

**Summary of New South Carolina Workers' Compensation Law  
For Injuries On or After July 1, 2007**

- Appeals
  - § 1-23-600(D): Cuts out the Circuit Court chain of appeal. Appeals from the Full Commission go directly to the Court of Appeals
  - § 14-8-200(a): Allows the Court of Appeals to hear appeals from the Full Commission
  - §42-17-60: In cases of an appeal from the decision of the commission on questions of law, the employer is required to make weekly payments of compensation and to provide medical treatment ordered by the commission. Interest accrues on an unpaid portion of the award.
  
- Basis of an award
  - § 42-9-5: An award must be based on specific and written detailed findings of fact that substantiate the award.
  
- Burdens of proof
  - §42-9-60: The burden of proof for intoxication or willful intent of the employee is on the party asserting that defense.
  
- Claimant's attorneys fees and costs
  - §42-3-175 (A)(1): If a claimant brings an action before the commission to enforce an order authorizing medical treatment or payment of benefits and the commission determines that an insurer or an adjuster, without good cause, failed to authorize medical treatment and/or pay benefits when ordered to do so by the commission, the insurer or the adjuster must pay the claimant's attorneys' fees and costs of enforcing the order. The commission may impose sanctions for willful disobedience of an order, including, but not limited to, a fine of up to five hundred dollars for each day of the violation.
  - §42-3-175 (A)(2) The commission must notify the Department of Insurance of an insurer's or an adjuster's failure to authorize and pay benefits for medical treatment. If the Director of the Department of Insurance determines that there has been a violation of any provision of Title 38, he may impose penalties for each violation.
  - §42-3-175 (B)(1): If the commission discovers a "pattern" of an insurer failing to pay benefits pursuant to an award, the chairman must notify the Director of the Department of Insurance. The director must hold a hearing to determine if the insurer had good cause for nonpayment. If the director determines that

nonpayment was intentional three or more times within a two-year period, the director may revoke the license of the insurer to do business in this State.

- §42-3-175 (B)(2): For purposes of this section, a pattern is established upon an insurer's failure to pay an award at least three times within a two-year period by failing to pay:
  - (a) for individual claims;
  - (b) for a claim in which the claimant had to request enforcement of an award;
  - (c) any combination of (a) and (b).
  
- Clincher Agreements
  - §42-9-390: If the employee is represented, the agreement only has to be filed with the commission. If the employee is unrepresented, the clincher must be approved by one commissioner.
  
- Commission Staff
  - § 42-3-20 (A): Appointment of a deputy commissioner in certain cases
  - § 42-3-20 (B): Appointment of a commissioner chairman.
  - § 42-3-60: Commissioner authorization to employ an administrative assistant.
  
- Compensation Schedule
  - §42-9-30 (14): A shoulder is worth 300 weeks.
  - §42-9-30 (17): A hip is worth 280 weeks.
  - §42-9-30 (21): A back impairment of 49% or less is worth 300 weeks; a back impairment of 50% or more is worth 500 weeks.
    - If the back impairment is 50% or more, there is a rebuttable presumption that the employee is permanently and totally disabled.
  
- Exempted Employees
  - § 42-1-360:
    - (1) a casual employee;
    - (2) any person who has regularly employed less than four employees;
    - (3) a state and county fair association;
    - (4) an agricultural employee;
    - (5) railroad employee;
    - (6) an agricultural salesperson;
    - (7) a licensed real estate sales person;
    - (8) a federal employee in this State; and
    - (9) tractor trailer independent contractor.
  
- Experience Modification Rate
  - § 38-73-495: The insurance director may disapprove an experience modification rate for workers' compensation insurance upon a finding that the rate is excessive, inadequate, or unfairly discriminatory. This includes an experience modification

rate that fails to account for third party reimbursements, including the Second Injury Fund.

- False statements and misrepresentation
  - § 38-55-530(D): "False statement or misrepresentation" specifically includes, but is not limited to, an intentional:
    - false report of business activities;
    - miscount or misclassification by an employer of its employees;
    - failure to timely reduce reserves;
    - failure to account for Second Injury Fund reimbursements or subrogation reimbursements; or
    - failure to provide verifiable information to public or private rating bureaus and the Department of Insurance;
    - statement or representation made by a person that is false, material, made with the person's knowledge of the falsity of the statement and made with the intent of obtaining or causing another to obtain or attempting to obtain or causing another to obtain an undeserved economic advantage or benefit or made with the intent to deny or cause another to deny any benefit or payment in connection with an insurance transaction
      - An undeserved economic benefit or advantage includes, but is not limited to, a favorable insurance premium, payment schedule, insurance award, or insurance settlement
  - § 38-55-540: Punishments and fines for false statements or misrepresentations include criminal penalties, along with fines and restitution.
  - § 38-55-560(E): The Attorney General's office is authorized to hire a forensic accountant for the Insurance Fraud Division.
  
- Forms 50 and 51
  - §42-1-700 (A): Injured or affected body parts and conditions shall be set forth with as much specificity as possible on the commission's Employee's Notice of Claim and/or Request for Hearing form (Form 50)
  - §42-1-700 (B): A commissioner can determine the compensability of a body part or condition not listed or described on a Form 50 if:
    - (1) the body part or condition is proved by a preponderance of the evidence to have arisen from the injury or injuries out of and in the course of employment as set forth on the Form 50;
    - (2) it is proven to the satisfaction of the commissioner that the employee had no knowledge of the injury or condition on the date of the completion of the Form 50. However, the employee is required to amend the Form 50 upon discovery, or
    - (3) the employee is represented and the condition appears on the Pre-Hearing Brief.

- §42-1-705 (A): Form 51 must describe with as much specificity as possible the defenses to be relied upon by the defendants. A Form 51 shall not state that "all defenses apply" or other similar language.
  - §42-1-705 (B): A commissioner can consider a defense not listed on a Form 51 if:
    - (1) it is proven that the defendants had no knowledge of the facts supporting the defense on the date of the completion of the Form 51; and
    - (2) the defense is set forth on a timely pre-hearing brief.
  - §42-1-705 (C): The Form 51 must be signed by an attorney, verifying that the contents of the form are accurate and true, if represented; If the employer is unrepresented, the employer must sign the form.
- Insurance Rates
    - § 38-73-520: Loss Cost Multiplier
    - § 38-73-520: Filing of multiplier
    - § 38-73-960: Review of filings
    - § 38-73-990: Notification of disapproval of filing
    - § 38-73-995: Disapproval of workers' compensation rates
    - § 38-73-526: Report to General Assembly
  - Medical Care
    - § 42-15-60 (A): There must be expert medical evidence that treatment will tend to lessen the claimant's period of disability. The carrier must provide any medical care or treatment that is considered necessary by the attending physician unless otherwise ordered by the commission for good cause shown. The employee must comply with an evaluation as well as treatment.
    - § 42-15-60 (B)(1): If settled on a Form 16A, the employer is not required to provide further medical treatment after one year from the date of full payment unless the form specifically notes otherwise.
    - § 42-15-60 (B)(2): Each award must contain a finding as to whether or not further treatment must be provided. If required, the treatment is to be provided with specificity in the order.
    - § 42-15-60 (B)(3): Future medicals are not required where there is a lapse in treatment by an authorized physician over one year unless:
      - (a) the settlement agreement or commission order provides otherwise;
      - (b) the employee has made reasonable attempts to obtain further treatment.
  - Medical Records
    - § 42-15-95 (A): Any employee who seeks treatment under the Act shall be considered to have given his consent for the release of medical records relating to such examination or treatment.
    - § 42-15-95 (B): A health care provider can discuss medical history, diagnosis, causation, course of treatment, prognosis, work restrictions, and impairments with

the carrier, carrier's attorney, rehab professionals, or the commission without the employee's consent, but the employee must be:

- (1) Given notification and have the ability to attend/participate; and
  - (2) Advised of the nature of the discussion in advance; and
  - (3) Provided with a copy of written questions and the provider's response.
- Any discussion must not conflict with or interfere with the employee's examination or treatment, and will not constitute a breach of the physician's duty of confidentiality.
  - § 42-15-95 (C): Any discussions, communications, medical reports, or opinions obtained in violation of this section must be excluded from any proceedings under the Act.
- Occupational Diseases
    - § 42-11-10 (A): The employee must show that the occupational disease arose directly and naturally from exposure in this State to the hazards peculiar to the particular employment.
    - § 42-11-10 (D): No compensation shall be payable for any occupational disease unless the employee suffers a disability as described in §§ 42-9-10, 42-9-20, or 42-9-30.
    - § 42-17-90 (C): A motion or application for change in condition involving an occupational disease must be made within one year from the date of the last compensation payment for the occupational disease.
  - Preexisting Condition
    - § 42-9-35 (A): The employee shall establish by a preponderance of the evidence:
      - (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.
    - § 42-9-35 (B): The commission may award compensation benefits to an employee who has a permanent physical impairment or preexisting condition and who incurs a subsequent disability from an injury; however, the subsequent injury must impair or affect another body part or system in order to obtain benefits in addition to those provided for in § 42-9-30.
    - § 42-9-35 (C): "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.
    - § 42-9-35 (D): Employer's knowledge of the preexisting condition is irrelevant.
    - § 42-9-35 (E): Where the subsequent injury affects one body part, recovery is limited based on § 42-9-30.
  - Rehabilitation Professionals

- § 42-15-80(B): The commission shall promulgate rules regarding the role of rehabilitation professionals and other similarly situated professionals.
  
- Repealed Sections
  - § 42-1-350
  - § 42-1-370
  - § 42-1-375
  - § 42-9-80
  
- Repetitive Trauma
  - § 42-1-172 (A): "Repetitive trauma injury" means an injury which is gradual in onset and caused by the cumulative effects of repetitive traumatic events. Compensability of a repetitive trauma injury must be determined only under the provisions of this statute.
  - § 42-1-172 (B): An injury is not considered a compensable repetitive trauma injury unless a commissioner makes a specific finding of fact by a preponderance of the evidence of a causal connection that is established by medical evidence between the repetitive activities that occurred while the employee was engaged in the regular duties of his employment and the injury.
  - § 42-1-172 (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 and qualified medical physician.
  - § 42-1-172 (D): A "repetitive trauma injury" is considered to arise out of employment only if it is established by medical evidence that there is a direct causal relationship between the condition under which the work is performed and the injury.
  - § 42-1-172 (E): Upon reaching maximum medical improvement, the employee may be entitled to benefits pursuant to §§ 42-9-10, 42-9-20, or 42-9-30.
  - § 42-15-20 (C): Notice must be given by the employee within ninety days of the date the employee discovered, or could have discovered by exercising reasonable diligence, that his condition is compensable, 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 unduly prejudiced thereby.
  - § 42-15-40: Compensation is barred unless a claim is filed with the commission within two years after the employee knew or should have known that his injury is compensable but no more than seven years after the last date of injurious exposure, regardless of whether the employee was aware that his repetitive trauma injury was the result of his employment.
  - § 42-17-90 (B): A motion or application for change in condition involving a repetitive trauma injury must be made within one year from the date of the last compensation payment for the repetitive trauma injury.

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- Retaining Commission files
  - § 42-3-230: Records must be retained for 15 years.
  
- Second Injury Fund
  - § 42-7-310 (d)(2): Assessment rate changes for SIF
  - § 42-9-400 (a): For SIF reimbursement, the subsequent injury must aggravate the preexisting impairment (not just “combine with”)
  - § 42-9-400 (d): Arthritis is no longer listed as a condition.
  - § 42-9-400 (34) (a) and (b) have been removed.
  - § 42-9-400 (f): Information required in the written notice of claim:
    - (1) date of accident;
    - (2) employee's name;
    - (3) employer's name and address;
    - (4) insurance carrier's name, address, and the NCCI code; and
    - (5) insurance carrier's claim number, policy number, and policy effective date.
  - § 42-9-400 (l): The carrier must have reduced the reserves and report to NCCI prior to reimbursement.
  - § 42-9-400 (m): The SIF director must submit information quarterly to NCCI.
  - § 42-9-400 (n): NCCI must report discrepancies to the Department of Insurance.
  - § 42-7-320 (A): SIF terminates July 1, 2013.
  - § 42-7-320 (B): SIF will not accept any claims for reimbursement after December 31, 2010. SIF cannot consider a claim for reimbursement for any injury occurring after July 1, 2008.
  - § 42-7-320 (B)(2): All information for SIF’s consideration must be submitted by June 30, 2011.
  
- Stress, mental injuries, heart attacks, strokes, embolisms and aneurysms:
  - §42-1-160 (B): Stress, mental injuries, and mental illness arising out of and in the course of employment unaccompanied by physical injury and resulting in mental illness or injury are not considered a personal injury unless the employee establishes, by a preponderance of the evidence:
    - (1) that the employee's employment conditions causing the stress, mental injury, or mental illness were extraordinary and unusual in comparison to the normal conditions of the particular employment; and
    - (2) the medical causation between the stress, mental injury, or mental illness, and the stressful employment conditions by medical evidence.
  - §42-1-160 (C): Stress, mental injuries, heart attacks, strokes, embolisms, or aneurysms arising out of and in the course of employment unaccompanied by physical injury are not considered compensable if they result from any event or series of events which are incidental to normal employer/employee relations.
  - §42-1-160 (D): Stress, mental injuries, and mental illness alleged to have been aggravated by a work-related physical injury may not be found compensable unless the aggravation is:

- (1) admitted by the employer/carrier;
    - (2) noted in a medical record of an authorized physician that, in the physician's opinion, the condition is at least in part causally-related or connected to the injury or accident, whether or not the physician refers the employee for treatment of the condition;
    - (3) found to be causally-related or connected to the accident or injury after evaluation by an authorized psychologist or psychiatrist; or
    - (4) noted in a medical record or report of the employee's physician as causally-related or connected to the injury or accident.
  - §42-1-160 (E): In medically complex cases, an employee must show by medical evidence that the injury arose in the course of employment. "Medically complex cases" means sophisticated cases requiring highly scientific procedures or techniques for diagnosis or treatment excluding MRIs, CAT scans, x-rays, or other similar diagnostic techniques.
  - §42-1-160 (F): "Accident" must not be construed to mean a series of events in employment, of a similar or like nature, occurring regularly, continuously, or at frequent intervals in the course of such employment, over extended periods of time. Any injury or disease attributable to such causes must be compensable only if culminating in a compensable repetitive trauma injury pursuant to § 42-1-172 or an occupational disease.
  - §42-1-160 (G): "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.
- Subsequent Injury
    - § 42-9-150: Where an employee sustains a subsequent injury under §§ 42-9-30 or 42-9-10 in a different employment, he can only receive an award for the degree of disability resulting in the later accident, unless he qualifies for more benefits under § 42-9-35 for subsequent injuries.
    - § 42-9-170: If the subsequent injury is sustained in the same employment, the employee cannot receive more than a total of 500 weeks.
      - Until June 30, 2008, if the employee incurs total disability through the loss of certain members in successive accidents, the employer is only liable for the subsequent injury except that the employee may receive additional benefits if qualified under §§ 42-7-310, 42-9-400 and 42-9-410.
      - After July 1, 2008, the employee can only get additional benefits if he qualifies under § 42-9-35.
  - Total and Permanent Disability
    - § 42-9-10: The loss of both shoulders or hips are added to the list of body parts constituting total and permanent disability (along with the loss of both hands, arms, feet, legs, vision in both eyes, or any two thereof).

- Uninsured Employers
  - § 42-5-40: Fines
- Uninsured Employers' Fund
  - § 42-7-200: Establishes the Uninsured Employers' Fund.