not be required to put on proof to support the fee in the first instance but will be required to substantiate the reasonableness of the fee.

An employer's subrogation lien may be extinguished by the statute of limitations. The employee has one (1) year to file a lawsuit against a third party tortfeasor.[18] If the employee fails to bring the claim within that period, then the right to bring the claim is assigned to the employer, who has an additional six (6) months to file a lawsuit in the employer's name, the name of the employee, or even in the name of a surviving beneficiary.[19] Failure to do so will result in the claim's being barred.

Also, if an employee timely files a lawsuit and then voluntarily dismisses the case and does not timely refile the case, then the employer does not receive the six month extension within which to file a lawsuit. In that case, the employer loses the ability to recover the subrogation lien. The employer may be able to avoid this consequence by intervening in the original tort case.

Finally, employers should be aware that they have no subrogation rights against an employee's recovery under an uninsured motorist policy. The employer's subrogation right is limited to cases where the employee can bring a third party claim based on a legal liability. An employee's recovery under an uninsured motorist policy involves a contractual liability.[20]

The following examples illustrate how the subrogation lien works:

Example 1: Employee is rear-ended in an automobile accident by Vehicle A. Employee collects workers' compensation benefits of $25,000.00 and the employer agrees to pay the employee's future medical bills related to the accident. Employee collects $40,000.00 from the driver of Vehicle A. Employer is entitled to receive from the employee $25,000.00, which it has already paid out. However, Employer does not get a credit for the future medical bills it will pay. Employer has to pay Employee's future medical bills regardless of what the employee receives from the driver of Vehicle A.[21]

Example 2: Employer has a $30,000.00 subrogation lien for amounts paid to the employee. Employer hires no lawyer. Employee hires lawyer on a one-third (1/3) contingency fee basis to represent Employee in the third party action. The third party action yields $60,000.00 judgment. Attorney for Employee is entitled to a one-third fee from the $30,000.00 subrogation money to be reimbursed to Employer.

Example 3: Employer has a $30,000.00 subrogation lien for amounts paid to Employee. Employer hires an attorney to represent it in recovering its subrogation money. Employee hires an attorney to prosecute the case against the third party tort-feasor. Judgment against the third party is for $60,000.00. Attorney's fee will be apportioned between the two (2) attorneys based upon the amount of work done by each in prosecuting the action. If this is not agreed upon between the attorneys, then a court will apportion the fee in proportion to services rendered.

C. Offset for Social Security Benefits. Workers' compensation payments can also be reduced by the amount of any old age social security benefits attributable to employer contributions the employee receives.[22] By statute, this offset applies to permanent total disability. However, the courts have also applied the offset to permanent partial disability benefits.[23] This offset does not apply to death benefits.

The statutory language provides that workers' compensation benefits shall be reduced by the amount of any old age insurance benefit payments attributable to employer contributions, which the employee may receive under the Social Security Act. Courts have construed that language to mean that an employer can get a credit equal to one half of all old age Social Security benefits received by the employee, not just the contribution of that particular employer.[24] Keep in mind when calculating this offset that Social Security benefits are paid once a month, but that total is not simply divided by four (4) weeks to calculate the weekly setoff. Since there are twelve (12) months in a year, the monthly Social Security benefit must be multiplied by twelve (12), then divided by fifty-two (52) weeks to calculate the weekly Social Security benefit. The actual offset is 50% of the weekly Social Security benefit.

D. Payment of Wages in Lieu of Temporary Disability Benefits. Rather than paying temporary disability benefits, an employer may pay the injured employee's regular wages or salary during the employee's period of temporary total and temporary partial disability. However, the payments shall not result in an employee's receiving less than the employee would otherwise receive for temporary disability benefits.[25]

A court may not require an employer to pay any temporary disability benefits, in addition to the employee's regular wages or salary. While the wages paid shall be credited towards any temporary disability benefits to which the employee is entitled, the wages shall not be credited against any award for permanent disability.[26]

Endnotes for Chapter XII

1 *See* Watson v. Cleveland Chair Co., 789 S.W.2d 538, 540 (Tenn. 1989); Payne v. Western & ATL R.R. Co., 81 Tenn. 507, 519-20 (1984); Anderson v. Standard Register Co., 857 S.W.2d 555 (Tenn. 1993).

2 Tenn. Code Ann. § 4-21-401; Tenn. Code Ann. § 50-3-106(7); Tenn. Code Ann. § 22-4-106(d)(i); Tenn. Code Ann. § 50-1-304(a)(3).

3 Clanton v. Cain-Sloan Co., 677 S.W.2d 441, 445 (Tenn. 1984); *see also* Sasser v. Averitt Express, Inc., 839 S.W.2d 422 (Tenn. Ct. App. 1992).

4 Tenn. Code Ann. § 50-1-304.

5 Anderson v. Standard Register Co., 857 S.W.2d 555, 558 (Tenn. 1993).

6 *Id*. at 556 *See also* Johnson v. St. Francis Hosp., Inc., 759 S.W.2d 925 (Tenn. Ct. App. 1988).

7 Tenn. Code. Ann. § 50-6-207(1)(B)(ii)

8 Tenn. Code Ann. § 50-6-114(b).

9 Simpson v. Frontier Cmty. Credit Union, 810 S.W.2d 147, 152 (Tenn. 1991); Stanley v. South Central Bell, 1998 WL 170132 (April 14, 1998).

10 Allen v. Consolidated Aluminum Corp., 688 S.W.2d 64, 67 (Tenn. 1985); Stavropoulos v. Saturn Corp., 1999 WL 194152 (April 9, 1999) (holding, "*any payment* to an employee under an employer funded plan which permits an offset and which involves the same injury . . . may be off-set from workers' compensation benefits.") (emphasis in original).

11 Tenn. Code Ann. § 50-6-128.

12 Tenn. Code Ann. § 50-6-112(c)(1).

13 Castleman v. Ross Engineering, Inc., 958 S.W.2d 720 (Tenn. 1997).

14 Graves v. Cocke County, 24 S.W.3d 285 (Tenn. 2000).

15 Tenn. Code Ann. § 50-6-112(b).

16 *Id*.

17 *Id*.

18 Tenn. Code Ann. § 50-6-112(d)(1).

19 Tenn. Code Ann. § 50-6-112(d)(2).

20 Hudson v. Hudson Municipal Contractors, Inc., 898 S.W.2d 187 (Tenn. 1995).

21 Graves v. Cocke County, 24 S.W.3d 285, 288 (Tenn. 2000).

22 Tenn. Code Ann. § 50-6-207(4)(A)(i).

23 Vogel v. Wells Fargo Guard Services, 937 S.W.2d 856, 862 (Tenn. 1996); McCoy v. T.T.C. Illinois, Inc., 14 S.W.3d 734, 737 (Tenn. 2000).

24 McCoy v. T.T.C., Illinois, Inc., 14 S.W.3d 734, 738 (Tenn. 2000).

25 Tenn. Code Ann. § 50-6-207(1)(B)(i).

26 Tenn. Code Ann. § 50-6-207(1)(B)(i).

XIII.

PENALTIES TO EMPLOYERS

It is important to remember that the Tennessee Workers' Compensation Law was created as a compromise between the competing interests of the employer and its employees. It provides employees easier access to benefits for injuries because it does not allow employers to use the defenses of contributory negligence (now comparative negligence) or assumption of the risk in defending workers' compensation claims brought by employees. The law also limits the employer's liability for a workers' compensation injury. In the interest of enforcing the employee's rights and the employer's obligations, There is a system of penalties for actions or inactions by employers in processing and reporting workers' compensation claims brought by their employees.

A. Fraud

Fraud under the Tennessee Workers' Compensation Law is covered in more detail in the next chapter. By way of introduction, however, employers are subject to substantial penalties for knowingly making false or fraudulent statements for the purpose of premium avoid-ance or denying/discouraging an injured worker from claiming benefits. An employer should never fraudulently try to deny an employee the statutory rights given to Tennessee employees under the Tennessee Workers' Compensation Law.

B. Turning in a Workers' Compensation Claim under the Health or Sickness and Accident Policy

An employer is subject to a $500.00 fine and the loss of any offset against sickness and accident benefits if the employer "knowingly, willfully, and intentionally causes a medical or wage loss claim to be paid under health or sickness and accident insurance, or fails to provide reasonable and necessary medical treatment, including a failure to reimburse when the employer knew that the claim arose out of a compensable work-related injury and should have been submitted under its workers' compensation insurance coverage. . .".[1] There are two (2) requirements that must be met for imposition of this fine:

1) The claim must have arisen from a compensable injury; and
2) The fine cannot be imposed unless there is a knowing, willful, and intentional filing of a workers' compensation claim with the improper carrier.[2]

There must be a genuine dispute as to whether or not the injury occurred within the course and scope of employment for the employer in order for the employer to successfully argue that turning the claim in to its major medical or disability carrier was appropriate. An inadvertent filing with the major medical carrier or a filing generated by the employee's failure to report the claim as a work-related injury should not result in the imposition of a $500.00 fine on the employer. Similarly, if the employer has a valid reason for challenging the compensability of the claim, it arguably is not a violation of the statute to allow the employee to file the claim under the major medical or sickness and accident insurance policy. The intent of this code provision is to prevent an employer from filing a valid workers' compensation claim under another category of insurance in order to reduce its workers' compensation claims experience and therefore reduce its premiums.

It is critical that an employer properly file claims with the appropriate insurance carrier. If the employer feels as though the employee was not injured on the job or that the employer has some other valid defense to the claim, the employer should still notify its insurance carrier and the Bureau of Workers' Compensation that the employee is making a claim that the injury is work-related.

C. Failure to Maintain Workers' Compensation Insurance

Every employer under and affected by the Tennessee Workers' Compensation Law shall either procure workers' compensation insurance or be self-insured.[3] Proof of compliance shall be filed with the Bureau of Workers' Compensation within thirty (30) days after procurement or renewal of suitable workers' compensation insurance or qualification as a self-insurer.[4]

Failure to procure insurance or qualify as a self-insurer has significant consequences. A noncompliant employer faces significant financial penalties and other sanctions. Additionally, the employer is liable to an injured employee either for compensation as provided in the workers' compensation law or for damages to be recovered as if the workers' compensation law had not been enacted.[5] The employee may elect whether to proceed under the workers' compensation law or tort.[6] If the employee proceeds in tort, the employer may not defend the action on the grounds that the employee was negligent, that the injury was caused by negligence of a coworker, or that the employee had assumed the risk of the injury.[7]

D. Bureau of Workers' Compensation Penalties[8]

These penalties are discussed in more detail below. All penalties collected by the Bureau from an employer for failure to provide workers' compensation coverage or failure to qualify as a self insurer shall be paid into the uninsured employers' fund. All other penalties, except for failure to pay temporary total disability, shall become a part of the Bureau of Workers' Compensation to offset the cost of administering the

workers' compensation law. In general, the penalties range from $50-$5,000 at the discretion of the Penalty Division of the Bureau of Workers' Compensation. The exceptions to this general penalty range are listed below.

1. Penalties for Failure to Timely Pay Temporary Total Disability. The court is empowered to assess a penalty against an employer or insurer who fails to pay, or untimely pays, temporary disability benefits within twenty (20) days after the employer has knowledge of any disability that would qualify for benefits. The penalty is up to the discretion of the court and shall be an amount equal to 25% of the amount of unpaid benefits. If such a penalty is assessed on temporary benefits, then it is paid directly to the employee.

Prior to assessing a penalty, the court must issue a request to the employer or insurer to provide documentation as to why the penalty should not be assessed. Should the court determine that the employer or insurer failed to pay temporary benefits as required, the court must issue an order that assesses the penalty in a specific dollar amount to be paid directly to the employee. If the employer or insurer fails to comply with that Order within fifteen (15), then the employer or insurer will be subject to additional severe penalties.

The 25% penalty is in addition to other penalties that may be assessed for failure to pay temporary disability benefits. The employer or insurer may be referred for additional penalties up to $5,000.00, which are assessed by the Bureau of Workers' Compensation. The additional penalties are paid to the Bureau to offset the costs of administering the workers' compensation law.

2. Non-Compliance with an Order of a Court. Failure to comply with an order or judgment within the time established by the court may result in penalty up to $5,000.00. If the order or judgment is appealed, then the party subject to the order has five (5) business days in which to comply with the order to avoid a penalty.

Endnotes for Chapter XIII

1 Tenn. Code Ann. § 50-6-128.
2 *Id*.
3 Tenn. Code Ann. § 50-6-405.
4 Tenn. Code Ann. § 50-6-405(a).
5 Tenn. Code Ann. § 50-6-405(b).
6 *Id*.
7 *Id*.
8 Rules of TN Dep't. of Labor and Workforce 0800-02-24

XIV.

WORKERS' COMPENSATION FRAUD

Years ago, the Tennessee Legislature enacted the Workers' Compensation Fraud Act.[1] As of July 1, 2003, all workers' compensation fraud referrals should be made directly to the District Attorney's office for the county in which the alleged fraud occurred and/or the Tennessee Department of Commerce and Insurance, depending upon the type of fraud involved. The Workers' Compensation Fraud Act covers all types of fraud claims, including employee or benefits fraud, premium avoidance fraud by employers, and fraud perpetrated by doctors, lawyers, chiropractors, and insurance agents or companies. It is important to point out that the State of Tennessee no longer has a Workers' Compensation Fraud Unit.

Tennessee employers should know that the workers' compensation defense attorney retained to represent them will need to conduct a complete and thorough investigation of the potential fraud and then try to persuade the District Attorney's office for the county in which the alleged fraud occurred to pursue an action. Employers who have valid reasons to suspect that an employee/injured worker is committing fraud should report the fraudulent act directly to the District Attorney. The applicable District Attorney may be located within the Tennessee District Attorneys Directory found at www.tndagc.com.

A. Elements

Basically, the statute provides two (2) causes of action regarding workers' compensation fraud: a criminal action for a fraudulent insurance act and a civil action for either a fraudulent insurance act or an unlawful insurance act. The key distinction between the types of prohibited conduct is that a fraudulent insurance act requires a knowing intent to defraud for the purpose of depriving another of property or for pecuniary gain, whereas an unlawful insurance act requires only intent to induce reliance on the false information. Examples of information subject to fraud include:

1) An application for, rating of or renewal of an insurance policy;
2) A claim for benefit or payment;
3) Payments made in accordance with the terms of any insurance policy;
4) The solicitation for sale of any insurance policy;
5) An application for certificate of authority; or
6) The financial condition of any insurer.[2]

B. Punishment and Remedies.

Criminal punishment for fraudulent insurance acts is based on the value of the property or services obtained and is the same as that set for theft under Tennessee law:

- Class A Misdemeanor: Theft of $500.00 or less.
- Class B Felony: Theft of $60,000.00 or more.
- Class C Felony: Theft of $10,000.00 but less than $60,000.00.
- Class D Felony: Theft of $1,000.00 or more but less than $10,000.00.
- Class E Felony: Theft of greater than $500 but less than $1,000.00.[3]

The civil remedies available for Fraudulent Insurance Acts and Unlawful Insurance Acts are different for each.[4] For fraudulent insurance acts, the remedies include restitution, disgorging of profit, benefit, or compensation; reasonable legal fees and costs, reasonable investigative fees, and all other direct economic damages.[5] A civil penalty of $1,000.00 to $10,000.00 may be imposed for fraudulent insurance acts.[6] Finally, the Fraud Act provides for treble damages, one-third (1/3) of which goes to the State, if the employee can show by clear and convincing evidence that the fraudulent insurance act was part of a pattern or practice.[7] The remedies for unlawful insurance acts are limited to disgorging of profit, benefit, or compensation, and recovery of reasonable legal fees and costs.[8]

C. General Provisions

The statute of limitations period for a criminal case involving fraudulent insurance acts ranges from two (2) to eight (8) years, depending on the level of the felony involved. The statute of limitations period for a civil case involving either fraudulent insurance acts or unlawful insurance acts is one (1) year from the commission of the last occurrence or discovery of the wrongful conduct, whichever is later.[9] A person economically injured by either a fraudulent insurance act or an unlawful insurance act may recover under one of those sections, but not both.[10] In any action pleading both exemplary damages and treble damages, the employee must elect one or the other, but not both, at the conclusion of the evidentiary phase of the trial.[11]

The Fraud Act grants absolute immunity from liability for libel, slander or any other similar cause of action, in the absence of actual malice, for any person furnishing, disclosing, or requesting information related to the enforcement of the Fraud Act.[12] Moreover, the Act provides for reasonable attorney's fees and costs to defend such suits if the person against whom the claim was brought is found to be immune under the Fraud Act.

D. Convictions

The Tennessee Bureau of Investigation Workers' Compensation Fraud Unit was eliminated, effective July 1, 2003. Accordingly, there is no longer a specialized unit of the Bureau of Workers' Compensation that reviews issues of fraud in workers' compensation cases. Nevertheless, cases of fraud may still be referred to the District Attorney's office for consideration for prosecution. The difficulty with this referral system is, as it has always been, the volume of claims submitted to the District Attorney's office and the nature of the seriousness of those offenses. The District Attorney's office has to take both factors into consideration in deciding which cases to prosecute, thereby not leaving much in the way of resources to deal with smaller less egregious claims that often typify the fraudulent referrals made in the area of workers' compensation.

E. New Referral Procedures

If a party is in possession of evidence of a criminal violation by an employee, a fraud referral form must be completed and forwarded to the District Attorney in the jurisdiction where the fraud occurred. Any relevant documents such as witness statements, surveillance reports or tapes, and medical reports are to be attached to the referral form.

When a referral is made to the District Attorney to pursue criminal prosecution of an employee, a copy of the form only is also to be sent to the Tennessee Department of Commerce and Insurance. The referral form is also completed if there is evidence of a criminal violation by an employer, provider, insurance agent or attorney. Again, a copy of the referral form is to be sent to the Tennessee Department of Commerce and Insurance.

F. Complaints Concerning Employers go to Commerce and Insurance Department

If the referral involving an employer concerns an employer not having obtained workers' compensation coverage for its employees, a Request for Investigation of the Uninsured Employers Fund is to be filed with the Tennessee Department of Commerce and Insurance.

The employer may be assessed civil fines and penalties even where there is not enough evidence to support a criminal conviction. Where there is evidence that the employer intentionally and knowingly did not obtain workers' compensation coverage that matter is to be referred to the District Attorney, who will make a decision on whether to pursue a criminal prosecution of the employer.

G. Recent Case Law in the "New Law" System

Unfortunately, there have been no reported cases in the "new law" system pertaining to prosecution of fraudulent workers' compensation claims. Manier & Herod will continue to monitor recent developments in Tennessee Workers' Compensation Law, specifically reported cases, to determine if there are any reported cases documenting fraud referrals and the outcome of those cases, for the benefit of our clients.

Endnotes for Chapter XIV

1 *See* Tenn Code Ann. § 56-47-101 et. seq.
2 Tenn Code Ann. § 56-47-103.
3 Tenn Code Ann. § 39-14-105; Tenn Code Ann. § 39-11-106(a)(36).
4 Tenn Code Ann. § 56-47-103, Tenn Code Ann. § 56-47-104.
5 Tenn Code Ann. § 56-47-106(a); Tenn Code Ann. § 56-47-108(b)(I).
6 Tenn Code Ann. § 56-47-108(b)(I)(v).
7 Tenn Code Ann. § 56-47-108(c).
8 Tenn Code Ann. § 56-47-108(a)(I).
9 Tenn Code Ann. § 56-47-108(f).
10 Tenn Code Ann. § 56-47-108(g).
11 Tenn Code Ann. § 56-47-109(a).
12 Tenn Code Ann. § 56-47-111.

XV.

WORKERS' COMPENSATION COMMITTEES PROMULGATED BY STATUTE

A. Advisory Council on Workers' Compensation

1. Purpose. The Advisory Council on Workers' Compensation exists to provide information, research, and recommendations concerning workers' compensation issues to the Tennessee General Assembly, the Department of Commerce and Insurance, the Department of Labor and Workforce Development, and the Bureau of Workers' Compensation. This committee meets at least twice a year with the purpose of reviewing the status of workers' compensation in the State of Tennessee.[1] The Advisory Council is responsible for preparing an annual report.[2] The Advisory Council's role is strictly advisory but in performing its responsibilities it may:

1) Make recommendations relating to adoption of legislation and rules;
2) Make recommendations regarding the method and form of statistical data collections; and
3) Monitor performance of the workers' compensation system in the implementation of legislative directives.[3]

Section 50-6-121(i) of the Tennessee Code Annotated provides that by January 15th of each year, the Advisory Council shall also submit an annual report of all significant supreme court decisions relating to workers' compensation.[4]

When a bill impacting the workers' compensation law is presented to the general assembly, the standing committee to which the bill is referred may then refer the bill to the Advisory Council.[5] The Advisory Council's review of the bill should be reported back to the standing committee "as quickly as reasonably possible."[6] The standing committee may review a bill at any time.[7] The chair making the referral must immediately notify the prime sponsors of the bill of the referral to the Advisory Council.[8] The comments of the Advisory Council must include the potential effects of the proposed legislation on the workers' compensation system.[9] These comments may include a recommendation for or against the proposed legislation.[10] Other than these recommendations, the Advisory Council may not lobby for or against the passage of the bill.[11]

2. Membership. The seventeen (17) members of the committee must have a working knowledge of the workers' compensation system.[12] Members appointed after July 1, 2010 may not be employed as a lobbyist for one (1) year following the date his or her service on the council ends.[13] Members are not paid but may be reimbursed for travel expenses.[14] Members serve four-year terms and are eligible for reappointment at the end of each term.[15] The Advisory Council is composed of two categories of members:

a. Voting Members. The Advisory Council has seven (7) voting members, who must include three (3) employer representatives, three (3) employee representatives, and one (1) member serving as the committee chair.[16] The Speaker of the House of Representatives, the Speaker of the Senate and the Governor each appoint one (1) employer and one employee representative to the Advisory Council.[17] When appointing the employer representatives, the officials must make every effort to have a balance of members from a commercially insured business, a small business, and a self-insured business.[18] Of the designated employee representatives, at least one (1) employee representative must be from organized labor.[19]

b. Non-Voting Members. These ten (10) members are appointed by the governor and consist of one (1) representative from local government, one (1) from representative of insurance companies, five (5) representatives of health care providers, and three (3) attorneys.[20] Section 50-6-121(a)(1)(E)(i) of the Tennessee Code Annotated sets out specific criteria for selecting the members of each representative group.[21]

c. Reports. The annual report of the Advisory Council must be submitted on or before July 1st of each year.[22] It is sent to the Governor, the Speaker of the House of Representatives, Speaker of the Senate, Chair and Vice-Chair of the Special Joint Committee on Workers' Compensation, Commissioner of Labor and Workforce Development, the Administrator of the Bureau of Workers' Compensation, Commissioner of Commerce and Insurance, and the clerks of the House of Representatives and the Senate.[23] Notice of publication of the report must be made to the general assembly.[24]

The current list of Advisory Council members can be viewed by visiting: www.treasury.state.tn.us/claims/wcadvisory.html.

B. Medical Care and Cost Containment Committee

1. Purpose. This statutorily mandated committee is appointed by the Administrator.[25] It has the authority to:

1) Approve regulations concerning health care providers' compliance with the statutory fee schedule and concerning a method of appeal for health care providers when payment is withheld after a determination that charges were excessive.[26]
2) Assist the Commissioner of Labor in the implementation of such regulations.[27]
3) Advise the Commissioner, at his request, concerning issues related to medical care and cost containment in the workers' compensation system.[28]

2. Membership. This committee is composed of seven (7) voting members.[29] Members are appointed to four year terms and are eligible for reappointment at the expiration of each term.[30] Members of the Committee are not paid but may be reimbursed for travel expenses associated with their service.[31] This Committee also has two categories of members:

a. Voting Members. These members must include the following: three (3) physicians licensed to practice medicine and surgery and must be selected from a list submitted by the Tennessee Medical Association; two (2) members representing employers selected from a list submitted by the Tennessee Chamber of Commerce and Industry; one (1) member representing employers selected from a list submitted by the Associated Builders and Contractors, Inc.; three (3) members representing employees selected from a list submitted by the Tennessee AFL-CIO State Labor Council; three (3) members representing hospitals selected from a list submitted by the Tennessee Hospital Association; one (1) member representing pharmacists selected from a list submitted by the Tennessee Pharmacists Association; one (1) member representing the health insurance industry; and one (1) member representing chiropractors selected from a list submitted by the Tennessee Chiropractic Association.[32]

b. Non-Voting Member. The medical director serves as the final member of the committee. The Director only votes when a vote taken by the voting members results in a tie.[33]

The current list of Medical Care and Cost Containment Committee members can be viewed by visiting: https://www.tn.gov/workforce/contact-the-department0/boards---commissions/boards---commissions-redirect/workers--compensation-medical-payment-committee.html

Endnotes for Chapter XV

1 Tenn. Code Ann. § 50-6-121(e).
2 *Id.*
3 Tenn. Code Ann. § 50-6-121(f).
4 Tenn. Code Ann. § 50-6-121(i).
5 Tenn. Code Ann. § 50-6-121(k).
6 *Id.*
7 *Id.*
8 *Id.*
9 *Id.*
10 *Id.*
11 *Id.*
12 Tenn. Code Ann. § 50-6-121(a)(1)(A).
13 Tenn. Code Ann. § 50-6-121(b)(1)(C).
14 Tenn. Code Ann. § 50-6-121(d).
15 Tenn. Code Ann. § 50-6-121(a)(1)(F).
16 Tenn. Code Ann. § 50-6-121(a)(1)(A).
17 Tenn. Code Ann. § 50-6-121(a)(1)(C).
18 *Id.*
19 *Id.*
20 Tenn. Code Ann. § 50-6-121(a)(1)(E)(i).
21 *Id.*
22 Tenn. Code Ann. § 50-6-121(e).
23 *Id.*
24 *Id.*
25 Tenn. Code Ann. § 50-6-125(a).
26 *Id.*
27 Tenn. Code Ann. § 50-6-125(a)(1).
28 *Id.*
29 Tenn. Code Ann. § 50-6-125(a)(2).
30 Tenn. Code Ann. § 50-6-125(d).
31 Tenn. Code Ann. § 50-6-125(c).
32 Tenn. Code Ann. § 50-6-125(a)(2).
33 Tenn. Code Ann. § 50-6-125(a)(2)(c).

XVI.

MEDICARE SET ASIDES

A. General Provisions

The world of Medicare Set Asides (MSA) in workers compensation claims continues to evolve. The rules and guidelines set forth by the Center for Medicare and Medicaid Services (CMS) are still works in progress. As the rules are constantly changing, this chapter focuses on the basic principles of MSA and how they affect workers' compensation claims. It serves only as an introduction. As this area of workers' compensation is still relatively new, and because the continually changing rules are complex, it is recommended that when MSA issues arise in a claim, legal counsel should be consulted.

The origins of the MSA began with a simple memorandum released by CMS on July 23, 2001, widely recognized as the "Patel memorandum."[1] It established that CMS has the responsibility of providing their opinions regarding the adequacy and acceptance of Medicare Set-Aside proposals. It is charged with protecting the interests of Medicare with adequate funding for future services. Section 1862(h)(5)(D) and (b)(6) of the Social Security Act require that CMS, its providers and its suppliers ask beneficiaries about payers that may be primary to Medicare.[1]

The term Medicare Set Aside and all of the related acronyms that have since developed over the past decade have led to the evolution of an entirely new industry within the workers' compensation system. CMS is constantly working to improve its policing of workers' compensation cases and to safeguard itself from being the primary payer when workers' compensation should instead be providing coverage.

Acronyms are widely used in discussions and preparation of MSA allocations. The website currently provides for over 4,400 acronyms. (See www.cms.gov/apps/acronyms/.)

Below are the most common and will be used throughout this chapter:

- CMS – Centers for Medicare and Medicaid Services
- COBC – Coordinator of Benefits Contractor
- COBSW – Coordinator of Benefits Secure Website
- CPL – Conditional Payment Lien
- CTR – Consent to Release
- ESRD – End Stage Renal Disease
- MIR – Mandatory Insurer Reporting
- MMSEA – Medicare, Medicaid and S-CHIP Extension Act
- MSA – Medicare Set Aside
- MSP – Medicare Secondary Payor Act
- NGHP – Non Group Health Plans
- ORM – Ongoing responsibility for medical payments
- POR – Proof of Representation

- RRE – Responsible Reporting Entities
- SSA – Social Security Administration
- Section 111 – When a claim needs to be reported
- THE S-CHIP Extension Act
- TPA – Third party administrator
- TPOC – Total payment obligation to claimant
- WCMSA – Workers' Compensation Medicare Set-Aside Arrangement

B. MSA and CMS Compliance Post - July 1, 2014

As explained previously in this book, on July 1, 2014, the Tennessee Department of Labor changed into the Bureau of Workers' Compensation. Since July 1, 2014, there have been many MSAs that have been approved by the Court of Workers' Compensation Claims. However, the new court takes a limited view as far as its jurisdiction. No longer will one be able to place indemnification language in the actual order. The courts are allowing attorneys to file an addendum with the protective language and the description of the MSA. However, the courts have been reluctant to exercise any jurisdiction over the MSA in the workers' compensation final order. Thus, closing future medicals in the State of Tennessee remains an elusive concept and requires creative analysis and thought.

When drafting new law settlements where a MSA has been provided, the WCC has approved the following language in approving at settlement agreement which contemplates closing future medicals with a WCMSA agreement:

> Employee further acknowledges that while the Workers' Compensation Judge has explained that agreeing to closure of future medical benefits MAY affect liability of Medicare and TennCare in the future, which includes but is not limited to:
>
> 1) Having to maintain a Medicare Set-Aside Trust account to the satisfaction of the Centers for Medicare & Medicaid Services.
> 2) Being responsible for reimbursing CMS for Medicare expenses paid on behalf of the Employee.
> 3) Suspension or termination of the Employee's Medicare benefits.
>
> Employee has not relied on any statement of the law or other explanation given in reaching her decision to close future medical benefits.
>
> Pursuant to this settlement, the parties have entered into a Medicare Set-Aside arrangement contemporaneously with this settlement (Exhibit B). The parties acknowledge that the Court has not reviewed or approved this arrangement.

The Courts habitually strike any attempt to indemnify the Employer or Carrier in the actual agreement.

C. Purpose of a MSA

A Medicare Set Aside is an account designed to pay future medical expenses for an injured party that would have been paid by Medicare had the injury NOT been the responsibility of a primary payer (i.e. the workers' compensation carrier). MSA funds should be sufficient to last the remainder of the employee's estimated life expectancy (unless documented otherwise). MSA funds may ONLY be used to pay for injury-related services that would otherwise be covered by Medicare.

Medicare places settlements into two categories:

1) A compromise settlement agreement intends to compensate an individual for medical expenses incurred prior to the date of settlement.
2) A commutation settlement agreement intends to compensate an individual for expenses after the date of settlement.

A combined settlement can possess both workers' compensation compromise and commutation aspects. Medicare Set Aside arrangements apply strictly to workers' compensation settlements that involve a commutation aspect, or those settlements intended to release the employer and/or insurance carrier from liability for the employee's future medical benefits. Medicare Set-Aside Arrangements are independent of any decision regarding past paid claims, which must be reimbursed to the Medicare Trust Fund.

42 C.F.R. 411 is the Medicare Secondary Payer Regulation (MSP), which makes MSAs applicable to workers' compensation and other no-fault insurance settlements, including automobile, homeowners and commercial insurance plans. Section 1862(b)(3) of the Social Security Act [42 U.S.C. 1395y(b)(2)] requires the Medicare payment may not be made for any item or service to the extent that payment has been made or can be reasonably expected to be made under a workers' compensation law or plan.

D. Statute of Limitations for Medicare to Enforce its Priority Right of Recovery

For all practical purposes, there is no statute of limitations. Some in the industry believe it to be four (4) years; however, the issue has not been conclusively addressed in case law. Medicare can choose to enforce its priority right of recovery or subrogation interest at any time. There is also no statute of limitations as to when Medicare can assess penalties for failure to adequately consider its interest, as discussed above. As for conditional payment liens, the statute is three (3) years from the date of notice of settlement.

E. When MSA Submission is Required[2]

1. Class I and Class II Beneficiaries.

Medicare Set Asides are required for two (2) classes of beneficiaries:

a) Class I: Claimants who are entitled to Medicare where the total amount of settlement exceeds $25,000.00, and

b) Class II: Claimants with a "reasonable expectation" of Medicare enrollment within thirty (30) months of the settlement date AND a total settlement of greater than $250,000.00. Until the individual actually becomes entitled to Medicare, funding for an approved workers' compensation MSA arrangement must not be used to pay Employee's medical expenses.

A "reasonable expectation" includes, but is not limited to, the following reasons:

1) The claimant has applied for Social Security Disability Benefits;
2) The claimant has been denied Social Security Disability Benefits or anticipates appealing and/or refiling for Social Security Disability Benefits;
3) The individual is sixty-two (62) years and six (6) months old; or
4) The individual has an ESRD but does not yet qualify for Medicare based upon the ESRD.

As a general rule, if the Employee is less than sixty-five (65) years old and has been receiving Social Security Disability Benefits for two (2) years of more, then he or she would usually be entitled to Medicare. Individuals over the age of sixty-five (65) are usually entitled to Medicare benefits.

If the employee is unsure of whether he or she is eligible for Medicare benefits, then you should obtain a release from the employee to obtain this information from the Social Security Administration at www.ssa.gov or 1-800-772-1213.

2. Class III Beneficiaries. On July 11, 2005, CMS released a Memorandum which stated the following:

> The thresholds for review of a WCMSA proposal are only CMS work load review thresholds – not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payor Law ("MSP"). Under the MSP provisions, Medicare is always secondary to workers' compensation and other insurance such as no fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case: even if review thresholds are not met, Medicare's interest must always be considered.

As if this was not abundantly clear, CMS reiterated this issue on April 25, 2006 stating that "the CMS wishes to stress [that the $25,000.00 monetary threshold related to Medicare beneficiaries] is a CMS workload review threshold and not a substantive dollar or "safe harbor threshold." Medicare beneficiaries must still consider Medicare's interest in all WC cases and ensure that Medicare is secondary to WC in such cases." This stated, CMS has effectively decreed that the employer and/or all parties may be determined to be liable for protecting Medicare's interests and must protect the interests of Medicare, even when Medicare does not assign guidelines on how to do so. Although it has not been named as such by CMS, the industry experts have named this catch-all area to be the Class III beneficiary.

In addressing these potential minefields, employers and carriers should develop their own specific protocols to ensure that Medicare's interests are properly addressed in such Class III cases. It is strongly encouraged that employers and/or carriers seek professional assistance in making a determination of how best to protect their interests. Commonly, additional language is included in the workers' compensation settlement documents on a case-by-case basis. Some examples of Class III non-threshold review cases are the following:

Example 1: Employer and Employee reach an agreement to settle a case for $5,000.00 on a doubtful and disputed basis for the Employee's claim that he suffered an exacerbation of his preexisting degenerative disc disease as a result of his employment with Employer. No medicals have been paid by the Employer. The Employee is presently receiving Medicare benefits.

Analysis: Under this scenario, Employee is on Medicare, but does not meet the $25,000.00 CMS threshold for purposes of review. It would be beneficial to insert language into the Order reflecting that, as no medical benefits have been paid, a zero dollar allocation is proper, and Medicare's interests have been protected. It would also be beneficial to include language that states that the parties have reviewed the recent Memorandum and policies of CMS and have determined that this matter does not meet the workload threshold limits for CMS review. Notwithstanding the foregoing, CMS's interests have been protected and considered accordingly.

Example 2: Employee has suffered a compensable medical injury resulting in permanent impairment. Employee originally settled his injury to his cervical spine for a lump-sum payment of $75,000.00. In addition, the medicals in this matter totaled $80,000.00, resulting in a total amount expenditure of $155,000.00. Five (5) years after the settlement was reached, the carrier approached the employee and offered $50,000.00 to close future meds. The employee is 62.5 years old and would therefore be eligible for Medicare within the next thirty (30) months. However, the total amount of settlement is only $125,000.00 and, therefore, CMS review is not merited. Also note that the $80,000.00 in medical costs is not included in the calculation.

Analysis: Under this scenario, it will be again the responsibility of legal counsel to make a determination as to whether a MSA might be of use. The safest action is for a Medicare Set Aside to be drafted and attached to the Order even though this case would not be submitted to CMS. Due to the increasing popularity of the settlement of future medical benefits, this would be the best way to protect the interests of the carrier and the employer. That said, many carriers instruct their attorneys to submit the MSA to Medicare so that CMS sends them a "no review" letter. However, CMS has stated that not only will it not review the MSA in such cases, but it could also result in the employer losing its ability to electronically file MSA submissions.

Example 3: Employee suffered a compensable carpal tunnel injury and is settling his case for $15,000.00 with closed future medical benefits. Employee is forty (40) years old, and is not anticipated to be on Medicare within the next thirty (30) months.

Analysis: Under this scenario, Employee does not meet the workload threshold limits for either Class 1 or Class 2. It would be beneficial to place language in the Order indicating that Employee is not presently on Medicare and also place language in the Order releasing the carrier and indemnity the carrier in the event of any claims arising out of this injury including liens.

F. The Non-Submit Trend

On May 11, 2011, CMS sent a memorandum through the acting director, Charlotte Benson. In this memorandum, CMS advised that, "Submission of a WCMSA proposal to CMS for review and approval is a recommended process. **There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review.** However, if an entity chooses to use the WCMSA review process, CMS requests that it comply with the established policies and procedures referenced on its website." Given the fact that the CMS submission is voluntary, many employers and carriers have chosen to forego the MSA process and simply create their own MSA. Many employers can save money by establishing a more realistic MSA than those required by CMS policy. These non-submitters argue that their MSA, if followed and attested to correctly, will be accepted by Medicare even though it was not previously submitted. This trend is becoming increasingly popular. Thus, while CMS continues to be vague on the actions it may take with non-submission MSAs, a non-submission MSA is a legal option and many vendors are implementing them with the use of professional administrators, structured settlements, and legal opinions on the MSA.

There are many different aspects and issues to address when making a decision as to whether or not to make a submission to CMS. Many times, the amount of the submission is the governing factor. For example, some large employers in the industry feel that any MSA over $75,000.00 should be submitted to CMS. Although this is an arbitrary number, the trend is to look at making a non-submitted MSA when the amount is in the $25,000.00 to $75,000.00 range. The pivotal factor of the non-

submission is that the MSA Beneficiary must follow CMS's compliance rules. They are also required to sign and submit an annual attestation letter to the BCRC. Again, whether one chooses to submit or not to submit the MSA, it is an issue that should be carefully examined and discussed with legal counsel.

G. Primary Components of a Medicare Set Aside Arrangement

A MSA arrangement contains the following:

1) A Medicare Set Aside Allocation, which projects the amount of money to be set aside at the time of settlement for future injury related allowable care;
2) A method of funding the MSA account;
3) A method of administering the MSA; and
4) A method of identifying an individual's injury related medical expenses of the type typically covered by Medicare and associated costs.

Services that are commonly covered by Medicare include, but are not limited to, doctor visits, diagnostic tests, steroid injections, hospitalizations, surgery, physical therapy, morphine pumps, TENS stimulator units and prescription medications. Services that are not currently covered by Medicare include, but are not limited to, dentures, glasses, hearing aids, travel expenses to medical appointments and custodial care.

H. Required items for MSA proposal

If a claimant is required to prepare a MSA proposal in conjunction with a workers' compensation settlement, the completed proposal must include a cover letter with the following information:

1) Employee's name, date of birth, health insurance or Social Security claim number, if he is not yet entitled to Medicare;
2) Employee's address and phone number;
3) Signed release by Employee to obtain his or her social security status;
4) The claimant's attorney's name, address and phone number;
5) Entitlement information;
6) Employer's and Insurance Carrier's names, addresses and phone numbers;
7) Date of injury or illness;
8) Total worker's compensation settlement amount;
9) Proposed Medicare Set Aside amount;

10) Court order;
11) Rated age;
12) Last two (2) years of medical expenses; and
13) Last two (2) years of prescription expenses.

Additionally, the documentation of the following information must be forwarded to CMS prior to the approval of the MSA proposal:

1) Life Expectancy: Includes rated age documentation on letterhead, if applicable;
2) Life Care Plan (if applicable);
3) MSA Allocation Cost Projection;
4) Proposed worker's compensation settlement agreement;
5) Proposed MSA Allocation Cost Projection;
6) Current treatment (supporting documentation);
7) Future treatment (supporting documentation);
8) Medical recovery prognosis;
9) Amount of future medical treatment;
10) Proposed Medicare Set-aside amount;
11) Administrator/workers' compensation MSA account/ custodial agreement;
12) Fees;
13) Final Workers' Compensation Settlement Agreement; and
14) Signed CMS/ Medicare Release.

With regard to life expectancy and rated age, CMS now uses the CDC Life tables as their basis of life expectancy. The tables are for determination of an unimpaired life expectancy and can he found on the CDC website, www.cdc.gov. CMS also accepts documentation from physicians and insurance underwriters regarding life expectancy. Physicians are often hesitant to render an opinion of life expectancy and commonly refuse to do so. Regardless of how the life expectancy of the beneficiary is derived, the rated age of the beneficiary must be submitted to CMS.

A rated age is the physical age of the beneficiary versus that of his chronological age based on his medical history, which tends to reduce his life expectancy. The rated age is then subtracted from his normal life expectancy resulting in a reduced life expectancy versus what his life expectancy would have been without his medical history.

There are several important issues that affect the determination of life expectancy. Heredity and preexisting medical conditions are factors to be considered. Keep in mind that the more that a life expectancy can be reduced, the fewer the number of years money must be provided for future medical care. This in turn could benefit the Medicare recipient as more money could be available for the Beneficiary that is not earmarked for the MSA.

Finally, with regard to medical documentation submission, it should be noted that medical records must be submitted in chronological order. Further, the projected costs should be adequate for coverage of the beneficiary's projected life expectancy, and it is imperative that the projected monies are only to be used for injury related services for which Medicare provides coverage.

I. Submitting a Proposed MSA Allocation

A WCMSA can be submitted in one of two ways: electronically through the WCMSA Portal (WCMSAP) on the internet, or by paper submission, with an enclosed CD, through the mail. Submission to CMS electronically through the WCMSAP is the preferred method for submission. Each individual or entity that wishes to use or access the portal must complete the WCMSAP registration process. To get started, go to: https://www.cob.cms.hhs.gov/WCMSA/ and click [I Accept] to agree to the terms for using the site. The Welcome to the WCMSAP page displays. Click [New Registration] and follow the instructions on the screen. Once this step is completed, you will be assigned an Account ID and Personal Identification Number (PIN). You will use this information to complete Step 2 of the process, Account Setup.

All WCMSA proposals that are mailed to CMS for review must be sent to the following address:

WCMSA Proposal/Final Settlement
P.O. Box 138899
Oklahoma City, OK 73113-8899

J. Administration of the MSA

The MSA Allocation can either be administered by the beneficiary or by a professional administrator. If a professional administrator is chosen, then he or she will establish a custodial account for the beneficiary, issue the beneficiary a card for submission to the healthcare provider and receive and process all of the medical billing related to the covered injury. The costs of administration are outlined at the time of settlement. If a beneficiary chooses to self-administer his or her account, then he or she will have to open an individual interest-bearing account used exclusively for the MSA Allocation. Self-administration will not be allowed if the beneficiary has been assigned a representative payee by the Social Security Administration.

K. Professional Administration

Professional administration has become increasingly popular and affordable. There now exist many different forms of professional administration. The professional administrator eases the burden from the beneficiary by handling the day-to-day prescription filling and medical treatment and/or bills. Many professional administrators have agreements with large providers which can insure that the MSA lasts longer as they are receiving a discounted rate. Moreover, professional administrators tend to be able to negotiate with physicians much better than an individual who is administrating the claim on his/her own. That said, once the custodial agreement has been executed, the money that is placed in that account will be only for the use of medical treatment. Thus, some claimants opt out as there is also a trend that once future medicals have been closed, many beneficiaries stop treatment altogether.

L. Self-Administration

Often, the individual closing future medical benefits is not represented by an attorney. When speaking to pro se claimants, one can assure them that CMS provides ample instruction for the self-administration of a structured WCMSA. The WCMSA funds must be placed in an interest bearing account. Funds in the account may not be used for any purpose other than payment of future medical care that is Medicare-covered and is related to the workers' compensation claim, or for certain allowable expenses. For details on using the account, you may advise claimants to see the WCMSA Reference Guide and the Self-Administration Toolkit located on their website at http://go.cms.gov/wcmsa.

M. Funding the MSA

The MSA can be funded with cash or seeding an annuity, regardless of the form of administration. CMS requires yearly accounting reports as to the spending of the funds. If the account is depleted during the course of the covered period of a year, then administrator will coordinate payments with Medicare and replenish the account. If the Administrator is audited by Medicare, and Medicare finds that its interest was not properly considered, then the beneficiary could incur penalties equal to double the damages. The beneficiary could also lose his or her future Medicare benefits.

N. Fees associated with the MSA

Fees and costs may be charged to the MSA arrangement if all the following are true:

1) The fees are related to the Medicare Set Aside itself;
2) The fees are reasonable in amount; and
3) The fees are included in the proposed Medicare Set Aside arrangement submitted to CMS and incorporated into the Medicare Set Aside approved by CMS.

It is important to note that all administrative fees and other costs and expenses associated with the disability/lost wages portion of the workers' compensation settlement and/or the portion of the settlement that provides for medical services that are not covered by Medicare cannot be charged to the MSA arrangement.

O. Time for Submission Response

Regional offices seek to review and make a decision regarding proposed workers' compensation settlements within forty-five (45) to sixty (60) days, from the time that all necessary and required documentation has been submitted. However, due to a back log of submissions, it often requires more time than CMS has stated.

P. Liability

Other than the fact that it is against federal law not to do so, if Medicare's interests are not adequately considered and protected, then Medicare can enforce its priority right of recovery against any entity. These entities include the beneficiary (i.e. employee), provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment, either directly or indirectly. Medicare also has a subrogation right with respect to any such third party payment. In the case of Medicare overpayments, if reimbursement is not made to Medicare (i.e. CMS) within sixty (60) days of a beneficiary receiving proceeds from a third party payer, then action may be brought against any entity responsible for payment.

It is important to note that the law allows CMS to collect double damages from insurance companies, beneficiaries, employers, attorneys of beneficiaries, or any entity that received settlement from a primary payer. If CMS does not receive a full refund from the beneficiary or entity, or adequate proof that no overpayment exists within sixty (60) days of being notified of CMS's demand, then interest will be assessed as of the date of the mailing of the demand letter. Interest will continue to be charged every thirty (30) days until reimbursement is made. If reimbursement is not made within

one hundred twenty (120) days after the demand, then the case will be referred to the Office of the General Counsel to recover the overpayment amount. Additionally, if Medicare audits the beneficiary and finds that its interest was not properly considered, the beneficiary could lose his or her future Medicare benefits.

> *Practice Note:* Make certain that any settlement agreement that you submit contains language such as the following: "The Employee further agrees to waive any and all future actions against the Employer/Insurer, including but not limited to any private cause of action for damages pursuant to 42 U.S.C. § 1395y(b)(3)(A) et seq."

Q. Expansion of CMS WCMSA Review Process

Prior to 2017, there was no formal process for re-review of MSAs that were submitted to CMS and approved. The difficulty arises when the parties decide not to settle the future medicals in the case at the time of the settlement of indemnity. Inevitably, claimants for whatever reason change their mind and attempt to request CMS approval for a re-review process. There has been discussion at CMS that the process should be expanded beyond the twelve (12) to forty-eight (48) month limit that is now in place. However, given that there is a new WCRC contractor, CMS may not be open to expanding the policy at this time. That said, the re-review process can create a useful tool to help settle old cases or cases that may change treatment over time. Quoting CMS, "Below are the criteria that if met CMS will permit a re-review."

R. Amended Review

Where the following criteria are met, CMS will permit a one-time request for re-review in the form of a submission of a new cover letter, all medical documentation related to the settling injury(s)/body part(s) since the previous submission date, the most recent six (6) months of pharmacy records, a consent to release information, and a summary of expected future care.

Note: In the event that treatment has changed due to a state-specific requirement, a lifecare plan showing replacement treatment for disallowed treatments will be required if medical records do not indicate a change.

- CMS has issued a conditional approval/approved amount at least twelve (12) but no more than forty-eight (48) months prior.
- The case has not yet settled as of the date of the request for re-review.
- Projected care has changed so much that the submitter's new proposed amount would result in a 10% or $10,000 change (whichever is greater) in CMS' previously approved amount.

- Where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased.
- This new submission may be delivered in both paper and portal formats. Please see the WCMSAP User Guide for more information.

In order to justify that the projected care would result in a 10% or $10,000 change (whichever is greater), the submitter must return CMS's Recommendation Sheet that was included in CMS's conditional approval letter and identify the following:

- Line items that were included in the approved amount, but are for care that has already been provided to the beneficiary. Please identify where references to records indicating that the care has already been provided can be found in the updated proposal.
- Line items for care that is no longer required. Please identify where references to replacement treatment can be found in the updated proposal.
- If additional care is required that was not otherwise included in CMS' conditional approved amount, please add line items.

Note: The approval of a new generic version of a medication by the Food and Drug Administration does not constitute a reason to request a new case review for supposed changes in projected price.

CMS will deny the request for re-review if submitters fail to provide the above-referenced justifications with the request for re-review. Submitters will not be permitted to supplement the request for re-review.

S. Mandatory Insurer Reporting

On December 28, 2008, President George Bush signed into law the S-Chip Extension Act. As a result, Section 111 of the S-Chip Extension Act of 2007 implemented the Mandatory Insurer Reporting ("MIR") section of the Medicare/ Medicaid S-Chip Extension Act of 2007 ("MMSEA"). This section of this chapter is designed to simply identify the terms and the parties that are required to report. As this area of the MSA field is still evolving, the laws and policies are subject to change regularly. As this information serves only as a guide, legal counsel should be consulting to determine an entity's reporting requirements.

1. Non-Group Health Plans (Non-GHP). The parties responsible for reporting for the MMSEA include liability insurance (including self insurance), no-fault insurance, and workers' compensation.

2. Responsible Reporting Entities (RREs). RREs are carriers, self-insureds, joint pools, and state-assigned funds. A third party administrator (TPA) is not a responsible reporting entity except to the extent that it might self insure its own workers' compensation and liability exposures. Please note that if an entity is active as an agent for multiple RREs, then the agent must submit a separate electronic reporting file for each RRE.

3. Compliance. The first step in complying with the Mandatory Insurer Reporting requirements is that the RRE's submission of registration data to the COBC via a secure website portal, the COBSW. The RRE must be the one to complete the registration process. The RRE may assign an agent for ongoing reporting at that time by completing the agent registration section. Agents are not permitted to complete the registration process. When the S-Chip Reporting Act is fully functional, the reporting will be required quarterly.

4. Deciding Which Cases to Report. Cases involving Medicare Beneficiaries should be reported. CMS has established two (2) reporting triggers:

a. ORM (Ongoing responsibility for medical payments). When responsibility for the claim has been assumed by the responsible reporting entity, this is referred to as an ORM. Under the ORM, there are two (2) reportable events:

1) When the ORM determination is made (i.e. when the carrier assumes responsibility for a worker's compensation case); and
2) When the ORM terminates (i.e. when responsibility for the claim has been completed). This may occur in a medical only situation involving a Medicare beneficiary. Also, the ORM will be filed when responsibility by the carrier terminates as a primary payer.

The second scenario occurs when the RRE's responsibility for the claim has been terminated by settlement, judgment, award, or other payment on or after January 1, 2010.

b. TPOC (Total payment obligation to Employee). The TPOC is essentially a one-time lump sum payment. In many workers' compensation cases, there has been a disputed and/or denied claim, no responsibility for the claim has been assumed by the RRE, and no payment is made by the RRE. Under this scenario, reporting is not needed until there is a settlement, judgment, award, or other payment.

5. Required Information for Reporting. Required information for reporting includes date of injury, settlement date, and exhaust of information. However, it should be noted that if CMS has regulatory definition of terms that they use, they will use those definitions even if they do not comport with the industry's definition of the same terms. In other words, many times insurance carriers will have ongoing future medical expenses, but will close their files. The fact that they have closed their files does not necessarily mean that the ongoing responsibility has ceased.

It should be noted that Section 111 provides for a $1,000.00 per day penalty. Regardless, it is imperative that the RRE establish whether the employee is a Medicare beneficiary at the onset of the claim.

T. WCMSA Portal

On November 29, 2011, CMS launched the WCMSA Portal to the general public. The WCMSA Portal is a web-based application that allows submitters to electronically submit MSA proposals to CMS for review. Users can upload and submit documents and any additional information that may be requested by CMS. The WCMSA Portal will then provide updates to the user including but not limited to the location of the file in the review process (i.e. whether it is with the workers' compensation review center or the applicable regional office), the current status of the file, and email alerts notifying users when a development or approval letter has been issued. The user will be able to access the submission online at any time.

Users are requested to utilize the same method of submission of documents and information throughout the process. Thus, if the user initially submits a proposal via mail, then all subsequent information should be mailed. Only if the information is initially submitted through the WCMSA Portal should additional information be submitted and requested via this online process.

The Portal is available on the CMS website via the following link:
https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSAP/WCMSA-Portal

Endnotes for Chapter XVI

1 More information on CMS can be found on its website at www.cms.gov.

2 The basis for submission of the MSA is governed by memorandums released by CMS. These memorandums are not law, but policy implemented by CMS. Thus, there are some who argue that a MSA is not required by law; however, this suggestion is risky and ignoring the interests of CMS is not recommended.

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