

Workers' Compensation Overview and Recent Changes

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I. Overview Of Benefits Provided Under Georgia's Workers' Compensation Act

There are three basic benefits provided to an injured worker under Georgia's Workers' Compensation Act: indemnity (income) benefits, medical benefits, and rehabilitation benefits. Below is a brief description of these benefits:

A. Indemnity Benefits

Indemnity benefits partially compensate a disabled employee for his or her loss of wages. There are three categories of indemnity benefits:

1. Temporary total disability: Temporary total disability benefits are paid when an employee's disability is temporary in duration, but total in character. The disability is generally authorized by the treating physician and usually continues as long as the physician certifies that the employee is disabled as a result of an on-the-job injury. The date of disability is the first day that the employee is unable to work a full day. Disability ends when the employee is able to return to his normal work activities. An employee is not entitled to these benefits, however, until his or her disability exceeds seven days from the date of injury.

An employee who is temporarily totally disabled due to an on-the-job injury will receive two-thirds of his average weekly wage, up to a statutory maximum. Effective July 1, 1997, this maximum is \$325.00 per week. The law also provides that, for accidents occurring on or after July 1, 1992, temporary total disability benefits are not to exceed 400 weeks, except for "catastrophic injuries." Catastrophic injuries include paralysis, amputation of an extremity, a severe closed head injury, and the like. If an employee is catastrophically injured on the job, he may receive temporary total disability benefits for the remainder of his life.

2. Temporary partial disability: This benefit is also for disability that is temporary in duration, but the disability is partial in character. In other words, temporary partial disability benefits are paid when an employee returns to work but suffers a loss in earnings either because he must work in a lighter duty job for fewer wages, work on an abbreviated schedule or work on a part-time basis, rather than full-time. Workers' Compensation pays two-thirds of the difference between the employee's average weekly wage before and after his injury, but not more than

\$216.67 per week (for accidents occurring on or after July 1, 1997) and not in excess of 350 weeks from the date of the injury. The employee remains entitled to these weekly benefits as long as he is earning a lesser wage, whether with the same or a different employer. When the employee is capable of earning the same wage that he was earning at the time of his injury, his entitlement to temporary partial disability benefits ceases.

3. Permanent partial disability: These benefits are paid for disability that is permanent in duration, but partial in character. That is, permanent partial disability benefits relate to a permanent physical impairment suffered from a work related injury. The treating physician gives the employee a permanent disability rating pertaining to the loss of use of whatever part of the employee's body that was injured in the accident. A schedule of body members is included in the Georgia Workers' Compensation Act, and this schedule sets forth the exact amount of money an injured employee will receive based on the physician's disability rating.

Example: Assume that an employee injures his right leg in a compensable on-the-job accident in July of 1997. He receives \$325.00 per week in temporary total disability benefits during the course of his disability. After the employee returns to work, his physician gives him a 10% permanent impairment rating to the right leg. This rating would entitle the employee to an additional \$7,312.50 in permanent partial disability benefits. This amount is determined by looking at the schedule provided in the Georgia statute. This payment of permanent partial disability benefits can be paid in a lump sum or on a weekly basis.

4. Reducing exposure by offering light duty

Once an injured worker has been released to light duty by the authorized treating physician, the employer can reduce its exposure for temporary total disability by offering the employee light duty work which is suitable to his/her condition. It is a good idea to have a few positions available which do not require much physical activity in order to get injured employees back to work as quickly as possible. Once you have offered a light duty job which has been approved by the authorized treating physician, the employee must attempt it or face suspension of his benefits. If he attempts the light duty job and works for fifteen (15) consecutive work days (not just 15 days from the start date), and later claims he cannot perform the job, it is his burden to prove that the job is not suitable to his condition. If, however, the employee works less than 15 days, the burden is on the employer to prove that the job is suitable. Therefore, the importance of having light duty jobs available cannot be overstated when trying to reduce your workers' compensation costs.

B. Medical Benefits

The employer is required by law to post a "Panel of Physicians" (which is discussed in detail later in these materials) and the employee must seek medical care from a physician posted on this panel if medical treatment is to be covered under workers' compensation. As long as the employee obtains medical treatment from a panel physician, workers' compensation will pay in full all of the medical expenses related to the injury. This includes doctor's bills, x-rays, medications, hospital bills, therapy, and all other treatment necessary to give relief or provide a cure to the injured employee. Treatment by a chiropractor, psychologist, etc., can be included

where the treatment is authorized by the employer, the employer's insurance carrier, or the State Board of Workers' Compensation. Workers' Compensation also pays for artificial members, prosthetic devices, and medical aids damaged or destroyed in a compensable accident. The employer/insurer is not required to pay for a private room in the case of hospitalization unless the doctor requests it.

The State Board of Workers' Compensation annually publishes a list of medical charges (Fee Schedule), and charges on this list are presumed to be reasonable. If a doctor's fee exceeds the listed charge, and if the charge cannot be medically justified, payment will be made in accordance with the Fee Schedule.

The law forbids medical providers from directly billing the employee for treatment rendered for an on-the-job injury. Further, the medical provider cannot bill the employee for the portion of the fee that exceeds the Fee Schedule limit.

An injured employee who has received income benefits has the right to one independent medical examination by a physician of his or her own choice. The examination must be scheduled within sixty (60) days of receipt of any income benefits. The employee must notify the employer in writing in advance of the examination.

The employer and insurer also have the right to require the employee to submit to an independent medical examination. The employee must be notified at least ten (10) days in advance of the examination and a check for mileage to and from the examination must be sent with the notice. If the employee refuses to submit to the examination or in any way obstructs the examination, then his entitlement to Workers' Compensation benefits may be jeopardized.

C. Rehabilitation

Rehabilitation benefits are designed to assist the injured employee in returning to suitable employment. In most cases, the services of a rehabilitation supplier are never offered to an injured employee, because the employee is restored to suitable employment soon after his accident through medical treatment and a routine course of recovery. However, if the disability continues for several months, rehabilitation services may be appropriate.

Injured employees are now divided into three different groups and their entitlement to vocational rehabilitation services depends upon which group they are in. The groups and their entitlements are:

(1) Employees who were injured before July 1, 1992, are entitled to receive vocational rehabilitation services paid for by the employer. These services can include medical management, job search, placement and even training.

(2) Employees who were injured on or after July 1, 1992, are not entitled to vocational rehabilitation services unless the employee's injury is "catastrophic." The employer can volunteer to provide vocational rehabilitation services to those employees whose injuries are not "catastrophic" but is not required to do so. However, effective July 1, 1997 agreements to

provide rehabilitation in non-catastrophic cases must be in writing. See O.C.G.A. § 34-9-200.1(h) as amended effective July 1, 1997.

(3) Employees who were injured on or after July 1, 1992, and whose injuries are "catastrophic" are entitled to have immediate and full rehabilitation services provided for them by the employer.

(4) If the claimant or the claimant's attorney withdraws consent, rehab cannot have any more contact with the authorized treating physician or the claimant or face a fine of up to \$1,000.00.

Generally, insurers or servicing agents assess the employee's need for rehabilitation and complete the necessary paperwork for the appointment of a rehabilitation supplier. The rehabilitation supplier will then make contact with the employer in an attempt to return the employee to an appropriate job position.

II. THE PANEL OF PHYSICIANS AND "BILL OF RIGHTS"

The Workers' Compensation Act in Georgia provides that an employer must maintain a list of at least four physicians from who injured employees may obtain treatment. The employer must post this list, which is known as the "Panel of Physicians," in a prominent place or places upon the business premises and must otherwise take all reasonable measures to insure that employees: (1) understand the function of the panel and their right to select a physician there from in case of an injury, and (2) are given appropriate assistance in contacting panel physicians when necessary. Appropriate prominent places for posting the panel would include the general office bulletin board, the employee's break stations, the personnel office, and any other places where the employees would be on a frequent basis.

The four doctors on the panel must be non-associated in order for the panel to be valid. If two or more doctors are in the same office or group, then the employer must list three other physicians in different offices or groups.

Effective July 1, 1992, the panel must include at least one physician who practices orthopedic surgery. The panel must also include at least one minority physician ("minority" is defined as a group that has been subjected to prejudice based on race, color, sex, handicap, or national origin, including, but not limited to, African-Americans, Hispanic-Americans, Native-Americans, or Asian-Americans). Failure to include a minority does not invalidate the panel, but it may give an injured employee the right to select a minority physician of his or her choice, who will then become the authorized treating physician. If it is not possible to select a minority physician, then special permission must be granted, in writing, by the State Board of Workers' Compensation to allow the exception. No more than two of the physicians on the panel may be from industrial clinics, and hospitals should not be posted on the Panel of Physicians. Doing so may authorize care by all physicians practicing at the posted hospital.

Although the law requires four physicians, it is recommended that an employer post more than the required four. This allows the employee additional choices and insures the continued validity

of the panel should the status of a posted physician change. (For example, if a panel physician moves out of the state, and the employer is not aware of the move and fails to replace the doctor's name with another name, the panel is invalid.) Additional specialties may be posted, such as an internist or a neurosurgeon, depending on the nature of the injuries most commonly suffered at the particular employer's place of business.

An employer should contact a physician prior to listing him or her on the panel to make certain that the physician will agree to treat employees for on-the-job injuries.

An injured employee must accept the services of a physician posted on the panel. The physician selected may arrange for appropriate consultations, referrals, and other specialized medical services as the nature of the injury may require. If the employee is dissatisfied with the physician selected, the employee may make one change to a second physician (also posted on the panel) without permission from the employer or insurer. However, any further changes require the permission of the employer/insurer or the State Board of Workers' Compensation.

In the event of an emergency, the employee should be taken to the nearest medical provider.

However, all follow up care must thereafter be rendered by a physician from the panel.

Employers should explain the purpose of the panel to new employees in orientation and employees should be reminded of its function about once a year.

Effective July 1, 1992, each employer is required by law to post the "Bill of Rights for the Injured Worker," in the same location as the Panel of Physicians. This document sets forth an employee's rights under Workers' Compensation, as well as his or her obligations.

Failure to post both a valid Panel of Physicians and the "Bill of Rights" in prominent places throughout the premises can result in fines from the State Board of Workers' Compensation. More important, an employer forfeits its right to control an injured worker's medical treatment if these documents are not properly posted.

Copies of the Panel of Physicians and the "Bill of Rights" are attached to these materials. To obtain originals, contact the State Board of Workers' Compensation at 404/656-3875.

Effective July 1, 1994, the law also allows employers two other choices in the manner in which they provide medical care to injured employees: (1) a Board certified managed health care organization; or (2) a "conformed panel" which is basically an expanded panel with additional doctors (i.e., chiropractor, neurosurgeon, orthopedic surgeon, etc.) from which the employee can choose.

III. REPORTING AND FORMS

The following forms, copies of which are attached to these materials, should be used by employers in handling Workers' Compensation claims.

A. Employer's First Report of Injury (Form WC-1)

The entire claims handling procedure originates with the Employer's First Report of Injury form, which is prepared by the employer and forwarded, along with other known facts pertaining to the injury, to the insurer, or servicing agent, immediately after the employer is made aware of an injury. Note that the first date of employer awareness is not always the same as the injury date. An injured employee often informs his employer of an alleged accident days or even weeks after the alleged injury.

The insurer/servicing agent has twenty-one days from the date of employer knowledge to deny a claim or to make payment of benefits due. The employer's failure to promptly report an injury on the First Report of Injury form causes a delay in the entire system and often results in hardship for the employee and the employer. The State Board of Workers' Compensation can assess penalties and attorney's fees against the employer if the claim is not either denied or paid within the requisite twenty-one days. The insurer/servicing agent cannot deny or pay the claim, however, until it is made aware of the injury through the Employer's First Report of Injury form. Thus, immediately after the employer is made aware of an alleged accident, the employer should complete Section A of the First Report of Injury form and send it to the insurer/servicing agent.

B. Wage Statement (Form WC-6)

A wage statement must be sent to the insurer/servicing agent when the weekly benefit for either temporary total disability or temporary partial disability is less than the maximum under the law. For example, as previously noted in the materials, the maximum benefit for temporary total disability for injuries that occur on or after July 1, 1997, is \$325.00 per week. If an injured employee has an average weekly wage of \$300.00 per week, his temporary total disability rate will be \$200.00 (two-thirds of \$300.00). In this situation, the wage statement must be filled out and sent to the insurer/servicing agent. The insurer/servicing agent will calculate the average weekly wage (based on the wage information provided by the employer) and will then file a wage statement with the State Board of Workers' Compensation. Note that the new WC-1's which are published by the State Board have a wage statement on the reverse side.

C. Notice to Employee of Offer of Suitable Employment (Form WC-240)

Rule 240 provides the mechanism by which an employer offers a modified duty position to a claimant. It is used when a claimant is receiving temporary total disability benefits but is capable of performing modified duty work. Rule 240 represents the most effective way to eliminate the claimant's right to continued indemnity benefits.

When a claimant receives a modified duty work release from the authorized treating physician, the insurer or their counsel will contact the employer to discuss the availability of modified duty work within the claimant's restrictions as set forth by his doctor. Employers are encouraged to make jobs available which can be tailored to meet the claimant's restrictions. If such a position

can be made available, the insurer will prepare a job description which sets forth in detail the claimant's proposed duties as part of the modified duty job to be submitted to the claimant's physician for approval. Written approval by the doctor must then be attached to a Form WC-240 which is prepared by the insurer. A WC-240 is used to officially offer the modified duty job to a claimant, in order to be effective the claimant must be served with the WC-240 at least ten (10) days prior to the scheduled return to work date. If the claimant returns to work, his benefits may be suspended, or reduced in the event he is earning less than his pre-injury wage. Failure to attempt a properly offered modified duty position pursuant to Rule 240 may adversely affect the claimant's right to continued indemnity benefits.

D. Useful Forms for Employers

1. Acknowledgment of Panel of Physicians and the Bill of Rights

One way of informing employees of the panel and the bill of rights is to ask the employee to sign a memo certifying that he or she has been advised of the Panel of Physicians and its purpose. Place the signed memo in the employee's personnel file. This will help avoid a common evidentiary problem that arises when a claimant falsely alleges he/she was never told about the posted panel or the bill of rights in an effort to force the employer to pay for a physician of the claimant's choice. This form can also be expanded to inform employees of the importance of reporting injuries. The following page is an example of such an acknowledgment form:

WORKERS' COMPENSATION ACKNOWLEDGMENT FORM

I, _____, Social Security No. _____, Date of Birth _____, acknowledge that I have reviewed the posted panel of physicians for work related injuries and the bill of rights for the injured worker and that it's importance and location has been explained to me. I acknowledge that a representative of the ABC Widget Company has explained the purpose of the posted panel of physicians and the bill of rights for the injured worker to me and that I understand the purpose of the posted panel of physicians and the bill of rights for the injured worker. I understand that if I am injured on the job I must report the accident immediately to my boss, foreman, immediate supervisor or employer representative (not to a co-worker or other subcontractor) , regardless of how minor the injury is. I also understand that if I fail to report any injury within 30 days of my injury to my boss, foreman, immediate supervisor or employer representative (not to a co-worker or other subcontractor), I could lose any and all workers' compensation benefits. I understand that if I am injured on the job, I may receive medical, rehabilitation and income benefits. I also understand that if I am injured on the job and require medical treatment I must choose one of the physicians on the posted panel and may make one change to another doctor on the panel without permission from the ABC Widget Company. However, in an emergency, I understand that I may get temporary medical care from any doctor until the emergency is over, but then I must get any other medical treatment from a doctor on the posted list. I also acknowledge that I have read and understand all my other rights and responsibilities listed in the bill of rights for the injured worker.

This _____ day of _____, 20_____.

X _____
Employee

X _____
Employer/Witness

2. Drug Testing Acknowledgment Form - This form should be utilized by all employers both at the time of hire and after an alleged job-related accident. This form is designed to prevent the problems encountered in the case of Thomas v. Diamond Rug & Carpet Mills, Case No. A97A0841 (decided May 9, 1997), discussed later in the materials. Employers who conduct random drug testing and employers who have a certified drug-free workplace program in effect will want to have other written materials including both written policy manuals and other acknowledgment forms. A sample form follows:

DRUG TESTING AND WORKERS' COMPENSATION ACKNOWLEDGMENT FORM

I, _____, Social Security No. _____, Date of Birth _____, acknowledge that a representative of the ABC Widget Company has explained to me that if I am injured in a work-related accident, I will be asked to submit to a drug test including any of the following types of tests or combinations of tests: breath analysis, urinalysis and/or blood tests to test for the presence of alcohol, illegal drugs, and/or pharmaceutical drugs and/or controlled substances. It has been explained to me and I understand that the testing for drugs, controlled substances and/or other medications which have been lawfully prescribed to me by a duly licensed physician will only be used to determine whether or not I have been taking the prescribed medication in accordance with my prescription. **It has also been explained to me and I understand that if I refuse to submit to any such breath analysis, urinalysis and/or blood tests, I may not be entitled to any workers' compensation benefits including, but not limited to, medical benefits, rehabilitation benefits and income benefits. I also understand that a positive drug or alcohol test could result in immediate termination of my employment and forfeiture of entitlement to Workers' Compensation benefits.**

This _____ day of _____, 20_____.

X _____
Employee

X _____
Employer

IV. The Employer's Role In Workers' Compensation

A. Pre-injury considerations

1. Employers need to inform their employees of the posted Panel of Physicians, and the importance of immediately reporting injuries to their supervisors after an injury has occurred.
2. Employers should regularly inspect their Panel of Physicians and "Bill of Rights" to confirm that they are properly posted and valid.
3. Employers regularly need to stress safety to their employees and conduct periodic drug screens to insure compliance. In fact, if an employer institutes a "Drug Free Work Place" program, it may be entitled to a discount in Workers' Compensation premiums.

B. Steps to take after an injury is reported

1. Take time to handle the injury properly - listen to the employee. If you suspect fraud, don't publicize it. Handle the report of injury as you would any report of injury, and then notify your insurer/servicing agent that the claim needs to be investigated.
2. Instruct the employee to obtain medical care only from a doctor listed on the posted Panel of Physicians. Assist the employee in obtaining an appointment with the panel doctor.
3. If the employee needs emergency care, then take him or her to the nearest medical provider for immediate medical treatment. All follow up treatment should then be rendered by a doctor from the posted Panel of Physicians.
4. Complete the First Report of Injury (form WC-1) and immediately forward it to your insurer/servicing agent. In your description of the accident, be brief. Do not recount the daily events leading up to and following the injury, and do not state any suspicions pertaining to the validity of the claim. Do not forward this form to the State Board of Workers' Compensation. Your insurer/servicing agent will file this form with the State Board, if necessary. (It would also be helpful if you also complete the WC-6, Wage Statement, on the reverse side and attach a copy of your Panel of Physicians to the WC-1 when you send it to your insurer/servicing agent.)
5. Fully investigate the accident and make notes of any pertinent information, such as: (a) how did it happen; (b) who saw it happen; and (c) what do these witnesses say about the accident?
6. Check on the injured employee periodically during the recovery period to learn about his or her progress and to let the employee know of your interest and concern.
7. Upon the employee's return to work, promptly notify your insurer/servicing agent.

C. When your employee retains an attorney

Very few employees retain attorneys when they are injured on the job. Generally, if an employee suffers an on-the-job injury, his medical bills and income benefits are paid, without dispute, under Workers' Compensation. This is the way the system was designed to work. Unfortunately, there will be occasions when employees will seek the services of an attorney, and

litigation often ensues following same. The possibility of litigation will require a change in your normal procedure.

1. Notice of attorney representation

If you receive notice that an attorney is representing your employee in regards to a Workers' Compensation claim, you can no longer discuss matters relating to the claim directly with your employee. This is not to say that you cannot continue to speak with an employee in matters of daily business, but if Workers' Compensation questions arise, advise your employee to have his attorney call the insurer/servicing agent or the attorney who has been retained to represent your interest.

Send copies of any documents you receive from the employee's attorney to the insurer/servicing agent and/or the insurer/servicing agent's attorney.

2. Notice of Request for Hearing (Form WC-14)

If you receive notice from your employee and/or his attorney that the employee is requesting a hearing, notify your insurer/servicing agent and/or the attorney for same immediately. Again, send any documents that you receive to the insurer and/or the insurer's attorney.

3. Notice of hearing

If you receive notice from the State Board of Workers' Compensation that a hearing has been scheduled, put the hearing on your calendar. It is important that you also immediately contact your insurer because the State Board can assess penalties/fines if the Employer/Insurer does not obtain counsel within 20 days of the Notice of Hearing.

4. Subpoenas, Requests for Production, Interrogatories, and other requests for information from the employee's attorney

(a) Informal requests: If you receive a request for information from an attorney for the employee, either orally or in a letter, do not respond to the request. If you are called on the telephone, for example, by the employee's attorney (or by a representative of the employee's attorney such as an investigator, secretary or paralegal), tell this person that you prefer that he or she contact the insurer/servicing agent or the attorney for same. Do the same if an investigator for the employee actually comes to your premises to ask questions. If you receive a letter, simply forward the letter to the insurer/servicing agent or the insurer/servicing agent's attorney without responding to it. In short, do not give any information to the attorney for the employee. The insurer/servicing agent and/or the attorney who has been retained to represent you are equipped to handle such matters on your behalf, so please ask them to do so.

(b) Formal requests: Likewise, if you receive a subpoena, a Request for Production of Documents, Interrogatories, or Requests for Admissions from the employee's attorney, you should not respond to these on your own. Immediately contact the insurer/servicing agent or the insurer/servicing agent's attorney. Do not simply file these documents away, in that the law

requires responses (which the attorney for the insurer/servicing agent will provide) to them within a certain time limit. Failure to timely respond could result in jeopardizing your defenses to a claim or other penalties.

Surveillance and the Claimant's right to discovery - Often in cases where fraud is suspected, we have surveillance placed upon the claimant by professional investigative companies. Many times the investigators will find that allegedly disabled employee working for another employer or engaged in activities inconsistent with the alleged disability. The question which naturally arises is whether or not the claimant and his/her attorney are entitled to discovery of surveillance. Claimant's attorneys often request surveillance video tapes and information regarding surveillance in interrogatories and requests for production of documents. While claimant's are entitled to this information, it is our position that they are not entitled to it until after we have had the opportunity to depose the claimant. Accordingly, if responses to such discovery requests are due prior to the claimant's deposition, our policy is to interpose a work-product objection arguing that the information was prepared in anticipation of litigation. However, once we have deposed the claimant, we are obligated to produce any surveillance tapes.

The reasons for this position are three-fold. First, information regarding whether or not the claimant is working or the claimant's true physical condition and ability to engage in certain activities is information of which the claimant is aware. Second, even if we do not have surveillance on the claimant, asserting an objection to the discovery requests as opposed to simply denying that any surveillance exists may get the claimant to be forthright about his work status and/or physical condition out of concern that we may have the claimant on surveillance video engaged in activity inconsistent with his/her alleged disability. Finally, if the surveillance were turned over to the claimant's attorney prior to the claimant's deposition, the claimant could be easily coached into testifying that he/she worked only on the particular day shown on the tape but it was simply too much for him/her. Furthermore, the claimant will only concede engaging in the activity he knows was captured on the surveillance video and nothing more. On the other hand, where the claimant is deposed while not sure whether he was caught on surveillance video, the claimant will either "come clean" admitting to activities and work which otherwise you would not have uncovered or the claimant will deny engaging in certain activity which you may have captured on the surveillance video.

5. Correspondence from the State Board of Workers' Compensation

The State Board of Workers' Compensation is an administrative agency for all Workers' Compensation claims filed against employers in the State of Georgia. All parties, including the employer, are copied with notices of hearings, interlocutory orders, awards, and so forth. Nonetheless, the employer should never correspond directly with the State Board upon receipt of such documents. Again, the insurer/servicing agent and/or the insurer/servicing agent's attorney are better equipped to communicate with the State Board on your behalf.

V. Hearings - The Judicial Process

Either the employee or the employer/insurer can request a hearing before the State Board of Workers' Compensation. Usually, the employee requests a hearing, but the employer/insurer

may also request a hearing if there is reason to believe that an employee receiving benefits should be disqualified. The employer/insurer may also request a hearing if they believe that another party is responsible for payment of the employee's benefits.

The first level of the judicial process in a Workers' Compensation claim is a hearing before an Administrative Law Judge. This is probably the most important level, as well, in that if a party does not prevail before the Administrative Law Judge, the party faces an uphill battle on appeal.

At a hearing, the parties are usually represented by counsel, although counsel is not required. The Administrative Law Judge listens to testimony from witnesses for both the employee and the employer. A court reporter is present and takes down everything that is said at the hearing. The court reporter will then transcribe the record of the hearing. The lawyers generally receive copies of this transcript and use it to write briefs to the Administrative Law Judge following the hearing. Decisions are rarely rendered at the hearing; rather, the Administrative Law Judge will write his/her decision up to sixty days after the hearing. The decision will be sent to all parties, including the employer and insurer.

After the Administrative Law Judge issues an award, the parties have twenty days to appeal this award to the Appellate Division of the State Board of Workers' Compensation. The Appellate Division sits in Atlanta, Georgia. It consists of the Chairman and two Directors of the State Board. They review the hearing transcript, the medical records, and any depositions that were tendered into evidence at the hearing before the Administrative Law Judge. The lawyers also write briefs to the Appellate Division, and they may request oral argument, which is limited to five minutes. No new evidence is admissible at the hearing before the Appellate Division. The Appellate Division simply reviews the evidence taken at the hearing before the Administrative Law Judge and either affirms the Administrative Law Judge's decision, modifies it, or replaces it. A unanimous vote is not required.

The next level of appeal is to the Superior Court of the county in which the injury occurred. However, unless there is an error of law, that is, unless the Administrative Law Judge or the Appellate Division misstated the law or misapplied it, there is no reason to appeal to the Superior Court. The Appellate Division findings are not appealable as long as any evidence supports its findings. If there is a possible legal error, however, you may appeal to the Superior Court, where briefs are again presented and a judge may choose to hear oral argument from the attorneys. Again, no new evidence is admissible.

After the Superior Court enters its order, the losing party can file a petition to the Georgia Court of Appeals, asking for permission to have the case heard. The Court of Appeals will grant permission only if there is a good reason for it to hear the appeal. That is, a party does not have an automatic right to have its case heard before the Court of Appeals.

After the Court of Appeals renders its decision, the Georgia Supreme Court may allow a party to file one last appeal, but this is unlikely. It occurs only in rare cases where the law is unclear and where the issues to be heard are of great interest to the public.

VI. ADVICE FOR EMPLOYERS WHEN TESTIFYING IN A WORKERS' COMPENSATION CASE

If a hearing is scheduled before the State Board of Workers' Compensation, you may be asked to testify in the proceeding, either at a deposition or at the hearing before the Administrative Law Judge, or both. At a deposition (which would be scheduled prior to the hearing) an attorney asks a witness to respond to extensive questions about his or her knowledge of the case. The attorneys for both the employee and the employer are present, but usually only one attorney asks the questions. The proceeding is taken down by a court reporter, who swears in the person being deposed. Depositions can be taken anywhere; however, they are usually taken in a conference room at a lawyer's office.

Even if you submit to a deposition, you may also be asked to testify live at a hearing, because depositions are generally not admissible in Workers' Compensation matters (except for doctor's depositions). The following suggestions apply to providing testimony at both depositions and live at hearings:

A. General advice:

1. Make yourself available to meet with your attorney prior to the deposition or hearing. Tell him or her everything that you know about the case, whether good or bad. This prevents surprises at the deposition or hearing. Your attorney will also use this meeting as an opportunity to prepare you for the questions you may face from the attorney for the employee.
2. Relax. You know the facts better than any of the lawyers or the judge, because you are testifying from your own personal knowledge. The lawyers and the judge do not have the personal knowledge that you have, so do not let them intimidate you into thinking that they do.
3. Tell the truth. Do not try to decide what the best answer will be for your "side" or the worst answer for the other "side". Whatever the truth is, that is the answer that you should provide.
4. Listen to the question. Take your time. Make sure you understand the question before you answer. If there is any part of the question that you do not understand, say so.
5. Answer the question that you are asked, not some other question. Say no more than is necessary to answer the question. Do not volunteer extra information or explanations. At the same time, you always have the right to explain an answer if you feel that it is necessary. Often, lawyers will ask you a yes or no question that really demands an explanation on your part. If you feel that this is the case, simply answer yes or no, adding "I would like to explain". Your lawyer will always make certain that you have that opportunity. (Nonetheless, keep in mind that a poor explanation will not help anyone.)
6. Do not guess. If you do not know the answer, say so. If you do not remember, say so. It is your job to give the answers you know, not to speculate about the answer you do not know.

7. Feel free to bring notes (that you do not mind sharing). It is a misconception that you cannot bring notes to assist you in testifying. However, keep in mind that if you use notes when you testify, the attorney for the employee may review these notes and cross-examine you on them. Thus, do not use notes that you would not want to have read by others. **Always show the notes to your attorney before you testify.**

B. When the attorney for the employee cross-examines you:

"Cross-examination" means that the attorney asking you questions can "lead" you, that is, the attorney can ask questions in a manner that "puts words in your mouth" if you allow this to happen. Your attorney will not cross-examine you; he or she will ask you "direct" questions that will allow you to freely tell the information that you know in response to a given question. In general, it is easier to answer "direct" questions than "leading" questions. Thus, when you are being cross-examined by the employee's attorney, you will want to keep in mind the following additional suggestions.

1. You are the witness, not the lawyer. Do not argue with the lawyer for the other side. Do not object to a question. If a question is objectionable, your attorney will object. If you are being cross-examined by the employee's attorney and your attorney objects, stop talking. Listen to the objection. Do not begin talking again until you are asked to do so. If your attorney instructs you not to answer a question, do not answer the question.

2. Watch out for questions that paraphrase your answers. The opposing lawyer may take your ideas and put them into his own words, changing your meaning in ways that you may not catch at the time. If the opposing lawyer asks if his paraphrasing is accurate, you are entitled to say you would rather stand on your answer and stick with the way you put it.

3. Beware of absolutes. Watch out for questions that use the words "always" and "never."

4. A deposition or hearing is serious business. Do not be sarcastic or whimsical. Do not make small talk with the opposing lawyer. Remember that no matter how nice he or she may seem, the other lawyer is not your friend.

5. Admit preparing for your testimony if you are asked. There is nothing wrong with meeting with your attorney to go over your testimony in advance.

VII. Establishing A Subsequent Injury Trust Fund Claim

The Georgia Subsequent Injury Trust Fund was established in 1977 as a separate State agency independent from any other department, and is governed by a five member Board of Trustees appointed by the Governor. In certain cases, employers can file claims against the Subsequent Injury Trust Fund, seeking reimbursement for income and medical benefits that have been paid, or will be paid in the future, on a Workers' Compensation claim. Typically, a claim is filed against the Subsequent Injury Trust Fund when an employee is injured, and the injury combines with a previous, known impairment to cause greater disability. In other words, this is a fund that is established as an incentive for employers to hire and retain employees who have certain pre-

existing disabilities. However, keep in mind that the Americans with Disabilities Act prohibits you from making any pre-employment inquiry about a disability or the nature or severity of a disability before making a job offer. An employer may, however, ask questions about the ability to perform specific job functions and may, with certain limitations, ask an individual with a disability to describe or demonstrate how he or she can perform certain functions.

After an employee is offered a job, the employer is permitted to make a post-offer inquiry or examination to discover pre-existing medical conditions or identify disabilities. Attached is a Post-Employment Health Questionnaire that should be completed by all employees after they have been offered a job. Note that this questionnaire must be kept separate from the employee's personnel file. We would recommend that you establish a medical file for all employees, in which you keep these questionnaires.

An employer can experience considerable savings in both indemnity and medical benefits if they are successful in obtaining reimbursement from the Subsequent Injury Trust Fund. However, to be eligible for reimbursement from the fund, an employer must establish several elements. First, the employee's subsequent injury must be either directly caused by the prior impairment, or combined with the prior impairment to create greater employer liability for lost time benefits and medical expenses. Second, the employee must have a pre-existing impairment that the employer considers to be permanent and a hindrance to employment. Third, the employer must have knowledge of the prior impairment before the subsequent injury occurs. Knowledge does not have to be obtained before or during the hiring phase.

Below are some suggestions that will help in establishing a claim for reimbursement against the Subsequent Injury Trust Fund:

A. Obtain as much information as possible about permanent pre-existing impairment at the time of hiring.

(1) Utilize an extensive and involved medical questionnaire, such as the one attached to these materials, **after a qualified hiring has taken place** (due to the Americans With Disabilities Act).

(2) Be sure to have the individual responsible for hiring and firing discuss any disabilities or conditions that the employee may have immediately after a qualified hiring has taken place. Be sure that the person hiring the worker makes notes regarding the pre-existing impairment at the time of hiring or as soon as he or she becomes aware of the impairment.

(3) Be sure that the individual hiring the employee reviews any pre-employment physician evaluation or post-employment health questionnaire.

(4) If possible, obtain medical records regarding permanent, pre-existing impairment just after the hiring.

B. Filing a Claim against the Georgia Subsequent Injury Trust Fund

1. As soon as practicable, but no later than seventy-eight (78) calendar weeks following an on-the-job injury or payment of an amount equivalent to 78 weeks of income or death benefits, whichever occurs last, the Notice of Claim form must be filed with the Georgia Subsequent Injury Trust Fund. (A Notice of Claim form is attached to these materials). This form should not be filed with the State Board.
2. Be certain that the Notice of Claim form has been filed adequately by sending it certified mail to the Subsequent Injury Trust Fund.
3. Be sure to complete the form as broadly as possible, but be certain that it is filed timely.

C. Establishing evidence of a permanent pre-existing impairment

1. Information must be filed with the Subsequent Injury Trust Fund establishing that the employee has a pre-existing permanent impairment.
2. This information can be established through the employee's own testimony or by medical records.
3. Obtaining a notarized affidavit from the employee can aid in this endeavor.
4. Medical records obtained after the hiring can be used to establish the impairment.

D. Employer Knowledge Affidavit

1. The person completing an Employer's Knowledge Affidavit must be in a hiring or firing capacity. In establishing knowledge, this person generally relies on documentary evidence as listed above in Section A. Conversations with the worker or other employees can establish employer knowledge, but additional documentary evidence would be helpful.
2. If the pre-existing condition is not one of those that specifically raises a presumption of employer knowledge (such as Diabetes, certain diseases, ruptured intervertebral disc, etc.), then the employer representative must establish his informed conclusion regarding the condition as being a likely hindrance to employment or re-employment. The hindrance to employment or re-employment element can be established through testimony from the employee representative.
3. Additional information from a personnel file can be helpful and can be submitted to the Fund.

E. Merger

1. The employer must establish merger of the prior impairment and the subsequent injury and submit this to the Subsequent Injury Trust Fund.
2. It is a virtual necessity that merger be established by medical evidence. Such evidence can include medical records, narrative reports or testimony.

3. A letter from a doctor establishing merger would be most helpful.

F. Submit all pertinent Workers' Compensation forms and awards to the Subsequent Injury Trust Fund

This documentary evidence helps to establish a claim.

G. Always include the Subsequent Injury Trust Fund in settlement negotiations if they have accepted a claim for reimbursement

If the employer has entered into a reimbursement agreement with the Subsequent Injury Trust Fund, and thereafter settles a claim without the fund's approval, the fund can refuse to reimburse the employer for any proceeds paid under the settlement agreement.

VIII. 1997 Legislative Changes

Below is a summary of recent changes to Georgia's Workers' Compensation Act. These changes became effective July 1, 1997:

Fraud Provisions: The Fraud provisions found at O.C.G.A. §34-9-18 and 34-9-24 were amended to allow for reasonable attorneys' fees as a cost of collecting penalties assessed by the Board for fraud, and fraud investigators will have the power to execute search warrants, make arrests pursuant to warrants, and serve subpoenas.

Further, no person or entity who furnishes the Board with information relevant and material to suspected fraud shall be liable for civil damages or criminal prosecution, absent fraud or malice. (It should be noted that a "whistle blower" protection amendment drew intense debate on the House floor, and was later rejected because it was viewed as an attack on Georgia's "employment-at-will" doctrine.)

Place of Hearings: Administrative Law Judges are now able to hear claims not only in the county where the injury occurred (or any contiguous county), but also in any county **within 50 miles** of the county of injury or death.

Superior Court Hearings: O.C.G.A. §34-9-105 was amended to provide for the holding of a hearing by the superior court within 60 days from the date of docketing in such court, rather than 60 days from the date the Notice of Appeal is filed with the Board.

Authority of Board to Promulgate Rules: O.C.G.A. §34-9-121 was amended to authorize the Board to promulgate rules and regulations with regard to third-party administrators and servicing agents with regard to their management or administration of workers' compensation claims. This amendment requires third-party administrators and servicing agents to demonstrate licensure and compliance with Title 33 (the Georgia Insurance Code).

Catastrophic Claims: The "catch-all" social security provision under O.C.G.A. §34-9-200.1(g)(6) was amended to provide that for a claim to be considered catastrophic the injury

must be of a nature and severity that prevents the employee from being able to perform his or her prior work **and** any work available in substantial numbers in the national economy **for which such employee is otherwise qualified.**

NOTE: Under the old statute, this provision has an "or" where the "and" has been inserted. Claimant's attorneys have argued that due to the placement of the "or," all that is needed in order to prove a catastrophic claim is proof that the claimant cannot "perform his or her prior work."

TTD Increase: O.C.G.A. §34-9-261 was amended to increase the maximum rate for temporary total disability benefits from \$300.00 to **\$325.00** per week. The minimum benefit will also increase from \$25.00 to \$32.50.

TPD Increase: O.C.G.A. §34-9-262 was amended to increase the maximum rate for temporary partial disability benefits from \$192.50 to **\$216.67** per week.

IX. Major Board Rule Changes

I. Alternative Dispute Resolution - Board Rule 100

As the previous rule required, each party must have a person(s) with adequate authority to resolve all issues attend the mediation. However, the new amendment to subsection (e) now requires a representative of the Employer/Insurer to be present who has authority to resolve all the issues. The Rule is specific in that it states this requirement ". . . would not be satisfied by the presence of legal counsel of the Employer." Thus, a representative of the Employer who has authority to resolve all issues at the mediation must be present in addition to counsel for the Employer.

The revised rule does provide for certain exceptions to this rule, namely by the consent of all parties or by advance permission of the A.L.J. from the A.D.R. Unit.

It should be noted that failure to abide by this rule without reasonable grounds will expose the Employer/Insurer to civil penalties, attorney's fees, and/or costs. Thus, the Board has made it clear that it wishes a representative of the Employer/Insurer to be present at all mediations in which there remain disputed issues to be resolved at the mediation.

II. Claimant's Right to Change of Physician in Controverted Cases - Board Rule 201(b).

This rule has been redrafted to clarify that if a controverted case is subsequently accepted or found to be compensable, the Claimant is allowed to choose one of the physicians who treated him prior to the claim becoming compensable who then becomes his authorized treating physician. Additionally, the Claimant may make one other "free change" to another physician without Board order.

III. Controverting Medical Treatment and/or Testing - Board Rule 205(b).

The old Board rule subsection is superseded with this revised rule which governs standard for payment of medical tests and new procedures relative to pre-authorization or pre-certification requests of the Claimant's authorized treating physician.

According to the revised rule, medical tests/treatment prescribed by the authorized treating physician shall be paid when they are:

(1) Related to the on the job injury; (2) Reasonably required and appear likely to accomplish any of the following: (a) affect a cure, (b) give relief, (c) restore the Claimant to suitable employment, or (d) establish the causation of the medical condition to the compensable accident.

The change in this rule of which Employer should be aware is that when an authorized treating physician requests pre-authorization for treatment or tests and it cannot be obtained verbally, within thirty days of a written request for pre-authorization the Employer/Insurer shall: (1) authorize the treatment/testing or (2) file a WC-3 controverting the treatment/testing enumerating grounds for same.

If the Employer/Insurer controverts on the grounds that the treatment/testing is not reasonably necessary, the burden is on the Employer to establish same at a hearing or mediation. Alternatively, if the Employer/Insurer controverts on the grounds that treatment is not authorized or is unrelated to the compensable injury, the burden of proof is on the Employee to prove same.

This rule has a built-in penalty for failure to follow its steps properly: According to Board Rule 205, if the Employer fails to comply with the terms of this revised rule, then the Employer/Insurer shall pay for the treatment/testing requested. Thus, in order to comply with revised Board Rule 205(b), and avoid payment for unnecessary treatment/testing, the procedure is as follows:

- (1) Employer/Insurer receives written request for pre-authorization of testing/treatment;
- (2) Employer/Insurer has thirty (30) days to decide whether to approve or controvert the testing/treatment;
- (3) If Employer/Insurer decides to controvert, they must file a WC-3 within the 30 day period:
 - (a) If controverting on the basis of the testing/treatment is not reasonably necessary, the burden is on the Employer.
 - (b) If controverting on the basis of non-authorized or unrelated treatment/testing to compensable injury, the burden of proof is on the Employee.
- (4) Failure to follow the steps will result in responsibility for payment of testing/treatment by the Employer/Insurer.

IV. Computing Temporary Partial Disability - Board Rule 262

The recent Court of Appeals decision in Mountainside Medical Center/Pickens Health Care, et al. vs. Tanner, Case No. A97A230 has given great ammunition to Employer/Insurers to reduce the Claimant's temporary total disability to temporary partial disability even where there is no

light duty position available for the Claimant with the Employer. The holding in *Mountainside* was limited to a situation wherein a Claimant undergoes a change of condition's for the better as a matter of law pursuant to O.C.G.A. §34-9-104. According to the holding, once a claimant has been receiving TTD benefits for 52 weeks consecutively, or 78 weeks in the aggregate, an employer is entitled to reduce the Claimant's indemnity benefits to two-thirds (2/3) of the difference between the Claimant's pre-injury average weekly wage, and the wage that the Employee is "able to earn" pursuant to O.C.G.A. § 34-9-262. The Court of Appeals stressed the fact that just because a Claimant's wage at that time is zero, the appropriate focus is on what the claimant is "able to earn", and thus an employer could reasonably theorize what the claimant is able to earn at the time, and reduce his benefits accordingly.

However, the State Board has struck back in an effort to undo what has been done by the Court of Appeals with the passage of its revised Board Rule 262. According to the revised rule, where an Employee receiving maximum benefits allowed under O.C.G.A. § 34-9-261 [\$325.00], the Employer/Insurer will simply have to pay the Claimant the maximum allowed under O.C.G.A. § 34-9-262 [\$216.67]. However, where an Employee is receiving less than the maximum allowed by O.C.G.A. § 34-9-261, the revised Board Rule states that the Employer ". . . shall continue to pay the Employee the same benefits as provided by O.C.G.A. § 34-9-261 not to exceed the maximum benefits provided by O.C.G.A. § 34-9-262." Thus, according to the revised Board Rule, if the Claimant is receiving less than the maximum TTD, and undergoes a change in condition for the better, pursuant to O.C.G.A. § 34-9-104, the Board has made it clear they will not permit an Employer/Insurer to reduce the claimant's indemnity benefits based upon a reasonable theory of what the claimant is "able to earn." As a result, an Employer who is entitled to convert the claimant's benefits from TTD to TPD pursuant to 34-9-104, will not be allowed to reduce the amount of the Claimant's benefits except in cases where the TTD rate is greater than the maximum under O.C.G.A. § 34-9-262. According to the revised Board Rule 262 the employer can only reduce TPD benefits below the maximum cap (\$216.67) when the Claimant is actually engaging in light duty work and earning a post-injury wage. In our opinion, the Board's recent amendment to this rule will not withstand review by the Court of Appeals. However, the reality of the situation is that unless an Employer/Insurer is willing to take the Board to task on this revised rule and pursue a costly appellate decision, it is fairly certain that any attempts to reduce the Claimant's benefits pursuant to the decision in *Mountainside Medical Center* will be defeated by the A.L.J.s and Full Board. The reason we believe this new rule will not withstand review by the Court of Appeals is that the State Board is limited in its rule making authority and does not have the authority to adopt rules in conflict with a statute within the Workers' Compensation Act. Likewise, the Board does not have authority to reverse a decision for the Court of Appeals interpreting a statute. The revised Board Rule 262 seeks to do just that by attempting to alter the Court of Appeals decision in *Mountainside* interpreting O.C.G.A. §34-9-262. Any Board Rule which enlarges, reduces or otherwise affects the substantive rights of parties will be held invalid. *Holt Serv. Co. v. Modlin*, 163 Ga. App. 283, 299 S.E.2d 741 (1982).

Other 1997 Revisions To The Board Rules Of The State Board Of Workers' Compensation

I. Fax Filings - Board Rule 60(f).

The Board has amended Rule 60 so that they will no longer accept fax filings of documents. The primary exception to this rule is that a Notice of Claim may be fax filed on the final day allowed by Statute. Additionally, the Board reserves the right to specifically request the filing of documents by fax from parties. However, it should be noted that if a document is filed by fax, the Certificate of Service should indicate concurrent service upon the opposing party also by fax if possible.

II. Benefit Levels

Although not memorialized in a revised Board rule, the recent legislative change to O.C.G.A. §34-9-261 and 262 bear mentioning since they will apply to any claims based upon accidents occurring after July 1st, 1997. According to the revision, the maximum temporary total disability payments are increased from \$300.00 to \$325.00 per week. Additionally, the maximum temporary partial disability payments are increased from \$192.50 per week to \$216.67 per week.

III. Notice of Representation - Board Rule 102(i).

Notice of Representation of Employer/Insurer's has been deleted from the previous form, W.C.-14, and been replaced by the reinstated form W.C.-102(i).

X. Recent Case Law Developments

Payment of medical expenses to a Claimant: Claimants are not entitled to be paid and employers are not obligated to pay to a claimant the amount of medical bills arising as a consequence of an injury which has already been paid by third party group health insurers. Carroll v. Diamond Rug & Carpet Mills, 224 Ga. App. 361 (1997). **CAVEAT:** This case only applies to injuries occurring after 1990. For injuries occurring prior to 1990, the claimant is entitled to a windfall if a third party provider does not seek reimbursement pursuant to O.C.G.A. §34-9-206.

FDA Approval Not Required for Medical Procedure: The State Board has authority to order an employer/insurer to pay for a prescribed surgical procedure even if same has not been approved by the FDA. Williams v. West Central Georgia Bank, 225 Ga. App. 237 (1997). This case may be used by Claimant's attorneys when seeking approval of a Dorsal Column Stimulator or implantation of a Morphine Pump.

Psychic Treatment and Mental Disability Compensable if Physical Injury Contributes to Continuation of Psychic Trauma: A claimant is entitled to benefits under the Workers' Compensation Act for mental disability and psychic treatment which, while not necessarily precipitated by a physical injury, arose out of an accident in which a compensable physical injury was sustained, and that injury contributes to the continuation of the psychic trauma. The physical injury need not be the precipitating cause of the psychic trauma; it is compensable if the physical injury contributes to the continuation of the psychic trauma. Atlas Automotive, Inc. v. Wilson, Case No. A96A2219 (2-28-97).

Employers Must Inform Employees That Refusing To Take A Drug Test After An Injury Would Affect The Employee's Right To Obtain Workers' Compensation Benefits: The claimant refused to take a drug test after the forklift he was operating ran into a wall, causing

injuries to his left foot and ankle. About an hour before the accident, his supervisor observed the claimant smoking what appeared to be a marijuana pipe. When taken to a medical center, the claimant was asked to give a urine specimen for the purpose of a workers' compensation drug screen, which he refused. The claimant alleges he refused the drug test because he had been given narcotic pain medications in the ambulance on the way to the medical center. The manner and method of the drug testing is controlled by O.C.G.A. § 34-9-410, et seq. (Drug-Free Work Place Program), which also states that at some time prior to the testing, all employees and job applicants must be given a notice of testing. O.C.G.A. § 34-9-414(a). They must be given a written policy statement which must advise that the employee or applicant of the consequences of refusing to submit to a drug test. O.C.G.A. § 34-9-414(a)(4). In this case, the claimant's refusal to submit to the drug test could not be used by the employer as an affirmative defense under O.C.G.A. § 34-9-17(b). The Court of Appeals held that before an employee's refusal to submit to a drug test can carry the rebuttal presumption which may bar benefits, due process requires that the employee be given notice of this consequence so he or she can choose knowledgeably. Thomas v. Diamond Rug & Carpet Mills, Case No. A97A0841 (May 9, 1997).

Independent Contractors/Tractor-Trailer Operators. Upshaw v. Hale Intermodal Transport Co., 224 Ga. App. 239 (1997). Mr. Upshaw, the owner-operator of an 18-wheel tractor trailer, leased both his trucks and his services as a driver to Hale Intermodal Transport. He was seriously injured in a motor vehicle accident after being dispatched to Charleston by Hale. He applied for Workers' Compensation benefits, which were denied on the basis that he was an independent contractor, and not an employee of Hale. The ALJ, Appellate Division and Superior Court affirmed the denial of benefits. The claimant argued that federal law contradicts and preempts state law regarding owner-operators in their employee status. However, the Court of Appeals rejected his argument and found that the owner-operator of a tractor trailer is not entitled to Workers' Compensation benefits because he is deemed an independent contractor under O.C.G.A. §34-9-1(2).

Late Controvert: Cartersville Ready Mix Co. v. Hamby, 224 Ga. App. 116 (1997). The employee filed a Workers' Compensation claim alleging he sustained a back injury at work. The employer suspected that the claimant's injury was not job related, but did not controvert the claim within 21 days after learning of the injury. Rather, the employer eventually voluntarily commenced payment of benefits paying a lump sum for 5 weeks, but without paying a penalty. Subsequently, the employer filed a notice to controvert pursuant to O.C.G.A. §34-9-221(h) within 60 days of the date payment of compensation was due. Simultaneously, the employer also suspended payments on the basis of the injury did not arise out of and in the course of employment. The employee argued that because the employer failed to pay a penalty pursuant to O.C.G.A. §34-9-221(e) the employer was estopped from filing a notice to controvert pursuant to O.C.G.A. §34-9-221(h). O.C.G.A. §34-9 221(h) provides "Where compensation is being paid without an award, the right to compensation shall not be controverted except upon a grounds of change in condition or newly discovered evidence unless notice to controvert is filed with the Board within 60 days of the due date of first payment of compensation." This case turned on the question of what is included within the term "compensation". Based upon the Court of Appeals decision in Southeastern Aluminum Recycling v. Rayburn, 172 Ga. App. 648, 324 S.E.2d. 194 (1984), the court held that the term "compensation" encompasses all accrued income benefits

including penalties provided for any late payment. Accordingly, the Court held that because the initial payment of compensation was late and because the employer failed to pay a penalty when it voluntarily commenced indemnity benefits, the subsequent controvert pursuant to O.C.G.A. §34-9-221(h) was invalid. It is important to note that had the employer in this case simply controverted the claim late without payment of any benefits, the controvert would still be valid but the employer would be subject to penalties and assessed attorney's fees if the employee prevailed at a hearing.

Employee's burden when terminated while receiving temporary partial disability

payments. In Waffle House, Inc. v. Padgett, 225 Ga. App. 144 (1997), the Court of Appeals held that when a claimant is terminated from employment while receiving temporary partial disability payments, he/she must show all the elements of a change in condition outlined in Maloney v. Gordon County Farms, 265 Ga. 825, 828, 462 S.E.2d. 606 (1995), including the diligent search for work. In Padgett the claimant suffered a work related injury in February, 1993 and received temporary total disability benefits until she returned to light duty work in November of 1993. She was terminated in September of 1994 but continued to draw TPD benefits. Subsequently, the claimant filed a claim seeking TTD benefits alleging a change in condition for the worse due to her inability to find other employment. The Claimant did not contend that her disability was physical in nature. The Court of Appeals held that in order to receive TTD benefits, the claimant must necessarily establish that she suffered a loss of earning power as a result of a compensable work related injury, continues to suffer physical limitations attributable to that injury, and has made a diligent, but unsuccessful effort to secure suitable employment following termination. In Padgett the ALJ specifically found that the claimant did not attempt to secure other employment and held that Padgett did not meet her burden of proof in order to establish her entitlement to TTD benefits.

Change in Condition. In Georgia Pacific Corp. v. Wilson, A97A0574 (dec'd 3/10/97), the claimant was disabled on March 3, 1992, and received TTD benefits after an award by an administrative law judge. On March 20, 1995, the claimant became employed by Spartan, and engaged in light duty work until he left on May 30, 1995. The claimant worked under his son's name and used his son's social security number. No medical release for claimant to return to work had ever been entered. When Georgia Pacific discovered that the claimant was working full time for Spartan, Georgia Pacific suspended claimant's TTD benefits on May 10, 1995. Georgia Pacific also requested a hearing regarding the issues of suspension of benefits under the prior award, or reduction of claimant's benefits as well as the determination of whether or not claimant had to reimburse the employer for any overpayment. At the hearing, the claimant did not testify nor did he appear at the hearing. In affirming the ALJ's award granting the claimant continuing TTD benefits, the Court of Appeals held that Georgia Pacific failed to prove the claimant had the ability to resume unrestricted full time work, that suitable work was available nor that the claimant no longer had an economic disability. Accordingly, the Court of Appeals affirmed the ALJ's award of temporary partial disability benefits. The ALJ's award was supported by evidence that Mr. Wilson still suffered from his original injury and could not resume regular duties.

Recent Decisions By The Georgia Supreme Court

An Employee's conduct in negligently aggravating a work related injury outside of the work place is not a bar to workers' compensation benefits: Hallisey v. Fort Howard Paper Company, Case No. S96G1408 (4-14-97). The Claimant in this case suffered a work related back injury. He completed his shift and worked a full shift the following day. Two days later, he played 23 holes of golf before his back became so painful that he had to seek medical attention. His medical records indicated that he had injured himself at work and aggravated his injury by playing golf. The Administrative Law Judge found that the golf game simply aggravated or accelerated his work related injury, and awarded benefits. The Appellate Division and Superior Court affirmed. However, the Court of Appeals reversed, holding that the Claimant's act of playing golf broke the chain of causation between his initial injury and his resulting disability. The Georgia Supreme Court reversed the Court of Appeals finding that Georgia's Workers' Compensation Act does not treat an Employee's negligence in aggravating a work-related injury by engaging in conduct outside the work place as an intervening cause, breaking the connection between a work injury and resulting disability.

Rycroft Defense is Available to Employers Who Violate ADA: Caldwell v. Aarlin/Holcombe Armature Co., 267 Ga. 613 (1997). The Claimant in this case suffered a back injury while working at Hardees in March of 1994. The Claimant received benefits and eventually returned to work. He thereafter quit and applied for a job with Aarlin/Holcombe Armature Co. However in applying for this subsequent employment, the Claimant denied any previous back injury. Obviously, this pre-employment inquiry about any prior injuries was in violation of the ADA. As a result of this violation, the Claimant argued that Rycroft should not apply because it is inconsistent with the ADA. The Court of Appeals disagreed with the Claimant, keeping the "Rycroft Defense" intact.

Bankhead Enterprises v. Beavers, 267 Ga. 506 (1997). In Bankhead, the Supreme Court addressed the Appellate Division's role in reviewing administrative law judge awards. Under O.C.G.A. §34-9-103(a), the Appellate Division has authority to vacate an administrative law judge's findings of fact and conclusions of law if same are unsupported by a preponderance of the competent and credible evidence, and to substitute its own findings. Although the Appellate Division is no longer authorized to conduct de novo review, the Appellate Division may substitute its own alternative findings for those of the administrative law judge and enter an award accordingly if it concludes that the administrative law judge award does not meet the statute's evidentiary standards. This procedure can be accomplished without sending the case back to the ALJ for further findings of fact.

XI. Illegal Aliens

If a claimant is an illegal alien, he/she is still entitled to TTD and medical benefits. However, in certain cases when an illegal alien has been released to return to light duty work, the employer's obligation for indemnity benefits ends. As you are aware, under normal circumstances when an injured worker is released to light duty an employer is still be obligated to pay indemnity benefits to the claimant if there is no light duty work available or if the claimant returns to light duty work with the same or a different employer but for a lesser rate of pay or for lower hours than the claimant's pre-injury wages. Furthermore, employers may suspend a claimant's benefits if the employer offers suitable employment to the claimant pursuant to O.C.G.A. § 34-9-240 and

Board Rule 240 if the claimant unjustifiably refuses same. However, this is not necessarily the case with respect to illegal aliens if the employer has "clean hands." For the employer to have "clean hands" the employer can not have known about the employee's illegal alien status and must have taken reasonable steps to insure that the claimant was not an illegal alien. This is usually easy to establish in the statutory employer setting, but in the normal employer/employee setting some kind of fraud or deceit on the part of the employee may be required.

Assuming that the employer can show that it has "clean hands," the employer can seek an interlocutory order suspending all indemnity benefits to the claimant once the claimant has been released to light duty work. If the employer can show that it had jobs available within the claimant's restrictions, the employer does not have to offer the claimant any light duty work as such an offer would violate federal immigration laws. Because a light duty job offer would violate federal immigration laws, the employer will not be required to do so. However, the claimant would still be entitled to continuing medical benefits to the extent that same are "reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment." O.C.G.A. § 34-9-200(a).

The fee schedule also limits the fee which a physician or other health care provider may charge for deposition or hearing testimony to a maximum of \$250 for the first hour and \$100 for each additional hour or part thereof. Often, Doctors charge rates well in excess of the fee schedule out of disdain for lawyers and the legal system in an effort to discourage attorneys from "wasting" their time with depositions. While you can hold a physician's feet to the fire with respect to his fee for testifying, an employer may want to consider paying the higher fee to avoid having an otherwise neutral witness turn the deposition into a personal vendetta against the employer. However, if the particular physician is a notorious plaintiff's physician, paying the higher rate will not help.

This argument was first accepted by ALJ Tony Murray in the case of Johnny Ramirez v. Lowry Construction and was affirmed on appeal by the Claimant to the Full Board. Robert Ingram represented the employer/insurer in that case and will provide copies of the decisions upon request. The Claimant did not appeal this decision beyond the Workers' Compensation Board.