How to Get the Most **Out of Your Industrial Commission** Hearing*

*With or Without Lawyer

> By: Michael J. Bertsch Moscarino & Treu LLP



"Well, this is a first. We've been predeclined for a credit card."

Telltale Troublesome Claims and Claims

Telltale Troublesome Claims and Claimants or

Telltale Troublesome Claims and Claimants How to Spot The Exception From The Rule



* New Hire Claimant

- * New Hire Claimant
- * Problem Employee / Multiple Claimant

- * New Hire Claimant
- * Problem Employee / Multiple Claimant
 - * No or Late Reporting of Incident

- * New Hire Claimant
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 - * No or Late Reporting of Incident
 - * No Witnesses When There Should Be

- * New Hire Claimant
- * Problem Employee / Multiple Claimant
 - * No or Late Reporting of Incident
 - * No Witnesses When There Should Be
 - * Lawyer Early On

Investigation: <u>FACTS</u>

- * Accident Report
- 1) Form
- 2) Statements Claimant / Witness



- 3) Photographs
- 4) Reasonable Suspicion Evidence
- 5) Video
- 6) Machine Information



First Report of an Injury, Occupational Disease or Death

WARNING:

Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

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INDUSTRIAL COMMISSION OF OHIO BUREAU OF WORKERS' COMPENSATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

		Claim Number:	
		Date of Injury:	
Claim	ant's Name:		
Socia	Security Number:		E(E)E
Emplo	oyer's Name		
Natur	e of Injury or Condition:		
or to d	ensation or the condition either allowed or etermine the eligibility of payment of com- insation claim.	r requested in my cla pensation and medic	aim, or to consider the payment cal benefits under my workers'
	copy of this release is valid as the original.	Signature of Claima	int
		Date /	
1) Ha	ave you received treatment for this con If so, at what medical facility or with treatment?	what physician or	YES / NO chiropractor did you receive
2) Ha	ave you ever had a similar condition o	or problem in the pa	ast? YES / NO
a)	If so, when did you experience simil	hat time? YES /	NO
a)	If so, when did you experience simil Did you seek medical treatment at the If so, with whom did you seek treatment.	hat time? YES /	NO

EMPLOYEE'S STATEMENT

I sustained an injury to my			36/3	which occurred as follows
	(Part of Body)			
			STREET, STREET,	CARLO SET AND SET OF THE SET OF T
(Describe the accident in detail	il, stating part of bo	ody injured)		
0				
Occupation	Dept_		Age	Gender: Male/Female
Where did accident occur?				
	(On company pro	perty, dept, pl	ant, etc.)	
Name(s) of witnesses:			M.	-1
reported this accident on _				
			And the same	
			217	
		ddress)	23 7	
Hospital and/or Doctor:	(Include mailing a			
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Hospital and/or Doctor:	(Include mailing a	/No If yes,	Of Employee)	
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SUPERVISOR'S REPORT

Fill out Page 1 Immediately, while all details are fresh and readily obtainable.

ACCIDENT REPORT ANALYS	SIS	ART 1 - THE	FACIS	
Time & Place Injured:				
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lame:	Soc. Sec.	#		Condon [] in 7 []
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[] Glasses [] Ear Muffs	·	Tripped	[] Shock	
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[] Other		Other		
I. WITNESSES:				
lameS of Witnesses:	Their Loc	ation at the T	ime of the Ac	ccident:
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1 - 1 Barta Takan Tak	Medical Attention	Given		
ijured Party Taken To:		by (amb	ulance,car,et	c.)
Hospital/Clinic Name:	, , .	AM / PM		
Taken Date & Time:	<i>'</i> :	AM / PM		
Time of Return to Basic, or	———	_ AIVI / PIVI		
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Lost Hours/Time:				
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STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT IDENTIFICATION INFORMATION Shift Name of employee alleging incident Department Occupation II. WITNESS' STATEMENT Your name has been given as a witness to an incident alleged by the above individual. Through your ecoperation information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement. Your occupation_ Your name_ Your telephone number (Your address Did you see an accident occur involving the above employee? Yes No If not, how did you learn about the accident?_ If you did see an accident occur: Time of accident O AM O Date of accident Describe what you observed Your signature State of Ohio County of _ Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

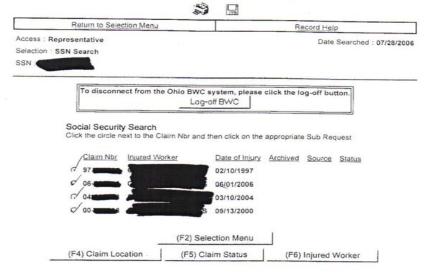
In testimony whereof, I have hereunto affixed my name and official seal at day of _______, 19_____. (signed) Name (printed or typed) (SEAL) Notary Public, State of Ohio My Commission Expires

PUBLIC RECORDS

- BWC-O.P.E.N. Online
- B M V
- Court Records
 - Criminal / Traffic
 - Civil / Personal Injury

OPENonline - Ohio Bureau of Workers Compensation

Ohio Bureau of Workers Compensation



OPENonline cannot warrant or guarantee the accuracy or completeness of data. By accepting this transmission, users certify that they are in compliance with the FCRA any other applicable federal, state and local laws. Users are responsible for the proper use of this account as stated in the certification of use and the Terms of Service Agreement. Any violation is grounds for termination and submission to the FTC or other appropriate agency.

Contact Customer Support for assistance at 1-800-366-0106

Ohio - Driving Record Detail



State Selection Screen | Choose a State Go | Search Screen | Record Help |

SSN : Date Searched : 03/03/2006

Driver Information

Name

SSN : DOB

Address

Gender : FEMALE Height : 5'03" Weight : 175

Hair : BLACK Eyes : BROWN

Lic Class : OPERATOR

License Information

Lic Status : VALID Status Date : 03/03/2006

Driving Record Detail

Record Group : Conviction

Record Type : IN-STATE CONVICTION

Record Type . IN-STATE CONVICTIO

Court Case Nbr : Court Name

Offense Desc : FAIL CONTROL 4511.202 County

Offense Date : 01/16/2004 Convicted Date : 01/28/2004

Accident Date : Points Assessed : 02

Suspended From : Suspended To : FRA Start : FRA End ::

0.01

Withdrawal

Record Group : Accident

Record Type

Court Case Nbr : Court Name

Offense Desc : COUYAHOGA

Offense Date : Convicted Date :

 Accident Date
 : 06/20/2005
 Points Assessed :

 Suspended From :
 Suspended To :

 FRA Start
 :
 FRA End :

Withdrawal :

: EUCLID MUNICIPAL COURT

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Cuyahoga Falls Municipal Court Clerk's Computerized Public records

City of Stow Vs BRIAN E ECKLEY

Docket for Case Number: 2004TRD08569

Date	Description							
	Case # : 2004TRD08569							
	Case filed on: 07/01/2004 Date of violation: 07/01/2004							
	Filing agency : City of Stow Officer badge : 733							
	Ticket # : 96586 Ticket location :							
	Violator name : BRIAN E ECKLEY							
	Violator address : 654 BETTES AVE AKRON OH-44310							
	Vehicle identification : OH BK7V							
	Applicable violations :							
	(1) 333.03D2 SPEEDING Degree : MM							
	Attorney last name : HART							
	Original plea : NG							
	Final plea : G							
	Sentence : Plea Changed to Guilty; Found Guilty of Amend Chg Date : 08/05/2004							
	Fine & costs: 162.00 Total amount to pay: 162.00							
	Receipt no: 00517412 Date: 08/05/2004 Amount: 162.00							
	Activities:							
07/02/2004	Initial Court Date: 07/07/2004 Initial Court Time: 08:30AM							
	New Arraignment hearing held. Judge: John W Clark							
	Plea of Not Guilty on violation 01: (333.03D2 SPEEDING)							
	Judge: Kim R Hoover, Auto Assigned - Control Number: 94417.							
	Date Arrested Set To: 07/01/2004							
	Time Waived Filed on: 07/02/2004							
07/06/2004	7/6/04 SET TRIAL 8/5/04 WITH ATTY BY PHONE. CT NOTICE MAILED TO PTL AND PROS							
	Notice: 3 Magistrate Card printed for Prosecutor							
	Notice: 3 Magistrate Card printed for Officer							
	Trial. scheduled before: Judge: Kim R. Hoover Assigned. On 8/5/2004 @ 02:00 PM							
07/26/2004	Court room changed from SOUTH COURTROOM to HEARING ROOM							
	Judge Changed From: Kim R. Hoover to John W. Clark							
08/05/2004	Case Sentence Order							
	Receipt number: 00517412 Date: 08/05/2004 Amount: \$162.00							
	Section: 333.03D2 - SPEEDING							
	Plea: Guilty on 08/05/2004							

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GOOGLE

Welcome to my web-site where I take pride in providing a variety of hay and straw to meet all the nutritio... Page 1 of 4

Miniature Straw Bales
Save on all 4 sizes of mini straw
bales at manufacturer direct prices

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Steve Rubendall Phone: 641-990-3200 Phone: 641-260-0463 Fax: 641-236-3958

Email: steve 70@crazyhaybiz.com

Kim Bilotta Phone: 740-244-6639 Email: klotta_72@yahoo.com klotta_72@crazyhaybiz.com

Welcome to Rubendall's Hay Sales. We take pride in providing a variety of hay and straw to meet the nutritious needs of your livestock. We farm around five hundred acres of various types of hay and straw each year. We use the latest in farming technology and equipment to produce small and large square bales. Iowa's top soil and climate is perfect for producing the highest quality hay and straw. We mow every 25 to 28 days to produce the highest protein levels and R.F.V. At Rubendall's Hay Sales, we are very proud of our farming heritage. This ongoing pride is evident in every product available.

Company History

Rubendall's Hay Sales is an independently owned and operated business. Steve Rubendall, Owner of Rubendall's Hay Sales, was born and raised in Grinnell, Iowa. Steve has been farming his whole life. He started farming as a child with his grandfather. After high school, Steve went to college while helping local farmers. He received a degree in Agricultural Mechanics at Hawkeye

SURVEILLANCE







































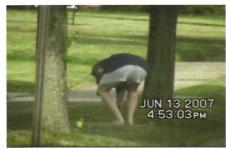
4:47 pm

The subject was observed as she walked back to her side door and entered the residence. Approximately a minute later, she exited the residence wearing a different shirt and carrying a flashlight. She then continued to search in the grass









5:00 pm

The investigator observed as the subject slowly headed back toward her side door while she continued to look in the grass around the sidewalk.









5:10 pm Surveillance was suspended.

MEDICAL INVESTIGATION

- A. Signed Authorization
- B. <u>Historical Records</u>
 - BWC EDA
 - Employment Records
 - Public Records
- C. <u>Drug Test Results</u>
- D. IME/Record Review
 - Review Records
 - History
 - Exam Findings
 - Conclusions
 - Report



First Report of an Injury, Occupational Disease or Death

WARNING:
Any person who obtains compensation from the person who obtains compensation from the person of the person who obtains a person of the person of th

Last name, first name, m	ame, first name, middle initial			Social Secu	Social Security number			Date of birth		
Home making address				Sex Male	☐ Female	Single Marrie	d I		dependents	
City		state 9	I-digit ZIP code	Country if o	ifferent from USA	Separ Widow	ated 7	Departmen	nt name	
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lave you been offered or	r do you expect to receiven? Yes \(\text{No If yes} \)	e payment	or wages for this cl	aim from an	one other than the	Ohio Bur	eau	Occupation	n or job title	
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Vas the place of accident	or exposure on employe on, street address, city,	er's premise	es? Yes No							
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Will the incident cause th	a initirad worker to									
miss eight or more days	of work?	Yes 🗆 No		is the injur	y causally related to			cident?	. Yes No	
nealth-care provider signs	sture				11-oigh byve pro	woer num	Der		Date	
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Vas employee treated in	an emergency room?	□ Yes □	No	Was emplo	yee hospitalized o	vernight as	an inp	satient?	□ Yes □ No	
f treatment was given as	way from work site, prov	de the facil	ity name, street ad	dress, city, s	tate and ZIP code					
Certification - The er certifies that the facts application are correct	in this		Rejection - T rejects the va the reasonist	lidity of this	claim for	For self-insuring employers only Clarification - The employer clarifies and allows the claim for the conditionit Medical only Lost time			ployer clarifies or the condition(s) below:	
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Employer signature and ti	tie .					Date			OSHA case number	
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BVC-1101 (Rev. 2/2008)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

D

AUTHORIZATION

1,	, (SS#); DOB:) hereby
authorize any and all hosp	oitals, physicians and/or	employers, to whom this	Authorization or a
photocopy thereof is deli	vered, to permit attorne	y Michael J. Bertsch or a	any other attorney
and/or legal assistant from	the law firm of Moscarin	no & Treu, L.L.P., to view	, inspect and copy
any and all records conce	erning any and all care a	and treatment rendered t	o me at any time,
including, but not limited	to, hospital records, co	rrespondence, reports, r	memoranda, x-ray
reports, test results, test	reports, nurses' and/or	doctors' notes, docume	ntation relating to
prescribed medication, re	eports pertaining to dia	agnosis, treatment and/	or prognosis and
consultation reports and/o	r opinions and all other v	vritten material for all adn	nissions, inpatient,
outpatient, emergency, ps	sychiatric, psychological	, and alcohol or drug re	lated treatment or
counseling and any/all per	sonnel and employment	records.	

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as the request for records relates to the administration of workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include, but are not limited to, the following:

- A copy of the medical information the employer receives may be forward to the BWC by the employer.
- A copy of the medical information will be available to me or my physician of record upon request to the employer.

(Claimant Name)		
Date:		



Authorization to Release Medical Information

This form can be obtained online at www.ohiobwc.com

· List the provider(s) you are authorizing to release medical records in the space indicated on this form.

. 1	Please sign ar	nd date the	form and	send to	the service	office	where your	claim is	s located	or to your	self-in	nsured o	mploy	yer
-----	----------------	-------------	----------	---------	-------------	--------	------------	----------	-----------	------------	---------	----------	-------	-----

injured worker name (first, M.I., last		Date of injury	Claim number			
Address	City		Sta	ite	9-digit ZIP code	
Employer name	Emplayer MCO or QHP				_	

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the following providers (persons or facilities) that attend, treat or examine me (list providers here)

to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC), the above-named employer, the employer's managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include, but are not limited to, the following:

- · A copy of the medical information the employer receives may be forwarded to BWC by the employer.
- · A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date
If signed by the injured worker's guardian or personal representative, provi	ide here a description of the guardian
or personal representative's authority to sign on behalf of the injured work	er

BWC-1224 (Rev. 3/24/2003)

C-101



Michael J. Bertsch mbertsch@mosctreu.com

July 11, 2008

VIA FACSIMILE ONLY

James M. Augusta, Esq. Hearing Administrator Industrial Commission of Ohio Cleveland Regional Office 615 West Superior Avenue, 7th Floor Cleveland, Ohio 44113-1898

Re: Claimant:

Employer:

Claim No.: XX-XXXXXX

D/Injury:

01/02/2008

Dear Mr. Augusta:

The undersigned represents the employer, the _____, in the above-referenced workers' compensation matter.

In that regard, the employer has requested that the claimant execute an authorization for release of medical information (copy of correspondence enclosed). To date, claimant has failed to produce a signed medical authorization and further refuses to do so. (See enclosed Affidavit).

As you know, R.C. §4123.651(C) provides that if a claimant refuses to execute a release for medical information, his right to have his claim for compensation or benefits considered, if his claim is pending before a District Hearing Officer, is suspended during the period of refusal.

Accordingly, the employer hereby requests that any and all activity on this claim be suspended until claimant provides the employer with a signed medical authorization.

By copy of this correspondence to claimant we are advising him of the foregoing.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact me directly.

Very truly yours,



Michael J. Bertsch mbertsch@mosetreu.com

July 11, 2008

VIA FACSIMILE

Ms. Ann Lischner Hearing Administrator Industrial Commission of Ohio 161 South High Street, Suite 301 Akron, OH 44308

Re: Claimant:

Employer: Claim Nos.: D/Injuries:

Dear Ms. Lischner:

This office represents _____ in the above-captioned workers' compensation matters.

In that regard, on June 11, 2004, our office requested a complete copy of claimant's chart from Dr.

1. More than three months later without any response, legal assistant, Sally Long, contacted Dr.

2. s office on October 27, 2004, to inquire about our unanswered June request for records. We were initially advised that Dr.

2. had not treated claimant for her workers' compensation claim. The medical records custodian/office manager, however, volunteered that the chart did contain complaints of pain and treatment to the left upper extremity; the body part at issue in this claim. So, the June 11th request was re-sent by facsimile to Dr.

2. s medical records custodian, with a note reiterating our need for complete records to properly evaluate claimant's condition and treatment.

Thank you for your courtesies and consideration. Should you have any questions, please do not hesitate to contact me.

¹ Copies of all referenced correspondence are enclosed.

THE HANNA BUILDING • 1422 EUCLID AVE. • SUITE 630 • CLEVELAND, OH 44115 (216) 621-1000 • Facsimile (216) 622-1556 • www.mosctreu.com

PREPARE – EARLIER THE BETTER

- A) Delegate vs. Abdicate
 - Coordinate/communicate with involved parties: TPA, counsel, supervisor, POR, MCO
- B) Request, Collect, and Analyze Medical and Fact Evidence, e.g. Records, Job Descriptions, Photos, Statements, etc.
- C) IME (?)
- D) Audio/Visual Evidence (?)
- E) How Much Time Will I Need to Be Ready (?): IME Schedule and Report

PREPARE - EARLIER THE BETTER (Con't.)

- F) How Much Time Will the Hearing Realistically Take?
- G) File All Records/Documents Intended to be Used in Advance of the Hearing
- H) Live Witness(es) v. Statements
- I) Audio/Visual Evidence Policy

BEFORE THE INDUSTRIAL COMMISSION OF OHIO

CLAIM NO. 05

	Claimant,		DATE OF INJURY: July 11, 2005
vs.			EMPLOYER'S NOTICE OF INTENT TO PRESENT AUDIO-VISUAL EVIDENCE
	Employer.)	
The	employer,		n, by and through its counsel, hereby
notifies the	Industrial Com	mission and cla	imant of its intent to present audio-visual
evidence at	the SHO Hear	ring scheduled for	or Tuesday,
Annexed he	rewith as Exhib	it "A" is a copy of	said hearing notice.
			have been previously filed with the Industrial claimant. See Exhibit "B" annexed hereto.
Commission	and served on	the attorneys for	Claimant. See Exhibit b annexed hereto.
5	SYNOPSIS OF	THE EMPLOYER	R'S AUDIO-VISUAL EVIDENCE
DVD # 1			
The e	events portrayed	d occurred between	een 2:45 and 3:20 p.m. on Thursday,
-			
Claim	ant is shown co	onducting busines	ss for com without any signs of
disability or	discomfort. Th	e proposed trans	saction she negotiated included the cost of

12.5 bales of straw/hay mix as well as the purchase of a corral gate. Quotes were

provided and claimant mentioned she was tending bar at the next day.

DVD # 2 and #3

These videos depict the same period of surveillance on Friday,

DVD #2 contains the raw footage. DVD #3 is a condensed version containing the most
relevant portions of the observed activity.

Respectfully submitted,

MICHAEL J. BERTSCH (0016619) KATHLEEN E. GEE (0074966) MOSCARINO & TREU, L.L.P. The Hanna Building 1422 Euclid Avenue, Suite 630 Cleveland, Ohio 44115 Phone: (216) 621-1000

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kgee@mosctreu.com

Counsel for Employer

THE HEARING

A. Defense Theory

- 1. Factual
- 2. Medical
- 3. Legal

B. Overall Objective

- 1. Win how defined
- 2. Containment

THE HEARING (Con't)

- C. Who Will Represent the Employer
 - 1. TPA
 - 2. Lawyer
- D. Who Else Needs to Attend?
- E. What Main Points Should be Made?
- F. Does Claimant Need to be Questioned?
- G. Is a Record Needed?

APPEAL PROCESS

A. The Next Level

- 1. Why did we lose?
- 2. What do we need to do differently
 - de novo?
- 3. What other evidence should we gather?

B. Cost/Benefit Analysis

Thank you for your time and the attention you gave me. My sincere hope is that each of you will leave with at least a few insights or new information to enhance your chances for success before the Industrial Commission.

THE END