SOUTH CAROLINA

Workers' Compensation Law

What to Do If Hurt at Work

What to Expect. What you need to know.

by Robert J. Reeves, Attorney

About the Author

Robert Reeves is an accomplished trial lawyer with over 24 years of experience handling South Carolina workers' compensation cases. During his first seven (7) years of practice, he was an insurance defense attorney. This background taught him how to negotiate effectively with adjusters and how to prepare for anticipated defenses. Prior to law school, he was a former Registered Nurse (RN) working in Intensive Care and surgery. From that training, Mr. Reeves understands complex injury cases and can explain the physiological consequences of serious accidents and resulting disability. Since 1996, he has proudly represented injured workers and their families who need aggressive

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Mr. Reeves is a member of the National Trial Lawyers Top 100 as well as Super Lawyers for South Carolina. He has also been a member of the South Carolina Workers' Compensation Educational Association since 1989.

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Chapter One

Who is covered by workers' comp

SC Code of Laws Section 42-1-130 defines "employee" as meaning "every person engaged in an employment under any appointment, contract of hire, or apprenticeship, expressed or implied, oral or written, including aliens and also including minors, whether lawfully or unlawfully employed, but excludes a person whose employment is both casual and not in the course of the trade, business, profession, or occupation of his employer…" So what does this statute really say about who is covered under workers' compensation law? The easiest cases are those persons who are hired full-time or part-time and receive a paycheck. Other examples of compensable employment include temporary jobs, job services (although you can technically be an employee of the service company), and contract employees who are hired to do a specific job or fill a job for a limited period of time. Employees also include aliens or immigrants, whether they are here legally or illegally. Persons who are NOT covered include "independent contractors" (although that classification can be challenged) and "casual employees" who are typically hired on a random basis to do random jobs.

Chapter Two
"Injury by Accident"

Every potential workers' compensation case starts with an "accident" on the job. However, not every "accident" results in a compensable "injury." And likewise, not every "injury" is the result of a compensable "accident."

SC Code of Laws Section 42-1-160 defines (A) "injury" and "personal injury" as meaning only "injury by accident arising out of and in the course of employment." This is an unusually short definition by legislative standards, but each word in the chain is critically important. All elements listed have to be satisfied to be a compensable claim. Lawyers have argued from the beginning over exactly what "arising out of" and "in the course of employment" actually means. In typical cases, the answer is obvious. If you are injured because your hand gets caught in a machine or if you are lifting something heavy and hurt your back, it is a valid claim. However, the answer is not always so clear. For example, if you slip in water or grease and injure your knee, it is compensable. On the other hand, if you simply lose your balance or stumble, it may not be compensable. Getting hurt at work is not enough. The injury must have some relationship to your job.

Chapter Three

Notice of Accident to Employer

SC Code of Laws Section 42-15-20 requires "(A) every injured employee or his representative immediately shall on the occurrence of an accident, or as soon thereafter as practicable, give or cause to be given to the employer a notice of the accident and the employee shall not be entitled to physician's fees nor to any compensation which may have accrued under the terms of this title prior to the giving of such notice, unless it can be shown that the employer, his agent, or representative, had knowledge of the accident or that the party required to give such notice had been prevented from doing so by reason of physical or mental incapacity or the fraud or deceit of some third person. (B)…no compensation shall be payable unless such notice is given within ninety (90) days after the occurrence of the accident or death, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been prejudiced thereby. So what does this mean practically?

If someone is seriously hurt at work, notice to the employer is immediate and medical care is usually in the form of an ambulance. No questions or issues here. However, for someone

who has a minor accident such as a strain, this provision can come into play. Oftentimes, a worker feels a strain or pain regularly if they work in intense or hard labor jobs. They cannot stop each time to report same. They may even go to an urgent care center or a chiropractor for relief. In these cases, it is still very important to report all accidents as soon as possible and request medical care from your employer so that the "notice" element is satisfied and a medical record is made. In many cases, what is first thought to be a relatively minor injury turns out later to be much more serious.

Another common scenario is where an employee slips or is injured while lifting heavy loads in an "unwitnessed" accident. These cases are the best example of why it is so important to immediately report all incidences and ask for a report to be made just to be safe. Given the many examples of fraudulent claims in the past, employers and the Commission are naturally skeptical of claims reported far removed from the date in question. Regardless, any claim reported beyond ninety (90) days without good reason is forever barred by law.

Chapter Four
How long to file a claim

SC Code of Laws Section 42-15-40 mandates the time for filing claim, stating "the right to

compensation under this title is barred unless a claim is filed with the Commission within two (2) years after an accident, or if death resulted from the accident, within two (2) years of the date of death." As with the "notice" standard, it is best to file a claim as soon as practical, but the law places a final time period on how long before a claim is barred. These are two separate requirements. Many people misunderstand and think they have two years to pursue a claim. However, if they do not report within ninety days, their claim is still lost even if they file within the two years statute of limitations.

Chapter Five
Medical Treatment

SC Code of Laws Section 42-15-60 requires, in relevant part, that "(A) the employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required…as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty…the refusal of an employee to accept any medical, hospital, surgical, or other treatment or evaluation when provided by the employer or ordered by the commission bars the employee from further compensation until the refusal ceases and compensation is not paid for the period of

refusal unless in the opinion of the commission the circumstances justified the refusal, in which case the commission may order a change in the medical or hospital service." Because of the wide varieties of injuries and range of medical treatments available, this statute had to be written in a very open manner. Basically, if you have a compensable workers' compensation claim, you are entitled to whatever reasonable medical treatment or care is recommended that may lead to improvement or cure. Certainly, any test, procedure, or surgery recommended by the "authorized treating physician" is going to be ordered. However, there are many cases where an "independent medical evaluation" results in treatment recommendations that the insurance carrier refuses. In these instances, the lawyers will get "opinion" letters from the different doctors and argue before the Commission seeking an Order for additional care. Pursuant to this statute, the Commission will require the carrier to pay for reasonable care that "will tend to lessen the period of disability."

This law also addresses those situations where an injured worker refuses to participate in medical treatment. In some cases, the "refusal" may just be a real concern about undergoing a risky surgical procedure, such as a neck fusion. The Commission will make a judgment on a case by case basis to determine if the claimant

is being reasonable and prudent or just unnecessarily prolonging a claim.

Chapter Six
Weekly Benefits

SC Code of Laws Section 42-1-40 defines "average weekly wages" as “the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of fifty-two weeks immediately preceding the date of the injury… (or) such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury…Whenever allowances of any character made to an employee in lieu of wages are a specified part of a wage contract they are deemed a part of his earnings.” This initial calculation is critical as it will become the “weekly benefit” amount and will also be used to calculate the value of any eventual permanent partial disability award. What the law requires is for the employer to look back over the preceding fifty-two (52) weeks and report all wages and other allowances and divide that amount by the number of weeks actually worked. That figure represents the “average weekly wage.” Then, that amount is reduced to two-thirds (2/3) to determine the “compensation rate.” This final calculation is

what the injured employee receives weekly and then used to determine any permanency award. These benefits represent periods of "temporary" and later "permanent" disability, not lost income. As a result, ALL workers' compensation benefits are NOT subject to either state or federal income taxes. Any amounts received are not even reported on tax filings. So when do benefits begin?

SC Code of Laws Section 42-9-200 mandates when benefits start and states, "no compensation shall be allowed for the first seven (7) calendar days of disability resulting from an injury…but, if the injury results in disability of more than fourteen days, compensation shall be allowed from the date of the disability." Provided an injured worker is written out of work by an authorized treating physician or placed on light duty restrictions that cannot be accommodated by the employer, the carrier begins owing weekly benefits on the eighth (8^{th}) day. If the employee remains out of work for a total of fourteen (14) days, the employer will owe back benefits for the first seven (7) days. Benefits will continue while under authorized medical care or until light duty restricted work is offered by the employer. What if the injured worker cannot perform offered light duty work?

SC Code of Laws Section 42-9-190 addresses "no compensation to injured employee refusing suitable employment' and states "if an injured employee refuses employment procured for him suitable to his capacity and approved by the Commission he shall not be entitled to any compensation at any time during the continuance of such refusal." We get this question in a lot of cases. Doctors tend to return injured workers to "light duty" restrictions rather early, and many employers claim to have such work when, in fact, they do not. And at the same time, injured employees are still given prescription pain medications that warn not to use "while driving or operating machinery." If taken, the injured worker risks a possible DUI arrest or being fired for being "intoxicated" on the job. This is a very difficult dilemma without an easy answer. Our first advice is to tell the doctor there are no "light duty jobs" and that the patient still needs their narcotic pain medication every day. If that approach fails, the injured worker will have to at least show up at work and try. If they still feel the offered work is too much, they can go home. But to avoid the punishment of this section, they have to show a documented effort to attempt to comply.

Chapter Seven

"Maximum Medical Improvement"

This is a phrase with both medical and legal significance. From a medical standpoint, it means the curative medical treatment has ended, and the injured worker is "as good as he is going to get." There may be a dispute about this status if there are other physicians still treating the injured worker for other problems. For example, an orthopedic surgeon may release a patient from care while the neurologist is still actively treating. And in other cases, there may be disagreement between an "authorized treating physician" and findings following an "independent medical evaluation." These types of disputes may have to be resolved at a hearing, but the Commission is very accommodating to any reasonable recommended procedure or treatment. Once all physicians and/or the Commission agree the injured worker has reached MMI, the next step in the process is to determine if and to what degree there is any "permanent partial disability."

Chapter Eight

Impairment Rating / Disability Award

At the same time a doctor determines an injured worker is reaching maximum medical improvement, they will start determining if there is any "permanent partial impairment." By its description, this term means there will be lifelong effects from the injury, and now, the degree or percentage must be measured. In many cases, the treating physician will do range of motion and limitation testing in the examining room. In more serious cases, a formal "Functional Capacities Evaluation" (FCE) may be required. In either situation, the doctor will ultimately consult the American Medical Association's Guide to the Evaluation of Permanent Disability book and assign a percentage of impairment to a particular body part. For example, a typical impairment rating following a microdiskectomy back surgery is 10-15% PPI to the spine. A fusion procedure might result in a 20-25% PPI rating. In some cases, physicians make a "whole person" rating, but the Commission will convert that rating to the spine.

It is important to remember that "impairment ratings" are determined by doctors. They consider such factors as restrictions in range of motion, ability to stand or bend, weight limitations, and even pain restrictions

(although you get nothing for pain and suffering under workers' compensation law). The Commission, on the other hand, has a much more expansive review and will consider such ratings only as part of a larger analysis before determining a "disability award." In their role, they also look at an injured worker's age, education, prior work history, work restrictions, and need for future medical treatment. As a result, a "disability award" will often be a higher "percentage" than the initial impairment rating and may include future care such as continuing prescription medication or other procedures. Any "prosthetic devices" implanted, such as plates, screws, rods, artificial disks or joints, are covered for the lifetime of the injured employee.

Chapter Nine
Permanent Partial / Total Disability

There are three (3) types of permanent disability options available to injured workers once their medical treatment is concluded which we will review in descending order of frequency. Fortunately, most injuries fall under a "scheduled member" disability. In this situation, someone injures a particular body part such as the back, or knee, or shoulder. At the end of medical care, the treating physician will assess an impairment rating. That rating is then applied to the value of the affected body

part to calculate an exact dollar value based on the claimant's compensation rate. For example, the loss of the back is worth a total of 300 weeks of compensation. If a doctor assigns a 10% impairment rating, that figure would represent 30 weeks (10% of 300 weeks) of compensation. If the claimant's compensation rate is $350.00 per week, the rating would then be worth $10,500.00 (30 weeks x $350.00). Basically, the human body is divided into parts and assigned a certain value. The statute below covers most common injuries but later had to be supplemented with a Regulation to address less encountered accidents. The statute and regulation are printed here:

SC Code of Laws Section 42-9-30 provides for a "schedule of period of disability and compensation" and basically assigns a value for particular body parts. For those parts not covered in the statute, the Commission amended the list in **Regulations 67-1101 - 1105**.

Section 42-9-30:

"In cases included in the following schedule, the disability in each case is considered to continue for the period specified and the compensation paid for the injury is as specified:

(1) for the loss of a **thumb** sixty-six and two-

thirds percent of the average weekly wages during sixty-five weeks;

(2) for the loss of a **first finger**, commonly called the index finger, sixty-six and two-thirds percent of the average weekly wages during forty weeks;

(3) for the loss of a **second finger**, sixty-six and two-thirds percent of the average weekly wages during thirty-five weeks;

(4) for the loss of a **third finger**, sixty-six and two-thirds percent of the average weekly wages during twenty-five weeks;

(5) for the loss of a **fourth finger**, commonly called the little finger, sixty-six and two-thirds percent of the average weekly wages during twenty weeks;

(6) the loss of the first phalange of the thumb or any finger is considered to be equal to the loss of one half of such thumb or finger and the compensation must be for one half of the periods of time above specified;

(7) the loss of more than one phalange is considered the loss of the entire finger or thumb; provided, however, that in no case shall the amount received for more than one finger exceed the amount provided in this schedule

for the loss of a hand;

(8) for the loss of a **great toe**, sixty-six and two-thirds percent of the average weekly wages during thirty-five weeks;

(9) for the loss of one of the toes other than a great toe, sixty-six and two-thirds percent of the average weekly wages during ten weeks;

(10) the loss of the first phalange of any toe is considered to be equal to the loss of one half of such toe and the compensation must be for one half the periods of time above specified;

(11) the loss of more than one phalange is considered as the loss of the entire toe;

(12) for the loss of a **hand**, sixty-six and two-thirds percent of the average weekly wages during one hundred and eighty-five weeks;

(13) for the loss of an **arm**, sixty-six and two-thirds percent of the average weekly wages during two hundred twenty weeks;

(14) for the loss of a **shoulder**, sixty-six and two-thirds percent of the average weekly wages during three hundred weeks;

(15) for the loss of a **foot**, sixty-six and two-thirds percent of the average weekly wages

during one hundred forty weeks;

(16) for the loss of a **leg**, sixty-six and two-thirds percent of the average weekly wages during one hundred ninety-five weeks;

(17) for the loss of a **hip**, sixty-six and two-thirds percent of the average weekly wages during two hundred eighty weeks;

(18) for the loss of an **eye**, sixty-six and two-thirds percent of the average weekly wages during one hundred forty weeks;

(19) for the complete loss of hearing in one ear, sixty-six and two-thirds percent of the average weekly wages during eighty weeks; and for the complete loss of hearing in both ears, sixty-six and two-thirds percent of the average weekly wages during one hundred sixty-five weeks, and the commission, by regulation, shall provide for the determination of proportional benefits for total or partial loss of hearing based on accepted national medical standards;

(20) total loss of use of a member or loss of vision of an eye is considered as equivalent to the loss of the member or eye. The compensation for partial loss of or for partial loss of use of a member or for partial loss of vision of an eye is the proportion of the payments provided in this section for total loss

as such partial loss bears to total loss;

(21) for the loss of use of the **back** in cases where the loss of use is forty-nine percent or less, sixty-six and two-thirds percent of the average weekly wages during three hundred weeks. In cases where there is fifty percent or more loss of use of the back, sixty-six and two-thirds percent the average weekly wages during five hundred weeks. The compensation for partial loss of use of the back shall be such proportions of the periods of payment herein provided for total loss as such partial loss bears to total loss, except that in cases where there is fifty percent or more loss of use of the back the injured employee shall be presumed to have suffered total and permanent disability and compensated under Section 42-9-10(B). The presumption set forth in this item is rebuttable;

(22) for the total or partial loss of, or loss of use of, a member, organ, or part of the body not covered in this section and not covered under Section 42-9-10 or 42-9-20, sixty-six and two-thirds of the average weekly wages not to exceed five hundred weeks. The commission, by regulation, shall prescribe the ratio which the partial loss or loss or partial loss of use of a particular member, organ, or body part bears to the whole man, basing these ratios on accepted medical standards and these ratios determine the benefits payable under this subsection;

(23) proper and equitable benefits must be paid for serious permanent disfigurement of the face, head, neck, or other area normally exposed in employment, not to exceed fifty weeks. Where benefits are paid or payable for injury to or loss of a particular member or organ under other provisions of this title, additional benefits must not be paid under this item, except that disfigurement also includes compensation for serious burn scars or keloid scars on the body resulting from injuries, in addition to any other compensation."

Regulation 67-1101. Total or Partial Loss or Loss of Use of a Member, Organ, or Part of the Body.

A. This regulation does not include injury to the many bodily systems, organs, members, and anatomical parts for which compensation is payable due to disability or serious disfigurement under Section 42-9-10 and Section 42-9-20.

B. This schedule of organs, members, and bodily parts lists prominent parts of the anatomy subject to occupational injury and is not complete. The value of an organ, member, or bodily part not included may be determined in accordance with the American Medical Association's "Guide to the Evaluation of

Permanent Impairment", or any other accepted medical treatise or authority. Compensation shall be payable shall be payable for total loss, permanent partial loss, or loss of use of a member, organ, or part of the body when compensation is not otherwise payable.

C. For total loss, partial loss, or loss of use of an organ, member, or body part listed in this regulation, disability shall be deemed to continue for the minimum period specified, if applicable. In cases involving impairment and disability in excess of the minimum period specified for partial loss of or loss of use of an organ, member, or bodily part, compensation shall be payable in such proportion as disability bears to the maximum number of weeks provided in this regulation. The maximum period of compensation for a combination of injuries is the legislative criterion of five hundred weeks.
Breast 75; 10-75
Breasts 250; 25-250
Coccyx 10; 1-10
Gall Bladder 75; 10-75
Kidney 400; 25-250
Lung 400; 25-250
Pancreas 500; 10-250
Rib 10; 1 1/2 -10
(Maximum award of 200 weeks for total loss of 4 ribs)
Scrotum and Testicles 350; 30-300

Spleen 25; 2 1/2 -25
Testicle 75; 10-75
Testicles 250; 25-250
Tongue 500; 50-500
Tooth 2; 1/2 -2
Biliary Tract 75-400
Bladder 25-250
Brain 25-250
Bronchi or Bronchus 25-400
Esophagus 25-400
Cervix 10-100
Clavicle 10-100
Colon 25-250
Diaphragm 25-250
Duodenum 10-250
Fallopian Tubes 10-100
Heart 25-250
Intestine, Small 10-400
Larynx 25-400
Liver 25-250
Mandible 10-100
Ovaries 10-100
Palate 25-250
Penis 25-250
Prostate 10-100
Rectum 10-250
Scapula 10-200
Skin 5-300
Spermatic Cord 10-100
Sternum 10-100
Stomach 25-250
Thyroid Gland 10-100

Ureter 10-100
Urethra 10-100
Vagina 25-250
Vulva 25-250
Nasal Pasage 10-75
Olfactory Nerve 10-75
Sinus 5-30
Zygomatic Arch or Facial Nerve
(In accordance with the AMA "Guides")

Regulation 67-1102. Loss of Hearing.

A. The method for determining hearing impairment is based on the American Academy of Otolaryngology "Guide for Evaluation of Hearing Handicap", copyright 1979, which is based upon the American Medical Association's "Guides to the Evaluation of Permanent Impairment", copyright 1977.

B. The calculation of a hearing handicap is derived from the pure tone audiogram, obtained with an audiometer calibrated to ANSI S3.6-1969 standards and as follows.

(1) The average of the hearing threshold levels at 500 Hz, 1000Hz, 2000Hz, and 3000Hz are calculated for each ear.

(2) The percent impairment for each ear is calculated by multiplying by 1.5% the amount that the above average hearing threshold level

exceeds 25dB (low fence) up to a maximum of 100%, which is reached at 92dB (high fence).

(3) The hearing handicap, a binaural assessment, is calculated by multiplying the smaller percentage (better ear) by five, adding this figure to the larger percentage (poorer ear), and dividing the total by six.

Regulation 67-1103. Amputation of Finger or Toe.

A. The amputation of any portion of the bone of the distal phalange of a finger or toe to a point opposite the base of the nail is deemed the loss of one-fourth of the finger or toe.

B. Amputation below the base of the nail of the bone in the distal phalange is deemed loss of one-half of a finger or toe.

Regulation 67-1104. Health Care for Injury Resulting in Hernia.

A. In a claim involving an injury resulting in a hernia in which liability is denied and the claimant will be disabled pending a hearing, the employer's representative may provide the claimant a truss.

B. Health care provided in section A above shall not be construed an admission of liability for

payment of temporary total compensation.

C. The costs incurred in providing the claimant a truss may be charged as a medical expense.

Regulation 67-1105. Loss of Vision.

A. Loss of vision is based on reading without the use of corrective lenses. Eighty percent loss of vision, or more, is considered one hundred percent industrial blindness.

B. The following table, derived from the Snellen Notation, is used to determine the percentage of impairment to vision. The physician also may rely upon the American Medical Association's "Guide to the Evaluation of Permanent Impairment" and any other accepted medical authority or treatise in deriving an impairment rating.

C. Loss in muscle function, in conjunction with other factors, may warrant a greater percentage of loss of vision.

Notation for Distance Notation for Near Percentage of Visual Percentage of Efficiency Vision

20/20 14/14 100.0 0.0
20/25 14/17/5 95.7 4.3
20/30 14/21 91.5 8.5

20/35 14/24.5 87.5 12.5
20/40 14/28 83.6 16.4
20/45 14/31.5 80.0 20.0
20/50 14/35 76.5 23.5
20/60 14/42 69.9 30.1
20/70 14/49 64.0 36.0
20/80 14/56 58.5 41.5
20/90 14/63 53.4 46.6
20/100 14/70 48.9 51.1
20/120 14/84 40.9 59.1
20/140 14/96 34.2 66.8
20/160 14/112 28.6 71.4
20/180 14/126 23.9 76.1
20/200 14/140 20.0 80.0
(80% is considered 100% industrial blindness.)
20/220 14/154 16.7 83.3
20/240 14/168 14.0 86.0
20/260 14/182 11.7 88.3

The only other points to be made here is that loss of vision and hearing are very specific and dependent upon testing results. There is very little subjectivity involved in ratings calculations. Also, when dealing with amputations, it is either "half or whole." Ratings assigned by physicians are not of much use given the clear directive of this Regulation. And finally, hernia claims are so subject to abuse that they have their very own law, and the requirements to prove a compensable claim here are sometimes very difficult in the real world.

The second type of permanent disability involves cases where more than one body part is affected, and the injured worker is not able to go back to a job making the same wages as before the accident. They are not permanently and totally disabled but will not be able to make the same amount of money. As a result, the legislature provides for a payment equal to the difference in pay for up to 340 weeks. This type of case is largely a battle of vocational experts to show what the predicted wage loss will be. The statute is as follows:

SECTION 42-9-20. Amount of compensation for partial disability.

Except as otherwise provided in Section 42-9-30, when the incapacity for work resulting from the injury is partial, the employer shall pay, or cause to be paid, as provided in this chapter, to the injured employee during such disability a weekly compensation equal to sixty-six and two-thirds percent of the difference between his average weekly wages before the injury and the average weekly wages which he is able to earn thereafter, but not more than the average weekly wage in this State for the preceding fiscal year. In no case shall the period covered by such compensation be greater than three hundred forty weeks (340) from the date of injury. In case the partial disability begins after

a period of total disability, the latter period shall not be deducted from a maximum period allowed in this section for partial disability.

The last type of permanent disability award is the most serious, and fortunately, the most rare. The cases where someone is permanently and totally disabled are truly limited for life and will need ongoing medical treatment and benefits. Under the statute, medical treatment does continue, but unless the person is blinded, has para- or quadraplegia, or suffers from a brain injury, their weekly benefits are stopped after 500 weeks. In those other scenarios, the injured worker gets both lifetime medical and weekly benefits. The assumption is that they will be placed on some type of long-term disability plan and/or Social Security disability. The general permanent disability statute is as follows:

SECTION 42-9-10. Amount of compensation for total disability; what constitutes total disability.

(A) When the incapacity for work resulting from an injury is total, the employer shall pay, or cause to be paid, as provided in this chapter, to the injured employee during the total disability a weekly compensation equal to sixty-six and two-thirds percent of his average weekly wages, but not less than seventy-five

dollars a week so long as this amount does not exceed his average weekly salary; if this amount does exceed his average weekly salary, the injured employee may not be paid, each week, less than his average weekly salary. The injured employee may not be paid more each week than the average weekly wage in this State for the preceding fiscal year. In no case may the period covered by the compensation exceed five hundred weeks except as provided in subsection (C).

(B) The loss of both hands, arms, shoulders, feet, legs, hips, or vision in both eyes, or any two thereof, constitutes total and permanent disability to be compensated according to the provisions of this section.

(C) Notwithstanding the five-hundred-week limitation prescribed in this section or elsewhere in this title, any person determined to be totally and permanently disabled who as a result of a compensable injury is a paraplegic, a quadriplegic, or who has suffered physical brain damage is not subject to the five-hundred-week limitation and shall receive the benefits for life.

Chapter Ten

Hearings / Appeals

SC Code of Laws Section 42-17-40 addresses the conduct of hearings and awards. That law states: "(A) The commission or any of its members shall hear the parties at issue and their representatives and witnesses and shall determine the dispute in a summary manner. The award, together with a statement of the findings of fact, rulings of law, and other matters pertinent to the questions at issue, must be filed with the record of the proceedings and a copy of the award must immediately be sent to the parties in dispute…" Although hearings are fairly informal in nature, they are still legal proceedings with a judge (Commissioner), court reporter, and witnesses. Medical evidence is submitted without testimony, unless there are depositions taken of treating physicians. Witnesses are called to the stand to testify and are subject to cross-examination. And other expert witness reports can be included for consideration as well. What is missing is a jury. There is no right to a jury trial in workers' compensation cases. As a result, there is also no "opening statement" or "closing argument." Instead, the Commissioner reviews the written medical records and considers the hearing testimony in making a determination on the issue(s) presented. Sometimes, only a partial dispute is in

controversy, such as a medical procedure. Other times, the entire claim is disputed. For admitted cases where the only issue is permanency, hearings are expected to last approximately 15 minutes. In disputed cases, only 30 minutes is allotted unless one or both parties request additional time. After carefully considering all of the evidence, the Hearing Commissioner will issue a Decision and Order with Findings of Fact and Rulings of Law. If either side wishes to appeal, they have fourteen (14) days to file a Notice of Appeal to the Full Commission where they will receive a *de novo* review by three (3) different Commissioners. The relevant statute is as follows:

SC Code of Laws Section 42-17-50 addresses review and rehearing by Commission and states, "if an application for review is made to the Commission within fourteen (14) days from the date when notice of the award shall have been given, the Commission shall review the award and, if good grounds be shown therefor, reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award.

A Full Commission review addresses both disputed issues of both fact and law. Generally, the Full Commission panel will defer to the Hearing Commissioner on a credibility finding

as that individual would have had the unique perspective of having personally observe the demeanor and hear the live testimony of witnesses. In this appeal, there is no more testimony. Rather, written appeal briefs are submitted and then argued by lawyers or injured workers, if unrepresented.

The next level of appeal is to the South Carolina Court of Appeals and possibly the South Carolina Supreme Court. However, in these reviews, only errors of law are considered. All findings of fact are deemed conclusive and cannot be raised on further appeal. The relevant statute is below:

SC Code of Laws Section 42-17-60 mandates: "the award of the commission, as provided in Section 42-17-40, if not reviewed in due time, or an award of the commission upon the review, as provided in Section 42-17-50, is conclusive and binding as to all questions of fact. However, either party to the dispute, within thirty days from the date of the award or within thirty days after receipt of notice to be sent by registered mail of the award, but not after, whichever is the longest, may appeal from the decision of the commission to the court of appeals." There are also provisions for payment of an award during further review, possible accrued interest, and even sanctions for frivolous appeals.

Chapter Eleven

Third Party Claims

The only option to "sue" an employer in South Carolina is by filing workers' compensation claim. Fault is not an issue. Whether the employer was or was not negligent in causing an accident or injury, they are protected from a private lawsuit. That statute is as follows:

SC Code of Laws Section 42-1-540 provides "the rights and remedies granted by this Title to an employee when he and his employer have accepted the provisions of this Title, respectively, to pay and accept compensation on account of personal injury or death by accident, shall exclude all other rights and remedies of such employee, his personal representative, parents, dependents or next of kin as against his employer, at common law or otherwise, on account of such injury, loss of service or death." However, if an accident is the result of someone's negligence that is not affiliated with the injured worker's employer, there may be a separate claim for a "third party action."

SC Code of Laws Section 42-1-560 addresses the "right to compensation not affected by liability of third party; rights and remedies against third party" and states, "(a) the right to compensation and other benefits under this

Title shall not be affected by the fact that the injury or death is caused under circumstances creating a legal liability in some person, other than the employer or another person exempt from liability under Section 42-1-540 to pay damages therefor, the person so liable being hereinafter referred to as the third party." The most common example of a workers' compensation claim with a third party action is when someone is involved in an automobile accident while on the job. Another common example is when someone is injured while working with a machine that is negligently maintained by a separate entity.

In these type of cases, the first priority is to finish the workers' compensation case first. All of the medical treatment and lost time benefits will be paid by the workers' compensation carrier. There will be a permanent impairment rating. At that point, the final "fixed damages" will be determined, and the only element left to be resolved will be "pain and suffering." Of course, the workers' compensation carrier will have a "lien" on any benefits recovered from a third party and must be negotiated, if possible, before dealing with the third party insurance carrier. Also, if you pursue your third party action improperly, you can be found to have "elected your remedy" and forego any workers' compensation benefits.

Chapter Twelve

Occupational Disease Claims

These type of claims are some of the most complicated from both a medical and legal perspective. These claims usually involve exposure to dangerous chemicals or other toxins. There is much debate and dispute between expert medical and vocational experts. There are also strict time deadlines to file such claims. The relevant statute is as follows:

SC Code of Laws Section 42-11-10 provides "(A) "Occupational disease" means a disease arising out of and in the course of employment that is due to hazards in excess of those ordinarily incident to employment and is peculiar to the occupation in which the employee is engaged. A disease is considered an occupational disease only if caused by a hazard recognized as peculiar to a particular trade, process, occupation, or employment as a direct result of continuous exposure to the normal working conditions of that particular trade, process, occupation, or employment. In a claim for an occupational disease, the employee shall establish that the occupational disease arose directly and naturally from exposure in this State to the hazards peculiar to the particular employment by a preponderance of the evidence.

(B) No disease shall be considered an occupational disease when it:
(1) does not result directly and naturally from exposure in this State to the hazards peculiar to the particular employment;
(2) results from exposure to outside climatic conditions;
(3) is a contagious disease resulting from exposure to fellow employees or from a hazard to which the workman would have been equally exposed outside of his employment;
(4) is one of the ordinary diseases of life to which the general public is equally exposed, unless such disease follows as a complication and a natural incident of an occupational disease or unless there is continuous exposure peculiar to the occupation itself which makes such disease a hazard inherent in such occupation;
(5) is any disease of the cardiac, pulmonary, or circulatory system not resulting directly from abnormal external gaseous pressure exerted upon the body or the natural entrance into the body through the skin or natural orifices thereof of foreign organic or inorganic matter under circumstances peculiar to the employment and the processes utilized therein; or
(6) is any chronic disease of the skeletal joints.

(C) As used in this section, "medical evidence" means expert opinion or testimony stated to a

reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider.

(D) No compensation shall be payable for any occupational disease unless the employee suffers a disability as described in Section 42-9-10, 42-9-20, or 42-9-30.

As you can readily see, this is a very complex area of law where legal and medical experience is going to make a real difference in the outcome of the case. Certainly, at a minimum, one should consult a seasoned workers' compensation attorney who can retain the necessary experts to prove the required elements of this type claim.

Appendix

Frequently Asked Questions

Will I lose my job if I hire an attorney?

These are still very difficult economic times. If you do get hurt at work, you're understandably reluctant to hire a lawyer or pursue a claim. No one wants to risk a good job, especially these days. Unfortunately, you're in a real trap. If you don't report an accident and later learn you have something more serious than first thought, you may lose the right to pursue a

claim later. Here's the reality. If your employer typically fires someone when they get hurt, it is even more important that you consult an attorney as soon as possible. We can help you, but you have to get us involved early.

What if I have a pre-existing injury or medical condition?

It doesn't matter. Whether it is a "new injury" or an "aggravation of a prior injury or condition," the claim is still compensable. The relevant statute provides:

SC Code of Laws Section 42-9-35 states "(A) The employee shall establish by a preponderance of the evidence, including medical evidence, that: (1) the subsequent injury aggravated the preexisting condition or permanent physical impairment; or (2) the preexisting condition or the permanent physical impairment aggravates the subsequent injury…(D) The provisions of this section apply whether or not the employer knows of the preexisting permanent disability." The last part of this statute complies with the federal law Americans with Disabilities Act (ADA) that prohibits employers from denying employment based on previous injuries or disabilities. Employers are not allowed to ask about prior injuries or claims. Only after you are offered a job can they require a pre-employment physical

examination. At that point, you should be absolutely honest about any conditions or surgeries.

Can my claim be denied based on a drug test?

It depends. Obviously, if you come to work impaired and are injured due to the impairment, no benefits will be awarded. However, the accident must be directly caused by the impairment. Even if you are "intoxicated" and something hits or falls on you, that claim would still be compensable under the law. Additionally, a "positive" drug test is not always fatal to a claim. As we all know, these urine tests are not always reliable, and you may need to get your own independent testing to refute such finding. The relevant statute provides as follows:

SC Code of Laws Section 42-9-60 states, "no compensation shall be payable if the injury or death was occasioned by the intoxication of the employee…in the event that any person claims that the provisions of this section are applicable in any case, the burden of proof shall be upon such person."

Can my medical records be given to my employer and insurance carrier without my permission?

Yes. But arguably not all of your past medical records is subject to disclosure. By seeking benefits, you give up your right to privacy for treatment relating to the claim. This area gets a little confusing given all of the HIPPA regulations. Regardless of the right, employers and adjusters still need to be very mindful of how such private, personal information is disseminated to others. The relevant statute provides:

SC Code of Laws Section 42-15-95 states "(A) any employee who seeks treatment for any injury, disease, or condition for which compensation is sought under the provisions of this title shall be considered to have given his consent for the release of medical records relating to such examination or treatment under any applicable law or regulation. All information compiled by a health care facility, as defined in Section 44-7-130, or a health care provider licensed pursuant to Title 40 pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their respective attorneys or certified rehabilitation professionals, or the South Carolina Workers' Compensation Commission, within fourteen

(14) days after receipt of written request.

Do I need to discuss my case with a lawyer?

It depends. If your injury is not serious or you expect to heal completely, then you probably do not need an attorney. Hopefully, this eBook has answered a lot of your questions. However, if you have something serious, such as surgery or prosthetic devices implanted, then you absolutely should consult with an experienced workers' compensation attorney to thoroughly review your particular circumstances. This information is very basic. The actual laws are much more complex and confusing. We get involved in our client's cases as soon as possible in order to guide treatment and anticipate problems. Please don't make the mistake of calling us after it is too late.

What will it cost me to consult an attorney?

The consultation is free if you call our firm. We will be happy to sit down with you and talk about your case and your options. If you decide to hire us, we charge a "contingency fee" which means we only get paid if we are successful. You don't have to pay any money out of pocket and owe us nothing if we do not win your case. If we do prevail, attorney fees are up to one-third (1/3) and must be approved by the Commission. In certain cases, we charge a

reduced fee of twenty-five (25) percent. The only costs you would owe is for medical records, deposition charges, and filing fees.

How should I choose a workers' compensation lawyer out of so many?

Many people just ask a friend, family member, or even a coworker. That's always a good start, but we encourage you to do your own research. This first decision is critical to your case. We respectfully suggest you carefully compare the actual credentials and real experience in handling workers' compensation cases. Interview several attorneys and ask how many cases they have tried vs. settled. Ask how long and how often they handle workers' compensation files. Is this a regular part of their practice or do they just take a few each year. Then, after you're satisfied all of your questions and concerns have been answered, hire the best, most qualified lawyer in whom you have the most confidence. After you have had an opportunity to review our credentials, please call us for a personal interview. We would like you to consider hiring our firm and let us help you and your family get through one of the most difficult times in your life. We hope to hear from you. You can reach me directly at **803-554-4157** or send me an email at **rjrlaw@gmail.com**.