CHAPTER 67

South Carolina Workers' Compensation Commission

Statutory Authority: 1976 Code §§ 42-3-30 and 42-3-80

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Editor's Note

The following regulations, unless otherwise noted, were added in State Register Volume 14, Issue No. 9, effective September 2, 1990.

ARTICLE 1
ADMINISTRATION

67–101. South Carolina Workers' Compensation Commission, Location, Transaction of Business.

A. The South Carolina Workers' Compensation Commission's offices are located in Columbia, South Carolina.

B. The Commission transacts business weekdays 8:30 A.M. to 5:00 P.M., excluding State holidays.

C. The South Carolina Workers' Compensation Commission remains in continuous session and meets regularly to transact business which comes before it.

D. The Commission determines the assignment of districts within the State and the district assignment of each Commissioner.

ARTICLE 2
GENERAL

67–201. Application of Regulations.

A. These regulations are entitled to a liberal construction in the furtherance of the purpose for which the South Carolina Workers' Compensation Law is intended.

B. In doubtful cases, the application of these regulations shall be in favor of the injured employee.

67–202. Words and Phrases, Defined.

A. The definition of words and phrases used in this Chapter include:

(1) Accident Reporting Division: A division of the Commission responsible for receipt and processing of the employer's first report of injury, Form 12A (ACORD 4) and Form 12M.

(2) Certified Mail: Mail including that which is certified by the U. S. Postal Service and that carried by a commercial carrier that keeps proper documentation.

(3) Claimant: The party making a claim including his or her attorney.

(4) Claims Department: A department of the Commission responsible for managing the workers' compensation file. The department reviews case files that are not contested and assures compliance with the provisions of this Chapter and the Act by requesting and, if necessary, assessing a fine for failure to file reports required by this Chapter and the Act.

(5) Compliance Division : A division of the Commission responsible for investigation and, if necessary, requests prosecution of an employer who refuses or neglects to comply with the insurance provisions of this Chapter and the Act. The division is authorized to request and, if necessary, assess a fine for failure to file reports required under this Chapter and the Act.

(6) Coverage Division: A division responsible for monitoring and maintaining coverage records of employers, employees, insurance carriers, self-insurance funds, and the State Accident Fund's compliance with the Chapter and the Act. The division is authorized to request and, if necessary, assess a fine for failure to file reports required under this Chapter and the Act.

(7) Employer's Representative.

(a) The employer's insurance carrier, the claims administrator for a self-insurance fund or a self-insured employer, the State Accident Fund, and counsel of record for the employer and its insurance carrier.

(b) If an employer is operating as an unqualified self-insured, the term "employer's representative" shall mean the unqualified self-insured employer and its attorney, if any, who shall be directly responsible for compliance with the provisions of this Chapter and the Act.

(8) Federal Employer Identification Number: "FEIN."

(9) Informal Conference: Also called a "viewing," an informal conference is a meeting with the claimant, the employer's representative, and a Commissioner or claims mediator. At the informal conference, the Commissioner or claims mediator answers questions about the claim and reviews, for approval, a proposed settlement of a claim. An informal conference may be held for the purpose of certifying a Form 17 according to R.67–505E and R.67–506F.

(10) Judicial Department: A department of the Commission which assigns the informal conference, contested case, and Commission review docket and issues the hearing notice. The department reviews the Commission's files and assures compliance with the provisions of this Chapter and the Act by requesting and, if necessary, assessing a fine for failure to file reports required by this Chapter and the Act.

(11) Medical Services Division: A division of the Commission which administratively reviews physician fees and hospital charges to assure compliance with the Medical Services Provider Manual and the Hospital and Ambulatory Surgery Center Payment Manual.

(12) Public Affairs Division: A division of the Commission responding to the general inquiries of employees and employers concerning their rights, benefits, and obligations under the Act. The service does not provide legal advice or offer opinions concerning a particular claim.

(13) Self-Insurance Division: A division of the Commission which monitors the compliance of self-insured employers and self-insurance funds with this Chapter and the Act. The division reviews applications to self-insure and is authorized to request and, if necessary, assess a fine for failure to file reports required under this Chapter and the Act.

(14) South Carolina Workers' Compensation Commission: the Commission.

(15) Unqualified Self-Insured Employer: An employer who refuses or neglects to comply with the insurance provisions of this Chapter and the Act.

(16) Workers' Compensation Law: the Act.

(17) Workers' Compensation Commission's file number: the W.C.C. file number.

(18) Rehabilitation professionals: coordinators of medical rehabilitation services.

B. In addition, other words and phrases are defined in the article most closely associated with the word or phrase.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–203. Official Forms and Documents.

A. The Commission prepares and approves all required forms. A person shall use a Commission form and shall not substitute another document for a form. Reproduction of a form the same size is permitted, provided content is not altered.

B. Commission forms are available on the web site. The Commission supplies at a reasonable charge, upon written request to the Commission's Mail Room, the following forms.

(1) Form S-1, Notice of Third Party Action, Employer;

(2) Form S-2, Notice of Third Party Action, Employee;

(3) Form S-3, Entitlement to Right of Action;

(4) Form S-4, Court Certificate;

(5) Form 2, Employer's Notice of Being Subject to the Act;

(6) Form 5, Corporate Officer Notice to Reject;

(7) Form 6, Application to Create a Self-Insurance Fund;

(8) Form 6A, Application for Membership in a Self-Insurance Fund;

(9) Form 7, Application to Individually Self-Insure;

(10) Form 7A, Corporate Guaranty;

(11) Form 8, Proof of Compliance, Surety Bond;

(12) Form 8A, Proof of Compliance, Securities Pledge;

(13) Form 8B, Proof of Compliance, Memorandum of Understanding, and Irrevocable Letter of Credit;

(14) Form 8C, Proof of Compliance, Excess Insurance;

(15) Form 9, Certificate for Self-Insurance;

(16) Form 10, Self Insurance Tax Return;

(17) Form 11, Self Insurer's Quarterly Financial Report;

(18) Form 11A, Self Insurer's Annual Financial Report;

(19) Form 12A, Employer's First Report of Injury (ACORD 4);

(20) Form 12M, Annual Minor Medical Report;

(21) Form 14A, Health Insurance Claim Form (HCFA-1500);

(22) Form 14B, Physician's Statement;

(23) Form 15, Temporary Compensation Report;

(24) Form 15S, Supplemental Report of Varying Temporary Partial Payments;

(25) Form 16, Agreement for Permanent Disability/Disfigurement Compensation (prior to July 1, 2007);

(26) Form 16A, Agreement for Permanent Disability/Disfigurement Compensation (after July 1, 2007);

(27) Form 17, Receipt of Compensation;

(28) Form 18, Periodic Report;

(29) Form 19, Status Report and Compensation Receipt;

(30) Form 20, Statement of Earnings of Injured Employee;

(31) Form 21, Employer's Request for Hearing;

(32) Form 24, Application for Lump Sum Award;

(33) Form 27, Subpoena;

(34) Form 30, Request for Commission Review;

(35) Form 31, Notice of Review Hearing;

(36) Form 32, Request to Waive Appeal Filing Fee;

(37) Form 36, Medical Fee Approval;

(38) Form 38, Employer's Withdrawal of Election to Adopt the South Carolina Workers' Compensation Act;

(39) Form 39, Coverage Coding Form;

(40) Form 50, Employee's Notice of Claim and/or Request for Hearing;

(41) Form 51, Employer's Answer to Request for Hearing;

(42) Form 52, Employee's Notice of Claim and/or Request for Hearing, Death Case;

(43) Form 53, Employer's Answer to Request for Hearing, Death Case;

(44) Form 54, Employer's Notice of Claim and/or Request for Hearing;

(45) Form 55, Second Injury Fund's Answer to Employer's Request for Hearing;

(46) Form 58, Pre-hearing Brief;

(47) Form 59, Appellant's Informal Brief;

(48) Form 61, Attorney Fee Petition;

(49) Form 65, Waiver of Claim Involving an Occupational Disease;

(50) Second Injury Fund Form 1, Agreement to Reimburse Compensation;

(51) Second Injury Fund Form 2, Reimbursement Request;

(52) Second Injury Fund Form 3, Employer's Notice of Claim for Reimbursement from Second Injury Fund;

(53) Second Injury Fund Form 4, Medical Information Request.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–204. Completing Forms.

A. A person filing a form with the Commission shall complete each information blank on the form. Each form shall contain the W.C.C. file number and the employer's FEIN, if known.

B. The Commission may return an incomplete form to the sender with an explanation of its deficiency.

67–205. Filing with the Commission, Defined.

A. The date of filing a form or document with the Commission is provided in subsections B, C, and D, below.

B. A form or document delivered to the Commission electronically, by first class mail or by hand delivery is filed the date of receipt in the Commission's offices as indicated by the earliest date stamped on the form or document by an official Commission stamp with the exception of forms and documents delivered pursuant to R.67–205C and R.67–205D.

C. A form or document delivered to the Commission by certified or registered mail is deemed filed the date of deposit in the United States Postal Service as indicated by the date of postmark.

D. The following forms or documents are deemed filed on the date on the accompanying certificate of service properly addressed to the Commission: Forms 15(III), 50, 51, 52, 53, 54, 55, 58, 30, and appellate briefs.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–206. Filing a Claim.

A. To file a claim, file with the Commission's Claims Department a Form 50, Form 52, or a letter as provided below.

B. To file a claim on a Form 50 or Form 52, mark the box at the signature line which states "I am filing a claim. I am not requesting a hearing at this time."

(1) Address and deliver the form to the Claims Department.

(2) Filing a claim requires the WCC file number or the Coverage Coding Form 39 must be included. This requirement may be waived for unrepresented claimants.

(3) Filing a claim does not request a hearing nor is the employer's representative required to file a Form 51 or 53.

C. A letter filed with the Commission also files a claim. The letter should include the information listed in items (1) through (13) below:

(1) Claimant's name (and worker's name, if different);

(2) Claimant's address (and worker's address, if different);

(3) Claimant's home and work telephone numbers (and worker's home and work telephone numbers, if different);

(4) Claimant's social security number (and worker's social security number, if different);

(5) Employer's name;

(6) Employer's address;

(7) Employer's telephone number;

(8) Employer's insurance carrier, if known;

(9) Date of injury;

(10) The county in which the injury occurred;

(11) Type of injury (to which area of body);

(12) Description of the accident;

(13) The WCC file number or Coverage Coding Form must be included.

D. Failure to include any of the information above does not bar the claim if the information necessary to an issue in the claim is given to the Commission upon request.

E. The Commission will notify the employer's representative a claim has been filed. The employer's representative shall immediately contact the claimant.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–207. Requesting a Hearing, Claimant.

A. To request a hearing, file a Form 15, Form 50, or Form 52 with the Commission's Judicial Department as provided below:

(1) Mark the box at the signature line on the Form 50 or Form 52 which states, "I am requesting a hearing," or sign and date under Section III of the Form 15 "Notice to Injured Worker or Legal Representative When Temporary Compensation Has Been Stopped."

(2) Address and deliver the form to the Judicial Department.

(3) The Commission serves the Form 15, Form 50, or Form 52 on the employer according to R.67–210 and R.67–211.

(4) When under the laws of this State the employer and its insurance carrier, if any, are required to be represented by an attorney in a contested case hearing, an attorney shall be designated according to R.67–603.

(5) The WCC file number or Coverage Coding Form must be included.

B. Filing a Form 50 or Form 52 with the Commission requesting a hearing also files the claim if a claim has not been filed before.

HISTORY: Amended by State Register Volume 19, Issue No. 5, eff May 26, 1995; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–208. Requesting a Hearing, Employer.

A. The employer's representative may request a hearing by filing the appropriate form as provided below with the Commission's Judicial Department and serving the form pursuant to R.67-211.

B. To request a hearing for permission to pay compensation due to death, permanent partial, or permanent total compensation, file a Form 21 with the Judicial Department.

(1) The claimant may, but is not required to, file a response to the Form 21 in writing.

(2) File a response, if any, as provided by R.67-604B(1) and B(2).

C. To request a hearing for permission to terminate temporary compensation after one hundred fifty days after notice of the injury to the employer, file a Form 21 with the Judicial Department pursuant to R.67-506.

D. To request a hearing between the employer and the Second Injury Fund, file a Form 54 with the Judicial Department and serve the Form 54 on the Second Injury Fund pursuant to R.67-211.

E. When under the laws of this State an employer and its insurance carrier, if any, are required to be represented by an attorney in a contested case hearing, its attorney must file a letter of representation with the Judicial Department and provide a copy to the opposing party no later than thirty days from the date of service of the Form 21 or Form 54. Notice will be served pursuant to R.67-210 based on the Commission records on the day the notice is mailed.

HISTORY: Amended by State Register Volume 19, Issue No. 5, eff May 26, 1995; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–209. Computation of Time.

A. The day of the event, after which a designated period of time begins, is excluded. The last day, of the designated time period, is included.

B. Saturdays, Sundays, State, and Federal holidays are included unless the designated time period ends on a Saturday, Sunday, State, or Federal holiday in which case the next day that is not a Saturday, Sunday, State, or Federal holiday is included as the last day.

67–210. Parties Served.

A. Serve the following parties:

(1) The insurer's designated recipient as in R.67-401 (the employer is not served);

(2) The employer directly when the employer is uninsured;

(3) The party when the party is not represented by an attorney;

(4) The Second Injury Fund;

(5) The State Accident Fund.

B. When an attorney represents a party, and notifies the Commission of his or her representation, the attorney is served. The party is not served.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–211. Service of Forms and Documents.

A. Claimant's Request for Hearing.

(1) When the claimant is represented by an attorney, the attorney shall serve a copy of the Form 15(III), Form 50, or Form 52 hearing request electronically or by depositing the form in the United States Postal Service first class postage, addressed to the opposing parties pursuant to R.67–210. Service is deemed complete upon mailing unless the form is returned. If the form is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure. A hearing will not be set until service is complete and proof of service is filed with the Judicial Department.

(2) When the claimant is not represented, the claimant may serve the Form 15(III), Form 50, or Form 52 hearing request as set forth in A(1) above. When the claimant does not serve the hearing request, the Commission will serve the request electronically or by depositing the form in the United States Postal Service first class postage, addressed to the opposing parties per R.67–210.

B. Employer's Representative's Request for Hearing and/or Response to a Request For Hearing.

(1) When the claimant is represented by an attorney, the employer's representative shall serve a copy of the Form 21, Form 51, or Form 53 electronically or by depositing the form in the United States Postal Service first class postage, addressed to the claimant's attorney. Service is deemed complete upon mailing unless the form is returned. If the form is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure. A hearing will not be set until service is complete and proof of service is filed with the Judicial Department.

(2) When the claimant is not represented by an attorney, the employer's representative shall serve a copy of the Form 21, Form 51, or Form 53 by personal service or by certified mail, return receipt requested, delivery restricted to the addressee. When service is by certified mail, service is complete the date of the addressee's receipt of the form as indicated by the signed certified mail return receipt. If the form is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure. A hearing will not be set until service is complete and proof of service is filed with the Judicial Department.

C. Other Forms and Documents.

(1) Unless otherwise specified in this Chapter, serve other forms and documents electronically or by depositing the form or document in the United States Postal Service first class postage, addressed to the opposing parties per R.67–210. Service is deemed complete upon mailing unless the document is returned. If the document is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure.

(2) When the claimant is not represented by an attorney, the claimant may serve a form or document according to C(1) above. When the claimant does not serve the form or document, the Commission will serve it by depositing the form or document in the United States Postal Service first class postage, addressed to the opposing parties per R.67–210.

(3) Hearing notices may be served electronically pursuant to R.67–210. All unrepresented claimants and uninsured employers shall be served by depositing the notice in the United States Postal Service, first class postage per R.67–210.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–213. Service of Orders, Hearing Notices, and Review Hearing Notices.

A. The Commission serves orders electronically, by certified mail, return receipt requested or by deposit in the United States Postal Service, first class postage, addressed to the parties according to R.67–210.

(1) Service is made by delivering a copy of the order to a party representing himself or herself or to the attorney representing the party.

(2) When service is made by certified mail, the date of service is the date of the addressee's receipt indicated by the certified mail return receipt. When service is made by first class mail, five days are added to the date of mailing. Service by first class mail is deemed complete five days after the date of deposit in the United States Postal Service.

B. The Commission serves hearing notices and Form 31, Review Hearing Notices, electronically or by deposit in the United States Postal Service first class postage, addressed to the parties according to R.67–210. Service is deemed complete upon mailing. All unrepresented claimants and uninsured employers shall be served by depositing the notice in the United States Postal Service, first class postage per R.67–210. The Commission may, but is not required to, serve such notices by certified mail, return receipt requested. Service by certified mail is complete upon receipt.

C. When an attorney represents a party, the party is not served. If the mailing is returned, service may be completed as in R.67–211.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–214. Subpoenas.

A. To subpoena a person or document(s), complete and serve a Form 27 as set out below.

B. When the party issuing the Form 27 is represented by an attorney, the attorney shall complete and sign the Form 27.

C. When the party issuing the Form 27 is not represented by an attorney, the party may obtain a blank Form 27 signed by an authorized representative of the Commission.

D. When the individual being served is represented by an attorney, serve by depositing the Form 27 in the United States Postal Service, first class postage addressed to the attorney. Service is deemed complete upon mailing, unless the form is returned. If the form is returned, service may be completed pursuant to South Carolina Rules of Civil Procedure.

E. When the individual being served is not represented by an attorney, serve the individual by personal service or by certified mail, return receipt requested, delivery restricted to the addressee. When service is by certified mail, service is complete the date of the addressee's receipt of the form as indicated by the signed certified receipt. If the form is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure.

F. Do not file the Form 27 with the Commission. When the Form 27 is to be used at a hearing, retain a copy and proof of service to be presented as necessary.

G. An individual may contest a Form 27 by filing and serving a motion to quash or modify pursuant to R.67-215.

HISTORY: Amended by State Register Volume 19, Issue No. 5, eff May 26, 1995; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–215. Motions.

A. A party may file a motion when a form is not applicable. The Commission will accept motions including, but not limited to, a motion

(1) Relating to a subpoena or discovery;

(2) Relating to the appointment of a Guardian ad Litem;

(3) Relating to an attorney's appearance, withdrawal, or fee;

(4) Relating to a claim pending Commission review;

(5) Relating to postponing or adjourning a hearing;

(6) Relating to self-insurance privileges;

(7) Relating to penalties and or interest;

(8) Relating to third party practice.

B. The Commission will not address a motion involving the merits of the claim, including, but not limited to, a motion

(1) For dismissal; or

(2) For summary judgment.

C. The Commission does not provide a form for a motion. A motion shall contain a complete caption of the case including the title of the action, the state and county in which the injury occurred, the Commission's name, the workers' compensation file number, and a designation of the relief or order sought.

D. The body of the motion shall contain numbered paragraphs each limited to a statement of a single set of circumstances. The final paragraph of the motion shall state specifically the relief or order sought.

(1) If the grounds on which the motion or reply depend is based on the existence of facts not in the Commission's file, the moving party shall file an affidavit or affidavits evidencing those facts. The opposing party may file an affidavit or affidavits in reply.

(2) If the motion or reply depends on the existence of facts in evidence or are admitted in forms on file with the Commission, the party shall cite the document and page number.

E. When the claimant or an uninsured employer is not represented by an attorney, the moving party shall serve the motion by personal service or by certified mail, return receipt requested, delivery restricted to the addressee.

(1) When service is by certified mail, service is complete the date of the addressee's receipt of the mailing as indicated by the signed certified return receipt. Otherwise, the moving party shall serve the motion by any of the methods listed or by depositing the motion in the United States Postal Service, first class postage, addressed to the appropriate party.

(2) If the mailing is returned, service may be completed pursuant to the South Carolina Rules of Civil Procedure.

F. The moving party shall file the motion and proof of service with the Judicial Department. The moving party may attach a memorandum in support. The opposing party may file a memorandum in reply within ten days of service of the motion. The parties may agree to an extension by filing a written consent. Failure to respond is deemed a general denial. No further memoranda are allowed, unless requested by a Commissioner.

G. The jurisdictional commissioner may consider the motion after the opposing party has had ten days notice of the motion and shall grant or deny the relief requested.

(1) The jurisdictional commissioner may hear the parties in any county or by telephone conference call, however, a hearing is not necessary.

(2) The jurisdictional commissioner shall issue a written decision to be filed with the record and served on all parties.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–216. Guardian ad Litem, Appointment.

A. When a minor or mentally incompetent person is a party, a Guardian ad Litem shall represent the minor or mentally incompetent.

B. When a claim involves a fatality, a Guardian ad Litem shall represent the minor child or children.

C. A Guardian ad Litem may file proof of guardianship with the Commission's Judicial Department or a person may request a Commissioner appoint a Guardian ad Litem by filing and serving a motion pursuant to R.67-215.

D. The qualifications of and proceedings for appointment of a Guardian ad Litem shall be the same as those found in the South Carolina Rules of Civil Procedure; but, a Commissioner may require the appointment of an attorney as the Guardian ad Litem.

E. The Commission shall not hold a hearing for final determination of benefits until proof of appointment of a Guardian ad Litem is filed with the Commission.

F. The Commissioner may order the Guardian ad Litem paid from the proceeds of the claim for services rendered. If the parties settle the case according to Article 8, the Guardian ad Litem shall file a Form 61, Attorney Fee Petition, according to R.67-1204 for approval of the fee. The employer's representative is not liable for the Guardian ad Litem's expenses; however, upon conclusion of the claim, the employer's representative may pay the Guardian ad Litem directly as provided by an approved Form 61 or as ordered by the Commission with such payment deducted from the recipient's compensation.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

ARTICLE 3
NOTICES REQUIRED UNDER THE ACT

67–301. Posting Notice.

A. All employers operating under the Act, whether by law or by election, shall post publicly and keep posted in their place of business a Form 2, Employer's Notice of Being Subject to the Act.

B. The notice shall state, substantially, the following:

"We are operating under and subject to the Workers' Compensation Act of South Carolina. In case of accidental injury or death to an employee, the injured employee, or someone acting on his or her behalf, shall give immediate notice to the employer or general authorized agent. Failure to give immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her beneficiaries and may result in failure to receive any compensation benefits whatsoever."

ARTICLE 4
REPORTS REQUIRED, EMPLOYERS AND INSURANCE CARRIERS

67–401. Designation of Authorized Recipient of Service and Other Demands.

A. Every workers' compensation insurance carrier, self-insured employer, and self-insurance fund doing business in this State shall designate one address and one electronic address as the authorized recipient in underwriting matters of service, mail, documentation, requests, inquiries, and other demands concerning the employer, the insurance carrier, the self-insured, the self-insurance fund, and a member of the self-insurance fund.

B. Every workers' compensation insurance carrier, self-insured employer, and self-insurance fund doing business in this State shall designate one address and one electronic address as the authorized recipient in claims and all other non-underwriting matters of service, mail, documentation, requests, inquiries, and other demands concerning the employer, the insurance carrier, the self-insured, the self-insurance fund, and a member of the self-insurance fund.

C. The workers' compensation insurance carrier, self-insured employer, and self-insurance fund shall provide in writing the name, address, electronic address, and telephone number of the authorized recipient to the Commission.

D. The designation is deemed continuous. A change in designation shall not be effective until after thirty days written notice to the Commission.

E. If coverage has been reported to the Commission by EDI and the report included an underwriting office address, the address most recently reported shall be deemed the designated address for all underwriting matters related to that coverage in lieu of the address designated under R.67–401A.

F. If a claim has been reported to the Commission by EDI and the report included a claims office address, the address most recently reported shall be deemed the designated address for all matters related to that claim in lieu of the address designated under R.67–401B.

G. Every workers' compensation insurance carrier, self-insured employer, and self-insurance fund shall provide in writing their home office address, electronic address, and telephone number.

HISTORY: Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–402. Corporate Officer Rejection of the Act.

A. A corporate officer may reject the Act by taking the following action:

(1) The corporate officer shall complete and file with the employer's insurance carrier a Form 5, Corporate Officer Notice to Reject.

(2) The effective date of rejection is the effective date listed on the Form 5, no sooner than the day following the day the corporate officer signed the form.

(3) The corporate officer shall provide notice to the employer of the rejection of the Act by giving a copy of the Form 5, personally, to the employer or its agent or by sending it by registered or certified mail to the employer or its agent.

B. An insurance carrier or self-insured fund may substitute its own form for the Form 5. Any substitute form must:

(1) Include substantially the same information included on the Form 5, including information that advises the corporate officer of the effects of rejecting the Act; and

(2) Require the corporate officer's signature be notarized.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–403. Election to Adopt the Act.

A. An employer adopts the Act by obtaining workers' compensation insurance or by operating under an approved self-insurance program.

B. When an employer exempt from the Act has with its employees elected to operate under the Act and has filed notice of such agreement and complied with the provisions of the Act, the employer and its employees who have elected with the employer shall, until notice to the contrary is filed with the Commission, continue to operate under the Act without additional election.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–404. Withdrawing from the Act.

A. An employer who, having elected to come under the Act, being at that time exempt, is deemed to continue to operate under the Act until a Form 38, Notice of Withdrawal from the Act, is filed with the Commission's Coverage and Compliance Department and its employees are provided written notice in section B below.

B. An employer shall withdraw from the Act by filing a Form 38 with the Coverage and Compliance Department as in subsection B(1), or, by notifying its insurance carrier as in subsection B(2) below.

(1) The employer shall complete and file with the Coverage and Compliance Department the original and one copy of a Form 38.

(a) Upon receipt of a completed, signed, and notarized Form 38, the Coverage and Compliance Department will return to the employer an approved Form 38.

(b) The effective date of withdrawal, sixty days from the date of filing, will appear on the form.

(c) The employer shall provide notice to its employees before the effective date of withdrawal by posting the approved Form 38 conspicuously in the place of employment or by giving each employee, personally, a copy of the approved Form 38.

(2) If the employer elects to withdraw from the Act by notifying in writing its workers' compensation insurance carrier, the employer's representative shall provide notice to the Commission by taking the following action:

(a) Before the effective date of the employer's insurance policy's cancellation, the insurance carrier shall complete and file with the Coverage and Compliance Department the original and one copy of a Form 38 signed by the employer.

(b) Upon receipt of a completed, signed, and notarized Form 38, the Coverage and Compliance Department will return to the insurance carrier an approved Form 38. The insurance carrier shall give the approved Form 38 to the employer.

(c) The effective date of withdrawal, sixty days from the date of filing, will appear on the form.

(d) The employer shall provide notice to its employees as in B(1)(c) above.

C. The insurance carrier's filing a policy cancellation or termination notice with the Coverage and Compliance Department or the National Council on Compensation Insurance shall not operate as notice of withdrawal from the Act. The insurance carrier shall file the Form 38 in addition to a notice of termination required in R.67-405.

D. A nonexempt employer, becoming exempt from the insurance provisions of this Chapter and the Act, may file an exemption with the Coverage and Compliance Department as provided below:

(1) File a Form 38, an attached affidavit, and supporting documentation with the Coverage and Compliance Department.

(2) The affidavit and supporting documentation must establish the employment and the employer are exempt from the insurance provisions of the Act.

(3) The form is subject to approval by the department if the supporting documentation establishes an exemption under the Act.

(4) It is the employer's responsibility to assure compliance with the insurance provisions of the Act.

(a) A Form 38 approved according to this Regulation creates a rebuttable presumption of exemption from the Act.

(b) An exemption established by a Form 38 shall not prevent the department from investigating and, if necessary, requesting prosecution of the employer.

(5) The Commission may impose the maximum penalty and fine available against the employer who, although previously exempt from the Act, then operates subject to the Act and fails to comply with the insurance provisions of this Chapter and the Act.

67–405. Employers and Insurance Carriers, Proof of Compliance.

A. Every employer operating under the Act shall file with the Commission proof of its compliance with the insurance provisions of this Chapter and the Act.

B. When an employer insures its liability under the Act, the insurer shall file a report of coverage within thirty days of the inception date of the policy with the Commission's authorized agent as proof of the employer's compliance with the insurance provisions of this Chapter and the Act and as provided herein.

(1) A workers' compensation insurance carrier shall file a report of coverage in accordance with R.67–416.

(2) The State Accident Fund shall file a report of coverage in accordance with R.67–416.

(3) A self-insurance fund shall comply with the insurance reporting requirements in Article 15 of this Chapter.

C. If the employer fails to renew its insurance, or the insurer cancels the policy, the employer's insurer shall immediately notify the Commission's authorized agent that it no longer insures the employer .

(1) A worker's compensation insurance carrier shall file a notice of termination in accordance with R.67–416. Such termination shall not be effective until thirty days after receipt by the Commission's authorized agent.

(2) The State Accident Fund shall file a notice of termination in accordance with R.67–416. Such termination shall not be effective until thirty days after receipt by the Commission's authorized agent.

(3) A self-insurance fund shall file notice of termination of a fund member's self-insurance privileges as provided in Article 15 of this Chapter.

D. The employer's representative and the State Accident Fund shall on behalf of the employer file with the Commission all reports and documents required by this Chapter and the Act.

HISTORY: Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–409. Duplicate or Dual Insurance Coverage.

A. When duplicate or dual coverage exists by reason of two different insurance carriers issuing two policies to the same employer securing the same liability, the Commission shall presume the policy with the later effective date is in force and the earlier policy terminated on the effective date of the later policy.

B. When both policies carry the same effective date, one policy may be cancelled by filing a notice of termination retroactive to the date of the policy's inception.

(1) Cancellation must be reported as provided in R.67–405.

(2) The insurance carrier issuing the notice of termination shall provide the employer notice of termination.

HISTORY: Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–411. Employer's Report of Injury, Form 12A.

A. Each employer shall keep a record of all injuries, fatal or otherwise, received by its employees in the course of their employment.

(1) The record must be made on the Form 12A and retained or filed according to section B below.

(2) The Commission shall not construe the filing of a Form 12A as an admission of liability on the part of the employer or the employer's representative.

B. Employer's Responsibilities

(1) The employer shall make a record of all work-related injuries reported by its employees on the Form 12A and retain the record for a period of two years.

(2) When an injury requires less than five hundred dollars in medical treatment and does not cause more than one lost workday or permanency, the employer may pay for the medical treatment. The employer is not required to make a written report to the employer's representative or to the Commission.

(3) If the employer denies the claim for injuries or does not elect to pay for the medical treatment, the employer shall send a copy of the Form 12A to the employer's representative immediately after the occurrence and knowledge of the injury.

(4) When an injury requires five hundred dollars or more in medical treatments or when it is determined more than one workday will be missed as a result of the injury or there is likely to be permanency, the employer shall send a copy of the Form 12A to the employer's representative immediately.

(5) The employer shall report all fatalities to its representative.

C. Employer's Representative's Responsibilities

(1) When an injury requires less than two thousand five hundred dollars in medical treatments and does not result in compensable lost time or permanency, the employer's representative shall retain the Form 12A filed by the employer for two years. The employer's representative shall make a report of the injuries in this category to the Commission as required in R.67–412.

(2) When an injury requires two thousand five hundred dollars or more in medical treatments or results in compensable lost time or permanency, the employer's representative shall send the Form 12A to the Commission within ten business days after the occurrence and the employer's knowledge of the injury. In the event the injury was previously processed under section C(1) above, the Form 12A shall be filed with the Commission within ten business days of the employer's representative's knowledge the limits set in section C(1) above have been exceeded. The Form 12A shall be marked "Previously Processed As Medical Only."

(3) If the employer's representative, or the employer, denies the claim for injuries, the employer's representative shall notify the claimant in writing and send the Form 12A, a Form 19 (reference R.67–414), and a copy of the letter denying the claim to the Commission within ten business days after the occurrence and the employer's knowledge of the reportable injury.

(4) The employer's representative is required to report all fatalities to the Commission.

D. An unqualified self-insured employer shall file a Form 12A with the Commission within ten business days after the occurrence and knowledge of an injury, regardless of the nature or seriousness of the injury.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–412. Employer's Report of Injury, Form 12M.

A. The employer's representative shall report to the Commission injuries reported by the employer pursuant to R.67–411C(1).

B. This report shall be made in accordance with R.67–416 within ten days of closing by the employer's representative.

C. Late reports shall be subject to a fine for late reporting plus an additional penalty of five dollars for each day late.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–413. Periodic Report.

A. The employer's representative shall file a Form 18, Periodic Report, as follows:

(1) Six months after the alleged date of injury and each six months thereafter until the Commission's file is closed;

(2) To request an informal conference;

(3) Within thirty days of service of a claimant's Form 50 or Form 52 request for a hearing or request for an informal conference; and

(4) At the request of the Commission.

B. The employer's representative may file a Form 18 at any time to transmit a message to the Commission.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–414. Status Report and Compensation Receipt.

A. After payment of all compensation the employer's representative shall file with the Commission's Claims Department a Form 19, Status Report and Compensation Receipt, as provided in Section C below. If an individual claim file has been created by the Commission, a Form 19 is required to close the file, even if no compensation has been paid.

B. When the employer's representative denies the claim, a Form 19 must be filed with the Claims Department, and the employer's representative shall:

(1) Attach to the form a copy of the letter provided to the claimant denying the claim; and

(2) Complete, sign, and file a Form 19. The claimant's signature is not necessary.

C. In all other cases, complete and file a Form 19 as provided below:

(1) When more than one person receives payment of compensation, prepare a separate Form 19 for each person or Guardian and a final, additional Form 19 indicating the total amount of compensation paid and all medical expenses incurred in the claim.

(2) Complete each line indicating payment of temporary total (TT), temporary partial (TP), and permanent partial (PP) compensation, disfigurement, and final release (an Agreement and Final Release), if applicable.

(3) The claimant's signature is required on the Form 19 when permanent disability, disfigurement, or death benefits are paid or when the claim is settled by a Full and Final Release. The preparer shall sign and date the Form 19.

(4) File the completed Form 19 with the Claims Department.

HISTORY: Amended by State Register Volume 19, Issue No. 5, eff May 26, 1995; State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–415. Documentation of Insurance.

A. For purposes of Section 42–1–415, either of the following is acceptable as documentation of insurance:

(1) The declaration page of a standard workers' compensation policy, as issued by the insurance carrier for the insured, serves as documentation of insurance for both South Carolina and out-of-state employers, provided South Carolina is indicated as a named state in section 3A or 3C.

(2) The ACORD Form 25-S, Certificate of Insurance, as issued by the insurance carrier for the insured, is acceptable documentation of insurance, provided the Certificate of Insurance indicates a valid South Carolina address for the insured, is dated, signed and issued by an authorized representative of the insurance carrier for the insured. For an out-of-state employer, the ACORD Form 25-S is acceptable, provided the authorized representative of the insurance carrier for the insured affirms the following in an accompanying statement: South Carolina is a named state in section 3A or 3C of the declaration page of the insured's policy.

B. If the employer is a member of a self-insured fund approved by the Commission, the ACORD Form 25-S, Certificate of Insurance, must be dated, signed, and issued by an authorized representative of the self-insured fund.

C. If the employer has been approved by the Commission to individually self-insure according to R.67–1500, et seq., the self-insurance certificate issued by the Commission shall serve as documentation of insurance as provided in Section 42–1–415.

HISTORY: Added by State Register Volume 21, Issue No. 4, eff April 25, 1997. Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–416. Electronic Data Interface.

A. All insurance carriers, third party administrators, self-insureds, self-insured funds, and the State Accident Fund reporting coverage, accident, and claims information to the Commission shall report such information using electronic interchange standards prescribed by the Commission.

B. Failure to comply with the Commission's prescribed electronic data interchange standard shall result in the assessment of fines in accordance with R.67–1401.

HISTORY: Added by State Register Volume 21, Issue No. 4, eff April 25, 1997. Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–417. Examination of Claim Files.

A. As part of the claims review process, the Commission may conduct on-site examinations of all records relating to injuries, fatal or otherwise, sustained in the course and scope of an employee's employment.

B. Insurance carriers, self-insured employers, self-insured funds, the State Accident Fund, and any claims administrator acting on their behalf are required to cooperate with examinations.

C. Claims will be reviewed to ensure timely and accurate payment of benefits and the proper filing of reports as required under Title 42 and Chapter 67.

D. Repeated violations of reporting standards shall be reported to the South Carolina Department of Insurance pursuant to Section 38–13–10.

HISTORY: Added by State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998.

ARTICLE 5
TEMPORARY COMPENSATION

67–502. Words and Phrases, Defined.

A. Day of incapacity: The day of the injury is the first day of incapacity unless the injured person receives full pay for the day. In that event, the first day of incapacity is the day following receipt of full pay from the employer.

B. Disability:

(1) Incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment.

(2) Disability is presumed to continue until the employee returns to work or compensation is otherwise suspended or terminated according to Section 42-9-260.

C. Fractional part of a week: For a fractional part of a week, the daily wage is one-seventh of the weekly wage.

D. Return to work without restriction: A statement of the authorized health care provider about the capacity of the claimant to meet the demands of a job and the conditions of employment. The determination must be made when the claimant's physical condition is static or is stabilized with or without medical treatment. The determination is appropriate when there are no physical limitations on the claimant's ability to perform the same or other suitable job as the claimant performed before the injury.

E. Temporary Partial Incapacity: Partial incapacity for work resulting from the injury.

F. Temporary Total Incapacity: Total incapacity for work resulting from the injury.

G. Waiting Period: The day or days lost because of inability to work on account of the injury are counted in the waiting period even though the days may not be consecutive.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–503. Payment of Temporary Total and Temporary Partial Compensation.

A. Medical, surgical, hospital, and other treatment including medical and surgical supplies are allowed from the first day of injury.

(1) Temporary total or temporary partial compensation is incurred on the eighth calendar day of incapacity and from the first day of incapacity if the injury results in incapacity for more than fourteen calendar days. The seven and fourteen day periods need not be consecutive days.

(2) Payment and acceptance of temporary compensation files a claim.

B. When the employer's representative begins to pay either temporary total or temporary partial compensation, or salary in lieu of temporary compensation, the employer's representative shall complete Section I of the Form 15, Temporary Compensation Report.

(1) The employer's representative shall file the Form 15 with the Claims Department within ten days of the date of first payment of compensation.

(2) The employer's representative shall serve the Form 15 on the Claimant according to R.67-211 with the claimant's first check.

C. When the compensation rate changes, the employer's representative shall complete, file, and serve, as set out above, a new Form 15.

(1) In an ongoing period of temporary partial compensation where the rate varies from week to week, the employer's representative shall report the first payment on the Form 15 as set out above.

(2) Supplemental payments shall be reported on the Form 15S, Supplemental Report of Compensation, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, whichever becomes due first.

D. If the employer's representative does not pay temporary compensation, the claimant may request a hearing to receive benefits according to R.67-207. Payment of temporary total or temporary partial compensation does not prevent the claimant from seeking any other benefits available under the Act.

HISTORY: Amended by State Register Volume 19, Issue No. 5, eff May 26, 1995; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–504. Terminating Payment of Temporary Total or Temporary Partial Compensation During the First One Hundred Fifty Days After Employer's Notice of the Accident.

A. The employer's representative may terminate or suspend temporary compensation during the first one hundred fifty days after the employer has notice of the injury according to Section 42-9-260. When compensation is terminated or suspended, the employer's representative shall complete Section I and Section II of the Form 15, Temporary Compensation Report. The employer's representative shall file the Form 15 immediately with the Claims Department and shall serve two copies of the Form 15 immediately on the claimant according to R.67-211 with documentation attached as to the reason for termination or suspension.

B. To terminate or suspend compensation pursuant to Section 42-9-260(B)(2), the employer's representative must obtain a signed Form 17.

C. The claimant may request a hearing to dispute the termination or suspension of temporary compensation by completing Section III of the Form 15 and filing it according to R.67-207.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–505. Suspending Temporary Compensation after the First One Hundred Fifty Days after the Employer's Notice of the Injury.

A. After the one hundred fifty day period, the employer's representative shall not suspend or terminate temporary compensation except as provided in this regulation or R.67-506.

B. Disability is presumed to continue until the claimant returns or agrees he or she is able to return to work for fifteen calendar days.

C. Temporary compensation may be suspended as follows:

(1) When the authorized health care provider reports the claimant is able to return to work without restriction to the same or other suitable job, and such job is provided by the employer, the employer's representative may suspend temporary compensation while the claimant is working unless temporary partial compensation is due.

(2) When the authorized health care provider reports the claimant is able to return to work at limited duty and the employer provides limited duty work consistent with the terms upon which the claimant has been released, the employer's representative may suspend temporary compensation while the claimant is working unless temporary partial compensation is due.

(3) When the claimant returns to work for another employer, the employer's representative may suspend temporary compensation while the claimant is working, unless temporary partial compensation is due.

D. When the claimant is unable to complete fifteen calendar days of work, the employer's representative shall reinstate temporary compensation according to the terms of the Form 15 and may request a hearing to terminate compensation by filing a Form 21 according to R.67-506.

E. When the claimant completes fifteen calendar days of work, or fifteen days after the claimant agrees he or she could have returned to work, the employer's representative immediately shall submit a completed Form 17 to the claimant for signature.

(1) The employer's representative shall file the Form 17 signed by the claimant and the employer's representative with the Claims Department within thirty-one days of the date the claimant returned to work or agreed he or she was able to return to work.

(2) Temporary compensation is terminated by the filing of the signed Form 17.

(3) A signed Form 17 does not prevent the claimant from seeking any other benefits available under the Act.

(4) When the claimant returns to work for at least fifteen calendar days but refuses to sign a Form 17, the employer's representative shall file a Form 21 according to R.67-506. The Commission may certify the Form 17 at an informal conference.

F. When the employer's representative suspends temporary compensation for refusal of medical treatment according to Section 42-15-60 or Section 42-15-80, the employer's representative shall file a Form 21 according to R.67-506.

G. If the employer's representative reinstates temporary compensation after the fifteen day period above, the employer's representative shall file a new Form 15 according to R.67-503.

H. If the employer's representative refuses to reinstate temporary compensation after the fifteen day period above, the claimant may request a hearing according to R.67-207.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–506. Terminating Temporary Compensation after the First One Hundred Fifty Days after the Employer's Notice of the Injury.

A. After the one hundred fifty day period, the employer's representative shall not suspend or terminate temporary compensation except as provided in this regulation or in R.67-505. Disability is presumed to continue until the employee returns to work, except as provided herein.

B. After the one hundred fifty day period, when the claimant is receiving temporary compensation and the authorized health care provider reports the claimant has reached maximum medical improvement, the employer's representative shall continue payment of temporary compensation until the Commission finds the employer's representative may terminate compensation unless compensation has been suspended according to R.67-505. When compensation has been suspended according to R.67-505, see section F below.

C. After the one hundred fifty day period, when the claimant is receiving temporary compensation and the authorized health care provider reports the claimant may return to work at the same or other suitable job and such job has been offered by the employer but the claimant refuses to return to work, the employer's representative must continue payment of temporary compensation until the Commission finds the employer's representative may terminate temporary compensation.

D. After the one hundred fifty day period, when the claimant is receiving temporary compensation and the authorized health care provider assigns an impairment rating and reports the claimant is unable to return to work at the same or other suitable job, the employer's representative must continue payment of temporary compensation until the Commission finds the employer's representative may terminate temporary compensation.

E. To request a hearing for permission to terminate temporary compensation, the employer's representative shall file a Form 21 with the Judicial Department.

(1) The employer's representative shall serve a copy of the Form 21 on the claimant according to R.67-211.

(2) The employer's representative shall certify temporary compensation is current or no hearing will be set.

F. After the one hundred fifty day period, when the employer's representative has suspended temporary compensation according to R.67-505, the employer's representative shall request permission to terminate compensation by filing a Form 21 with the Judicial Department.

(1) Serve a copy of the Form 21 on the claimant according to R.67-211.

(2) The Commission may schedule an informal conference to certify a Form 17 when compensation has been suspended according to R.67-505.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–509. Medical Treatment While Receiving Temporary Compensation Benefits.

A. The employer's representative chooses an authorized health care provider and pays for authorized treatment.

B. The claimant should contact the employer's representative with questions about medical care and payment.

67–510. Unauthorized Suspension or Termination of Temporary Compensation Benefits.

A. If the employer's representative suspends, terminates, or reduces temporary total or temporary partial compensation benefits without first complying with the procedures in this Article, the claimant may be entitled to additional compensation and penalty as provided in this Chapter and the Act.

B. The claimant may request a hearing as provided in R.67-207 for the relief in section A above.

Article 6
Contested Case Procedure

67–601. Hearings, Generally.

A. The Commission may, on its own motion, order a hearing.

B. The Commission will not set a hearing until a conflict arises.

67–602. Hearings, Required Information.

A. The Commission's file must contain all required forms and medical reports filed according to R.67-1301.

B. In a claim involving a fatality, the claimant must obtain the following items:

(1) The death certificate;

(2) Marriage license, if any;

(3) Divorce decree, if any;

(4) Birth certificates of children, if any; and

(5) A statement of burial expenses.

C. In a claim involving a change of condition, the moving party must attach to the hearing request form a medical report(s) indicating a change in the claimant's condition. The claimant may request an informal conference to determine if the claimant may receive a medical evaluation at the expense of

the employer's representative by writing the Commission's Judicial Department. Additional experts reports may be admitted at the hearing according to R.67-612.

D. The documents listed in sections A, B, and C must be filed in the Commission's file before the date set for the hearing.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992.

67–603. Employer's Answer to a Request for Hearing, Time for Filing and Service.

A. The employer's representative shall respond to a Form 50 by preparing a Form 51 and respond to a Form 52 by preparing a Form 53.

B. The employer's attorney shall fully state its position and defenses, if any, replying to each specification in the Form 50 or Form 52 and:

(1) File the Form 51 or Form 53 and a proof of service with the Commission's Judicial Department within thirty days of service of the Form 50 or Form 52; and

(2) Serve the claimant a copy of the Form 51 or Form 53 according to R.67–211.

C. Failure to file a Form 51 or Form 53 within the period in section B(1) shall be deemed a general denial of liability for the benefits claimed and the employer and its representative by the failure to respond within the period in section B(1) shall forfeit each special and affirmative defense allowed by the Act including the defenses available in Sections 42–9–60, 42–15–20, 42–15–40, and 42–17–90 of the Act.

D. When under the laws of this State an employer and its insurance carrier, if any, are required to be represented by an attorney in a contested case hearing, its attorney must file a letter of representation with the Judicial Department and provide a copy to the opposing party no later than sixty days from the date of service of the Form 50 or Form 52.

E. A Form 51 must describe with as much specificity as possible the defenses to be relied upon by the defendants. A Form 51 shall not state "all defenses apply" or other similar language unless such is actually the case. A Form 51 not complying with this regulation shall not be considered at a hearing.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–604. General Denial to Employer's Request for Hearing.

A. Except when the employer is seeking permission to pay compensation as provided by R.67-208B, each allegation made in a Form 21 is deemed denied.

B. The claimant may, but is not required to, file a response to the Form 21 in writing.

(1) File the response, if any, and proof of service with the Commission's Judicial Department within thirty days of service of the Form 21.

(2) Serve the employer's representative according to R.67-211.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–605. Second Injury Fund's Answer to a Request for Hearing, Time for Filing and Service.

A. The attorney for the Second Injury Fund shall file and serve a Form 55, Answer of the Second Injury Fund to Employer's Request for Hearing, as provided below.

B. File the Form 55 and proof of service with the Commission's Judicial Department within thirty days of service of the Form 54.

C. Serve the employer according to R.67-211.

D. Failure to file a Form 55 within the period in section B above shall be deemed a general denial of liability for the benefits claimed and the Second Injury Fund by the failure to respond within the period allowed in Section B shall forfeit each special and affirmative defense allowed by the Act.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–606. Employee's Wage Determination.

A. The average weekly wage and compensation rate is an issue for determination at the hearing unless stipulated by the parties.

B. The employer's representative shall prepare, file, and serve a Form 20 according to R.67-1603.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–607. Hearing Notice.

A. Each party is afforded at least thirty days notice of a hearing.

B. The Commission issues a hearing notice to the parties which includes the date, place, time, and purpose of the hearing.

C. Hearing notices may be issued electronically.

HISTORY: Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–608. Failure to Appear at a Hearing.

A. The Commission may issue an order assessing a fine of up to one hundred dollars against a party who properly served a hearing notice fails to appear at a scheduled hearing.

B. The party has the right to review and appeal as in other cases.

67–609. Withdrawing a Request for Hearing.

A. A claimant may withdraw a Form 50 or Form 52 once as a matter of right with leave to renew.

(1) A Form 50 or Form 52 may be withdrawn by writing the Commission's Judicial Department, if a hearing notice has not been issued, or, the Commissioner's office identified on the hearing notice.

(2) When a Form 50 or Form 52 is withdrawn, a notice removing the case from the docket will be filed in the Commission's record and a copy sent electronically or mailed to the parties in R.67–210.

B. The notice is without prejudice to the claimant's right to proceed with his or her claim.

(1) If the nature of the claim and the relief requested does not change, write the Judicial Department requesting the Form 50 or Form 52 be reset for hearing.

(2) If the nature of the claim or relief requested changes, file according to R.67–207, a new Form 50 or Form 52 with the word "Amended" printed or typed boldly on the top of the form.

C. Withdrawing a Form 50 or Form 52 the second time without good cause may operate as a voluntary dismissal of the claim when the form is withdrawn by a claimant who has once withdrawn a Form 50 or Form 52 based on the same set of facts, and, in the opinion of the Commissioner, the form is withdrawn merely for the purpose of delay.

D. Withdrawing a Form 15 request for hearing waives the sixty day hearing requirement. If the jurisdictional commissioner is unable to reschedule the case, the file will be returned to the Judicial Department to be reassigned.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–610. Continuing Obligation to Update, Request for Hearing, and Answer.

A. After a Request for Hearing and Answer are filed with the Commission, an "Amended" form must be filed to indicate a change in the nature of the claim, relief requested, or another defense.

B. A party may amend a form once as a matter of course at any time before or within thirty days after it is served. Otherwise a party may amend a form no later than ten days prior to the hearing and only by leave of the Commissioner or by written consent of the adverse party.

(1) A party shall file and serve an amended form and move at the hearing to go forward on the issue(s), as amended. Type or print boldly across the top of the form the word "Amended".

(2) Leave shall be freely given when justice so requires and does not prejudice any other party.

(3) A party shall plead in response to an amended form within the time remaining for response to the original form or within ten days after service of the amended form, whichever period may be longer, unless the Commission otherwise orders.

(4) Attorneys for the parties shall serve the opposing party according to R.67-211.

(5) If the claimant is not represented by an attorney, the Commission will serve the employer's representative or attorney.

C. An amended form must be timely filed and served. The Commissioner will determine at the hearing whether to allow a party to rely on new facts or defenses.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–611. Pre-hearing Brief.

A. A claimant who is representing himself or herself is not required to file a Form 58, Pre-hearing Brief.

(1) If the claimant elects to file a Form 58, mail the Form 58 to the Commissioner's office identified on the hearing notice.

(2) The Commissioner's office will send a copy of the Form 58 to the employer's attorney.

B. Each attorney representing a party at a hearing shall file and serve a Form 58 according to the following:

(1) File a Form 58 and proof of service at least ten days before the hearing with the Hearing Commissioner's office identified on the hearing notice. Complete the Form 58 and give the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements including video recordings and/or transcribed audio recordings have been taken from one of the witnesses including the claimant and indicate who has possession of same. A party is under a duty to promptly supplement a response with respect to any question directly addressed on the form and amend a response if the party obtains information upon the basis of which the party knows the response was incorrect when made, or the party knows the response thought correct when made is no longer true and the circumstances are such that a failure to amend the response is in substance a knowing concealment.

(2) Serve the opposing party according to R.67-211.

C. The Form 58 shall remain in the Commission's file but shall not constitute evidence or become part of the record of the hearing.

D. If an attorney fails to file and serve a Form 58, the Commissioner may postpone the hearing according to R.67-613 or assess against an attorney by written order a fine of up to one hundred dollars.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–612. Admission of Expert's Report as Evidence.

A. This regulation does not apply to the Form 14A filed according to R. 67–1301, nor shall this regulation be construed to limit a party's right to call a witness (lay or expert) or present evidence (lay or expert) in the form of a deposition.

B. A written expert's report to be admitted as evidence at the hearing must be provided to the opposing party as follows:

(1) The moving party must provide the report to the opposing party at least fifteen days before the scheduled hearing.

(2) The non-moving party must provide to the moving party any report not provided by the moving party at least ten days before the scheduled hearing.

(3) Where both parties file hearing requests the first party to file shall be considered the moving party.

(4) The carrier shall be deemed the moving party in all hearings scheduled pursuant to a request under R. 67–504C.

C. Proof of notice as required under this section shall be filed with the Commission at the time such reports are provided to a party.

D. Any report submitted to the opposing party in accord with B(1) or B(2) above shall be submitted as an APA exhibit at the hearing unless withdrawn with the consent of the other party, and the non-moving party shall submit only reports not submitted by the moving party. The actual report shall not be filed with the Commission prior to the hearing.

E. Failure to provide reports and notices as required under this section may result in the exclusion of such reports from the evidence of the case. This paragraph shall not be construed to limit the discretionary authority of a Hearing Commissioner to accept reports, depositions or other evidence at the conclusion of the scheduled hearing pursuant to subsection J below.

F. If the parties consent to the admission of a report, then the Hearing Commissioner shall receive such report into evidence without regard as to whether the parties have complied with this section.

G. The following rules in this subsection shall govern the format in which Administrative Procedures Act (APA) exhibits are submitted into evidence. Each APA or set of APA's shall have:

(1) An index sheet listing the APA number, name of the provider, dates of service and number of pages in the APA, with the records from each medical provider identified in groups, as APA #1, APA #2; etc. The reports of each expert shall be arranged in either chronological or reverse chronological order.

(2) A consecutive number beginning with the first page of APA #1 and continuing through the final page of the last APA submitted.

H. Counsel for all other parties appearing at the hearing shall be given the opportunity to review the APA exhibits as prepared in accordance with this regulation and to supplement the record with any properly noticed APA exhibits which may have been omitted from the Claimant's and Defendants' single sets.

I. By complying with this regulation, the parties do not waive any evidentiary objections to the introduction of a particular exhibit. Such objections may include, but are not limited to relevancy, materiality, qualification of the expert, timeliness, privilege, hearsay or authenticity as may relate to the document in controversy.

J. All available evidence and testimony shall be presented at the scheduled hearing or a party must move for an adjournment according to R.67–613.

(1) The Commissioner may adjourn the hearing, and testimony of a necessary witness unable to appear at the scheduled hearing may be presented by deposition or at a hearing reconvened at a later date.

(2) The Commissioner may order the party moving for adjournment to take the de bene esse deposition of the expert. The Commissioner may order the party moving for adjournment to pay hearing costs if it is necessary to reconvene.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998; State Register Volume 25, Issue No. 6, eff June 22, 2001.

67–613. Postponement or Adjournment of the Scheduled Hearing.

A. Each party shall arrange and present all evidence at the hearing. Testimony of a necessary witness unable to appear at the hearing may be presented by deposition.

B. A commissioner may postpone a hearing for good cause.

(1) Good cause includes but is not limited to:

(a) The attorney is actually engaged in another court;

(b) Illness;

(c) Additional discovery is necessary;

(d) A conflict of interest exists requiring another Commissioner hear the case;

(e) It is premature to hear the case.

(2) To request a postponement, file and serve a motion pursuant to R.67–215 at least ten days before the hearing. If the moving party can show emergency or other circumstance beyond its control, the motion may be filed and served as soon as reasonably possible before the hearing.

(3) If the moving party postpones a hearing set pursuant to Section 42–9–260, the requirement to hold the hearing within sixty days is waived. The hearing will be postponed only until the following month. If the commissioner cannot hear the case by the following month, the case will be returned to the Judicial Department for reassignment.

(4) All hearings other than those set pursuant to Section 42–9–260 are postponed only until the following month. If the commissioner cannot hear the case the following month, the hearing will not be reset until the moving party files a written request with the Judicial Department. If the nature of the claim or the relief requested changes, file a new hearing request according to R.67–207 unless R.67–610 applies.

C. A party may move for adjournment at a hearing under the following circumstances:

(1) To procure additional evidence when the evidence is in existence, identified, and necessary for the decision, but unavailable at the hearing.

(2) When a witness fails to appear.

(a) If the witness has been properly subpoenaed, produce a copy of the Form 27 and proof of service. The Commission may allow the testimony to be made part of the record by de bene esse deposition or by testimony at a reconvened hearing.

(b) If the witness has not been properly subpoenaed, the moving party shall provide a reasonable basis for failure to subpoena the witness. The testimony may be allowed at the Commissioner's discretion.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998.

67–614. Hearing Costs.

A. A Commissioner may issue an order assessing the actual cost of a hearing as established by the Commission if the Commissioner determines that the hearing has been brought, prosecuted, or defended on unreasonable grounds.

B. The party assessed has the right to review and appeal as in other cases.

67–615. Transcripts of Hearings.

A. A person may request in writing to the Commissioner's office all or a portion of a transcript of a hearing.

B. A request for a portion of a transcript shall be limited to the entire testimony of a particular witness, the opening or closing statement.

C. The hearing reporter shall transcribe and deliver the request as soon as reasonably possible.

D. The cost will be at the prevailing rate established by the Commission and the responsibility of the party ordering the transcript. Bills shall be paid within thirty days of the receipt of the transcript, and failure to do so shall result in the party's inability to obtain additional transcripts or copies until the account is current.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

ARTICLE 7
REVIEW AND HEARING

67–701. Requesting Commission Review of the Hearing Commissioner's Decision.

A. Either party or both may request Commission review of the Hearing Commissioner's decision by filing the original and three copies of a Form 30, Request for Commission Review, with the Commission's Judicial Department within fourteen days of the day the Commissioner's order is received. The fourteen day period is jurisdictional. The Commission will not accept for filing a Form 30 that is not postmarked or delivered to the Commission by the fourteenth day from the date of

receipt of the Hearing Commissioner's order. The appellant shall attach a copy of the Order and Decision being appealed to the Form 30 and to the brief.

(1) The party requesting review is the appellant. The opposing party is the respondent. Place the proper designation after the names of the parties on the form.

(2) The W.C.C. file number assigned to the case is retained and must be on the Form 30.

(3) The grounds for appeal must be set out in detail on the Form 30 in the form of questions presented.

(a) Each question presented must be concise and concern one finding of fact, conclusion of law, or other proposition the appellant believes is in error.

(b) References to evidence must be by title and exhibit number.

(4) To request oral argument, mark the space provided on the Form 30.

(a) If the space provided on the Form 30 requesting oral argument is not marked, oral argument is waived. The Commission will review the Commissioner's decision on the record without oral argument.

(b) If the appellant does not request oral argument, the respondent may request oral argument by writing the Judicial Department. A copy of the letter requesting oral argument must be sent to all opposing parties pursuant to R.67–211.

(c) If respondent requests oral argument, both parties may present oral argument.

(5) File the Form 30 and proof of service with the Judicial Department. Serve the opposing party pursuant to R.67–211.

(a) The Judicial Department will not set a Form 30 for review until proof of service is filed.

(b) Failure to file proof of service will result in receipt of a notice administratively dismissing the Form 30.

(c) An administrative dismissal does not bar review if the Form 30 has been timely filed. When service is completed, write the Judicial Department requesting the Form 30 be set for review.

B. If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of the Form 30 and serve the Form 30 on the opposing party.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–702. Filing Fee.

A. The appellant shall attach to the Form 30 the filing fee required by the Act.

B. If a party is representing himself or herself and is unable to pay the filing fee, the party must file the Form 30 within fourteen days of receipt of the Commission's order. The party may file a Form 32, Request to Waive Appeal Filing Fee, with the Form 30.

(1) The Commission's Chair reviews the Form 32.

(2) If the filing fee is not waived, the appellant must pay the filing fee within ten days of the date of receipt of a notice denying waiver of the filing fee.

67–703. Appeals without Merit.

A. At the conclusion of the review if the Commission determines that the appeal was without merit, it may charge, in its sole discretion, the appealing party an additional fee not to exceed two hundred fifty dollars.

B. The person charged the additional fee has the right to appeal as in other cases.

67–704. Notice of Review Hearing.

A. The Commission serves the parties in R.67-210 a Form 31, Notice of Review, at least thirty days before the date of review hearing.

(1) The Form 31 states the date, place, time, purpose of the review hearing, and the filing date for the appellant's brief.

(2) The appellant's brief must be filed with the Commission according to R.67-205 and R.67-705 on or before the date stated on the Form 31.

B. The Commission's Judicial Department will set several "standby" cases for review each month, issue a Form 31 as in A above, and notify the parties to appear for oral argument if the case is reached on the review hearing docket.

C. The Judicial Department will set cases for review on the record without oral argument and issue a Form 31 as in A above.

D. The appellant in B and C above must file his or her brief according to R.67-205 and R.67-705 on or before the date stated on the Form 31.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992.

67–705. Briefs, Filing and Service.

A. On each case appealed to the Commission for review, the appellant shall file a brief that includes a statement of the case, questions presented, argument, and conclusion.

B. The appellant shall file the brief and proof of service on the opposing party with the Commission's Judicial Department according to R.67-205 on or before the date on the Form 31.

C. The respondent may file a brief and proof of service on the opposing party with the Judicial Department within fifteen days of service of the appellant's brief.

D. The appellant may file a reply brief and proof of service with the Judicial Department within ten days of service of the respondent's brief.

E. No further briefs are permitted unless requested by the Commission.

F. The original and three copies of the brief must be filed when a three member Commission panel reviews the case as indicated on the review hearing notice. The original and six copies of the brief must be filed when a six member Commission panel reviews the case as indicated on the review hearing notice.

G. Serve the briefs pursuant to R.67-211. If the claimant is representing himself or herself, the Judicial Department prepares the additional copies of the brief and serves the brief on the opposing party.

H. With the consent of the opposing party, the time for filing a brief may be extended if a letter acknowledging the agreement is filed with the Commission on or before the original filing date.

(1) All briefs must be filed at least five days before the scheduled date for review. The Commission will exclude from consideration a brief filed later than five days before the scheduled review.

(2) The party extending the time for filing a brief shall file with the Judicial Department a copy of the agreement. The agreement must state the date the brief is due.

(3) If the appellant fails to file a brief within ten days of receipt of the Form 31, the Judicial Department may remove the case from the review hearing docket by issuing an administrative order dismissing the appeal.

(4) An appeal administratively dismissed by the Judicial Department may be reinstated for a good cause upon motion to the Commission.

(a) A motion to reinstate the appeal must be filed with the Commission and served on all parties no later than thirty days from the date of service of the administrative order dismissing the appeal.

(b) The motion will be heard by the Full Commission without oral argument or appearance of the party.

(c) If the case is reinstated, the Commission may impose against the appellant costs up to two hundred fifty dollars.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–706. Oral Argument.

A. Each party is permitted ten minutes for oral argument. The appellant is permitted three minutes for reply.

B. If both parties have appealed, each party is permitted ten minutes for oral argument, and each party is permitted three minutes for reply.

C. A party may request additional time for argument by attaching a motion to the Form 30. The Commission will issue an order before the case is set for argument.

67–707. Additional and Newly Discovered Evidence.

A. When additional evidence is necessary for the completion of the record in a case on review the Commission may, in its discretion, order such evidence taken before a Commissioner.

B. When a party seeks to introduce new evidence into the record on a case on review, the party shall file a motion and affidavit with the Commission's Judicial Department.

C. The moving party must establish the new evidence is of the same nature and character required for granting a new trial and show:

(1) The evidence sought to be introduced is not evidence of a cumulative or impeaching character but would likely have produced a different result had the evidence been procurable at the first hearing; and

(2) The evidence was not known to the moving party at the time of the first hearing, by reasonable diligence the new evidence could not have been secured, and the discovery of the new evidence is being brought to the attention of the Commission immediately upon its discovery.

(a) File the motion and affidavit with proof of service as soon as the new evidence is discovered. The motion and affidavit may be filed with the Form 30.

(b) Serve the opposing party pursuant to R.67-215.

(c) Oral argument will not be heard on the motion. The Commission will act upon the motion and issue an order before the review hearing is held.

(d) If the Commission grants the motion, the review hearing is stayed. The case will be remanded to the original Hearing Commissioner who may, unless otherwise provided, reconvene the hearing or admit the deposition of a witness into the record.

(e) The original Hearing Commissioner will issue his or her findings and recommendations in the form of an order to the Commission and the parties.

(f) Upon the receipt of the Commissioner's order, the Judicial Department will reset the case on the review hearing docket.

(g) If the Commission denies the motion, the case may remain on the review hearing docket unless otherwise provided.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–708. Postponement.

A. A review hearing may be postponed for the reasons in R.67-613.

B. Either party may contact the Commission's Judicial Department to request postponement. A case may be postponed administratively.

C. When the appellant has caused postponement of a review hearing two times, the appellant's request for oral argument is deemed waived. The case may be reviewed on the record.

67–709. Commission Review, Procedure.

A. Commission review may be conducted by a three or six member review panel either of which excludes the original Hearing Commissioner. An order of a three member review panel has the same force and effect as a six member review panel and is the final decision of the Commission.

B. The Commission's Chair with approval of the majority of the other Commissioners shall assign cases to a three member panel according to the following subsections:

(1) When a Form 30 is filed, the Hearing Commissioner is notified. If the Hearing Commissioner determines the review involves a novel issue of law or fact, the Hearing Commissioner may request the Commission's Chair set the case for review by a six member review panel.

(2) If the Hearing Commissioner does not request a six member review, the Commission's Chair may assign the review to a three member panel.

(3) The Commission's Chair may appoint by random selection two review panels and exclude, on a rotating basis, one Commissioner from the panels each month. The Commission's Chair may assign a case for review as in B(2) above to a three member panel that excludes the original Hearing Commissioner.

C. The Commissioners reviewing the case may confer and shall vote within ten days of the date of review. The original Hearing Commissioner's decision is neither a vote, nor shall it be considered as a vote, of the Commission's final decision.

D. To reverse the Hearing Commissioner's decision requires a majority decision of the Commissioners reviewing the case.

(1) A majority of a three member panel consists of two votes to reverse.

(2) A majority of a six member panel consists of four votes to reverse.

(3) If one Commissioner is temporarily incapacitated or a vacancy exists on the Commission, review may be conducted by the remaining Commissioners sitting as a five or three member panel.

(a) The Hearing Commissioner may request review of the case as in B(1) above, and a panel of five may review the case. A majority consists of four votes to reverse.

(b) If the Hearing Commissioner does not request review as in B(2) above, the Commission's Chair may assign the review to a three member panel. A majority consists of two votes to reverse.

E. A Hearing Commissioner's finding of fact or conclusion of law subject to review by the Commission may be modified by the entry of the review panel's order making a new finding of fact, conclusion of law, or modifying the Hearing Commissioner's finding of fact or conclusion of law.

(1) On review, a vote to affirm and modify is deemed a vote to affirm, or a vote to reverse and modify is deemed a vote to reverse.

(2) The Commissioners, together, shall agree on a modification if any and record their findings of fact and conclusions of law on a vote sheet.

(3) If the case is reviewed by a three member panel and the panel cannot agree on modifying the Hearing Commissioner's decision, the Commissioners on the three member panel may request the remaining Commissioners, excluding the Hearing Commissioner, review the case and the issue in dispute as follows:

(a) The panel may certify an issue for review to the remaining Commissioners, excluding the Hearing Commissioner, by completing a vote sheet and phrasing the issue in dispute in the form of a question.

(b) The Commission's Judicial Department will notify the parties of the question presented to the remaining Commissioners and the parties may file briefs according to R.67–705 on or before the date stated on the notice. Oral argument is not permitted.

(c) The remaining Commissioners shall consider the question presented, briefs if any, and register their decision on the vote sheet within thirty days of the date of notice to the parties.

(d) The panel members shall issue an order thirty days from the date the remaining Commissioners register their decision.

(4) The Commission sitting as a five or six member review panel shall register a vote in accordance with section C above. The Commission sitting as a five or six member panel may remand a case to the Hearing Commissioner only for taking additional or newly discovered evidence or for exceptional circumstances set forth in its order.

F. If a Commissioner fails to register a vote within the periods referred to above, the Commissioner is deemed to have registered a vote affirming the Hearing Commissioner and may not vote otherwise.

G. [Repealed]

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–710. Settlement of a Claim Pending Review.

A. If the parties settle a claim after filing a Form 30, the appellant shall immediately notify the Commission's Judicial Department in writing.

B. The Judicial Department will remove the case from the review hearing docket or notify the Commission an order is not required.

C. When the terms of the settlement, as in Article 8, are filed with the Commission, an administrative order will be issued dismissing the appeal upon consent of the parties.

67–711. Transcripts.

A. Oral argument presented to the Commission is recorded.

B. A transcript may be requested by notifying the Commission's Judicial Department. The terms and costs as in R.67-615 shall apply.

67–712. Requesting Higher Court Review.

A. Notice shall be given to the Judicial Department of any and all subsequent appeals and orders. See Rule 203(b)(6), SCACR.

B. The appellant shall provide the Judicial Department with a copy of any orders issued.

HISTORY: Added by State Register Volume 34, Issue No. 2, eff February 26, 2010.

ARTICLE 8
SETTLEMENTS, PROCEDURES

(Statutory Authority: 1976 Code § 42–3–30)

67–801. Settlement of the Claim, General.

A. After the claimant reaches maximum medical improvement the parties may agree to settle the claim by signing a Form 16 or Form 16A, Agreement for Permanent Disability/Disfigurement Compensation, or by signing an Agreement and Final Release (clincher).

B. If each party is represented by an attorney, an appearance before a Commissioner is not required for approval of a settlement unless either party requests an informal conference, or the Commissioner schedules a hearing.

C. If the claimant is not represented by an attorney, the parties must appear before the Commissioner assigned to the claim at an informal conference for approval of the settlement. At the informal conference, the Commissioner will review the proposed settlement and may approve it if the Commissioner finds the settlement fairly made and in accordance with the provisions of the Act.

D. A Form 16 or Form 16A retains the claimant's right to request a hearing according to R.67–207 for additional benefits not later than one year from the date of the last compensation payment. By signing the Form 16 or Form 16A, the employer's representative does not agree it will make any additional payments in the future unless the form specifically provides otherwise.

E. An Agreement and Final Release (clincher) relieves the employer and its representative from any further responsibility for payment of compensation or medical expenses, unless the Agreement and Final Release specifically provides otherwise. When the claimant signs the Agreement and Final Release and it is approved, the claimant does not have the right to ask for additional payments in the future even if the claimant's medical condition worsens, unless otherwise specifically provided in the document.

F. An official copy of the settlement is approved and certified by the Commission as binding.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–802. Settlement, Form 16, Form 16A.

A. If parties agree to the terms of a Form 16 or Form 16A, the employer's representative completes a Form 16 or Form 16A by recording the claimant's compensation rate, the percent of disability agreed

upon, disfigurement, if any, and the number of weeks of compensation the claimant will receive. The form may be approved as follows:

(1) If the claimant is not represented by an attorney, the Form 16 or Form 16A must be approved at an informal conference.

(a) The employer's representative must request an informal conference by filing an updated Form 18 showing the status of payment of temporary compensation, if any, and medical expenses with the Commission's Judicial Department. For claims arising after July 1, 2007 a Form 14B is also required. The claimant may request an informal conference by writing to the Judicial Department.

(b) If the parties reach an agreement at the informal conference which the Commissioner approves, or the claims mediator recommends, the parties sign the agreement. (A Commissioner must approve a claims mediator's recommendation before the settlement is recorded as binding.)

(c) If the parties do not reach an agreement with which the Commissioner approves the Commission will set a hearing according to R.67–804I.

(2) If the claimant is represented by an attorney, the claimant, his or her attorney, and the employer's representative sign the Form 16 or Form 16A. The Form 16 or Form 16A may then be filed with the Commission for approval without an appearance before a Commissioner, as follows:

(a) The employer's representative files an original and one copy of the Form 16 or Form 16A with the Commission's Claims Department. The employer's representative shall file the Form 14B with the Form 16A for claims arising after July 1, 2007.

(b) A Commissioner reviews the Form and may approve the Form.

(c) If the Commissioner signs the Form approving it, the Claims Department records the settlement and returns an approved copy of the Form to the employer's representative.

(d) The employer's representative must provide the claimant a copy of the approved Form 16 or Form 16A.

(3) If the claimant is represented by an attorney, and the employer is represented by an attorney, a Form 16 or a Form 16A shall be filed with the Commission.

(a) The attorney for the employer's representative files an original and one copy of the Form 16 with the Commission's Claims Department. A Commissioner reviews the Form and may approve the Form.

(b) The attorney for the employer's representative files an original and one copy of the Form 16A with the Commission's Claims Department.

(c) The Commission's Claims Department reviews and records the settlement and returns an official copy of the Form to the attorney for the employer's representative.

B. The Commissioner may schedule an informal conference to discuss the terms of the settlement when necessary.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–803. Settlement by Agreement and Final Release.

A. If the parties agree to the terms of a settlement by entering into an Agreement and Final Release, the document shall include the following:

(1) The caption of the claim;

(2) A statement of the facts at issue;

(3) The date and nature of the alleged injury coinciding with the date and nature of each injury on the Form 12A, Form 50, or Form 52;

(4) The amount of the settlement and terms of payment; and

(5) The signature of the claimant, his or her attorney, if any, and the attorney for the employer's representative.

B. An Agreement and Final Release shall be approved as follows:

(1) If the claimant is not represented by an attorney, the Agreement and Final Release must be approved at an informal conference.

(a) The employer's representative must request an informal conference by filing an updated Form 18 showing status of payment of temporary compensation, if any, and medical expenses with the Commission's Judicial Department. For claims arising after July 1, 2007 a Form 14B is also required. The claimant may request an informal conference by writing to the Judicial Department.

(b) The attorney for the employer's representative and the claimant attend the informal conference. If the parties reach an agreement at the informal conference that the Commissioner approves, the Agreement and Final Release is signed by the claimant, the attorney for the employer's representative, and the Commissioner.

(c) The attorney for the employer's representative must provide the original and two copies of the Agreement and Final Release to the Commissioner at the informal conference. The Commission returns an official copy to the attorney for the employer's representative, and the attorney for the employer's representative shall provide the claimant a copy of the official Agreement and Final Release.

(d) If the Commissioner does not approve the Agreement and Final Release, the Agreement and Final Release is neither approved nor binding. The Commission will set the claim for hearing according to R.67–804I.

(2) If the claimant is represented by an attorney, the claimant, his or her attorney, and the attorney for the employer's representative sign the Agreement and Final Release. The Agreement and Final Release shall be filed with the Claims Department.

(a) The attorney for the employer's representative files the original and two copies of the proposed Agreement and Final Release with the Claims Department.

(b) An official copy of the Agreement and Final Release is returned to the attorney for the employer's representative.

(c) The employer's representative shall provide the claimant an official copy of the Agreement.

C. The Commission shall not approve an Agreement and Final Release that is not fairly made and in accordance with the Act. An approved Agreement and Final Release is binding. The employer's representative shall pay compensation according to its terms.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 24, Issue No. 4, eff April 28, 2000; State Register Volume 30, Issue No. 5, eff May 26, 2006; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–804. Informal Conference.

A. A claims mediator may appear on behalf of a Commissioner at an informal conference and review a proposed Form 16 or Form 16A settlement or review a R.67–505 or R. 67–506 request to certify a Form 17. A claims mediator may not appear on behalf of a Commissioner at an informal conference requested for review of a proposed Agreement and Final Release.

B. An informal conference is defined in R.67–202(8).

C. Request an informal conference as follows:

(1) File an updated Form 18 indicating the status of payment of temporary compensation, if any, and medical expenses and complete Section 6 by checking "yes."

(2) When a request for an informal conference is received, the Commission's file is reviewed for required reports. The employer's representative must assure the following reports are in the Commission's file before the informal conference is held or it may be subject to a fine.

(a) Form 14B, if applicable; and

(b) Form 15, if applicable; and

(c) Form 17, if applicable; and

(d) Form 20, if applicable; and

(e) All medical reports required by R.67–1301; and

(f) An authorized health care provider's report stating the claimant has reached maximum medical improvement and an impairment rating, if any; and

(g) An amputation chart, if applicable.

D. The claimant may request an informal conference by writing the Commission's Judicial Department and stating whether the parties propose to settle the claim on a Form 16, a Form 16A, or by Agreement and Final Release.

E. An informal conference may be held with less than thirty days notice to the parties. The conference shall be held at a hearing site as designated by the jurisdictional commissioner. If the parties request in writing to convene the conference in a different hearing site, all parties agree, and the letter is received before the conference hearing notice is issued, the request may be approved administratively.

F. Only the Commissioner assigned to the claim is authorized to approve a Form 16, a Form 16A, or an Agreement and Final Release.

G. When the claimant fails to appear at an informal conference, the Commission reschedules the conference.

(1) If the claimant fails to appear twice, the claim is taken from the informal conference roster and administratively dismissed.

(2) The claimant may request the Commission schedule another informal conference and the Commissioner assigned to the claim may, if a good cause is shown, allow the claimant to proceed with his or her claim.

H. If the employer's representative or an attorney, if any, fails to appear at the informal conference, the Commission reschedules the conference. The Commissioner assigned to the claim may impose on the employer's representative or an attorney, if any, the actual costs of the conference as established by the Commission.

I. If the parties fail to reach an agreement at the informal conference or the proposed Agreement and Final Release is not approved, the Commission will set the claim on the contested case hearing docket. A Form 50 or Form 52 is not required, but if filed, the opposing party must respond according to R.67–603.

J. Either party may request postponement of the informal conference by writing the Commissioner whose name appears on the informal conference notice or the Judicial Department. The Commissioner may reschedule the conference during the term the Commissioner is in the district. If the Commissioner cannot reschedule the conference during his or her term in the district, the Commission will reschedule the conference, unless otherwise provided.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996; State Register Volume 21, Issue No. 4, eff April 25, 1997; State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–805. Third Party Settlements.

A. The distribution of third party settlement proceeds must be filed with the Commission unless otherwise directed by a court of competent jurisdiction.

B. File the settlement documents with the Claims Department.

C. If the parties agree, third party settlements less than two thousand five hundred dollars do not need to be filed with the Commission.

D. If the claimant is not represented by an attorney, the third party settlement must be approved at an informal conference according to R.67–803B(1).

HISTORY: Added by State Register Volume 21, Issue No. 4, eff April 25, 1997. Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

ARTICLE 9
PROCEDURE FOR CLAIM INVOLVING A FATALITY

67–901. Notification that a Fatality has Occurred, Required.

A. The employer's representative must state on the Form 12A a fatality has occurred.

B. If after a Form 12A is filed the claimant dies, the employer's representative must notify the Commission's Claims Department by letter stating the date of death and whether the fatality is believed to be related to the earlier injury.

C. The Commission will notify the Second Injury Fund of reported fatalities.

67–902. Discovery of Beneficiaries.

A. The employer's representative must make a good faith effort to discover the decedent's beneficiaries.

B. The employer's representative shall attach to the Form 12A a list of the names, addresses, and ages of all known beneficiaries.

C. If the employer's representative discovers additional beneficiaries after the 12A is filed it shall immediately notify the Commission's Claims Department in writing of the beneficiaries names, addresses, and ages, if known.

67–903. Fatality, Statement on Liability Required.

A. When the Commission is notified a fatality has occurred, the Commission's Claims Department requests a statement from the employer's representative on liability.

(1) The employer's representative shall file a reply in writing with the Claims Department at least thirty days from the date of the Commission's inquiry.

(2) The letter must state the employer's position on liability and that all known beneficiaries have been reported.

(3) The Claims Department will send a copy of the letter to all reported beneficiaries and request from the known beneficiaries the names and addresses of any other beneficiaries.

(4) Failure of the employer's representative to respond may result in a fine imposed against the employer's representative. Failure to reply is deemed a denial of liability.

B. If the employer's representative determines upon good faith investigation there are no known beneficiaries, it may attach a Form 19 to the letter filed according to A above.

C. The file may be reopened by filing a Form 52 according to R.67-207.

67–904. Employer Accepts Liability, Procedure.

A. If the employer's representative accepts liability for a claim involving a fatality the Commission will automatically set a hearing to determine beneficiaries.

(1) The parties are notified of the date, time, and place of the hearing.

(2) A Guardian ad Litem must be appointed according to R.67-216.

(3) The amount of compensation due each beneficiary will be determined at the hearing.

B. The parties are not required to file a request for hearing. If a request for hearing is filed, the opposing party must respond as provided in R.67-603.

67–905. Employer Denies Liability, Procedure.

A. If the employer's representative denies liability of a claim involving a fatality, the claimant must request a hearing by filing a Form 52 according to R.67-207.

B. A Guardian ad Litem must be appointed according to R.67-216.

C. If a hearing is not requested by a claimant within sixty days from the date the notice in R.67-903 is mailed to the known beneficiaries, the employer's representative may file a Form 19 with the Commission's Claims Department.

D. The file may be reopened by filing a Form 52 according to R.67-207.

ARTICLE 10
OCCUPATIONAL DISEASE, PROCEDURE, AND WAIVER OF CLAIM

67–1001. Parties, Generally.

A. The proper parties in a claim involving an occupational disease are often a matter in dispute.

B. The claimant may request a report from the Commission of the insurers of an employer or employers at or during the period of alleged exposure. The period of alleged exposure must be provided for each employer.

HISTORY: Amended by State Register 34, Issue No. 2, eff February 26, 2010.

67–1002. Occupational Disease, Waiver of Claim.

A. A person affected by occupational disease who desires to continue in the same employment or to obtain new employment to which such disease is a hazard, may waive his or her right to further benefits for any incapacity or disability caused by an aggravation of the occupational disease in the same or new employment according to the following sections.

B. File a Form 65, Waiver of Claim Involving an Occupational Disease, and physician's statement with the Commission's Judicial Department at least ten days after signing the Form.

(1) The physician's statement must state the physician has examined the applicant, the nature, extent, and probable duration of the disease and an opinion as to whether or not the employee runs the risk of becoming partially or totally incapacitated due to the employment involved.

(2) The Judicial Department will notify the applicant, the employer, and the employer's representative of approval or disapproval of the form.

(3) The Commission's determination shall be deemed effective the date of filing the Form 65 with the Judicial Department.

C. The Commission may reject a Form 65 and recommend against the employment of an employee if the Commission concludes that to permit the employee to work in the employment will expose him or her to a hazard which may imminently render him disabled from an occupational disease.

D. An informal conference will be held with the applicant before the Commission rejects a Form 65.

ARTICLE 11
SCHEDULED LOSSES

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

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

B. This schedule of organs, members, and bodily parts lists prominent parts of the anatomy subject to occupational injury and is not complete. The value of an organ, member, or bodily part not included may be determined in accordance with the American Medical Association's "Guide to the Evaluation of Permanent Impairment", or any other accepted medical treatise or authority. Compensation shall be payable shall be payable for total loss, permanent partial loss, or loss of use of a member, organ, or part of the body when compensation is not otherwise payable.

C. For total loss, partial loss, or loss of use of an organ, member, or body part listed in this regulation, disability shall be deemed to continue for the minimum period specified, if applicable. In cases involving impairment and disability in excess of the minimum period specified for partial loss of or loss of use of an organ, member, or bodily part, compensation shall be payable in such proportion as disability bears to the maximum number of weeks provided in this regulation. The maximum period of compensation for a combination of injuries is the legislative criterion of five hundred weeks.

Organ, Member or Body Part	Total Loss	Partial Loss or Loss of Use
Breast	75	10–75
Breasts	250	25–250
Coccyx	10	1–10
Gall Bladder	75	10–75
Kidney	400	25–250
Lung	400	25–250

Organ, Member or Body Part	Total Loss	Partial Loss or Loss of Use
Pancreas	500	10–250
Rib	10	1 ½–10
(Maximum award of 200 weeks for total loss of 4 ribs)		
Scrotum and Testicles	350	30–300
Spleen	25	2 ½ -25
Testicle	75	10–75
Testicles	250	25–250
Tongue	500	50–500
Tooth	2	½ -2
Biliary Tract		75–400
Bladder		25–250
Brain		25–250
Bronchi or Bronchus		25–400
Esophagus		25–400
Cervix		10–100
Clavicle		10–100
Colon		25–250
Diaphragm		25–250
Duodenum		10–250
Fallopian Tubes		10–100
Heart		25–250
Intestine, Small		10–400
Larynx		25–400
Liver		25–250
Mandible		10–100
Ovaries		10–100
Palate		25–250
Penis		25–250
Prostate		10–100
Rectum		10–250
Scapula		10–200
Skin		5–300
Spermatic Cord		10–100
Sternum		10–100
Stomach		25–250
Thyroid Gland		10–100
Ureter		10–100
Urethra		10–100
Vagina		25–250
Vulva		25–250
Nasal Pasage		10–75
Olfactory Nerve		10–75
Sinus		5–30
Zygomatic Arch or Facial Nerve		
(In accordance with the AMA "Guides")		

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–1102. Loss of Hearing.

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

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

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

(2) The percent impairment for each ear is calculated by multiplying by 1.5% the amount that the above average hearing threshold level exceeds 25dB (low fence) up to a maximum of 100%, which is reached at 92dB (high fence).

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

67–1103. Amputation of Finger or Toe.

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

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

67–1104. Health Care for Injury Resulting in Hernia.

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

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

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

67–1105. Loss of Vision.

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

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

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

Notation for Distance	Notation for Near	Percentage of Visual Efficiency	Percentage of Vision
20/20	14/14	100.0	0.0
20/25	14/17/5	95.7	4.3
20/30	14/21	91.5	8.5
20/35	14/24.5	87.5	12.5
20/40	14/28	83.6	16.4
20/45	14/31.5	80.0	20.0
20/50	14/35	76.5	23.5
20/60	14/42	69.9	30.1
20/70	14/49	64.0	36.0
20/80	14/56	58.5	41.5
20/90	14/63	53.4	46.6
20/100	14/70	48.9	51.1
20/120	14/84	40.9	59.1
20/140	14/96	34.2	66.8
20/160	14/112	28.6	71.4
20/180	14/126	23.9	76.1
20/200	14/140	20.0	80.0
(80% loss of vision is considered 100% industrial blindness.)			
20/220	14/154	16.7	83.3
20/240	14/168	14.0	86.0

Notation for Distance	Notation for Near	Percentage of Visual Efficiency	Percentage of Vision
20/260	14/182	11.7	88.3

ARTICLE 12
ATTORNEY PRACTICE AND FEES

67–1201. Appearances Before the Commission.

A. In all contested cases before a single Commissioner and in all cases on Commission review, only attorneys licensed in South Carolina may practice before the Commission except as provide in section C below.

B. This regulation shall not be construed to prevent a party from representing himself or herself as otherwise allowed in this State.

C. An attorney licensed in another state may represent a party by associating himself or herself with an attorney licensed in South Carolina and receiving permission as provided below.

(1) The attorney may file a motion with the Commission's Judicial Department according to R.67-215.

(2) The motion must be limited to one case or proceeding and state the following:

(a) The state in which the attorney is licensed to practice and the names of the Bars with which the attorney is in good standing.

(b) That the attorney will represent the party until a final determination of the case or proceeding unless he or she is permitted to be relieved as counsel.

(c) The attorney agrees to be subject to the orders, disciplinary rules, proceedings, and jurisdiction of the Commission and the State of South Carolina as if the attorney were a member of the South Carolina Bar.

(d) The signature of an attorney licensed in South Carolina.

(e) A statement that the South Carolina attorney is licensed, in good standing, is associated with the moving attorney for the case or proceeding, is authorized to receive service, orders, and other forms and documents, and that the South Carolina attorney will appear with the moving attorney in Article 6 or Article 7 proceedings.

(3) Upon receipt of a motion, the Judicial Department will assign the motion to a Commissioner assigned the claim. The Commissioner may grant the motion without appearances by the attorneys or the parties.

67–1202. Attorney's Letter of Representation.

A. When an attorney is employed to represent a party before the Commission, the attorney must notify the Commission by writing the Commission's Judicial Department.

B. The attorney may notify the employer's representative.

C. If an attorney representing a claimant files a letter of representation with the Commission and at the same times files a claim as provided in R.67-206, the letter of representation must contain the information in R.67-206C(1) through (12).

(1) The Commission will notify the employer's representative a claim has been filed unless the letter states the employer's representative has been given a copy of the letter.

(2) The attorney may state in the letter the date the attorney was employed. If a date of employment is not included in a letter of representation, the date of the letter of representation is deemed the date of employment.

67–1203. Withdrawing Representation.

A. An attorney shall not withdraw as counsel without first obtaining an order from the Commission.

B. An attorney may withdraw as counsel on the showing of good cause. South Carolina Supreme Court Disciplinary Rules and the Common Law of this State define good cause.

C. An attorney may file with the Commission's Judicial Department a Motion To Withdraw As Counsel, according to R.67-215.

(1) A Form 61, Attorney Fee Petition, may accompany the motion.

(2) The Commissioner assigned the claim, or the Chair if a Commissioner has not been assigned the claim, will consider the motion.

(3) The Commissioner may on a showing of good cause, order the attorney relieved as counsel. If a Form 61 accompanies the motion, the Commissioner may issue an appropriate order allowing a fee or ordering the attorney's fee considered upon the final resolution of the claim.

67–1204. Reporting Attorneys Fees for Approval.

A. An attorney shall report and obtain approval of any fee for services rendered in a worker's compensation claim as follows.

B. When the parties agree to a fee based on an hourly rate and/or retainer the total amount of the fee shall be reported on the Form 19, filed according to R.67–414.

C. When the parties agree to a contingent fee contract, the attorney shall report the fee by filing the original and one copy of a Form 61, Attorney Fee Petition, and an Order, along with a stamped, self-addressed envelope with the Commission's Claims Department.

D. Upon receipt of a Form 61 and Order, the Order may be signed and a copy returned to the attorney when the fee calculation complies with R.67–1205.

E. The Commissioner may amend, sign, and return a copy of the Order. If the attorney disagrees with the Amended Order, the attorney may file a motion according to R.67–1205 with the Commission's Judicial Department. The motion may be heard according to R.67–215, unless the motion requests a hearing to present testimony or evidence.

F. If the Form 61 and Order do not comply with R.67–1205, the Commissioner reviewing the Form 61 and Order shall immediately schedule a hearing to consider argument of counsel and testimony, if any.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 24, Issue No. 4, eff April 28, 2000; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–1205. Determining a Reasonable Fee.

A. If the parties fix the fee by contract and base the fee on an hourly rate and/or a retainer, the fee is deemed reasonable unless it conflicts with the South Carolina Supreme Court Disciplinary Rule on determining reasonable fees.

B. If the parties agree to a contingent fee contract, the fee is deemed reasonable when the following requirements are met and the requested fee does not conflict with the South Carolina Supreme Court Disciplinary Rule on determining a reasonable fee.

(1) The attorney fully explains the fee agreement to the client and informs the client of the total dollar amount of the fee that will be deducted from the client's benefits; and

(2) The client agrees to the fee by signing a completed Form 61; and

(3) The attorney calculates the fee according to C below.

C. An attorney may charge up to, but not more than, 33.3% of the total amount of compensation, except in the following situations, where the attorney shall set the fee as instructed. When unusual circumstances exist, the attorney may attach to the Form 61 a short memorandum supporting approval of a fee calculated on an hourly rate or by quantum meruit.

(1) If the amount of compensation secured is derived from an impairment rating rendered by an authorized health care provider before the party employed the attorney, the attorney shall base the fee on the difference between the original impairment rating and the disability rating ultimately secured. The attorney shall include on the Form 61 the date the impairment rating was rendered, the percentage and the name of the rating physician. The fee shall not exceed 33.3% of the difference between the original impairment rating and the disability rating secured.

(2) If the attorney secures temporary compensation for a client on a Form 15, the attorney shall calculate the fee on the number of weeks that are past due at the time that the Form 15 is approved. The attorney may not charge a fee on temporary compensation that is due in the future. If the attorney secures the payment of permanent disability later, the attorney may charge, according to these regulations, up to but not more than 33.3% of the settlement or award.

(3) If the claim involves a fatality and the employer's representative does not contest liability, compensability or beneficiaries, the attorney may charge a fee up to but not more than two thousand five hundred dollars. If the claim involves a fatality and the employer's representative contests liability, compensability or a party disputes the status of the client as a beneficiary, the attorney may charge up to but not more than 33.3% of the settlement or award.

(4) If the claim involves lifetime compensation and the employer's representative does not contest liability or the claimant's entitlement to lifetime compensation, the attorney may charge up to but not more than two thousand five hundred dollars. When the claim involves lifetime compensation benefits and the employer's representative contests liability and/or the claimant's entitlement to lifetime compensation, the attorney's fee shall be considered on a case by case basis. The attorney shall attach to a Form 61, a Motion to Award Fee, according to R.67-215.

(5) If the attorney files or intends to file a Form 24, Lump Sum Application, for the client, the attorney shall base his fee calculation on the amount paid or payable to the client after the award or settlement is reduced to present day value.

(6) The combined fee of all attorneys for one party may not total more than 33.3% of the compensation. The Commissioner shall review jointly the motion for fee filed by a previous attorney for the client and the additional Form 61. The Commissioner assigned the claim shall indicate the portion of the fee approved for each attorney.

(7) When an attorney is employed after the employer's representative makes a written offer of settlement to the claimant, the attorney shall base his or her fee on the amount of compensation secured in excess of the settlement offer. The fee shall not exceed 33.3% of the difference between the offer of settlement and the amount of compensation secured.

D. If the claimant refuses to sign a Form 61, the attorney shall file the unsigned Form 61 and motion requesting a hearing which states the claimant refuses to sign the form. The Commission will notify the claimant by issuing a hearing notice according to R.67-213.

67–1206. Costs.

A. In addition to an attorney's contingent fee, an attorney may request approval of the actual costs incurred in the prosecution of a claim by attaching a statement of costs to the Form 61.

(1) The attorney waives the request for reimbursement of costs when he or she does not attach the statement to the Form 61.

(2) Costs include witness fees, expenses associated with the deposition of a witness, service costs, or expenses associated with the evaluation or treatment of the client.

B. If the attorney requests approval of costs not listed in A(2) above, the attorney must attach to the statement a copy of the employment contract. Additional costs may be allowed, in the commissioner's discretion, when the employment contract specifically states that the client agreed to pay the costs of phone calls, travel, copies, and other specifically stated expenditures.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992.

67–1207. Collection of Attorney's Fee in a Lump Sum.

A. If the claimant receives an award or settlement of more than one hundred weeks that is not to be paid in a lump sum, and there are not sufficient accrued weeks to satisfy the attorney's fee and costs, the attorney may request collection of the commuted value of his or her approved fee directly from the employer's representative

B. To request payment of the attorney's fee in a lump sum, file a motion for Lump Sum Payment of Attorney's Fee according to R.67-215 with the Commission's Judicial Department.

(1) Attach a completed Form 61 to the Motion. The Commission will commute the fee to present day value as provided below.

(a) The number of weeks to which the fee is equivalent is determined by dividing the approved fee by the claimant's compensation rate.

(b) The present day value of the weeks is determined according to the discount tables approved by the Commission.

(c) The present day value is multiplied by the compensation rate, resulting in the attorney's fee reduced to present day value.

(2) The amount of each payment the claimant receives shall not be altered or interrupted. The attorney's fee is deducted from the end of the award. The attorney may obtain a calculation of the commuted value of the attorney fee by writing the Commission's Claims Department.

(3) If the parties agree to pay the attorney in a lump sum, the attorney shall attach to the motion, a consent order containing the signature of the client and the employer's representative. If the parties do not agree to the payment in lump sum, the attorney shall request, in the motion, a hearing.

ARTICLE 13
MEDICAL REPORTS, PHYSICIAN'S FEES AND HOSPITAL CHARGES

67–1301. Medical Reports.

A. A medical practitioner or treatment facility shall furnish upon request all medical information relevant to the employee's complaint of injury to the claimant, the employer, the employer's representative, or the Commission. Payment for services rendered may be withheld from any medical practitioner or treatment facility who fails to comply with a request for this information.

B. The employer's representative shall submit to the Commission a report indicating the claimant's final rating of permanent impairment.

C. A health care facility and a health care provider may charge a fee for the search and duplication of a medical record not to exceed the fee published in the Medical Services Provider Manual.

HISTORY: Added by State Register Volume 14, Issue No. 9, effective September 2, 1990. Amended by State Register Volume 17, Issue No. 4, eff April 23, 1993; State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–1302. Maximum Allowable Payments to Medical Practitioners.

A. The Commission shall establish maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the Commission.

(1) The maximum allowable payments and any policies governing the billing and payment of services provided by medical practitioners shall be published in a medical services provider manual.

(2) The Commission may review and update the relative values and/or the conversion factor as needed.

B. Medical practitioners submit claims for payment to the employer or insurance carrier on the Form 14A.

(1) The Commission recognizes the Health Care Financing Administration Form 1500 (HCFA-1500) as its Form 14A for medical practitioners.

(2) Any narrative records or reports pertaining to the services rendered must be attached to the Form 14A and supplied at no charge to the employer or carrier.

C. An employer or insurance carrier may not pay, and a medical practitioner may not accept, more than the maximum allowable payment amounts listed in the provider manual.

D. Providers of general dental services, pharmaceuticals, durable medical equipment, and other medical products and services not covered by the medical services provider manual shall bill at the provider's usual and customary charge.

HISTORY: Added by State Register Volume 14, Issue No. 9, effective September 2, 1990. Amended by State Register Volume 17, Issue No. 4, eff April 23, 1993; State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67–1303. Payments for Hospital Inpatient Services.

A. The Commission shall maintain a prospective payment system based on diagnosis related groups with methodology and prices established by the Commission for the payment of inpatient hospital services.

(1) Hospitals submit claims for payment to the employer or insurance carrier on the Form 14A.

(2) The Commission recognizes the current uniform billing (UB) form as its Form 14A for hospitals.

(3) The employer or insurance carrier reviewing the claim for payment shall be entitled to a copy of the applicable hospital records at no charge.

B. The Commission may review and revise the prospective payment system as needed.

C. An employer or insurance carrier may not pay, and a hospital may not accept, more than the amount set by the Commission for inpatient hospital services.

HISTORY: Added by State Register Volume 14, Issue No. 9, effective September 2, 1990. Amended by State Register Volume 17, Issue No. 4, eff April 23, 1993; State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67–1304. Payments for Hospital Outpatient Services and Ambulatory Surgical Centers.

A. The Commission shall develop a prospective payment system for outpatient hospital services and services rendered by ambulatory surgical centers.

B. Until such time as the prospective payment system is operational the payments for hospital outpatient services and ambulatory surgical centers shall be set by the Commission based on a discount to the provider's usual and customary charge.

HISTORY: Amended by State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67–1305. Medical Bill Review.

A. Upon receipt of a medical claim, the employer or carrier shall review the bill for compliance with the policies and maximum payments set forth by the Commission.

(1) An employer or insurance carrier who reviews medical claims for payment must apply to the Commission for approval to review and reduce medical bills. An employer who is not an approved reviewer may solicit the services of an approved bill reviewer, but may not rely on the Commission for bill review services.

(2) In cases where the billing involves unusual or complex circumstances the bill may be sent to the Commission's Medical Services Division for initial review.

(3) Whenever a charge is reduced to the Commission's maximum allowable payment, the reviewer shall include on the explanation of benefits (EOB) form a statement which explains the reduction and indicates the provider's right to appeal the reduction as outlined in subsections B and C.

B. A medical provider who disagrees, based on Commission payment policy, with a reduction may appeal the decision directly to the payer/reviewing entity.

C. If the disagreement cannot be resolved between the provider and the payer/reviewer, the matter may then be referred to the Commission's Medical Services Division for review and resolution.

(1) A provider or reviewer may request a review by submitting to the Medical Services Division:

(a) A cover letter outlining the dispute and stating the requesting party's position regarding the correct payment;

(b) A copy of the bill;

(c) A copy of the explanation of benefits (EOB); and

(d) Any supporting documentation.

(2) The Medical Services Division shall review the bill and supporting documentation, using its medical consultant as needed, and shall make a determination regarding correct payment.

(3) The decision of the Medical Services Division shall be final.

D. Any medical provider who discovers an incorrect payment within two years of the original billing date may resubmit the claim to the payer for the correct payment.

E. Any payer who discovers an overpayment made to a provider within two years of the original billing date may request a refund from that provider.

HISTORY: Amended by State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67–1306. Medical Advisory Committees.

A. The Commission may convene advisory committees to make recommendations to the Commission on medical matters such as medical payment systems, rate setting methodology or other medical policy issues.

B. The advisory committees are convened at the Commission's discretion.

HISTORY: Amended by State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67–1307. Rehabilitation Professionals.

A. Rehabilitation professionals are coordinators of medical rehabilitation services, including but not limited to state, private, or carrier based, whether on site, telephonic, in or out of state.

B. The role of a rehabilitation professional is to ensure the primary concern and commitment in each workers' compensation case is to advance the medical rehabilitation of the injured worker.

C. A rehabilitation professional must comply with S.C. Section 42–15–95 and R.67–1308 when communicating with a health care provider who provides examination or treatment for any injury, disease, or condition for which compensation is sought. A rehabilitation professional shall possess one of the following certifications:

(1) Registered Nurse - RN;

(2) Certified Rehabilitation Counselor - CRC;

(3) Certified Registered Rehabilitation Nurse - CRRN;

(4) Certified Disability Management Specialist - CDMS;

(5) Certified Occupational Health Nurse - COHN; or

(6) Certified case manager - CCM.

D. Rehabilitation professionals shall be subject to the requirements, rules, regulations, and Code of Ethics specific to their license and certification.

HISTORY: Added by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–1308. Communication Between Parties And Health Care Providers.

A. A health care provider who provides examination or treatment for any injury, disease or condition for which compensation is sought under the provisions of this title may discuss or communicate an employee's medical history, diagnosis, causation course of treatment, prognosis, work restrictions, and impairments with the insurance carrier, employer, their respective attorneys or certified rehabilitation professionals or the Commission without the employee's consent.

B. The claimant must be:

(1) Notified by the employer, carrier or its representative requesting the discussion or communication with the health care provider in a timely fashion, but no less than ten days notice unless the parties agree otherwise. Notification may be oral or in writing.

(2) Allowed to attend and participate, along with claimant's attorney, if any.

(3) Advised by the employer, carrier or its representative requesting the discussion or communication prior to the discussion or communication.

(4) Provided a copy of the written questions at the same time the questions are submitted to the health care provider and provided a copy of the response by the health care provider.

HISTORY: Added by State Register Volume 34, Issue No. 2, eff February 26, 2010.

ARTICLE 14
ENFORCEMENT PROCEEDINGS

67–1401. Fines, Assessment and Review.

A. The Commission is authorized to assess fines as provided in this Chapter and the Act. The following provisions shall apply to the assessment and request for review of a fine against a party or its representative.

B. The department or division of the Commission charged with assessing the fine shall provide written notice of a failure to file a form and an assessment.

(1) Within thirty days of the date of service of the notice, the form must be filed and the assessment paid to the Commission. A request for a director's review of the assessment may be filed according to C below.

(2) Failure to file the form and make prompt payment of an assessed fine or to request review of the assessment as provided in C below shall result in an order issued.

C. Review of an assessment and possible abatement of a fine may be requested as follows:

(1) Set forth in writing the reasons for contesting the assessment.

(2) File the request with the Department or Division that issued the assessment as indicated on the notice within thirty days of service of the notice.

(3) The department or division director will review the request and may abate the fine if good cause is shown.

(4) The director will provide written notice to the party requesting review and set forth the reasons for the director's determination.

(5) If the director affirms the assessment, a hearing may be requested and shall be granted if timely filed according to E below.

D. Failure to file a written request for a director's review of an assessment of fine within thirty days of service of the notice shall constitute waiver of a director's review.

E. A request for an opportunity to be heard to show cause why the person or party assessed is not in violation of the provisions of this Chapter or the Act shall be granted if timely filed as provided below.

(1) Request a hearing in writing.

(2) File the request for a hearing with the department or division director who reviewed the assessment within fourteen days of director's determination as in C(5) above or fourteen days from the date of service of an order as in B(2) above.

(3) An Order and Rule to Show Cause will be issued to the party requesting a hearing according to R.67-1404.

HISTORY: Amended by State Register Volume 20, Issue No. 5, eff May 24, 1996.

67–1402. Unqualified Self-Insured Employer, Prosecution.

A. When it appears an employer is operating in violation of this Chapter and the Act by failing to provide proof of compliance with the insurance provisions of this Chapter and the Act, the Commission shall institute an investigation of the employer and its operations.

(1) An officer of the department is authorized to conduct the investigation.

(2) The officer shall gather information necessary to make a recommendation concerning the employer's compliance with the provisions of this Chapter and the Act.

B. If the officer determines an employer has complied with the provisions of this Chapter and the Act, the department's director shall issue an administrative order dismissing the investigation.

(1) An administrative order dismissing an investigation shall not deny a claimant an opportunity to proceed with the prosecution of a claim.

(2) If an investigation is dismissed, a claimant may request a hearing by filing a Form 50 or Form 52 according to R.67–207. The hearing will be conducted according to Article 6.

(a) A Commissioner assigned to the claim shall determine the issue of jurisdiction and the underlying claim at the request of the claimant.

(b) The parties have the right to review as in other cases.

C. If the officer determines that the employer is not in compliance with the provisions of this Chapter and the Act, the officer shall issue a citation to the employer stating the officer's findings of fact and conclusions.

(1) The citation may recommend a fine as provided in this Chapter and the Act.

(2) The citation and Compliance Agreement shall be served on the employer according to R.67–213.

D. The employer shall respond to the citation within fourteen days of the date of receipt of the citation.

(1) The employer may sign the Compliance Agreement and pay the fine as proposed, if any, or request the director's review of the citation.

(2) Failure to respond to the citation within fourteen days of receipt shall result in prosecution of the employer according to R.67-l404.

E. The employer may request the director's review of a citation by writing the Commission within fourteen days of the date of receipt of the citation.

(1) The department director shall review the citation, confer with the employer and issue a written determination of the director's findings and conclusions.

(2) If the employer disputes the director's findings and conclusions, the employer may request an opportunity to appear at a hearing before a Commissioner to show cause why it is not in violation with the provisions of this Chapter and the Act.

(3) An Order and Rule to Show Cause shall be issued to the employer according to R.67–1404.

F. A Compliance Agreement is evidence of voluntary compliance with the insurance provisions of this Chapter and the Act. By signing and filing a Compliance Agreement, the employer is not required to appear at a compliance hearing. The form is an agreement to the following:

(1) The Commission's jurisdiction; and

(2) The employer should have had worker's compensation insurance during the period stated in the Compliance Agreement but did not; and

(3) The employer will comply with the insurance provisions of this Chapter and the Act, or otherwise comply with the provisions of this Chapter and the Act; and

(4) The employer will defend any worker's compensation claims brought against it; and

(5) If the claim is found compensable the employer will comply with the reporting requirements of this Chapter and the Act; and

(6) The employer will make prompt payment of a claim found compensable under the Act .

G. When a final decision concerning jurisdiction is rendered the claimant may proceed with a claim for compensation by filing a Form 50 or Form 52 as provided in R.67–207.

HISTORY: Amended by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67–1404. Order and Rule to Show Cause, Hearings.

A. The Commission may issue an Order and Rule to Show Cause requiring an appearance before a Commissioner.

(1) An Order and Rule to Show Cause is served according to R.67-213.

(2) The hearing shall be convened at the Commission's offices located in Columbia, South Carolina unless otherwise provided by order of the Commission.

B. The party has the right to review as provided in Article 7.

C. Failure of a party to appear at a hearing after having been properly served with an Order and Rule to Show Cause shall constitute an admission of the allegations contained in the Order and Rule to Show Cause.

ARTICLE 15
SELF–INSURANCE

67–1501. Self-Insurance, Application.

A. An employer may apply to individually self-insure by filing a Form 7, Application To Individually Self–Insure, with the Commission's Self-Insurance Division and as follows.

(1) Complete and sign the Form 7 and attach to the form the following:

(a) A two hundred fifty dollar application fee; and

(b) A statement describing in detail the proposed claims administration program including the resume of each member of the claims administration staff if claims will be administered by the

employer, or a copy of the service contract and quote for service fee if claims will be administered by a third party claims administrator; and

(c) A description of an outside safety consultant program and annual fee, if any; and

(d) Three year's audited financial statements, audited according to generally accepted accounting principles, or a 10K report for each of the previous three years; and

(e) Quotes for excess insurance according to R.67–1503.

(2) In lieu of submitting audited financial statements, the sworn statement or affidavit of an independent auditor may be provided which verifies, based on financial ratios and guidelines set by the Commission, the financial condition of the employer.

(a) Upon application to self-insure, the Self-Insurance Division will provide the applicant with the following financial ratios to be used by the independent auditor. The ratios provided to the applicant will be at the twenty-fifth percentile for the applicant's industry and, if available, asset size will be obtained by the Self-Insurance Division from an independent financial information provider.

(1) Current Ratio. The current ratio is calculated by dividing total current assets by total current liabilities.

(2) Total Liabilities to Net Worth. Total liabilities to net worth is calculated by dividing total current liabilities and long term debt by net worth.

(3) Fixed Assets to Net Worth. Fixed assets to net worth is calculated by dividing fixed assets by net worth.

(4) Return on Sales. Return on sales is calculated by dividing net profit after taxes by annual net sales.

(5) Return on Assets. Return on assets is calculated by dividing net profit after taxes by total assets.

(6) Return on Net Worth. Return on net worth is calculated by dividing net profit after tax by net worth.

(b) The independent auditor must provide to the Self-Insurance Division a sworn statement or affidavit that the applicant has a net worth which equals or exceeds ten million dollars, that the applicant exceeds all six ratios, that the applicant's ratios are based on financial statements prepared according to generally accepted accounting principles and that the ratios were calculated according to R.67–1501 A(2)(a).

B. When a parent company applying to self-insure desires to include a subsidiary company in the parent's self-insurance program, the parent company shall attach to the Form 7 the following items in addition to the items in A(1)(a) through (e) above:

(1) A separate Form 7 and a Form 7A, Corporate Guaranty, for each subsidiary company.

(2) A one hundred dollar application fee for each subsidiary company.

C. When a subsidiary company applies to self-insure under a parent company's existing self-insurance program, the subsidiary company shall file a Form 7 as in A above and attach to the Form 7 the following items in addition to the items in A(1)(a) through (e) above:

(1) A Form 7A, Corporate Guaranty; and

(2) A one hundred dollar application fee.

D. When a subsidiary of a parent company desires to create its own self-insurance program, the subsidiary company shall file a Form 7, as in A above and attach to the Form 7 the following items, in addition to the items in A(1)(a) through (e) above:

(1) A Form 7A, Corporate Guaranty; and

(2) A two hundred fifty dollar application fee.

E. To apply for approval of a proposed self-insurance fund, an officer of the proposed fund shall file a Form 6, Application to Create a Self-Insurance Fund, with the Commission's Self-Insurance Division. The Form 6 must be completed, signed by an officer of the proposed fund, and have attached to it:

(1) A two hundred fifty dollar application fee; and

(2) A copy of the proposed fund's by-laws; and

(3) A current audited financial statement, audited according to generally accepted accounting principles, for each proposed member of the fund; and

(4) A list of the estimated standard premium collected by the fund, by month, for the first fiscal year; and

(5) An indemnity agreement which jointly and severally binds each member of the fund, signed by each proposed member; and

(6) A statement describing in detail the proposed claims administration program including the resume of each member of the claims administration staff if claims will be administered by the fund, or, a copy of the service contract and quote for service fee if claims will be administered by a third party claims administrator; and

(7) Quotes for excess insurance according to R.67–1503; and

(8) A completed Form 6A, Application for Membership in a Self-Insurance Fund for each employer applying for membership in the proposed fund. The proposed members of the fund must have a minimum combined total net worth of one million dollars.

(9) Fund investments shall be restricted to bonds, notes, or other evidence of indebtedness by the United States of America, or by an agency or instrumentality thereof, certificates of deposit in a federally insured bank, shares or savings deposits in a federally insured savings and loan association or credit union, certificates of deposit insured by a commercial bank duly chartered under the laws of this State, and other investments the Self-Insurance Division approves.

F. An employer may apply for membership in an existing self-insurance fund as follows.

(1) Qualify for membership in the self-insurance fund by:

(a) Operating a business similar in nature to the businesses in the fund; and

(b) Qualifying under the by-laws of the fund; and

(c) Being financially sound and have a net worth of not less than twenty-five thousand dollars.

(2) To apply for membership in a self-insurance fund, file a completed and signed Form 6A, Application for Membership in a Self-Insurance Fund, with the Commission's Self-Insurance Division and attach:

(a) A twenty-five dollar application fee; and

(b) A current financial statement.

G. The Self-Insurance Division will notify the applicant by letter if the application does not contain required information and attachments.

(1) The applicant shall complete the application process within one hundred and twenty days from the date of filing the application by providing requested information and documentation required above.

(2) Failure to complete the application process within one hundred and twenty days from the date of filing the application shall be deemed a voluntary withdrawal of the application.

(3) Further requests for approval to individually self-insure, to create a self-insurance fund, or to join a self-insurance fund shall be made by refiling the application and attaching the application fee and attachments provided above.

HISTORY: Amended by State Register Volume 19, Issue No. 7, eff July 28, 1995; State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998.

67–1502. Self-Insurance, Granting the Privilege and Providing Proof of Compliance.

A. Each application in R.67-1501 is reviewed by the Commission's Self-Insurance Division. The Commission may approve an application contingent on the applicant's filing the proper forms and documents evidencing proof of compliance.

(1) Proof of compliance consists of the following documents filed with the Self-Insurance Division.

(a) A copy of the excess insurance policy according to R.67-1503; and

(b) A Form 8, Proof of Compliance, Surety Bond, or a Form 8A, Proof of Compliance, Securities Pledge, or a Form 8B, Proof of Compliance, Memorandum of Understanding and Irrevocable Letter of Credit; and

(c) Proof of a reserve account, if applicable, according to R.67-1504; and

(d) Compliance with the terms and conditions for approval of the self-insurance program as ordered by the Commission.

(2) Commercial insurance must be continued until the forms as provided above are filed with the Commission's Self-Insurance Division and until the effective date of the self-insurance program as provided on the Form 9, Certificate for Self-Insurance.

B. The Self-Insurance Division notifies the applicant in writing of its recommendation to the Commission and the terms of the Commission's contingent approval, if any.

(1) The forms evidencing proof of compliance shall be filed at least sixty days from the date of the Commission's contingent approval.

(2) Failure to file proof of compliance provided in A above shall result in the administrative recision of the Commission's approval. The applicant may refile its application according to R.67-1501.

(3) The applicant may make a written request to the Self-Insurance Division for a sixty day extension of time to file the forms and documents evidencing compliance.

(4) Each form and document evidencing compliance shall be filed no later than one hundred twenty days from the date of the Commission's contingent approval.

(5) Failure to file the forms and documents evidencing proof of compliance at least one hundred twenty days from the date of contingent approval shall result in the administrative rescission of approval. The applicant may refile its application according to R.67-1501.

67–1503. Proof of Compliance, Excess Insurance.

A. Each self-insurer shall purchase specific excess insurance in an amount determined by the Commission. The Commission may also require a self-insurer to purchase aggregate excess insurance, in addition to specific excess insurance, depending on the self-insurer's financial condition, size, loss history, and exposure. The Self-Insurance Division will notify the self-insurer of the amount and type of excess insurance required.

B. Provide proof of excess insurance by filing a copy of the excess insurance policy with the Self-Insurance Division.

(1) The self-insurer may file an acceptable certificate of insurance, as proof of excess insurance coverage, in lieu of a policy, for the first forty-five days following approval to self-insure or a change in excess insurance carriers.

(2) The applicant shall file a copy of the excess insurance policy within the period in R.67–1502B.

C. The following provisions shall apply to excess insurance.

(1) The excess insurance shall be issued by a carrier licensed by the South Carolina Department of Insurance.

(2) The policy shall include as a named insured each subsidiary company in a parent company's self-insurance program, if any.

(3) The excess insurance policy shall include an endorsement that cancellation shall not be effective until after sixty days written notice to the Commission's Self-Insurance Division.

(4) Excess insurance shall be deemed continuous.

(5) Excess insurance may be cancelled only upon sixty days written notice to the Self-Insurance Division.

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1504. Proof of Compliance, Reserve Account, and Other Accounts.

A. Each proposed self-insurance fund shall establish a reserve account and other accounts as necessary. To provide proof of a reserve account, an officer of the fund shall file an affidavit with the Self-Insurance Division within the time provided in R.67-1502B.

(1) The affidavit shall state the name of the bank, the account number and the current account balance.

(2) The fund initially shall deposit into the reserve account not less than twenty-five percent of the first year's total estimated annual standard premium.

(3) The fund initially shall deposit into accounts other than its reserve account seventy-five percent of the first year's total estimated annual standard premium from which expenses may be paid.

(4) After the self-insurance fund's first year, the fund shall maintain the reserve at no less than twenty-five percent of the total estimated annual standard premium for all members of the fund.

B. The fund shall neither distribute nor pay a dividend from the reserve account or any part thereof to any member without approval of the Self-Insurance Division.

67–1505. Proof of Compliance, Surety Bond.

A. File a Form 8, Proof of Compliance, Surety Bond, with the Self-Insurance Division within the time provided in R.67–1502B. The amount of the bond is determined by the Commission based on an analysis of the total self-insurance program including but not limited to an analysis of the applicant's excess insurance, loss history, and financial condition.

B. The minimum bond amount is two hundred and fifty thousand dollars.

C. The following provisions shall apply to a bond.

(1) The bonding company must be licensed by the South Carolina Department of Insurance.

(2) The bond shall be deemed continuous beginning with the date of contingent approval of the self-insurance program and continuing until sixty days after a written notice of cancellation is reviewed by the Self-Insurance Division.

(3) When the Self-Insurance Division receives a bond cancellation notice, the self-insured is notified to replace the bond before the expiration of the original bond. The Commission shall institute revocation proceedings upon the failure to renew or replace the bond as described in R.67–1513.

D. When a self-insurer loses or withdraws its privilege of self-insurance, the bond remains with the Commission to guarantee payment of any claims occurring during the self-insured period.

(1) The Commission may release the bond, or any part thereof, when the Commission determines that all contingent liability arising during the period of self-insurance has expired.

(2) The employer or fund may request the release of a bond, or any part thereof, by writing to the Self-Insurance Division. The Self-Insurance Division shall notify the employer or fund of its administrative determination. If the employer or fund disagrees with the administrative determination, the employer or fund may request a hearing by filing a motion for a hearing according to R.67–215. The parties shall proceed according to Article 6.

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1506. Proof of Compliance, Securities Pledge.

A. The Commission in its discretion may accept a pledge of securities issued by this State or the federal government as proof of compliance instead of a bond or letter of credit.

B. The Commission shall determine the amount of securities required by R.67–1505A and shall notify the self-insurer of the amount.

C. The securities shall be held by a trust department of a South Carolina bank and pledged to the South Carolina Workers' Compensation Commission.

D. To pledge securities, the bank shall provide an acceptable safekeeping receipt.

(1) The bank safekeeping receipt must outline the details of the securities, and pledges the securities to the South Carolina Workers' Compensation Commission.

(2) File the bank safekeeping receipt with the Self-Insurance Division within the time provided in R.67–1502B.

E. When a self-insurer loses or withdraws its privilege of self-insurance, the securities remain pledged to the Commission to guarantee payment of any claim occurring during the self-insured period.

(1) The Commission may release the securities, or any part thereof, when the Commission determines that all contingent liability arising during the period of self-insurance has expired.

(2) The Commission may release the securities, or any part thereof, by notifying the bank holding the securities in trust to release the pledged securities.

(3) Request the release of securities or any part thereof by writing to the Self-Insurance Division.

(a) The Self-Insurance Division will notify the employer or fund of its administrative determination.

(b) If the employer or fund disagrees with the Commission's determination, the employer or fund may request a hearing by filing a motion for hearing, according to R. 67–215. The parties proceed according to Article 6.

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1507. Proof of Compliance, Irrevocable Letter of Credit.

A. The Commission in its discretion may accept a Form 8B, Proof of Compliance, Memorandum of Understanding and Irrevocable Letter of Credit, as proof of compliance instead of a surety bond or securities. The Commission will determine the amount as provided by R.67–1505A.

B. The applicant for self-insurance shall file the Form 8B with the Commission's Self-Insurance Division within the time provided in R.67–1502B.

C. The following provisions shall apply to a letter of credit.

(1) The letter of credit must be issued by a bank chartered in this State or a federally chartered bank with a branch office in this State.

(2) The bank shall offer the irrevocable letter of credit by completing a Form 8B.

(3) The South Carolina Workers' Compensation Commission shall be the named beneficiary.

(4) A proposed letter of credit must be approved by the Commission before the Commission issues a Form 9, Certificate for Self-Insurance.

D. Once an irrevocable letter of credit is established, it may be revoked only with the consent of the Commission.

(1) The Self-Insurance Division may grant consent only when the self-insurer offers proof of the purchase of a surety bond, pledges securities or obtains another irrevocable letter of credit.

(2) Expiration or cancellation of a letter of credit is effective only after sixty days written notice filed with the Self-Insurance Division.

(3) The self-insurer shall file notice of the replacement to the Self-Insurance Division in writing by certified mail.

(4) When the self-insurer fails to replace the letter of credit with another accepted proof of compliance, the Commission may demand payment of the letter of credit and deposit the proceeds in the South Carolina State Treasurer's Office to guarantee payment of any claim occurring during the self-insured period.

(5) The Commission may exercise the letter of credit at any time if the proceeds are needed for payment of a claim that occurred during the self-insured period.

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1508. Effective Date of R.67–1503.

A. Regulation 67-1503 shall not apply retroactively to a self-insurance program existing on or before the effective date of these regulations.

B. Self-insurance programs approved on or before the effective date of these regulations may continue to operate under the terms of the program previously approved but shall comply with all other provisions in this Chapter.

67–1509. The Self-Insurance Program, Amendments to and Renewal of.

A. The Commission may amend the self-insurance program when analysis of the program shows a significant change in the number of employees in the state, the financial condition, losses, the excess insurance program, management of funds, or in material conditions of the self-insured program.

(1) The self-insurer is notified in writing of the Commission's proposed amendment.

(2) If the self-insurer does not comply within a time period determined by the Self-Insurance Division, but not less than thirty days, the Self-Insurance Division may institute revocation proceedings according to R.67–1513.

B. The self-insurer shall report any proposed changes to its self-insurance program to the Self-Insurance Division.

(1) A change includes, but is not limited to, altering an endorsement or amending an excess insurance policy, any change to retention or limits of an excess insurance policy, any change in the carrier of a surety bond, pledged securities, or letter of credit, any change regarding a letter of credit, replacement of matured securities, or changes in the by-laws of a fund.

(2) The Self-Insurance Division may administratively approve a proposed change determined not a material or substantial change to the program.

(3) If a change in a self-insurance program is determined to affect the self-insurance program materially, the Self-Insurance Division may request the self-insurer to comply with the program as approved. The self-insured may request the Commission's approval of a change in the program by writing the Self-Insurance Division.

(4) If the self-insurer refuses or neglects to continue a self-insurance program according to the terms approved by the Commission, the Self-Insurance Division may institute revocation proceedings according to R.67–1513.

C. The self-insurer shall report a renewal of existing excess insurance policies to the Self-Insurance Division. When the renewal is with the same carrier, the self-insurer may report the change by filing an acceptable certificate of insurance. When the self-insurer changes carriers, the self-insurer shall file a copy of the policy as required in R.67–1503B(1).

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1510. Financial Analysis and Reports.

A. A self-insured employer shall file audited financial statements, prepared in accordance with generally accepted accounting principles, or the United States Securities & Exchange Commission's Form 10K with the Self-Insurance Division within ninety days following the close of each fiscal year for analysis of the self-insurer's financial condition. In lieu of audited financial statements, a self-insured employer may provide the sworn statement or affidavit from an independent auditor as provided in R.67–1501A(2).

B. Each self-insurance fund shall file with the Self-Insurance Division a Form 11, Self-Insurer's Quarterly Financial Report, or equivalent financial report, immediately after each quarter of its fiscal year. Each self-insurance fund also shall file with the Self-Insurance Division audited financial statements, prepared in accordance with generally accepted accounting principles within one hundred twenty days following the close of each fiscal year.

C. A sixty day extension of time in which to file a Quarterly Financial Report or Annual Audited Financial Statements may be requested by writing the Self-Insurance Division.

D. Failure to file timely the forms referred to above may result in the institution of revocation proceedings.

HISTORY: Amended by State Register Volume 19, Issue No. 7, eff July 28, 1995; State Register Volume 22, Issue No. 6, Part 3, eff June 26, 1998; State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1511. Audits.

A. The Self-Insurance Division or its representative may audit the self-insured employer and self-insurance fund. The audit may include examination of evidence supporting the information filed on the Form 10, Self-Insurance Tax Return, Form 11, Self-Insurer's Quarterly Financial Report, Form

11A, Self-Insurer's Annual Financial Report, financial reports, claims administration, fund membership, and an evaluation of the financial condition of the self-insurer.

B. The Commission may request additional documentation to support the information reported on the above referenced forms. If the Commission determines that the self-insured or self-insurance fund is financially unqualified to continue its privilege of self-insurance, the Commission may institute revocation proceedings in accordance with R.67–1513.

HISTORY: Amended by State Register Volume 30, Issue No. 5, eff May 26, 2006.

67–1512. Voluntary Withdrawal from a Self-Insurance Program and Cancellation of a Member's Self-Insurance Privileges.

A. A self-insured employer may withdraw its privileges to self-insure by notifying the Self-Insurance Division in writing of its intent to withdraw. Withdrawal shall not be deemed effective until thirty days after the date the Self-Insurance Division receives notice of intent to withdraw.

B. A member of a self-insurance fund may withdraw from a fund by the fund's notice to the Self-Insurance Division in writing of the members intent to withdraw. Withdrawal is not effective until thirty days after the date the Self-Insurance Division receives the written notice of intent to withdraw.

C. A self-insurance fund may cancel a member's self-insurance privileges by notifying the Self-Insurance Division in writing of its intent to cancel membership. Cancellation shall not be deemed effective until thirty days after the date the Self-Insurance Division receives notice of cancellation. Membership in a fund may be reinstated, without a lapse in coverage, by notifying the Self-Insurance Division in writing of renewal. Notice of renewal must be filed with the Self-Insurance Division at least thirty days from the date of the notice of cancellation to avoid a lapse in coverage, unless the letter states the reinstatement is retroactive.

D. The Commission may assess a penalty of not less than one hundred dollars but not more than two hundred and fifty dollars for the refusal or neglect to notify timely the Self-Insurance Division of the intent to withdraw and cancellation.

67–1513. Revocation Proceedings.

A. The Commission institutes revocation proceedings by Order and Rule To Show Cause.

B. The self-insurer or self-insurance fund shall be afforded an opportunity to be heard and the right to review as in other cases.

67–1514. Self–Insurance Tax.

A. Each self-insured employer and each self-insurance fund shall file a Form 10, Self-Insurance Tax Return, and make payment of its tax liability according to the Act.

B. The Commission may assess a penalty and institute revocation proceedings for failure to pay the tax within fifteen days of its due date as required by the Act.

C. A sixty day extension of time in which to file a Form 10 may be requested in writing before the Form 10 is due. An extension of time in which to file the Form 10 may be granted by the Self-Insurance Division provided the estimated tax liability is paid at the time of the request for an extension is made.

D. If an employer or fund withdraws its self-insurance privileges, self-insurance privileges are revoked, or an employer or fund ceases to operate, the self-insured or the self-insurance fund shall continue to file the Form 10 for a minimum of three years and continue to file the Form 10 until notified by the Self-insurance Division that there exist no other contingent liabilities arising during the period of self-insurance and the Form 10 is no longer required to be filed.

67–1515. Confidentiality of Information.

A. Records and information concerning the solvency and financial condition of an employer acquired by the Commission under the authority granted by this Chapter and the Act shall not be subject to inspection nor shall any information in any way be divulged by the Commission or any of its members unless by order of a Court.

B. The Commission shall not release to the public any information concerning a self-insured or a self-insurance fund other than confirmation that an employer is individually self-insured or is a member of a specific self-insurance fund, its address, the effective date of the such insurance program, and the name of the claims administrator.

67–1516. Municipalities and Political Subdivisions.

A. An application of a municipality or political subdivision shall be approved without submission of proof of financial ability and without deposit of bond or other security.

B. Assurance must be provided that provisions shall be made for payment of all awards for compensation, medical fees and burial expenses available under the Act.

C. As proof of the assurance in B above the Commission will accept a copy of the municipality's or political subdivision's annual budget or a letter signed by each member of a council.

ARTICLE 16
AVERAGE WEEKLY WAGE, COMPENSATION RATE, AND PAYMENT

67–1601. Expenses Incurred in Receiving Medical Treatment, Reimbursement.

A. The expenses incurred for travel to receive medical attention which shall be reimbursed to the claimant are:

(1) Mileage to and from a place of medical attention which is more than five miles away from home in accordance with the amount allowed state employees for mileage; and

(2) Actual cost of expenses incurred in using public transportation; and

(3) Actual cost of reasonable overnight lodging and subsistence.

B. The claimant shall receive reimbursement from the employer's representative.

67–1602. Payment of Compensation.

A. The employer's representative shall pay all compensation directly to the claimant or guardian, unless otherwise ordered by the Commission.

B. The employer's representative may make a check payable to the claimant and the claimant's attorney, as allowed according to an approved Form 61, Attorney Fee Petition, or by order of the Commission.

C. The employer's representative shall make each payment in the form of a check. Payment to a person other than as directed above shall not acquit, protect, or discharge the employer or its representative for the payment due.

D. The claimant may request a hearing to assess a penalty and, or, interest for late payment by filing with the Commission's Judicial Department a motion to increase compensation payments according to R.67-215.

HISTORY: Amended by State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–1603. Calculating the Compensation Rate.

A. The employer's representative shall calculate the claimant's compensation rate by completing a Form 20, Statement of Earnings of Injured Employee. When using a Form 20 results in a compensation rate that is not fair and just to either the employer or the claimant, an alternative method of computing the average weekly wage may be used which will most nearly approximate the amount the injured employee would be earning were it not for the injury.

B. Wage information shall be provided by the employer. The employer shall report gross wages, not net, and shall include gross pay allowed for vacations, bonuses, overtime, and allowances of any character made to an employee in lieu of wages as specified in a wage contract.

C. Completion of Form 20 for claims involving temporary compensation.

(1) The employer's representative shall prepare a Form 20 and serve the claimant a copy of the Form 20 according to R.67-211 within thirty days after temporary compensation begins.

(2) If the claimant disagrees with the compensation rate on the Form 20, he or she should contact the employer's representative in an effort to reconcile the differences. If a fair and just amount cannot be agreed upon, the employer's representative shall refer the question to the Commission's Claims Department for an administrative recommendation. If the claimant does not agree with the administrative recommendation, the claimant may request a hearing to determine the correct compensation rate by filing a Form 50 according to R.67-207.

(3) When the compensation rate on the Form 20 differs from that previously reported on the Form 15, the employer's representative shall adjust temporary compensation payments to reflect the compensation rate on the Form 20. The employer's representative shall file and serve a new Form 15 according to R.67-503 within thirty days. Check "corrected compensation rate" on the new Form 15.

(a) When the compensation rate on the Form 20 is higher than previously reported on the Form 15, the employer's representative immediately shall pay the accrued compensation to the claimant and begin paying the claimant the revised compensation rate.

(b) When the compensation rate on the Form 20 is less than previously reported on the Form 15 and:

(i) The claimant agrees to the reduction, the employer's representative may deduct no more than twenty-five percent from the weekly payments to recover the overpayment. The employer's representative may not stop temporary compensation payments unless otherwise ordered by the Commission.

(ii) During the first one hundred fifty days, when the claimant does not agree to the reduction, the employer's representative shall adjust the compensation rate to that reported on the Form 20. The claimant may request a hearing by filing a Form 50 according to R.67-207.

(iii) After the first one hundred fifty days, when the claimant does not agree to the reduction, the employer's representative shall continue paying the compensation rate reported on the Form 15 and may file a Form 21 to request a reduction in compensation.

D. Completion of Form 20 when no temporary compensation has been paid.

(1) The employer's representative shall prepare and file with the Judicial Department a Form 20 with its request for an informal conference or hearing when no Form 15 or Form 20 has been previously filed or when salary is paid in lieu of temporary compensation. The employer's representative shall serve the claimant a copy of the Form 20 according to R.67-211.

(2) The employer's representative shall prepare and file a Form 20 with the Judicial Department within thirty days of the claimant's request for a hearing or informal conference when no Form 15 or Form 20 has been previously filed or when salary is paid in lieu of temporary compensation. The employer's representative shall serve the claimant a copy of the Form 20 according to R.67-211.

E. When the parties stipulate the maximum compensation rate applies, the employer's representative shall complete Section C of the Form 20. File and serve the Form 20 as set forth above.

F. The employer's representative may use an alternative method to calculate the compensation rate when the Form 20 results in a compensation rate that is not fair and just to the claimant or the employer's representative. The employer's representative shall complete Section A(1)(4) of the Form 20 and calculate the compensation rate by the alternative method. Serve the Form 20 on the claimant according to R.67-211 within the times set forth above and attach documentation to the Form 20 showing how the compensation rate was calculated. Refer to section C(2) above when the claimant does not agree with the calculated compensation rate.

G. Failure to file and/or serve the Form 20 as set forth above may result in a fine and/or the commissioner or claims mediator determining the average weekly wage and compensation rate from information in the Commission's file and statements or evidence presented at the hearing or conference.

H. If the claimant alleges he or she worked for two or more employers when the injury occurred, the claimant may request the additional wages be included as part of his or her average weekly wage. The claimant shall obtain a completed Form 20 from each of the other employers and file the Forms 20 with the Claims Department. The claimant shall provide a copy of each Form 20 to the employer's representative. The Commission will calculate the new compensation rate and notify the parties. If the

employer's representative does not agree to pay the new compensation rate, the claimant may request a hearing to determine the proper compensation rate by filing a Form 50 pursuant to R.67-207.

HISTORY: Amended by State Register Volume 16, Issue No. 4, eff April 24, 1992; State Register Volume 21, Issue No. 4, eff April 25, 1997.

67–1605. Lump Sum Payment.

A. The employer's representative shall pay, in lump sum, a settlement or award which is less than one hundred weeks. When a settlement or award is more than one hundred weeks, the Hearing Commissioner may order a lump sum payment or the claimant may request a lump sum payment by filing a Form 24, Application for Lump Sum Payment.

B. If the claimant is not represented by an attorney, the claimant may request lump sum payment by filing a Form 24 with the Commission's Claims Department. The department will contact the employer's representative to inquire if it consents to payment in lump sum.

C. An attorney for the claimant must request the employer's consent to payment in lump sum payment prior to filing a Form 24.

(1) If the parties agree to payment in lump sum, the claimant's attorney may file with the Claims Department a Form 24 and attach to the Form 24 a signed agreement for payment in lump sum.

(2) If the employer's representative does not consent to payment in lump sum, the claimant's attorney may file a Form 24 with the Claims Department and attach a letter stating that the insurance carrier does not consent to the lump sum payment.

(3) The Commission will automatically set a hearing. The parties will be notified according to R.67–607.

D. If the employer's representative consents to payment by lump sum, the Claims Department forwards the Form 24 to the original Hearing Commissioner who reviews the Form 24 and may approve the Form 24 without the appearance of the parties.

(1) If the Commissioner approves the Form 24, he or she signs the Form 24 and the Claims Department commutes the award or settlement to present day value as provided in E below.

(2) The employer's representative is notified of the amount of the lump sum payment.

(3) If the Commissioner does not approve the Form 24, a hearing will be set automatically and the parties notified according to R.67–607.

E. Unless a Commissioner orders otherwise, or unless the settlement or award is less than ten weeks, the insurance carrier receives a discount for payment in lump sum.

(1) To determine the discount, the Commission subtracts the number of weeks already paid from the total number of weeks as awarded.

(2) Weeks that have accrued but are not paid at the time of the commutation are not included in the calculation.

(3) Three weeks of compensation are accrued into the future to allow for processing the Form 24 and issuing the check to the claimant.

(4) The number of accrued weeks are deducted from the total number of weeks due the claimant, resulting in the number of weeks commuted.

(5) The present worth of the remaining weeks is determined according to the discount tables designated by the Commission.

(a) Each installment yet to accrue of the first one-hundred weeks of the award shall be discounted at a rate of two percent. The Commission shall publish a present value table showing the conversion factors for zero through one-hundred weeks.

(b) Each installment yet to accrue of weeks one-hundred and one through five-hundred shall be discounted at the yield-to-maturity rate of the Five Year U.S. Treasury Note as published on the first business day after January 1st each year, but in no case shall the discount rate exceed six percent or be less than two percent. The Commission shall publish a present value table showing the conversion factors for weeks one-hundred and one through five-hundred on the first business day following January 1st of each year. The present value table for weeks one-hundred and one through five-hundred published on the first business day following January 1st shall apply to all

awards made during the year and until a new present value table is published the following year. The present value of the commutable weeks shall be determined based on the present value tables in effect on the date of the award or settlement.

(c) In the event the Commission makes an award of a partial lump sum in excess of five-hundred weeks in accordance with S.C. Code § 42-9-10(C) and § 42-9-10(D), the discount rate shall be determined on a case by case basis.

(6) Multiplying the present worth of the weeks by the claimant's compensation rate results in the commuted value of the remaining weeks.

(7) Adding the value of the accrued weeks to the commuted value of the remaining weeks results in the total amount due the claimant.

F. The dollar value of a lump sum payment may be requested by writing the Claims Department.

HISTORY: Amended by State Register Volume 38, Issue No. 6, Doc. No. 4399, eff June 27, 2014.

67–1606. Lump Sum Payment in a Claim Involving a Fatality.

A. When the Commissioner orders or approves a lump sum payment to whole dependent(s), the accrued weeks are subtracted from the number of weeks awarded.

(1) The present worth of the weeks remaining is calculated and multiplied by compensation rate to obtain the commuted value.

(2) Adding the commuted value to the accrued value results in the total amount to be paid. This amount is divided proportionally among the dependents as ordered.

(3) Burial expenses are payable in addition to the five hundred weeks and are not commuted.

B. When the Commissioner orders or approves a lump sum payment to partial dependent(s), the number of accrued weeks of compensation is determined and multiplied by the proportion of the compensation rate awarded to the partial dependent resulting in the accrued weeks the partial dependent receives.

(1) Subtract the total accrued weeks from the number of weeks awarded.

(2) The present worth of the weeks remaining is calculated and multiplied by the proportion of the compensation rate payable to that partial dependent. The partial dependent is paid its proportional commuted amount plus the accrued amount allotted.

(3) The present worth of the total award is multiplied by the remaining portion of the compensation rate to obtain the commuted value of the remainder of the award. From the commuted value, the entire funeral expenses are deducted. The employer's representative pays the remaining amount as ordered.

C. When the Commissioner orders payment to nondependent children, multiply the present worth of the award by the compensation rate to obtain the commuted value of the award.

(1) Subtract the entire amount of the funeral bill from the commuted amount.

(2) The employer's representative pays the amount remaining as ordered.

D. When the Commissioner orders payment to the mother and, or, father, multiply the present worth of the award by the compensation rate to obtain the commuted value of the award. Subtract the entire amount of the funeral bill from the commuted amount. The employer's representative pays the amount remaining to the mother and father, divided equally.

E. When the Commissioner finds the deceased had no dependents, nondependent children, or mother or father, and orders payment to the Second Injury Fund, the burial expenses and the costs of administration of the deceased's estate are deducted from the total amount of the award. The remaining amount is commuted by dividing the amount of money remaining by the compensation rate to obtain the number of weeks remaining. The present worth of the weeks remaining is determined and multiplied by the compensation rate to obtain the commuted value. The employer's representative pays this amount to the Second Injury Fund, as ordered.

F. Refer to Section 42-9-320 for the payment of benefits to a minor child. Refer to the Probate Code of this State for payment in excess of ten thousand dollars. A conservator must be appointed for receipt of benefits.

Article 17
Repeal and Adoption

67–1701. Repeal of Existing Regulations and Adoption of Articles 1 through 17, Inclusive.

A. Existing Regulations 67-1 through 67-38, inclusive, are repealed effective ninety days from the date of the General Assembly's approval of the adoption of Chapter 67, Article 1 through Article 17, inclusive.

B. The Regulations in Chapter 67, Article 1 through Article 17, inclusive, shall apply to claims filed, claims pending review, and requests for review filed on and after ninety days from the date of the General Assembly's approval of the adoption of Chapter 67, Article 1 through Article 17, inclusive.

Article 18
Mediation

67–1801. Mediation.

A. This mediation regulation is established to resolve disputes without the necessity of a hearing. The purpose is to afford a meaningful opportunity to the parties to achieve an efficient and a just resolution of their disputes in a timely and a cost-effective manner.

B. A Commissioner has the discretion to order mediation in any pending claim before the Commissioner and to select a duly qualified mediator.

(1) A Commissioner must retain jurisdiction of the claim solely for those issues being mediated.

(2) A Commissioner does not retain jurisdiction of the claim for the life of the claim, unless the Commissioner so chooses, only until those pending issues are resolved.

(3) A Commissioner's authority to order mediation in any pending claim is not limited by claims listed in Section 67–1802.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1802. Mediation Required with Certain Claims.

A. It is ordered by the Commission that claims arising under Section 42–9–10, or claiming permanent and total disability pursuant to Section 42–9–30 (21), occupational disease cases, third-party lien reduction claims, contested death claims, mental/mental injury claims, and cases of concurrent jurisdiction under the South Carolina Workers' Compensation Act and the Federal Longshore and Harbor Workers' Compensation Act must be mediated prior to a hearing.

(1) In contested death claims, a Commissioner must still make a finding that a good faith dependency investigation has been completed.

(2) Except for contested death claims, all claims listed in this section would apply only to claims where compensability of the accident is admitted by the employer/carrier.

(3) Claims involving multiple employees arising out of employment with the same Employer, whether or not compensability has been admitted, shall be subject to a scheduling order and shall be mediated prior to a hearing. Participation in mediation in no way constitutes an admission of compensability at any subsequent proceeding.

(4) Unless an unrepresented claimant requests that the claimant's case be mediated, the Commission shall enter an order dispensing with mediation.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1803. Mediation Requested by Parties.

The parties may request mediation by the proper submission of a Form 21, Form 50, Form 51, or the response to the Form 21, indicating a request for mediation. Except as provided in section 67–1802 A, either party may object to mediation by the proper submission of the Form 21, Form 50, or the

response to the Form 21. If the parties do not agree to mediation, pursuant to this section, then the case shall be set by the Judicial Department in the normal course of the docket scheduling.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1804. Selection of Mediator and Required Schedule.

A. The parties may consent to use any mediator who is duly qualified. The mediator must be certified as a mediator per the certification process established by the South Carolina Bar Association.

B. The parties must select a mediator within ten days of the filing of the Form 51 or the response to the Form 21, and must promptly notify the Commission of the mediator and proposed mediation date.

C. The mediation must be completed within sixty days of the filing of the Form 51 or the response to the Form 21, unless otherwise agreed to by the parties. If the mediation is not completed within the sixty day timeframe then the case shall be set by the Judicial Department in the normal course of the docket scheduling.

D. If the parties cannot agree on a mediator, the Commission shall appoint a duly qualified mediator for them.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1805. Parties Represented.

In addition to their attorney being present, each party shall provide a representative, who shall attend the mediation in person or via telephone. The representative shall have authority to enter into negotiations, in good faith, to resolve the issues in dispute. If the representative attends via telephone, they shall be available by telephone for the duration of the mediation. Reasonable notice shall be provided to the opposing party concerning attendance via telephone, prior to the mediation. This regulation does not prevent a claimant from proceeding pro se.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1806. Mediation Communications Confidential.

A. All communications and statements that take place within the context of mediation shall be confidential and not subject to disclosure. Such communications or statements shall not be disclosed by any mediator, party, attorney, or attendee and may not be used as evidence in any proceeding. An executed agreement resulting from mediation is not subject to the confidentiality requirements described above.

B. Neither the mediator nor any third-party observer may be subpoenaed or otherwise required to testify concerning a mediation or settlement negotiation in any proceeding. The mediator's notes shall not be placed in the Commission's file, shall not be subject to discovery, and shall not be used as evidence in any proceeding.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1807. Expense of Mediation.

The parties shall share the cost of mediation equally, unless otherwise agreed by the parties, or as otherwise ordered by the Commission.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1808. Penalties.

Any party who refuses or neglects to act in good faith during the mediation may be subject to a fine not to exceed the actual cost of the mediation. Any party who believes this provision has been violated may file a Motion for a Rule to Show Cause before the jurisdictional Commissioner for purposes of assessing fines and penalties. The parties shall have the right of review and appeal as in other cases.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.

67–1809. Forms Required Upon Completion.

A Form 70 shall be filed by the Mediator with the Judicial Department at the conclusion of the mediation. A Form 70 shall not become a part of the Commission's file and will solely be used for tracking purposes.

HISTORY: Added by State Register Volume 37, Issue No. 6, eff June 28, 2013.