



NORTH CAROLINA
WORKERS' COMPENSATION REFORM:
AN INSIDER'S VIEW

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The overall theme of the 2011 North Carolina workers' compensation reform is a focus on returning claimants to work. In fact, the bill was entitled, "An Act Protecting and Putting North Carolina Back to Work by Reforming the Workers' Compensation Act." Many of the reform provisions make it easier for employers and carriers to get claimants back to work, and in some circumstances, it actually mandates that employers and carriers do vocational rehabilitation. It also provides increased benefits for those employees who do return to work and strengthens the penalties, sanctions and consequences for those employees who refuse to return to work.

I. BACKGROUND

A. Prior Attempt at Reform in 2005

In 2005, there was an attempt to reform the workers' compensation. There were numerous lessons learned from the earlier reform effort from 2005; namely, that adding too many issues to a reform package could end up killing any bill. The more issues that are added, the more targets there are for various special interest groups.

B. A New Majority and a New Perspective in 2011

After the Republicans took control of both of the North Carolina House and North Carolina Senate last November, with near veto-proof majorities, it was presumed that workers' compensation reform would be inevitable. Consequently, a large group of employer organizations throughout the state convened to develop an overall strategy. As a result of the learned lessons in 2005, a list of general reforms was prepared and then ranked in order of priority. A conscious effort was made to not include every possible area of reform. The number one and two priorities from the employers' perspective were to put a legitimate cap on temporary total disability benefits and to amend the suitable employment standards so that we would have better options to get claimants back to work than the current system.

After the list of general reforms was identified and prioritized, then a smaller working group was tasked with drafting proposed legislation. The initial legislation was fairly aggressive in several significant areas. Even with the Republican majority in the legislation, however, the political reality was that the plaintiff's bar was still formidable and was able to bring a lot of pressure to the General Assembly on any workers' compensation bill. The plaintiff's bar made a very good strategic political decision by agreeing to negotiate the bill rather than just opposing it outright. There was a split at the Advocates for Justice (formerly the Academy of Trial Lawyers) on this strategy, but the group that wanted to negotiate and compromise won out over the "hard liners" who simply wanted to oppose any reform effort at all. In addition, there were numerous trial lawyers within the Republican caucus. Consequently, several items were included in the initial proposed legislation that were actually advantageous to employees.

The initial bill was filed in April of 2011 and immediately drew protest from numerous groups because it had a 500 week cap on temporary total disability benefits under N.C.G.S. § 97-29, with the only exception being lifetime benefits for specifically designated catastrophic cases. The Governor's office also weighed in with objections to the 500 week cap and the

definition of suitable employment. There was a clear indication that the Governor would consider vetoing the bill unless further changes were made. A veto was the worst case scenario for employers because this would have left the system at the status quo and any additional possible reform would have to wait 2 more years. Consequently, a smaller group of attorneys and lobbyists from both sides began meeting in early May to try and work out compromise language. On June 9, 2011, the following reforms were passed by the General Assembly. This vote was 110-3 in the House and 46-0 in the Senate. Governor Purdue signed the bill into law on June 24, 2011.

II. THE ACTUAL AMENDMENTS AND THEIR IMPLICATIONS

A. N.C.G.S. § 97-2 – Definitions

1. Attendant care

The definition of medical compensation was amended to indicate that rehabilitative services includes **attendant care** services when **prescribed** by a healthcare provider authorized by the employer or subsequently by the Commission. The language regarding attendant care services was a direct result of the Court of Appeals decision in *Shackleton* which came down in early April. The case was a dramatic departure from the existing case law on attendant care because the Court basically said that attendant care services could be awarded on a case by case basis by the Industrial Commission and that the only evidence necessary in order to prove an attendant care claim would be a prescription by a doctor, the testimony of the claimant, the testimony of the claimant's family members, **or** based upon the nature of the injury alone. The decision also suggested that there was no time limit on when attendant care services could be requested. Therefore, the concern was that you could have a death claim in which a family member could show up for the first time and ask for 2 years, 5 years, 10 years, or longer, of attendant care services and the Commission could award that based simply upon the family member's testimony or the nature of the injury itself. Because the new definition requires a doctor's prescription, it should at least put some parameters on when attendant care can be provided.

This provision applies to claims arising on or after June 24, 2011.

2. Vocational Rehabilitation

Vocational rehabilitation was added to the definition of medical compensation and makes vocational rehab available to anyone who has returned to work at less than 75% of their pre-injury average weekly wage. An entirely new Section, N.C.G.S. § 97-32.2, that deals with vocational rehabilitation was also added. This provision was a major compromise of the legislation because there was a fairly strong dispute over what type of employment claimants would have to return to following an injury. As explained later in this manuscript, the definition of suitable employment has changed and caps have been placed on temporary total disability benefits. Consequently, if a claimant could do any type of employment and had any wage earning capacity, then they would not be entitled to any extended TTD benefits under N.C.G.S. § 97-29(c). They might still be entitled to some temporary partial disability benefits under N.C.G.S. § 97-30, but they would not get total disability benefits. The

plaintiff's bar was concerned that these two provisions would allow employers to dump employees in low paying jobs with no future prospects. Consequently, an agreement was reached whereby vocational rehabilitation would be available to anyone who has returned to work at less than 75% of their pre-injury average weekly wage. It is anticipated that a claimant will continue to work in the lower paying job while also engaging in the vocational rehabilitation services.

This provision applies to claims arising on or after June 24, 2011.

3. Suitable Employment

The next biggest change in Section 2 under the Definitions section was including suitable employment as a defined term rather than leaving it to the courts to define. Suitable employment is broken down into two definitions. At pre-MMI, an employee has to return to work as long as they are physically capable of doing their job and the job is approved by the authorized healthcare provider. Specifically, this is an adoption of the *Russos* case, which indicates that pre-MMI employment can include pretty much any type of employment, even make work, as long as the authorized treating physician feels that it would be rehabilitative for the claimant. Specifically, this is the situation where an employer might want the claimant to come back and do clerical work 2 hours a day or come back to some type of modified job, simply to keep the claimant engaged and in the workforce rather than sitting home all day. Please note that the introductory paragraph says that the employment is actually offered to the employee, so there needs to be an actual job offer rather than just a labor market survey. However, if claimant is an undocumented worker and offering employment is not an option, then all we need to prove is that the employment is available, presumably through a labor market survey. This pre-MMI return to work is limited to the employer of injury. However, if the doctor agrees that this type of employment would be rehabilitative, such as Goodwill Industries, then defendants may be able to argue it is suitable.

After the claimant reaches maximum medical improvement, then the requirements for the job increase. At that point, the employment is considered suitable if the claimant is capable of performing the job, taking into account their preexisting and injury related physical and mental limitations, vocational skills, education, and experience and is located within 50 miles radius of the employee's residence at the time of the injury or the employee's current residence if the employee had a legitimate reason for relocation. The most significant portion of the definition is that wages have been removed from the definition. Therefore, if an employer or carrier finds employment for the claimant paying less than their pre-injury average weekly wage, that will not be a basis for them to refuse the employment and it should not be a basis for denial of a Form 24 Application. There is no requirement that the post-MMI job offer even include any specific likelihood that the claimant will advance to their pre-injury average weekly wage. However, as discussed earlier, the new vocational rehabilitation statute does allow a claimant to request vocational rehabilitation services if they are paid less than 75% of their pre-injury average weekly wage. In addition, the employer has a longer period of temporary partial disability exposure under N.C.G.S. §97-30. Therefore, it is in the employer's best interest to maximize the claimant's post-injury average

weekly wage so that TPD exposure can be reduced and potential costs of engaging in vocational rehabilitation services can be avoided.

This provision applies to claims arising on or after June 24, 2011.

B. N.C.G.S. § 97-12.1 – Misrepresentation

This Section deals with willful misrepresentation in applying for employment. This Section is a direct result of the *Freeman v. J.L. Rothrock* case from a few years ago where claimant lied about a back injury and then subsequently suffered a new back injury with the new employer. The Court of Appeals adopted the standard defense from *Larson* about misrepresentation in the employment application, but the Supreme Court rejected that indicating that any changes needed to be made legislatively as opposed to by the courts. The Act as amended bars an injured employee from receiving compensation if the employer is able to establish that (1) the employee “knowingly and willfully made a false representation as to his physical condition” in his employment application or while undergoing a post-offer medical examination; (2) the employer relied on that misrepresentation and the reliance was a substantial factor in the decision to hire the employee; and (3) the injury for which a claim is subsequently made is causally connected to the employee’s misrepresentation.

Some practice pointers regarding this: normally, an employer cannot ask any of these questions until an offer of employment has actually been made. Once the offer of employment has been made, then the employer can do a post-offer physical and questionnaire as well. It is important to note that any misrepresentation by the claimant has to be to the body part that is eventually injured in the subsequent work related injury. If the claimant lies about a foot injury, but subsequently injures his back that is not going to be a basis for a defense. There is some concern that this new provision will negatively impact vocational rehabilitation efforts because new employers will ask about prior injuries. However, the same rules apply in a post-injury vocational rehabilitation setting, in that a new employer cannot ask any of these questions about prior injuries or physical capacity until an offer of employment has been made. In reality, most new employers know a candidate has a comp claim when vocational rehabilitation is involved anyway.

This provision applies to claims arising on or after June 24, 2011.

C. N.C.G.S. § 97-17 – Settlements

This portion of the Act simply documents that parties are not prevented from settling an employment claim or other issues at the same time as a workers’ compensation settlement. Workers’ compensation settlements still need to be separate from the employment settlement or any other settlements, but this Section simply clarifies that the Industrial Commission cannot prohibit this. There will likely need to be a change to the Industrial Commission Rules regarding settlements which indicate that no other claims other than the Workers’ Compensation Act are being released by the settlement.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

D. N.C.G.S. § 97-18(k) – Pre-emptive hearing to reinstate benefits

This was a concession made to the plaintiff's bar in response to changes to suitable employment and other amendments in the Act regarding Independent Medical Evaluations, medical treatment and other issues, since it is expected that the revisions will make it easier to terminate a claimant's benefits. If it is in fact easier to terminate benefits, then the plaintiff's bar wanted some type of a preemptive procedure to reinstate benefits where there had previously been an award of benefits or an agreement to pay benefits. Significantly, a preemptive hearing is different than the expedited medical motions currently established by the Commission. This provision anticipates or contemplates a full evidentiary hearing before a Deputy Commissioner, but it will get scheduled on a preemptive basis rather than the expedited medical motion process that is currently in place for the medical motions. If the Industrial Commission tries to start holding telephonic hearings regarding reinstatement of benefits, then we need to know about that.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

E. N.C.G.S. § 97-25 – Medical Compensation

N.C.G.S. §§ 97-25, 25.6 and 27 need to be read in tandem, since they all are somewhat interrelated. Significantly, N.C.G.S. § 97-25 did **not** change the sentence, "Medical compensation shall be provided by the employer." Therefore, defendants still have the right to direct medical care in all workers' compensation claims. What this section allows is an employee to request a second opinion evaluation, not to be confused with a second opinion on the rating with respect to N.C.G.S. § 97-27. The procedure requires the claimant to first contact the defendants and make a request in writing for an Independent Medical Evaluation. The defendants then have 14 days to try and work out some agreement on the request for an IME. The goal is to have the parties agree on IME physicians rather than having the Commission routinely decide this issue. However, if the parties cannot reach an agreement on the IME, then the claimant can file a motion with the Industrial Commission seeking authorization for a second opinion evaluation. The second opinion evaluation can be on any issue in the case, work restrictions, medical treatment options, surgical options, etc.

The next paragraph indicates that an employee does have the right to select their own medical care subject to the approval of the Industrial Commission, just like they can now. However, there is now a higher standard on the Commission's ability to actually transfer care away from one doctor, as opposed to allowing the IME discussed above. In order for the Industrial Commission to order a change in treating physician, the employee must prove by a preponderance of the evidence that the change is reasonably necessary to effect a cure, provide relief, or lessen the period of disability. One significant change that was added was that when deciding whether to grant an employee's request to change treatment or healthcare provider, the Commission may disregard or give less weight to the opinion of a healthcare provider from whom the employee sought evaluation, diagnosis or treatment before the employee first requested authorization in writing from the employer, insurer or Commission. This was specifically designed to address the practice of some plaintiff's firms which send an employee to a doctor unauthorized, establish a period of treatment, and then

move to have the treatment transferred to that doctor based upon the fact that the employee has now been treating with the doctor for a significant period of time.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

F. N.C.G.S. § 97-27 – IMEs

N.C.G.S. § 97-27, basically makes it an absolute right that the employer/carrier can get an IME in any case, even a denied case. Defendants get to pick the IME physician and are allowed to engage in direct communications with the IME physician. If the IME physician physically examines the employee, the employer must produce a copy of the IME report within 10 business days of receipt along with copies of all documentation and written communications sent to the IME physician. If the claimant refuses to attend an IME, then defendants can go straight to a Form 24 Application and no longer have to go get an Order to Compel Cooperation first.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

G. N.C.G.S. § 97-27 (b) – Second Opinions as to Ratings

Section (b) deals with a plaintiff's attorney's request for a second opinion on the rating. The goal with this reform was to stop is the practice of some plaintiff's attorneys requesting a second opinion on the rating when in fact the second opinion doctor gave opinions on work restrictions, medical treatment, etc. The theory behind this is that a second opinion evaluation on the rating is done at the sole discretion of the claimant; the defendants have absolutely no input into the choice of physician. Therefore, defendants have always argued that it was improper for that doctor to go beyond the rating when providing their evaluation report. During the discussions about Reform, The Medical Society stepped in and said no one could tell a doctor what they could or couldn't put in a second opinion report, so the changes to the Act focused on what the Industrial Commission can do with those reports. Consequently, if a plaintiff's attorney requests a second opinion on the rating and the rating physician goes beyond the rating to discuss other issues, then the Industrial Commission **must** either disregard or give less weight to the opinions of that second opinion physician on the issues outside the scope of the rating. The overall concept is that if a plaintiff wants an IME regarding work restrictions, medical treatment or any other issue, then they need to contact the employer or carrier under N.C.G.S. § 97-25 and the parties can negotiate an appropriate IME physician or the Industrial Commission can designate one. However, if the claimant truly only wants a second opinion on the rating, which they should be able to choose a physician without any input from the defendants, then they can do so, but that opinion needs to be limited to the rating alone.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

H. N.C.G.S. § 7 97-25.6 – Reasonable Access to Medical Information

The overall goal with this Section was to make it easier for defendants to obtain medical documentation and communicate with medical providers, while balancing the claimant's

right to some privacy for unrelated matters as well as preventing the improper disclosure of prejudicial information to the claimant's treating physician. This is a direct response to the *Salaam* case and all the cases that have come after it. It is an attempt to create a statutory framework for communication with physicians rather than leaving this issue to the courts.

The intent of this statute is to provide a process for requesting information. In general, the information requested must be related to the employee's particular injury or disease, reasonably related to the injury or disease, or related to an assessment of the employee's ability to return to work as a result of the injury or disease. The overall process breaks down as follows:

First, the employer/carrier may request medical records directly from the healthcare provider. In a compensable case, where the employer and carrier are paying benefits, authorization from the employee is not necessary to obtain medical records. This is the same as the current law. In a denied case, the employer and carrier must give contemporaneous notice to the employee when they are requesting these records. This is technically in the current law, but it is somewhat confusing. Therefore, many medical providers out there still insist on a release from the employee prior to releasing any medical records. Consequently, it is a good practice for employers and carriers to obtain medical records releases when possible, but, if they are unable to obtain one, or there is a delay in obtaining it, they are not precluded from requesting medical records from various medical providers even if they don't have a release. This will probably require some long term education of medical providers in North Carolina that releases are no longer necessary.

If the employer/carrier does not get the information they needed through a simple records request, the employer or carrier may write the healthcare provider with contemporaneous notice to the employee, or their attorney, and ask questions that are relevant to a longer list of issues that are typically covered by the Medical Status Questionnaire. Employers and carriers can still use the Medical Status Questionnaire if they want to, but are no longer limited to it. In addition, the employer or carrier needs to provide a copy of any response to the employee within 10 business days of receipt by the employer. Basically, this allows defendants to have a more open dialogue with medical providers, since the Medical Status Questionnaire was fairly limited.

Finally, if the employer or carrier cannot secure information by requesting medical records or sending a letter to the medical provider, then the employer or carrier can schedule a telephone conference with the doctor so long as the employee is allowed to participate in the conversation. Consequently, if an employer or carrier wants to talk to a doctor, they must give the employee prior notice of the purpose of the intended oral communication and an opportunity for the employee to participate in the communication. Many times an adjuster can't read a doctor's writing or is confused over some type of recommendation. The thought is that the adjuster can then contact the plaintiff's attorney and say that they need to have the doctor decipher their medical notes or they need a little bit more information and it is hoped that in many cases the employee or employee's attorney will allow the communication to take place. The employer or carrier is required to provide the employee with a summary of the communication with the healthcare provider within 10 business days of any oral communication in which the employee did not participate. Oral communications will

probably not occur very often, but it does give the carrier and adjuster greater flexibility. As a side note, this was one of the most difficult areas to negotiate, since the Medical Society was involved as well. The Medical Society actually wanted an all or nothing standard. Basically, they wanted to be able to talk to everybody at any time or they wanted to talk to nobody. Neither the plaintiff's side or defense side thought that was a good idea, so a standard that incorporates increasing burdens with increased communication was developed. Requesting medical records is fairly open, writing the doctor and requesting information is fairly easy, but talking to the doctor is somewhat more difficult.

This brings us to the **Section D** of the statute, which deals with allowable communication in addition to what is listed above. This is really the section that deals with the *Salaam* requirement. In addition to the communication provisions outlined above, the employer or carrier will also be allowed to provide additional information to the healthcare provider that is not contained in the medical records (i.e., surveillance, prior medical records of which the doctor may not be aware, etc.). However, the employer or carrier must provide a copy of the communication and additional information/documentation to the employee or counsel 10 business days in advance of the transmittal to the doctor. The employee will then have a right to object and file a motion to prohibit the communication if warranted. If either party acts unreasonably by initiating or objecting to the communication, that party can be sanctioned. This deals with the normal situation where there is a surveillance report, medical records or some other information that is relevant to a doctor's evaluation and treatment of a claimant, but which doctor may not be aware of. Under the prior rules, defendants were basically prohibited from providing that information to the healthcare provider. Under the new rules, defendants will be able to get that information to the doctor, but we are going to have to give prior notice to the other side.

In addition, an adjuster may still request medical records, bills and other non-substantive information, such as claimant's attendance at an evaluation, etc., by phone without notifying the employee. Adjusters need to be careful that any oral communication done in this way is limited to this non-substantive information. In most cases, it is understood that this communication will be with the physician's staff as opposed to the actual physician. This basically adopts a Court of Appeals decision that was unreported a few years ago that indicated *Salaam* did not apply to basic requests for information regarding the claimant's care.

This provision applies to all claims pending as of June 24, 2011 and all future claims.

I. N.C.G.S. § 97-29 – Temporary Total Disability Benefits – Caps and Credits

This is the meat of the workers' comp reform bill, since it institutes some level of caps on a claimant's entitlement to benefits. Here is how the overall scheme is intended to work: there are 3 levels of benefits available under N.C.G.S. § 97-29, which is for total disability benefits.

This provision applies to claims arising on or after June 24, 2011.

1. N.C.G.S. § 97-29 (b)

First, under Section (b), an employee needs to prove, by a preponderance of the evidence, that the s/he is unable to earn the same wages that s/he had earned before the injury, either in the same or other employment. This is basically the standard enunciated in *Hilliard* and *Russell v. Lowe's*. If the claimant proves this, or the defendants agree to this under N.C.G.S. § 97-18 pursuant to a Form 60, then claimant would be entitled to benefits up to a maximum of 500 weeks from the first date of disability. This is significant in that it is not tied to the date of injury, since an employee could have an injury, wait several years before having surgery, and then go out of work. Therefore, the 500 weeks runs from the first date of disability. If the claimant has disability, returns to work, then the period of time when they return to work is still counted against the 500 weeks.

2. N.C.G.S. § 97-29 (c)

The next section, Section (c) is for extended compensation in excess of the 500 week cap. The purpose behind this section is that the courts and the Industrial Commission had gotten away from the earlier Supreme Court decisions requiring an employee to prove s/he was permanently and totally disabled and that s/he had to have a total loss of wage earning capacity or an obliteration of his/her wage earning capacity get TTD benefits after MMI. The Commission was routinely looking at the initial standard under *Hilliard* and *Russell v. Lowe's* and determined whether an employee had established a basic right to total disability benefits. Once an employee established disability, then the burden basically shifted to the employers to prove that the claimant was capable of suitable employment in order to terminate those benefits. The Commission and the courts never got around to analyzing whether an employee had proven a total loss of **any** wage earning capacity in order to get ongoing benefits under N.C.G.S. § 97-29. One could argue that what was supposed to have occurred after *Whitley* and *Gupton* was that as soon as a claimant reached maximum medical improvement, they were entitled to elect benefits under N.C.G.S. §§ 97-29, 97-30 or 97-31. The original intent was that only individuals who were seriously disabled would be entitled to ongoing benefits under N.C.G.S. § 97-29 for a total loss or obliteration of wage earning capacity. However, the Commission and courts ignored that standard and instead focused on the initial burden of proving total disability, which would then morph into an allegation of permanent and total disability benefits. When that analysis was combined with the *Dixon* case and other cases that limited suitable employment, it became almost an impossible burden for employers to show that an employee was capable of earning wages and therefore no longer entitled to TTD benefits. This part of the Act puts that standard back into place.

The main goal with Section (c) was to eliminate the 30-40 year old claimant with a back strain and a 5% rating from ever arguing that s/he is permanently and totally disabled. In fact, those individuals should certainly be limited to N.C.G.S. § 97-30 or PPD (rating) benefits. The thought process is that only the most seriously disabled individuals or an individual with a significant disability and possibly serious educational deficiencies, work deficiencies, etc., will receive benefits past the 500 weeks. If a 60 year old illiterate claimant, who has worked construction work his entire life, has a 3-level fusion resulting in a sedentary work capacity, that individual may in fact qualify for benefits beyond the 500 weeks, unless the employer, within those 500 weeks, engages in some pretty good vocational rehabilitation

to try and get the claimant back into the workforce. Again, the argument here will be that if we can find the claimant any type of real job, not a made up job like sitting on a stool somewhere, but a real job, they will be obligated to take that job regardless of its pay. If it pays less than 75% of pre-injury average weekly wage, then they can request vocational rehabilitation assistance.

In a further negotiated element of this benefit, the defendants originally wanted a hard cap at the claimant's retirement age. In other words, the claimant would not get any N.C.G.S. § 97-29 or TTD benefits beyond when they qualified for Social Security retirement. This was a political problem, since there were problems with AARP lobbying group among others. The plaintiff's bar wanted no cap whatsoever. The compromise is that if an employee qualifies for benefits beyond the 500 weeks, then the employer will be entitled to a 100% credit for Social Security **retirement** benefits received by the claimant. The credit doesn't include cost of living increases. The theory is that an elderly individual, who may qualify for extended benefits based upon their injury and age, will not get a retirement plan based upon workers' compensation benefits, since the employer will be able to take a credit for those retirement benefits. This does **not** apply to Social Security **disability**. There is no Social Security retirement credit **within** the 500 weeks under Section (b).

It is also important to note that the 500 week cap under Section (b) is a solid cap. Therefore, if claimant is receiving benefits pursuant to a Form 60 and does nothing further, when they reach 500 weeks of benefits from the first date of disability, those benefits will terminate without the need for a Form 24 or any other action by the Commission. This brings us to when employee can seek extended benefits under Section (c).

The claimant is going to have to go through an entirely new evidentiary hearing in order to prove their entitlement to extended benefits under Section (c). The test will be whether, at week 500, the claimant has a total loss of wage earning capacity. An employee may not even seek extended benefits under Section (c) until 425 weeks have elapsed since the first date of disability. This Section becomes effective when signed by the Governor. Therefore, the very first application for extended benefits will not be made until 425 weeks from now or sometime in 2019. In addition, it would be our argument that, even if the claimant applies for those extended benefits at 425 weeks, the Commission has to wait until 500 weeks have elapsed or have some evidence as to what the employee's condition will be at 500 weeks before they can award these extended benefits. The employer will presumably have 75 weeks to do vocational rehabilitation or other rehabilitation efforts in order to establish that the claimant does have wage earning capacity and therefore would be ineligible for extended compensation benefits. As you can see, this is going to be a somewhat complicated section of the Act.

It is also anticipated that cases may settle sooner rather than later under the new Act. Under the current law many plaintiff attorneys feel the value of claims increase the longer it goes along with no return to work. However, under the new Act with the 500 week cap, the lump sum settlement value may actually go down the longer the claim remains open. In addition, employers and carriers will need to analyze many more cases under a § 97-30 TPD analysis than under the current Act.

3. N.C.G.S. § 97-29(d) – Permanent and Total Disability, exceptional case

This section deals with the only part of the statute that allows for permanent and total disability benefits. This is reserved for catastrophic cases and incorporates the prior analysis under N.C.G.S. § 97-31(24) where a claimant actually loses two or more limbs they are entitled to lifetime benefits without regard to whether they return to work or not. However, three other categories were created as a rebuttable presumption of permanent and total disability benefits. These include spinal injury involving severe paralysis of both arms, both legs or the trunk, severe brain or closed head injury as evidenced by severe and permanent motor disturbances communication disturbances, etc., and second or third degree burns to 33% or more of the total body surface. Under these final three sections, if the employer can prove that the claimant is capable of suitable employment, then permanent and total disability benefits would not be due and payable. **There is no credit for Social Security retirement benefits under this Section.**

4. N.C.G.S. § 97-29(f) – Collins Credit

N.C.G.S. § 97-29(f) also includes a provision that incorporates the *Collins* decision. In other words, employers are entitled to a credit if the claimant received TTD or TP benefits and then subsequently decides to elect the rating/PPD benefits under N.C.G.S. § 97-31.

J. N.C.G.S. § 97-30 – Temporary Partial Disability

In N.C.G.S. § 97-30, the temporary partial disability benefit increased from 300 weeks to 500 weeks and it is now 500 weeks of payments rather than 500 weeks from the date of injury. This is a significant change. Again, the theory is that claimants will be getting back to work sooner and it is only appropriate that this be a total benefit. However, this Section also makes it clear that it is not a total of 500 weeks of benefits in addition to the 500 weeks of benefits a claimant can recover under N.C.G.S. §97-29. In other words, if the claimant receives TTD benefits, those weeks of benefits are deducted from the 500 weeks under N.C.G.S. § 97-30.

K. N.C.G.S. § 97-32 – Suitable Employment

Under N.C.G.S. § 97-32 was amended to incorporate the definition of suitable employment discussed above. Employers are entitled to communicate job offers directly to the employee and copy the attorney. In addition, any order allowing termination of benefits must specify exactly what the plaintiff needs to do to correct that problem.

This provision applies to claims arising on or after June 24, 2011.

L. N.C.G.S. § 97-32.2 – Vocational Rehabilitation

This is the new vocational rehabilitation section. Under this Section, vocational rehabilitation, including a one-time assessment, will be allowed regardless of whether the employee has reached MMI. If the employee is out of work completely or returned to work and earning temporary partial disability benefits under 97-30, and his post injury wages are

less than 75% of his pre-injury average weekly wage, then the employee may request vocational rehabilitation which could include courses in the North Carolina community college and university systems. Many of the vocational rehabilitation provisions in this Section track the current rules for rehabilitation professionals. Unfortunately, employers and carriers still need to get an Order to cooperate in these cases before filing a Form 24, but given that the vocational rehabilitation has been included in the statute, perhaps Orders compelling cooperation will be routinely granted. The goal here is that vocational rehabilitation will be real and that if the claimant doesn't return to work or is refusing to cooperate, then benefits will be terminated much more often, especially with the new definition of suitable employment.

This provision applies to claims arising on or after June 24, 2011.

M. N.C.G.S. § 97-38 – Death benefits

The burial expenses increase from \$3,500 to \$10,000. Death benefits increase from 400 weeks to 500 weeks. An issue that will need to be decided by the court is whether an injury that occurs prior to June 24, 2011, but results in death on or after June 24, 2011, provides a 400 week benefit or 500 week benefit. Defendants should argue that in this situation the death claim is derivative of the original injury and therefore, the 400 week cap applies. Plaintiffs will likely argue that the death claim is a new claim subject to the 500 week benefits.

This provision applies to claims arising on or after June 24, 2011.

N. Changes to the Commission

The remaining provisions of the Act have to do with a lot of specifics regarding the makeup of the Industrial Commission and other Industrial Commission procedures. Neither the plaintiffs' attorneys nor the defense attorneys were involved in any of the negotiations regarding the makeup of the Industrial Commission. As a side note, this was a big political compromise between the Governor's office and the Republican leadership. The Governor wanted to retain 7 commissioners and the Republican leadership wanted to reduce the number of commissioners to 5. The original bill has the Commission going from 7 members to 5 members. The negotiated settlement was a Commission of 6 members. In addition, there are now term limits on the Commissioners. They can serve no more than 2 terms and a partial term of 3 years or more will be constituted as a full term. In addition, the Governor is now going to have to appoint any new Commissioner on or before March 1st, so that the practice of letting Commissioners go out of term for an extended period of time is no longer an option. Any nominations need to be submitted to the General Assembly for the approval of the House and Senate. In addition, the Governor can no longer move Commissioners from one slot to another in order to extend a Commissioner's term as they have done in the past.

Under Section 18, the Judicial Code of Conduct shall apply to Commissioners and Deputy Commissioners now. As an interesting side note, the Commission apparently adopted the Code of Judicial Conduct back in October of 2008, but they failed to notify anyone that they

had done so. Now that this is part of the statute, employers and carriers have somewhere to go if a Deputy or Commissioner is completely out of line.

Under Section 20, there was a change to Section 97-84. The Act now plainly states that the Commission must decide cases and issue findings of fact based upon a preponderance of the evidence in view of the entire record.

In addition, the lobbyists felt that it was very important that the Industrial Commission be subject to the Administrative Procedures Act. Therefore, the Commission is going to have to entirely rewrite its workers' compensation rules and if there are 10 or more objections to the rules, then they are going to have to go through a more detailed process for promulgating those rules or end up in the Legislature.

III. WHEN THE AMENDMENTS GO INTO EFFECT

A. Sections of the Act that Apply to Existing Claims

- Right to execute a resignation and release contemporaneously with a settlement agreement.
- Employee's right to seek immediate reinstatement of benefits.
- Provisions related to communications with physicians.
- Provisions related to IMEs, second opinions and change of physician.

B. Sections that Apply to Future Claims

- Suitable employment definition
- Attendant care defined as medical treatment
- Misrepresentation of physical conditions
- Benefits under N.C.G.S. §§ 97-29, 97-30 and 97-31
- Benefit caps
- Vocational rehabilitation
- Death benefits
- Credits for benefits