

# **A DRAFTING GUIDE FOR 8(i) SETTLEMENTS**

**LEWIS S. FLEISHMAN**

## **A. INTRODUCTION**

A primary U.S. Department of Labor complaint in longshore cases is the inability of the parties to draft an 8(i) agreement which complies with applicable statutes and regulations. It is the author's experience that between thirty and forty percent of 8(i) applications are initially rejected by the United States Department of Labor. A notice of deficiency generally issues when a proposed 8(i) agreement lacks an essential ingredient or contains an unacceptable "add-on" provision. A deficiency notice can be avoided by reference to the 8(i) checklists, the sample 8(i) agreement and the drafting examples contained in the following article. The main statutes and regulations regarding the settlement of claims are provided herewith for handy reference. Use of these materials will result in better 8(i) agreements and swifter approval.

## **B. BASIC REFERENCE TOOLS FOR DRAFTING 8(i) AGREEMENTS**

The following materials found in this article serve as drafting guides for preparing 8(i) agreements:

1. Section 8(i) of the Act;
2. 20 CFR 702.241 through 702.243;
3. 8(i) settlement checklist: 7th Compensation District;
4. 8(i) settlement checklist: 13<sup>th</sup> Compensation District;
5. Model 8(i) agreement;
6. Notice of Deficiency;
7. Notice re: Settlements - medicare;
8. Settlement Agreements - ALJ hearing notice;
9. Sample medicare set-aside affidavit;
10. Industry Notice No. 117 Vocational Rehabilitation.

### **C. LIST OF COMMON MISSING 8(i) INGREDIENTS: THE RECIPE FOR REJECTION.**

A recent informal survey conducted at a Department of Labor District Office shows the following common missing ingredients resulting in a Notice of Deficiency. The list below is not meant to be all encompassing. Rather, it is a guide for what needs to be included and the legal authority for inclusion. Regulatory citations are placed first so that the draftsman will remember that the content of 8(i) agreements is governed by statute and regulation, not whim and caprice.

1. 702.242 (b) 1 - The parties need to list separate amounts for compensation and future medicals in the agreement. A combined lump-sum will not suffice.
2. 702.242 (b)(7) - The parties need an itemization of past medicals by year for the past three years if future medicals are to be closed. Any agreement attempting to close future medicals should contain an estimate of future medicals. The parties may request a waiver of a doctor's estimate by pointing to existing medicals showing that claimant has been released from care or that he only need return "pm". The application should note whether recent medical expenses have been minimal or non-existent in the event that future medicals are to be closed.
3. 702.242(b)(6) - A detailed explanation of adequacy is needed. The explanation must be stated in dollar amounts. The old "best interests of the claimant" is not enough. The explanation must be based on the particular facts of the case. The parties should cite disputed facts and why the 8(i) agreement is adequate in terms of probable or possible outcomes. The explanation must be based on evidence in dispute, not speculation or fantasy. In a "waive and pay" combined 8(i)/third-party settlement, the net third-party recovery to claimant needs to be broken out so that there is a basis for determining adequacy. The stipulation on adequacy should not list every office visit and physical therapy session that claimant attended. The medical information relevant to the issue of adequacy is what is important. Therefore, items such as initial treatment, hospitalization, positive tests, surgery, the attainment of maximum medical improvement, impairment ratings, physical restrictions and long-term prognosis should be included.
4. 702.242(a) - The summary of compensation or average weekly wage in the stipulation should match the information in the Department of Labor's file. The U.S. Department of Labor will check the proposed 8(i) agreement against forms LS-208 in the administrative file. If there is a discrepancy, it will need to be reconciled. It is best to review this material before submitting the application, not later.

5. 702.242(b)1 and Section 28: Settlement agreements often provide a specific attorney's fee for claimant's counsel. An application may well be held up until a fully documented fee application is submitted.
6. 702.242(a) and 702.242(b)(5): The parties need to include an impairment, or ppd rating, and permanent physical restrictions, if any. These cannot generally be provided by a physician until claimant has reached maximum medical improvement (MMI).
7. 702.241 (b) - The 8(i) agreement needs to be submitted to the right place. If the case is at the District Office level, it can be submitted to the proper USDOL office. If the case is pending at the Office of Administrative Law Judge level, the 8(i) agreement can be submitted to the Administrative Law Judge, or remanded to the District Office level for approval.
8. 702.242(b)(3) - The 8(i) agreement needs to contain a date of birth for the claimant, or the survivors if it is a death case.
9. 702.242(b)(4) - An agreement needs to contain the claimant's work, wage, earnings and educational history. If claimant has no actual wages post-injury, a labor market survey can prove suitable alternate employment.
10. 42 U.S.C. 1395(y)(b) and 42 C.F.R §411.46. Medicare or Medicaid settlement considerations in an 8(i) agreement. (See attached description of Medicare/Medicaid considerations and sample affidavit.)

**D. COMMON 8(i) INGREDIENTS LIKELY TO CAUSE INDIGESTION: "ADD-ONS" RESULTING IN REJECTION.**

Just as the failure to include an essential ingredient will result in a notice of deficiency, the inclusion of an offending "add-on" provision will likely achieve the same result. The draftsman who approaches an 8(i) agreement with the same mindset used in drafting a third-party release will find the final work-product rejected. That is because the scope of an 8(i) agreement cannot approach the breadth of a personal injury release. Here are some of the more common offending provisions likely to cause rejection of an 8(i) agreement:

1. 702.241(g) - "Any and all claims" or "any and all accidents/injuries". The global release implies that, for example, a subsequent death claim would be settled by approval of the underlying inter-vivos injury claim. Since only claims in existence can be settled, these types of "kitchen sink" provisions will ultimately not pass scrutiny. Similarly, any attempt to settle a state worker's compensation claim within the language of an 8(1) agreement

should result in rejection because the Department of Labor is not empowered to approve state claims in instances where there is contemporaneous jurisdiction. Likewise, attempts to settle "back pay", "EEOC" "ADA" issues, non-LHVVCA issues or actions in other courts/jurisdictions will run afoul of 702.241(g) and likely result in rejection of the proposed settlement agreement.

2. 702.242(b)(7) and 8(i)(1) of the Act. "Past medical benefits". Past medical benefits can present a vexing problem for the drafter of an 8(i) settlement agreement. The Department of Labor will not approve "pig in a poke" settlement agreements. If the employer's liability for past unspecified medical costs is terminated, how can the adjudicator determine adequacy? The Department of Labor will not shift liability to claimant for medical costs that should have routinely been paid in the normal course of business. For a more detailed explanation of the problem presented in closing past medicals, see the attached notice of deficiency detailing what needs to be addressed when the parties seek to close past medicals.
3. Section 15(e) and 702.241 (g) - "All penalties". While there are legitimate reasons why a carrier does not want to pay penalties in connection with a settled claim, the parties cannot settle any penalties that might accrue after the settlement, such as the-Section 14(f) penalty for late payment. The "all penalties" provision should result in rejection of an 8(i) agreement. in order to avoid the late payment penalty, the Department of Labor encourages stipulations regarding claimant's address to avoid Section 14(f) issues.
4. Section 39 - The attempted settlement of future vocational rehabilitation expenses presents its own set of problems. An 8(i) agreement can discharge any potential "Abbott" liability for compensation. However, the attempted closure of future vocational rehabilitation services is beyond the proper scope of an 8(i) agreement. It is the within the sole authority of the District Director to authorize vocational rehabilitation. The industry notice regarding the U.S. Department of Labor's policy of continuing vocational rehabilitation services even after the approval of an 8(i) agreement is provided herewith for a better understanding why future vocational rehabilitation services are not properly closed pursuant to the terms of an 8(i) agreement. It should be noted that the notice/award process at the Department of Labor regarding proposed vocational plans provides adequate carrier input post-settlement.

## **E. THE REWARD FOR UNDER AND/OR OVER-INCLUSION: NOTICE OF DEFICIENCY**

In the event that a proposed 8(i) agreement fails to include an essential ingredient or contains an offending "add-on" provision, the result will probably be a notice of deficiency. An example of a stock notice of deficiency is contained in the basic reference tools section of the appendix to this paper. As a final step in preparing an 8(i) settlement agreement, the

Careful drafter should check the stock notice of deficiency to see whether any of the more common deficiencies are contained in the proposed agreement. It is much easier, and less embarrassing, to check the deficiency list before submitting an 8(i) agreement for approval than to open the mail and find a deficiency notice enclosed.

## CONCLUSION

The settlement of a longshore claim is the only realistic way in which a claimant can obtain closure. In order to finalize a claim, it is important to follow the aforementioned provisions of the Longshore and Harbor Workers' Compensation Act and its implementing regulations. The failure to prepare a well thought out 8(i) agreement only serves to frustrate all parties in a dispute and to waste the time of those who adjudicate claims. Hopefully, the materials provided herewith will serve to streamline the process of bringing cases to an end without undue delay.

LEWIS S. FLEISHMAN

Special thanks to those who have provided materials used as basic reference tools for drafting 8(i) agreements:

Chris Gleasman, District Director, 8<sup>th</sup> Compensation District  
Carolyn Salyer, Claims Examiner, 8<sup>th</sup> Compensation District  
David Duhon, District Director, 7<sup>th</sup> Compensation District  
Todd Bruininks, District Director, 13<sup>th</sup> Compensation District  
The Hon. William Dorsey, Administrative Law Judge

**Section 8(i) of the Act (33 USC 908(1))**

**(i)(1)** Whenever the parties to any claim for compensation under this Act, including survivors benefits, agree to a settlement, the deputy commissioner or administrative law judge shall approve the settlement within thirty days unless it is found to be inadequate or procured by duress. Such settlement may include future medical benefits if the parties so agree. No liability of any employer, carrier, or both for medical, disability, or death benefits shall be discharged unless the application for settlement is approved by the deputy commissioner or administrative law judge. If the parties to the settlement are represented by counsel, then agreements shall be deemed approved unless specifically disapproved within thirty days after submission for approval.

**(2)** If the deputy commissioner disapproves an application for settlement under paragraph (1), the deputy commissioner shall issue a written statement within thirty days containing the reasons for disapproval. Any party to the settlement may request a hearing before an administrative law judge in the manner prescribed by this Act. Following such hearing, the administrative law judge shall enter an order approving or rejecting the settlement.

**(3)** A settlement approved under this section shall discharge the liability of the employer or carrier, or both. Settlements may be agreed upon at any stage of the proceeding including after entry of a final compensation order.

**(4)** The special fund shall not be liable for reimbursement of any sums paid or payable to an employee or any beneficiary under such settlement, or otherwise voluntarily paid prior to such settlement by the employer or carrier, or both.

## 8 (i) Settlement Applications Checklist:

1. \_\_\_\_\_ **Self-Sufficient:** Make sure that the settlement application, when read on its own without any background information, stands on its own and supports that the settlement is adequate and should be approved.
2. \_\_\_\_\_ **Stipulations signed by all parties:** Don't forget to have all parties sign, especially claimant.
3. \_\_\_\_\_ **Brief summary of the facts:**
  - A. description of the accident
  - B. description of the nature and extent of the injury
  - C. degree of impairment./ disability
4. \_\_\_\_\_ **Compensation:** Make sure average weekly wage and compensation rate are listed as well as summary of compensation paid. (You can attach a copy of the LS-208 form when appropriate)
5. \_\_\_\_\_ **Full Description of the Terms of the Settlement**
  - A. list separate amounts for the settlement of compensation and medical benefits
  - B. list amount of attorney fees agreed upon (itemized in accordance with 702.132)  
\*make sure power of atty. and fee application are enclosed\*
6. \_\_\_\_\_ **Reasons for settlement/Issues in Dispute**
7. \_\_\_\_\_ **Claimant's Information:**
  - A. date of birth or (if death claim) date of death, and list of dependents
8. \_\_\_\_\_ **Claimant's employment status:**
  - A. Is claimant working? (where? what rate of pay/salary?)
  - B. Not working? (attach vocational rehabilitation reports, describe claimant's educational level, work history, or other factors that would affect employability)
9. \_\_\_\_\_ **Current Medical reports:** attach reports that
  - A. Describe injuries and impairment
  - B. Describe other unrelated conditions
  - C. Lists the Maximum Medical Improvement Date
  - D. Describes anticipated future treatment and disability
10. \_\_\_\_\_ **Statement of Adequacy:** please explain in detail how the amount of settlement is an adequate amount given the facts of the case. Be specific.
11. \_\_\_\_\_ **Include the statement "Claimant attests that this settlement was not procured under duress".** To protect all the parties involved, every settlement is required to have a statement verifying that the proposed agreement was not forced upon the claimant. .
12. \_\_\_\_\_ **Collateral Sources:** list any sources claimant has available or is expected to have available to pay medical bills if settlement is approved. \*Remember that Medicare is NOT a collateral source\*
12. \_\_\_\_\_ **Listing of past 3 years of medical payments:** (if meds settled)  
Don't use unqualified "past medicals" language to include bills which should be paid

## Elements for Section 8(i) Applications

\_\_\_ **Self sufficient**

\_\_\_ **Signed by all parties**

\_\_\_ **Contains a brief summary of the facts including:**

- date of injury
- name and address of claimant, all employers, insurance carriers and third party administrators
- description of the incident
- description of the nature of the injury
- degree of Impairment
- degree of disability
- availability of the type of work claimant can perform

\_\_\_ **Claimant's:**

- date of birth
- date of death and list of dependents with their dates of birth
- work status and ability to work
- educational level, work history, other factors that could effect future employability

\_\_\_ **Benefits:**

- summary of compensation paid
- average weekly wage
- compensation rate
- a full description of the terms of the settlement
- settlement amount for compensation
- settlement amount for survivor's benefits
- amount for attorneys fees Itemized in accordance with Section 702.132 (if claimant was represented by more than one attorney, each attorney should itemize fees)

\_\_\_ **Contains the reason for the settlement and any issues still in dispute**

\_\_\_ **Current medical report containing:**

- description of injuries relating to impairment
- description of any other unrelated conditions
- date of maximum medical improvement
- anticipated future disability and needed -medical treatment

\_\_\_ **Statement of why settlement is adequate**

\_\_\_ **Statement that the settlement was not procured under duress**

\_\_\_ **If medical benefits are covered in settlement:**

- an Itemized list of amounts paid for medical treatment during the three previous years
- settlement amount for medical treatment
- an estimate of claimant's need for future medical treatment and the cost of the treatment which should indicate the inflation factor and/or the discount rate
- Information on any collateral sources available to pay for future medical expenses
- a statement that the parties have considered Medicare requirements

\_\_\_ **If mental disability or incompetence alleged:**

- is there medical opinion/report as to claimant's capacity to understand the consequences of entering into a settlement
- is there an indication that the claimant can administer a lump sum settlement
- If the answer to the above is no, is there a court appointed guardian or personal representative, separate and distinct from the claimant's legal counsel

An Order or Notice of Deficiency will be Issued by the Department of Labor within 30 days.

You must pay the settlement within 10 days from the date of the Order and you must file Form LS.200 with the Department of Labor within 16 days from the date of the last payment. Failure to do so will result in penalties.

Should you have questions, please call us:

– R. Todd Bruininks, District Director  
415-848.8675

– Maria Mayrand, Claims Examiner  
415-848-6673

– Charles Holbrook, Claims Examiner  
415-848-6680

U.S. Department of Labor  
Office of Workers' Compensation Programs  
Longshore and Harbor Workers' Compensation  
P.O. Box 193770  
71 Stevenson, Suite 1705  
San Francisco, CA 94119.3770

(A "BASIC" 8(i) FORMAT)

UNITED STATES DEPARTMENT OF LABOR  
EMPLOYMENT STANDARDS ADMINISTRATION  
OFFICE OF WORKERS' COMPENSTAION PROGRAMS  
EIGHTH COMPENSATION DISTRICT

\*\*\*\*\*

In the matter of the claim for Compensation  
under the Longshore and Harbor Workers' Compensation Act

Employee v. Employer  
CASE NUMBER:

and  
Insurance Carrier

AGREED SETTLEMENT PURSUANT TO SECTION 8(i) OF THE ACT AND COMPENSATION ORDER  
APPROVING SAME

\*\*\*\*\*

The parties hereto, [employee's name], Employee, [employer's name], Employer, and [carrier's name], Insurance Carrier, have reached an agreement for the settlement of this claim for [compensation, medical treatment, or both] on a lump sum basis pursuant to Section 8(i) of the Longshore and Harbor Workers' Compensation Act, and as a basis for said agreed settlement the parties agree and stipulate as follows:

1.

That on [date of injury], the Employee was in the employ of the above-named Employer, and the liability of Employer for the payment of workers' compensation benefits was insured by [name of insurance carrier or "was self-insured", if applicable].

2.

That on [date of injury], while performing services as a [title or description of Employee's job], the Employee [description of accident and nature of injury].

3.

That the Employee has met the notice requirements of Section 12 of the Act. Although written notice of injury was not received within thirty days of the accident, the Employer had knowledge of the injury and has not been prejudiced by lack of written notice. (if written notice was timely provided, note the date and form of such notice as a substitute for the above)

4.

That the Employer has furnished medical services in accordance with Section 7 of the Act. [Revise as necessary where disputes regarding medical treatment continue. ex: The Employer and their insurance carrier have not paid for the services of Dr. X, as it continues to be their position that Dr. X is not an authorized physician under the provisions of Section 7 of the Act.]

5.

That the Employee selected [name of doctor] as his treating physician. [Give history of medical treatment. Do not list each and every doctor's visit. Confine the summary to the important points (the names of the doctors involved, the diagnoqds• the treatment provided, the diagnostic studies, any surgery performed, the MMI date, any PPD or

restrictions, but not every single detail about every single follow-up visit)]

6.

That the Employee's Average Weekly Wage at the time of the injury was

7.

That as a result of the injury the Employee was [note ALL periods of temporary disability (TTD, TPD) and the amounts paid. Make certain that these amounts are accurate and match the LS-208 in the file. Submit an amended LS-208 if necessary]

8.

That the Employee has reached, maximum medical improvement as a result of the injury. [Note the particulars' regarding the rating and any compensation due or paid for permanent disability. Remember, MMI is a prerequisite to settlement! Attach medical report showing that the employee is at MMI.]

9.

Solely for the purpose of this application, the parties have compromised their differences. The parties do not wish to proceed to a Formal Hearing of this claim and agree to settle for a lump sum of [term & amount of B(i) settlement) to be paid directly to the Employee, in addition to compensation previously paid. [If settling compensation and medical treatment the parties must list separate amounts for settling compensation and medical treatment or the application will be returned as l'inoomplete."3  
[if the settlement is for waiver of a lien in a 3rd party action list the gross and net amount of the employee's 3rd party recovery and the "consideration" for settlement (waiver of lien, "new money", or both. Again, even if settlement is for waiver of lien, separate amounts MUST be designated for the settlement of compensation and medical treatment.)

10.

Approval and payment of this agreed settlement under Section 8(i) of the Act shall discharge the Employer and their Insurance Carrier's liability for the payment of [further compensation and/or future medical benefits, as appropriate).

11.

[if medical left open: This settlement does not affect the entitlement of the Employee to medical treatment as provided in Section 7 of the. Act).

[if medical is settled, list the medical costs paid for each of the three years preceding the settlement. Provide the details of the agreement (medical to close after a specific period, etc.) along with information regarding the extent of future treatment and its cost, with reference to a specific medical report. Do not list the medical payments in an addendum; do not attach a printout of payments made. It is the parties' responsibility to list medical payments by year as required by the Regs. Separate amounts are required even if the "consideration" for settlement is a waiver of lien in a related 3rd party matter. In such an event, state the total amount of the lien waived and the separate amount of the lien designated to settle comp, along with the separate amount designated to settle future medical treatment.]

[if medical is settled, 702.242(b)(7) requires an estimate of future medical expenses. If such an estimate is not necessary cite the evidence making an estimate unnecessary (ex.: a currently available medical report releases the claimant from treatment) and request that the requirements of 702.242(b)(7) be waived.]

[if Medicaid benefits are not an issue, so state, or indicate that an affidavit is attached, if applicable. If Medicaid benefits are potentially an issue (because claimant is currently eligible or will be eligible and settlement exceeds Medicare's threshold amount) advise of the status of this issue, i.e., either that claimant has considered the issue and has decided not to get Medicare approval, that Medicare's approval letter is attached, or indicate that an affidavit is attached.]

[unless the circumstances are unusual (all medical is controverted and unpaid due to a real issue of jurisdiction or causal relationship) the settlement should be confined to future medical benefits, as stated in 8(i) of the Act. It is contrary to the policy of OWCP to shift the liability to an injured employee for cost of medical treatment that should have been provided in the normal course of the claim. If the parties wish to settle past medical then all medical

providers furnishing treatment must be listed, along with the amounts owed to each provider (-0- if applicable) and claimant's affirmation that each provider has been contacted to confirm the amount of any outstanding charges. Absent the specific amount of the total of charges outstanding for past medical treatment it will be impossible for the adjudicator to determine the adequacy of the settlement and the 8(1) will be returned as incomplete.]

12.

[Provide rationale for the settlement. Include the Employee's date of birth, extent of education, work experience, service in the armed forces, skills or abilities, current earnings or earning capacity and other relevant information. Make the rationale applicable to the case at hand. Do not use "canned" language. Settlements with only "canned" language ("Parties do not wish to proceed to a formal hearing..." "Parties wish to settle this case..." will be returned as "incomplete." Show how the settlement should be considered "adequate" in view of the range of potential Longshore recoveries and the amount tendered in settlement. Confine the rationale to legitimate disputes only (those supported by evidence) and not pro forma issues (ex. If claimant sustains a witnessed amputation at work, then "Employer disputes the fact that the employee sustained an injury" would not be a "legitimate" dispute to list.) ]

[if the 8(i) is in conjunction with a 3rd party settlement, at the very least, employer is entitled to a credit for the net recovery, so the net recovery should be compared to claimant's potential Longshore recovery in order to put the settlement in context. Additional issues, such as a potential bar to recovery under section 33 should also be discussed]

13.

[Attorney fee information, if applicable, including amount if in addition or a lien on the settlement. A fee petition MUST BE ATTACHED to the settlement or the application is incomplete..]

14.

The Employee attests that the proposed settlement has not been procured by duress.

#### APPLICATION FOR LUMP SUM SETTLEMENT

The undersigned parties have read the above stipulation of facts and approve of the same. The parties request that the Department of Labor approve the proposed settlement under Section 8(i) of the Act, discharging the Employer and Insurance Carrier's liability for the payment of [compensation\_ and/or future medical treatment].

Employee

Employee's Attorney[if applicable]

Employer's Representative

Employer/Carrier's Attorney[if applicable]

PLEASE NOTE: IT IS STRONGLY URGED THAT THE PARTIES FURNISH THE DISTRICT OFFICE WITH THE FOLLOWING PROPOSED ORDER AND PROOF OF SERVICE. FURNISHING A PROPOSED ORDER WILL REDUCE PROCESSING TIME CONSIDERABLY. IN ADDITION, BY PREPARING THEIR OWN PROOF OF SERVICE THE PARTIES ASSURE THAT THE SETTLEMENT WILL BE PROPERLY SERVED ON ALL OF THE INTERESTED PARTIES, AN IMPORTANT CONSIDERATION FOR ANYONE WISHING TO AVOID THE 20% PENALTY UNDER .14(f) FOR LATE PAYMENT OF COMPENSATION.

## FINDINGS OF FACT

1. The agreed settlement is adequate and not procured by duress;
2. Settlement in the amounts set forth in the stipulation is hereby approved, and the parties are directed to carry out the requirements of the settlement;
3. The liability of the Employer and Insurance Carrier for all payments of [compensation and or future medical benefits, as applicable] under the Longshore and Harbor Workers' Compensation Act as a result of the Employee's accident and injury of [date of injury] will be discharged upon payment of the agreed-upon sums;
4. [if medical kept open: The Employee shall continue to be entitled to medical treatment in accordance with the provisions of Section 7 of the Act.]
5. [if the Employee has an attorney: A fee in the amount of \$ [amount of fee] is hereby approved in favor of [name of firm], such fee to be paid directly to [name of firm], [in addition to compensation or as a lien upon compensation, as appropriate] awarded herein.

## ORDER

It is hereby ORDERED that the Employer and Insurance Carrier shall forth with pay all amounts due in accord with the provisions of this agreed settlement.

GIVIN UNDER MY HAND at Houston, Texas, the day of       , 2004.

CHRIS JOHN GLEASMAN  
DISTRICT DIRECTOR  
EIGHTH COMPENSATION DISTRICT

PROOF OF SERVICE

I certify that on \_\_\_\_\_ the foregoing Compensation Order was filed in the Office of the District Director, Eighth Compensation District, and that a copy thereof was mailed on said date by certified mail to the parties at the last known address of each, as follows:

CLAIMANT

EMPLOYER

INSURANCE CARRIER

A copy was also mailed by regular mail to the following:

EMPLOYER/CARRIER'S ATTORNEY

EMPLOYEES ATTORNEY

CHRIS JOHN GLEASMAN  
DISTRICT DIRECTOR  
EIGHTH COMPENSATION DISTRICT

Mailed:

If any compensation, payable under the terms of an award, is not paid within ten days after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof. The additional amount shall be paid at the same time as, but in addition to, such compensation.

The date compensation is due is the date the District Director files the Decision and Order in his office.

U. S. Department Of Labor  
Employment Standards Administration  
Office of Workers' Compensation Programs  
Division of Longshore and Harbor Workers' Compensation  
8866 Gulf Freeway, Suite 140  
Houston, TX 77017-6528

XXXXXXXX, Esq.  
The Law Offices XXXXXXXXXXX,  
Ste XXXX, TX XXXXX

File Number: XXXXXXXXXXX  
Injured Employee: XXXX  
Date of Injury: XXXXXXXXXXX  
Employer: XX XX

NOTICE OF DEFICIENCY

Dear Ms. XXXXX:

The Application for Approval of Agreed Settlement in the above-referenced case, which was received in the District Office on XXXXXXXX XX, 2003, has been found deficient for the following reason and is not deemed approved within 30 days as set forth in 20 CFR 702.243(b) for the following reasons:

1. The Regulations at 20 CFR 702.242(b)(1) require that settlement applications contain "a full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation and medical benefits." (emphasis added) In the present case the application contains only one settlement amount even though the document proposes to close out the employee's right to both compensation and medical treatment.
2. Section 20 CFR 702.242(b)(7) requires "an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment." The claim payment history attached to this application does not comply with the requirements of this section. These amounts need to be broken down by year and presented as the parties' stipulation.
3. No explanation of adequacy - must be in \$\$ - not "Best interest of the claimant.
4. 20 CFR 702.242(a) requires that the parties stipulate to an average weekly wage (AWW) and compensation rate. You have reported that your vocational research yielded a post injury earning capacity of \$7 per hour, however, without knowing the pre-injury weekly earning capacity, we have no means to determine adequacy of the settlement.
5. Section 28 - No attorney fee application
6. No PFD rating/restrictions. Section 20 CFR 702.242(6) requires that a complete settlement application include the parties' explanation as to why the proposed settlement is adequate. The proposed settlement intends to terminate the claimant's right to compensation benefits based on a dispute involving the impairment rating, however the only impairment rating in the administrative file indicates a 20% impairment to the right lower extremity. In such a case, based on the average weekly wage of \$104.65 per week, a settlement of indemnity benefits for less than \$4,018.56 is inadequate.  
The Division of Longshore and Harbor Workers' Compensation (DLHWC) PROCEDURE MANUAL states the following, "For settlements submitted involving injuries covered by section 8 (c) (1) - (20) of the Act, where there is only one medical opinion, e.g., the treating physician's, the settlement should not be based on a lower-percent than that established by that physician. A proposed settlement for a lesser amount should be considered inadequate and should be rejected."
7. This claim was referred to the Office of Administrative Law Judges on [DATE], and there is no remand order in the administrative file. Since this claim remains with the Office of Administrative Law Judges I do not have

the authority to consider the proposed settlement. The parties may request the return of the original settlement document for submission to - the Office of Administrative Law Judges, or file a request with the Administrative Law Judge for remand of the claim to the District Office. If the case is remanded the 30-day period set forth in section 8(1) does not begin to run until the case is received by the District Office (20 CFR 702.241(b)).

8. 702.242(b)(3) No DOB for claimant or survivors.

9. A settlement pursuant to Section 8(i) of the Act is limited by 20 CFR 702.241(g) "to claims then in existence." The language under the section entitled Terms of the Settlement, ("this application intends to settle any and all other rights or claims afforded by the LHWCA.") is inconsistent with the Regulations. Any language regarding discharge of rights must always refer to the cause of action being settled (which in this instance is the accidental injury that occurred on or about {DATE}).

The District Director does not have any authority to adjudicate or approve settlements under the Jones Act or any other state or federal law, and therefore has no authority to release the employer and carrier from claims in those venues. If the parties include language relating to the discharge of liability under any other act or in any suit filed in another venue the District Director will make a specific finding and order regarding the absence of authority to support the parties stipulation.

10. The parties are attempting to allocate monies paid in settlement of a matter pending in another venue towards settlement of the workers' compensation claim. No specific amount has been offered to settle the Longshore (Defense Base Act) claim under Section 8(i) of the Act. It is axiomatic that a settlement for nothing would be deemed inadequate under the Act. If the parties intend to settle this claim, they need to allocate monies specifically for that purpose.

11. This application purports to settle "past medical benefits." This creates a significant issue in determining adequacy when the existence of any "past" unpaid medical expenses is unknown. If there are outstanding medical bills that are due and payable in this case they should be paid. If certain bills are not going to be paid then the parties must state the reason(s) for non-payment. Without specific knowledge of any "past medical benefits" currently outstanding the Director could very well approve a settlement where the outstanding bills substantially reduce or even eliminate the claimant's recovery in settlement. This would not be an "adequate" settlement in accordance with section 8(i) of the Act. Further, an injured employee is entitled to medical treatment pursuant to Section 7 of the Act. This office is not going to shift the responsibility for the payment of past medical bills to an injured worker when these bills should have been routinely paid by the employer in the normal course of the claim. It is recommended that the following format be utilized to address the issue of adequacy when settling past medical expenses are at issue:

- A stipulation by the parties that outstanding medical expenses amount to \$ (or a joint stipulation that there are no outstanding medical expenses, if such is the case);
- A list of physicians and facilities where the employee has obtained treatment, along with claimant's affirmation that he has checked with these providers regarding any outstanding balances due. The amount of any outstanding balance (-0- if applicable) should be listed next to each provider;
- Claimant's acknowledgement that any medical provider not listed will be deemed "unauthorized" in accordance with Section 7, and that the bills from any unauthorized medical provider will be the sole responsibility of the claimant;
- Carrier's affirmation that there is no outstanding balance due for any employer/carrier-selected exam or any Department of Labor-ordered exam.

12. Trying to settle Vocational Rehab.

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### Adequacy Issues

Section 20 CFR 702.242(6) requires that a complete settlement application include the parties' explanation as to why the proposed settlement is adequate. Any explanation of adequacy in this case must acknowledge the consensus of evidence in the file that the employee is unable to return to work at his usual and customary occupation. (Carrier's physician, XXXXXXX, states he "is not certain whether he [claimant]) will be able to return to work as a

sandblaster/painter." The employee is therefore entitled to a presumption of total disability, shifting the burden to the employer to show that the employee has an earning capacity (either actual earnings or the results of a labor market survey that contains the elements required by applicable case law). In the alternative, the employee can make representations as to how much he is or is capable of earning based on his current or promised employment. In the case at hand, there is no evidence of the claimant's current earning capacity and therefore no means to determine adequacy.

This letter is issued as provided for in 20 CFR 702.243(c). Upon receipt of a letter addressing the above deficiencies, or an amended application correcting them, final settlement of the case will be reconsidered. Please remember that the time limitations to approve a settlement do not begin to run until the District Director receives a complete application for settlement.

Sincerely,

CHRIS JOHN GLEASMAN  
District Director

1. Paragraph VI. of the settlement application states that the claimant "was not temporarily and totally disabled as a result of this injury." The employer further contends that Mr. Macias was paid full wages from February 12, 2004 through March 8, 2004, following his surgery." The fact that the claimant was paid his full wages during his period of temporary total disability has no bearing on the nature and extent of his disability. Mr. Macias was indeed temporarily totally disabled (i.e., unable to work at his usual and customary occupation). As a result, the employer/carrier is required to notify the District Director, pursuant to Section 14(c) of the Act, of the date compensation payments commenced, the average weekly wage and the compensation rate being paid. Without this information, it is impossible to determine the amount of any credit the employer might be due under Section 14(j) of the Act (see Flynn v John T. Clark, 30 BRBS 73) and, therefore, the adequacy of the proposed settlement.

The employer/carrier was advised that this information was required by letter dated April 16, 2004 (see attached)



NOTICE TO CLAIMANTS AND REPRESENTATIVES:  
SETTLING CLAIMS

If You Are A Benefits Claimant: If you file a claim for disability or medical benefits under the Longshore and Harbor Workers' Compensation Act, you are a "claimant." A claimant and his or her employer/insurance carrier may agree to "settle" a claim at any time. This means that you agree to accept less money or other benefits than you might receive if you win an award on your claim. This **NOTICE** applies to you if either one of the following is true:

- You settle your claim for any amount AND you are presently entitled to Medicare because of your age or disability; OR
- You settle your claim for more than \$250,000 AND you believe that you will become entitled to Medicare within 30 months (that is, two and one-half years) after the date you settle your claim.

**If you meet either one of these requirements, we strongly advise you to submit your settlement to Medicare for review and approval before you submit it to the Department of Labor.**

By law, your employer or insurance carrier, not Medicare, is responsible for the cost of medical treatment of your work-related injury or illness. When you become eligible, Medicare may pay for these costs if you have settled your medical claim with the employer/carrier. Medicare will decide whether your settlement provides the right amount of money from your employer for your medical treatment. Medicare may refuse to pay for some, or all, of your injury-related medical treatment if your settlement does not include enough money from your employer for your medical treatment. Asking Medicare to review your settlement before you agree to it may help protect your rights in the future.

**IMPORTANT:** A Department of Labor District Director, or an Administrative Law Judge must also approve your Longshore settlement. Their approval does not mean that Medicare will approve your settlement. Even if the District Director or Administrative Law Judge approves your settlement, you should still ask Medicare to review the settlement.

You may submit your settlement to the following address for Medicare review:

[INSERT APPROPRIATE ADDRESS AND TELEPHONE NUMBER]

If you do not understand this NOTICE, you should contact

[INSERT APPROPRIATE CONTACT, ADDRESS AND TELEPHONE NUMBER].

If You Are A Claimant's Representative: Claimants' representatives should be aware that settlements under the Longshore and Harbor Workers' Compensation Act (LHWCA) are subject to Medicare requirements in certain cases. Medicare requires pre-approval of workers' compensation settlements if either one of the following is true:

- Any settlement, regardless of amount, if the claimant is currently entitled to Medicare; or
- Any settlement greater than \$250,000, if the claimant may reasonably expect to become eligible for Medicare within 30 months of the settlement date.

The private parties must take into consideration Medicare's interests in structuring the settlement. 42 C.F.R. §§ 411.43. In general, this interest involves ensuring that the parties do not use the terms of the settlement to evade the employer's lawful responsibility for the medical treatment of the employee's work-related injury or illness. If the private parties do not account for Medicare's interests, Medicare may later refuse to cover some, or all, of the claimant's medical expenses for treating his or her work-related injury or illness. The Medicare regulations outline the circumstances in which Medicare is not responsible for paying the claimant's medical expenses. 42 C.F.R. §§ 411.40 – 411.47. The parties may also be sued by the Department of Health and Human Services (which administers Medicare) for improperly shifting medical expenses from the legally liable employer or insurance carrier to Medicare.

Although District Directors and Administrative Law Judges approve settlements (see 33 U.S.C. § 908(i)), they are not authorized to determine if a settlement makes adequate provision for Medicare's interests. Their authority extends only to ensuring that a settlement is not "inadequate or procured by duress." Consequently, the private parties must consult with the Center for Medicare and Medicaid Services for answers about their legal obligations under Medicare.

[INSERT SPECIFIC CONTACT INFORMATION, INCLUDING ADDRESSES, TELEPHONE NUMBERS, OR WEB ADDRESSES]

## SETTLEMENT AGREEMENTS

"Any application for approval of a settlement pursuant to 33 U.S.C. §908(i) must contain all information required by 20 C.F.R. §702.242. In addition, parties submitting a settlement agreement for approval should be aware of the potential impact of the Medicare as Secondary Payer (MSP) statute, 42 U.S.C. §139y(b), on lump sum settlements that purport to release employers/carriers from liability for future medical expenses. If Medicare's interests in the lump sum payment are not adequately considered per 42 C.F.R. §411.46, Medicare may refuse to make medical payments once the Claimant becomes entitled to Medicare benefits. Furthermore, the parties and their attorneys should be aware that, if Medicare makes conditional payments of medical expenses that the Center for Medicare and Medicaid Services (CMS) determined should have been paid by the primary payer, then CMS has the authority to seek reimbursement of those conditional payments, as well as interest, from virtually any entity involved in the claim. Finally, CMS may continue to hold employer/carriers responsible for future Medicare payments if medical expenses are compromised without approval of the settlement by CMS. It is the responsibility of the parties to decide whether to obtain advance approval of their settlement terms from CMS. Settlements submitted for approval must 1) state that the parties have considered Medicare's requirements as they may pertain to the settlement, and 2) whether the Claimant currently is eligible for Medicare or Medicaid benefits. For additional information on Medicare's role in workers' compensation settlements, practitioners should refer to [www.cms.gov/medicare/cob](http://www.cms.gov/medicare/cob)

AFFIDAVIT REGARDING MEDICARE BENEFITS

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

BEFORE ME, the undersigned authority, personally came and appeared, \_\_\_\_\_, who, first being duly sworn, did depose and says that:

1. He/She was an Employee of \_\_\_\_\_
2. He/She has made a claim for workers' compensation benefits and has been paid workers' compensation benefits by the insurance carrier for \_\_\_\_\_
3. He/She is not eligible for, nor has he applied for, nor is he receiving, nor has he in the past received Social Security Disability Income (SSDI) or Medicare benefits,
4. He/She has not received benefits relating to his/her injury of \_\_\_\_\_, from SSDI, Medicare, or any other collateral source including, but not limited to, individual or group health insurance benefits and medical benefits provided to veterans of the United States military.
5. He/She does not reasonably expect the receipt of benefits from SSDI, Medicare, or any other collateral source related to his/her injury of \_\_\_\_\_
6. He/She asserts that the purpose of this settlement is not to shift responsibility for payment of medical expenses resulting from the alleged work injury to Medicare.
7. He/She understands that Employer, \_\_\_\_\_, has relied on this information in consideration of the settlement of his/her claim.

FURTHER AFFIANT SAYETH NOT.

CLAIMANT

SWORN TO AND SUBSCRIBED, before me this \_\_\_\_\_ day \_\_\_\_\_ of 20xx.

NOTARY PUBLIC  
IN AN FOR THE STATE OF

July — 2004

Industry Notice No. 117  
NOTICE TO ALL REHABILITATION COUNSELORS  
PROVIDING SERVICES UNDER THE LONGSHORE AND HARBOR WORKERS'  
COMPENSATION ACT

Subject: Notice and Appeal Procedures for Vocational Rehabilitation Services Approved under the Longshore and Harbor Workers' Compensation Act.

The OWCP, Division of Longshore and Harbor Workers' Compensation, has adopted new requirements and procedures for vocational rehabilitation services provided under Section 39 of the Longshore and Harbor Workers' Compensation Act (LHWCA).

Vocational rehabilitation under the Act is voluntary. The Act and its implementing regulations do not establish a direct role for employers or carriers in the provision of vocational rehabilitation services. However, in certain circumstances, employers and their insurance carriers may be found liable for total disability compensation during a period when the injured worker is enrolled in vocational rehabilitation services. As a consequence of the employer's potential increased liability, the Benefits Review Board has held that the employer and carrier are entitled to notice and an opportunity to comment prior to implementation of a vocational rehabilitation award.

Therefore, before a proposed vocational rehabilitation award to a Longshore injured worker is approved and implemented, the Rehabilitation Counselor must send a Notice of Proposed Rehabilitation Plan and Award to the employer, the insurance carrier or its claims administrator, and to their attorneys, to notify them of the proposed plan and to allow them the opportunity to comment.

Attached is a copy of LHWCA Bulletin No. 04-03 of June 16, 2004, with background information and detailed instructions of the new program requirements. These instructions only pertain to services provided under the Longshore and Harbor Workers' Compensation Act and its extensions, and do not apply to services provided under the Federal Employees' Compensation Act (FECA).

Also attached is an acknowledgement of receipt of this notice, to be signed and returned to the District Rehabilitation Specialist.

MICHAEL NISS  
Director, Division of  
Longshore and Harbor  
Workers' Compensation

Attachments:

- (1) LHWCA Bulletin 04-03
- (2) Rehabilitation Counselor Acknowledgement