

THE PROCEDURE AND PRACTICE

AUGUSTUS BEALL, JR.* AND WALTER C. BEALL*

INTRODUCTION

One of the purposes envisioned at the time of the adoption of workmen's compensation as a governing principle of Ohio law was the substitution, for adversary proceedings in determining the rights of a disabled workman, of an administrative procedure, completely informal, without two sides to the case, and with the Industrial Commission seeking simply to determine facts and administer justice, free of partisan urgings. In pursuance of that ideal, it has always been and is now the statutory rule that neither the Industrial Commission nor the Administrator shall be bound by common law or statutory rules of evidence nor by any technical or formal rules of procedure.¹

The early concept of non-adversary proceedings has, however, been abandoned by reason of two developments. The first was the granting of authority to the Commission to merit-rate employers, so that those with a sufficiently high payroll (paying premiums averaging at least \$200.00 per year for the period of the last five years) shall be charged more or less than the standard premium for their particular operations, depending on whether payments to their employees on injuries occurring or diseases contracted within the same five year period are greater or less than the state-wide average for their particular operation. The motive for merit-rating was two-fold. First it created a motive for the promotion of safety. Second, it created a motive for the employer to check all applications for compensation, eliminating or warning the Commission against any that were unfounded.

In practice, merit-rating achieved to considerable degree its two originally conceived purposes but also produced a third. With a view to assuring employers that their individual rating of premiums was properly calculated, there developed a substantial amount of actuarial services, whose practitioners checked the individual records of each of their employer clients in the Actuarial and Auditing Departments of the Commission, to make certain that the increase or decrease from the basic premium was correctly calculated. Since the allowance of a claim originally, or of additional compensation subsequently, affected the employer's premiums for a period of five years, the so called actuaries quickly expanded from the mere checking of mathematical calculations, into the field of checking the merits of every claim, either originally or for additional compensation, and then began to appear on behalf of their employer clients at all hearings, with a view to procuring the disallowance of claims where they felt that was indicated, and to reducing

*Of the firm of Hoover, Beall & Eichel, Cincinnati, Ohio; members of the Ohio Bar.

¹ OHIO REV. CODE §§ 4123.10 (1953), 4123.515 (Baldwin Supp. 1958).

the amounts of compensation allowed where such amounts might be in dispute.

These appearances on behalf of employers inevitably turned hearings into adversary proceedings. This accentuated the realization that employers had a direct interest in the allowance of claims and in the fixing of the amounts of compensation; this gave rise to agitation for the extension of the right of appeal to employers, and this right was granted by amendments adopted in 1955. As a result, all applications for workmen's compensation are now at least potentially adversary in nature, even though in practice, a large majority of all claims filed are not opposed by the employer.

FILING THE CLAIM

Initial claims for compensation may be divided into three groups: (A) Claims against subscribers to the State Fund; (B) Claims against self-insuring employers; and (C) Claims against employers amenable to the law but not having complied with it, either through failure to subscribe initially to the State Fund or by failure to pay subsequent premiums within the time allotted.

Generally speaking, all of these claims must be initiated by the filing of a written application by the injured or diseased employee. Blank forms for these claims must be prepared and furnished by the Administrator.² They may be filed with any office of the Bureau of Workmen's Compensation, either at Columbus or at any of the branch offices scattered over the state or with the Industrial Commission itself. Claims for injury or for death due to injury must be filed within two years after the injury or the death.³ Claims for silicosis or other diseases of the respiratory tract due to dust must be filed within one year following total disability or within six months after diagnosis, whichever date is later.⁴ Claims for occupational disease other than silicosis must be filed within six months after disability began. Claims for death due to occupational disease, including silicosis, must be filed within six months after the death.⁵

Claims against a self-insuring employer, qualified to act as such by the Commission under the act, may be filed directly with the employer, although, in the event of dispute, there must be a further filing with the Commission. Claims on behalf of public employees (those working for any governmental unit or subdivision), while they are technically State Fund claims, must be filed on different forms, and in practice are separately processed.

Two exceptions exist to the necessity for the filing of written

² OHIO REV. CODE § 4123.07 (Baldwin Supp. 1958).

³ OHIO REV. CODE § 4123.84 (1953).

⁴ OHIO REV. CODE § 4123.68 (Baldwin Supp. 1958).

⁵ OHIO REV. CODE § 4123.85 (1953).

claims. Employers are required by the act to report in writing to the Commission all injuries received by their employees in the course of their employment and resulting in seven days or more of total disability.⁶ The filing of such a report is not to be considered as an application for compensation sufficient to toll the statute of limitations; the Administrator is directed by the act to investigate such reports and determine whether the employee is entitled to an award without awaiting the filing of his application. If an award is made, the filing of a formal application is unnecessary.⁷ Since the requirement of the employer to report injuries is almost universally ignored, instances of the payment of an award without the filing of an application are almost, if not entirely, unknown.

With reference to self-insuring employers, there is a fairly general practice of the payment of compensation without the necessity of filing a written claim with the Commission; and the act provides that such payment of compensation tolls any limitation and makes the filing of a written claim with the Commission unnecessary. Of course, if the employer and the claimant in a self-insuring case are unable to agree on further compensation, a written application to the Commission will be needed to bring the Commission into the picture as an arbitrator of the dispute, but that application need not be filed within two years after the injury, provided compensation was paid on the claim within that two year period.⁸

In connection with the limitation in time for filing claims, two points are worthy of mention. The filing of a claim for the payment of medical services only, in a case where disability extends for less than seven days tolls the statute of limitations in State Fund claims. Such claims are frequently filed under such circumstances that the claimant himself is not aware of their filing. He has signed a paper while in the doctor's office and has heard nothing further from it because the doctor has filed it and has been paid his fee direct from the Commission. For that reason, in a State Fund case where it may appear that the statute of limitations has run, it is always important to give consideration to the possibility of an application for the payment of medical fees only. On the other hand, the extension of medical services or the payment of medical fees by a self-insuring employer is not, in practice, considered to be a payment of compensation sufficient to avoid the necessity of filing a written application with the Commission within the two year period.

CONTENTS OF THE CLAIM

Since the act requires the Administrator to furnish blank forms

⁶ OHIO REV. CODE § 4123.28 (1953).

⁷ OHIO REV. CODE § 4123.512 (Baldwin Supp. 1958).

⁸ OHIO REV. CODE § 4123.84 (1953).

for the filing of claims, it is of course advisable to use them, even though there have been instances in which applications by letter or upon improper or informal blanks have been ruled by the Commission or by court to be sufficient. It is a simple matter to fill out the form, but two cautions are appropriate. It would seem that if the injury is reported and a claim made for compensation for resultant disability, nothing further with reference to the right to recover for all disability which thereafter results should be required, since by statutes, the Commission and Bureau have continuing jurisdiction once a claim has been filed. Nevertheless, the courts have not been consistent in their decisions on this point.

The supreme court held⁹ in 1940 that an application for compensation for the result of freezing the right foot under circumstances that made that freezing an injury in the course of employment was sufficient to entitle the claimant to recover for disability resulting from the freezing of the left foot at the same time, even though the disability to the left foot did not manifest itself until more than two years after the injury. Later, the court held¹⁰ that a claim for injury to one part of the body in a fall did not serve to permit the payment of compensation for an injury to an entirely separate part of the body which was sustained in the same fall but did not manifest itself until more than two years had passed. In view of these two discrepant decisions, and in the light of the fact that proceedings for compensation have become highly adversary, with counsel for an employer seeking out defenses against claims for further compensation which the Administrator or the Commission itself might pass over, it is clearly wise for counsel for a claimant to make the description of the injury itself and of the resultant disabilities as broad as possible. As a protection against possible future eventualities, every facet of the injury should be described and every part of the body affected, even in the slightest degree, should be mentioned. These precautions will in ninety-nine cases out of a hundred be unimportant, but the one case where they will avoid litigation or protect a client's rights that might otherwise be lost, will more than compensate for the slight additional care required in filing a claim.

The filing of claims and subsequent procedure in the case of non-complying employers will be separately discussed at a later point.

PROCEDURE AFTER FILING

Once a claim has been filed, procedure thereafter is informal and does not fall into any hard and fast patterns. Claim blanks provide for certification by the employer in addition to signing by the claimant. While a claim may be filed without such certification, in order to toll the limitation, good practice calls for its submission to the employer.

⁹ *Kaiser v. Industrial Comm'n*, 136 Ohio St. 440, 26 N.E.2d 449 (1940).

¹⁰ *Miller v. Spicer Mfg. Co.*, 159 Ohio St. 571, 113 N.E.2d 4 (1953).

Employers who have actuarial representation or legal representation with reference to compensation claims usually prefer to file the claims themselves rather than return them to the claimant or his counsel. There is no reason to object to this procedure, but it is important to follow the matter up and make sure that the claim has been filed. The failure of the employer to file the claim after it is submitted to him does not avoid the bar of the statute of limitations, the courts holding that it is the obligation of the claimant to see that the claim is actually filed with the Commission or the Administrator. All claims, when filed, are assigned to the Administrator for processing, and the act itself provides that this be done in the branch office where it can be most expeditiously handled.¹¹ The extent and nature of investigation is a matter of judgment and necessary information may be obtained either in writing, orally, or by telephone or telegraph.

In a case that seems clear to the Administrator, he may notify the employer in writing of his conclusion or may enter a tentative order for the payment of compensation. If the employer advises the Administrator that he agrees that the claim is valid, compensation will be payable at once. If the employer within ten days notifies the Administrator of an objection to the validity of the claim or to the tentative order, compensation will not be paid until the matter has been set for hearing.

The statute¹² permits the Administrator to start the payment of compensation immediately upon receipt of notice that the employer agrees or at the expiration of ten days after notice to the employer that the Administrator considers the claim valid, if the employer does not respond to the notice. The following section¹³ provides for a tentative order with the same provision as to payment upon lack of notice from the employer. However, the next section¹⁴ requires a hearing on all disputed claims, with an opportunity to the claimant and the employer to be heard and to present testimony and facts pertinent to the claim. In practice it follows that most claims which are of a nature to lead a claimant to seek legal help, would go to formal hearing. In any case where the employer is represented, it would seem the first duty of his counsel to notify the Administrator that the claim is disputed and that a hearing will be required. Procedure at the hearing is completely informal, the act itself providing that the Hearing Deputy is not bound by any rules of evidence nor of procedure. It is not even necessary that any notes or memoranda of the proceedings at the hearing, including the evidence offered orally, be preserved.

PROCEDURE AFTER INITIAL HEARING

Following the initial hearing, invariably held before a Deputy Ad-

¹¹ OHIO REV. CODE § 4123.512 (Baldwin Supp. 1958).

¹² OHIO REV. CODE § 4123.513 (Baldwin Supp. 1958).

¹³ OHIO REV. CODE § 4123.514 (Baldwin Supp. 1958).

¹⁴ OHIO REV. CODE § 4123.515 (Baldwin Supp. 1958).

ministrator, either the claimant or the employer may within ten days of the receipt of the Administrator's decision request a reconsideration by filing the request in writing with the Administrator.¹⁵ The Administrator need not grant the application; but in practice he almost universally does grant it and assign the matter for reconsideration before a Deputy Administrator at Columbus. Both the claimant and the employer must be afforded the right to be heard on such reconsideration and to present additional evidence.

Further provision is made for an appeal by either party from the Administrator's decision to a regional board of review and that appeal must be filed within twenty days, the period running from the original decision of the Administrator if no reconsideration is asked, from receipt of notice of a refusal to reconsider, or from receipt of notice of the decision of the Administrator upon reconsideration, these limitations being, of course, in the alternative. The notice of such appeal may be filed with an office of the Administrator, with any regional board of review, or with the Commission itself.

As a practical matter an application for reconsideration by a claimant is normally wasted energy. If his claim has been denied by the Deputy Administrator, he would do best to proceed immediately with an appeal to the board of review, without bothering about reconsideration. Employers, on the other hand, have during the three years that the present statute has been in effect, had a much higher degree of success in obtaining reversals of orders of allowance upon reconsideration, and should avail themselves of the right to seek reconsideration because of a difference in the payment of compensation pending final determination.

PROCEDURE BEFORE THE BOARD OF REVIEW

When an appeal is filed from the Administrator's decision (as distinguished from an application for reconsideration by the Administrator himself) the act requires that it be assigned to a regional board of review most convenient to the claimant.¹⁶ The board of review is required by the act to set the claim for conference between the board, the claimant and the employer, prior to setting it for hearing. This conference is intended to agree upon uncontroverted facts and define controverted issues, agree upon documents, reports and records and to make other agreements and arrangements. The statutory description of the conference makes it clearly similar to pre-trial in a court action, and the statute as written was originally intended for a procedure on appeal which was never actually adopted by the legislature. In practice the requirement for a pre-hearing conference is more honored in the breach than in the observance. Normally the appeal is set for hearing

¹⁵ *Ibid.*

¹⁶ OHIO REV. CODE § 4123.516 (Baldwin Supp. 1958).

and the board in its order on the appeal includes a notation of its opinion that a pre-hearing conference would serve no useful purpose.

The section covering procedure on appeal before the board of review¹⁷ permits the parties to present the testimony of witnesses and other evidence, but does not provide for the keeping of a record of the evidence thus presented. Procedure is normally quite informal with counsel for the claimant, the employer, and the Attorney General sitting around a table, submitting written evidence, if any, or the oral testimony of witnesses, and discussing the merits of the claim. The Attorney General attends as the representative of the Administrator. Either the claimant, the employer or the Administrator may within twenty days after notice of the order of the board of review file with the Commission an application in writing for permission to appeal from the board to the Commission. If that permission is refused, the order of the board of review becomes the final order of the Commission, subject to an appeal to court within sixty days after notice of the refusal to permit the appeal from the board.¹⁸ If the Commission grants leave to appeal from the board, procedure on such appeal before the Commission, held at Columbus, is similar to that before the board; and appeal to the court lies from the decision of the Commission within sixty days after receipt of notice of the Commission's decision, subject only to the limitation that there can be no appeal upon a decision as to the extent of disability.

PROCEDURE BEFORE THE ADMINISTRATOR AND THE COMMISSION FOLLOWING AN INITIAL ALLOWANCE

Representation of a claimant or the employer in a workmen's compensation claim comes more frequently at some time after the initial allowance of the claim, rather than before the claim has first been heard. Under those circumstances the problem is one of further compensation rather than of original allowance. Discussion of the practice and procedure called for in those circumstances necessitates a brief review of the classes of disability for which a claimant may be entitled to compensation.

The first is temporary total disability, which may be defined roughly as the period of time when he is completely barred from work and under a doctor's care. Second, there is partial disability on a basis of impairment of earning capacity which covers the situation when he has been discharged by his doctor and pronounced able to do some work, but still has a disability which impairs his earning capacity. Third, is permanent partial disability on a percentage basis. This represents an alternative form of compensation for partial disability, based solely upon the percentage of his physical disability, and payable without refer-

¹⁷ OHIO REV. CODE § 4123.518 (Baldwin Supp. 1958).

¹⁸ OHIO REV. CODE § 4123.519 (Baldwin Supp. 1958).

ence to the effect of the disability upon his earning capacity, or the vocational handicap arising from the disability. The fourth is permanent disability for loss by amputations or destruction of sight or hearing. The fifth is compensation for permanent and total disability.

The second and third classes, both covering partial disability, overlap. Partial disability is compensable on an impairment basis only for a period of forty weeks after the end of temporary total disability, after which it is presumed in law that the condition has become static and permanent. After the period of forty weeks, a determination is made as to the percentage of physical disability and compensation is tendered in an amount equal to the correlative percentage of \$8,050.00, payable in weekly installments as other compensation is paid. The claimant must take his choice between the two. If he chooses to be paid on the percentage basis, credit is taken for anything he has previously drawn on the impairment basis; roughly speaking, he should determine his choice by a consideration of the extent by which his earning capacity has been impaired. If he has a substantial impairment, he can continue to draw on that basis until he has received a total of \$7,500.00. If on the other hand, he is back at work at the same wage that he drew before his injury (a very likely result if he works in a union shop) he should of course choose to be paid on the percentage basis.

Now the man who seeks additional compensation may be entitled to it for a considerable number of varying reasons. He may have been totally disabled for a longer period than the award made to him; he may be partially disabled and suffering a wage impairment; forty weeks may have passed since the end of his temporary total disability so that he is entitled to a determination of the percentage of his partial disability; he may have suffered an amputation, or loss of part of his vision or hearing; or he may have become permanently and totally disabled.

Procedure varies according to the rights he claims. If he seeks compensation for a period beyond that for which he has been paid, he must prepare and file an application for additional compensation (Commission form C-85A). He may by this application seek further compensation for temporary total disability, compensation for partial disability on an impairment basis, compensation for an amputation or loss of sight or hearing, or compensation for permanent and total disability. This form carries within it provision for additional medical proof and a certification by the employer, as well as a record of the man's earnings since the last payment of compensation. It needs to be completely filled out, or some explanation made for the portions not completed. If not completely executed it is subject to summary dismissal on the grounds of its incompleteness.

On the other hand, the claimant may have been paid compensation for a certain period and feel that he has been improperly compensated. This may be because his average wage has been incorrectly computed,

because he has been paid for partial disability when he was actually totally disabled, or for some other reason. His relief under those circumstances is the filing of an application to modify his award (Commission form C-85). This form likewise calls for certification by the employer, but has no provision on its face for additional medical proof. Under such circumstances medical proof, if it is needed, should be filed by separate written report.

If the claimant is ready for a determination of his percentage of permanent partial disability he uses an application for that particular purpose (Commission form C-92). This form does not require certification by the employer nor does it provide any place for medical information beyond the name of the doctors who may have been treating the claimant. However, it is important from the claimant's standpoint that medical proof on his behalf as to the percentage of his disability be obtained and either be filed with the Commission prior to the hearing of his application or be available for presentation at the time of his hearing.

Percentage of physical disability is something that is not subject to any very clear scientific measurement. The extent of a man's disability, measured on a percentage basis following an operation for a slipped disc, or as the after effect of a broken leg is largely a matter of opinion. The determination by the Commission is based normally on the opinion of his attending physician and the opinion of an examiner on the Commission's medical staff. But many attending physicians and surgeons tend to underestimate the percentage of residual disability to any patient who has had the benefit of their excellent care, and some members of the medical section of the Commission have been notoriously conservative if not reactionary in their estimate of percentages of disability. Counsel for a claimant should, for the protection of his client, have available the written report of a competent specialist as to the percentage of physical disability present. Whether that report is obtained before the filing of the application to determine percentage and filed with the application, or held for presentation at the hearing, is a matter of judgment. The authors tend to the feeling that holding it for presentation at the hearing is a practically superior method.

Applications for compensation for amputation may be filed without medical proof if material already in the claim file shows the existence of the amputation. If the file does not contain that information it must be furnished with the application. In some instances the exact amount of recovery depends upon the exact point of amputation, particularly with reference to loss of parts of fingers or hands and losses of a part of the foot or leg. The distinctions here are too many and too finely drawn to be encompassed in this article, but when injuries are on the borderline, the expense of an x-ray to show the exact point of amputation is almost always justified, if not required. The Commission medical section will make their determination upon visual examination only and without

an x-ray, and on a borderline case the determination will always tend to be on the conservative side.

Applications for permanent and total disability are normally not reached until the claimant has exhausted all other compensation; that is, has received all that he can be paid on a basis of temporary total disability or on a basis of partial disability.

TIME LIMITATIONS

On all of the above applications, two time limitations are applicable. First, the claim becomes completely closed, and subject to actual destruction of the file, when a period of ten years has passed since the last payment of compensation. In this connection it should be borne in mind that the payment of medical expense is compensation for the purpose of tolling this ten year limitation.

The other limitation is that no accrued compensation can be paid for a period more than two years prior to the date that the application for it is filed.¹⁹

JURISDICTION OF CLAIMS FOR ADDITIONAL COMPENSATION

Applications for further temporary total disability, for partial disability on an impairment basis or for permanent disability due to amputation, loss of vision or loss of hearing, are processed and heard first by the Administrator and are subject to the same appellate procedure previously outlined in connection with the original allowance of claims, except for the fact that questions based on the extent of disability are not appealable to court.

Application to determine percentage of disability or to award compensation for permanent and total disability are, as a matter of practice by the Commission under the advice of the Attorney General, processed and determined only by the Commission itself or its referees. For that reason those questions are not subject to any reconsideration by the Administrator nor to any appeal to a board of review. They are subject only to reconsideration by the Commission itself; in the case of applications to determine percentage of disability, such application for reconsideration must be filed within eight days, in the absence of a showing that there has been a changed condition since the time of the previous determination.

PROCEDURE ON APPEAL TO COURT

Appeal from the Industrial Commission to the court is of course strictly limited by the statute, as to grounds, venue, and method. The statute now makes any decision of the Commission itself (or of a board of review, if an appeal to the Commission has been sought and refused), except one involving the extent of disability, subject to appeal

¹⁹ OHIO REV. CODE § 4123.52 (1953).

to the court. This is in general a broader basis for review than existed previously, when review was permitted only on certain assigned claims. However, one of the assigned grounds previously listed in a statute did deal with the extent of disability and is now no longer appealable.

The venue on appeal is to the common pleas court of the county in which the injury occurred, or in a case where the injury occurs outside the State of Ohio, to the common pleas court of the county where the contract of employment was entered into. This statute has been construed by the supreme court as being jurisdictional, so that a petition filed in the wrong court vests no jurisdiction in the court whatever on appeal.²⁰ This can be a very important point when you have a client living in your county, working for an employer in your county, but injured while temporarily across the county line on some matter in connection with his employment. If in the course of carrying a claim through the sometimes extended periods that pass before it reaches the point of an appeal to court, the situs of the injury is forgotten and the appeal is filed in the home county, the resultant embarrassment can be extreme.

The method of appeal is quite simple. The appellant, either claimant or employer, files notice of appeal with the Industrial Commission and with the court of common pleas within the necessary sixty day period. That notice states the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that an appeal is taken. That filing vests jurisdiction in the court.²¹ No summons is issued upon the appeal, but the Commission itself gives notice to all parties who are appellees. The appellant then files a petition on appeal setting forth the basis for jurisdiction of the court and the statute simply recites that "further proceedings shall be had in accordance with rules of civil procedure."

This statute was a last minute substitute for an earlier draft calling for an entirely different form of appeal. It leaves unanswered a great number of questions such as the burden of proof, the status of the Commission's order in favor of a claimant as a prima facie case in his favor, the right to open and close in case of an appeal by the employer, and others. The statute has been in effect for less than three years, during which time there have been very few decisions on procedure in the lower courts and none at all in the supreme court. We venture no opinion whatever as to the correct answer of any of the problems that come to mind under the statute; the Bar will have to await the slow grinding of the mills of justice for the necessary answers.

EFFECT OF APPEALS ON PAYMENT OF COMPENSATION

Before the enactment of the 1955 amendments, no appeal was

²⁰ Ford v. Industrial Comm'n, 145 Ohio St. 1, 60 N.E.2d 471 (1945).

²¹ OHIO REV. CODE § 4123.519 (Baldwin Supp. 1958).

permitted to an employer. Accordingly, if an award was ordered, that closed the matter and the claimant received his compensation. Objections were made to the granting of a right of appeal to employers upon the ground that it might be exercised for purpose of harassment only, and perhaps to force settlements. To meet this objection, various provisions were made as to the payment of compensation pending an appeal. These provisions can be summed up as follows. On an award by the Administrator, payment is made after a period of ten days in the event there has been no application for reconsideration by the employer. An application for reconsideration filed within the necessary ten days stays the payment of compensation until the Administrator finally disposes of the claim.

An appeal from a decision of the Administrator awarding compensation does not stop the payment of compensation for the period following the date of the filing of the claim but does stay the payment of any compensation which accrued between the date of the injury and the date of the filing.

The statute does not specifically cover the situation of compensation payable after an award by the board of review and the effect of an application for leave to appeal to the Commission itself. In practice the Commission has construed the situation as calling for the payment of compensation under those circumstances, in the light of the fact that the next section of the act, covering an appeal to court, specifically provides that an appeal by an employer shall not stay the payment of compensation during the pendency of the appeal.

In all of these cases it is provided that if it be finally determined that compensation should not have been paid, the amounts paid shall not be charged against the employer's risk in determining his merit rating, and shall be refunded to him out of the surplus fund of the Commission if he is a self-insurer.

PROCEDURE IN SELF-INSURING CASES

The procedure in self-insuring cases is theoretically identical with that in State Fund cases, except for the fact that all such claims are processed through a special department in Columbus, and a different set of forms are used.

PROCEDURE IN THE CASE OF NON-COMPLYING EMPLOYERS

When the employee of an employer who has not complied with the compensation act, either by subscribing to the State Fund or qualifying as a self-insurer, sustains an injury, he has an immediate right of election. He may either apply for compensation through the Industrial Commission or he may sue his employer at common law, in which latter event the employer is barred from certain defenses. We shall consider here only the procedure in the event he elects to seek compensation. In that event he files an application in writing with the Commission, filing

in triplicate on forms prepared by the Commission for the specific use of cases involving non-complying employers. His claim is then investigated and processed in the same manner as other claims except for the fact that it is handled by a particular section at Columbus. After hearing and determination, it is subject to the same appellate procedure, on behalf of either the claimant or the employer, as any other claim. When the award in the claimant's favor has become final, and has not been paid by the employer within ten days, it becomes the duty of the Commission to certify the claim to the Attorney General of Ohio for the purpose of filing a suit to obtain a judgment in the amount of the award against the employer. When and if that judgment is obtained and has itself become final, the Commission must then pay the award to the claimant out of its surplus fund and must proceed with collection of the judgment against the employer. The claimant collects his full award, entirely independent of the ability of the Commission to collect the judgment.

However, if in the suit to obtain a judgment covering the award, the employer succeeds in a defense, then the award is not payable by the Commission.

In this connection there is a definite caveat for counsel for non-complying employers. Prior to 1955 it had always been the law,²² that in the suit against the employer by the Attorney General, the employer had available all defenses except the extent of disability and the amount of the award. He could, for instance, defend on the question that he was not amenable to the act, that the claimant was not an employee of his, that the injury was not incurred in the course of employment, or that the disability involved did not constitute a compensable injury. The reason for this holding was that the employer had no other due process by which to protect himself because he had no appeal from a decision by the Commission, and if he were not permitted to raise these defenses in the suit by the Attorney General, he would have been deprived of his property without due process. It seems quite probable that in the light of the amendments of the law which have given the employer a right of appeal, he has lost his right to present his defenses in the Attorney General's suit if he fails to exhaust his administrative remedies by appeals before the Commission and to the common pleas court from the Commission's final decision.

AWARDS FOR VIOLATION OF SPECIFIC REQUIREMENTS

When the Workmen's Compensation Act was first adopted, it gave to a workman the option of seeking compensation or suing his employer. A decade or more later the Ohio Constitution was amended to take away this option of the injured workman and to substitute for it a right to seek an additional award if his injury was caused by the violation of

²² *Fassig v. State*, 95 Ohio St. 232, 116 N.E. 104 (1917).

a specific safety order enacted in the form of a statute or adopted in the form of an order by the Industrial Commission.

An application for such benefits can be filed only after an application for compensation itself has been filed. It requires a separate application on a specific form, and, by interpretation of the supreme court,²³ is subject to the two year statute of limitations. The decision of the Commission on the subject is final and not subject to review, except through the means of mandamus or prohibition on pure questions of law.

The staff assigned to the investigation of this particular type of claim is too small, with the result that investigations are not completed for a year or two after claims are filed. After investigation has been completed by the Commission, copies of the investigator's report are submitted both to the claimant and to the employer with the opportunity to file further proof. When all of the proof has been filed the matter is reviewed by the legal section of the Commission and set for hearing.

Claims are normally heard by one or more Deputy Commissioners and are of course subject to an application for reconsideration by the members of the Commission themselves. Procedure is informal. The amount of the award is grounded upon a percentage of the maximum compensation that could have been awarded for the injury in question.

PROCEDURE IN OCCUPATIONAL DISEASE CLAIMS

Occupational disease may be defined generally as a disability which does not develop accidentally and at a particular time but which comes as the result of conditions of employment, distinguished from conditions to which the general public is exposed. At one time the diseases that were compensable were narrowly limited by statutory schedule, but since 1938 the limited schedule has been turned into a broad catchall by having added to it a provision making compensable "all other occupational diseases."²⁴

The distinction between injury and occupational disease produces some distinctions in practice. The time limitations are different, different forms are used, there is no appeal permitted to court, and a much broader use is made of what is known as the Medical Advisory Board.

The time limitations, subject to some distinctions which appear in the statute with reference to diseases of the respiratory tract, are six months from the beginning of disability or from the date of death.²⁵ In this connection it is important to note that the term "beginning of disability" has been defined by the Industrial Commission by rule as being the time of diagnosis, medical treatment, or cessation of work,

²³ State *ex rel.* DeBoe v. Industrial Comm'n, 161 Ohio St. 67, 117 N.E.2d 929 (1954).

²⁴ OHIO REV. CODE § 4123.68(X) (Baldwin Supp. 1958).

²⁵ OHIO REV. CODE § 4123.85 (1953).

whichever is latest.²⁶ This means that a man may have been disabled and off work for a long period of time for a condition not recognized or diagnosed as an occupational disease and still have time to file his claim within six months after such diagnosis is finally made. On the other hand he may be suffering from pathology diagnosed as occupational and receiving treatment for it while continuing to work. In such event time does not run out for the filing of his claim until six months after he finally quits work.

No special mention seems indicated as to forms beyond the fact that, as stated previously, the care necessary in completing an initial application is doubly applicable in the case of occupational disease.

Procedure after the filing is essentially the same as in injury cases. There is a right, in both the claimant and the employer, to ask for reconsideration of a Deputy Administrator's order, to appeal to the district board of review and to appeal from that board to the Commission. There is however no appeal to court in an occupational disease claim.²⁷

MEDICAL ADVISORY BOARD

The original exclusion of occupational diseases from the right of appeal to court was the result of a bit of legislative trading. Historically, the absence of a right of appeal gave rise to some arbitrary denials of compensation and this in turn resulted in the creation of a Medical Advisory Board.²⁸ This board, originally authorized solely for occupational disease claims, now has the right to consider injury claims also. The board consists of three doctors selected from a panel, and its membership varies from time to time. It holds hearings in the city closest to the claimant's residence, and while it has authority to administer oaths, take testimony, and subpoena witnesses and evidence, its proceedings are usually informal. Counsel for either a claimant or an employer can best serve their client by bringing doctors supporting their client's position into the hearing of the board, for informal discussion with the members of the board. The board has the right to make its own determinations, rather than to make mere advisory pronouncements, and these determinations were originally binding upon the Commission and are still in practice so treated.²⁹

SILICOSIS AND BERYLLIOSIS

All claims for silicosis and other diseases of the respiratory tract and for berylliosis must by provision of the statute be referred, before determination, to a board referred to by the statute as the "Silicosis Referees," who are required to be physicians with special knowledge of

²⁶ INDUSTRIAL COMMISSION RULES (April 1, 1956).

²⁷ OHIO REV. CODE § 4123.519 (Baldwin Supp. 1958).

²⁸ OHIO REV. CODE § 4123.15 (Baldwin Supp. 1958).

²⁹ OHIO REV. CODE § 4123.151 (Baldwin Supp. 1958).

pulmonary diseases.³⁰ This board does not make determinations, but only findings. These findings are not binding upon the Administrator, the Commission or the Medical Advisory Board, though there is of course a strong tendency to follow them.

By the statute³¹ silicosis is compensable only in the event of total disability or death, and silicosis and berylliosis have a further limitation requiring an injurious exposure in the State of Ohio before definite periods fixed by the statute.³²

Because a man with silicosis, even though not yet totally disabled, may be required to seek other employment in order to escape further exposure, provision is made for compensation for such required change of occupation.³³ Should such compensation be indicated, it requires a special application, subject to particular statutory limitations.

³⁰ OHIO REV. CODE § 4123.68 (Baldwin Supp. 1958).

³¹ *Ibid.*

³² *Ibid.*

³³ OHIO REV. CODE § 4123.57(D) (Baldwin Supp. 1958).