

THE 12 RULES OF WORKERS' COMPENSATION

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The purpose of this article is to provide an overview of certain primary aspects of the New Hampshire workers' compensation law and process. It is intended to be a summary for employers, adjusters and those that toil day in and day out in the fields of workers' compensation claims.

Brief History

New Hampshire was one of the first states to adopt a comprehensive compensation scheme for those workers that had suffered an industrial accident. A child of the industrial era, compensation schemes were intended to provide prompt and certain benefits to workers when they were injured or could not work due to an industrial accident. Employees gave up the right sue their employer in tort --- i.e. for pain and suffering, while in exchange employers paid defined wage, medical, vocational and permanent impairment awards for work related injuries. This is the so called *quid pro quo* of most if not all workers compensation statutes.

Since this legislation was put in place, employers either directly, through their insurers or through homogeneous groups that self insure, have been obligated to administer claims and provide those benefits required under law. Thus, in addition to having workers' compensation programs in place, employers pay wage and medical benefits, establish return to work programs and compensate injured workers for loss of strength and function in permanent impairment of awards. Almost remarkably, the employee's limited obligations under the system are to keep the employer informed, get better, and return to work.

This system is managed and adjudicated by the New Hampshire (DOL). The DOL has broad and sole jurisdiction over a multitude of issues in workers' compensation from tracking an employer's coverage, to management of self insured programs, to the resolution of workers' compensation disputes in hearings – that are in fact mini-trials, and through the approval of lump sum settlements. In addition, any appeals are taken to the Compensation Appeals Board, which is administratively tied to the DOL. Each day substantial rights (and dollars) are overseen and adjudicated by the DOL.

There are a handful of critical rules that apply within the workers' compensation system. They affect a variety of entities and people involved in the system, including employers and insurers. In no special order, they are outlined below.

1. File a Wage Schedule

If workers' compensation/disability payments are made or modified, a *Memo of Payment* must be filed with the DOL reflecting the issuance or modification of disability benefits. If it is the first time disability payments are being issued a wage schedule and a *Memo of Payment* must be filed with the DOL. (See Lab 506.02 Payments of Benefits and Filing of Reports.) The requirements

of a wage schedule are outlined in New Hampshire Administrative Lab Rule [hereinafter “Lab Rule”] 515.13.

A wage schedule is used to compute average weekly wage. The wage schedule form should be used for filing. However, the DOL will accept a computer printout of wages if it is in an equivalent and usable format. On the computer printout of wages, the time period, the number of weeks of wages, and the gross wages should be easily identified and unencumbered by deductions for health insurance, retirement savings, Medicare contributions, FICA contributions and net wage information. If the computer printout is not in an equivalent format to the wage schedule, it is likely to be rejected by the DOL.

The wage schedule is used to calculate average weekly wage (AWW). Typically, the AWW is calculated through the use of a 26 week wage schedule. The 26 weeks preceding the date of injury are used. The week of hire and week of injury are not included if it would reduce the AWW. (See Lab Rule 506.02 (e)(2).) Up to a 52-week wage schedule can be used. A 52-week wage schedule must be provided and used if requested by the employee or the DOL. (See Lab Rule 506.02 (e)(4).) Where wages for 26 weeks prior to the date of injury are not available, average weekly wage will be established through an alternate method, including potentially the use of rate of hire or wages from similarly situated employees.

For the law and regulation governing the calculation of average weekly wage for purposes of workers’ compensation benefits, see RSA 281-A: 15, Average Weekly Wage and New Hampshire Administrative Lab Rule 506.02 (e)(1-7).

Relevant to the calculation of average weekly wage is the issue of concurrent earnings. The carrier or self-insured must inform the claimant of their right to benefits based on concurrent earnings. (See Lab Rule 506.02 and Lab Rule 507.03.)

2. Accept / Deny Medical Bills Within 30 Days

In an accepted workers’ compensation claim all medical bills that are reasonable, necessary and causally related to the work related injury should be paid. Carriers and self-insured often pre-approve payment of medical bills associated with medical treatment clearly related to the work injury. However, under the New Hampshire workers’ compensation law, carriers and self-insureds are not required to pre-approve payment for medical treatment, unless ordered to do so by the DOL, after a hearing addressing a request to pre-approve medical treatment. In New Hampshire there is no medical fee schedule.

If a medical note and bill are reviewed and deemed unnecessary, unreasonable or unrelated to the work related injury a medical bill denial should be issued. If a medical bill is received with insufficient information to determine reasonableness, necessity and relatedness, it may also be denied. A medical bill denial must: 1) be issued within 30 days of receipt of the medical bill; 2) be in narrative (letter form) to the claimant copied to the medical care provider and the DOL; 3) advise the claimant of the reason for denial (e.g., treatment not causally related to injury); and 4) advise the claimant of their right to request a hearing at the New Hampshire DOL, if the claimant disagrees with the denial. (See Lab Rule 506.02 (i) and (j).)

If a medical bill denial is not properly issued and the matter goes to a hearing the bills may be ordered paid without the merits of the denial being heard. In addition, if a medical bill denial is not properly issued, the DOL has the authority to assess fines. (See Lab Rule 506.02 (k).)

Although a fee schedule does not exist in New Hampshire, the carrier or self-insured has the option to accept the reasonableness, necessity and relatedness of medical treatment but object to the amount of the bill. For detailed information on this process, see RSA 281-A:24 – Reasonable Value of Services and Lab Rule 506.02 (l).

3. Provide Temporary Alternative Duty

If an employer has five or more employees, the workers' compensation law requires that temporary alternative duty ("TAD") is provided. RSA 281-A:23-b Alternative Work Opportunities is actually quite brief while the associated Lab Rule, 504.04 Development of Temporary Alternative Work is more instructive. Both 23-b and 504.04 require the provision of TAD. 504.04 states the work is to be transitional in nature and consistent with the claimant's restrictions. The claimant's physician should approve a written description of the alternative position and the claimant should be advised of and offered the alternative position in writing.

The claimant has a responsibility to make a reasonable effort to comply with the offer of TAD. For practical purposes, if TAD is approved and offered and the claimant does not comply, a request for hearing under NH RSA 281-A:48 – Review of Eligibility for Compensation can be submitted to review the entitlement to ongoing weekly benefits. If TAD is not offered, a claimant on total benefits, with a restricted work release will likely remain on total weekly benefits, despite a work release.

4. Report Injury Within Two Years

RSA 281-A:19 Notice of Injury states that a claim for workers' compensation benefits will be barred unless notice of the injury is provided to the employer within two years from the date of the injury.

RSA 281-A:21-a Time Limitations for Filing Claim states that "compensation for disability, rehabilitation, medical benefits, shall be barred unless a claim is filed within three years." The statute requires notice by two years and a claim for benefits be made within three years or the claim is time barred. The time periods begin on the date of injury, or the date the employee knows—or by reasonable diligence should know—of the nature of the injury and its possible relationship to the employment. In cases of death, the date of injury is when any dependent should have reasonably known nature of injury and its relationship to employment.

5. Accept / Deny Claim Within 21 Days

The New Hampshire workers' compensation law requires that a workers' compensation claim be accepted or denied by an insurance carrier or self-insured within 21 days of notification of the claim. The requirement is outlined in:

LAB RULE 506 RESPONSIBILITIES OF CARRIERS

Lab 506.01(f) “After receiving the first notice of a claim, the claim shall be paid or denied within 21 days subject to penalties under RSA 281-A:42, I”

The requirement to accept or deny a claim within 21 days and the potential penalty for failure to do so is outlined in RSA 281-A:42 I Failure to Make Payments of Compensation. The Labor Commissioner has discretion under RSA 281-A:42 II to grant an exception to the 21-day filing requirement. In addition, insurance carriers are not held to the 21 day requirement if the employer has failed to notify the carrier of the claim. RSA 281-A:42,II(b). Pursuant to Lab Rule 506.02 Payment of Benefits and Filing of Reports, if the claim is accepted and disability payments are made a *Memo of Payment* (MOP) must be filed with the DOL. If the claim is denied, a *Memo of Denial* must be filed with the DOL. The requirements for proper filing of a *Memo of Denial* are listed in Lab Rule 515.04.

If a *Memo of Denial* is properly issued, a claimant then has 18 months from the date the claimant received the denial, to request a hearing at the New Hampshire DOL or the claim is time barred pursuant to RSA 281-A:42 – Time Limitation for Petition for Hearing.

6. File a Correct Memo of Payment

281-A:40 Memorandum of Payment. – *An employer or the employer's insurance carrier shall make payment of compensation in the amount and manner provided by this chapter. The employer shall file memoranda of such payments with the commissioner in accordance with rules adopted by the commissioner under RSA 281-A:60.*

A MOP must be filed to reflect any payment of workers’ compensation disability benefits or change in payment of workers’ compensation disability benefits made to a claimant. Failure to submit a MOP can result in fines being assessed by the DOL. MOPs filed with the DOL can be and are regularly rejected and returned if incorrect or incomplete. For detailed instruction on the completion of MOPs, see Lab Rule 506.02 Payment of Benefits and Filing of Reports.

7. Heed Second Injury Fund Criteria

What is commonly referred to in New Hampshire as the "second injury fund" is actually the "Special Fund for Second Injuries" and is established by RSA 281-A:55 Special Fund for Second Injuries. Requirements to be eligible for payments from the second injury fund are outlined in RSA 281-A:54 Payment for Second Injuries From Special Fund and RSA 281-A:55-a Reimbursement of Payment of Additional Compensation. NH RSA 281-A:54 and 55-a address potential reimbursement from the special fund for workers’ compensation benefits paid as a result of work-related subsequent injuries, concurrent earnings, and job modification expenses.

RSA 281-A: 54 states that an individual with a preexisting permanent mental or physical impairment (work related or not) that suffers a subsequent work related injury and the combined effect of the preexisting and subsequent condition create a greater disability may be eligible for reimbursement from the second injury fund.

In order to be eligible for reimbursement for a subsequent injury: 1) the fund must be put on notice within 100 weeks of the date of subsequent injury; 2) the preexisting impairment must be serious enough to be considered a hindrance or obstacle to the worker in obtaining employment; 3) the subsequent injury must arise out and in the course of employment; 4) the combined effects of the preexisting and subsequent injury must create a greater disability; 5) a physician must certify that the combined disability is greater; 6) the employer must be able to demonstrate that it had written knowledge of the preexisting impairment prior to the date of the subsequent injury. (The prior written knowledge must be prior to the date of injury but can be subsequent to the date of hire).

RSA 281-A: 54 also provides reimbursement for certain pre-approved job modifications at a rate of 50 percent of the cost of the modification up to \$5,000 per employer per year. RSA 281-A:55- a applies to reimbursement for disability payments made attributable to concurrent earnings represented in the average weekly wage and therefore the compensation rate for total or partial disability benefits. The Special Fund will issue reimbursement for payments issued as a result of concurrent earnings. The fund must be put on notice of potential concurrent earnings/additional compensation claims within 100 weeks from the date of work related subsequent injury.

8. Demonstrate Change in Condition

In order to request a DOL hearing to review a claimant's eligibility for weekly compensation, the requesting party must demonstrate a "change in condition." The statutory authority for this is in RSA 281-A:48 Review of Eligibility for Compensation which states the following:

I. Any party at interest with regard to an injury occurring after July 1, 1965, may petition the commissioner to review a denial or an award of compensation made pursuant to RSA 281-A:40 by filing a petition with the commissioner not later than the fourth anniversary of the date of such denial or the last payment of compensation under such award or pursuant to RSA 281-A:40, as the case may be, upon the ground of a change in conditions, mistake as to the nature or extent of the injury or disability, fraud, undue influence, or coercion.

The Lab Rule governing the requirements for a review of eligibility for compensation is Lab 510.01 Basis of Petition, which states the following:

Either claimant, carrier or employer may petition the commissioner under RSA 281-A:48 to review eligibility for compensation by reason of a change in condition, mistake as to the nature or extent of the injury or disability, fraud, undue influence, or coercion.

The requirement that a "change in condition" be established in order to review an award or denial of benefits is also supported in the case law. (Appeal of Erlon Elliott, 140 N.H. 607 (1996).) The New Hampshire Supreme Court confirmed that the petitioning party has the burden to demonstrate a change in condition prior to reviewing the issue of eligibility for compensation. The Supreme has also held that a change in condition is not limited to a change in the medical condition. (Appeal of Woodmansee, 150 N.H. 63 (2003).)

9. Get Permanent Impairment Assessment

RSA 281-A:32 Scheduled Permanent Impairment Awards provides the requirements for assessment and payment of permanency. An assessment of permanent impairment for purposes of workers' compensation should occur at maximum medical improvement. The physician assessing permanency should use the most recent edition of the *AMA Guideline to Assessment of Permanent Impairment*.

Once a permanent impairment assessment, after maximum medical improvement, is disclosed the carrier or self-insured can accept or not accept the permanent impairment as it has been assessed. If accepted, a *Memo of Permanent Impairment Award* should be filed with the New Hampshire DOL, requesting approval of the award. If the DOL approves the permanency, payment should be issued.

If the carrier or self-insured objects to the assessed permanent impairment, the claimant and the DOL should be notified of the objection, in writing, within 15 days from the date the permanent impairment was disclosed to the carrier or self-insured. The carrier or self-insured then has 30 days to schedule an Independent Medical Exam (IME) to assess permanent impairment. Please note that the IME does not have to take place within 30 days, it has to have been scheduled prior to 30 days elapsing from the date of the objection.

Changes to the statute include that the average weekly wage used for calculation of permanency is the average weekly wage established using the date of injury for calculation of weekly benefits. Previously, the average weekly wage at the time the permanent impairment was assessed was used for calculating permanency. Under the current law, the payment of a permanent impairment award is in a single sum. Previously payment was made weekly but could be made in a lump sum if approved by the DOL.

10. Evaluate Recovery / Lien Rights

RSA 281-A:8 Employees Presumed to Have Accepted embodies what is commonly referred to as "the workers' compensation bar". RSA 281-A:8 removes the workers' compensation claimant's right to sue its employer directly in civil court for damages associated with a work related injury. The bar extends to spouses of claimants as well. (See NH RSA 281-A:8 II.) There are exceptions related to intentional torts. RSA 281-A:8, I(a). Wrongful termination claims are expressly excluded from the bar. (RSA 281-A:8, III.)

While employees are generally prevented from suing their employer, save a few exceptions, liability may exist in a third party. Third party liability is not barred by the workers' compensation statute. The issue of third party liability is addressed in RSA 281-A:13 – Liability of Third Persons.

If a successful third party action results from a work related injury and workers' compensation benefits have been paid, a workers' compensation lien is created against the third party proceeds. The workers' compensation carrier or self-insured can assert its lien against the third party proceeds minus a pro rata share of attorney fees.

In addition, to the extent a claimant receives a net settlement from the third party action, the carrier or self-insured is not required to pay work related injury medical bills. This is called the “holiday.”

A legal issue exists with respect to how the carrier or self-insured is required to pay attorney fees for use of the holiday. The issue is whether the carrier or self-insured must pay attorney fees when the holiday is established or when it is used. Claimant’s counsel may suggest that the case of Knapp v. Tennessee Gas Pipeline Co., 149 N.H. 740 (2003), from the New Hampshire Supreme Court controls indicating the holiday must be paid for upfront. Defense counsel is likely to suggest it is a case-by-case analysis and pro rata attorney fees are due upon actual use of the holiday (referred to as “pay as you go” system).

11. Comply with DOL Orders

There are several provisions of the New Hampshire workers’ compensation statute and Lab Rules that provide the DOL authority to assess fines. An employer or insurer’s failure to pay claims timely or file proper documentation often lead to fining situations up to \$2,500. (See Lab Rule 512, Civil Penalties for Non-Compliance.)

12. Return Labor Department Calls

If a representative of the New Hampshire DOL calls a representative of an employer, third party administrator, self insured, or insurance carrier in regard to an issue or claim, return the call as promptly as possible. If you are having a problem with a claim or are not sure how to complete a filing, call the **DOL** at **603.271.3176**.

In addition, the DOL has a comprehensive and easy-to-use Web site at ***www.labor.state.nh.us***. The statute and the administrative rules, as well as the DOL forms, can be accessed on the Web site.

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