BASIC OHIO WORKERS' COMPENSATION

I. INTRODUCTION.

A. Workers' Compensation began in Ohio in 1912 as a creation of statute. It replaced the common law recovery for workplace injuries. The essential purpose of workers' compensation is to provide medical benefits and compensation to workers and/or their decedents as a result of their workplace injury. The entire workers' compensation statutory construction is contained within Ohio Revised Code Sections 4123.01 through 4123.94, inclusive. O.R.C. Section 4123.95 mandates that Sections 4123.01 through 4123.94 are to be **liberally construed on behalf of injured workers**. This means that the statutory sections are to be liberally construed in favor of injured workers. This does **not** mean that the **facts** of each individual case should be liberally construed in favor of injured workers.

1. Employers in Ohio are either state-funded or self-insured. There is no difference in the benefits available to injured workers, however, there are some procedural differences in how the benefits are obtained.

2. There are two state agencies charged with duties regarding workers' compensation in Ohio (The Bureau of Workers' compensation and the Industrial Commission of Ohio).

    a. The Bureau of Workers' Compensation ("BWC") handles the administrative and ministerial functions of the workers' compensation system. The BWC has a central office in Columbus and various district offices throughout the state.

    b. The Industrial Commission of Ohio ("I.C.") is the adjudicatory branch charged with deciding disputes arising from determinations made by the BWC.

3. Workers' Compensation coverage is mandatory in Ohio.

    Premiums are first estimated and then confirmed at a later date. **This is a major recent change. Premiums used to be paid in arrears, now they are paid like most other insurance premiums.** Employers have the choice to pay for workers' compensation coverage on a monthly, quarterly, bi-yearly, or yearly basis. It is the employer's responsibility to ensure that they correctly report and pay premiums. To accomplish this, companies must file "true-up reports" to confirm wages and classifications upon which their premiums are based. Even though many services (Accountants, Payroll Service Companies, etc.) perform this function for

employers, it is the responsibility of each employer to make sure that this is done accurately. Any errors will be charged against the individual employer (even though the employer may have an action against their reporting agency).

4. Workers' Compensation claims are either medical-only claims (claims with less than 7 days of time missed from work as a result of the workplace injury) **or** lost-time claims (claims with 8 days or more of time missed from work as a result of the workplace injury).

II. HOW TO BEGIN LEGAL REPRESENTATION FOR WORKERS' COMPENSATION MATTERS.

A. In-person meeting with prospective client.

All new representation of either injured workers or employers should begin with a detailed face-to-face meeting with the prospective client to assess a potential case, determine any conflicts, and set forth the basis for remuneration. In no event should a telephonic or computer-based evaluation take the place of an in-person meeting with a prospective client. Many times, the client may want to have a family member or friend in attendance at the attorney-client meeting. This should be discouraged inasmuch as it undermines the attorney-client privilege. While the client may waive this, it should be avoided in all but the very rarest of cases.

B. Fee agreement.

In all cases in which legal representation is undertaken, a **written** fee agreement should be signed by both parties after the terms have been thoroughly explained to the client. Beyond merely setting forth the monetary expectations, other issues should be clearly set forth in the fee agreement. Some of these include the client's responsibilities to advise counsel of any changes and/or updates which may affect the underlying case(s).

C. Creating and maintaining a client file.

During the client meeting, certain information should be recorded and kept in the client's file. This can be either a paper file or an electronic file. Neither party should rely on their respective memory when dealing with facts in a workers' compensation case. Some of the information which should be recorded is as follows:

1. Client name, address, and phone number. Alternative contacts should be documented in case the client becomes inaccessible for whatever reason.

2. Claim number, date of injury, social security number, and birth date should also be noted. Remember that you have an obligation to protect your client's information. Do not leave file information where others can access it. In addition, shred all written information that contains client information.

3. Accident report(s), witness statements, treating physicians' / hospital information, alleged body parts involved, and any days missed from work as a result of the workplace injury.

4. Any BWC and/or I.C. Forms that your client has signed (see attached Table of Contents of Forms).

Data collection is an ongoing process in workers' compensation cases.

D. File the necessary forms with the respective agencies / parties.

When representing either injured workers or employers before the BWC / I.C., a signed R-2 or R-1 form respectively must be filed with the state agencies (see attached Table of Contents of Forms, pgs. 33 & 41. Throughout the life of the claim, various forms / reports will need to be filed.

III. WORKERS' COMPENSATION STATUTORY DEFINITIONS.

A. Employment status.

1.) To be covered under Ohio Workers' Compensation, an individual must be an employee. Whether an employer has coverage or not, an employee will receive benefits under Ohio Workers' Compensation. Discuss non-complying employers.

a.) An Independent Contractor is not considered an employee for purposes of workers' compensation. However, merely saying that someone is an independent contractor and not withholding taxes is not automatically sufficient to establish an independent contractor status.

B. An injury / occupational disease must occur as a result of and arising out of one's employment.

C. Workers' compensation benefits are available in cases of an injury, an occupational disease, or a death claim.

1.) INJURY.

a.) Ohio Revised Code Section 4123.01 (C) defines what injuries are covered under workers' compensation:
"Injury" includes *any injury*, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. An injury can occur even if there is no unusual circumstance preceding the injury while an employee is performing their normal work duties.

1.) An independent contractor does not qualify. However, merely paying someone and reporting income via a 1099 tax from does not automatically cause them to be an independent contractor. The determining factor is based on a number of factors, with the main one being, "Who maintains the reservation of the right to control the worker's actions." Be careful with this when representing employers. Employers should insist on anyone alleging independent contractor status to show a valid certificate of coverage from the BWC. If not, severe financial penalties may result.

b.) An employee can qualify for workers' compensation benefits for a gradually-developing injury. This was first recognized in a case which involved a battery installer on an assembly line who developed a backache over a period of five days on a job, whereas, on the sixth day his back pain became severe. He was unable to point to a specific incident occurring at a specific time and/or place. This is also known as a "cumulative trauma-type injury." This will be contrasted later with an occupational disease.

c.) An aggravation of a pre-existing condition is compensable as an injury. For injuries arising prior to August 25, 2006, even a slight aggravation of a pre-existing condition would qualify as an injury. However, for injuries occurring on or after August 25, 2006, an injured worker must establish that a "substantial aggravation" of a pre-existing condition occurred for the claim to be covered. Once the condition returns to pre-injury status, no further benefits are payable. Proving a "substantial aggravation" has elicited much discussion; however, it mainly is a medical determination.

d.) If an employee is injured while attending and participating in a company-sponsored recreational program, the employee will have a valid claim unless he/she had signed a specific waiver prior to the event. (See Table of Contents of Forms – pg. 46).

e.) Several exceptions exist to the inclusion as an injury. One of these is a purely psychological injury without any corresponding physical injury. Another is the natural deterioration of an organ or system. Yet another exclusion is a self-inflicted injury. Even though workers' compensation is a "no fault" system, a self-inflicted injury is excluded from coverage. Finally, any injury which occurs as a result of an idiopathic cause will not be covered. Although an injury which is solely due to an idiopathic cause would not be compensable, where the employment significantly contributed to the injury by putting the employee in a "position which increased the dangerous effects", then the injury would be compensable.

2). OCCUPATIONAL DISEASE.

a). Occupational diseases are compensable if they fit into either one of two categories;

1). There is a "schedule" of diseases listed in Ohio Revised Code 4123.68. The "schedule" is a listing of diseases which are automatically considered to be a valid occupational disease. These are sometimes called "scheduled occupational diseases";

and,

2). Employees may qualify to claim an occupational disease if they are encompassed within the language set forth under the general occupational disease definition set out under Ohio Revised Code 4123.01 (F). This statutory definition sets forth three elements of which the employee must establish all three elements for an unscheduled disease to be compensable. The definition (with the three elements highlighted) is; "…a disease [1] contracted in the course of employment, [2] which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and [3] the employment creates a risk of contracting the disease in a greater degree and in a different manner from the public in general." This is different from the "cumulative trauma-type injury" previously mentioned.

Medical evidence is necessary to establish occupational disease claims. Traditionally, it is generally considered that an employee

cannot successfully maintain a claim for an aggravation of an underlying occupational disease. The Supreme Court cases used to support this contention are: *State, ex rel. Miller V. Mead* (1979), 58 Ohio St.2d 405, and *Brody v. Mihm* (1995), 72 Ohio St.3d 81. However, when reading the Supreme Court's decision in *Oswald v. Connor* (1985), 16 Ohio St.3d 38, it is clear that the Court found that a worker's death due to an aggravation caused by an occupational disease was compensable under the Ohio Workers' Compensation System.

IV. INITIAL PROCESSING AND THE ONGOING PURSUIT OF A WORKERS' COMPENSATION CLAIM.

A. Filing the FROI Application for an injury claim, an occupational disease claim, and/or a death claim. The timing of these filings is critical as failure to do so will result in the denial of the claim. The filing timelines for injury claims and death claims is within one (1) year after the date of the workplace injury or death. Thus, if an employee had an injury on January 5, 2018, he/she would need to file the FROI by January 5, 2019. This is a recent change from previous timelines. Occupational disease claims have a different time frame calculation which will be discussed later.

1.) When filing any of the above-noted claims, make sure the FROI Form is accurately and completely filled out and filed with the necessary medical support evidence. The FROI Form can be viewed at the attached Table of Contents of Forms at pgs. 9-11
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2.) If filing for a lost time claim, make sure wages are filed so that compensation can be properly paid. There are two different calculations of wages that are necessary to properly pay workers' compensation benefits. The first calculation is the Full Weekly Wage (FWW). The FWW is used to pay for the first twelve weeks of lost time in a claim. Beginning with week 13 forward, the Average Weekly Wage (AWW) calculation is needed.

a. The FWW is determined by looking at the **highest** of three numbers:

1.) The 6 week period immediately preceding the injury, including overtime pay divided by 6; or,
2.) The week immediately prior to the injury, excluding any overtime pay; or,
3.) The number of hours the employee was scheduled to work in the week of the injury times the hourly rate of pay.

Once the FWW is determined, 72 % of the FWW is paid to the injured worker for the first twelve weeks that he/she is off work as a result of the workplace injury.

b. The AWW is determined by looking at the total pay received during the 52 week period prior to the injury divided by 52. This can be from several different employers and more than one job as long as it is within the 52 weeks prior. If there are weeks that the injured worker did not work during the 52 week period preceding the injury due to circumstances beyond the employee's control (not just based on the choice of the employee to not work), then those weeks can be excluded from the calculation. Once the AWW is determined, 66 2/3 % of the AWW is paid for week 13 forward for any days missed due to the workplace injury. See pgs. 19-23 in Forms.

B. Filing the C-84 Form and making sure that the MEDCO-14 Form is completed by the attending physician so that time missed from work can be paid to the injured worker due to the workplace injury. These benefits are called temporary total disability benefits. See the Table of Forms at pgs. 17-18 to locate a C-84 Form and pgs. 13-16 to locate a MEDCO-14 Form. As counsel to injured workers, you should carefully advise your client to read and accurately complete the front portion of the C-84 Form. Failure to do so and/or concealing any remuneration received (especially money paid "under the table") during periods in which compensation is sought can result in civil and criminal fraud charges being filed by the BWC.

C. Obtaining required medical evidence and processing the same by filing a C-86 Motion Form to seek additional benefits in an existing workers' compensation claim. Should the injured worker seek to have his/her FWW/AWW amounts increased due to newly discovered evidence, this should be done via a C-86 Motion Form (see Table of Forms at pgs.26-27). Or, should additional medical conditions arise as a result of the original injury as evidenced by supporting medical from a licensed physician, these conditions should be sought to be additionally recognized in the workers' compensation claim via a C-86 Motion Form. Note, however, that if the additional condition is of a psychiatric/psychological nature, the disclaimer portion of the C-86 Motion form must be signed by the injured worker and filed along with the C-86 Motion form itself. Additionally, subsequent periods of temporary total disability (due either to a worsening of the injured worker's condition or as a result of treatment, i.e., surgery) should be sought via a C-86 Motion Form. Finally, treatment which has been denied can be requested, with medical justification, via a C-86 Motion Form. C-86 Motions can be granted by the BWC **or** referred to the Industrial Commission for a hearing on the issues raised by the C-86 Motion.

D. Filing a C-92 Application to obtain benefits for a permanent partial disability or an increase in permanent partial disability. See Forms at pgs. 24-25. An application for permanent partial disability benefits should be filed 26 weeks after the date of injury in medical-only claims or 26 weeks after the most recent payment for benefits paid pursuant to Ohio Revised Code Section 4123.56. Once this is received by the BWC, the BWC will schedule the injured worker with an independent physician for an examination to determine the percentage of permanent partial disability. When the report is received by the BWC, the BWC will issue a tentative order based on the physician's opinion. Either the employer or the injured worker or their respective representatives may file an objection to the tentative order and then attend a hearing to argue for a higher or lower percentage, depending on which side is seeking the relief. Both sides my seek relief from the determination if they desire. Either party will need to obtain and introduce medical evidence to support their position(s). Once an initial award is made, an injured worker may seek to have the award increased in the future based on new and changed circumstances. Supporting medical evidence would be needed to be successful. However, if new conditions are added to a claim, an increase can be sought without the injured worker having to first obtain medical evidence. The C-92 Application form would need to be filed, with the newly allowed condition box checked, and the BWC will set up a new examination to determine whether an increase is warranted in the agency's view. These benefits are determined under R.C. 4123.57 (B). If an injured worker has sustained an amputation of an appendage, or if the injury has progressed to the point wherein an appendage is rendered more useless than not, benefits under R.C. 4123.57 (A) may be sought. These benefits can be paid, with supporting medical evidence for the following types of losses: Fingers, toes, hand, arms, feet, legs, eyes, and hearing loss. These two types of benefits are paid at a radically different amount which is indicated on the Compensation Rate Chart on pg. 4.

E. In cases where a physician has offered an opinion that the injured worker will never be able to engage in sustained remunerative employment, a permanent total disability (PTD) application should be filed in an effort to obtain lifetime benefits for the injured worker (see Forms at pgs.63-68). Once this application is received by the I.C., an examination will be scheduled with an I.C. Medical Specialist to determine whether or not the injured worker should be awarded PTD benefits. Usually, a hearing will need to be held before a Staff Hearing Officer to determine whether PTD benefits should be granted. In addition to the medical evidence outlining medical restrictions following the Ohio Administrative Code, other factors (age, education, work experience, and transferability of work skills) will be considered by the SHO when deciding whether the injured worker should be entitled to PTD Benefits. Since these benefits are granted for the life of the injured worker, the various factors are scrutinized.

The statute of limitations for Workers' Compensation Claims (with a date of injury of August 25, 2006 forward) to be able to continue to be a valid claim is 5 years from

the date of last **payment** or **application for payment** of either a medical bill or compensation paid to or applied for by the injured worker. That means that, if no payment or application for medical services or compensation is made for a 5 year period, then the workers' compensation claim would be considered dead and no further benefits would be able to be sought as a result. The claim would expire by operation of statute. However, the mere filing for an application of benefits would need to be accompanied by a successful determination by either the BWC or the IC to toll the statute. Thus, an application which ultimately gets denied will not toll the statute of limitations.

V. HEARINGS BEFORE THE INDUSTRIAL COMMISSION.

There are 3 levels of hearings available to either injured workers or employer on contested / disputed issues. The first level of hearing is at the District Hearing Officer (DHO) level. If either party disagrees with the DHO determination, an appeal must be filed within 14 days from the date of receipt of the DHO Order; see Forms at pg. 74. (The one exception to this is when the DHO makes a determination on permanent partial disability. In that case, a Request for Reconsideration must be filed within 10 days from the receipt of the DHO Order – See Forms at pg. 73.) The second level of hearing is the Staff Hearing Officer (SHO) level. An appeal to an SHO Order is an appeal of right. However, the last level of appeal (an appeal to the 3 members of the Industrial Commission) is purely discretionary. It is very rarely granted. Instead, the appeal is reviewed by a different SHO and usually a "refusal order" is issued. Most DHO and SHO hearings are informal and last approximately 10-15 minutes. The rules of evidence do not apply at these hearings. These hearings are radically different from Court proceedings. Hearings before the 3 members of the Industrial Commissioners are scheduled for approximately 45 minutes. If any case is extremely complicated, either party may request that the hearing be scheduled for additional time. This must be requested in advance of the actual hearing date. Also, if an interpreter is needed – the I.C. will provide one at no cost to either party. However, this must be requested prior to the hearing and needs to be requested using the Interpretive Services Request Form (see pg. 75 at Forms).

VI. FURTHER LITIGATION BEYOND THE I.C. HEARING PROCESS.

Before a party may institute further litigation proceedings in the court system, the party must exhaust his/her administrative remedies first. Failure to do so will result in the court proceeding being dismissed. Thus, the failure to appeal an SHO Order will defeat the ability to appeal into common pleas court. Even though, as previously mentioned, the majority of appeals to an SHO Order result in a "refusal order" being issued – it is a necessary step if an appeal to common pleas court will be sought. Having said that, a notice of appeal to common pleas court must be filed within 6o

days of receipt of the "refusal order" from the Industrial Commission Staff Hearing Officer(s).

1.) Common Pleas Court Appeals.

a. Common Pleas Court Appeals are usually "right to participate" issues. These appeals are governed by Ohio Revised Code 4123.512. These issues concern the initial allowance of the claim, any additional allowances sought in a claim, and/or an abatement of claim issue. Appeals of this nature may be decided by either a common pleas court judge (or an assigned magistrate) or by a jury. It is incumbent on the filing party to request a jury. However, either side may request a jury, but it must be done in the initial pleading. An unusual twist is that either party is strictly prohibited from mentioning what transpired at the lower Industrial Commission level. The trial is a de novo appeal. The correct common pleas court jurisdiction is determined by R.C. 4123.512. If an injured worker is successful in their appeal, they will have the right to participate in the state insurance fund for the conditions addressed at trial. No money issues (compensation for the injured worker is never addressed at a common pleas court .512 appeal). If an employer is successful in their appeal, it will have the effect of denying the injured worker the right to participate in the state insurance fund for the workplace injury and/or additional conditions sought by the court filing. Another unusual nuance concerns the actual mechanics of how the appeal to common pleas court is filed. The Notice of Appeal is jurisdictional and must be complied with to vest jurisdiction with the common pleas court. The requirements are set forth on R.C. 4123.512. The appealing party is required to file the Notice of Appeal within sixty days of the receipt of the "refusal order". However, if the employer files the Notice of Appeals (as the appealing party), it is incumbent upon the injured worker to file the Complaint in common pleas court. The Complaint is used synonymously with the term "Petition" stated in R. C. 4123.512. This difference is only found within workers' compensation common pleas court cases. In all other common pleas court cases, the appealing party files the appeal and petition. The workers' compensation statute created this distinction in workers' compensation cases.

2. Appeals to Courts of Appeals and/or the Ohio Supreme Court.

a. A decision from the common pleas court may be appealed to the relevant court of appeals where the common pleas court is located. This type of appeal is extremely rare inasmuch as a clear error would be needed to pursue such an appeal and prevail.

b. Much more common is the filing of a mandamus action. A mandamus action is filed when the issue contested concerns a monetary award on behalf of the injured worker. Regardless of where the case is located in the state, the mandamus issue must be filed with the 10th District Court of Appeals located in Columbus, Ohio. A mandamus issue does not automatically have to originate in the 10th District Court of Appeals. Instead, it can begin in the common pleas court in the county where the claim originated. Or, it can be filed directly with the Ohio Supreme Court. The choice of which court is sought to initiate a mandamus action rests solely with the party seeking relief. If the case originates in the 10th District Court of Appeals, an appeal to the Ohio Supreme Court is an appeal of right. However, if the mandamus action originates in common pleas court, the appeal of right is to the Court of Appeals. If a mandamus action is instituted in a common pleas court and is followed by an appeal of right to an appeals court, then any further appeal to the Ohio Supreme Court would be strictly a discretionary appeal. Can you guess why a party would choose different courts in which to institute a mandamus action?

VII. ANCILLARY ISSUES.

Other issues that will be touched on briefly are Subrogation Issues, Violations of Specific Safety Requirements (VSSR), and Managed Care Organization Alternative Dispute Resolution Appeals.