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North Carolina Workers' Compensation Case Law Update

August 1, 2017 – August 7, 2018

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N.C.G.S. § 97-2 – Injury by Accident/Arising Out of/in the Course of Employment

A. *Cohen v. Franklin Cty. Sch.*, ___ N.C. App ___, 814 S.E.2d 610 (April 2018) (Davis, J.) (Injury by Accident; Stroke During Meeting with Supervisor)

FACTS:
Plaintiff was hired by Defendant to work as a full-time math teacher at Early College High School. Each teacher at Early College was required to create an individual PDP [Professional Development Plan] at the beginning of the year that stated their goals and also a plan as to how to accomplish those goals with an associated timeline. As part of her employment, Plaintiff underwent periodic classroom observations and was evaluated by the school principal, James A. Harris, Jr. Pursuant to his duties as the school principal, Harris would normally conduct "three observations with an evaluation" for each teacher throughout the course of the year. In 2013, Harris received complaints with regard to Plaintiff's teaching. He then prepared an observation and a principal-directed PDP to go over with Plaintiff. He asked a director of secondary education to sit in on the meeting because he did not think Plaintiff would take it well. The meeting did not go well and Plaintiff refused to sign the PDP and asked for a sheet of paper to instead write that she had been pushed to sign the PDP without reading it.

Plaintiff testified that at some point during the meeting she began to experience "horrible head pain" and felt as though "her head was going to blow up." She was seen by Dr. Richard Noble, an internist, and later that same day she was examined by Dr. Mitchell Freedman, a neurologist at Duke Health. It was determined that Plaintiff had suffered a stroke.

Plaintiff initiated a workers' compensation claim, which Defendants denied pursuant to a Form 61. Following a hearing, the Deputy Commissioner issued an Opinion and Award determining that Plaintiff's meeting was "an ordinary incident of employment constituting circumstances common to employees in any profession. There was nothing unexpected or unusual with regard to the way the meeting was arranged or conducted," and he concluded that Plaintiff "did not experience an unlooked for and untoward event . . . [and] did not suffer an injury by accident within the meaning of the North Carolina Workers' Compensation Act." Plaintiff appealed to the Full Commission, who issued an Opinion and Award affirming the Deputy Commissioner's decision and denying Plaintiff's claim for benefits. Plaintiff appealed.

ISSUE:
Whether the Commission erred in determining that Plaintiff did not suffer an injury by accident within the terms of the Workers' Compensation Act after suffering illness allegedly resulting from a meeting with her supervisor.

HOLDING:
No. The Court held that even though a higher-level superior sat in on Plaintiff's meeting with her principal, Plaintiff was asked to sign a PDP drafted by the principal, Plaintiff left the contentious meeting without signing the PDP, and the headache Plaintiff said she developed during the meeting turned out to be a symptom of a stroke; Plaintiff had not shown that she suffered an "accident" for purposes of a

workers' compensation claim. Finally, the Court held that at most, Plaintiff received critical feedback that was unwelcome to her – an occurrence that is not unusual for an employee at any job.

B. *Brooks v. City of Winston-Salem*, ___ N.C. App. ___, 816 S.E.2d 260 (May 2018) (Davis, J.) (Causation; Arising Out of Employment; Fall from Work Truck; Blackout)

FACTS:
Plaintiff was employed by Defendant as a senior crew coordinator in the City of Winston-Salem's Utilities Department. On the day of Plaintiff's injury, he purchased an electronic cigarette during his lunch break and smoked it in Defendant's vehicle. As he ignited the e-cigarette, he began coughing uncontrollably. He opened the vehicle door and stepped out of the truck before he passed out and fell, landing on the cement curb. His fall caused injury to his right hip, back, and head.

The Deputy Commissioner issued an Opinion and Award determining that Plaintiff's injuries were not the result of a compensable injury by accident arising out of and in the course of employment. Plaintiff appealed to the Full Commission. The Full Commission issued an Opinion and Award affirming the Deputy Commissioner's decision and denying Plaintiff's claim for benefits. Plaintiff appealed.

ISSUES:
1. Whether Plaintiff's injuries resulted from conduct traceable to his employer.

2. Whether the "unexplained fall doctrine" creates the inference that Plaintiff's injuries were the result of his employment.

HOLDINGS:
1. No. Plaintiff's fall resulted from his own idiopathic condition and was not caused by a hazard of his employment. Where an employee's injury is caused solely by his or her idiopathic condition, the injury does not arise out of employment. However, the injury does arise out of employment where the idiopathic condition combines with risks attributable to the employment to cause the injury. Although Plaintiff would not have been at the gas station but for his job, his fall was not traceable to the conditions of his employment. Instead, his own action and idiopathic condition were the sole causes of the injury. The Court held that the Commission properly concluded that that the injury did not arise out of his employment and was therefore not compensable under the Workers' Compensation Act.

2. No. The "unexplained fall" doctrine would apply in cases where there is no explanation for the fall and the Commission has not made any finding that some force or condition caused the fall. In those cases, there is an inference that the fall arose out of the employment. Here, the Commission did expressly find that Plaintiff's idiopathic condition was the sole cause, making the "unexplained fall" doctrine inapplicable.

Parsons Presumption

A. *Pine v. Wal-Mart Associates, Inc. #1552*, ___ N.C. App. ___, 804 S.E.2d 769 (September 2017) (Inman, J.) (Parsons Presumption; Causal Relationship)

FACTS:

Plaintiff fell over a stairway ladder while at work, alleging injuries to her left knee, right hand, right wrist, and right shoulder. Defendants admitted compensability for Plaintiff's injuries to the right shoulder and arm; however, Defendants denied compensability as to Plaintiff's alleged aggravation of pre-existing cervical disc disease, carpal tunnel syndrome, sagittal band rupture, aggravation of carpal boss, left knee problems, and dystrophic right hand symptoms. Defendants argued that the denied medical conditions were both unrelated to the original fall and unrelated to Plaintiff's employment. Following a hearing, the Deputy Commissioner concluded that Plaintiff's workplace fall resulted in injuries to her right wrist and left knee and also aggravated a pre-existing cervical disc condition. Both parties appealed to the Full Commission. The Full Commission determined that, because Defendant-Employer accepted the right shoulder injuries, Plaintiff was entitled to a rebuttable presumption that her other medical conditions concerning her wrist, knee, and spine were causally related to the compensable injury. Defendants appealed.

ISSUES:

1. Whether the Commission erred by applying the *Parsons* presumption to a medical condition not listed on the employer's admission of compensability form.

2. Whether, absent the *Parsons* presumption, the Commission erred in finding that Plaintiff's injuries were causally related to the compensable injury.

HOLDINGS:

1. Yes. The Commission erred in applying the *Parsons* presumption. Citing N.C.G.S. § 97-82(b) (recently amended by the General Assembly to limit the Supreme Court's decision in *Wilkes v. City of Greenville)*, the Court asserted that an injury that is not accepted by a Defendant, or listed on its admission of compensability form, is not presumed to be causally related to a compensable injury. The relevant portion of the statute was enacted after the Commission heard this case. However, the Court noted that the statute is nevertheless applicable because the appeal was pending after enactment. Here, the conditions at issue were not listed by Defendants on the Form 60 (only admitting compensability for the right shoulder and arm). Therefore, under the statute, the Commission's application of the *Parsons* presumption was incorrect. As a result, Plaintiff was required to produce evidence that the additional conditions are more likely than not related to the original injury.

2. No. The Court noted that in addition to applying the *Parsons* presumption, the Commission also made findings that Plaintiff proved by a preponderance of the evidence that the additional injuries were causally related, and therefore, compensable. Defendants argued that the expert testimony from Plaintiff's treating physicians relied on by the Commission was merely speculative and insufficient to prove causation. The Court disagreed. The Court highlighted that, based on expert medical testimony, no other potential causes of Plaintiff's injuries existed. Moreover, the

Court found that the testimonies and evidence presented by Plaintiff's treating physicians were anchored by Plaintiff's medical history, physical examinations, diagnostic testing, and medical literature. Thus, Plaintiff's evidence went beyond mere speculation or conjecture. Accordingly, the Commission's Opinion and Award was affirmed despite the incorrect application of the *Parsons* presumption.

DISSENT (Tyson, J):
Judge Tyson wrote a separate opinion concurring in part and dissenting in part. Judge Tyson concurred with the majority's holding that the Commission erred in applying the *Parsons* presumption in light of the recent amendment to the statute. However, Judge Tyson disagreed with the majority's conclusion that the Commission made any factual findings without relying on the *Parsons* presumption. Instead, Judge Tyson asserted that the burden was improperly placed on Defendants to show absence of causation.

B. *Adame v. Aerotek*, ___ N.C. App. ___, 809 S.E.2d 922 (February 2018) (Stroud, J.) (Unpublished) (*Parsons* Presumption)

FACTS:
Plaintiff was a 55-year-old man who was working through a temporary staffing agency when he suffered a low back injury in June 2013, which was accepted as compensable. Plaintiff was from Mexico and attended "something like high school" in Mexico until the age of 12 but did not graduate. He spoke English but could not read as well as he spoke. His work experience was mostly in manual labor, which included construction, farm work, and welding.

Defendants filed a Form 24 after Plaintiff was released to return to full-duty work by his treating doctor, which was granted. Plaintiff did not appeal this Order. Plaintiff continued treating and was assigned additional work restrictions, including a permanent restriction of no lifting more than 40 pounds. Plaintiff then requested additional indemnity benefits and vocational assistance. The Deputy Commissioner entered an Opinion and Award denying Plaintiff's request. The Full Commission affirmed holding that Plaintiff had failed to produce evidence that he was disabled. Defendants appealed to the Court of Appeals.

ISSUE:
Whether Plaintiff met his burden of establishing disability by way of futility under the *Russell* test.

HOLDING:
Yes. The Court of Appeals specifically concluded that Plaintiff met his "burden of production of evidence of futility" by presenting evidence of his age, lack of education, lack of vocational training, limited fluency in written English, and lifting restrictions. Therefore, the burden shifted to Defendants to show that suitable jobs were available to Plaintiff, and that Plaintiff was capable of obtaining a suitable job in light of his physical and vocational limitations. Defendants relied on the testimony of a vocational expert who had prepared labor market surveys in order to meet their burden. Defendants' vocational expert had very limited knowledge of Plaintiff's education and qualifications, and the Court found Plaintiff could not meet the minimum qualifications of most of the jobs that were identified as suitable; therefore, the Court held Defendants had not met their burden, and the Industrial Commission erred in relying on the

vocational expert's testimony. The Court concluded Plaintiff was able to establish disability due to futility. The case was nevertheless remanded for the Commission to determine whether Plaintiff's incapacity to earn wages was caused by his work injury under the third prong of *Hilliard*.

Disability

A. *Neckles v. Harris Teeter,* ___ N.C. App. ___, 812 S.E.2d 178 (February 2018) (Calabria, J.) (Disability; N.C.G.S. § 97-2(9))

FACTS:
Plaintiff began working for Defendant-Employer as a meat cutter in 2007. Approximately two years later, Plaintiff injured his right hip, low back, and right extremities while moving a box of meat. Defendants accepted the claim and initiated payment of temporary total disability benefits. On June 25, 2014, Defendants filed a Form 33 requesting a hearing on the grounds that Plaintiff was no longer disabled.

Following the hearing, the Deputy Commissioner determined Plaintiff was entitled to continued temporary total disability benefits and payment of all related medical expenses. The Deputy Commissioner reasoned that it would be futile for Plaintiff to engage in a job search given his age, education, work experience, work restrictions, unrelated health conditions, and difficulty communicating. Defendants appealed, and the Full Commission affirmed that Plaintiff was entitled to receive continued medical compensation related to his injury; however, the Commission found that Plaintiff was no longer entitled to temporary total disability benefits because he failed to show that a job search would be futile.

The Court of Appeals reversed the Commission's Opinion and Award. Relying on its own decision in *Wilkes v. City of Greenville*, the Court of Appeals held that Plaintiff met his burden of proving disability under the "futility method" as outlined in *Russell v. Lowe's Prod. Distrib'n*.

Thereafter, the Supreme Court modified the previous Court of Appeals decision in *Wilkes* on the issue of disability. The Supreme Court in *Wilkes* noted that it has not adopted the *Russell* method of proving disability. Accordingly, Defendants filed a petition for discretionary review for the limited purpose of reconsidering the decision in this case in light of the Supreme Court's opinion in *Wilkes*.

ISSUE:
Whether the Commission must make findings regarding a plaintiff's wage earning capacity and ability to obtain a job, considering the plaintiff's compensable injury in the context of all pre-existing and co-existing conditions bearing upon his wage-earning capacity.

HOLDING:
Yes. Under *Wilkes*, if a plaintiff establishes disability, then the burden shifts to the defendant to show (1) that suitable employment is available and (2) that the plaintiff is capable of obtaining said employment given plaintiff's physical and vocational limitations. Judge Calabria emphasized the Supreme Court's language in *Wilkes* requiring the Commission to consider "age, education, and prior work experience, as

well as other preexisting and coexisting conditions" when determining a plaintiff's wage-earning capacity.

Here, Plaintiff's limitations in communication, education, and work experience were reflected in the Commission's findings of fact but not in its determination of disability. Therefore, the Court remanded the case back to the Commission in order to make specific findings regarding Plaintiff's wage earning capacity and specifically addressing Plaintiff's injury in the context of all pre-existing and co-existing conditions affecting his disability.

B. *Garrett v. The Goodyear Tire & Rubber Co.*, ___ N.C. App. ___, ___ S.E.2d ___ (July 2018) (Murphy, J.) (Causation; Law of the Case Doctrine; Disability)

FACTS:
Plaintiff worked as a production service carcass trucker, which required her to operate a stand-up, three-wheeled motorized vehicle (a fork lift) in a warehouse. In December 2013, Plaintiff's vehicle was hit by another vehicle while working. Plaintiff returned to work, but soon described "feeling something weird" and a numbness in her neck. Plaintiff reported the accident to her supervisor, was medically evaluated on site, and then went to the emergency department. The Defendant-Employer filed a Form 19 stating that it knew of the incident and that Plaintiff received "[m]inor on-site remedies by employer medical staff." Plaintiff began a course of treatment for the neck and back, and returned to work two weeks after the accident in her pre-injury position as a carcass trucker, but subject to light-duty restrictions imposed by her treating provider.

On May 12, 2014, the Defendant-Employer notified Plaintiff that it could no longer accommodate the work restrictions, and Plaintiff went on disability leave. While on leave, she completed a functional capacity evaluation which found her to be capable of performing the physical demands and essential functions of the carcass trucker position. Plaintiff returned to work, but soon obtained a note from an unauthorized doctor which excused her from this position for "treatment for degeneration of a cervical intervertebral disc" and she remained out of work.

Plaintiff filed a Form 18 on January 2, 2015, and Defendants obtained an IME a few weeks later which found Plaintiff incapable of the carcass trucker position, but indicated that she could work at a sedentary level. Defendants filed a Form 63 for payment of medical benefits only. Plaintiff filed a Form 33 on April 22, 2015, requesting a hearing because "Defendants failed to file any forms" and "treated the claims as compensable." Three months later, Defendants offered Plaintiff a position as a carcass trucker, but Plaintiff refused the offer, stating she did not want the position due to the bouncing nature of the truck. Defendants then filed a Form 61.

The Deputy Commissioner found that Plaintiff's neck and low back conditions were causally related to the work accident, but held that Plaintiff's bilateral shoulder condition was not compensable and also that she was not entitled to attorney's fees. The Deputy Commissioner stated "[t]he Commission may not prohibit Defendants from contesting compensability of Plaintiff's claims as a sanction for Defendants' failure to timely admit or deny the claims." [Plaintiff was asserting that her claims should be deemed admitted based upon the actions of Defendants]. Defendants appealed to the Full Commission.

The Full Commission found that Plaintiff's low back condition was not a compensable injury but her neck condition was. Plaintiff was awarded TTD between the dates Defendants stopped accommodating her restrictions (May 2014) and the date Plaintiff refused Defendants' job offer (July 2015). Both parties appealed this decision to the Court of Appeals.

ISSUES IN PLAINTIFF'S APPEAL:

1. Whether the Commission failed to consider Plaintiff's argument that Defendants were estopped from denying the compensability of her claims through their actions.

2. Whether the Commission erred by concluding Plaintiff failed to provide adequate evidence that her low back condition was caused by the workplace accident.

3. Whether the Commission misapplied the law of *Russell v. Lowes Product Distribution* in analyzing Plaintiff's disability claims.

HOLDINGS FROM PLAINTIFF'S APPEAL:

1. Yes. The Commission failed to address Plaintiff's argument for estoppel and Plaintiff properly raised the issue before the Deputy Commissioner and the Full Commission. Of the five issues to be heard, as noted by the Deputy Commissioner's Opinion and Award, the issue of estoppel was included, but the Commission failed to rule on this specific issue. The Full Commission invoked the "law of the case" doctrine and determined that Plaintiff failed to appeal this issue to the Full Commission. This was an error by the Commission. The Court stated the law of the case doctrine "provides that when a party fails to appeal from a tribunal's decision that is not interlocutory, the decision below becomes the 'law of the case' and cannot be challenged in subsequent proceedings in the same case." Boje v. D.W.I.T., L.L.C., 195 N.C. App. 118, 122, 670 S.E.2d 910, 912 (2009). However, "[t]he doctrine of the law of the case is not an inexorable command, or a constitutional requirement, but is, rather, a flexible discretionary policy which promotes the finality and efficiency of the judicial process." Goetz v. N.C. Dep't of Health & Human Servs., 203 N.C. App. 421, 432, 692 S.E.2d 395, 403 (2010) (quotation marks omitted). Additionally, the Full Commission "is not an appellate court" and "[t]he Commission may not use its own rules to deprive a plaintiff of the right to have his case fully determined." Joyner v. Rocky Mount Mills, 92 N.C. App. 478, 482, 374 S.E.2d 610, 613 (1988).

2. No. The Full Commission did not err in concluding that Plaintiff failed to prove her low back condition was caused by the workplace accident. Plaintiff offered a doctor's opinion, who based his findings on her back injury on a hypothetical, but this opinion was based exclusively on the temporal relationship between the date Plaintiff sought medical attention and the date of the workplace accident. Thus, the opinion constituted *post hoc ergo proper hoc* and was insufficient to establish a causal relationship between Plaintiff's low back condition and the workplace accident

3. No. The Full Commission properly analyzed Plaintiff's disability claim using the non-exhaustive factors considered in *Russell v. Lowe's Prod. Distrib'n*. The Court viewed Plaintiff's argument as a

request to re-weigh the evidence presented to the Full Commission, which the Court refused to do. Additionally, Plaintiff argued that the Full Commission failed to consider her rationale for refusing the job offer, which she claimed was due to fear of re-injury. The Court found the Full Commission made the necessary findings to support its conclusion that Plaintiff unjustifiably refused Defendants' offer of suitable employment. The facts showed that Plaintiff continued to drive the same vehicle at work for 15 months after her injury, which negated her argument of fear of re-injury.

ISSUES IN DEFENDANTS' APPEAL:

1. Whether the Full Commission erred in concluding that Plaintiff's cervical spine condition was a compensable injury based on the testimony of Plaintiff's treating physician regarding her condition prior to and after the workplace accident.

2. Whether the Full Commission erred by failing to enter sufficient findings to support its conclusion that Plaintiff was disabled between the dates Defendants stopped accommodating her restrictions and the date Plaintiff refused Defendants' job offer.

HOLDINGS FROM DEFENDANTS' APPEAL:

1. No. The Full Commission did not err in concluding that Plaintiff's cervical neck condition was a compensable injury. Although the physician relied on Plaintiff's "pain complaints," which suggest speculation in diagnosing and post hoc ergo propter hoc reasoning, the Court stated the temporal sequence of events was not the only factor the physician considered in making his diagnosis. Additionally, the Court stated "an expert is not always precluded from relying on the temporal sequence of events (e.g., "post hoc ergo propter hoc") in forming his or her opinion as to the cause of the Plaintiff's injury."

2. Yes. The Full Commission erred by failing to enter sufficient findings to support its conclusion regarding the disability period. The Court relied on *Wilkes v. City of Greenville*, which requires the Commission to make findings addressing how a plaintiff's injury "may have affected his ability to engage in wage-earning activities." *Wilkes v. City of Greenville*, 369 N.C. 730, 747-48, 799 S.E.2d 838, 850, (2017). Applying this standard, the Court found the Commission did not make these findings. In this case, the Opinion and Award did not sufficiently address how Plaintiff's neck injury affected her ability to engage in wage-earning activities after Defendants stopped accommodating her restrictions. The Commission also failed to make any findings addressing whether, after a reasonable effort on Plaintiff's part, she had been unsuccessful in her effort to obtain employment, or it would have been futile for her to seek other employment. As such, there are no findings addressing whether Plaintiff had any limitations that precluded her from obtaining any other employment at the same wages.

The ultimate outcome was that the Commission's decision was affirmed in part and remanded in part. The Court affirmed the Commission's conclusions that: (1) Plaintiff failed to prove that her low back condition was caused by the December 2013 workplace accident; (2) Plaintiff met her burden to establish that her neck condition was caused by the accident; and (3) Plaintiff's refusal of Defendant-Employer's July 2015 employment offer was unjustified. The Court remanded to: (1) consider whether the facts of

the case support a conclusion that Defendants should be estopped from denying coverage; and (2) make specific findings addressing Plaintiff's wage-earning capacity between May 2014 and July 2015.

C. *Stippich v. Reese's Transit, Inc.*, ___ N.C. App. ___, ___ S.E.2d ___ (July 2018) (Elmore, J.) (Causation; Disability; Lapse of Coverage)

FACTS:

Plaintiff worked as a driver transporting students to and from school for Defendant-Employer. Plaintiff had a history of pre-existing shoulder, knee, left upper extremity, and back pain. On October 6, 2014, Plaintiff was injured in a motor vehicle accident that caused damage in excess of $10,000 to the vehicle. He initially treated for neck, bilateral shoulder, right knee, and right hip pain. Approximately one month later, Plaintiff treated for the same conditions with the addition of the low back. Plaintiff did not treat again for two months, and on January 8, 2015, he presented to an urgent care provider reporting persistent neck and back pain. He was referred to an orthopaedist. Plaintiff was thereafter able to return to work. On January 15, 2015, Plaintiff was involved in a second work-related motor vehicle accident causing minimal damage to his vehicle. By this time, Defendant-Employer's workers' compensation insurance coverage had lapsed.

Plaintiff presented to Dr. Mikles, an orthopaedist, who recommended conservative treatment. Dr. Mikles restricted Plaintiff from work "at this point" and instructed him to follow up after he completed the conservative treatment recommended, which included medication and physical therapy. Plaintiff did not follow up for approximately 10 months and did not return to work or seek other employment. In the meantime, Plaintiff presented to Dr. Herzig, a neurosurgeon, and Dr. Chen, a pain management provider. Plaintiff "basically declined" conservative treatment and seemed "infatuated" with having surgery. Neither provider addressed issues regarding Plaintiff's work status.

The Deputy Commissioner found Plaintiff sustained a compensable aggravation of his neck and low back conditions as a result of the 2015 accident, and Defendants were liable for TTD and medical benefits. The Deputy Commissioner further concluded Plaintiff failed to establish disability beyond December 2015. The Full Commission reversed, finding Plaintiff's pre-existing back and neck conditions were aggravated by the 2014 accident; that the 2015 accident caused, at most, a temporary flare up in symptoms; that Plaintiff had established ongoing disability, and that Riverport, the insurance carrier from the 2014 injury, was solely liable for all benefits as a result of the accidents. Riverport appealed.

ISSUES:

1. Whether the Commission erred in finding and concluding that Plaintiff's current conditions were attributable to the 2014 accident.

2. Whether the Commission erred in concluding Plaintiff established ongoing disability as a result of the 2014 accident.

3. Whether Riverport and Defendant-Employer were jointly and severally liable for the medical treatment as a result of the 2014 accident because of the lapse in workers' compensation coverage.

HOLDINGS:

1. No. The Court held that, despite the fact that the medical records showed both accidents aggravated Plaintiff's pre-existing back and neck pain, the totality of the evidence supported the Commission's finding that Plaintiff's current conditions were attributable to the 2014 accident. The Court focused specifically on the low-impact nature of the 2015 crash.

2. Yes. The Court held the Commission erred in finding Plaintiff was disabled beyond December 2015. The Commission found Plaintiff satisfied the first prong of the *Hilliard* test under *Russell* by presenting medical evidence that he was incapable of any work because of the work-related injury. The Court held that Dr. Mikles' note did not indicate Plaintiff should remain out of work completely until he received conservative treatment, rather the evidence showed Plaintiff was simply to follow up once he had received said treatment. The Court also relied on Dr. Mikles' testimony that it was not his intention for Plaintiff to remain out of work completely until he received conservative treatment. In addition, Plaintiff also refused conservative treatment and was obsessed with seeking surgery even though all his providers agreed it was not warranted. The Court held the record was totally devoid of medical or other competent evidence to support the finding that Plaintiff was disabled after December 2015.

3. Yes. Despite the precedent for joint and several liability for aggravation of a pre-existing work injury from one employer in a subsequent work-related accident with another employer, the Court held this case was distinguishable. Plaintiff did not need new medical treatment and the 2015 accident only caused what Plaintiff described as a "flare-up" of his pre-existing conditions from 2014. As a result, the Court held Riverport was solely liable for all medical treatment, and that liability should not be split between Riverport and Defendant-Employer.

Occupational Disease

A. *Penegar v. United Parcel Serv.*, ___ N.C. App ___, 815 S.E.2d 391 (May 2018) (Inman, J.) (Last Injurious Exposure; Average Weekly Wage Calculation; Full Commission Authority to Amend an Award)

FACTS:

Decedent worked for UPS for 30 years as a feeder driver based in Charlotte, NC. The Charlotte facility was a large building that consisted of various bays where UPS mechanics serviced vehicles in the fleet. Decedent walked through the shop nearly every day to get from his truck to the employee locker room. Brake service was performed in the shop and, although protective masks were provided to mechanics, protective masks were never provided to Decedent. Following his employment with UPS, Decedent drove a transfer van, worked for a church, and worked for Union County Schools.

On February 8, 2013, Decedent was diagnosed with mesothelioma. Prior to his death, Decedent filed a claim with the Commission alleging that his mesothelioma developed as a result of asbestos exposure during his employment with UPS. Plaintiff presented testimony from two former UPS mechanics and two medical experts. The mechanics testified that asbestos was present at the UPS facility and the experts

testified that exposure to asbestos in the UPS facility caused Decedent to develop mesothelioma or contributed to him developing that disease.

The Deputy Commissioner issued an Opinion and Award finding that Decedent was last injuriously exposed to asbestos during his employment with UPS. Plaintiff was awarded 500 weeks of compensation, calculated using Decedent's average weekly wage from the last year he worked for UPS and the maximum compensation rate from that year.

Plaintiff filed a motion for reconsideration of the maximum compensation rate arguing that the Deputy Commissioner should have used the maximum compensation rate from 2015, which was the date of Decedent's death. The motion was denied.

Both parties appealed to the Full Commission. The Full Commission held that Decedent was injuriously exposed to asbestos while employed by UPS and awarded Plaintiff compensation for all of Decedent's medical expenses associated with his diagnoses of mesothelioma, along with total disability compensation, burial expenses, and death benefits. The Commission also recalculated and substantially reduced Plaintiff's average weekly wage, based on Plaintiff's earnings in the year prior to his diagnosis, when he was no longer employed by UPS. Defendants appealed on the grounds that the Commission's findings were unsupported by competent evidence. Plaintiff also appealed, arguing that the Commission lacked jurisdiction to revise the Deputy Commissioner's calculation of the average weekly wage, and, assuming jurisdiction, that the Commission's calculation was incorrect.

ISSUES:

1. Whether the Full Commission erred in finding that the Decedent's last injurious exposure to asbestos, which contributed to his development of an occupational disease, occurred during the thirty years he worked for his primary lifetime employed, based on the testimony of his former co-workers and medical experts, and in the absence of any evidence that he was exposed to asbestos at any subsequent job.

2. Whether the Commission erred in calculating the Decedent's average weekly wage based on his earnings in the year immediately preceding his diagnoses.

HOLDINGS:

1. No. Defendants argued that Plaintiff failed to present evidence that Decedent was not exposed to asbestos during his subsequent employments and therefore, the Commission's finding that Decedent's last injurious exposure to asbestos occurred at UPS is unsupported by the evidence. The Court disagreed, holding that once Plaintiff presented evidence that her husband was injuriously exposed to asbestos in his job for Defendant, the burden shifted to Defendant to produce some evidence of a subsequent exposure. Shifting the burden of production does not shift the burden of proof. The Court further held that while there is no affirmative evidence proving a lack of exposure to asbestos in the Decedent's subsequent employment, nothing in the evidence regarding his subsequent employment – as a van driver and a church and school employee – suggests any inference to the contrary. Without any such evidence, it would have been error for the Industrial Commission to find that the Decedent was later exposed.

2. No. When the Decedent was diagnosed with mesothelioma, he had not worked for the Defendant-Employer for 15 years. The Court held that the Commission fulfilled the goal of finding an average wage that "most accurately reflects the wages decedent would have continued to earn, but for his diagnosis with mesothelioma, and [that] is fair and just to both parties" when it looked at the Decedent's most recent earnings: the $4,272.92 he earned in his 2012 post-retirement part-time employment, resulting in a compensation rate of $54.78.

B. *Briggs v. Debbie's Staffing, Inc.*, ___ N.C. App. ___, 812 S.E.2d 706 (March 2018) (Davis, J.) (Increased Risk; Expert Testimony; COPD/Asthma)

FACTS:
Plaintiff worked as a ceramic technician at a plant that manufactured troughs and molds that were used in the molten metal industry. He alleged he developed COPD and asthma as a result of his employment. The evidence established that Plaintiff was required to wear a respirator while working, the exposure limits were well below OSHA's permissible exposure limits, and Plaintiff smoked cigarettes. Plaintiff was terminated from employment for attendance issues not related to the alleged claim. A few months after his termination from employment, Plaintiff sought treatment for wheezing and shortness of breath. He claimed his symptoms began in November 2011, as a result of his employment.

The Deputy Commissioner found Plaintiff's claim to be compensable and awarded benefits. The Full Commission reversed. The Court of Appeals affirmed.

ISSUE:
Whether a plaintiff is required to produce expert medical evidence in order to establish that his employment conditions placed him at a greater risk for contracting the occupational disease complained of when compared to the general public.

HOLDING:
Yes. The Court held that, in addition to establishing causation, Plaintiff must also produce expert medical evidence to establish that his employment placed him at an increased risk of contracting and/or aggravating his disease in order to be entitled to benefits. The Court cited the test outlined in *Rutledge v. Tultex Corp./Kings Yarn*, 308 N.C. 85, 301 S.E.2d 359 (1983), for establishing a compensable occupational disease. The Court emphasized that medical expert evidence was needed to answer complicated medical questions such as these. Here, Plaintiff did not produce medical evidence that Plaintiff's employment placed him at an increased risk of contracting or aggravating his asthma, and as such, he could not carry his burden of establishing a compensable occupational disease.

N.C.G.S. § 97-24 – Statute of Limitations

A. *Hall v. U.S. Xpress, Inc.*, ___ N.C. App. ___, 808 S.E.2d 595 (December 2017) (Zachary, J.) (Timeliness of Claim Under N.C. Gen. Stat. 97-24(a)(ii); Disabled Plaintiff's Contribution to Handicapped Accessible Housing)

FACTS:

Plaintiff lived in Fayetteville, NC and worked as a truck driver for Defendant-Employer, a Tennessee company. Plaintiff was severely injured in a work-related accident in 2002 occurring in North Carolina, and Defendants began paying him benefits under Tennessee workers' compensation law.

Plaintiff initially treated in North Carolina, then in West Virginia, where he moved with his girlfriend. His care was then transferred to Boston, Massachusetts. Benefits paid on behalf of Plaintiff were payments made to health care providers in Boston, pursuant to the Tennessee workers' compensation statutes and fee schedule. Plaintiff eventually realized that his benefits were being paid under Tennessee law rather than North Carolina workers' compensation law, and he filed a Form 18 with the North Carolina Industrial Commission on April 8, 2013. On May 2, 2013, Defendants filed a Form 61 asserting that the Industrial Commission lacked jurisdiction over Plaintiff's claim.

The Deputy Commissioner entered an Opinion and Award on January 12, 2015, concluding that the Industrial Commission had jurisdiction over Plaintiff's claim. Defendants appealed. The Full Commission affirmed and awarded Plaintiff medical and indemnity benefits. Both Plaintiff and Defendants appealed portions of the Full Commission's Opinion and Award.

ISSUES:

1. Whether the Commission erred when it determined Plaintiff timely filed his North Carolina workers' compensation claim, and therefore, that the Commission had jurisdiction over Plaintiff's claim.

2. Whether the Commission erred in its award for attendant care benefits.

3. Whether the Commission erred in denying an award of per diem payments.

4. Whether the Commission erred in requiring Plaintiff to contribute toward his housing costs.

5. Whether the Commission erred in awarding sanctions against Defendants.

HOLDINGS:

1. No. The Court affirmed the Commission's Opinion and Award. The Court noted that in order for the Commission to have jurisdiction over a claim, N.C.G.S. § 97-24(a)(ii) requires that a Plaintiff show that: (1) his claim was filed within two years after the last payment of "medical compensation," (2) no "other compensation" was paid, and (3) the employer's liability has not otherwise been established under the Workers' Compensation Act (the Act). Here, the Court

found that these prongs were met because Plaintiff filed his claim within two years after Defendants' last payment of medical compensation, no "other compensation" was paid under the Act, and the employer's liability had not otherwise been established under the Act.

The Court additionally held that Plaintiff's receipt of benefits under Tennessee's workers' compensation statute from 2002 to 2011 did not deprive the NC Industrial Commission of jurisdiction over Plaintiff's claim. The Court relied on *McGhee v. Bank of America Corp.*, 173 N.C. App. 422, 618 S.E.2d 833 (2005), and *Clark v. Summit Contrs. Group, Inc.*, 238 N.C. App. 232, 767 S.E.2d 896 (2014), to establish that: (1) medical compensation provided to a health care provider outside of North Carolina or pursuant to the workers' compensation laws of another state may be considered in determining whether a plaintiff has filed a workers' compensation claim in North Carolina within two years of the last medical compensation, but (2) for purposes of determining a plaintiff's compliance with § 97-24(a)(ii), disability or other indemnity payments are not considered "other compensation" within the meaning of the statute unless the payments were made pursuant to a North Carolina workers' compensation claim.

Here, Plaintiff filed his Industrial Commission Form 18 seeking workers' compensation benefits within two years of the last payment of medical compensation. The fact that the payments were made to health care providers in Massachusetts pursuant to the Tennessee workers' compensation statute and fee schedule did not invalidate them for purposes of determining whether Plaintiff's claim was timely filed.

In addition, Plaintiff's entitlement to disability payments under the North Carolina Workers' Compensation Act had not been previously determined at the time that Plaintiff filed a workers' compensation claim. Thus, Plaintiff met the criteria of § 97-24(a)(ii), and the Industrial Commission had jurisdiction over Plaintiff's claim.

2. No. The Commission did not err in awarding attendant care benefits. The Court found Plaintiff did seek approval for payment of these benefits within in reasonable time given the conclusion that Plaintiff had properly filed a claim for workers' compensation benefits within two years of the last payment of medical compensation. Further, the Court found that the Commission had the discretion to limit the award of attendant care benefits to eight hours per day based on the evidence, and the Court refused to overturn this holding.

3. No. The Court found the Commission did not err in failing to require Defendants to continue a per diem payment of $50.00 per day for meals. Despite that Defendants had paid this per diem payment between 2004 and 2011, the Court agreed that these per diem payments were not medical compensation. As such, Defendants were entitled to cease these payments.

4. No. The Court found that, while an employer may be required to pay for the expense of providing handicapped housing for a disabled plaintiff, the Commission has the discretion to require the plaintiff to contribute a reasonable amount toward rent. The Court noted that an example of a "reasonable rent" could be the amount of the plaintiff's pre-injury rent.

5. No. The Court found the Commission did not abuse its discretion by awarding attorney's fees to Plaintiff's counsel as sanctions for Defendants' unfounded litigiousness.

N.C.G.S. § 97-10.2 – Third-Party Lien

A. *Easter-Rozzelle v. City of Charlotte*, 244 N.C. App. 198, 780 S.E.2d 244 (December 2015) (Tyson, J.) (N.C.G.S. § 97-10.2; Settlement of Third-Party Personal Injury Claim Without Written Consent by Employer)

FACTS:

Plaintiff sustained injuries to his neck and right shoulder while working as a utility technician. Plaintiff's claim was accepted as compensable pursuant to a Form 60. Following the injury, Plaintiff continued to experience pain and was unable to perform his work duties. Defendant-Employer instructed him to obtain an updated work note from his doctor. On the way to his doctor's office to pick up the out-of-work note, Plaintiff was involved in a motor vehicle accident and sustained a traumatic brain injury. Plaintiff provided his wife his supervisor's contact information, and Plaintiff's wife contacted Defendant-Employer to report that Plaintiff was on his way to pick up the requested work note when the accident occurred and that he would be unable to come to work that day. Plaintiff himself spoke with his supervisors on at least two occasions in the three days following the accident. He also advised his supervisor that he had been injured in a car accident while traveling to his doctor's office to pick up the work note that continued him out of work. Plaintiff had also reported this to his safety manager and other employees in Defendant-Employer's personnel office.

Plaintiff filed a personal injury claim for the motor vehicle accident. He had different attorneys representing him in the personal injury claim and in the workers' compensation claim. Plaintiff ultimately settled the personal injury claim for $45,524.00. After paying attorney's fees, costs, and medical expenses, Plaintiff received $16,000.00. The settlement proceeds were disbursed without reimbursement to Defendants. There likewise was no Superior Court order eliminating the lien and no Industrial Commission Order allowing distribution of the funds. In the personal injury case, Plaintiff's attorney alleged in correspondence to Plaintiff's personal health insurance carrier that he was not "at work" when he sustained his injuries and the attorney maintained that the personal health insurance carrier should be responsible for those bills. In terms of the workers' compensation claim, Plaintiff's workers' compensation attorney first became aware at the mediation that Plaintiff was traveling to obtain an updated work note for Defendant-Employer when he was involved in the accident. Plaintiff's attorney then suspended the mediation and filed a Form 33. Defendants denied the claim on the basis of estoppel and because the settlement proceeds were disbursed without Industrial Commission approval or release by Superior Court.

The Deputy Commissioner found for Defendants, holding that Plaintiff had no right to recover additional compensation from Defendants when the third-party settlement funds had already been disbursed. Plaintiff appealed. The Full Commission reversed, concluding that Defendants had sufficient actual notice of the motor vehicle accident and subsequent injuries. The Commission found that Defendants were entitled to a statutory lien on recovery from the third-party proceeds Plaintiff received from settlement

of his personal injury claim, once the subrogation amount was determined by agreement of the parties or by a Superior Court judge.

ISSUE:
Whether the Full Commission erred in concluding Plaintiff was entitled to recover additional compensation from Defendants for injuries sustained in a third-party motor vehicle accident when the settlement amount had already been disbursed.

HOLDING:
Yes. The Court reiterated the rule from *Hefner v. Hefner Plumbing Co., Inc.*, 252 N.C. 277, 113 S.E.2d 565 (1960), which states that where an employee is injured in the course of his employment by the negligent act of a third party, settles with the third party, and proceeds of the settlement are disbursed in violation of N.C.G.S. § 97-10.2, the employee is barred from recovering compensation for the same injuries from his employer in a proceeding under the Workers' Compensation Act. The Court determined the Full Commission should have applied *Hefner*. In *Hefner*, the Plaintiff was injured in an automobile accident during the course and scope of his employment. Plaintiff's counsel advised the workers' compensation carrier that Plaintiff was not making a claim for workers' compensation benefits. Following settlement of the third-party claim, Plaintiff then filed a workers' compensation claim with the Industrial Commission. He argued the carrier should be ordered to pay a proportionate amount of Plaintiff's attorney's fees. The Supreme Court held Plaintiff could not seek compensation from his employer after having settled the third-party claim and having disbursed the proceeds. In this case, the Court held that, regardless of the settlement amount, which Plaintiff argued as "grossly inadequate," Plaintiff was not entitled to recover additional compensation as Defendants were not given the opportunity to participate in settlement or allocation of its disbursement, which contravened the intention of N.C.G.S. § 07-10.2. Defendants maintained the right to participate in settlement process by requiring review and written consent to the settlement agreement. Given the holding, the Court did not address the applicability of the principles of judicial and equitable estoppel.

B. *Easter-Rozzelle v. City of Charlotte*, 370 N.C. 286, 807 S.E.2d 122 (December 2017) (Hudson, J.) (N.C.G.S. § 97-10.2; Settlement of Third-Party Claim Without Written Consent by Employer)

FACTS:
As outlined above. Plaintiff appealed the Court of Appeals decision.

ISSUE:
Whether the Court of Appeals erred in concluding Plaintiff was barred from recovering workers' compensation benefits for injuries sustained in a third-party motor vehicle accident when Plaintiff had already recovered from the third-party without notice to the employer.

HOLDING:
Yes. The Court held that an employee who: (1) had been injured at work; (2) was on his way to see his approved treating physician; (3) was injured again in an auto accident during the trip; (4) notified his employer of the new accident; and (5) settled with the third-party tortfeasor without notifying his employer is not barred from receiving workers' compensation benefits. The Court highlighted that an employer's lien interest in third-party proceeds is mandatory, so there is no windfall to Plaintiff here

because the employer is entitled to recover the amount of its lien by means of a credit against Plaintiff's ongoing workers' compensation benefits. The Court noted that N.C.G.S. § 97-10.2(j) contains no temporal requirement, and that either party may apply to the Superior Court judge to determine the amount of the employer's lien.

The Court further observed that the Court of Appeals relied on *Hefner v. Hefner Plumbing Co.*, 252 N.C. 277, 113 S.E.2d 565 (1960). However, the Court noted, the applicable statutes had been revised since the *Hefner* decision was entered. The Court noted that the current version of N.C.G.S. § 97-10.2 provides that no consent is required when a case is settled in accord with subsection (j). N.C.G.S. § 97-10.2(h). The Court concluded that barring a plaintiff, who has received funds from a third party, from pursuing a workers' compensation claim contravenes the express language of § 97-10.2(i).

In this case, Defendant-Employer had an opportunity to participate in the settlement process with the third-party tortfeasor, but did not do so. Plaintiff had no reason to delay negotiations with the third party or disbursement of the settlement proceeds because, at the time, he did not realize that his injuries were potentially compensable under the Workers' Compensation Act.

The Court further highlighted that Defendant-Employer received actual notice of the accident, and as a result, had an opportunity to promptly investigate the claim and determine its compensability. Had Defendant-Employer done so, it would have discovered Plaintiff had suffered compensable injuries, and it could have participated in the settlement process.

Jurisdiction

A. *Hawkins v. Wilkes Regional Medical Center*, ___ N.C. App ___, 808 S.E.2d 505 (December 2017) (Stroud, J.) (N.C.G.S. § 97-97; Jurisdiction)

FACTS:
Plaintiff sustained a compensable low back injury in 2007 while working for Defendant-Employer. Key Risk Insurance Company was the carrier at the time. In January of 2012, Plaintiff sustained another injury to her back at work and was diagnosed with recurrent lumbar pain; however, Plaintiff did not file a Form 18 regarding this 2012 incident. At that time, Defendant-Employer's insurance company was United Heartland Insurance Company. Key Risk took the position that Plaintiff's condition in 2012 and onward was due to Plaintiff's 2012 injury, arguing that United Heartland was liable because it was a new injury, not related to the 2007 injury, and that Key Risk was not the insurer at the time of this 2012 injury.

In September 2014, Key Risk filed a Form 33 contending that Plaintiff's low back condition since January 12, 2012 was not casually related to the accident in April 2007. Plaintiff responded with a Form 33R alleging that her back condition since January 12, 2012 was causally related to the accident and injury of April 10, 2007. Key Risk then moved for United Heartland to be added as a party-Defendant. United Heartland responded to the Motion arguing that no Form 18 had ever been filed as to the January 12, 2012 alleged injury, and that more than two years had passed since the alleged injury and any claim would now be time barred pursuant to N.C.G.S. § 97-24. The Commission denied Defendant-Key Risk's motion to add United Heartland as a party.

The case then proceeded to hearing and Plaintiff argued that her back condition in 2012 and ongoing was related to the 2007 claim that had been accepted by Key Risk. Key Risk took the position that Plaintiff's current condition was caused by the 2012 incident. The Full Commission entered an Opinion and Award concluding Plaintiff's existing back condition was caused by her January 12, 2012 injury, not her April 10, 2007 injury, and that Plaintiff's claim was barred because she had not brought a timely claim against the proper insurer, United Heartland. Plaintiff appealed.

ISSUE:
Whether Plaintiff's claim was time barred because she failed to direct her claim towards the specific carrier on the risk.

HOLDING:
No. The Court reversed the Commission's denial of Plaintiff's claim and remanded the case. The Court noted that neither the Commission's Opinion and Award nor Defendants' brief cited any law to support the proposition that the employee must bring a workers' compensation claim against a specific insurance carrier. It further noted that N.C.G.S. § 97-97 clearly places the responsibility for compensation for work-related injuries on the employer, and provides that notice to the employer is notice to the carrier.

The Court held that in this case there was no question that Plaintiff timely gave notice of "the occurrence" of her back injury in January 2012 to the Defendant-Employer, even if she identified the incorrect insurance carrier. The Court also highlighted the Commission's own standard forms reflect the necessity for the employee to notify the employer of a claim, but places the burden of identification of the proper insurance carrier on the employer and the Commission, thus holding that the Plaintiff's correct identification of the employer's insurance carrier is not a jurisdictional requirement of a workers' compensation claim.

The Court ultimately found that the Commission's findings supported Plaintiff's claim that she sustained a compensable back injury in 2012 and that the Defendant-Employer had immediate notice of this injury. Therefore, given that the employer is responsible for compensation for a plaintiff's injury, and Plaintiff in this case needed only to notify her employer, not the specific insurer, as required by N.C.G.S. § 97-97, the Court held that Defendant-Employer was responsible for any compensation due. The Court further held that any dispute Defendant-Employer may have with either Key Risk and/or United Heartland is beyond the scope of this appeal. However, in the Court of Appeals decision, the Court makes the statement that United Heartland did not contest that Plaintiff had filed a proper claim for her 2012 injury with Defendant-Employer. In reality, United Heartland did contest that Plaintiff had properly filed a claim for the 2012 injury. That was the specific argument in the response to Key Risk's Motion to add United Heartland as a party.

B. *Burgess v. Smith*, ___ N.C. App. ___, ___ S.E.2d ___ (August 2018) (Elmore, J.) (Wrongful Death; Subject Matter Jurisdiction)

FACTS:
Plaintiff was the administratrix of the estate of the deceased employee, Stephanique D. Bell, and brought a wrongful death suit against Bell's co-workers, Rasheka Renee Smith, Thomas Cheek Marshall, and Anthony Johnson, as well as Bell's employer, Chicnylnn Solutions, Inc. Bell was a passenger killed in a

motor vehicle accident on a sales trip with Defendant Smith. Defendants Marshall and Smith failed to answer the summons and complaint, and a default judgment of over $2,000,000 was entered against them jointly and severally. Marshall filed a pleading five months later asserting Bell was an employee and had been killed in the scope of her employment, relying on the exclusivity provision of N.C.G.S. § 97-10.1, and moved to stay the proceedings to enforce the judgement, to set aside the default judgment, and to dismiss the claims for want of subject matter jurisdiction. The Superior Court denied the motions and affirmed the judgement based on the doctrine of equitable estoppel and laches. Marshall appealed.

ISSUE:
Whether the Superior Court erred by refusing to resolve the matter on the basis that Marshall was barred from challenging subject matter jurisdiction.

HOLDING:
Yes. The Court held that the Superior Court failed to follow proper procedure in issuing findings and conclusions to determine jurisdiction. Thus, the Court of Appeals lacked necessary information to meaningfully consider the jurisdictional challenge. The Court instructed the lower court to hold an evidentiary hearing to determine jurisdiction and then grant or deny Marshall's original motions. The Court further instruction the Commission, should a claim be brought there, not to apply the two-year filing requirement to bar the claim because Marshall's conduct caused the delay.

C. *Haulcy v. The Goodyear Tire & Rubber Co.*, ___ N.C. App. ___, ___ S.E. 2d ___ (June 5, 2018) (Elmore, J.) (Compensability; Employer-Funded Disability Benefits and Credit; Full Commission Authority to Amend an Award; Issue Preservation)

FACTS:
At the time of her injury, Plaintiff was employed by Defendant-Employer as a paint machine operator. On March 19, 2013, Plaintiff injured her back while attempting to push a flatbed with a stuck wheel and was diagnosed with low back strain. She did not file a workers' compensation claim after this incident. On April 23, 2014, Plaintiff was manually lubricating tires when she felt a pain in her lower back. MRIs later revealed a small disc herniation and Plaintiff was diagnosed with multiple injuries to her lumbar spine.

After her April 2014 injury, Plaintiff worked modified duty in accordance with the company's 90-day modified-duty policy. When the policy expired, Defendant-Employer prohibited Plaintiff from working because she had neither been released to full-duty work nor had she been assigned permanent restrictions that allowed a job match. Defendant also began paying Plaintiff weekly disability payments from an employer-funded accident and sickness (A&S) disability plan.

Both Plaintiff and Defendants appealed an Opinion and Award, which awarded Plaintiff retroactive workers' compensation benefits and awarded Defendants a credit for disability payments paid to Plaintiff under the employer-funded A&S disability plan during that time.

ISSUES IN DEFENDANTS' APPEAL:

1. Whether the Commission's findings of fact regarding whether Plaintiff had suffered a compensable injury were supported by competent evidence as they were limited to "back pain" or "symptoms" caused by the accident and not any particular "injury."

2. Whether the Commission's findings of fact establishing the requisite causal link between the April 2014 incident and Plaintiff's back injuries were supported by competent evidence, where the evidence provided is expert testimony and those experts are alleged to have committed the logical fallacy of *post hoc, ergo propter hoc*.

HOLDINGS IN DEFENDANTS' APPEAL:

1. Yes. The fact alone that the Commission never made "a finding of an 'injury,'" was not sufficient to show that the finding of a compensable injury was unsupported. Although experiencing pain alone is insufficient to support a finding of a compensable injury, the Commission explicitly found that Plaintiff suffered an injury in the form of a material aggravation to her pre-existing low back condition, rather than just pain. Similarly, testimony provided by treating physicians was sufficient competent evidence to support a finding of fact that Plaintiff sustained a compensable injury.

2. No. Defendants' assertion that *post hoc ergo propter hoc* was not competent evidence of causation was correct. However, both expert witnesses in this case testified explicitly that their opinions were not based solely on temporality, but were grounded in consideration of Plaintiff's medical history, the reported incident, physical exams, and diagnostic evidence. The Court held there was sufficient competent evidence to support findings of fact that established the requisite causal link.

ISSUES IN PLAINTIFF'S APPEAL:

1. Whether the Commission lacked jurisdiction to award Defendants a credit for weekly disability payments paid to Plaintiff through an employer-funded A&S disability plan based on Defendants' failure to preserve the issue in their pre-trial agreement to the Deputy Commissioner and in their Form 44 to the Commission.

2. Whether the Commission's finding of fact that Plaintiff received disability payments through the employer-funded A&S disability plan was supported by competent evidence.

HOLDINGS IN PLAINTIFF'S APPEAL:

1. No. Even if Defendants failed to preserve this issue by omitting it from the pre-trial agreement, the Commission has the power to amend the award, even on issues not presented to the Deputy Commissioner. Similarly, although Defendants failed to raise the issue on their Form 44, the issue was not barred for consideration by the Commission. Although Rule 701 of the Workers' Compensation Rules of North Carolina provides that grounds for review not stated in a Form 44 are "abandoned," those rules do not limit the power of the Commission to review or modify findings of fact found by a Deputy Commissioner. The Commission has the jurisdiction to amend

the Deputy Commissioner's Opinion and Award by making findings on the A&S credit issue even if it was not adequately presented.

2. Yes. The A&S records were included as an exhibit to Defendant's Motion to Revise the Deputy Commissioner's Opinion and Award filed on January 13, 2016. The exhibit established that A&S records were generated from Human Resource Management Systems and detailed all payments made to Plaintiff through the A&S disability plan. These records were sufficient competent evidence to support the findings of fact.

Average Weekly Wage

A. *Frank v. Charlotte Symphony*, ___ N.C. App. ___, 804 S.E.2d 619 (September 2017) (Tyson, J.) (Average Weekly Wage; N.C.G.S. § 97-2(5))

FACTS:
Plaintiff was employed by Defendant-Employer as a violinist for seventeen (17) years. In the fifty-two (52) weeks preceding her date of injury (December 15, 2013), Plaintiff performed services for Defendant-Employer for a total of thirty-six (36) weeks and earned gross wages of $39,412.83. Plaintiff alleged suffering a compensable injury to her right shoulder. Defendants initially denied the claim but later accepted it as compensable prior to hearing. However, the parties went forward with a hearing to determine the proper calculation of Plaintiff's average weekly wage.

The Commission rejected the first four methods enumerated under N.C.G.S § 97-2(5) as unjust or inapplicable and applied the fifth method (exceptional circumstances catch-all) to calculate Plaintiff's average weekly wage. As a result, Plaintiff's annual gross earnings with Defendant-Employer were divided by fifty-two (52) weeks. Plaintiff appealed, arguing that the Commission erred and should have used the second method enumerated in the statute (pro rata) allowing her gross earnings to be divided by the number of weeks she actually worked – thirty-six (36).

ISSUE:
Whether the Commission erred in applying the fifth method under N.C.G.S § 97-2(5) to calculate Plaintiff's average weekly wage.

HOLDING:
No. The Court held that Plaintiff failed to show any error in the Commission's chosen method of calculation. The Court's analysis addressed each of the five methods in turn. As for method one, the Court stated that it is inapplicable when the injured worker has worked for less than fifty-two (52) weeks prior to the injury. Method four (casual employment) was not discussed as both parties stipulated that it was inapplicable in this case.

The Court rejected Plaintiff's argument for applying method two. Method two requires the injured worker to have "lost more than seven consecutive calendar days at one or more times" during the fifty-two (52) week period leading up to injury. The Court held that the sixteen (16) weeks that Plaintiff did not work were not "lost." Rather, Plaintiff's contract with Defendant-Employer only contemplated a total of thirty-six (36) weeks of work. The remaining days in the fifty-two (52) week period were never

available for Plaintiff to work. Moreover, the Court stated that the application of method two requires the employee to have been employed for the entire fifty-two (52) weeks preceding injury (citing *Conyers v. New Hanover County Schools* holding that the ten week summer vacation period in which a school bus driver was not obligated to perform work rendered method two inapplicable because the driver was not employed for a fifty-two week period.)

The Court's rejection of method three relied on the requirement that method three only be used when results are "fair and just to both parties." The Court emphasized that application of method three would result in an annualized wage that was much higher (over $17,000 more) than Plaintiff's pre-injury wages. Accordingly, method three was rejected because it would unfairly place Plaintiff in a better position than she was in prior to the injury.

Finally, the Court determined that because of the exceptional circumstances rendering the previous methods inapplicable, the case required the application of method five. Using *Conyers* as a model, the Court affirmed the Commission's decision and determined that dividing the Plaintiff's gross annual earnings by fifty-two (52) weeks most nearly approximated the amount that Plaintiff would have expected to earn had she not been injured.

B. *Myres v. Strom Aviation, Inc.*, ___ N.C. App. ___, 804 S.E.2d 785 (September 2017)(Stroud, J.) (Per Diem Payments; Average Weekly Wage)

FACTS:
Plaintiff suffered a compensable ankle injury while working as an airplane mechanic for Defendant-Employer. Defendant-Employer is a staffing company that provides airspace industry groups with temporary employees. As such, employees working away from home are eligible for a non-taxed per diem amount intended as reimbursement for living expenses (in addition to a fixed hourly wage). Per diem amounts were adjusted in accordance with an assessment of the reasonably anticipated costs of living and working in a certain location. Plaintiff's hourly wage was $7.25/hour. With the per diem payments included, his hourly wages were $20.50/hour. Defendants contested Plaintiff's allegation that his average weekly wage should be based on the $20.50/hour rate. At hearing, the Deputy Commissioner held that the per diem payments were not to be included in Plaintiff's average weekly wage calculation. Plaintiff appealed to the Commission and the decision of the Deputy Commissioner was affirmed. Plaintiff appealed.

ISSUE:
Whether the Commission erred in calculating Plaintiff's average weekly wage based solely on his hourly rate and ignoring his per diem payments.

HOLDING:
No. The Court affirmed the Commission's decision because the per diem payments were not made "in lieu of wages" (N.C.G.S. § 97-2(5)). The Court emphasized that a finding as to whether a payment to an employee is made in lieu of wages is a finding of fact. As such, the Commission controls the determination. In affirming the Commission's decision, the Court stated that the Commission's factual findings were consistent with its conclusions of law.

Additionally, the Court cited *Thompson v. STS Holdings, Inc.*, an earlier case with an almost identical fact pattern. In *Thompson*, the Commission decided to exclude per diem payments from wages because the payments were non-taxable and set at varying amounts based on the costs of staying at a given location. Accordingly, the Court agreed that the payments were meant as reimbursement for living expenses while traveling and not made "in lieu of wages."

Bar Date/Constitutionality

A. *Booth v. Hackney Acquisition Co*., ___ N.C. App. ___, 807 S.E.2d 658 (November 2017) (Murphy, J.) (Constitutionality; Bar Date; North Carolina Insurance Guaranty Association; Occupational Disease; Statute of Repose)

FACTS:
Plaintiff worked as a welder for Hackney Industries, Inc., who was insured by Home Insurance Company from 1988 until 1990. Home Insurance Company was declared insolvent by a New Hampshire court on June 13, 2003 and all claims against it were ordered to be filed by June 13, 2004 (the bar date). Plaintiff developed lung cancer in 2008 and passed away in April 2009. In November 2009, a doctor opined that the cancer was attributable to Plaintiff's exposure to welding rod fumes during his years of employment. Soon after the diagnosis, Plaintiff filed a claim for workers' compensation benefits. The North Carolina Insurance Guaranty Association (NCIGA) filed a Form 61 denial on behalf of the insolvent carrier Home Insurance. The Form 61 alleged that the NCIGA owed no obligation to Plaintiff because the claim was filed after the bar date had passed and statute of repose had tolled. After the Deputy Commissioner denied Defendants' Motion to Dismiss because of the bar date and statute of repose, the Full Commission (before entering an opinion and award) certified the question for presentation to the Court of Appeals.

ISSUES:
1. Whether the bar date for filing a claim against the insolvent insurer violated Plaintiff's right to equal protection of law under the North Carolina and United States Constitutions.

2. Whether the five-year statute of repose for bringing a claim against an insolvent insurer or the NCIGA violated Plaintiff's right to equal protection of law under the North Carolina and United States Constitutions.

HOLDINGS:
1. No. The Court held there was a legitimate State interest in setting a bar date for filing claims in order to protect the integrity of the NCIGA. Plaintiff argued both were unconstitutional as to workers' compensation claimants with occupational diseases which, due to their nature, develop many years later. The Court applied minimum scrutiny as the statutes did not affect a fundamental right or involve a suspect class. North Carolina Statutes define the purpose of the NCIGA as providing payment for covered claims when carriers become insolvent. Claims "filed after the final date set by the court for the filing of claims" are excluded from the definition of covered claims under N.C.G.S. § 58-48-35(a)(1). The Court held that there are several legitimate State interests in limiting the time for filing and that the bar date passes constitutional muster in that regard.

2. No. The Court held the statute of repose is not unconstitutional because, with regard to statutes of repose, there is a presumption in favor of constitutionality and the enactment of such statutes is "exclusively a legislative decision." Plaintiff presented the same constitutional argument regarding statutes of repose as she did for the bar date, and the Court was unpersuaded as the deceased was both diagnosed and died after the five-year statute of repose had tolled.

Fee Schedule

A. *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*, ___ N.C. App. ___, 807 S.E.2d 679 (November 2017) (Bryant, J.) (Fee Schedule; Enabling Legislation; Statutory Interpretation)

FACTS:
On July 23, 2013, the North Carolina General Assembly ratified 2013 N.C. Sess. Laws ch. 410, § 33(a), which established a mandate for the Industrial Commission regarding its medical fee schedule. Under the new mandate, the Commission adopted Rules 04 NCAC 10J .0102 and .0103, and amended Rules 04 NCAC 10J .0101 and .0102. Under Rule 04 NCAC 10J .0101, the Commission established its "Hospital Fee Schedule," which included reimbursement for services provided by ambulatory surgery centers. Further, the Commission reasoned that by following the procedures for rulemaking as outlined in Chapter 150B of the General Statutes, a rebuttable presumption was created that the rules were adopted in accordance with the Administrative Procedure Act.

Plaintiff challenged the Commission's determination that ambulatory surgical centers were included as "physical and hospital compensation" under the fee schedule. Plaintiff further argued that the adopted and amended rules were invalid due to the Commission's failure to meet the fiscal note requirements of N.C.G.S. § 150B-21.4. The Commission reasoned that Plaintiff failed to rebut the presumption of validity regarding the Commission's adopted and amended rules, and denied Plaintiff's requested relief. Plaintiff subsequently filed a petition for judicial review in Superior Court. The trial court concluded hospitals were separate and legally distinct entities from ambulatory surgical centers, and the Commission failed to comply with the fiscal note requirements in adopting a new fee schedule for these centers. Therefore, the trial court reversed the Commission's declaratory ruling. The Commission appealed to the Court of Appeals.

ISSUE:
Whether the trial court erred when it determined that ambulatory surgical centers are not "hospitals" within the meaning of the hospital fee schedule.

HOLDING:
Yes. The Court held the accepted method for determining the word's plain meaning was to simply consult a dictionary, which defined "hospital" as "a[n] institution that provides care and treatment for the sick or injured." The Court further considered the purpose of 2013 N.C. Sess. Laws ch. 410, § 33(a), noting the focus of the session law was to contain medical care costs attributable to injured workers, while reasonably reimbursing medical care providers for services. Including ambulatory surgical centers in the

definition of hospital, and thereby subjecting Plaintiff to the fee schedule, did not frustrate this objective, and could be construed as in harmony with the reason for the session laws. Therefore, the trial court erred by concluding that hospitals are separate and legally distinct entities from ambulatory surgical centers.

N.C.G.S. § 135-106(b) – Social Security Offset

A. *Trejo v. N.C. Dep't of State Treasurer Ret. Sys. Div.*, ___ N.C. App. ___, 808 S.E.2d 163 (November 2017) (Dietz, J.) (Unpublished) (Social Security Offset)

FACTS:
Plaintiff was injured while working as a public school teacher and vested in the State Disability Income Plan for state employees. She applied for Social Security disability benefits, but was denied. She later applied for long-term disability benefits through the State Disability Income Plan and was approved in 2009. She was provided benefits retroactive to 2004. In July 2013, Defendant notified Plaintiff that it had failed to apply the statutory offset pursuant to N.C.G.S. § 135-106(b) based on the hypothetical Social Security disability benefits she might have received beginning in January 2008. Plaintiff challenged these reductions via the Office of Administrative Hearings, and an Administrative Law Judge entered summary judgment in favor of Defendant. The lower court reversed and entered in favor of Plaintiff. Defendant then appealed to the Court of Appeals.

ISSUE:
Whether N.C.G.S. § 135-106(b) requires a mandatory offset for Social Security disability benefits to which the recipient could have been entitled.

HOLDING:
Yes. N.C.G.S. § 135-106(b) provides that long-term disability benefits will be offset by the amount of Social Security disability benefits the recipient might be entitled. Plaintiff argued that this mandatory offset did not apply to her. The Court rejected Plaintiff's argument. The Court held that the statute did not require a recipient to be insured by the Social Security disability program when long-term disability benefits commenced, although in this case Plaintiff was in fact insured by the Social Security Disability when her long-term disability benefits commenced. The important inquiry for this issue is whether, at some point after becoming disabled, the recipient was insured under the Social Security disability program and might have been awarded benefits, regardless of whether that recipient ever applied for benefits or was denied. Further, Defendant was not barred by any equitable doctrine from applying the mandatory statutory offset to Plaintiff by reducing her future benefits.

Role of Courts in Policy Decisions

A. *Davis v. Craven Cty. ABC Board*, ___ N.C. App. ___, 814 S.E.2d 602 (April 2018) (Dietz, J.) (Medical Compensation; Non-FDA-Approved Drugs; Role of the Courts in Policy Decisions)

FACTS:
Plaintiff began working for the Craven County ABC Board in 2009. In May 2010, he injured his right ankle while at work and began receiving workers' compensation benefits. In 2014, Plaintiff was diagnosed with

complex regional pain syndrome by Dr. Garlon Campbell, a pain management physician. Dr. Campbell prescribed a compound cream. The compound cream was not approved by the FDA; however, the drugs that were "compounded" together to create the cream were each FDA-approved on their own for the treatment of various medical conditions. After using the compound cream, Plaintiff told Dr. Campbell that it relieved some of his symptoms. Dr. Campbell recommended continued use of the compound cream for three months. Defendants refused to pay for this non-FDA-approved drug treatment and refused to authorize any further treatment by Dr. Campbell. Plaintiff continued to be treated by Dr. Hines, with whom he had previously treated. Dr. Hines prescribed a similar non-FDA-approved compound cream to treat Plaintiff's pain, and Defendants again refused to authorize or pay for the prescription.

Plaintiff filed a Motion to Compel Defendants to pay for the compound cream. In his deposition, Dr. Hines testified that the compound cream was reasonably necessary to provide Plaintiff with pain relief. On cross examination, Dr. Hines acknowledged that the compound cream was not FDA-approved and that many health insurers refuse to approve the compound cream for treatment. When asked who would bear the risk if something happened to a patient while using a non-FDA-approved medicine, Dr. Hines stated he was no longer comfortable prescribing compound creams and would not do so for other patients. But, because Plaintiff had a successful experience with the compound cream, Dr. Hines testified he would still prescribe the compound cream for Plaintiff with the understanding that if Plaintiff experienced any problems, he would immediately stop prescribing it. Dr. Campbell also testified he often prescribed compound cream and had experience with patients who had used the cream long-term. Dr. Campbell further testified that, while he had noticed skin irritation in connection with the cream, he had never seen a toxic reaction. Dr. Campbell stated the compound cream was "very safe," even though the combination of drugs was not FDA-approved. Finally, Dr. Campbell opined the compound cream was reasonably necessary to relieve Plaintiff's pain, and that he would prescribe the compound cream to others and was unaware of any toxicity or death with patients who used the compound cream.

The Deputy Commissioner concluded the compound cream was reasonably necessary to effect a cure, provide relief, or lessen Plaintiff's period of disability. Defendants were ordered to authorize and pay for the compound cream. Defendants appealed to the Full Commission, and the Commission affirmed the Deputy Commissioner and again ordered Defendants to authorize and pay for the compound cream. Defendants timely appealed.

ISSUE:
Whether the Commission erred in ordering Defendants to pay for a non-FDA-approved drug.

HOLDING:
No. The Court affirmed the Commission's award of benefits and held that, even though the skin cream that Plaintiff's doctors prescribed was not approved by the FDA, it provided pain relief and the Industrial Commission could require Defendants to pay for it. The Court emphasized that the text of the Workers' Compensation Act does not limit the types of drugs that might reasonably be required solely to those that are FDA-approved. Instead, the statute indicates that whether a particular medical treatment "may reasonably be required to effect a cure or give relief" is a fact question that must be individually assessed in each case.

The Court acknowledged that, although Defendants point to a number of persuasive policy reasons why non-FDA-approved drugs are dangerous, the Court had no authority to create exceptions to the plain text of statutes on policy grounds.

Finally, the Court held the testimony of Plaintiff and his doctors was competent to show that the cream provided more effective pain relief than other available treatments and that neither Plaintiff nor other patients the doctors knew of had suffered adverse side effects when using the cream. Even though other evidence supported Defendants' position, there was at least some evidence supporting the Commission's finding that the cream was reasonably necessary to effect a cure, provide relief, or lessen Plaintiff's period of disability.