2016 MISSISSIPPI WORKERS' COMPENSATION CLAIMS GUIDE

This Guide, now in its third edition, represents a collaborative effort by representatives of the Mississippi Workers' Compensation community who served at the request of the Board of Directors of the Mississippi Workers' Compensation Educational Association, Inc. Those original committee members were Jim Anderson, Chairman and Editor; Becky Hillhouse; Stephanie Kilpatrick; James Murphy; Marjorie O'Donnell; Steve Smith; Beth Trammell, and Kathy Weisensee.

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The Guide was designed to provide those responsible for claims decisions with information that will facilitate appropriate claims handling. It is intended to only be a summary that includes the basic provisions of the Mississippi Workers' Compensation Law, and it does not attempt to cover every issue that might be encountered in the handling of claims or to be a substitute for competent legal advice. This guide is not an official publication of the Mississippi Workers' Compensation Commission and since cases are usually fact intensive and the law is continually evolving, it should not be construed as the Commission's official pronouncement of the law on any issue.

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Chapter 1
THE BASICS

1.1. WHAT IS WORKERS' COMPENSATION?

Workers' compensation is a social program that is designed to provide wage replacement and medical benefits to workers who are injured on the job. Although the roots of workers' compensation can be found in Germany in the 1800's, it was not until 1911 that the first workers' compensation law that sustained constitutional challenges was enacted in this country. Now virtually every state in the United States has a workers' compensation law and there are also federal workers' compensation laws applicable to certain employees. Mississippi adopted its workers' compensation law in 1948 with the law becoming effective January 1, 1949. The Mississippi Workers' Compensation Law is codified at Miss. Code Ann. §71-3-1, *et. seq.* (1972, as amended). Numerous Commission Rules have also been adopted that explain and assist in the implementation of the law. Those are available on the Commission Web site at http://www.mwcc.state.ms.us/pdf/gen&proRules.pdf.

1.2. ADMINISTRATION OF MISSISSIPPI WORKERS' COMPENSATION

In Mississippi, the Mississippi Workers' Compensation Commission administers the workers' compensation law. See Miss. Code Ann. §71-3-85 (1972, as amended). The Commission is comprised of three individuals appointed by the Mississippi Governor with approval of the Mississippi Senate. Each appointment is for a six-year term and the appointments are staggered so that an appointment comes up every two years. One Commissioner is designated as Chairman who is the administrative head of the agency. One of the members of the Commission must be a licensed Mississippi attorney, another is appointed

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to represent business interests and the other is chosen to represent employee interests.

In Mississippi, litigated cases are tried before an Administrative Judge (often referred to as an AJ or ALJ) who is an employee of the Commission. All of the Administrative Judges are licensed Mississippi attorneys. See Miss. Code Ann. §71-3-93 (1972, as amended). There are 8 Administrative Judges who are hired by the Commission with the approval of the Governor, and their appointments are not for any specific amount of time. The Commission employs a staff to carry out the Commission's statutory responsibilities. When an Administrative Judge's decision is appealed to the full Commission, the Commission considers the appeal based on the record made before the Administrative Judge. The Commission appellate review is not a new trial.

The Mississippi Workers' Compensation Commission is located at 1428 Lakeland Drive, Jackson, Mississippi 39216. The Mailing address is P. O. Box 5300, Jackson, Mississippi 39296-5300. The telephone number is 601 987 4200 or toll free, 866 473 6922.

1.3. WHO PAYS WORKERS' COMPENSATION CLAIMS?

Although some employers are exempt from the application of the law (as discussed more fully in subsequent sections), all other employers are required to protect their liability for the payment of workers' compensation benefits by either purchasing a workers' compensation insurance policy, qualifying as a self-insurer before the Mississippi Workers' Compensation Commission, or participating in a group self-insurance fund which is regulated by the Mississippi Workers' Compensation Commission. The Commission does not pay claims. Some employers might self-administer their workers' compensation programs and pay the claims themselves, but most employers utilize an insurance company or third party administrator to pay their claims. Miss. Code Ann. §71-3-75 (1972, as amended).

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1.4. WHAT ARE AN ADJUSTER'S RESPONSIBILITIES?

The primary duties of a workers' compensation adjuster, whether that person is working for an employer, an insurance company or a third party administrator, are very similar. Those responsibilities begin with **completing a prompt and thorough investigation** of every claim so that an informed and timely decision may be made regarding the payment of benefits as is appropriate under the facts of each claim. Talking with employers, claimants, and co-employees to determine facts; obtaining and evaluating medical documentation concerning the medical problems which are a part of each claim; evaluating disability information from the medical providers; and timely paying compensation, medical and rehabilitation benefits, as appropriate under the law and the circumstances of each claim, are all a part of the claims professional's job. Those responsibilities require effective written and oral communication skills and the ability to interact with employers, claimants, witnesses, the medical community, attorneys, and the Commission staff regarding decisions made and the reasons for those decisions and actions.

1.5. ADJUSTER LICENSING

Adjusters must obtain a Property and Casualty license from the Mississippi Department of Insurance unless that adjuster only handles claims for the insurance company by whom he or she is employed. (To explain, adjusters employed by an insurance company and only handling claims for that insurance company do not have to have a Mississippi adjuster license, while adjusters for a third party administrator do have to obtain a license.) Effective July 1, 2016 there is a separate insurance adjuster license applicable only to workers' compensation claims, although a general adjuster's license such as is required to handle all other kinds of claims may be utilized instead of the specific workers' compensation adjuster's license. The applicant is required to attend training as

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dictated by the Mississippi Department of Insurance and pass a test. However, a test is not required for one who is licensed as an adjuster in another state with which the Mississippi Department of Insurance has entered into a Reciprocity Agreement. For licensing requirements, see Miss. Code Ann. §83-17-417 (1972, as amended) or details on the Mississippi Department of Insurance's website, http://www.mid.ms.gov/licensing/adjuster-licensing.aspx.

1.6. ADJUSTER CANONS OF ETHICS

Although there are no officially adopted canons of ethics applicable to Mississippi workers' compensation adjusters, the law indicates that an adjuster is in a position of fiduciary responsibility and is responsible for making sure that legitimate claims are paid timely. Many see the adjuster's job as one that includes responsibility for the maintenance of the integrity of the workers' compensation system consistent with the social purposes of the legislation so as to promote public confidence and trust in the system. Others urge that care should be taken not to violate laws or regulations applicable to a situation and argue that a sense of urgency to do the job promptly should be paramount. Nearly everyone would agree that being courteous and sensitive to the issues is a part of maintaining professionalism expected by the workers' compensation system. Just as the adjuster should strive to avoid unnecessary litigation and delays, it is argued that the adjuster should also support efforts to prevent fraud within the system. Common sense suggests that care must be taken by the adjuster to avoid a conflict of interest and to make decisions free from personal prejudices or other form of illegal discrimination.

The current adjuster continuing education hour requirements are 24 CEU credits every two years and 3 ethics hours.

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Chapter 2
COVERAGE

2.1. EMPLOYERS COVERED BY THE ACT

The Mississippi Workers' Compensation Act requires coverage if an employer "has in service five or more workmen or operatives regularly in the same business or establishment under any contract of hire, express or implied." See Miss. Code Ann. §71-3-5 (1972, as amended). Often, the number of workers employed may fluctuate above and below five and the employer and/or carrier may be left wondering whether coverage is necessary. The test is generally one of the size of the operation and whether five or more employees are "regularly" used to carry it on (even if all 5 employees are not employed at the same time). If the answer is "yes," then coverage is necessary, and if in doubt, the employer is encouraged to obtain coverage. There are certain categories of employers who are not subject to the coverage requirements of the Act, regardless of the number of workers employed. The list of exempted employers includes nonprofit charitable organizations, fraternal, cultural, or religious corporations or associations.

2.2. WHAT HAPPENS IF AN EMPLOYER REFUSES TO GET COVERAGE?

An employer who fails to secure workers' compensation payments under the Act, when required to do so, faces statutory criminal and civil penalties. See Miss. Code Ann. §71-3-83 (1972, as amended). In addition, an employee injured in the course and scope of his employment has the choice of either suing the employer in tort or proceeding against the employer under the Act. See Miss. Code Ann. §71-3-9 (1972, as amended). If suit is filed against the uninsured employer, the employer may not plead as a defense that the injury was caused by the negligence of a fellow servant, nor that the employee assumed the risk of

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his employment, nor that the injury was due to the contributory negligence of the employee.

2.3. INSURANCE COVERAGE

Employers may discharge their duty to provide workers' compensation coverage for their employees in several different ways. See Miss. Code Ann. §71-3-75 (1972, as amended). The first method is by securing coverage with a third-party insurer. According to the Act, once coverage is secured, the insurer's liability is coextensive with the employer's, meaning that the insurer is obligated to pay all workers' compensation liability of the insured employer, despite any limitations which the contract for insurance may contain which purports to limit the insurer's liability. See Miss. Code Ann. §71-3-77 (1972, as amended).

Nearly every insurance company utilizes the same basic workers' compensation insurance policy form, and it is a policy form that has been in use since the 1950's with some revisions over the years. The National Council of Compensation Insurance (NCCI) owns the copyright to the policy form. There are endorsements to the policy form that can be used to modify or explain some of the coverage details.

Details as to how to search for who has coverage for an employer on a specific date of injury can be found at https://www.ewccv.com/cvs/.

2.3.a. STANDARD WORKERS' COMPENSATION INSURANCE POLICY

The standard workers' compensation policy form includes two coverage parts. The first part of the policy requires the insurance company to pay on behalf of its insured employer the workers' compensation benefits owed by the employer to its employees. Each policy has an "Information Page" that defines the extent of the coverage by listing the States covered by the policy. The workers' compensation part of the policy does not have policy limits and requires

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the carrier to pay the insured employer's liability under the specified workers' compensation law.

2.3.b. EMPLOYER'S LIABILITY INSURANCE COVERAGE

The second part of the policy form is an Employers' Liability Insurance Policy which was originally included in the policy form at a time when some kinds of injuries, such as occupational diseases, were not covered by workers' compensation systems. Because the law evolved over the years to include all kinds of injuries and occupational diseases, this part of the policy form was basically dormant and inactive in most jurisdictions for many years. With increasing efforts to avoid the exclusive remedy doctrine (the thrust of which is that workers' compensation is intended to be the only remedy a claimant has against his employer for a workplace injury—See Chapter 4 herein), the policy has started being considered more frequently in recent years. It is written as a more traditional kind of insurance policy with policy limits, exclusions, and other specific provisions. In its simplest form, the policy imposes a contractual obligation on an insurance carrier to indemnify and defend the insured employer for those claims by employees against the employer for injuries arising out of and occurring in the course of employment that are not covered by the workers' compensation law. A careful coverage analysis will be required in the event a claim is made which might fall under the terms of that policy.

2.3.c. CANCELLING AND NON-RENEWING COVERAGE

Cancellation and non-renewal of a workers' compensation insurance policy must be done in specific conformity with the law or the coverage could be extended beyond the intent of the carrier. In an effort to provide a claimant with a source to get his claim paid, coverage is going to be found to remain in effect unless the carrier has precisely complied with the law regarding *notice to the insured and the Commission* when cancelling or non-renewing the coverage. For specific details, see Miss. Code Ann. §71-3-77 (1972, as amended) and MWCC

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Rule 1.5.

2.4. SELF-INSURANCE AND GROUP SELF-INSURANCE

A company which wishes to be exempt from insuring its liability under the Act may make application with the Mississippi Workers' Compensation Commission to be considered a "self-insurer." The application must, among other things, demonstrate the company's financial ability to pay all compensation required by the Act. The Act also provides for the pooling of liabilities by two or more employers for the purpose of establishing a self-insured group. All employers who wish to establish such a group must be comprised of members of the same bona fide trade association or trade group, and all must be domiciled in the State of Mississippi. See Miss. Code Ann. §71-3-75 (1972, as amended) and Commission Rule 1.7.

2.5. ASSIGNED RISK COVERAGE

Finally, the Act provides for a "Mississippi Workers' Compensation Assigned Risk Plan" to be administered by the Mississippi Commissioner of Insurance. See Miss. Code Ann. §71-3-111 (1972, as amended). These policies are "for the assignment of risks which in good faith are entitled to insurance under this chapter but which, because of unusual conditions and circumstances, are unable to obtain such insurance." In order to effectuate this provision, the Commissioner of Insurance is authorized to advertise and contract with carriers doing business in Mississippi to be servicing carriers for the Plan.

2.6. NOTICE OF COVERAGE

An employer is required to post a Notice of Coverage form on its premises revealing details as to its coverage under Miss. Code Ann. §71-3-81 (1972, as amended) and Commission Rule 1.8. Also, under Rule 1.3, each employer must provide proof of its coverage to the Commission, but this reporting is handled

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electronically. See additional provisions regarding these requirements on the MWCC website at: http://www.mwcc.state.ms.us/pdf/nccicircular.pdf. See Chapter 7.2. for additional information regarding these notices. A 2012 amendment to the Act requires that the Commission's notice regarding the 2012 amendments be posted alongside the Employer's Notice of Coverage. See http://www.mwcc.state.ms.us/pdf/sb2576.pdf.

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Chapter 3
JURISDICTION

3.1. MISSISSIPPI JURISDICTION

Most work-related accidents that fall within the Act are easy to identify as such. The typical scenario involves a Mississippi resident working for a Mississippi employer who has a work accident in Mississippi. Generally, coverage exists if 1) the injury occurred in Mississippi, 2) the claimant was regularly employed in Mississippi, or 3) the claimant was hired in Mississippi. The Commission has exclusive jurisdiction over those cases covered by the Act. See Miss. Code Ann. §71-3-47 (1972, as amended).

3.2. INJURIES OUTSIDE OF MISSISSIPPI

Questions arise, however, in situations where Mississippi workers are injured outside of this State. For coverage to exist where an employee is injured outside of Mississippi, the employee must have been hired or regularly employed in Mississippi, and his work outside of the state must be temporary (generally less than six months absent an election to extend coverage). In determining coverage, the place of the claimant's residence or domicile is not relevant. Instead, the question is one of whether the work assignment outside the State is temporary or permanent and not necessarily whether the worker's departure from the State was temporary or permanent. The Act does not apply if the work assignment outside of the State is permanent (which includes work in a foreign country.) See Miss. Code Ann. §71-3-109 (1972, as amended).

3.3. NON-RESIDENTS OF MISSISSIPPI INJURED IN MISSISSIPPI

When employees who were hired and/or regularly employed in another state are injured in Mississippi while on a temporary job assignment, Mississippi

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law might not apply. However, in these situations, generally Mississippi law applies unless all three of the following requirements are met: 1) the employer has provided coverage under the laws of another state which cover the employee for his work in Mississippi; 2) the other state recognizes the extraterritorial provisions of the Act; and 3) the workers' compensation law of the other state must exempt Mississippi claimants and employers from its application. See Miss. Code Ann. §71-3-109 (1972, as amended). The practical effect is that either Mississippi law or the applicable law of the other State will cover a foreign worker injured in Mississippi.

3.4. CONCURRENT JURISDICTION

One additional point to be made regarding jurisdictional issues relates to successive awards: the Mississippi Workers' Compensation Act does not bar a claimant from filing a claim in Mississippi if benefits were awarded under the laws of another State. The problem typically arises where an employee who was hired and/or regularly employed in Mississippi is injured while on a temporary work assignment in another state. It is possible that the employee would be covered for that injury by the laws of the State in which he was injured. At the same time, the claimant could also be entitled to coverage by the Mississippi Act. If the employee is awarded benefits in the State where he was injured, he would not be barred from filing a claim in Mississippi; however, the employer would be entitled to credit for any award made in the foreign State against any liability under the Mississippi Workers' Compensation Law. (However, a denial of a claim in the foreign jurisdiction will in some instances be construed to be *res judicata* of the same issues if it is subsequently filed in Mississippi). Whether or not the other involved State would have jurisdiction of the claim in addition to Mississippi will depend entirely on the applicable provisions of the other State. The claims professional should seek advice of counsel in the State where the other claim is filed to fully evaluate those issues.

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Chapter 4
EXCLUSIVE REMEDY

4.1. WHAT IS EXCLUSIVE REMEDY?

The Mississippi Workers' Compensation Law is the exclusive or only remedy available to a claimant for an injury arising out of and occurring in the course and scope of employment. See Miss. Code Ann. §71-3-9 (1972, as amended). Stated differently, the employer cannot be sued by an employee for a compensable injury pursuant to common law for work related injuries based on a negligence theory.

4.2. EXCEPTIONS TO THE EXCLUSIVE REMEDY DOCTRINE

There are exceptions to the rule that workers' compensation is the only remedy a claimant has against his employer. The first exception is where the employer has not "secured payment of compensation", which means that the employer has failed to have in effect a workers' compensation insurance policy or failed to qualify as a self-insurer pursuant to procedures set forth in the Act. If the employer does not have workers' compensation coverage in effect, or is not a qualified self-insurer, the employee is free to sue the employer outside the confines of the workers' compensation system and pursue remedies he has at common law, and in that contingency, the employer loses certain defenses it would otherwise have available. See Miss. Code Ann. §71-3-9 (1972, as amended).

Another exception to the exclusive remedy rule involves claims for which the Mississippi Workers' Compensation Law does not provide a remedy. This is best illustrated by the case of *Miller v. McRae's*, 444 So.2d 368 (1984), in which an employee was "falsely imprisoned" by a co-worker while in the course and scope of employment. The co-employee detained the employee to question her regarding a missing sum of money. The claimant filed a tort suit against the

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employer claiming that as a result of the false imprisonment, she suffered great humiliation, loss of reputation, and physical illness. The Supreme Court held that the exclusive remedy provisions in the Mississippi Workers' Compensation Act did not bar the employee's false imprisonment claim since there was no "injury" as defined by the Act for which a remedy would be available to the employee.

Still another area where the exclusive remedy provision does not apply is where the employer intentionally injures the employee. In *Franklin Furniture v. Tedford*, 18 So.3d 215 (Miss. 2009), the Mississippi Supreme Court held that where acts committed by the employer are "substantially certain" to cause injury to an employee, if there is actual intent to injure the employee, such actions fall outside the exclusivity of the Act and the employee will be allowed to pursue damages at common law.

As examined more fully in Chapter 17 herein, another type of claim that is often discussed as an exception to the exclusive remedy doctrine is a claim in tort by the employee against his employer, carrier, and others based on allegations of "bad faith" claims handling. The details of issues involving those claims are very important, and the claims professional is encouraged to read that chapter closely.

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Chapter 5
COMPENSABILITY

The premise of the Mississippi workers' compensation system is to provide an injured employee a recovery for injuries that arise out of (referring to a causal connection to the employment) and occur in the course of his employment (involving an analysis of the time, place, and situation of the injury). Compensability is established even if the employee caused or contributed to his own injuries. Miss. Code Ann. §71-3-7. In exchange for imposing that liability on an employer without determining who is at fault in causing the injury, the law imposes a limit on the amount of money and type of benefits that can be recovered by the injured employee. The system has survived constitutional challenges over the years, but the fact that a claimant gives up an unlimited recovery historically resulted in the workers' compensation system being liberally interpreted in favor of the claimant. This means that disputed or doubtful cases were resolved in favor of awarding compensation and the claimant was given the benefit of the doubt in resolving issues or disputes. Legislative amendment in 2012 has potentially altered this historic interpretation as discussed below but the trend toward resolving doubtful cases in favor of awarding benefits continues.

Miss. Code Ann. §71-3-7 (1972, as amended) provides that a claim must arise out of and occur in the course of employment and that medical causation be established in order to receive compensation for an injury. Although both tests must be met to establish compensability, practically the two are often considered collectively so that compensability is found if "arising out of" is high and "course of employment" is low, or vice versa. Some call such analysis the "unitary test of work connection" or the "quantum theory of compensability."

5.1. BURDEN OF PROOF

The claimant bears the burden of proving every element in his claim essential to a recovery, and that includes the fact of an injury that arose out of

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and in the course of employment, that the medical problem in question is causally related to the injury in question, and that claimant's disability is supported by medical findings. In meeting that burden, however, claimant has traditionally been given the benefit of the doubt, and there is much case law providing that "doubtful cases are to be resolved in favor of compensation" or "the beneficent purposes of the Act" require a liberal interpretation of the evidence in favor of claimant. The prior requirement that doubtful cases were to be resolved in favor of compensability made it easier for a claimant to meet his burden of proof with the burden then shifting to the employer/carrier to establish that claimant's story was inherently improbable of that the greater weight of the evidence did not support claimant's claim.

For injuries on or after July 1, 2012, the law is to be impartially construed so as to favor neither the claimant nor employer/carrier, and the workers' compensation laws are not to be liberally construed in order to fulfill any beneficent purposes. That said, most workers' compensation professionals believe that close cases will probably result in awarding compensation even if "liberal construction" is no longer mandated or mentioned in the MWCC Order.

5.2. INJURY DEFINED

The Act includes a definition of the term "injury" at Miss. Code Ann. §71-3-3 (b) (1972, as amended). The complete definition is pasted below, and the claims professional is encouraged to review the details when analyzing a compensability issue. Some of the key phrases within the definition have been bolded for emphasis and are further discussed in the following sections.

> "Injury" means accidental injury or accidental death **arising out of and in the course of employment** without regard to fault which results from an **untoward event** or events, **if contributed to or aggravated or accelerated by the employment in a significant manner**. Untoward event includes events causing unexpected results. **An untoward event or events shall not be presumed to have arisen out of and in the course of**

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> **employment, except in the case of an employee found dead in the course of employment**. This definition includes injuries to artificial members, and also **includes an injury caused by the willful act of a third person directed against an employee because of his employment** while so employed and working on the job, and disability or death due to exposure to ionizing radiation from any process in employment involving the use of or direct contact with radium or radioactive substances with the use of or direct exposure to roentgen (X-rays) or ionizing radiation. In radiation cases only, the date of disablement shall be treated as the date of the accident. **Occupational diseases, or the aggravation thereof, are excluded from the term "injury," provided that, except as otherwise specified, all provisions of this chapter apply equally to occupational diseases as well as injury**.

PRACTICE NOTE: The determination of compensability requires a thorough analysis of facts and the application of law to those facts. Although this guide attempts to address many of the concepts encountered in this analysis, it does not attempt to address every conceivable situation. The claims professional is encouraged to not rely solely on this representative summary of decisions in making decisions regarding compensability. These examples are intended to be instructive in the analysis of whether a claim is compensable, but cases are uniquely fact intensive, and every case must be considered on its own merits. The claims professional is encouraged to seek advice of counsel to analyze compensability before issuing a denial. As emphasized in this Guide, the reliance upon the advice of counsel can shield the decision of the claims professional from a punitive damage claim even if the claim decision is later claimed to have been made in "bad faith."

5.2.a. ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT

Compensability analysis begins with a look at the issues of "arising out of and in the course of employment". In its simplest form, the "arising out of" requirement refers to the causal origin of the injury. The question focuses on whether it is connected to the employment. Mississippi has adopted the

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"positional risk test" in analyzing the issue which means that the injury would not have occurred but for the fact that the employment placed a claimant in a position where he was injured. As an example, in *Wiggins v. Knox Glass, Inc*., 219 So. 2d 154 (Miss. 1969), the Court ruled that an injury from an act of nature arises out of and in the course of employment so long as the worker is injured at a place where he was required to be by the conditions of the employment.

The "course of employment" component of compensability generally refers to the time, place and circumstances of the accident in relation to the employment. If the claimant is generally doing his job at a time and place he is supposed to be doing his job, the requirement is met.

Compensability is broadly construed and can still be found if there is a sufficient work contribution present. As an example, there is no requirement that the injury actually occur during work hours or on the employer's premises. In *Mississippi Research and Development Center v. Dependents of Shults*, 287 So. 2d 273 (Miss. 1973), the employee died in his kitchen at home, but compensability was found on the premise that workplace stress had contributed to a heart attack. Another illustration of the rule is one where the employee manifested symptoms of a brain hemorrhage one evening at work and the acute event actually did not occur until the next morning at home. *Walker Mfg. Co. v. Pickens*, 206 So. 2d 639 (Miss. 1968).

Just because something occurs at work, however, does not make it compensable. When the workplace is merely the place where the injury occurs, it might not be compensable even though it occurs during the time of and at the place of employment. It still has to arise from a risk incidental to the employment. In *Mathis v. Nelson's Foodland, Inc*., 606 So. 2d 101 (Miss. 1992), the claimant was injured when he lit a firecracker at work but the injury was not compensable because the lighting of the firecracker has no relationship to the employment.

PRACTICE NOTE: The "arising out of" and "in the course of" requirements for compensability are captured in all workers' compensation systems, but the

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concepts have evolved uniquely in the different workers' compensation systems, and the conclusions reached on similar fact scenarios vary widely across the United States. For that reason, a claims professional should not assume that a fact scenario found compensable in one jurisdiction automatically translates to the same conclusion in any other jurisdiction.

5.2.b. UNTOWARD EVENT

Note that the definition of "Injury" in section 5.2 above includes a requirement for an "untoward event" as a part of the analysis of compensability. Except in the case of a "Mental/Mental" injury discussed in section 5.5 of this Guide, the significance of that phrase is hard to find in existing case law. An incident can apparently meet the requirement of "untoward event" quite easily as illustrated by the case of *Beverly Healthcare v. Hare*, 50 So.3rd 1003 (Miss. 2011). That case involved an elderly employee with a significant history of pre-existing problems with her leg (4 different identified injuries). She "pivoted" and a bone in her leg snapped. Those facts were interpreted as representing a compensable injury in spite of the significant pre-existing problems and apparently minor work incident giving rise to the claim.

5.2.c. CONTRIBUTED TO, AGGRAVATED, OR ACCELERATED BY THE EMPLOYMENT

Compensability is found when the employment, or some component of the employment, combines with pre-existing medical problems or congenital defects to create disability. The employment need not be the sole cause of problem, and it is sufficient to meet the definition of injury by showing that the employment "contributes" to the disability, "aggravates" dormant or active medical problems so as to create disability, or "accelerates", "exacerbates" or "lights up" an underlying medical problem so as to make it symptomatic. Cases abound finding an employment connection, and therefore a

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compensable injury, when medical problems such as heart attacks, strokes, hypertension, dermatological problems, cancer, arthritis, hemorrhoids, pulmonary problems, and other conditions have been aggravated or accelerated by the employment or injury.

In *Quitman Knitting Mill v Smith*, 540, So. 2d 623 (Miss. 1989) a claimant purchased a cold tablet from her employer's first aid station, and that tablet was found to have contributed to the onset of the claimant's essential tremors. The Court reasoned that the employer benefited from selling such items by lessening absenteeism as a part of the basis for finding the claim compensable.

5.2.d. PRESUMPTION IN DEATH CASES

There is a presumption of compensability if a worker is *found dead* at a time and place he was reasonably supposed to be during the performance of his job. See e.g., *Road Maintenance Supply, Inc. v. Dependents of Maxwell*, 493 So. 2d 318 (Miss 1986).

The "found dead" presumption is contained within the definition of "injury" in Chapter 5.2 above. It should be noted that the presumption is rebuttable and after it has made its appearance, the employer/carrier have the burden of proving that the claim is not compensable.

Also, where an employee falls dead in front of witnesses as opposed to being "found dead" where no one witnessed the death, there is no presumption of compensability. See *In Re Dependents of Harbin*, 958 So. 2d 1620 (Miss. App., 2007).

5.2.e. WILLFUL ACT OF A THIRD PERSON/ASSAULTS

When a claimant is assaulted while on the job, compensability analysis focuses on the one who committed the assault to the extent necessary to determine whether the assailant is connected to the employment, such as a co-

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employee, or whether the assailant is a "third party" to the employment relationship, such as a criminal.

If an assault causes injury between co-employees, it should be determined whether the dispute between the co-employees that results in the injury is rooted in personal, non-employment activity. If the assault is due to a personal issue between the parties and not over an employment related issue, the injury may not be compensable even if it happens on the job site. *Sanderson Farms, Inc. v. Jackson*, 911 So. 2d 958 (Miss. Ct. App. 2005).

Conversely, if a claimant is injured from the intentional act of another person who is a stranger to the employment relationship, compensability analysis shifts to a determination as to whether there is a connection between the employment and the assault. Stated differently, those injuries are compensable only if the assault was committed "because of" the employment. Miss. Code Ann. §71-3-3(b) (1972, as amended). For example, where an assault was committed by a stranded motorist the claimant had stopped to help, the "because of the employment" test was met because the employer benefitted by having its employees attempt to provide "Good Samaritan" assistance to the public. *Big "2" Engine Rebuilders, v Freeman, 379 So. 2d 888 (Miss. 1980)*

If the intentional assault has no connection to the employment, the claim may not be found compensable. In *Ellis v. Rose Oil Co. of Dixie*, 190 So. 2d 450 (Miss. 1966), a claim involving a worker who was killed by his paramour's vengeful husband, the claim was not compensable since it was the worker's personal activity that created the risk of harm.

PRACTICE NOTE: If there is a work injury to an employee flowing from an assault, the employer might be confronted with a suit under tort law such as those causes of action discussed in Section 4.2 of this Guide. Such a claim might require a focus on whether or not the loss is covered by the Employer's Liability Insurance Policy as mentioned in Section 2.3.b. of this Guide.

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5.2.f. OCCUPATIONAL DISEASES

Occupational diseases can be compensable and the analysis is usually focused on the medical proof as to whether or not the job caused the alleged occupational disease or contributed to the development of the disease/injury in a significant manner. Cases have supported a finding of compensability involving allegations of increased blood pressure, cardiac problems, strokes, and many other medical problems. Again the cases are all unique and require a clear understanding of the allegations, the job in question, and the medical opinions addressing causation.

5.3. HERNIA CLAIMS

Hernia claims are treated specially under the Mississippi Workers' Compensation Act with specific tests to prove compensability and limitations on the amounts payable. See Miss Code Ann. 71-3-23 (1972, as amended). The statute lists 5 requirements for a compensable hernia paraphrased as follows:

1. The hernia immediately follows sudden effort.
2. There was severe pain in the area of the hernia.
3. There had not been a descent or protrusion in that area before this hernia.
4. That the problem was noticed immediately and reported to the employer within a reasonable time.
5. That the problem was such to have required medical treatment within five days after the injury.

These "requirements" have not always been strictly enforced and many cases have found compensability despite one or more of the statutory elements being unfulfilled. In *Lindsey v. Ingalls Shipbuilding Corp.,* 219 Miss 437, 442 (1954), the claimant clearly did not have treatment within five days, but the court said that the "statute does not require that the claimant prove that he was actually attended by a physician or surgeon within five days after the injury. The

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statute only requires that the claimant prove that the physical distress following the descent of the hernia was such as to require the attendance of a physician or surgeon within five days." Id.

It is also noteworthy that the statute provides that a post-operative hernia is considered an "original" hernia. That means that a hernia that occurs in the same area, which was earlier repaired surgically, will still be compensable if the five requirements are otherwise met.

PRACTICE NOTE: There is a statutory limitation on the number of weeks an employer must pay compensation benefits related to a hernia. The benefits for temporary total disability cannot exceed twenty-six (26) weeks when the claimant has surgery to repair the hernia but only thirteen (13) weeks when he or she undergoes conservative treatment instead of surgery.

5.4. GOING TO AND COMING FROM WORK

Generally, an injury that occurs while the employee is travelling to and from work is not compensable. *King v. Norrell Services, Inc.*, 820 So.2d 692 (Miss. Ct. App. 2000); *Miller Transporters, Inc. v. Seay's Dependents*, 350 So.2d 689 (Miss. 1977). There are important exceptions to that generality, however, many of which are tied to unique circumstances of the work in question. Examples of such exceptions include: (1) where the employer furnishes the means of transportation, or remunerates the employee for the travel; (2) where the employee performs some duty in connection with his employment at home; (3) where the employee is injured by some hazard or danger which is inherent in the conditions along the route necessarily used by the employee; (4) where the employer furnishes a hazardous route (5) where the injury results from a hazardous parking lot furnished by the employer; (6) where the place of injury, although owned by one other than the employer, is in such close proximity to the premises owned by the employer as to be, in effect, a part of such premises; or (7) when the employee is on a special mission or errand for his employer, or

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where the employee is accommodating his employer in an emergency situation.

PRACTICE NOTE: Claim denials based on the "going to and coming from" work general rule against compensability should almost always be supported by legal advice of counsel that none of the "exceptions" apply.

5.5. MENTAL INJURIES

When mental stress leads to mental injury without a physical injury, the claim could be compensable, but the claimant has a heightened burden of proof. For a "mental-mental" injury to be compensable, the claimant bears the burden of proving, by clear and convincing evidence, that the mental injury resulted from "more than the ordinary incidents of employment" and that there was an "untoward event or unusual occurrence" that contributed to the mental or emotional injury. The claimant's burden of proof is greater than that encountered in proving compensability in a physical injury situation, and all of the cases are factually intensive.

Illustrations of cases found compensable for a mental-mental injury are *Brown & Root Construction v. Duckworth*, 475 So. 2d 813 (Miss. 1985) (psychological symptoms resembling a stroke after not getting a promised promotion); *Borden, Inc v. Eskridge*, 604 So. 2d 1071 (Miss. 1991) (work harassment and demotions caused depression); *Mid-Delta Home Health, Inc v. Robertson*, 749 So. 2d 379 (Miss. App. 1999) (TTD awarded due to emotional disorder stemming from being overworked and harassed); *Kemper National Insurance Co. v. Coleman*, 812 So.2d 1119 (Miss. App. 2002) (a workers' compensation adjuster was treated for depression as the result being passed over for a promotion and being harassed by his supervisor).

Illustrations of cases found non-compensable for a mental-mental injury are *Smith and Sanders, Inc. v. Peery*, 473 So. 2d 423 (Miss. 1985) (claimant experienced a psychological problem after being laid off due to a decline in business); *Smith v. City of Jackson*, 792 So. 2d 335 (Miss. App. 2001) (claimant

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had anxiety [a "nervous breakdown"] due to overwork; *Radford v. CCA-Delta Correctional Facility*, 5 So. 3d 1158 (Miss. App. 2009) (claimant had depression and post-traumatic stress disorder after being reassigned to another supervisor).

PRACTICE NOTE: All of the reported decisions illustrate a fact intensive analysis, and no conclusions as to compensability or non-compensability should be drawn from a scenario such as "overwork means it is compensable or not compensable." Most of the cases involving an individual who had been treated for pre-existing psychological problems were ultimately denied, but again that does not mean that all of those cases are automatically denied. The claims professional should thoroughly investigate every claim of this nature and would be well served to seek advice of counsel in developing the correct position to take on each matter.

When an employee has emotional stress from work activity that leads to an ailment with physical manifestations, the physical injury could be compensable. *Berry v. Universal Mfg. Co.*, 597 So. 2d 623 (Miss. 1992) was a compensable claim where job stress contributed to hypertension.

Sometimes a mental injury causes another physical injury. In *Weyerhaeuser Co. v. Ratliff*, 197 So. 2d 231 (Miss. 1967), a worker lacerated three fingers in a work-connected injury and had stress and anxiety over the finger injury which aggravated a chronic duodenal ulcer requiring surgery. An award of benefits related to the surgery to repair the ulcer was approved.

Also, mental injury stemming from the physical injury (e.g. pain related depression or Post Traumatic Stress Disorder from an accident) are not subject to the heightened burden that applies to pure mental injuries. This is also true for physical injuries that manifest from mental ailments.

5.6. CUMULATIVE AND REPETITIVE INJURIES

A compensable claim does not have to be tied to a single incident. A compensable disability can flow from a series of events or repetitive motion, the

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cumulative effect of which can qualify as a compensable injury. Carpal tunnel claims are illustrative of this rule of law. Compensable results have also been found in other kinds of cumulative injury claims such as spine ailments caused or aggravated by the work activity. See, e.g. *Smith v. Masonite Corp*., 48 So.3d 656 (Miss. Ct. App. 2010).

PRACTICE NOTE: Compensability of cumulative or repetitive injury claims is heavily dependent upon medical opinions from the providers as to how the work did or did not contribute to the injury.

5.7. LAST INJURIOUS EXPOSURE

Mississippi has adopted the "last injurious exposure" rule that is applicable in cases where the exposure occurs over an extended period of time. In its simplest form, that rule is that if a claimant has a series of employers (or different carriers for the same employer) and the work activities ultimately cause the claimant to be disabled, the last employer (or carrier) in that series of events is responsible for the entire claim. See *Thyer Mfg. Co. v. Mooney*, 173 So. 2d 652 (Miss. 1965) (claimant worked for a manufacturer through three successive carriers, and the last carrier was the one that bore the responsibility for the claim).

Cases of this nature are always factually intensive, however, and the claims professional is encouraged to thoroughly investigate the facts, analyze the medical opinions, and seek advice of counsel if the correct response to the claim is not apparent.

5.8. MULTIPLE CARRIERS IN COMPENSABILITY DISPUTE

Sometimes, in the cases involving a cumulative impact or repetitive motion injury, progressive occupational disease, or multiple consecutive injuries, it is not readily apparent which of the various employers and/or carriers might ultimately be responsible for a claimant's injuries and medical treatment. Miss. Code Ann.

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§71-3-37(13) (1972, as amended) provides a solution so that the claimant is not left without treatment and benefits while the process for determining responsibility evolves. The Commission can order the disputing parties to provide the benefits equally until it is determined which party is solely liable, and at that determination, the liable employer/carrier must reimburse the non-liable employer/carrier for the benefits paid by the non-liable employer/carrier, with interest.

PRACTICE NOTE: If confronted with this situation, the parties are encouraged to get an Order from the Commission as contemplated by the referenced code section. A volunteer who makes a payment that it doesn't owe might not have a remedy to recover payments which are ultimately not found to be its responsibility unless the payments are done pursuant to the statute.

5.9. IDIOPATHIC FALLS

Sometimes the claimant is suffering from a medical condition that is not caused by the job but the medical condition causes claimant to fall at work and sustain other injuries. For example, if a claimant with epilepsy suffers a seizure and is injured in a fall, the employer/carrier would not owe benefits for the treatment of the epilepsy, but would owe benefits for the injuries caused by striking the employer's floor, or table or equipment. In *Chapman, Dependents of v. Hanson Scale Co.*, 495 So. 2d 1357 (Miss. 1986), the Mississippi Supreme Court said:

> We consider exposure to falls upon a concrete floor a sufficient risk attendant upon employment so that an injury caused in part thereby is compensable. Larry Ray Chapman, while at his usual place of work, fell and struck his head upon just such a floor and as a result died. His death arose out of and within the course and scope of his employment.

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Chapter 6

DEFENSES TO CLAIMS

6.1. EMPLOYEE STATUS

It is important to remember that only claims by employees of the employer are payable. Often times questions center on whether or not someone is an employee as opposed to a volunteer or an independent contractor.

In its simplest form, an employee is a person under a contract of hire, expressed or implied. An independent contractor, on the other hand, is not an employee who is entitled to benefits. The individual might be doing work for or on behalf of the employer, but that alone is not enough to make that person an employee. A variety of things are analyzed to determine whether a person is an independent contractor as opposed to an employee, and among those things are whether or not the employer has the right to control the work activities of the person in question. Remember that the right to control is not the same thing as actually exercising that control, however. Generally speaking, if an employer specifies the time that an individual comes to work, when they leave, how the work is supposed to be done, provides the tools necessary to do the job, etc., the person will be considered an employee.

Sometimes the right of control question is not very clear and the Court has, in those circumstances, then looked at whether or not the work being performed is an integral part of the employer's business enterprise. When analyzing the nature of the work in question to address this issue, an employee/employer relationship is found when the work performed is an integral part of the employer's business. As an example, trucking companies will sometimes enter into a contract with a truck driver and that contract could actually call the driver an "independent contractor". However, in analyzing the relative nature of the work test, the Court might find that trucking companies are hired to deliver products in a truck from Point A to Point B and the only way they can do that is

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by having truck drivers. As a consequence, the truck driving activity is an integral part of the trucking business' operations, and the injured worker driving the truck is therefore an employee. Conversely, however, if there is a refrigerator in the office of a trucking company that breaks and someone is called to the office to fix that refrigerator, that person is likely not doing something that is an integral part of the employer's business operation. Accordingly, he will probably not be considered an employee for workers' compensation purposes.

A "volunteer" is a person who is not hired to do the work of the employer but just shows up and starts working. Under those circumstances he will probably not be considered an employee, but the analysis is usually fact intensive. That concept should not to be confused with a volunteer fireman, as an example, because a volunteer fireman is actually doing the activities of the employer entity as specifically agreed by the parties and he would therefore be an employee.

A "statutory employee" is a concept generally tied to the issue involving an employee of an uninsured subcontractor. As a simple illustration, if the employer contracts to build a house and he then subcontracts to a roofing contractor to put on the roof of that house, and one of the employees of that roofing subcontractor is injured, the injured employee will have a claim against his subcontracting employer, but if his employer does not have workers' compensation insurance coverage, he would also have a viable claim against the general contractor as the general contractor's "statutory employee".

6.1.a UNDOCUMENTED WORKERS/ALIENS

Undocumented workers, or those who are not citizens of the United States or who do not have legal documentation permitting them to be in the United States, can be employees for workers' compensation purposes. The Mississippi Workers' Compensation Law makes no special provisions regarding "aliens" other than to say that if they have an injury and return to their home country, any

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permanent disability benefits due can be paid in a lump sum rather than bi-weekly. Miss. Code Ann §71-3-27 (1972, as amended). (As stated in Chapter 10.3.a, herein, that code section also limits the death beneficiaries entitled to benefits in claims involving undocumented workers.)

6.2. PRE-EXISITING CONDITIONS

It is important to remember that the aggravation of a pre-existing condition is still a compensable injury. Cases have variously described the issue as one involving the *aggravation, exacerbation, acceleration, or lighting up* of the pre-existing condition. All of that together or singularly can constitute a compensable injury if the pre-existing condition was aggravated in a significant manner. Stated differently, the employment or work injury does not have to be the sole cause of a medical problem in order for it to be compensable.

Where there is a pre-existing condition, however, two possibilities can be considered in limiting the indemnity benefits payable, the second Injury Fund and Apportionment, both of which are discussed below. Neither has any effect on medical benefits.

6.2.a. SECOND INJURY FUND

Mississippi has a very limited Second Injury Fund that is rarely applicable. One of the definitions of permanent total disability is dismemberment or loss of use of both arms, legs, hands, feet, eyes or any combination of those five scheduled members. To illustrate, the loss of a hand and an eye is permanent and total disability.

If, at the time of the accident in question, the claimant had already lost one of those scheduled members and in the accident in question loses another of those scheduled members, the claimant is permanently and totally disabled. The Mississippi Workers' Compensation Commission's Second Injury Fund is applicable in those very limited circumstances. In such a case, the

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employer/carrier must pay claimant's temporary total disability benefits related to the injury in question and the permanent partial disability benefits for the loss of the scheduled member lost in the compensable accident; the Commission's Second Injury Fund will pay the balance of indemnity benefits for permanent total disability. To illustrate, if the injury involves the loss of use of an arm and the injury in question involves twenty weeks of temporary total, the employer/carrier would pay twenty weeks of temporary total, two hundred weeks for loss of the arm, and the Commission Second Injury Fund would pay the remaining two hundred thirty weeks so that the claimant recovers the full four hundred fifty week benefit for permanent total disability.

The Second Injury Fund has no application in any other circumstances such as a back injury or other "body as a whole" cases.

6.2.b. APPORTIONMENT

For pre-July 1, 2012 injuries, where the claimant is suffering from a pre-existing condition that is a material contributing factor to his permanent disability or death, then permanent disability or death benefits can be reduced by the proportion to which the pre-existing condition contributes to the disability or death. The burden of proof for apportionment is on the employer/carrier and case law requires that the employer/carrier prove that: (a) from a medical standpoint, the pre-existing condition is a material contributing factor to the disability; and, (b) from an occupational standpoint, the pre-existing condition had already affected claimant's earning capacity. To receive an apportionment of benefits, the injury must involve the same part of the body.

To illustrate, in a back injury case where the medical testimony establishes that fifty percent of claimant's permanent disability is the result of a pre-existing condition and fifty percent of his permanent disability is related to the effects of the injury in question, the permanent disability benefits could be reduced if the proof also establishes that the pre-existing condition had already caused a loss of

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wage earning capacity. If the employer did not even know that the claimant had a pre-existing condition and was not accommodating claimant because of the pre-existing condition, apportionment will not likely be available.

For injuries on or after July 1, 2012, the requirement to prove that the pre-existing condition had affected claimant's employability before the injury is eliminated. Stated differently, the pre-existing condition does not have to be occupationally disabling for apportionment to apply.

The amount of apportionment or reduction of an award due to the pre-existing condition is not limited to the medical estimate regarding the degree of contribution. In other words, in the case illustrated above, the Administrative Judge, after considering all the testimony, could apportion (or reduce) the award by more or less than the fifty percent medical estimate.

The rule regarding proof of the effects of the pre-existing condition from an occupational standpoint has never been held applicable in cases involving conditions such as heart attacks.

6.3. STATUTE OF LIMITATIONS

There are two separate and distinct statutes of limitations with which to be concerned. The first applies where compensation benefits have not been paid and the second applies where compensation benefits have been paid.

6.3.a. WHERE NO INDEMNITY BENEFITS ARE PAID

In those cases where no indemnity or compensation benefits are paid to a claimant, there is a two-year statute of limitations beginning on the date of injury. Miss. Code Ann §71-3-35 (1972, as amended). Once the statute of limitations has run, the claim for both indemnity and medical benefits is barred. *Speed Mechanical, Inc. v Taylor,* 342 So. 2d 317 (Miss. 1977).

The claimant can toll or stop the running of the statute of limitations by filing a Petition to Controvert. Also, if indemnity benefits are paid or if the

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employer pays salary in lieu of compensation benefits, the statute of limitations is no longer applicable.

There are some cases indicating that if the claim is a "lost time" claim but the employer/carrier never filed the First Report of Injury with the Commission, the statute of limitations does not begin to run.

There can be issues involving a latent injury or one in which the effects of the injury do not show up until a later time. These cases are always factually intensive, but in general terms, the statute of limitations begins to run on the date that the claimant, as a reasonable person, recognizes the nature, seriousness and probable compensable character of his injury or illness.

6.3.b. WHERE INDEMNITY BENEFITS ARE PAID

If compensation benefits are paid, the two-year statute of limitations is not applicable. In those cases where compensation or indemnity benefits are paid, a claimant has one year from the date that Commission Form B-31, Notice of Final Payment, is properly filed with the Mississippi Workers' Compensation Commission. The one year statute of limitations is technically a jurisdictional issue taken from the combined reading of Miss. Code Ann §§71-3-37(7), 71-3-53 (1972, as amended), and Commission Rule 2.17. A combined analysis of those sections indicates that the Commission loses jurisdiction of the case one year after the proper filing of a B-31, and if the Commission loses jurisdiction of a case, no one has jurisdiction over the claim since workers' compensation issues are exclusively reserved for determination by the Commission. The net result is still a one year limitation after the filing of a B-31.

As discussed in Section 7.3.e of this Guide, a claimant should be given an opportunity to sign the B-31 and if he does and it is filed signed with the Commission, the one year period begins to run on the date it is filed with the Commission.

if after giving the claimant an opportunity to sign the B-31, he fails or

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refuses to sign and return the form, the B-31 should be filed with the Commission unsigned. After waiting an appropriate period of time for the signed form to be returned, the employer/carrier should send an original and two copies of the completed and unsigned B-31 form to the Commission and request that the two extra copies be date-stamped "filed" and returned to the employer/carrier.

PRACTICE POINT: Enclosing a self-addressed and stamped envelope is often utilized to facilitate the return of those forms.

Once the stamped "filed" copies of the B-31 are returned, the employer/carrier then send a copy of the completed B-31 form to the claimant with a letter stating that the form has been filed with the Commission unsigned and that the employer/carrier consider their obligation to provide benefits concluded. This letter and the copy of the stamped "filed" B-31 must be sent to the claimant by <u>certified mail, return receipt requested</u>. Claimant has one year from the date of the certified mail receipt showing that he received notice of the unsigned filing of the B-31 to make further claim.

PRACTICE POINT*:* Most claims professionals file with the Commission a copy of the certified mail receipt showing the date that it was signed by the claimant.

If additional benefits are paid or treatment authorized after the filing of form B-31, the running of the one-year statute of limitations is tolled (or stopped), and an amended B-31 showing the new payment totals is required. *The same procedures as outlined above must be followed in filing the amended form B-31.*

Sometimes, after the B-31 has been filed, additional medical bills will be paid that concern treatment rendered before the date of the B-31 filing, and arguably, payments for those items would not toll the statute requiring a new form B-31 to be filed.

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6.4. INTERVENING CAUSE OF DISABILITY

The employer/carrier are responsible for compensation and medical benefits that are related to the claim in question. Sometimes an issue will arise which challenges whether or not the current medical problem, treatment and/or disability is related to the accident in question as opposed to an intervening cause. As with all affirmative defenses, the employer/carrier bear the burden of proving that the continuing disability and medical treatment should not be their responsibility.

There is a presumption under the law that disability, once it is shown to exist, continues to be causally related to the accident. The presumption is not that the disability in fact continues, but if it does continue, the presumption is in favor of a continued causal connection.

The burden is on the employer/carrier to prove that the effects of the original injury have subsided and that disability is now only the result of the new or intervening accident. *Medart Division of Jackes-Evans Manufacturing Company, Inc. v. Adams*, 344 So.2d 141 (Miss. 1977). It is not enough that the new incident or medical problem simply combines with the original injury to create disability. *Rathborne, Hair & Ridgeway Box Company v. Green*, 115 So.2d 674 (Miss. 1959).

6.5. INTOXICATION

For pre-July 1, 2012 injuries, no compensation is payable if the proximate cause of the injury in question is the employee's intoxication. Miss. Code Ann. §71-3-7 (1972, as amended). *Sanderson Farms, Inc. v. Deering,* 909 So.2d 1169, 1171 (Miss. App. 2005). The burden of proof is on the employer/carrier to establish the defense, and it is a difficult burden to meet. *Edwards v. World Wide Personnel Services, Inc.*, 843 So.2d 730, 733 (Miss. App. 2003). The employer must prove that the claimant was intoxicated at the time of the accident ***and*** that his intoxication was the proximate cause of his injury.

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Reading & Bates, Inc. v. Wittington, 208 So.2d 437, 440 (Miss. 1968). Citing *U.S. F & G, Co. v. Collins*, 96 So.2d 456 (Miss. 1957). To deny workers' compensation benefits, the claimant's intoxication must be the proximate cause of the accident and not just a contributing factor. Deering, 909 So.2d at 1173. (Citing *Murphy v. Jack-See Packing Co.*, 208 So.2d 773, 777 (Miss. 1968)).

Mississippi has adopted a Drug Fee Workplace Policy Law, Miss. Code Ann. §71-7-1, *et. seq*. (1972, as amended), and the intoxication defense has been interpreted by incorporating those provisions into the application of the intoxication defense. *Kennethton Curtis v. Custom Car Corporation and AmFed National Ins. Co.*, MWCC No. 0311207-D-9668. In its simplest form under that interpretation, the defense is applicable only if the employer/carrier can prove:

1. That the employer has a written drug free workplace policy in effect at the time of the accident in question;
2. That at the time of the accident, there was a reasonable suspicion that intoxication was the cause of the accident;
3. That claimant was in fact intoxicated by either drugs or alcohol at the time of the accident; and
4. That claimant's intoxication was the proximate cause of the accident.

The defense requires proof, usually from a toxicologist, to establish that the claimant was in fact intoxicated. That alone, however, is not enough because proof must also establish that the proximate cause of the accident was the intoxication.

Proving the defense of intoxication is always factually intensive. Reported decisions confirming the application of the defense are quite rare. Simply testing positive for a controlled substance is not a valid reason to deny the claim without the other components of the defense being established. Except for someone driving a vehicle who, at the time of the accident, tests positive for alcohol at a blood level greater than .08%, there is no presumption of intoxication. There is never a presumption that intoxication was the proximate cause of the accident, however, even in those instances involving a driver who tests positive for alcohol

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at a level greater than .08%.

Although an employer might have a policy stating that an employee who either tests positive for a controlled substance or refuses to take the test can be terminated, those policies have no impact on the applicability of the intoxication defense in the workers' compensation setting. In other words, although an employee can be fired for a positive drug test, that fact alone does not provide grounds for denial of the workers' compensation claim. Proof as outlined above must be provided.

2012 Amendment Regarding Intoxication Defense—For injuries on or after July 1, 2012, the intoxication defense is completely rewritten. Changes were made to Miss. Code Ann §71-3-7, Miss. Code Ann. §71-3-121, and Miss. Code Ann. §71-7-5 (1972, as amended). The changes are intended to make the defense work in such a way that the burden of proof is passed to the claimant when alcohol, improperly used prescription drugs, or illegal drugs are involved in a claim. The basic provisions include the following:

- No compensation will be payable if the use of alcohol, illegal drugs, or a prescription drug taken inconsistent with the prescribing physician's instructions is the proximate cause of the injury.
- The Employer has the right to request that a claimant undergo a drug or alcohol test following an on-the-job injury.
- A rebuttable presumption is created that the use of alcohol/drugs was the proximate cause of the injury in the event of a positive test for:
    - A blood alcohol content of .08% or greater;
    - An illegally used drug; or
    - A prescription drug taken contrary to the prescribing physician's orders.
- If the Claimant refuses the drug test, it is presumed that one of the above three reasons was the proximate cause of the injury.
- Once the presumption arises, it is the claimant's burden to prove that the alcohol or illegal/improperly taken drug was not a contributing cause of the

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accident.

- Other provisions permit the results of the alcohol/drug tests to be admissible into evidence; provide the employer with protection against a cause of action for defamation, libel, slander when relying on the defense; and confirm the right of the employer to administer a drug/alcohol test whenever an on-the-job injury is claimed.

PRACTICE POINT: Much is being said and written arguing that these provisions might not sustain a constitutional challenge, and it will take some time for cases to make it through the litigation process to see how the defense is interpreted by the judiciary. The claims professional will be well served to seek advice of counsel in dealing with cases involving the defense. Remember that the presumption in favor of the defense is rebuttable, and in those cases where the facts of the accident clearly indicate that the intoxication was not the cause of the accident, the intoxication presumption can be rebutted. Some practitioners believe that denying a claim based only on that positive test without proper analysis of the facts of the accident will possibly lead to a suit alleging a "bad faith" denial of a claim as more fully discussed in Chapter 17.

6.6. WILLFUL INTENT TO INJURE SELF OR OTHER

Another statutory defense to claims concerns injuries intentionally caused by the claimant where he is trying to injure himself or someone else. Miss. Code Ann. §71-3-7 (1972, as amended). The cases involving the potential defense are always factually intensive and there is no presumption in favor of the defense in any circumstances. As an example, cases involving horseplay have generally been held compensable on the reasoning that employees working together will sometimes engage in frivolity and sometimes someone gets hurt; when that happens, it is just a risk assumed by the employer. *Mutual Implement and Hardware Ins. Co. v. Pittman*, 59 So. 2d 547 (Miss. 1952). Clearly, however, the horseplay could involve such an abandonment of the job to challenge compensability on the argument that claimant deviated from the employment.

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Mathis v. Nelson's Foodland, Inc., 606 So. 2d 101 (Miss. 1992).

Cases involving co-employee altercations have become increasingly difficult to analyze in recent years. A long line of older cases can be cited that found compensability on the "risk assumed by the employer" argument similar to that found in the horseplay cases. However, the more recent approach has been to challenge a finding of compensability where the reason for the co-employee altercation is personal to the employees rather than something related to the employment. In other words, if they are fighting over a personal loan one made to the other, the injury might not be compensable. *Sanderson Farms, Inc. v. Jackson*, 911 So. 2d 958 (Miss. App. 2005).

The defense is tied to the concept that one who intentionally tries to hurt himself just to collect workers' compensation benefits should not be entitled to recover. That premise has its limits, however, as illustrated by a case where a claimant had a compensable back injury, developed significant pain issues, and ultimately committed suicide from an inability to deal with the pain. Even though the suicide was an "intentional" event, the claim was still held compensable due to the unique circumstances presented. *Printer's Truck and Tractor Co. v. Spencer*, 87 So. 2d 272 (Miss. 1956).

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Chapter 7

COMMISSION FORMS

There are three groups of forms utilized by the Commission broken down into the "A" forms, "B" forms and "R" forms.

All MWCC forms are available at http://www.mwcc.state.ms.us/#/forms.

7.1. ADDRESS FOR FORM FILING

The mailing address for filing forms is:

The Mississippi Workers' Compensation Commission
PO Box 5300
Jackson, MS 39296-5300

For information regarding electronic filing, go to http://www.mwcc.state.ms.us/#/electronicDataInterchange.

It should be noted that Miss. Code Ann. §71-3-67 (1972, as amended), gives the Commission authority to assess a fine of $100 for the failure to timely file any form required by the Commission. A $100 penalty can also be added to an award to the claimant for failure to file a required report. The Commission has issued a Memorandum regarding the filing of forms and penalties. See the form at http://www.mwcc.state.ms.us/pdf/monitoringofreports.pdf.

7.2. "A" FORMS

7.2.a. A-16 Notice of Coverage

The first official form of the Commission was originally called the A-16, "Notice of Coverage." It is a notice which is to be posted in a conspicuous place by the employer so that employees will know who to contact in the event of an on-the-job injury. The amended version of the rule regarding the form permits employers to design their own form for these purposes so long as the form includes all of the information originally included in the A-16 form. See MWCC

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Rule 1.8.

2012 Amendment Regarding Notice—One of the provisions in the 2012 legislation requires Employer to post near their Notice of Coverage form a Notice prepared by the Commission detailing the 2012 Amendments. A copy of that notice to be posted is available at http://www.mwcc.state.ms.us/pdf/sb2576.pdf.

7.2.b. A-24 Proof of Coverage

Every employer subject to the Mississippi Workers' Compensation Law must file proof of compliance with the insurance provisions of the law consistent with MWCC Rule 1.3. The A-24 form is therefore used only by self-insured employers and self-insured groups that do not report to NCCI.

7.3 "B" FORMS

7.3.a. B-3 (IAIABC IA-1), First Report of Injury (FROI)

A standardized form designed by the International Association of Industrial Accident Boards and Commissions is the First Report of Injury form, the B-3. It is entitled "WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS." Note that the back of the form has some specific instructions on the completion of the form. See also MWCC Rule 2.1.

Employers should complete and file a first report of injury (FROI) with their carrier or third party administrator immediately upon receiving notice of an injury, if the injury requires a loss of more than the shift on which the injury occurs. If the injury causes lost time in excess of five days, or if the injury results in permanent impairment, the carrier or third party administrator must file the form with the Mississippi Workers' Compensation Commission. The Commission will return a file number to be used for any future filings related to the claim. The statute contemplates such filing within ten days of the employer's notice of the injury or notice that the injury has resulted in lost time in excess of the waiting period or permanent impairment. See Miss. Code Ann. §71-3-67

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(1972, as amended) and MWCC Rule 2.1.

As of this printing, the Commission is accepting the FROI's electronically with the intent that eventually all FROI's, and eventually other forms, will be filed electronically. Details relating to the Electronic Data Interface (EDI) requirements, deadlines, and procedures are available on the Commission web site at http://www.mwcc.state.ms.us/#/electronicDataInterchange.

PRACTICE POINT: The failure to file a First Report of Injury has resulted in court decisions refusing to apply the two year statute of limitation on a claim and has served as the basis for an employer to become a defendant in bad faith litigation.

7.3.b. B-18, Notice of Payment

Once payments are initiated, the Commission is notified of that development by the use of form B-18. Likewise, when benefits are stopped, restarted, converted to permanent disability benefits, or otherwise changed, the B-18 is the notice form used. Note that it does not have to be signed by the claimant, but the claimant should be given a copy of any such filing.

PRACTICE POINT: The filing of a B-18 by the employer/carrier indicates to the Commission that the employer/carrier are willing to pay the benefits specified on the form. It is in effect an "admission of liability" for the specified benefits. If the agreement to pay stated on the B-18 relates to the payment of permanent disability or death benefits, the claimant can apply to the Commission to allow those benefits to be paid in a lump sum. See B-19 below and Chapter 14 relating to Lump Sum Payments.

7.3.c. B-19, Application for Lump Sum Payment

Recall that benefits are to be paid bi-weekly unless otherwise ordered by the Commission, and this is the form filed by a claimant to obtain authority to get paid for permanent disability or death benefits in a full or partial lump sum. See

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Chapter 14 for further discussion as to Lump Sum Payments.

7.3.d. B-9, 27, Medical Report

The Commission has replaced all previous medical report forms (B-9, B-27, and B-27-D) with a new form numbered B-9, 27. Commission Rule 1.9 allows medical providers to provide copies of their office notes along with the CMS-1500 medical report forms used for health insurance purposes in lieu of these Commission forms. All medical information relating to a claim is to be filed with the Commission on all cases where the First Report of Injury is filed with the Commission. Medical records filed with MWCC must contain the MWCC file # on them or they will be returned by the Commission. A medical provider is required to submit reports regarding treatment to the employer/carrier (and not directly to the Commission) before being entitled to payment and should do so within twenty days of the first treatment and periodically thereafter.

7.3.e. B-31, Notice of Final Payment

One of the most important forms to use and understand is the B-31, "Notice of Final Payment." It is often a source of frustration for the Claims Professional, but is one of the most important forms that the Claims Professional uses in properly handling Mississippi Workers' Compensation claims. *This form, when filed properly, starts the one-year statute of limitations on cases where indemnity benefits are paid.* If the form is not filed properly, the case in question may never have a statute of limitations defense and will remain open indefinitely. Stated differently, the function of this form is to provide the notice required by Miss. Code Ann §71-3-37(7) before the claimant's rights to benefits can be terminated.

Since the proper filing of a B-31 terminates a claimant's rights to benefits, Court interpretations relating to its use have mandated that the procedures be followed precisely. *Hale v. General Box Mfg. Co.*, 228 Miss. 394 (1956).

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Commission Rule 2.17 provides that if the worker signs the properly completed B-31, the one-year statute of limitations begins on the date the Commission receives the signed B-31.

If after giving the claimant an opportunity to sign the B-31, he fails or refuses to sign and return the form, then it can be filed with the Commission unsigned. After waiting an appropriate period of time for the signed form to be returned, the employer/carrier should send an original and two copies of the completed and unsigned B-31 form to the Commission and request that the two extra copies be date-stamped "filed" and returned to the employer/carrier. Enclosing a self-addressed and stamped envelope is often utilized to facilitate the return of those forms.

The employer/carrier then sends a copy of the completed B-31 form to the claimant with a letter stating that the form has been filed with the Commission and that the employer considers its obligation to provide benefits as being at an end. This letter should be sent to the claimant by <u>certified mail, return receipt requested</u>. Claimant has one year from the date of the certified mail receipt showing that he received the B-31 form to make further claim.

If additional benefits are paid or treatment is authorized after the filing of a B-31, the running of the one-year statute of limitations is tolled (or stopped), and a corrected B-31 showing the new amounts of payments is required. *The same procedures as outlined above must be followed in filing that corrected B-31.*

Sometimes additional bills will be presented for payment for treatment that was rendered before the date of the B-31 filing, and arguably, payments for those items would not toll the statute requiring a new B-31 to be filed.

PRACTICE POINT: In completing the B-31, care should be taken to clearly explain payments made. Although a full week of disability (five, six or seven consecutive days) results in the payment of the weekly maximum amount, scattered or non-consecutive days of disability where six or seven days in total are paid at the daily rate will yield a higher total amount due. That should be reflected and explained on the B-31. See Section 8.3 for further information

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regarding the calculation of those benefits.

PRACTICE POINT: When the B-31 is filed, the Commission usually sends to the claimant a notice in a form letter designated the C-1. That letter contains information regarding the legal effect of the B-31 filing similar to what is discussed in this Guide.

7.3.f. B-52, Employers' Notice of Controversion

Commission form B-52, Employer's Notice of Controversion, is filed to give notice to the Commission of a controversy on a particular case, and a copy should also be sent to the claimant when it is filed. See MWCC Rule 2.2. It does not initiate litigation but is simply notice to the Commission and the claimant that there is an issue which is either under review or that the claim has been denied. Filing a B-52 within fourteen days of the employer's notice of an injury will avoid the imposition of the 10% penalty for the untimely payment of compensation benefits that may later be awarded.

PRACTICE POINT: Care should be used in completing this form to accurately state the issue and explain the basis for the Controversion. The claims professional should not state that the claim is denied unless a full investigation has been completed and the decision to deny the claim has been through appropriate internal protocols. Consider instead a statement such as: "The employer/carrier controverts the right to benefits at this time as the investigation is continuing and not yet complete; this is not a denial of the claim." Another possibility is to precisely state the reason benefits are not being paid such as: "The employer/carrier have not received any medical information in support of disability" or "The employer/carrier have not received any medical information confirming that the claimant's alleged disability is causally related to the job".

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7.3.g. B-5, 11 and B-5, 22, Petition to Controvert and Answer

These two forms are used in connection with litigated cases. The claimant's "Petition to Controvert," form B-5, 11, is used by a claimant to formally make a claim for benefits and seek a hearing on his claim. See MWCC Rule 2.2. The employer's "Answer" to that Petition to Controvert is the B-5, 22. See MWCC Rule 2.4. Once the Commission receives a claimant's Petition to Controvert, the Commission will send a letter to the employer/carrier informing them of that filing; the employer/carrier's Answer to the Petition is due twenty three days from the date of the Commission's letter. Except in a situation where an employer is representing himself, a licensed Mississippi attorney must file the Answer. See Miss Code Ann. § 71-3-63 (1972, as amended). Failure to timely file an Answer could result in a default, loss of affirmative defenses, and impair the ability to successfully defend the claim.

7.4. R FORMS

7.4.a. R-1, Early Notification of Severe Injury

The Commission wants to be notified immediately of a severe injury such as a head injury, paralysis injury, or severe burn injury, and they have designated the R-1 as the form to be filed along with a FROI to complete that notice.

7.4.b. R-2, Referral for Rehabilitation and Initial Report

The R-2 is a form used by the Commission to refer a claimant to the Vocational Rehabilitation Division of the Mississippi Department of Education and to other rehabilitation suppliers. It is not a form filed by the employer/carrier.

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Chapter 8
AVERAGE WEEKLY WAGE

All workers' compensation benefits are based on the claimant's average weekly wage. Consequently, it is important to understand how average weekly wage should be calculated. Essentially Mississippi uses the wages earned during the 52 weeks before the injury date in making this determination. To be precise, there are three mutually exclusive methods for calculating the Average Weekly Wage under Miss. Code Ann. §71-3-31 (1972, as amended):

8.1. THREE FORMULAS

a. If a claimant has worked for the employer for 52 weeks and has missed less than seven unpaid days during that time, divide the total earnings by 52 to determine the average weekly wage. For example, if the claimant has earned $20,000.00 (gross wages) in the 52-week period prior to the date of injury, the claimant's average weekly wage would be $384.62 ($20,000 divided by 52 = $384.62).

b. If a claimant has worked for the employer for 52 weeks and has missed more than seven unpaid days during that time, convert the lost time into workweeks and subtract the number of lost time weeks from 52 and use the remainder to divide into the total earnings. For example, if the claimant missed ten days of work during the year in question and had a 5-day workweek, he would have missed two workweeks. Subtracting 2 from 52 means that the divisor into the total earnings would be 50. Consequently, if the claimant earned $20,000.00 during the 52-week period prior to the injury in question and missed two workweeks, the AWW would be $400.00. ($20,000 divided by 50 = $400.00). For the purposes of this illustration, the 10 days missed from work are not days for which the employee was paid sick leave or vacation leave, but unpaid missed days from work that were available for other similarly situated

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employees to work.

c. If a claimant has not worked for the employer for 52 weeks prior to the injury, divide the total earnings of the employee by the number of weeks (or parts of weeks) during which wages were earned. For instance, if the claimant worked for 40 weeks prior to the date of injury and earned $20,000.00, the AWW would be $500.00 ($20,000 divided by 40 = $500.00)

8.2. PARTIAL WEEKS WORKED

It is typically argued that for partial weeks worked, one day will count as .20 weeks, two days will count as .40 weeks, three days will count as .60 weeks, and four days will count as .80 weeks for purposes of determining the appropriate divisor. As an example, assume the claimant worked for parts of four weeks before the injury date and earned a total of $1000. During those four weeks, he worked one day one week, two days one week, three days one week and 4 days one week. Adding up those partial weeks worked of .2, .4. .6, and .8 would total 2.0, so the $1000 earnings would be divided by 2 instead of 4 to give an average weekly wage of $500.

Case law has held that as few as four weeks is an adequate period of time to calculate the average weekly wage if those weeks are illustrative of the typical workweek expected by similarly situated employees.

8.3. EMPLOYED FOR SHORT TIME BEFORE INJURY

If none of these methods work due to the shortness of time during which a claimant was employed before the injury in question, the average weekly wage to be used will be that of a similarly situated employee calculated according whichever of these three methods is applicable.

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8.4. GRATUITIES/TIPS

Gratuities or tips are a part of the average weekly wage as well and should be included in the total wages earned as a part of the calculation. In fact, allowances of any character that are paid the claimant, which are in lieu of wages or specified as part of the wage contract, are a part of the earnings to be considered. Miss. Code Ann. §71-3-31 (1972, as amended).

PRACTICE POINT: Proof of the amount of tips to be considered as part of the average weekly wage can be problematic, and decisions can be found supporting the proposition that only reported taxable income from tips can be a part of the average weekly wage, while other decisions have permitted the claimant's testimony on tips received to be the "best evidence" of the total income. When confronting this issue, the claims professional will need to fully investigate the allegations regarding tips received so that an informed decision can be made as to the appropriate average weekly wage to use.

8.5. SICK PAY AND VACATION PAY

Sick pay and vacation pay are not "salary in lieu of compensation" meaning that the employer/carrier do not take credit for those payments against compensation benefits that are due. Whether an employer's policies permit or prohibit that is not addressed in the workers' compensation law. However, in dealing with an employee of the State of Mississippi, there is statutory authority addressing the extent to which an employee can take both workers' compensation benefits and accrued sick leave. See Miss. Code Ann. §25-3-95 (1972, as amended). In summary of those provisions, a state employee who misses work due to a work injury can receive both workers' compensation benefits and personal/medical leave; however, the amount of personal/medical leave can be limited to prevent the employee from receiving benefits which exceed the total amount of wages earned at the time of injury. The statute does not allow for a reduction in workers' compensation benefits based on the receipt

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of sick leave benefits.

8.6. PART TIME EMPLOYEES

Part time employees are not discriminated against and are entitled to benefits based on their actual average weekly wage calculated as above. The minimum compensation rate, however, is $25 per week.

8.7. CLAIMANT WITH MORE THAN ONE JOB AT TIME OF INJURY

If a claimant is working for more than one employer at time of injury, only the wages paid to the claimant from the job in which the injury occurred are included in the average weekly wage calculation; however, those additional wages will be included in the average weekly wage calculation if both jobs are for the same employer. As an example, if the claimant is working for a school as a cafeteria worker and also drives a bus for the school, the wages earned in both jobs will be included in the total earnings to calculate the average weekly wage.

PRACTICE NOTE: The Claims Professional is encouraged to obtain the claimant's wage record and analyze it appropriately to calculate the correct average weekly wage and compensation rate so that payments are correctly made.

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Chapter 9
DISABILITY BENEFITS

9.1. MAXIMUM AND MINIMUM WEEKLY AMOUNTS

The weekly compensation rate for disability is calculated by taking 66 2/3% of the claimant's average weekly wage subject to the applicable maximum and minimum weekly rates established under the law. The Act sets a maximum weekly compensation rate as well as a weekly minimum in Miss. Code Ann. §71-3-13 (1972, as amended). The maximum and minimum weekly rates in effect as of the date of injury will remain with the claim throughout its life. A listing of those applicable weekly minimums and maximums is available on the MWCC Web site: http://www.mwcc.state.ms.us/#/maximumBenefitMileageRatesChart.

9.2. WAITING PERIOD

There is a five (5) day waiting period for disability benefits, but after fourteen (14) days of disability, the waiting period is eliminated and benefits are paid from the date of injury. See Miss. Code Ann. §71-3-11 (1972, as amended). If the employee is paid in full for the date of injury, disability is calculated as beginning on the day following the injury date. If the employee is not paid in full for the injury date, disability is calculated as beginning on the injury date. Neither the five-day waiting period nor the fourteen-day period of disability has to be consecutive days. See MWCC Rule 1.11.

It is important to note that a day of disability, under the stated rule, is any day on which the injured employee is unable, because of injury, to earn the same wages as before the injury. That means that lost time, if supported by medical findings, includes weekend days or other days on which the employee is not scheduled to work. To illustrate further, assume an employee usually works Monday through Friday and is injured on Friday and is paid his wages in full for the injury date. His five-day waiting period would be Saturday, Sunday, Monday,

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Tuesday and Wednesday. See Commission Rule 1.11.

9.3. NON-CONSECUTIVE LOST TIME DAYS

Lost time does not have to be consecutive or even full days in order to trigger an obligation to pay compensation benefits. When completing the B-31 in a situation involving non-consecutive lost time days, care should be taken to clearly explain payments made. Although a full week of disability (five, six or seven consecutive days) results in the payment of the same weekly maximum, scattered or non-consecutive days of disability, where six or seven days in total are paid at the daily rate, will yield a total amount due that is higher than the weekly maximum. That should be reflected and explained on the B-31.

9.4. DAILY COMPENSATION RATE

Under Commission Rule 1.10, the daily rate of compensation is the weekly compensation rate divided by five. That means that a claimant gets the same compensation amount if he or she is being paid five, six or seven days. To illustrate, assume the claimant has an Average Weekly Wage of $500 and a resulting compensation rate of $333.33. His daily compensation rate is therefore $66.67 ($333.33 divided by 5) and if he has five days of disability, he gets $333.33 (daily rate multiplied by 5). If he is being paid for six days of disability, he also gets $333.33; and if he is being paid for a full seven days lost time, he also gets $333.33. See Commission Rule 1.10.

9.5. MAXIMUM RECOVERY

There is a dollar maximum applicable to indemnity or compensation benefits set forth in Miss. Code Ann. §71-3-13 (1972, as amended). It is reached by the payment of a single period of 450 weeks at the applicable maximum compensation rate for the year in which the injury occurred. As per

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the chart on the MWCC website explaining the weekly indemnity maximum at http://www.mwcc.state.ms.us/#/maximumBenefitMileageRatesChart, there is also a lifetime disability maximum which is reached by the payment of the applicable weekly maximum for 450 weeks. It is an overall dollar maximum applicable to the claim for indemnity benefits. This indemnity maximum is not applicable to a claim for medical benefits.

9.6. PENALTIES FOR LATE PAYMENTS

Any installment of compensation not paid within fourteen days of the due date is subject to a 10% penalty. See Miss. Code Ann. §71-3-37(5) (1972, as amended). Each installment of compensation is to be paid beginning on the 14th day of disability with additional installments due each fourteen days thereafter. Miss. Code Ann. §71-3-37(2). To illustrate, if the disability begins on January 1, the first installment of compensation is due on January 14; if that payment is not made by January 28, then the penalty is applicable.

The penalty can be avoided by (1) paying the amount due within fourteen days of the due date; (2) controverting the right to compensation benefits within fourteen days of the employer's notice of the injury by filing a Form B-52, Employer's Notice of Controversion (See Section 6.3.f); or (3) proving that the inability to make payments was due to circumstances beyond the control of the employer.

If an installment of compensation payable under the terms of an award is not paid within 14 days of the due date, the penalty is 20%. Miss. Code Ann. §71-3-37(6).

In addition to penalties for late payments, the Commission can determine that interest might also be payable on late installments of compensation.

9.7. OVERPAYMENTS

If the employer has made advance payments of compensation, it shall be

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entitled to be reimbursed out of any unpaid installment or installments of compensation due. Miss. Code Ann. §71-3-37(11) (1972, as amended).

9.8. CHILD SUPPORT LIENS

Child and spousal support liens against workers' compensation benefits are enforceable. See Miss. Code Ann §71-3-129 (1972, as amended). A lien against the wages of a claimant served on the employer is not the same thing as a valid and enforceable lien against the claimant's workers' compensation benefits, but that notice should serve as a requirement to further investigate the obligation to honor the attempted lien. A lien formally attaches to workers' compensation benefits once the Mississippi Department of Human Services, Division of Child Support Enforcement, obtains the lien in the court of appropriate jurisdiction. Notice of that lien, once established, must then be filed (my mail or fax) with the Executive Director of the Mississippi Workers' Compensation Commission. The Commission Executive Director then puts the employer/carrier on notice of the lien, and, once that notice is received by the employer/carrier, the lien attaches to the workers' compensation benefits payable to that claimant. The parties are deemed to have notice of the lien within five days of the mailing and the lien shall attach to all workers' compensation benefits that are thereafter payable.

If payments are ongoing, the appropriate child support department may send an income withholding order. It will specify the monthly payments as well as provide weekly and bi-weekly breakdowns. There are limits as to how much can be withheld from the benefits, however. Child support payments are excepted from the limits on normal garnishments in Miss. Code Ann. §85-3-21 (1972, as amended). For child support payments, limits are established as follows:

If the employee is supporting a spouse or dependent other than the dependent named in the Order, the maximum is 50% of disposable income;

If the employee is not supporting a spouse or dependent other than the

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dependent named in the Order, the maximum is 60% of disposable income;

If the payment is in arrears for more than 12 weeks, those limits get a 5% bump to 55% and 65%, respectively.

Child and spousal support liens are the only liens against workers' compensation benefits that are enforceable pursuant to Miss. Code Ann §71-3-43 (1972, as amended).

Cases being settled: The Commission, pursuant to an official notice dated June 26, 2012, has been working with the Mississippi Department of Human Services (DHS) to establish a uniform policy regarding the handling of support liens in cases that are being settled. That policy notice is found on the Mississippi Workers' Compensation Commission website at http://www.mwcc.state.ms.us/pdf/Child%20Support%20Web%20Policy.pdf. In summary, the policy places on the employer/carrier the responsibility for withholding the proceeds needed to satisfy a support lien and to pay those proceeds directly to the Department of Human Services, or to a support obligee who has his or her own attorney and is not using the DHS to help with collection. If the DHS has negotiated the amount of the lien with the parties, a written confirmation from the DHS regarding that compromise of the lien is required by the Commission before approval of the settlement. Note, however, that the employer/carrier still has the obligation to withhold the necessary proceeds to satisfy the lien in the situation involving lien compromise.

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Chapter 10
CATEGORIES OF DISABILITY

There are four categories of disability benefits and they will each be discussed briefly in turn. Disability is defined under the Act as "the incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or other employment, which incapacity and the extent thereof must be supported by medical findings." Miss. Code Ann. §71-3-3(i) (1972, as amended). Disability benefits are therefore conditional on a medical opinion to the effect that the injury prohibits or impairs the claimant from working on either a temporary or permanent basis.

10.1. TEMPORARY TOTAL DISABILITY

Temporary Total Disability (TTD) benefits are discussed in Miss. Code Ann. §71-3-17(b) (1972, as amended), and are generally payable when the employee is completely unable to work because of injury but the disability is not expected to be permanent. Installments of compensation are payable every fourteen days (although weekly payments are permissible).

The weekly maximum changes annually but the weekly minimum is $25.00. A complete listing of the applicable maximum and minimum compensation rates is on the MWCC website at http://www.mwcc.state.ms.us/#/maximumBenefitMileageRatesChart. Each category of benefits (i.e. TTD, TPD, PPD, or PTD) is payable for a maximum of 450 weeks. However the overall indemnity maximum discussed in Section 9.5 will be reached in a single 450-week period at the weekly maximum.

As previously noted, there is a five-day waiting period for benefits unless the disability lasts longer than fourteen days. Temporary total disability is essentially a medical issue in that if medical opinions support the inability to return to work, then benefits would be payable. Conflicting medical opinions on this issue are often a source of contention and the basis for controversion and

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litigation. The resolution of such disputes is often fact intensive.

The first installment is due on the fourteenth day after the employer has notice of the disabling injury or death and is paid bi-weekly thereafter until the claimant is released to return to work full duty, placed at maximum medical improvement (MMI) or returns to work in any capacity.

An Order from the Commission is not usually required to suspend TTD benefits, but suspending benefits without an appropriate reason could be problematic from a bad faith standpoint. In two similar circumstances, an Order authorizing the suspension of benefits must be obtained if the basis for the suspension of benefits is an assertion that the claimant is (1) unreasonably refusing to submit to medical treatment or (2) unreasonably refusing to submit to an examination at the instance of the employer/carrier. In those instances, a hearing is first required to determine whether claimant's refusal to do either is unreasonable. Miss. Code Ann. §71-3-15(1), Miss. Code Ann. §71-3-37(3) (1972, as amended) and MWCC Rule 1.9.

PRACTICE POINT: The suspension of benefits issue usually comes up at the point when a claimant is at maximum medical recovery or is released to return to work. Suspending benefits without an Order when neither of those contingencies has occurred can be particularly problematic from a bad faith standpoint. In addition, automatically suspending benefits when those contingencies occur can also be problematic in those cases, as examples, where there is an issue of permanent disability, conflicting medical opinions on the release, or multiple body parts involved and claimant is only at maximum medical recovery from a part of his injury. To further illustrate, in scheduled member disability cases, the employer/carrier owe at a minimum the medical impairment rating. (As an example, if a claimant is released to return to work with a 10% impairment rating to an arm, 10% of 200 weeks or 20 weeks is also due at a minimum so those benefits should continue. See Chapter 9.3.a for a discussion of those benefits).

Also, in body-as-a-whole cases such as back injuries, which are more fully

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discussed in Chapter 9.3.b, a "big picture" analysis must be made to see if benefits should be suspended at maximum medical recovery or release to return to work. As examples: Does the claimant have permanent work restrictions? Can the employer accommodate the restrictions? Has the employer terminated the claimant? A decision to terminate benefits is too important to adopt an "always or never" approach to handling this issue. A decision to terminate benefits that is designed to use the superior economic weight of the employer/carrier to force the claimant to settle his case for less than it might be worth can be fuel for a bad faith case, and a claims professional should carefully evaluate facts and analyze a decision to terminate benefits. That analysis might also include advice of counsel if uncertainty prevails on the appropriate decision to take.

Form B-18 is the MWCC form used to inform the Commission and the claimant that his benefits have started, stopped, restarted, or changed to a different category.

It is possible that the employer will pay claimant's regular salary in lieu of compensation benefits, and that is permissible. However, those payments must be reported to the Commission on a B-18 and B-31 as well.

PRACTICE NOTE: If an employer pays salary in lieu of compensation on a case involving more than five days lost time, the claim becomes a lost time claim that must be reported to the Commission. A B-31 will need to be filed in order for the statute of limitations to beginning running. The case is not a "medical only" just because the employer pays salary in lieu of compensation.

10.2. TEMPORARY PARTIAL DISABILITY

Temporary Partial Disability (TPD) benefits are payable when the employee sustains a partial disability before maximum medical recovery. It is usually found in those cases where claimant returns to work with temporary work restrictions and, due to the injury, is unable to earn the same wages he was earning prior to

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the injury. Miss. Code Ann. §71-3-21 (1972, as amended). The benefit is calculated by taking the pre-injury average weekly wage minus the wage-earning capacity after the injury times 66 2/3%. The TPD benefit is subject to the same maximum limitations as to TTD benefits, but there is no applicable minimum weekly benefit. Examples: A claimant's pre-injury weekly wage was $500. After the injury (and before maximum medical recovery) claimant had a wage earning capacity of $200. The TPD benefit would be calculated as follows: $500 - $200 = $300 x 66 2/3rds % = $200.00 per week. Assume instead the AWW of $500 but claimant returns to work at $490 per week. The benefit is arguably $6.67 per week or 66 2/3rds% of the $10 per week difference in his pre- and post-injury wages.

A common question dealing with TPD benefits is what to do if a claimant has been released to return to light duty work, and the employer is willing and able to accommodate the restrictions, but the claimant refuses to return to work. Arguably TPD benefits are not owed because claimant is under a duty to make a reasonable effort to return to work. At the same time, if the employer is unwilling to or unable to accommodate the light duty work restrictions, claimant's benefits probably continue at the same rate paid for TTD.

MWCC Form B-18 is the form used to notify the MWCC and the claimant about the payment of TPD benefits.

10.3. PERMANENT PARTIAL DISABILITY

Permanent Partial Disability (PPD) benefits are payable after the claimant attains maximum medical improvement and is left with a disability that is less than total but nonetheless permanent. See Miss. Code Ann. §71-3-17(c) (1972, as amended). Permanent partial disability benefits fall into two categories: those involving scheduled injuries and those involving non-scheduled injuries, or what are generally referred to as "body as a whole" cases. There are similarities as well as differences in the analysis and payment of these benefits. PPD for certain

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body parts likes arms, legs, hands, feet, eyes, etc. are "scheduled" members, while injuries not included in the schedule, such as back or head injuries, are "body as a whole" injuries.

10.3.a. SCHEDULED MEMBERS

Scheduled member PPD benefits are in addition to temporary disability benefits and begin once a claimant is at maximum medical improvement. The value of the impairment is a reflection of the claimant's "industrial loss of use" of the scheduled member. For a partial loss of use of a scheduled member, the benefit is calculated by applying the percentage of industrial loss of use of the scheduled member to the applicable number of weeks in the schedule, and those benefits are then paid out at the same compensation rate paid for TTD (2/3rds of the AWW subject to the weekly maximum). Unless ordered by the Commission, they are not to be paid in a lump sum but should be paid out biweekly (although weekly payments are also permissible).

USE OF AMA GUIDELINES: The permanent impairment rating obtained from the claimant's doctor should be calculated according to the latest edition of the Guidelines to the Evaluation of Permanent Impairment published by the American Medical Association, currently in its Sixth edition. See General Rule IV.A. of the Mississippi Workers' Compensation Medical Fee Schedule.

The medical impairment rating stated by the treating physician is not, however, the only factor to be considered in evaluating the industrial loss of use of the scheduled member, and often times a claimant is entitled to more than just the permanent impairment rating. The value of a scheduled member permanent disability is based on a number of factors taken together including claimant's age, education, training, work experience, transferrable work skills, and post-injury work history and earnings. The employer/carrier owe at least the medical impairment rating to the scheduled member even if the industrial loss of use is less than the rating. Stated differently, a claimant is entitled to the

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greater of (1) the functional or medical impairment or (2) the industrial loss of use of the scheduled member. *Ard v Marshall Durbin Companies, Inc*., 818 So. 2d 1240 (Miss. 2002). In general terms, *if the scheduled member injury prohibits a claimant from performing the substantial acts of his usual employment*, the whole scheduled member can be awarded. There are even instances where permanent total disability can be awarded where the scheduled member impairment prohibits a claimant from returning to any work for which he is capable when considered in light of those factors identified above.

To calculate the amount payable for a scheduled member PPD rating, the doctor should first calculate the permanent impairment rating pursuant to the latest edition of the AMA Guidelines to the Evaluation of Permanent Impairment. Once that number is established, multiply the percentage loss of the scheduled member times the number of weeks allowed for total loss of the scheduled member and pay benefits for that number of weeks at the claimant's applicable compensation rate beginning with the date of maximum medical improvement. To illustrate, the leg is worth 175 weeks under the Act. Assume a compensation rate of $400 and a 10% PPD rating to the leg. Benefits would be calculated as follows: 175 weeks x 10% = 17.5 weeks x compensation rate of $400 to be paid out biweekly. Recall, however, that the real issue is not just the impairment rating, and if this rating represents a 25% industrial loss of use of the scheduled member, the number of weeks payable would be 175 weeks x 25% or 43.75 weeks at the claimant's compensation rate.

PPD benefits are supposed to be paid biweekly. Weekly payments can by made although monthly payments cannot be made unless ordered by the Commission. The agreement to pay PPD benefits is reported to the Commission, with notice to the claimant, on Form B-18. The clamant can request that the Commission allow future benefits to be paid in a lump sum payment by filing form B-19, Application for Lump Sum Payment. Upon receipt of the Order and the lump sum calculation from the Commission, payment should be made within fourteen days of the Order date.

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Inasmuch as it is often difficult to determine the exact amount payable for injuries to scheduled members without having a hearing and determination by an Administrative Judge, these cases are often settled on a compromise basis pursuant to Miss. Code Ann. §71-3-29 (1972, as amended), and MWCC Rule 2.15. These compromise settlements, which often also include a closure of medical, are referred to as 9(i) settlements, a reference to the original code section nomenclature when the law was first passed. See Section 14.1 for further discussion of these settlements. Any settlement is subject to approval by the Commission, and a licensed Mississippi attorney must be retained by the employer/carrier to prepare the proper paperwork and present the settlement to the Commission. The claimant does not have to be represented in such a settlement, but if he is not, the Commission will interview him (usually in person, but sometimes by telephone), to make sure that the settlement is in his best interests. The MWCC has established a number of specific rules regarding settlements and those rules may be obtained from the MWCC website: http://www.mwcc.state.ms.us/pdf/memotoattorneys.pdf.

A chart showing the number of weeks payable for scheduled members follows. Other specific provisions are included in the Act relating to amputations of fingers and toes, hearing loss, and loss of sight that should be consulted. See Miss. Code Ann. §71-3-17(c) (1972, as amended). It is important to note that the impairment rating for a partial loss of use of a schedule member must be determined by a licensed medical doctor. A quick listing of the number of weeks scheduled for most of the "scheduled members" is as follows:

Arm	200 weeks	**Third finger**	20 weeks
Leg	175 weeks	**Toe other than great toe**	10 weeks
Hand	150 weeks	**Fourth finger**	15 weeks
Foot	125 weeks	**Testicle, one**	50 weeks
Eye	100 weeks	**Testicle, both**	150 weeks
Thumb	60 weeks	**Breast, female, one**	50 weeks
First finger	35 weeks	**Breast, female, both**	150 weeks
Great toe	30 weeks	**Loss of hearing, 1 ear**	40 weeks
Second finger	30 weeks	**Loss of hearing, both ears**	150 weeks

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10.3.b. BODY AS A WHOLE INJURIES

The permanent partial disability benefits for non-scheduled injuries such as those involving the back, head, or heart are calculated differently but have some commonality with the scheduled member awards. The claimant is entitled, in those cases, to two-thirds of his/her loss of wage earning capacity payable over 450 weeks. See Miss. Code Ann §71-3-17(c)(25) (1972, as amended). Please note that such benefits are not calculated by multiplying 450 weeks by the permanent impairment rating as might be done in scheduled member cases. Also, the loss of wage earning capacity percentage may be more or less than the medical impairment rating and, in some instances, a claimant might receive permanent total disability benefits even though he/she had only a partial disability rating.

A formula to follow as a starting point in calculating PPD benefits to the body as a whole is the average weekly wage of the claimant, times the percent of his/her loss of wage earning capacity, times 66 2/3rds percent, for 450 weeks. Again, the concept of loss of wage earning capacity encompasses a review of multiple factors such as the claimant's age, education, training, work experience, transferrable work skills, post-injury efforts to find a job, and actual work history and earnings, all in an effort to evaluate claimant's ability to earn wages on the open labor market. The net result of that kind of analysis is that the outcome is quite subjective. An award is not limited to an impairment rating.

To illustrate the calculation of benefits, assume the claimant has a back injury and is left with a 15% anatomical impairment rating. His pre-injury average weekly wage is $500. If he has a 15% loss of wage earning capacity consistent with the rating, the amount payable is calculated as follows: $500 times 15% ($75.00) times 2/3rds ($50.00) for 450 weeks. The benefit would total $22,500, but is supposed to be paid bi-weekly unless the Commission orders a lump sum payment (or a 9(i) settlement is reached).

The calculation is easy to conceptualize and implement once the percent

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loss of wage earning capacity is known. The harder part is the analysis of how to establish the percentage of loss of wage earning capacity. Since the award is supposed to be a reflection of how the injury has affected claimant's ability to earn wages on the open labor market, the analysis is subjective. Whatever the loss of wage earning capacity percent turns out to be, however, the formula is the same. If it is 25% loss of wage earning capacity, the benefit is calculated as follows: $AWW x 25% x 2/3rds payable for 450 weeks. If it is a 50% loss of wage earning capacity, the benefit is calculated as follows: $AWW x 50% x 2/3rds payable for 450 weeks. The formula remains the same with the variable being a change in the assumed percent loss of wage earning capacity. The benefit is not calculated by taking a percent of 450 weeks.

Although Mississippi contemplates the payment of PPD benefits to the body as a whole based on a loss of the *capacity* to earn wages due to the injury, sometimes the result is a reflection of a comparison of the pre-injury and post-injury earnings. Although those decisions do not appear to analyze the *capacity* to earn wages issue, it is another way to look at a potential result. If the pre-injury AWW is $500 and the post-injury AWW is $300, a potential result is 2/3rds of the difference for 450 weeks. $500 - $300 = $200 x 2/3rds = $133.33 for 450 weeks.

The $25.00 per week minimum is not applicable for partial disability cases, but the same weekly maximum for temporary total disability does apply. See Commission Rule 1.13 for additional provisions applicable to paying PPD benefits at the same rate as TTD being considered an acceptable acceleration of payments.

There are some presumptions to consider in evaluating these cases, all of which are considered rebuttable:

A. If claimant returns to work at the same wage he/she was earning before the injury date, it is presumed that claimant has no loss of wage earning capacity; claimant can rebut that presumption, however, by showing that his post-injury earnings are not a reliable basis for evaluating the capacity to earn

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wages on the open labor market. Proof that claimant is only receiving sympathy wages, or that the job is only temporary, or other similar factors, could still yield an award for benefits.

B. If an employer refuses to allow a claimant to return to work after maximum medical improvement and claimant presents himself for re-employment at that time, there is a presumption that the claimant is totally disabled. That presumption can be rebutted, however, by proof that there was another legitimate reason the claimant was not rehired other than the refusal to accommodate the injury. As an example, proof that the claimant violated an established employment policy, such as failing to abide by the drug free work place policy, or violating an established "no call, no show" policy, could be adequate to rebut that presumption.

C. If the claimant fails or refuses to make a legitimate effort to return to work, there is a presumption that the claimant has sustained no loss of wage earning capacity.

10.3.c. SERIOUS HEAD OR FACIAL DISFIGUREMENT

A claimant who sustains serious head or facial disfigurement is entitled to a payment not to exceed $5,000.00. No such award can be made, however, until a lapse of one year from the injury date that caused the disfigurement. See Miss Code Ann. §71-3-17(c) (24) (1972, as amended). The parties are permitted to agree on the amount to be paid and report it on a B-18 or the claimant can go to the Commission on a Tuesday or Wednesday and have the Commission make the determination of the amount due.

10.4 PERMANENT TOTAL DISABILITY

Permanent Total Disability (PTD) benefits are not payable for life but are subject to the same 450-week limitation, weekly minimums and maximums, and overall dollar maximum referenced above. PTD is payable for loss, either by amputation or total loss of use, of both arms, legs, hands, feet, eyes, or any

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combination, and in other cases as the facts may appear. Miss. Code Ann. §71-3-17(a) (1972, as amended). The "other cases" provision is where PTD comes up most frequently, and in its simplest form, PTD is payable when an employee is unable, because of the injury, to return to any reasonable employment for which he is trained by education, training or experience. PTD could be the result even if the injury concerns only the loss of or loss of use of a single scheduled member. The analysis is always focused on how the injury has affected a claimant's ability to earn wages on the open labor market, and a review of multiple factors such as the claimant's age, education, training, work experience, transferrable work skills, post-injury efforts to find a job, and actual work history and earnings, is all a part of the analysis on the extent of disability.

From a claims handling standpoint, the benefit is calculated by taking 66 2/3% of the claimant's average weekly wage, subject to the maximum and minimum compensation rates applicable for TTD. Installments of compensation are payable every fourteen (14) days unless otherwise ordered by the Commission. In some cases, the permanent and total nature of the disability is apparent at the time of injury and benefits are therefore commenced immediately. In most cases, however, benefits are paid for a period of temporary total disability and at some later date, it is determined that PTD is due. In these cases the employer/carrier take credit for the number of weeks previously paid for temporary disability and pay the balance of the remaining 450 weeks for PTD. As an example, if the claimant has been paid fifty weeks of TTD when he is found to be at MMI and deemed PTD, the employer/carrier would get credit for the previously paid 50 weeks and owe an additional 400 weeks to be paid because the total disability has existed since the beginning of the claim.

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Chapter 11
DEATH BENEFITS

Death benefits are payable only for a maximum of 450 weeks and are subject to the same minimum and maximum weekly compensation rates as disability cases. As with disability benefits, the statute contemplates the payment of benefits on a bi-weekly basis unless otherwise ordered by the Commission. Benefits payable are set forth in Miss. Code Ann. §71-3-25 (1972, as amended) and include the following:

11.1. IMMEDIATE PAYMENT

An immediate lump sum payment of one thousand dollars ($1,000.00) is owed to the surviving spouse.

11.2. FUNERAL ALLOWANCE

Reasonable funeral expenses, not to exceed five thousand dollars ($5,000.00), are owed on behalf of the decedent. The benefit is payable even if the funeral expenses were paid by any other insurance or collateral sources.

11.3. WEEKLY BENEFITS TO DEPENDENTS

A surviving spouse and minor children are conclusively presumed dependent on the decedent. They are in a priority category for the death benefits and will take to the exclusion of any other dependents. A surviving spouse is entitled to 35% of the decedent's average weekly wage and each child is entitled to 10% of the decedent's average weekly wage, so long as the total payable to all dependents does not exceed 66 2/3% of the decedent's average weekly wage.

If there is no surviving spouse, each child gets 25% of the decedent's average weekly wage, subject to the overall 66 2/3% for all dependents

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combined. If the surviving spouse remarries, the surviving spouse's death benefit is suspended and each child's rate is increased from 10% to 15%.

Children above age 18 may be entitled to benefits if they are incapable of self-support by reason of mental or physical disability or if they are under age 23 and remain a full-time student. The Commission may, in its discretion, require the appointment of a guardian for the purpose of receiving the compensation of a minor dependent, but usually payments are made to the surviving parent who is considered under Mississippi law to be the "natural guardian."

If the surviving spouse and children do not take the full 66 2/3% of the decedent's AWW, then other dependents of the decedent such a parents, grandparents, brothers, and sisters may qualify. Dependency is not presumed, and each would have to prove at least a partial dependency on the decedent at the time of the decedent's death. Each such dependent would be entitled to 15% of the decedent's average weekly wage, but remember that they are in a secondary category and are paid only if the amount payable to the surviving spouse and minor children is less than 66 2/3rds% of the decedent's AWW.

As an example, assume a decedent leaves as dependents a surviving spouse, 3 children and his mother. The widow's portion is 35% and each child is 10% for a total of 65%. In that scenario, the decedent's mother would be paid 1 2/3rds% of the decedent's AWW since it is the amount between the 65% for the priority beneficiaries and 66 2/3rds percent of the AWW.

The $25 minimum payment has been held to be applicable to all beneficiaries collectively and not to each individual death beneficiary.

If the total percentage of the decedent's AWW for all beneficiaries collectively exceeds 66 2/3rds, the benefits are distributed based on a proportionate basis. Assume the decedent had a $600 AWW giving him a maximum compensation rate of $400, and he leaves a widow and 5 children. In that instance, the total percentage of the AWW would be 85% (35% + 10% + 10% + 10% + 10% + 10%), but the benefit is subject to a maximum of 66

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2/3rds %. In that scenario, the widow's portion would be 35/85ths of $400 and each child's portion would be 10/85ths of the $400 compensation rate.

Since benefits for each child stop at age 18 (unless he/she remains a full time student or is incapable of self-support because of a mental or physical disability), once the benefits for a child stop, it is necessary to recalculate each benefit. In other words, in our assumed scenario above, once the first child's benefits stop, the widow's portion is recalculated at 35/75ths of $400 and each child's portion is 10/75ths of $400. When the next child's benefits stop, the widow's portion becomes to 35% of the $600 AWW and each remaining child gets 10% of $600 since total percentages for the remaining widow and 3 children are now only 65%.

Dependency status is determined as of the date of death. Definitions of "surviving spouse" and "child" in Miss. Code Ann. §71-3-3 (1972, as amended) must be consulted for careful analysis in most cases. With the modern American family, it is not unusual to find multiple families with a connection to the decedent claiming benefits. It is the Claims Professional's responsibility to do a thorough investigation into those allegations so the payments are made to the appropriate parties. This is another instance when consultation with counsel might be warranted to thoroughly evaluate those issues.

11.3.a DEATH CLAIMS INVOLVING UNDOCUMENTED WORKERS

There are special provisions applicable to death claims involving undocumented workers (still referred to in the statute as "aliens") who are not residents (or about to become residents) of the United States or Canada. As an example of those differences, death beneficiaries living in a foreign country are limited to the surviving wife and child or children of the decedent (with other provisions also applicable as a contingency). When confronted with this situation, consult the specific provisions applicable to cases of this nature in Miss. Code Ann. §71-3-27 (1972, as amended) and seek advice of counsel.

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11.4. PAYMENT TO SECOND INJURY FUND

An additional payment due on a death claim, but not a benefit to death claim beneficiaries, is a payment to the Mississippi Workers' Compensation Commission Second Injury Fund. If there are no dependents entitled to benefits, a $500 payment should be paid to the MWCC. If there are dependents entitled to benefits, the payment due to the MWCC is $300; however, that payment can be suspended by the MWCC once the amount of money accumulated in the Fund exceeds a statutorily established level. See Miss. Code Ann. §71-3-73 (1972, as amended).

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Chapter 12
MEDICAL BENEFITS

Restoring the claimant to good health (and thus gainful employment) is a primary objective of the Mississippi Workers' Compensation Law. Miss. CODE ANN. §71-3-1. To that end, the employer must furnish the claimant all necessary and reasonable medical services, supplies and other attendance or treatment such as the nature of the injury and the process of recovery requires. Medical Benefits under the Mississippi Workers' Compensation Act are unlimited in amount and have no time limitations unless a statute of limitations proves applicable. Miss. Code Ann. §71-3-15 (1972, as amended).

12.1. CHOICE OF PHYSICAN

An employer's obligation in the event of an injury is to tender medical treatment to the claimant. The claimant's option is to either accept that tender or to choose his own. Acceptance of the employer's tender of a physician must be made in writing in order to be enforceable. *MWCC Rule 1.9.* In addition, a part of the 2012 amendments provides that a physician shall be deemed to be claimant's choice whether or not the claimant had previously "chosen" that physician in writing, if (1) the claimant had treated with that physician for six months or (2) had undergone surgery by that physician.

Once the choice is made, the claimant's choice is limited to the chosen physician and referrals by that physician to one physician in other areas of specialty. In other words, a general practitioner chosen by the claimant can make a referral to one orthopedic surgeon, one neurosurgeon, one neurologist, one psychiatrist, etc., but could not make a referral to two different orthopedic surgeons.

A chiropractor may be chosen as a treating physician, but the Mississippi Workers' Compensation Medical Fee Schedule limits chiropractic treatment to

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fifteen visits or treatment for thirty days, whichever occurs first, unless additional treatment is authorized by the employer/carrier. See Mississippi Workers' Compensation Medical Fee Schedule, Therapeutic Services, X.

Claimant's choice of physician is limited to an area reasonably convenient to the injury or the residence of the claimant.

PRACTICE POINT: An open discussion with claimant about physician choice issues is encouraged to avoid misunderstanding and added expense. Remember that the Commission can still permit a change of physician after the physician choice has been established, so a pragmatic analysis of these issues is recommended.

12.1.a. SELECTION OF DME VENDOR, PHARMACY VENDOR

An interesting point involving choice issues is that the Mississippi Workers' Compensation Medical Fee Schedule gives to the employer/carrier control over the vendor to be used for durable medical equipment. However, the selection of a pharmacy vendor is left to the claimant. See Mississippi Workers' Compensation Medical Fee Schedule, General Rules XI and Pharmacy Rules III. B.

12.1.b. SELECTION OF DIAGNOSTIC TESTING FACILITIES

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to CAT scans, MRI, x-ray, lab, physical and occupational therapy, work hardening, FCE, back school, chronic pain programs, massage therapy, EMG/NCV shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the employer/carrier, in consultation with the treating or prescribing physician, shall make the selection.

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12.2. TRAVEL EXPENSE

Travel expense to and from medical treatment is the responsibility of the employer/carrier, and there is no minimum distance to travel before the obligation to pay accrues. The rate changes regularly consistent with the rate approved for reimbursement to state employees. See MWCC Rule 1.14. For a complete listing of the applicable mileage reimbursement rates, see http://www.mwcc.state.ms.us/#/maximumBenefitMileageRatesChart. The Fee Schedule requires the payer to notify claimant in writing of his or her right to receive mileage reimbursement, and reimbursement must be paid within 30 days of the receipt of the request. *Failure to do so can result in an assessment of attorney's fees, expenses, and a penalty of up to $10,000!*

PRACTICE POINT: Remember that the applicable mileage reimbursement rate is the rate in effect at the time the travel occurs rather than the rate in effect at the time payment is actually issued.

12.3. EMPLOYER'S MEDICAL EXAM (EME)

The employer/carrier have the right to have a claimant evaluated by a physician of their choosing for the purposes of evaluating disability issues, the necessity or reasonableness of treatment recommended by claimant's treating physician, and other issues. Miss. Code Ann. §71-3-25 (1972, as amended) and *MWCC Rule 1.9.* The procedure to be used is as follows:

(a) The appointment is scheduled with the treating physician and notice, in writing, is given to the claimant and the Commission of the appointment date, time, place, etc.

(b) The claimant's travel expense to and from the scheduled evaluation at the applicable mileage rate must be prepaid.

(c) Once the evaluation has been completed, all of the expenses in connection with same must be paid and a copy of the report

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setting forth the physician's findings must be provided to both the claimant and the Commission.

There may be instances where an employer is entitled to an evaluation by more than one physician. As an example, if a claimant alleges both back and psychiatric injuries, an evaluation by separate specialists for those different problems might be obtainable. Also, there may be a situation where an EME for the purpose of evaluating whether or not a person needs surgery is obtained and then, a year or so later after the surgery has been performed, another examination to evaluate whether disability is ongoing may be permitted. The Commission will obviously not permit an abuse of the procedure, however, and the focus is on what is "reasonable" under the circumstances.

As referenced in Chapter 12.9 of this guide, there is a two day time limitation for notifying a provider of the intent to use an EME in lieu of pre-certification.

12.4. INDEPENDENT MEDICAL EXAM (IME)

Miss. Code Ann. §71-3-15(2) (1972, as amended) provides that the Commission may order the worker to submit to an independent medical evaluation ("IME") when it suspects a treating or examining physician may not have correctly estimated the extent or duration of disability or for other issues such as appropriate treatment protocols to be provided. The Commission generally requests the evaluating physician to do an extensive review of all prior medical records relating to the work injury, to order diagnostic procedures as needed, and to submit a written report of the findings of the evaluation. The Commission may use an IME as a "tie-breaker" to resolve a dispute between physicians offering different opinions about a worker's disability or necessity of certain medical treatment. The employer/carrier must pay for the evaluation.

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12.5. *EX PARTE* COMMUNICATIONS WITH MEDICAL PROVIDERS

Miss. Code Ann. §71-3-15(6) (1972, as amended) specifically provides that medical treatment obtained in connection with a workers' compensation claim is not privileged information. Case law has had a significant impact on that provision, however, and once a case becomes controverted, case law indicates that there can be no *ex parte*, or one sided, communications with the medical providers. The fruit of such inappropriate contact with the medical providers could be that the information obtained is not admissible in a hearing. The rule of law is tied to the idea that such is inappropriate discovery under established rules. Arguably, other problems could also be flow from such inappropriate contact.

PRACTICE NOTE: The prohibition against *ex parte* communications with medical providers is not applicable to such things as obtaining medical records and bills or, usually, dealing with pre-certification of testing and treatment issues. Whether the activity is done by the claims professional or by a nurse case manager, the professional is encouraged to not have one-sided communications with medical providers to avoid these problems in controverted cases. Conferencing with the medical providers when claimant is not present or writing to the providers and not copying claimant's attorney is not the way to handle claims appropriately under the law as currently interpreted. Writing the medical providers to ask the necessary questions and copying the claimant's attorney with that letter can still permit the claims professional to obtain information regarding claimant's injuries, however.

The issue often comes up as well in cases where the claimant is represented but the case is not yet controverted, and claimant's attorney requests that no *ex parte* communications take place with the medical providers. Although technically the rule of law is not applicable in non-controverted cases, ignoring the request will only result in a controversion to invoke the rule, and that will only add legal expense to the claim and impair the claims professional's

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working relationship with the attorney.

12.6. HIPAA COMPLIANT MEDICAL AUTHORIZATION

Although the medical privilege is statutorily minimized in workers' compensation cases as noted above, and the HIPAA regulations specifically provide that they are not applicable to workers' compensation cases, the Claims Professional is encouraged to request that a claimant sign and return a HIPAA compliant medical authorization. Many medical practitioners are reluctant to release medical information, which is necessary to properly handle the claim, without the authorization. See provisions on the MWCC WEB site relating to the HIPAA issues at http://www.mwcc.state.ms.us/pdf/HIPAAWebNotice.pdf. Also see the provisions on the website of the U. S. Department of Health & Human Services related to disclosures for workers' compensation purposes: http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-workers-compensation/index.html

12.7. TREATMENT BY VA HOSPITAL OR PAID FOR BY GOVERNMENT

Sometimes a claimant's medical treatment is obtained at a Veterans Administration Hospital or at the expense of the State Division of Medicaid or the Mississippi Department of Rehabilitation Services. Pursuant to Commission Rule 1.9, the employer/carrier are not liable for that treatment UNLESS the officials at those facilities fully comply with Miss. Code Ann. §71-3-15 (1972, as amended) and the Commission Rules. *With recent changes required by the Centers for Medicare and Medicaid Services relating to Medicaid, this rule as it relates to Medicaid may no longer be the final word related to a claim by Medicaid for reimbursement as discussed in Chapter 14.5 of this Guide.*

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12.8. MEDICAL PAYMENTS BY HEALTH INSURANCE PROVIDERS

If medical treatment for a work-related injury is paid for by a health insurance carrier, that health carrier may put the employer/carrier on notice of its lien, and the employer/carrier may reimburse the health carrier. Payment to the health carrier shall be considered payment of the employer/carrier's obligation to pay for medical expenses under the workers' compensation law. See Miss. Code Ann. §71-3-15(7) (1972, as amended).

12.9. MISSISSIPPI WORKERS' COMPENSATION FEE SCHEDULE

The Mississippi Workers' Compensation Medical Fee Schedule was established pursuant to statutory authority under Miss. Code Ann. §71-3-15(3) (1972, as amended) and adopted pursuant to Commission Rule 1-12. It provides rules and regulations for reimbursement of services provided to the workers' compensation claimant. It includes maximum allowances for medical procedures, as well as rules for appropriate services and determination of medical necessity.

A significant provision included in the statute authorizing the establishment of the Fee Schedule is that a medical provider is not permitted to "balance bill" a claimant for the charges of the medical provider that exceed the reimbursable amount specified in the Fee Schedule. See Miss. Code Ann. §71-3-15(3) (1972, as amended).

12.9.a. WHERE TO OBTAIN FEE SCHEDULE

The Fee Schedule has been amended by the MWCC several times since its first implementation, and the latest version was adopted effective November 12, 2016. http://www.sos.ms.gov/ACProposed/00022323b.pdf. It can be purchased at https://www.optum360coding.com/Product/46440/.

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12.9.b. ISSUES ADDRESSED IN THE FEE SCHEDULE

The Fee Schedule is a comprehensive document spanning more than 1200 pages. A discussion of every point included in the Fee Schedule is not the intent of this publication, but a few important points and time frames will be mentioned. The Fee Schedule addresses numerous issues including important things such as, but not limited to:

- Rules/guidelines to provide and pay for medical treatment;
- Maximum reimbursement levels;
- Utilization review;
- Peer Review to determine medical necessity;
- Pre-certification;
- Procedures considered to be investigational and not reimbursable;
- Deposition/witness fees;
- Medical report fees;
- Billing Guidelines;
- Impairment ratings;
- Out-of-state services;
- Authorized providers;
- Medical records requirements;
- Provider rights for reconsideration and dispute resolution; and
- Reimbursement requirements.

12.9.c. PRE-CERTIFICATION

One early distinction is important: utilization review companies provide *certification* for proposed treatment while claims professionals provide *approval* for those services to be rendered. The claims professional sometimes will be called upon to overrule a pre-certification opinion. Care must be taken in overruling an approval as denying procedures without a compelling and legitimate reason when the pre-certification opinion favors approval can be fuel

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for a bad faith lawsuit. Many claims organizations recognize the need to override the pre-certification only when it is in favor of approving the procedure.

Under Fee Schedule Utilization Rule I, specific procedures requiring utilization review are listed to include;

a. Inpatient admissions;
b. Surgical procedures;
c. Repeat MRI and other similar studies;
d. Pain Management;
e. Chiropractic treatment in excess of fifteen visits or thirty days;
f. Psychiatric treatment.

When a medical provider requests authorization to proceed with treatment, initial review determination must be made within two (2) business days of receiving the review request. Fee Schedule Utilization Rule IV A. Also see the MWCC's Notice Regarding Utilization Review Rules dated August 13, 2015 which is incorporated into the Fee Schedule by reference. http://www.mwcc.state.ms.us/pdf/utilizationreviewnotice.pdf

If the Provider chooses to obtain an Employer's Medical Exam (EME) in lieu of pre-certification, notice of such election must be given to the Provider within the same 2-day period applicable to a utilization review.

Failure to follow the required timelines with an ultimate determination of the requested treatment in favor of the provider could result in the imposition of penalties, attorneys and expenses.

When an initial determination is made to certify the service, notification shall be provided within at least one (1) business day or before service is scheduled, whichever occurs first. If initial determination to certify is provided by phone, written confirmation shall be provided within two (2) business days thereafter.

12.9.d. APPEALS FOR DENIALS OF PRE-CERTIFICATION

When a determination is made to not certify the procedure, the ordering

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medical provider should be notified by phone within one (1) business day with written notification within one (1) business day thereafter. Written notification must include the principal reason for determination not to certify and instructions regarding how to complete an appeal.

The Medical Services Provider has the right to either an expedited or standard appeal:

An expedited appeal is appropriate when denial of services interrupts current treatment (i.e. the patient is in the hospital and additional days to stay in the hospital are denied). The provider has right to an appeal response within one (1) business day.

A standard appeal is just that: "standard". It requires notification of the decision regarding the appeal to the provider within twenty (20) days.

After this appeals process, if the payer and medical provider cannot agree on the appropriate resolution of the dispute, either party can appeal to the Cost Containment Division of the Commission within twenty (20) days following the conclusion of the underlying appeal process described above.

It is important to note that failure to timely notify the medical provider of the decision regarding the requested service shall be deemed an approval by the payer, and shall obligate the payer to reimburse the provider in accordance with the fee schedule. Notification can be by mail, fax, email or phone (followed by written notification), as long as provided within the applicable time periods set forth in the Fee Schedule. As earlier indicated, *failure to follow the required rules and denying certification of procedures consistent with the Fee Schedule rules can result in the imposition of penalties, attorneys and expenses.*

12.9.e. RETROSPECTIVE REVIEW

The failure to obtain pre-certification shall not, of itself, result in denial of payment for the services. Instead, the payer, if requested to do so by the provider within one (1) year of the date of service, shall conduct a retrospective review of the services, and if the payer determines that the services would have

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been pre-certified if it had been timely sought, the payer shall reimburse the provider according to the Fee Schedule, less a 10% penalty (computed as 10% of the total allowed reimbursement). Fee Schedule General Rules IX. E.

12.9.f. PROVIDER'S RESPONSIBILITIES

The medical provider must file appropriate billing forms and necessary supporting documentation within thirty days of rendering services. The required documentation is mandatory and must support medical necessity. Late billings are subject to discounts (a one time 10% discount if over sixty days late) and penalties (not to exceed 1 ½% per month). Billing & Reimbursement Rule II(B).

Providers must include with their bills the medical records supporting the charges. *Medical records must include:*

- Office notes;
- Progress notes
- Lab, x-ray and diagnostic test results;
- Physical medicine evaluation and treatments;
- Operative reports;
- Consult reports;
- Impairment rating (projected and actual);
- Anticipated MMI date.

A plan of care should be included and should address:

- The disability;
- Degree of restoration anticipated;
- Measurable goals;
- Specific therapies to be used;
- Frequency and duration of treatments to be provided;
- Anticipated return to work date;
- Projected impairment.

Facilities must submit:

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- Admission History and Physical;
- Discharge summary;
- Operative reports;
- Pathology/lab reports;
- Radiology reports;
- Consult reports;
- Other dictated reports; and
- Emergency room records.

See Fee Schedule Billing and Reimbursement Rules I.

12.9.g. FEES FOR COPY EXPENSES

The above listed records are to be provided at no cost to the payer. Any additional records requested may warrant a copy fee as follows: $20.00 for the first 20 pages; $1.00 per page for pages 21—100; $0.50 per page for everything thereafter. Added to these charges are 10% of the total charge for postage and handling and an additional $15.00 for retrieving records stored off premises. There may also be up to 10% of this amount added for postage and handling, and/or $ 15.00 for obtaining records from an off-the-premise site. These charges apply regardless of the media/storage system used. In-patient admissions are reimbursable at the same levels subject to a maxim reimbursable allowance of $100.00 per admission. Charges for copies of x-ray films are $10.00 per film. Providers are supposed to provide these records within 14 working days of the request.

See Fee Schedule Billing and Reimbursement Rules II.

12.9.h. PAYER'S RESPONSIBILITIES

Properly submitted bills (with the required supporting documentation) must be paid within thirty days of receipt. If not fully paid within thirty days, the provider is also entitled to be paid interest (not to exceed 1 ½% per month) and

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penalties (a one time 10% if over sixty days late). Fee Schedule Billing & Reimbursement Rule III(D).

When part of a bill is disputed, the undisputed portion must be paid within thirty days of receipt of the properly submitted bill with supporting documentation. The Payer must notify the Provider of the basis for the dispute within thirty days from its receipt of the bill. Fee Schedule Billing & Reimbursement Rule III(E).

12.9.i. FACILITY FEE ISSUES

The Payer must reimburse a hospital within 30 days of receipt of a valid claim form (with supporting documentation) if prepayment review criteria are met. If additional mandatory documentation is requested, the Payer must make payment within 30 days of its receipt of the additional documentation, if criteria are otherwise met. Fee Schedule Billing & Reimbursement Rule IV(A)(2).

When a hospital bill is found to be correct or has been corrected, it must be paid within thirty (30) days. If it is not paid when due, interest (1 ½% per month) must be added to the payment and, if still not paid after sixty days, an additional 10% penalty must be added to the payment.

12.9.j. EXPLANATION OF REVIEW

When any payment is made, an Explanation of Review (EOR) must accompany the payment. When the Payer's reimbursement differs from the amount billed, the EOR must be provided within thirty days of receipt of the bill. Fee Schedule Billing & Reimbursement Rule V(A).

12.9.k. REQUEST FOR RECONSIDERATION

If the medical provider challenges the conclusion regarding the

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reimbursable amount under the Fee Schedule, the medical provider must make a written request for reconsideration within thirty days from its receipt of the EOR or other written documentation evidencing the basis for the dispute. Fee Schedule Billing & Reimbursement Rule VI(B).

The payer must provide notification of its decision on the requested reconsideration to the requesting party within thirty days after receipt of the request for reconsideration. Fee Schedule Billing & Reimbursement Rule VI(C).

If the Payer finds that the Provider's request for reconsideration is well taken, the additional payment should be made within the same thirty day period as notification of outcome mentioned above. The additional payment shall include interest from original due date of payment and the additional 10% penalty, if applicable.

Failure of the Provider to seek reconsideration within the established time shall bar any further reconsideration of the bill or other issue unless the Commission, for good cause, extends that time period; however, the time shall never be extended by more than thirty additional days. Fee Schedule Billing & Reimbursement Rule VI(E).

12.9.l. DISPUTE RESOLUTION

The Fee Schedule includes significant Dispute Resolution Rules to which the readers are referred as all of the details are too cumbersome to be incorporated into this summary. In brief summary, a request for resolution of a dispute may be filed with the Cost Containment Division of the Commission. Following review, the Cost Containment Division of the Commission shall render an administrative decision.

An appeal to the Commission is permissible thereafter within 20 days of the decision of the Cost Containment decision. Failure to timely request Commission review shall bar further review. No extension of this time shall be allowed. If no request for review to the Commission is filed, the parties to the dispute shall

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have fourteen days thereafter to comply with the final decision of the Cost Containment Division.

Unless permitted by the Commission to proceed *pro se*, all parties participating in a Commission review of the Cost Containment Division are required to be represented by an attorney licensed in Mississippi.

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Chapter 13
VOCATIONAL REHABILITATION

Although Mississippi Law does not have mandatory vocational rehabilitation for claimants, considerable focus on those issues occurs inasmuch as one of the stated purposes of the Act is to assist claimants in "their rehabilitation or restoration to health and vocational opportunity…." See Miss. Code Ann. §71-3-1, (1972, as amended). Therefore, the Commission also focuses on vocational rehabilitation, and the claims professional is encouraged to review the information on the Commission WEB site regarding vocational rehabilitation at http://www.mwcc.state.ms.us/#/frequentlyAskedQuestions. In addition, the Mississippi Department of Rehabilitation Services, http://www.mdrs.state.ms.us/, can offer assistance in dealing with rehabilitation issues.

In the event a claimant is enrolled in a vocational rehabilitation program, the employer/carrier have an obligation to pay $25.00 a week for a maximum of fifty-two weeks during the period of time a claimant is undergoing an approved vocational rehabilitation program. That payment is in addition to compensation benefits that are otherwise payable. Miss. Code Ann §§71-3-19 and *71-3-105,* (1972, as amended) and MWCC Rule 2-19.

13.1. USE OF VOCATIONAL REHABILITATION PROFESSIONALS

Vocational rehabilitation counselors and case managers are often used by claims professionals to assist in finding post-injury employment possibilities for a claimant to consider. In addition, vocational rehabilitation counselors are often called as expert witnesses in the hearings on cases to offer opinions as to post-injury employability.

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Chapter 14
GENERAL ISSUES

14.1. SETTLEMENTS

Mississippi workers' compensation claims can be settled; typically settlements include a closure of medical as well as indemnity benefits. Miss. Code Ann §71-3-29 (1972, as amended) is the statutory basis for a compromise settlement. These settlements are often referred to as 9(i) settlements, a reference to the original code section nomenclature when the law was first passed. All settlements are subject to the approval of the Commission, and a licensed Mississippi attorney must be retained by the employer/carrier to prepare the proper paperwork and present the settlement to the Commission. For a complete summary of the Commission's requirements related to settlements, see http://www.mwcc.state.ms.us/pdf/memotoattorneys.pdf.

A claimant does not have to have an attorney to settle his case. If he is not represented, he will have to be interviewed by a Commissioner (or an Administrative Judge) to make sure that the settlement is in the claimant's best interests. During the interview, the claimant is usually told that he: (1) has a right to have an attorney represent him regarding his claim; (2) could have a hearing before an Administrative Judge of the Commission for a determination of the benefits to which he is entitled to under the law; (3) in such hearing, he could get more or less than the amount of the settlement; (4) the settlement is closing his claim; and (5) settlement approval means that he will not be entitled to any additional compensation benefits (nor additional medical benefits if his settlement terms so dictate). The Commissioner or Judge conducting the settlement interview may discuss other matters with the claimant as well so as to be assured that the claimant wants the settlement, fully understands the terms of the settlement, and has not been pressured into making the settlement, all as a part of the determination that it is in claimant's best interests for the

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compromise settlement to be approved.

If the claimant travels to the Commission to have his settlement considered, the employer/carrier is supposed to pay claimant's mileage expense to and from the interview just as is paid for travel to and from medical treatment. See Commission Rule 2.15.

If an attorney represents a claimant, the interview of the claimant by the Commission is not required. The Commission processes those settlements based on the representations of the parties, through their attorneys, as to the terms and sufficiency of the settlement in their determination that the settlement is in the claimant's best interests.

If the claimant is a minor or is incompetent, the settlement might also have to be considered by the Chancery Court so that an appropriate person who is competent can be appointed to represent claimant in a fiduciary capacity before consideration of the settlement by the Commission.

The Commission usually considers these types of settlements on Tuesdays and Wednesdays. See Commission Rule 2.15 for additional details and rules regarding settlements.

A settlement approved by the Commission can be set aside if it is determined that the settlement was induced by fraud. There is also case law supporting the proposition that a settlement can be set aside and the case reopened for other reasons, and fortunately those circumstances rarely occur.

As discussed in Section 9.8, if there is a spousal or child support lien pending at the time of any settlement, the employer/carrier have the obligation to withhold proceeds necessary to satisfy the support lien and to pay those directly to the Mississippi Department of Human Services, or, in some circumstances, directly to the obligee. See the notice regarding this issue that is posted on the website of the Commission at http://www.mwcc.state.ms.us/pdf/Child%20Support%20Web%20Policy.pdf.

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14.2. LUMP SUM PAYMENTS

A lump sum payment, as contemplated by Miss. Code Ann §71-3-37(10) (1972, as amended), is often confused with a "settlement". Some refer to it as a "13(j) settlement, but the lump sum payment is neither a settlement nor an adjudication of any liability. It is only a vehicle for paying, in a lump sum, permanent disability or death benefits awarded following a hearing or agreed to be paid on a form B-18. Recall that benefits are to be paid bi-weekly, unless otherwise ordered by the Commission, and this is the vehicle used for getting authority to pay benefits in a partial or full lump sum. To obtain an Order Authorizing Lump Sum Payment, the claimant would file a B-19, Application for Lump Sum payment, and the Commission would consider that application with the only issue being whether or not the lump sum payment would be in the claimant's best interests.

The Commission on Tuesdays or Wednesdays of each week usually considers lump sum payment applications. See Commission Rule 2.15 for other provisions regarding lump sum payments.

PRACTICE NOTE: Remember that a 13(j) lump sum payment is not a settlement of anything. It is only a way to pay in a lump sum weekly benefits that were either awarded by an Administrative Judge or voluntarily set up to be paid as shown on a B-18. A compromise 9(i) settlement discussed in section 14.1 above where medical is left open is possible, but that is not a 13(j) lump sum settlement.

14.3. SUBROGATION/CLAIMS AGAINST THIRD PARTIES

Under Mississippi Law, a claimant (or his dependents in a death claim) has a right to pursue a claim for workers' compensation benefits <u>and</u> a claim against a third party responsible for causing the injury. See Miss. Code Ann. §71-3-71 (1972, as amended). That third party claim would be pursued in a court of general jurisdiction and not before the Commission. When a third party suit is

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filed, the employer/carrier is authorized by law to intervene in the suit, and a claims professional should retain legal counsel to pursue the intervention. If there is a recovery from the third party, it is distributed as follows: the costs of collection (including claimant's attorney's fees) are paid first; the employer/carrier are reimbursed for their compensation and medical expense payments on the claim; and any balance thereafter belongs to the claimant. The employer/carrier are also entitled to a credit against any additional liability they might have to claimant in the workers' compensation claim up to the amount of the balance that was paid to the claimant over and above the costs of collection and the amount used to reimburse the employer/carrier.

The employer/carrier has the right under the statute to pursue the claim against the third party on its own behalf and in the name of the claimant, but that rarely happens since the employer/carrier's claim is heavily dependent on claimant's cooperation in the suit. There is a three-year statute of limitations on most causes of action that could be brought against a third party in these circumstances. For intentional torts such as an assault, however, the statute of limitations is one year.

Any settlement of the third party claim is subject to the approval of the Commission, unless suit has been filed against the third party. In the event the claimant has filed suit against the third party, the settlement is subject to the approval of the court in which the suit against the third party is pending. The established Commission procedures relating to settlements must be followed regarding the settlements of third party claims: http://www.mwcc.state.ms.us/pdf/memotoattorneys.pdf. It is also important to note that in a third party settlement, the third party must have a Mississippi attorney sign the documents on its behalf; it would be deemed an unauthorized practice of law for the claims professional to sign the documents.

Some claimant's counsel will argue that the employer/carrier should not be reimbursed in a third party recovery until the claimant is "made whole", but the Mississippi Supreme Court specifically rejected that argument in *Federated*

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Mutual Insurance Company v. McNeal, 943 So.2d, 658 (Miss. 2006).

PRACTICE NOTE: In some cases, the employer/carrier may be called upon to compromise their lien in the third party claim. Sometimes it is prudent to do so, particularly where the liability of the third party is doubtful or when there are inadequate assets with which to satisfy the entire claim. A pragmatic approach in dealing with such issues is usually the better course to follow.

14.4. MEDICARE'S INTERESTS

The Mississippi Workers' Compensation Commission has not adopted any rules specifically dealing with the Medicare Secondary Payer Statute, 42 USC 1395(y), a statute designed to keep the nation's Medicare system viable by requiring that any other entity who is liable for medical expenses, such as a workers' compensation insurance carrier, pay for that medical expense before Medicare is responsible for that payment. Approval of a settlement of a workers' compensation claim by the Center for Medicare and Medicaid Services (CMS) is required: (a) on all workers' compensation settlements involving a Medicare beneficiary where the settlement amount is more than $25,000; and, (b) where the claimant has a reasonable expectation that he will become a Medicare Beneficiary within thirty months from the date of the settlement **AND** the settlement is for more than $250,000. These factors are referred to by CMS as its "workload management thresholds" and, if the case meets these thresholds, CMS will be asked to approve a Medicare Set-Aside Arrangement. A Medicare Set-Aside Arrangement provides or "sets aside" a specified amount of the settlement proceeds to cover claimant's future medical expenses for which Medicare would otherwise be responsible.

Therefore, the settlement of a workers' compensation claim will often involve approval by the Commission and by the CMS. There is no requirement as to which entity must approve the settlement first; as such, that decision is left to the agreement between the claims professional and claimant.

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Another important issue involving Medicare concerns payments already made on claimant's behalf by Medicare for the medical problems associated with the claim. The CMS calls these "conditional payments" that were made pending reimbursement by the responsible party such as a workers' compensation insurer, and those conditional payments will have to be considered and handled independently of the Medicare Set-Aside Arrangement for claimant's future medical expenses.

14.5. MEDICAID'S INTERESTS

Medicaid is a "need based" system that sometimes pays medical expenses for people who have been injured on the job. It is administered by the State of Mississippi, and payments made by the Division of Medicaid for medical problems which are related to an on-the-job injury are intended under the law to be the responsibility of the employer/carrier. Medicaid is supposed to be notified when a Medicaid recipient files a claim and Medicaid may intervene in the action. A claimant who fails to cooperate with the Division of Medicaid in its claim against someone else liable for payment of the medical expenses, such as an employer/carrier in a workers' compensation claim, or who fails to pay to the Division proceeds received by claimant from a "third party" as provided by the Mississippi Medicaid Law, will become ineligible for Medicaid benefits. Miss. Code Ann. §43-13-307 (1972, as amended).

Unlike the Medicare Secondary Payer Statute, discussed in the previous section, the Mississippi Statutes which authorize and outline the Medicaid system in Mississippi do not appear to impose any duties on parties to a workers' compensation settlement relating to medical expenses for treatment to be obtained in the future. However, Medicaid has the right to recover its payments already made for a claimant's medical services out of a recovery in a workers' compensation and a third party claim. Miss. Code Ann. §43-13-125 (1972, as amended). Failure to honor Medicaid's subrogation rights by an employer/carrier

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could permit Medicaid to recover double the benefits paid by Medicaid and costs of collection. Miss. Code Ann. §43-13-315 (1972, as amended).

PRACTICE POINT: The claims professional would be well served to ascertain whether a claimant is a Medicaid beneficiary prior to the settlement of any claim in order to insure the finality of the settlement. If the claimant is a Medicaid recipient at the time of settlement, no compromise is binding upon the Medicaid Division unless ratified and/or approved by the Division. Miss. Code Ann. §43-13-125(3) (1972, as amended).

14.6. SOCIAL SECURITY OFFSETS

The Mississippi Workers' Compensation Law is silent regarding Social Security benefits. As such, a claimant's entitlement to Social Security benefits does not affect the workers' compensation benefits payable. However, according to Section 224 of the Social Security Act, if a claimant receives workers' compensation benefits and Social Security benefits, the Social Security benefits will be reduced under rules adopted by the Social Security Administration.

14.7 FRAUD

The pursuit of, or defense of, a claim without reasonable grounds is contrary to public policy and is discouraged in several ways. There are both civil and criminal remedies and penalties that can be brought into play.

Under Miss. Code Ann. §71-3-59 (1972, as amended), costs of proceedings, including attorney's fees, can be assessed against the party who institutes or continues a claim without reasonable grounds. Further, under paragraph 2 of that code section, and in addition to the costs referenced above, a civil penalty not to exceed $10,000 may be assessed against the party, the attorney advising or assisting the party, or both. This administrative remedy is vested with the Commission.

Miss. Code Ann. §71-3-69 (1972, as amended) provides that it is a felony

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to make a false or misleading statement or representation to obtain or wrongfully withhold workers' compensation benefits, punishable by a fine not to exceed $5000.00, or double the value of the fraud, whichever is greater, or by imprisonment not to exceed three years, or both fine and imprisonment.

The Mississippi Attorney General operates a Fraud Unit that can be of assistance in investigating and prosecuting suspected fraud. Additional information regarding those efforts is available from the Office of the Attorney General, http://www.ago.state.ms.us/.

14.8 CLAIMANT'S ATTORNEY FEES

Fees due an attorney representing a claimant are addressed in Miss. Code Ann. §71-3-63 (1972, as amended) and Commission Rule 2.12. Under that statute and rule, the attorney is obligated to inform the Commission of his/her representation of a claimant and get the approval of the Commission for any fee in excess of $200.00. The Commission cannot approve a fee in excess of 25% of the recovery, but a court on appeal may approve a higher fee. Those fees are paid by the claimant out of a recovery and are not in addition to the benefits due the claimant.

2012 Legislative Amendment—For injuries on or after July 1, 2012, an attorney is not entitled to recover a fee from benefits voluntarily paid for temporary or permanent disability; however, any settlement negotiated by the attorney is not considered a voluntary payment under this provision.

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Chapter 15
LITIGATION PROCEDURES

The litigation of a claim for benefits is not a matter handled in the courts of Mississippi, but instead takes place pursuant to Rules of the Mississippi Workers' Compensation Commission. The trial is held before an Administrative Judge who is an employee of the Commission. Even in subsequent appeals, there is not a new trial where additional evidence is offered.

A claimant controverts a case by filing a Petition to Controvert, Form B-5,11. The Commission provides written notice of that filing to the employer/carrier. In cases in which no indemnity or medical benefits have been paid, a claimant is required to file medical records supporting the claim along with the Petition to Controvert; however if a statute of limitations is about to run, claimant shall file them within 60 days of the filing of the Petition.

The employer/carrier's Answer, B-5,22, is due within twenty-three days of the date the Commission mails the Petition to Controvert to the employer/carrier, and its cover letter will show the date that the Answer is due. The Answer should be filed by a licensed Mississippi attorney, and should contain any affirmative defenses that the employer/carrier intend to raise.

The rules of the Commission provide that discovery shall be completed within one hundred twenty days from the date of notice from the Commission that the case has been placed on the active docket. Discovery may include interrogatories, depositions, requests for production of documents, and requests for admissions.

Either party can file prehearing motions to be heard before the Administrative Judge. Motions may be heard in person or by telephone conference between the parties and the Judge on pre-established motion days or at the discretion of the Administrative Judge. If a party desires oral argument, the party should notice the motion for any motion day at least five calendar days before the motion day. Emergency hearings can be scheduled in certain

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circumstances consistent with statutory notice requirements and Rules.

Within fifteen days of the expiration of the discovery period, claimant is required to file a properly completed prehearing statement. The employer/carrier have fifteen days after the filing of claimant's properly completed prehearing statement to file a properly completed prehearing statement. These deadlines can be, and often are, extended. The claimant's failure to timely file a prehearing statement may result in the dismissal of the case. Failure of the employer/carrier to file a timely and complete prehearing statement can result in a unilateral setting of the case by the claimant. The rules are designed to have a controverted case tried to a conclusion before the Administrative Judge within about six months from the date of controversion, although from a practical standpoint, that rarely occurs.

Generally a prehearing statement contains the following documentation: (1) claimant's education and employment history; (2) a description of the accident and injuries which are alleged; (3) dates and amounts of indemnity benefits paid; (4) the medical treatment and maximum medical improvement date; (5) permanent partial impairment rating and restrictions, if any; (6) all affirmative defenses; (7) the details of disputes regarding unpaid medical expenses; (8) the claimant's post-injury job search efforts; (9) the claimant's post-injury employment details; (10) any reports regarding vocational efforts and labor market surveys; (11) stipulations; (12) hearing exhibits; and (13) a proposed witness list.

After the Pre-Hearing Statements are filed, the case is set for hearing before the Administrative Judge. The hearing is usually held at one or more central locations with the territory of each Administrative Judge. *The claims professional handling the claim is required to be present or available to the Commission by phone during the entirety of the hearing.* The evidentiary record is created at that hearing, and, although the Administrative Judge is not bound by technical or formal rules of procedure or evidentiary rules, the hearing has the appearance of a trial, except there is no jury present. The Administrative Judge

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does not usually announce a decision at the hearing but will usually issue a written order that includes an itemization of the issues, analysis of evidence, findings of fact, conclusions of law, and an award or denial of benefits. Depending on the judge and the complexity of the case, the Judge's decision may be received anywhere between a week and six months after the hearing.

Once the Administration Judge's order is written, it becomes final unless, within twenty days of the date of the decision, either side may file an appeal to the Full Commission. The three Commissioners do not generally hear new evidence sitting in their appellate capacity. The full Commission reviews the record, considers the briefs of the parties, hears oral arguments (if requested by the parties and granted by the Commission), and then by written Order either affirms, reverses, or amends the Administrative Judge's decision.

Within 30 days of the Commission's Order, either party has the right of appeal that decision to the Mississippi Supreme Court. The Mississippi Supreme Court, in its discretion, will either hear the appeal or assign it to the Court of Appeals for final disposition. From a practical standpoint, most workers' compensation appeals do get referred to the Court of Appeals. This is an appellate review and not a trial *de novo*, and the appeals court is not permitted to disturb the Commission's findings if its findings are supported by substantial evidence. After the decision by the Court of Appeals, the Mississippi Supreme Court can thereafter review the Court of Appeals' decision by granting *certiorari*.

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Chapter 16
MEDIATION

Mediation is not mandatory on any case but is permissible by agreement of the parties. Members of the Workers' Compensation Section of the Mississippi Bar Association often serve as mediators, and many of them agree to donate a part of the fees paid to them to the Kid's Chance Scholarship Fund, a college scholarship program designed to assist the children of workers who were significantly injured or killed on the job. It is not mandatory that Kid's Chance Mediators be used for mediation and the parties are free to choose any qualified mediator.

That said, the panel of mediators approved by the Kids' Chance program have received specific training in mediation and were selected based on their extensive experience with Mississippi workers' compensation law. Since its inception the mediation program has successfully helped parties reach compromise resolution of thousands of claims.

The decision to mediate and the decision to agree upon settlements is always voluntary. Mediation of workers' compensation claims – like most litigation – is strongly encouraged and recommended by the judiciary and the Mississippi Workers' Compensation Commission.

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Chapter 17
BAD FAITH CLAIMS

17.1. WHAT IS BAD FAITH?

In Mississippi, courts have recognized a separate cause of action against employers, carriers, and third party administrators for a "bad faith" denial of a claim—a potentially dangerous issue that should not be taken lightly. "Bad faith" breach of contract is often described as the willful or intentional denial of a claim, or a part of a claim, without reasonable grounds, where the denial reflects an intent to injure the claimant or was made in reckless disregard of the claimant's rights. *Southern Farm Bureau Casualty Ins. Co. v. Holland*, 469 So.2d 55, 59 (Miss. 1985). The cause of action can lie against the employer as well as the carrier. *Luckett v. Mississippi Wood Inc.*, 481 So. 2d 288 (Miss. 1985). Damages recoverable in such a suit are not a part of the workers' compensation system and the cases are not tried before the Commission but in state or federal court. *Mississippi Power & Light Co. v. Cook*, 832 So. 2d 474 (Miss. 2002) illustrates the exposure in such cases because the jury awarded $150,000 for actual damages, $5,000,000 for punitive damages and a large attorney's fee. On appeal, the punitive award was somewhat reduced but bad faith cases can be very expensive due to the exposure to a punitive damage award. Cook, 832 So.2d 474 (Miss. 2002).

AmFed Companies, LLC v Jordan, 34 So3d 1177 (Miss. App. 2009), cert granted, 31 So.3d 1217 (Miss. 2010) is a recent example of a bad faith determination and verdict where the thrust of the alleged wrongdoing was a delay of about 11 weeks in making a payment.

Mississippi imposes an affirmative duty on employers, carrier and third party administrators to perform a reasonable and prompt claim investigation. *Bankers Life & Cas. Co. v. Crenshaw*, 483 So. 2d 254 (Miss. 1985). What constitutes a "reasonable" investigation will vary on a case-by-case basis but

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will typically require that all relevant witnesses be interviewed and all relevant documents (especially relevant medical records) be obtained. *Eichenseer v. Reserve Life Ins. Co.,* 682 F. Supp. 1355 (N.D. Miss. 1988). See also, *Crenshaw* at 271-73. The claim investigation should allow for a realistic evaluation of the claim and decision. If the claim is owed, benefits should be promptly paid. If the claim is to be denied, then there is an affirmative duty to honestly advise the claimant why the claim has been denied. Even after a claim is denied there is an ongoing duty to reevaluate and reconsider if new evidence develops.

Unfortunately mistakes can and will happen. Claims personnel are human and it is important to remember that clerical errors and inadvertence do NOT represent bad faith conduct. *Universal Life Ins. Co. v. Veasley*, 610 So. 2d 290 (Miss.1982). General negligence, unaccompanied by malice, does not rise to the level of bad faith conduct. *Consolidated Am. Life Ins. Co. v. Touche*, 410 So.2d 1303 (Miss. 1982). Moreover, as mentioned throughout these materials, seeking and relying on the advice of counsel is not only good claim investigation but can also provide protection from a subsequent punitive damage claim if the claim decision is incorrect. *Murphree v. Federal Ins. Co.,* 707 So.2d 523 (Miss.1997). Reliance on objectively reasonable legal advice in making a claim decision will almost always prevent a conclusion that the denial was make in bad faith.

Punitive damages, when awarded, are designed to punish the wrongdoer and to set an example to keep others from committing a similar wrong. Effective in 2004, statutory limits were imposed on punitive damages based on the net worth of the defendant. Miss. Code Ann §11-1-65 (1972, as amended). Nevertheless, modest punitive damage awards can be staggering in comparison to the relatively limited benefits involved in most compensation claims. Punitive damages awards, and the potential for such in bad faith causes of action, cannot be overemphasized.

The potential for bad faith exposures can be reduced through a focus on

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timely, informed, and reasonable claims handling practices. Unnecessary delays in the processing of claims are the primary basis for such suits, and legitimate disputes can become disastrous bad faith suits by the simple failure to follow through on the completion of a prompt and thorough investigation so that an informed and timely decision can be made.

17.2. SUGGESTIONS FOR AVOIDING BAD FAITH

To avoid "bad faith" suits, it is recommended that the claims professional (1) encourage prompt reporting of injuries; (2) act with a sense of urgency in the proper handling of the claim; (3) complete a prompt and thorough investigation of the claim; (4) have a legitimate and arguable basis for any denial; (5) act with a commitment to competent, rational, and objective professionalism; and (6) seek advice of counsel before issuing a denial.

Some other common sense points to consider include the following as well:

A. Do not write disparaging comments about the claimant or his claim that could be considered as anything less than an unbiased professional analysis of the facts and the application of law to those facts.

B. Be open minded and objective in analyzing the law and the facts on every claim. Thinking the answer to a question is "always or never this or that" is generally a path that can become problematic.

C. Consider having committee reviews that include the adjuster, supervisor, manager, and defense attorney before issuing a denial. Again, advice of counsel is a powerful defense to bad faith cases and should be part of the claim decision process.

D. Avoid delays in the processing of each claim. Unexplained delays in processing benefits and failing to communicate about issues can lead to problems.

With a focus on quality claims handling practices rooted in rational and objective professionalism, the claims professional will avoid the pitfalls of "bad faith" allegations.

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Chapter 18.

2012 LEGISLATIVE CHANGES

Interspersed throughout this Guide are references to the 2012 legislative changes that are applicable to injuries that occur on or after July 1, 2012. Injuries that occurred before July 1, 2012, are to be paid pursuant the law in effect at the time of that injury. In an effort to include all of the changes in a single list for quick reference, please note the following:

- The legislation requires that the evidentiary field in workers' compensation cases be level and not favor either the claimant or the employer/carrier. It eliminates the tradition upon which the workers' compensation system was formed to the effect that the claimant gets the benefit of the doubt in furtherance of the "beneficent purposes of the Act."
- The "purpose of the Workers' Compensation Act" is amended to provide that the law is designed to pay timely disability benefits for legitimate claims, to pay reasonable and necessary medical expenses related to the injury, and to encourage a return to work.
- In cases in which no indemnity or medical benefits have been paid, the claimant is required to file medical records in support of a claim along with the Petition to Controvert. If the statute of limitations is coming close to running, Claimant is allowed 60 days to file the appropriate medical records after filing the Petition to Controvert.
- The Apportionment defense is amended to return to pre-1988 case law. Apportionment is the reduction of permanent disability or death benefits based upon the proportion to which a pre-existing condition contributes to the permanent disability or death. The change specifies that apportionment is applicable without having to prove that the pre-existing condition had affected claimant's employability before the injury.
- Provisions regarding "choice of physician' were amended to provide that a physician (1) who has treated a claimant for 6 months or (2) performed surgery on the claimant is deemed to be claimant's physician choice

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whether or not the claimant had documented that choice in writing.

- Benefits increases:
  - The facial disfigurement maximum is increased from $2000.00 to $5000.00.
  - In a death claim, the surviving spouse's lump sum payment is increased from $250.00 to $1000.00 and the funeral benefit is increased from $2000.00 to $5000.00.
  - A claimant enrolled in a vocational rehabilitation program is entitled to an additional benefit of $25.00 per week for a maximum of 52 weeks, (an increase from $10.00 per week).
- A claimant's attorney is not allowed to recover a fee from benefits voluntarily paid by the employer/carrier for temporary or permanent disability. Settlements are specifically excluded from that prohibition.
- The intoxication defense is revised in a significant way:
  - No compensation is payable if the use of alcohol or drugs (including illegal drugs as well as prescription drugs taken inconsistent with the instructions of the prescribing physician) is the proximate cause of the injury.
  - The employer has the right to request that a claimant undergo a drug or alcohol test.
  - A rebuttable presumption is created that the use of drugs or alcohol was the proximate cause of the injury in the event of a positive test revealing:
    - A blood alcohol content of .08% or greater;
    - An illegally used drug; or
    - A prescription drug taken contrary to the prescribing physician's orders.
  - If a claimant refuses the drug test, it is presumed that one of the above reasons was the proximate cause of the injury.
  - Once the presumption arises, it is the claimant's burden to prove

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that the drug or alcohol use was not a contributing factor in causing the injury.

- The Commission is required to issue a statement detailing these changes which must be posted by an employer adjacent to the "Notice of Workers' Compensation Coverage" that is required to be posted by all employers.

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EPILOGUE

This Mississippi Workers' Compensation Claims Guide is designed to provide claims and other professionals with an outline of the basic provisions in the Mississippi Workers' Compensation law, and every issue cannot be thoroughly addressed. No guide of this nature should be treated as a substitute for advice from competent legal counsel, so every professional is encouraged to consider seeking such advice when confronted with an unusual situation or if there is uncertainty as to the correct steps that should be taken on a claim.

To reiterate what was stated at the outset of this Guide, it is not to be construed as an official publication of the Mississippi Workers' Compensation Commission. Cases are usually fact intensive and the law is continually evolving, and it is not the intent for this guide to be construed as the Commission's official pronouncement of the law on any issue.

The Mississippi Workers' Compensation Educational Association, Inc. (MWCEA), the publisher of this Guide, is a non-profit entity whose purposes include the dissemination of information related to Mississippi Workers' Compensation Law and the education of those interested in that area of the law. The MWCEA does not provide legal advice or services, nor is it involved in the adjudication of any disputes. The MWCEA may be contacted at P O Box 13508, Jackson, Mississippi 39236 or at info@mwcea.com or by contacting the Chairman of the Mississippi Workers' Compensation Commission at 601 987 4200.

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MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and **[select one]** [has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer], or [maintains workers' compensation insurance coverage with the following:]

_____
(Name of insurance carrier or self-insurance group)

_____

_____
(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

_____
(Name of third party claims administrator or claims office)

_____

_____
(address & phone number)

III. This workers' compensation coverage is effective for the following period: _____ to _____.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

_____
(Name of employer contact person)

_____
(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

TO THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION:

Employer _____

Address _____

Locations Covered _____

Nature of Business _____

This is to certify that the Workers' Compensation policy of the employer described herein has been:

Issued _____ Renewed _____ Canceled _____

Policy Number _____ Effective _____ Expires _____

Reason for cancellation _____

_____

Compulsory risk _____ Exempted Risk _____

Carrier: _____ Issuing office _____

Revised 7/15/49 Form A-24

TO THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION:

Employer _____

Address _____

Locations Covered _____

Nature of Business _____

This is to certify that the Workers' Compensation policy of the employer described herein has been:

Issued _____ Renewed _____ Canceled _____

Policy Number _____ Effective _____ Expires _____

Reason for cancellation _____

_____

Compulsory risk _____ Exempted Risk _____

Carrier: _____ Issuing office _____

Revised 7/15/49 Form A-24

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)

☐ FEMALE (F)

☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)

☐ MARRIED (M)

☐ SEPARATED (S)

☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

- NO MEDICAL TREATMENT (0) ☐
- MINOR: BY EMPLOYER (1) ☐
- MINOR CLINIC/HOSP (2) ☐
- EMERGENCY CARE (3) ☐
- HOSPITALIZED > 24 HRS (4) ☐
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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MISSISSIPPI WORKERS' COMPENSATION COMMISSION

MWCC FILE NO. _____ Injury Date _____/_____/_____

Carrier File No. _____ Disability Date _____/_____/_____

Type of NOTICE: (Click to select) _____ ____ **NOTICE OF FIRST PAYMENT OF T.T.D. BENEFITS**
_____ **SUPPLEMENTAL AGREEMENT AS TO COMPENSATION**
_____ **NOTICE OF SUSPENSION OF PAYMENT**

I. GENERAL INFORMATION (Use Tab key to advance through fields)

Employee Name and Address (Include City, State, and Zip) SSN: _____-_____-_____ Birth Date_____/____/_____	Insurance Carrier Name and Address (Include City, State, and Zip) FEIN: _____
Employer Name and Address (Include City, State, and Zip) FEIN: _____	Claim Administrator Name and Address (Include City, State, and Zip) FEIN: _____

II. NOTICE OF FIRST PAYMENT: Please take notice that payment of compensation for temporary total disability has begun and will continue until further notice:

Date of First Check: _____/_____/_____ Average Weekly Wage: $_____

Period Paid From: _____/_____/_____ to _____/_____/_____

First Check Amount: $_____ Compensation Rate: $_____

III. SUPPLEMENTAL AGREEMENT: Please take notice that we agree, subject to applicable statutory limitations, to the following:

☐ **TEMPORARY TOTAL:** Employee again became temporarily totally disabled on _____/_____/_____, and is now receiving benefits therefor at the rate of $_____ per week and continuing until further notice.

☐ **TEMPORARY PARTIAL:** Employee first became, or again became temporarily partially disabled on _____/_____/_____, and is now receiving benefits therefor at the rate of 2/3 of the decrease in wage earning capacity and continuing until further notice.

☐ **PERMANENT TOTAL:** Employee is entitled to compensation for permanent total disability commencing on _____/_____/_____, at the rate of $_____ per week, and continuing for a period of _____ weeks.

☐ **PERMANENT PARTIAL:** Employee is entitled to compensation for the _____% loss of _____, commencing on _____/_____/_____, at the rate of $_____ per week, and continuing for a period of _____ weeks.

☐ **DEATH:** Dependents are entitled to death benefits commencing on _____/_____/_____, at the combined rate of $_____ per week. Said benefits will continue for the statutorily prescribed period. (Itemize below - attach additional page if necessary).

☐ **OTHER:**_____

Death: Name of Beneficiary and Address	Relation	Date of Birth	Weekly Rate
a.			$
b.			$
c.			$
d.			$

IV. NOTICE OF SUSPENSION OF PAYMENT: Please take notice that the payment of compensation has been suspended, and was last paid on

_____/_____/_____, at the rate of $ _____ per week for the following:

☐ **TEMPORARY TOTAL** ☐ **TEMPORARY PARTIAL** ☐ **PERMANENT TOTAL** ☐ **PERMANENT PARTIAL** ☐ **DEATH** ☐ **OTHER**_____

Reason compensation was suspended: _____.

Average weekly wage at time of injury was $ _____. Employee returned to work at weekly wage of $_____.

I certify that a copy of this Form has been furnished to the above named employee, beneficiary, or representative on _____/_____/_____.

Name: _____ Title: _____ Phone:_____

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

P. O. Box 5300
JACKSON, MISSISSIPPI 39296

MWCC File No. _____

APPLICATION FOR LUMP SUM PAYMENT

Miss. Code Ann. §71-3-37(10) (Rev. 2000)

1. Name of injured employee and SSN:_____ (First Name) _____ (Middle Initial) _____ (Last Name) _____ (SSN)
2. Date of Injury _____
3. Employer: _____ Carrier:_____

NOTE: In answering the following questions, use separate sheet of paper or back of this form, if necessary, to give complete answers.

PART I - FOR EMPLOYEE BENEFITS: (Complete Items 1 thru 10 **and** 14 thru 18)

4. Employee's address _____ (No. and Street) _____ (City) _____ (State)
5. Employee's date of birth _____ (Mo.) (Day) (Yr.) 6. Date Disability began _____
7. Have you returned to work? _____ If so, give date _____
8. Have you been released by a physician as able to return to work? _____. If so, date? _____
9. How many weeks' compensation have you received since being released to return to work? _____
10. Total amount of compensation received since being released to return to work _____

PART II - FOR DEATH BENEFITS: (Complete Items 1 thru 3 **and** 11 thru 18)

11. Name of applicant _____ (First Name) _____ (Middle Initial) _____ (Last Name)
12. Applicant's date of birth _____ (Mo.) _____ (Day) _____ (Year)
13. Address of applicant _____ (No. and Street) _____ (City) _____ (State)

PART III - FOR ALL APPLICANTS:

14. For what purpose do you request a lump sum payment? _____
15. List name and date of birth of all members of your immediate family _____

_____

16. Do any of them have an independent income separate from yours? _____. Amount: _____
17. Do you have an income other than your compensation payments? _____. Amount: _____
18. If request is other than Full Lump Sum Payment, state amount requested _____

_____
Date

_____
Signature of Employee/Applicant and Phone Number

STATE OF _____
COUNTY OF _____

SUBSCRIBED AND SWORN TO before me this the _____ day of _____, 20_____.

_____
Notary Public

_____
Signature and MS Bar Number of Attorney for Employee/Applicant

Mississippi Workers' Compensation Commission

MEDICAL REPORT

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE MISSISSIPPI WORKERS' COMPENSATION LAW AND MUST BE FILED WITH CARRIER IMMEDIATELY.

PRELIMINARY REPORT ☐
PROGRESS REPORT ☐
FINAL REPORT ☐

PRINT OR TYPE

Failure to submit this report will jeopardize payment of fees.

MWCC #	CARRIER FILE #

GENERAL INFORMATION (ALL REPORTS)

EMPLOYEE (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)	SOCIAL SECURITY NUMBER			DATE OF BIRTH
	AGE	SEX	DATE OF INJURY	DATE DISABILITY BEGAN

EMPLOYER (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)	INSURANCE CARRIER (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)
FEIN:	FEIN:

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM (E) DIAGNOSIS CODE BY LINE)

1
2
3
4

(A) DATE(S) OF SERVICE FROM	TO	(B) Place of Service	(C) Type of Service	(D) PROCEDURES, SERVICES OR SUPPLIES (Explain unusual Circumstances) *INCLUDE DRUGS PRESCRIBED*	(E) DIAG CODE	(F) $ CHARGES	(G) DAYS OR UNITS

PRELIM./PROGRESS

PATIENT'S DESCRIPTION OF ACCIDENT OR OCCUPATIONAL ILLNESS	HOSPITAL NAME/ADDRESS IF HOSPITALIZED

NOTE ANY CHANGE IN DIAGNOSIS MADE ON ANY PREVIOUS REPORT AND EXPLAIN.	SERVICES ENGAGED BY

IF PATIENT HAS A PRIOR IMPAIRMENT CONTRIBUTING TO PRESENT DISABILITY, GIVE PARTICULARS.	IS CONDITION WORK RELATED? IF SO, DESCRIBE	DATE FIRST TREATMENT
		EXPECTED DATE MMI

FINAL REPORT

DATE PATIENT REFUSED TREATMENT	DATE PATIENT STOP TREAT. W/O ORDER	DATE DISCHARGED AS CURED/MAX MED IMP.	DATE ABLE TO RETURN WORK	VOCATIONAL REHABILITATION WILL BE UNLIKELY	PROBABLE	NECESSARY
			☐ LIGHT ☐ NORMAL			

IS PATIENT CAPABLE OF DOING SIMILAR/OTHER EMPLOYMENT AS BEFORE INJURED? IF NO, WHY?

DOES PATIENT HAVE ANY PERMANENT DISABILITY RESULTING FROM THIS INJURY? IF SO, GIVE PART OF BODY AND *PERCENT OF DISABILITY* (INCLUDING VISION AND HEARING IF AFFECTED). _____ %

PHYSICAL RESTRICTIONS, IF ANY

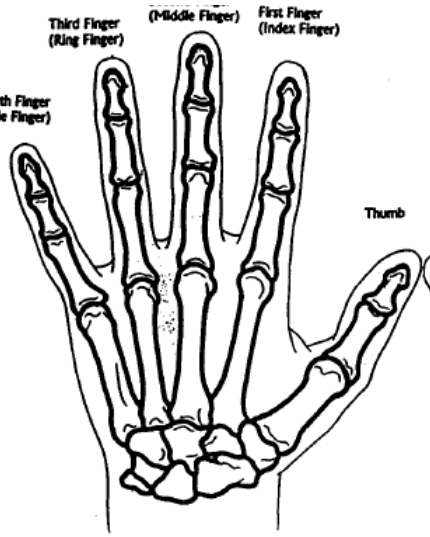
WAS THERE FACIAL OR HEAD DISFIGUREMENT? IF YES, DESCRIBE FULLY.

GEN./ALL

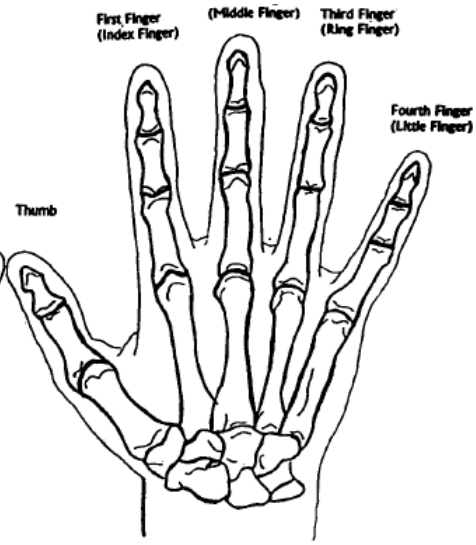
DOCTOR'S NAME AND ADDRESS	DOCTOR'S ID NUMBER	DATE
	SIGNATURE	

AMPUTATION CHART ON BACK

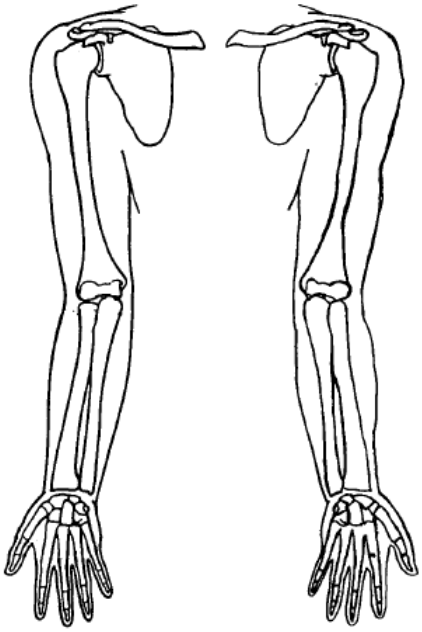
Right Leg Left Leg



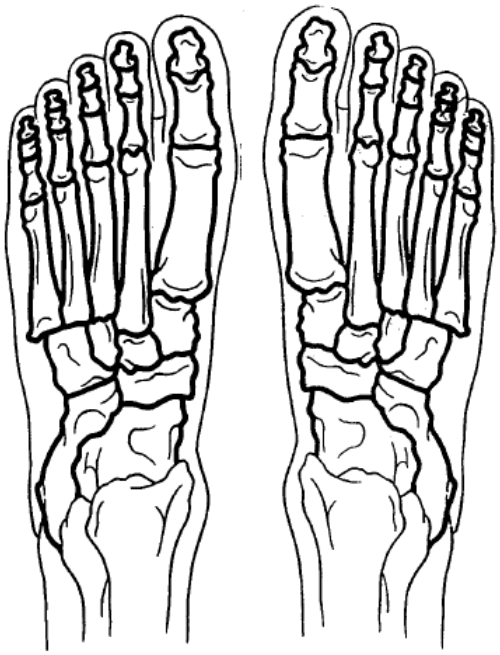
Left Hand



Right Hand



Right Arm Left Arm



Left Foot Right Foot

Mark Facial or Head Disfigurement

If you are using Adobe Acrobat, navigate using the Tab key.

Mississippi Workers' Compensation Commission

NOTICE OF FINAL PAYMENT

PRINT OR TYPE

GENERAL INFORMATION

MWCC #	CARRIER FILE #
(2) SOCIAL SECURITY #	(3) DATE OF INJURY OR DEATH
(4) DATE DISABILITY BEGAN	(5) DATE MAXIMUM MEDICAL IMPROVEMENT
(6) DATE RETURNED TO WORK	(7) DATE OF FINAL PAYMENT

(1) EMPLOYEE NAME AND ADDRESS - (INCLUDE CITY, STATE and ZIP)

(8) EMPLOYER NAME AND ADDRESS - (INCLUDE CITY, STATE and ZIP)

(9) INSURANCE CARRIER NAME & SERVICING CO. (if applicable)

COMPENSATION PAYMENTS

Compensation payments were made as follows:

NOTICE: If salary paid in lieu of compensation, report below the amount of compensation which would have otherwise been due.

(10) Average Weekly Wage: $_____

(11) Rate of Weekly Compensation $_____

A. DISABILITY PAYMENTS		B. DEATH PAYMENTS	
(12) ____ Weeks ____ Days Temporary Total	$	(16) ____ Weeks ____ Days (itemize at 26 below)	$
(13) ____ Weeks ____ Days Temporary Partial	$	(17) $250 Payment to Spouse (Section 71-3-25(a))	$
(14) ____ Weeks ____ Days Permanent Partial	$	(18) Funeral Expenses	$
_____% loss to _____		(19) Second Injury Fund	$
(15) ____ Weeks ____ Days Permanent Total	$		
Total Disability Payments	**$**	**Total Death Payments**	**$**

C. SETTLEMENT PAYMENTS		D. OTHER PAYMENTS	
(20) Lump Sum	$	(23) Total Medical Expenses	$
(21) Compromise	$	(24) Rehabilitation Expenses	$
(22) Third Party: (Attach order if not approved by MWCC)		(25) Other (Specify)	$
a. Amt. reimbursed for comp. previously paid *(Subtract reimbursements)*	$ ( )		
b. Amt. credited against future liability	$	TOTAL PAYMENTS (A + B + C* + D) **If C is a negative amount, subtract from total)*	$
Total Settlement Payments	**$**		

(26) Dependents and Spouse Payments Itemized Below (attach separate page if necessary)

Name and Relationship	Rate	Weeks	Days	Total
a.				$
b.				$
c.				$
d.				$

(27) If full compensation was not paid, explain: (attach separate page if necessary)

NOTICE

NOTICE TO EMPLOYEE OR BENEFICIARY

This is **NOT** a release of the employer's or the insurance carrier's workers' compensation liability. It is a statement of workers' compensation benefits already paid. If no further workers' compensation benefits are provided within one (1) year from the date this form is properly filed with the Commission, the right to any further such benefits may be barred by the applicable statute of limitations and this claim finally closed. Exceptions may apply for incompetents or minors. **If you incur additional loss of time from work, additional medical expense, or other additional expense, due to this injury, you should immediately contact your employer, the insurance carrier, or the Mississippi Workers' Compensation Commission for further guidance.**

PHONE #:

Prepared by: _____ Date ___/___/___

Employee's Signature: _____ Date ___/___/___
(or representative or beneficiary)

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

Post Office Box 5300, Jackson, Mississippi 39296-5300

EMPLOYER'S NOTICE OF CONTROVERSION

MWCC FILE NUMBER
CARRIER FILE NUMBER

EMPLOYEE CLAIMANT			SOC. SEC. NO.			NATURE OF INJURY
ADDRESS			DATE OF BIRTH	AGE	SEX	
CITY	STATE	ZIP	INJURY DATE			

EMPLOYER	INSURANCE CARRIER
_____	_____
_____	_____
ADDRESS	ADDRESS
_____	_____
CITY STATE ZIP	CITY STATE ZIP

Pursuant to Section 71-3-37(4) of the Mississippi Workers' Compensation Act, the above named employer controverts the referenced employee's right to workers' compensation upon the following grounds:

I hereby certify that a copy of this notice has been served, by mail or personal delivery, to the above named employee at the most current address which can be determined by diligent inquiry or to his or her attorney, if represented.

Dated: _____

_____
Signature of Employer/Carrier Representative

_____
Title

_____
Address

_____
City State Zip

Telephone number: _____

MWCC Form B-52 (1993)

MISSISSIPPI WORKERS' COMPENSATION COMMISSION
PETITION TO CONTROVERT

PLEASE COMPLETE ALL INFORMATION **MWCC #:**

Claimant Name: **Address:** **City:** **State:** **Zip:** **SSN:** **Date of Birth:**	**Insurer Name:** **Address:** **City:** **State:** **Zip:**
Employer Name: **Address:** **City:** **State:** **Zip:**	**Claims Administrator (TPA) Name:** **Address:** **City:** **State:** **Zip:** **Phone:**

Comes now the claimant and controverts this cause and in support thereof alleges the following:

1. On the _____ day of _____, _____, claimant received a compensable injury while in the employ of the captioned employer.
2. Claimant's Occupation: _____ Average Weekly Wage: _____
3. ***County*** and place of accident or illness: _____
   A. Nature of work in which claimant was engaged at the time of injury or illness: _____
   _____
   B. Description of accident or illness and how it happened: _____
   _____
   C. Accurately describe the part or parts of body involved or injured, or type of occupational disease: _____
   _____
   D. Date employer first notified of injury or illness and name and title of person notified: _____
   _____
   E. Name and addresses of witnesses: _____
   _____
4. Names and addresses of attending physicians and hospitals with dates medical treatment rendered: _____
   _____
   _____
   A. Was medical treatment furnished by employer? Yes ___ No ___.
   B. Is medical treatment presently being furnished by employer? Yes ___ No ___.
5. Compensation has ___ has not ___ been paid for _____disability from _____ to _____at the rate of $ _____.
   A. Period of temporary disability: _____
   B. Date of maximum medical improvement: _____
   C. Date able to resume employment: _____
   D. Nature, degree and extent of permanent disability: _____
   E. Loss of wage earning capacity, if applicable: _____
6. Injury did ___ did not ___ result in death. Date of death (if applicable): _____
   Name, address, date of birth and relationship of each claimant who was dependent and for whom claim is made is listed on Exhibit "A", attached hereto, and made a part hereof by reference.
7. Are penalties demanded: Yes ___ No ___. If yes, why? _____
8. Other matters in dispute are as follows: _____
   _____

This the _____ day of _____, _____.

_____
Signature of Claimant or Representative
Name, address, phone number, & bar number of attorney:

_____
_____
_____
_____

MWCC Form B-5,11 (Revised 3-15-2008) _____

Medical records are no longer to be filed with the Petition to Controvert. A party to a controverted claim shall not file medical records with the Commission unless attached to a Prehearing Statement, or unless relevant to a motion or response to motion and attached thereto as an exhibit.

GENERAL

Mississippi Workers' Compensation Commission
ANSWER
PRINT OR TYPE

MWCC#

**If Employer or Carrier Utilizes a Third Party Administrator, Provide Name and Address*

CLAIMANT

VS

EMPLOYER

INSURANCE CARRIER

NAME

ADDRESS

CITY, STATE, ZIP

EMPLOYER AND/OR CARRIER RESPONSE

The Employer and/or Carrier above named, for answer to the Petition to Controvert herein, respectfully states:

1. It is *admitted* ___ *denied* ___ that claimant sustained an injury or occupational disease on or about the date set forth in the Petition to Controvert.
2. It is *admitted* ___ *denied* ___ that the relationship of employer and employee existed at the time of the alleged injury or occupational disease.
3. It is *admitted* ___ *denied* ___ that the parties were subject to the Mississippi Workers' Compensation Act at the time of alleged injury or occupational disease. If denied, state reason: _____
4. It is *admitted* ___ *denied* ___ that at the time of the alleged injury or occupational disease the employee was performing service growing out of and in the course of employment.
5. It is *admitted* ___ *denied* ___ that the accident causing the disability for which compensation is claimed arose out of the alleged employment.
6. It is *admitted* ___ *denied* ___ that notice of injury or occupational disease complained of in the Petition to Controvert was received.
7. It is *admitted* ___ *denied* ___ that the employer was insured under the Mississippi Workers' Compensation Act at the time of alleged injury or occupational disease, or was a Self-Insurer under the Mississippi Workers' Compensation Act.
8. It is *admitted* ___ *denied* ___ that the average weekly wage as set forth in the Petition to Controvert is correct. If denied then state the average weekly wage, attach hereto a wage statement or state reason not furnished: _____
9. It is *admitted* ___ *denied* ___ that claimant was temporarily disabled for the period stated in the Petition to Controvert. If denied, state temporary disability admitted: _____
10. It is *admitted* ___ *denied* ___ the claimant is permanently disabled to the extent and for the period stated in the Petition to Controvert. If denied, state permanent disability admitted: _____
11. It is *admitted* ___ *denied* ___ that claimant sustained the loss of wage earning capacity stated in the Petition to Controvert. If denied, state loss of wage earning capacity admitted: _____
12. Affirmative defenses, special pleadings or matters in dispute (use additional sheet if necessary)_____
13. Has any compensation been paid to date? *YES* ___ *NO* ___ If yes, state amount and give inclusive dates: _____

DATE

This the _____ day of _____, _____.

_____

Name

_____ Title

_____ Phone

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

P. O. Box 5300
JACKSON, MISSISSIPPI 39216

EARLY NOTIFICATION OF SEVERE INJURY

Date of Injury _____

Employee's Name _____

Address _____ Home Telephone # _____

Employer _____

Address _____

Carrier _____

Name and Address of Hospital _____

_____

Name and Address of Physician _____

_____

Type of Injury: ☐ Major Amputation ☐ Spinal Cord Injury ☐ Brain Damage

☐ Loss of Sight, one or both eyes ☐ Severe Burns, 2nd° and 3rd°

☐ Other: explain _____

_____

Remarks _____

_____

_____

Signed _____

Title _____

NOTICE: This notification must be filed with MWCC immediately.

THIS DOES NOT REPLACE B-3

Send this report directly to:

Mississippi Workers' Compensation Commission
P. O. Box 5300
Jackson, MS 39216

Attention: Rehabilitation Unit

MWCC Form R-1 (Adopted 7-82) (Color Code - White)

Stocked For Sale By: The Office Supply Co.
P. O. Box 965 — Jackson, Miss. 39205

MISSISSIPPI WORKERS' COMPENSATION COMMISSION
P. O. BOX 5300
JACKSON, MISSISSIPPI 39216

REFERRAL FOR REHABILITATION

Date _____

Name _____ MWCC # _____

Address _____ SS # _____

_____ Phone _____

Age _____ Sex _____ Race _____ County _____

Employer _____

Address _____

Occupation _____

Carrier _____

Address _____

Disability _____

Referred by _____ Signature _____

MWCC Form R-2 (Revised 9-81)

Stocked For Sale By: The Office Supply Co.
P. O. Box 965 — Jackson, Miss. 39205

REHABILITATION INITIAL REPORT

Assigned to: _____ **Date** _____

Date of Initial Contact: _____

Findings: _____

_____

_____

No Rehabilitation Services Needed - Case Closed ☐

Will Accept Case and Develop Program ☐

Plans and Recommendations: _____

_____

_____

_____

_____ **Date** _____

Signature of Counselor / Or Rehabilitation Supplier

NOTICE: THIS FORM DUE 30TH DAY AFTER RECEIPT.

Stocked For Sale By: The Office Supply Co.
P. O. Box 965 — Jackson, Miss. 39205

MWCC Form R-2,(Revised 9-81)

File copy