2019 GEORGIA WORKERS' COMPENSATION GUIDE

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CHAPTER 1 - THE HISTORY OF GEORGIA'S WORKERS' COMPENSATION ACT

1-1. Introduction

Workers' Compensation is a state-created, statutory system of law. Georgia enacted its original statute in 1920. The purpose of the statute was to strike a balance between the competing interests of the employee and the employer. It allowed employees to recover for accidents arising out of and in the course of employment in a timely manner and regardless of fault in most instances. In return, the employee was not allowed to seek tort damages for injuries he or she sustained on the job. The employer relinquishes traditional common law defenses which normally serve to bar recovery, but the benefits the employee receives are limited by statute. The result is a balance between the worker's right to timely recovery and the employer's limited liability for work injuries. The system allows the employee to receive prompt medical treatment and envisions a prompt return to work in most cases, while the employer's liability is limited to statutorily-defined benefits.

1-2. The Industrial Revolution and Employers' Liability

As national economies changed from rural to urban and agrarian to industrial, workers were subjected to more dangerous and taxing working conditions. The rise of the industrial factory system was marked with an increase in workplace accidents. An injured worker's only recourse was to maintain a civil action, which often proved unsuccessful and was cost prohibitive to pursue. The social and economic discontent over the oppressive working conditions of the industrial worker spawned the advent of compensation systems for workers involved in work-related accidents.

1-3. The Problem with Negligence and Damages

Prior to the enactment of the modern Workers' Compensation Act, a worker who was injured on the job had recourse solely through filing a civil suit against his or her employer alleging that the employer's negligence caused the injury. To recover, the worker typically had to overcome at least three common law defenses.

The first common law defense was Contributory Negligence. Under this defense, an injured worker could not recover for injuries if his or her own negligence contributed to the injuries. The second common law defense was Assumption of the Risk. This defense provided that an employee who assumed the risk of injury by working at a particular job, or putting his or herself in danger, should not be allowed to recover for injuries. The third common law defense was based on the Fellow Servant Doctrine. Under this doctrine, an employer was not held liable for injuries to an employee caused by a co-worker.

Because these defenses were available to employers, workers often could not recover damages, and the pursuit of same was often time consuming and expensive. Indeed, suits frequently dragged on for many years in the courts. This placed the injured worker in a position of being unable to work or pay for medical expenses for prolonged periods of time. At the same time, employers also faced high defense costs and the risk of significant verdicts. In other words, if the employee was successful in proving the merits of his or her case, the employee could be awarded substantial damages and the employer might incur significant legal fees.

1-4. Workers' Compensation Laws as a Solution

The enactment of workers' compensation laws was designed to strike a balance between the competing interests of employers and employees. The employers lost their rights to assert common law defenses and, in exchange, gained limited exposure to liability. Likewise,

employees lost their rights to maintain civil actions for damages in exchange for a more affordable avenue to pursue benefits and more timely payment of those benefits without regard to fault.

1-5. State Legislation

The Georgia Workers' Compensation Act is governed by Title 34, Chapter Nine of the Official Code of Georgia Annotated. The premise behind the Act is that there is a large element of public interest in accidents occurring from modern industrial conditions, and the economic loss caused by such accidents should not necessarily rest upon the public. Rather, the industry in which an accident occurred should pay in the first instance for the accident. Over the years, Georgia has made significant changes to its workers' compensation legislation. In particular, adjustments have been made to the employee's entitlement to benefits based upon when the accident occurred—that is, the employee may be entitled to differing amounts of income benefits depending on when the injury occurred. Therefore, one must always be aware of the date of accident as it could affect an employee's entitlement to income benefits. Furthermore, the Georgia General Assembly has limited the period of time that the employee is eligible to receive income benefits and has also mandated that the State Board promulgate a fee schedule to limit expenses from individual health care providers.

1-6. The No-Fault System

Georgia's Workers' Compensation Act is often referred to as a "no-fault" system. This simply means that an employee's own negligence does not bar his or her claim for benefits. All that must be shown is that he or she suffered an injury that arose out of and occurred in the course of his or her employment.

1-7. Compulsory Law

Generally, every employer in Georgia with three employees regularly in the course of business is subject to the provisions of the Workers' Compensation Act. However, there are several employers and employees exempt from these provisions. For example, railroad workers; farm laborers; domestic workers; employees whose employment is not in the usual course of the trade, business, profession, or occupation of the employer; and federal employees are excluded from the Act. Sole proprietors, partners in a partnership, and independent contractors have also been exempted. However, partners or sole proprietors can make an election, by filing a State Board form, to be covered under their workers' compensation policy.

1-8. Method of Funding

If an employer is subject to the provisions of the Workers' Compensation Act, the employer is required to carry a policy of insurance to insure payment of benefits to injured employees. This is accomplished by one of the following three methods: (1) obtaining a policy of insurance from a private carrier licensed to write workers' compensation insurance in Georgia, (2) qualifying as a self-insurer, or (3) becoming a member of a group self-insurance plan. An insurer authorized to write workers' compensation insurance in Georgia must maintain an office within the state for the handling of Georgia claims or designate an agent within the state with the authority to execute instruments for payment of compensation benefits.

If, for some reason, an employer is unable to obtain insurance coverage after four attempts, the employer may still be able to obtain insurance coverage from the Assigned Risk Pool pursuant to O.C.G.A. § 34-9-133. In that instance, the State Board, in conjunction with the Commissioner of Insurance, can, in essence, compel an insurer to provide an employer with coverage.

In some states, private insurance companies are forbidden from providing workers' compensation insurance. In this type of monopolistic state fund, employers must buy insurance coverage from state-sponsored funds. Competitive state funds, on the other hand, give the employer the option of purchasing workers' compensation insurance from a state fund or from a private insurance company.

1-9. The Creation of the State Board of Workers' Compensation

Georgia enacted its first Workers' Compensation law in 1920. Among other things, it created the Industrial Commission, which was composed of the Commissioner of Commerce and Labor, the Attorney General, an employer Representative appointed by the Governor, and an employee Representative appointed by the Governor. This commission was charged with appointing worker deputies to hear the merits of workers' compensation cases.

In 1931, the Department of Industrial Relations was created within the Department of Commerce and Labor to administer workers' compensation laws. The Department was run by the Secretary of Commerce and Labor, an employee Representative appointed by the Governor, and an employer Representative appointed by the Governor. Then, in 1937, the Industrial Board was created to foster the administration of workers' compensation laws. It consisted of three members, all appointed by the Governor. It was not until 1943 that the Industrial Board was abolished and the quasi-independent State Board of Workers' Compensation came into being.

Currently, the State Board of Workers' Compensation is responsible for the administration of the workers' compensation laws. The Board carries out regulatory, administrative, and judicial functions. The Board's regulatory functions consist of licensing insurers to provide workers' compensation coverage in Georgia and approving applications of employers who desire to qualify as self-insurers. The administrative functions of the Board

consist of the review of benefit payments to injured workers and their dependents. The judicial function of the Board includes providing a trial forum for the resolution of disputes arising under workers' compensation law, as well as approving settlements and attorney fee contracts.

1-10. Exclusive Remedy

Generally, an employee forfeits his or her rights to file a personal injury suit against the employer in exchange for the exclusive right to recover workers' compensation benefits for his or her work-related injury. In return, the employers are required to accept liability for the claim without regard to fault. Nevertheless, an employee maintains the right to sue and collect damages in a civil action if the employer fails to carry insurance for payment of benefits to the injured worker. And despite the general rule, the parties can still contract to nullify the exclusive remedy provision and provide additional rights and remedies to the employee. O.C.G.A. § 34-9-11(a).

Conversely, the parties cannot contract to avoid the obligations owed under the Workers' Compensation Act. Carr v. FedEx Ground Package System, Inc., 317 Ga. App. 733 (2012). Thus, a general contractor cannot contract with a subcontractor or employee to avoid coverage under the Act. Claimants are also barred from bringing tort actions against co-workers so long as the co-worker was functioning in his capacity as an employee of the employer at the time of accident or injury. Smith v. Ellis, 291 Ga. 566 (2012). Likewise, claimants cannot file tort actions against intermediate subcontractors or general contractors who would otherwise be obligated to provide workers' compensation coverage. O.C.G.A. §34-9-11(a); Carr, 317 Ga. App. 733. Finally, if a claimant deviates from his or her job, is on a scheduled break, or is coming to or going from work (ingress/egress), certain facts could cause an injury to fall outside of the Act. Dixie Road Builders, Inc. v. Sallet, 318 Ga. App. 228 (2012).

CHAPTER 2 - EMPLOYMENT

2-1. Employment in General

The injured worker has the burden of proving his or her status as an "employee." An injured worker can prove the existence of an employment relationship with the employer by offering evidence of a written or oral contract of hire, whereby the worker was subject to the control of the employer. Otherwise, determining whether an employment relationship existed on the date of accident is fact intensive and unique to each case. As a general rule, however, there must be payment or at least the expectation of payment, in the form of wages or something else of value. Notably, the employment relationship begins once the employee commences the performance of the duties expected of him or her by the employer.

2-2. Excluded Employees

The Georgia Workers' Compensation Act has expressly excluded certain employees from receiving benefits, even if the other elements of establishing an employment relationship exist. For example, railroad workers are not covered by the Act, but are covered under federal laws. Likewise, domestic workers—*i.e.*, those who perform work in a private dwelling—are not considered employees for purposes of coverage under the Act. The domestic worker exemption, however, does not apply to workers who are employed by a separate business. For example, a maid employed by a cleaning service, while not considered an employee of the homeowner, is not excluded from benefits, but is considered an employee of the cleaning service. Additionally, farm laborers are also excluded from the Act. Farm laborers are defined as workers employed in or about the business of farming, and classification of a worker under this definition is determined by looking at the general nature of the employment, not the specific duties of the worker. Lastly, an employee whose employment is not in the course of the employer's trade or

business is excluded from receiving benefits under the Act. The applicability of this exclusion is based upon the purpose for which the worker was hired, rather than the activities the worker actually was performing at the time of the injury.

2-3. Number of Employees

The employee has the burden of proving that the employer is "subject to the Act," meaning that the employer employed three or more "employees" in the regular course of business. An independent contractor does not have employee status, and therefore, is not counted as an "employee." Moreover, an employee is considered "regularly employed" when he or she performs duties that are required in the ordinary or established custom or plan of operation for the business. However, "regular" does not require continuous employment. Therefore, casual employees—those that work on an inconsistent basis—are covered by the Act.

Even if an employer does not have three employees, the employer may elect to come under the Act by purchasing workers' compensation insurance. That is to say, if an employer does not have three or more employees but has purchased workers' compensation insurance, the injury cannot be denied on the grounds that the employer is not covered by the Act.

2-4. Independent Contractors

An independent contractor is not entitled to recover workers' compensation benefits from the company contracting for his or her services. The key issue in determining whether a worker qualifies as an independent contractor or an employer is whether or not the employer has the right to control the time, manner, and method of executing the work. There are several factors that have been found to indicate independent contractor status rather than an employee/employer relationship:

(1) A contract, written or oral, expressing the intent of the parties to create an independent contractor relationship.

(2) A person may have the right to exercise control over the time, manner and method of the work to be done.

(3) A person is paid by the unit of work rather than on a salary or hourly basis.

(4) A person has worked for a short period of time.

(5) The agreement between the parties has a definite beginning and end.

(6) The individual provides his own equipment or tools of the trade.

(7) The work performed by the individual requires a certain level of skill or specialization.

(8) The individual sets his own working hours.

(9) The individual has the right to control his own employees.

(10) The business of the individual is separate from that of the alleged employer.

(11) The alleged employer does not withhold taxes from the individual.

(12) The individual is not required to work exclusively for the alleged employer.

(13) The alleged employer may not add additional work without adding additional cost to the contract price.

An individual can be an independent contractor in one part of his or her work and an employee in another part. Therefore, the individual's status at the time of the injury is determinative.

2-5. Sole Proprietors

An owner or sole proprietor is considered an employer, not an employee and is, therefore, not entitled to coverage under the Act. The sole proprietor, however, may elect to be included as

an employee if he or she is actively engaged in the operation of the business. The insurance carrier or State Board must be notified of this election by the filing of a State Board form. Additionally, even though a sole proprietor may not be entitled to benefits if injured while working as a sole proprietor of his or her own business, he or she may still be covered as an employee in another employer's business.

2-6. Statutory Employment Law

An injured employee of a subcontractor may, in certain circumstances, have the right to recover benefits for an injury from a general contractor, intermediate contractor, or higher level subcontractor, who contracted out the work to the employee's immediate employer. In this case, the injured employee would be the "statutory employee" of the general, intermediate, or other subcontractor. Statutory employment law exists primarily to ensure that injured workers in the construction setting have benefits available from an insured employer. In return, any party potentially liable for workers' compensation benefits is immune from tort liability.

For the statutory employment provisions to be applicable there must be a contractual obligation creating a principal-contractor/subcontractor relationship. In general, an owner is not considered a statutory employer and therefore, is not potentially liable for benefits. However, an owner can be liable for benefits to the injured worker if the owner has a contractual obligation to another, making the owner a principal contractor. Moreover, the injury must have occurred on or about the premises on which the principal contractor has decided to execute work or be under the principal contractor's control for statutory employment to exist. And if the statutory employer has fewer than three employees, then he or she is still not subject to the Workers' Compensation Act and cannot be liable for payment of benefits to an injured worker. If, however, the statutory

employer has elected to have workers' compensation coverage, the Act will apply, even if the statutory employer has less than three employees.

If an employee's immediate employer is not subject to the Act, he or she may bring the initial claim against the statutory employer. On the other hand, when the employee's immediate employer is subject to the Act, the employee must file the initial claim against his or her immediate employer. After filing a claim against the immediate employer, the employee may then file a claim against the statutory employer. The employee may recover the amount in benefits from a statutory employer that the employee could have recovered from his or her immediate employer. The statutory employer then has the right to seek reimbursement (indemnification) from the immediate employer if the immediate employer should have had workers' compensation insurance to cover the claimant's injuries.

2-7. Employment by Estoppel

Even in the absence of an employment relationship or a statutory employment relationship, the Board may, nonetheless, find an employment relationship through the doctrine of estoppel. Estoppel is a legal fiction based upon fairness, whereby the employer is prevented from denying coverage in certain circumstances. For example, an insurer may not assert a defense that it is not subject to the Act where the insurer has issued to the employer a workers' compensation insurance policy. Additionally, if an employer pays insurance premiums based upon the earnings of an independent contractor, or the employer withholds a percentage of the independent contractor's earnings to cover insurance, the independent contractor may be eligible to recover benefits.

2-8. Borrowed Servant Doctrine & Joint Servant

The borrowed servant doctrine pertains to situations when one employer borrows the employees of another. The employer who loans the employee is called the "general master," and the company to whom the employee is loaned is referred to as the "special master." This doctrine typically arises with temporary employment agencies or with professional employment organizations or employee-leasing companies- that is, situations where an agency hires the employee but then places that employee in a work assignment where the client controls the day-to-day work of the employee. Both the special and general masters can be liable for the payment of an injured worker's benefits. However, both the special and general masters are also immune from tort liability, and the injured worker's recovery is limited to that which is provided by the Act.

For the borrowed servant doctrine to apply, the following circumstances must exist at the time the injury occurred:

(1) The special master must have complete control of the employee for that occasion;

(2) The general master must have no control for that occasion; and

(3) The special master must have the authority to discharge the employee, substitute another employee in his place, or change the job duties of the employee. KISSIAH'S GEORGIA WORKER'S COMPENSATION LAW, 3d Ed., Kissiah (2007), at §3.06[1].

A claimant can also be a joint employee at the same time that he or she is a borrowed servant. Pursuant to O.C.G.A. § 34-9-224, "Whenever any employee whose injury or death is compensable under this chapter shall at the time of the injury be in the joint service of two or more employers subject to this chapter, such employers shall contribute to the payment of such

compensation in proportion to their wage liability to such employee." Accordingly, if a claimant is in the joint service of two employers, each employer will be responsible for compensation benefits at the percentage rate they paid the claimant at the time of injury. Aimwell, Inc. v. McLendon Enterprises, Inc., 318 Ga. App. 394 (2012).

2-9. Illegal Aliens

A valid and enforceable contract ordinarily cannot be said to exist where the act to be performed is an illegal one. It has been argued that an individual who unlawfully secures employment by claiming to have proper resident alien status when in fact he or she is an undocumented alien should be denied workers' compensation benefits for any injuries sustained in the course of the illegal employment. However, in brief, where it is only the individual's own personal status, rather than the act for which he or she was employed, which was illegal, the courts have usually rejected any such contentions and have, instead, been willing to extend workers' compensation protection to undocumented aliens who are injured during the course of their unlawful employment. Defensive strategies for handling illegal alien claims are discussed more in depth in Chapter 15.

2-10. Concurrent Similar and Dissimilar Employment

Issues arise when an injured worker maintains two or more jobs at the time of the injury. The primary issue is whether wages earned from all employment , rather than only the wages earned from the employer for whom the employee was working at the time that the injury occurred, should be used to determine the claimant's average weekly wage. Georgia law provides that if the employment is similar, all wages should be used to determine the applicable average weekly wage. Conversely, if the concurrent work is dissimilar, only the wages earned

from the employment where the injury actually occurred will be used to calculate the average weekly wage.

In determining whether or not employment is similar, the Board compares the physical demands of each employment, rather than the specific job duties. If the concurrent employment is similar, and the injured worker returns to work for the other employer after the injury, the Employer/Insurer's exposure for income benefits would be limited to Temporary Partial Disability benefits. If the employee's concurrent employment is dissimilar, the injured worker's return to the dissimilar concurrent employment does not impact income benefit exposure.

CHAPTER 3 - THE WORKERS' COMPENSATION INJURY

3-1. Injuries in General

For an accident or injury to be considered compensable, the employee must show that he or she sustained an "injury" which arose out of and occurred in the course of his or her employment with the employer. By definition, "injury" includes an aggravation of a pre-existing condition, provided that the accident which caused the aggravation arose out of and occurred in the course of the injured worker's employment.

3-2. Arising out of Employment

Whether the injury results from an accident "arising out of the employment" is a question of causation. Where there is a causal connection between the conditions under which the work is required to be performed and the resulting injury, the accident is said to have arisen out of the employment. This test is generally applied liberally by the Board and the Courts. In essence, any injury which "flows as a natural consequence" of a risk connected with the business of the employer is considered to have arisen out of the employment. Williams v. Maryland Cas. Co., 99 Ga. App. 489 (1959); Zamora v. Coffee General Hosp., 162 Ga. App. 82 (1982).

3-3. In the Course of Employment

In addition to the causal connection, the injury must have occurred at a time, place, and under circumstances which are "in the course of the employment." As such, where an injury occurs during a time in which the employee is engaged in employment, and in a location where the performance of the employee's duties may be reasonably carried out, it will be considered to have occurred in the course of the employment, provided the employee was in the process of performing his or her duties or an act in furtherance of those duties at the time of the injury.

3-4. Aggravation of a Pre-Existing Condition

O.C.G.A. § 34-9-1(4) defines an injury as including an aggravation of a pre-existing condition, provided that same occurs "by accident arising out of and in the course of employment, but only for so long as the aggravation of the pre-existing condition continues to be the cause of the disability; the pre-existing condition shall no longer meet this criteria when the aggravation ceases to be the cause of the disability." As such, when it can be shown that the employee has returned to his or her pre-existing state of health, the employee's entitlement to ongoing benefits ceases.

3-5. Breaking the Causal Chain (new injuries)

Issues often arises where an employee returns to work after a compensable injury and, once again, becomes disabled due to either a gradual worsening or a specific incident or simply as a result of the wear and tear of ordinary life and/or activity connected with performing the employee's regular duties. This scenario raises the question of whether a change in condition for the worse or a new accident has occurred. The issue often comes about with successive employers or successive insurers insuring the same employer. The issue is also raised in cases concerning whether the applicable statute of limitations has expired.

As a general rule, if the employee returns to work after an injury and continues to perform his or her regular duties until such time that the employee is forced to cease work because of a gradual worsening of his or her condition, which is at least partly attributable to the physical activity in performing regular work, it has been held to be a new accident and is the responsibility of the employer/insurer at the time the disability manifests. This is especially true if there is evidence that the injury has worsened since returning to work. Evergreen Packaging, Inc. v. Prather, 318 Ga. App. 440 (2012). If, after the employee returns to work, the employee is

involved in a specific, job-related incident which aggravates a pre-existing condition, the employee is also said to have undergone a new accident, making compensability the responsibility of the employer/insurer at the time the second accident occurred.

Conversely, where the employee returns to work performing his or her ordinary duties (after an injury that was deemed compensable by award or voluntary commencement of benefits) and, as the result of the normal wear and tear of ordinary life and/or activity connected with performing the employee's normal duties, the condition gradually worsens to the point that the employee can no longer perform his or her job duties, a change in condition for the worse has occurred, meaning that the employer/insurer at the time of the original injury is responsible. No matter the scenario, however, if the claim has never been found compensable, by award or otherwise, then the Claimant cannot be said to have undergone a change in condition. Northbrook Property & Casualty Insurance Company v. Babyak, et al., 186 Ga. App. 339 (1998).

3-6. Suspending Benefits Based on a New Injury

Pursuant to Board Rule 204, an employer/insurer cannot unilaterally suspend weekly benefits on the grounds that a subsequent non-work related injury has broken the chain of causation between the compensable injury and the employee's disability. In order to suspend benefits, an employer/insurer must file a WC-14 requesting a Hearing for Suspension of Benefits seeking a change in condition based on subsequent non-work related injury. You may also file a Motion for an Interlocutory Order suspending the employee's income benefits pending the hearing.

CHAPTER 4 - SPECIAL INJURIES

4-1. Death

If an injury arising out of and in the course of employment results in death, instantly, or at a later time, the employer/insurer has a responsibility to pay benefits to the deceased's dependents, if any. Death benefits are explained in great detail in Chapter 5. Briefly, any person who can establish a financial dependence on the deceased employee may be entitled to death benefits. The determination of a person's dependency is measured at the moment of the death. All dependents are categorized, prioritized, and paid according to O.C.G.A. § 34-9-265.

If death benefits are owed, the employer/insurer is required to pay the compensation rate which would have been paid to the injured employee, pursuant to O.C.G.A. § 34-9-261, to be divided among dependents following a determination of which category of dependents exist, as discussed further in Chapter 5. The employer/insurer will also be responsible for the "reasonable expenses of the employee's burial, not to exceed $7,500.00." O.C.G.A § 34-9-265(b)(1).

Where there are no dependents qualifying to receive dependency benefits, the employer is required to pay to the State Board one half of the benefits which would have been payable to such dependent(s), or the sum of $10,000.00, whichever is less. (Death benefits are explained in more detail in Chapter 5).

4-2. Hernia

Pursuant to O.C.G.A. § 34-9-266, in order for an employee to be compensated for a work-related hernia, the employee must definitively prove the following five factors, "to the satisfaction of the Board":

(1) that there was an injury resulting in hernia;

(2) the hernia appeared suddenly;

(3) the hernia was accompanied by pain;

(4) the hernia immediately followed an accident; and

(5) the hernia did not exist prior to the accident for which compensation is claimed."

O.C.G.A. §34-9-266. (Emphasis added.)

The case law provides that, while there may not be a recovery of compensation for disability due to a pre-existing hernia, there may be a recovery of compensation due to an aggravation of a pre-existing hernia.

4-3. Occupational Disease

The definition of an injury under the statute *excludes* "a disease in any form except where it results naturally and unavoidably from the accident." O.C.G.A. § 34-9-1(4). O.C.G.A. § 34-9-280(2) defines an occupational disease as:

> those diseases which arise out of and in the course of the particular trade, occupation, process, or employment in which the employee is exposed to such disease, provided the employee or the employee's dependents first prove to the satisfaction of the State Board of Workers' Compensation all of the following:
>
> (A) A direct causal connection between the conditions under which the work is performed and the disease;

(B) That the disease followed as a natural incident of exposure by reason of the employment;

(C) That the disease is not of a character to which the employee may have had substantial exposure outside of the employment;

(D) That the disease is not an ordinary disease of life to which the general public is exposed **[PROPOSED LEGISLATION] provided, however, that for firefighters, as defined in Code Section 25-4-2, the disease of cancer, otherwise considered an ordinary disease of life, is shown by a preponderance of the competent and credible evidence, which shall include medical evidence, to have been attributable to the firefighter's performance of his or her duties as a firefighter; and**;

(E) That the disease must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence.

The occupational disease statute specifically states that partial loss of hearing due to noise shall not be considered an occupational disease. The statute also excludes psychiatric and psychological problems and heart and vascular diseases, except where they arise from a separate occupational disease.

4-4. Heart Attack or Stroke

The Act's definition of "injury" also *excludes* "heart disease, heart attack, the failure or occlusion of any of the coronary blood vessels, stroke, or thrombosis unless it is shown by a preponderance of competent and credible evidence, which shall include medical evidence, that

any of such conditions were attributable to the performance of the usual work of employment." O.C.G.A. § 34-9-1(4). In such cases, whether an actual injury occurred must be closely scrutinized. The claimant has the burden to show the occurrence of a myocardial infarction (heart attack) rather than angina pectoris (chest pain). In a stroke case, the employee must demonstrate an actual stroke rather than the occurrence of a transient ischemic attack (TIA), which includes an episode of stroke-like symptoms of short duration.

As with all injuries, to receive compensation for a heart attack or stroke, the heart attack or stroke must arise out of and occur in the course of employment. However, case law has recognized that a heart attack or stroke may be connected to the employment, even though the injury did not occur while the employee was actually at work. The employee must demonstrate a causal connection between the heart attack or stroke and employment, through the use of medical opinion, lay observation, and the "natural inference through human experience." Employees Mutual Liability Insurance Co. v. Bennett, 148 Ga. App. 129, 251 S.E.2d 96 (1978). Furthermore, the risk factors created by the work environment need only be a contributing factor in the heart attack or stroke. As such, the employee may be able to recover benefits even though he has several risk factors which are totally unrelated to the employment environment.

4-5. Idiopathic Injuries

An idiopathic injury exists when the cause of the injury is a physical or mental condition personal to the employee. Idiopathic injuries are not compensable, as they do not arise out of the employee's employment. Kissiah at §5.06. The cases that have addressed idiopathic injuries in the past have been inconsistent, frequently overturned, and rely heavily on a fact-based analysis. As such, it is difficult to assess the viability of an idiopathic "defense." Nonetheless, the most well-known exception holds that when a claimant strikes some object specifically related to the

Claimant's employment (such as a workbench, desk, piece of equipment, etc.), during an idiopathic fall, then the injury is generally compensable because the employment-related object increased the risk of injury. U.S. Cas. Co. v. Richardson, 75 Ga. App. 496 (1947). However, the law has been inconsistent with regard to what will constitute an employment-related object.

Chaparral Boats, Inc. v. Heath, 269 Ga. App. 339 (2004) is the case most frequently cited regarding idiopathic injuries. Briefly, Chaparral Boats held that in order for an injury to be compensable, there must be "some causal connection between the conditions under which the employee worked and the injury." An injury which comes from a hazard to which the employee was equally exposed to apart from employment will not be compensable as the causative danger must be peculiar to the work and not entirely independent of the employment relationship. The Court went on to state that an injury will not arise out of employment if the causative danger is not "peculiar to the work" in such a way that reasonable minds could find that the employment and injury are causally connected. In sum, when evaluating whether an injury is idiopathic in nature, an "entire picture" approach, including utilization of the doctrines of peculiar risk and positional risk, must be used in order to determine whether there is a causal connection between the employment and injury.

4-6. Psychological or Mental Illnesses A growing area in the field of workers' compensation is the compensability of psychological injuries. For a psychological or mental illness to be compensable, it must arise from an underlying compensable physical injury. A psychological or mental illness caused solely by a psychic, non-physical injury, has been held not to be compensable. Moreover, the courts have distinguished between mild depression and psychological illness. Mild depression has been determined to be the body's natural response to a severe physical injury, and it is not generally compensable. Kissiah at §6.05.

4-7. Hearing Loss

Traumatic hearing loss is compensable if it arises out of and occurs in the course of employment. An employee must be exposed to "harmful noise," which is defined as sound of an intensity of more than 90 decibels. O.C.G.A. § 34-9-264. Hearing loss must have occurred in both ears to be compensable, and the exposure must have occurred during a period of 90 working days or parts thereof. An employer will not be liable for any pre-existing hearing loss suffered on the part of the employee. It is a defense to a hearing loss case if the employee has failed to regularly utilize hearing safety devices provided by the employer. Traumatic hearing loss is compensable in the same manner as other injuries and permanent partial disability benefits for same are based on 150 weeks of compensation for a complete loss of hearing in both ears. O.C.G.A. § 34-9-263(c)(12).

Before filing a claim alleging hearing loss, an employee must remove his or herself from the environment creating the hearing loss for six (6) months. This can be accomplished by physically avoiding the work environment or through the use of hearing-protection devices. The purpose of this requirement is to ensure that the hearing loss sustained by the employee is permanent. O.C.G.A. § 34-9-264(c).

4-8. Vision Loss

Just as with any other injury, an employee is entitled to benefits for the loss of vision if same is the result of a work-related injury. The total loss of vision of a single eye will result in 150 weeks of permanent partial disability benefits. O.C.G.A. § 34-9-263(c)(13). A percentage loss of each eye is to be determined by an ophthalmologist pursuant to the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*.

4-9. Cumulative Trauma Injuries (e.g., Carpal Tunnel Syndrome)

Repetitive stress or cumulative trauma injuries, without a specific accident or event, are compensable. The most common cumulative injury is carpal tunnel syndrome. As there is no specific accident or event, the date of disability (i.e., the date the injured worker is unable to work) will be deemed the date of accident. For an employee who has worked for multiple, consecutive, employers while the condition worsens, it is the employer that the employee was working for at the time of the disability that will be deemed responsible (the last employer).

CHAPTER 5 - DEATH CLAIMS

Death claims under the Workers' Compensation Act are governed by O.C.G.A. § 34-9-265. Initial questions to consider when evaluating these claims are as follows: whether the death was related to work; whether any dependents survived the employee; and whether such dependents were wholly or partially dependent on the deceased employee.

5-1. Non-Work-Related Death of Disabled Claimant

Where an employee receiving workers' compensation benefits dies from a cause unrelated to the work injury, the employer's liability for future benefits terminates. In such circumstances, the employer should file a Form WC-2 Notice to Suspend Benefits, with a copy of the death certificate attached, if possible. The employer should also file a Form WC-3 Notice to Controvert. A copy of these forms should be provided to the representative of the employee's estate.

5-2. Death Related to Work

In contrast, where the employee's death results from a compensable work injury, the employer is obligated to pay death benefits, including reasonable funeral expenses not to exceed $7,500.00, and weekly dependency benefits. The amount of death benefits paid to a dependent depends on whether the dependent was wholly or partially dependent on the employee's income. Note that the total amount of benefits paid is in no way affected by the number of dependents left by the employee. Rather, the same set amount of benefits is divided among all eligible dependents.

5-3. Who is a Dependent?

A beneficiary entitled to recover death benefits is a person who relied on the employee in order to maintain his or her standard of living. It is not necessary that the dependent be related to

or live with the employee, nor is it necessary that the dependent actually receive money from the employee. A person who lived in a meretricious relationship with the employee is not eligible to receive dependency benefits. Note that where the dependency grew out of a meretricious relationship, such as adultery, the dependent is not entitled to benefits. Insurance Co. of North America v. Jewel, 118 Ga. App. 599 (1968). A common-law marriage is not considered a meretricious relationship. Note that Georgia abolished common law marriage in 1997. Therefore, in order for a common law marriage to exist, it must have been entered into by the parties prior to 1997.

5-4. What if there are no Dependents?

Where there are no dependents eligible to receive death benefits, the employer/insurer is still obligated to pay reasonable funeral expenses up to $7,500.00. In addition, the employer/insurer must pay to the State Board one-half the benefits which would have been payable to a dependent or $10,000.00, whichever is less. If a qualified dependent makes a claim after this payment has been made, the insurer will be entitled to reimbursement of the payment.

5-5. Total Dependents

If the employee's dependents are wholly dependent, then the employer must pay them a weekly compensation amount as provided by O.C.G.A. § 34-9-261 (the Code Section dealing with compensation for total disability). Where there exists a wholly dependent beneficiary, that person is entitled to the entirety of the payable death benefits. In other words, partial dependents only receive benefits if there are no total dependents entitled to receive benefits.

Certain individuals are presumed to be total dependents. For example, a surviving spouse (so long as the spouse had not voluntarily abandoned the employee at the time of the injury), children under age 18 at the time of the death (or under age 22 if the child is a full-time student

in a post-secondary educational institution), and children over the age of 18 who are physically or mentally unable to support themselves. Children presumed to be total dependents include natural children of the deceased employee, dependent stepchildren, legally adopted children, posthumous children (children born after the employee's death), and illegitimate children (as long as they are dependent upon the employee at the time of death and had been acknowledged by the employee). Where the surviving spouse was employed for at least 90 days before the employee's injury, the employer/insurer may rebut the presumption that the spouse was wholly dependent on the employee. Additionally, other dependents not listed above may prove they were total dependents, but they do not have the benefit of any presumption of dependency.

5-6. Partial Dependents

If there are no total dependents, then people who were only partially dependent on the employee's earnings at the time of the injury are entitled to benefits. Partial dependents are paid according to the following formula: the percentage of the employee's average weekly wage that the employee contributed to the partial dependent is multiplied by the amount which would be payable to a total dependent. For example, if a deceased employee paid a partial dependent 50 percent of his average weekly wage before his or her death, then that dependent would only be entitled to 50 percent of the amount a total dependent would be entitled to receive.

5-7. Termination of Benefits

A child's dependency status expires when the child reaches 18 (or 22 if in a post-secondary educational institution) unless the child is mentally or physically incapable of earning a living. The dependency of a spouse terminates with remarriage or cohabitation in a meretricious relationship. Otherwise, the dependency of a spouse and of any partial dependent

terminates at age 65 or after payment of 400 weeks of benefits, whichever provides greater benefits. O.C.G.A. § 34-9-13(e).

5-8. Limitations on Sole Surviving Spouse's Entitlement to Benefits

If the spouse is the sole dependent at the time of the employee's death, and if there is no other dependent for one year or less after the death, then the total death benefits cannot exceed $230,000.00 effective July 1, 2016 (for deaths prior to July 1, 2016, the limit is $220,000.00).

5-9. Statute of Limitations on Death Claims

A claimant has one year from the date of the employee's death within which to file a claim for dependency benefits against the employer with the State Board. It is the date of the employee's death that starts the running of the Statute of Limitations and not the date of accident. However, where the dependent is a minor with no trustee or guardian, the Statute of Limitations does not begin to run until the dependent reaches the age of majority (18). The one-year Statute of Limitations only applies to a primary beneficiary dependent and not to a secondary beneficiary dependent who is only contingently entitled to death benefits. Kissiah at §17.04.

5-10. Death Due to Intentional Act of Employer

If the death of the employee was caused by the intentional act of the employer with specific intent to cause that injury, the State Board must add a 20 percent penalty to the weekly dependency benefits payable up to $20,000.00.

CHAPTER 6 - CATASTROPHIC INJURIES

6-1. What is a Catastrophic Injury?

As defined by O.C.G.A. § 34-9-200.1(g), a catastrophic injury includes:

(1) Spinal cord injuries involving severe paralysis of an arm, a leg, or the trunk;

(2) Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

(3) Severe brain or closed head injury as evidenced by the following:

(A) Severe sensory or motor disturbances;

(B) Severe communication disturbances;

(C) Severe complex integrated disturbances of cerebral function;

(D) Severe disturbances of consciousness;

(E) Severe episodic neurological disorders; or

(F) Other conditions at least as severe in nature as any condition provided in subparagraphs (A) through (E) of this paragraph;

(4) Second or third-degree burns over 25 percent of the body as a whole or third-degree burns to 5 percent or more of the face or hands;

(5) Total or industrial blindness; or

(6) (A) Any other injury 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 within the national economy for which such employee is otherwise qualified. However, if the injury has not already been accepted as a catastrophic injury by the employer, and the authorized treating physician has released the employee to return to work with restrictions, then there shall be a rebuttable presumption, during a period not

to exceed 130 weeks from the date of injury, that the injury is not a catastrophic injury. During such period, in determining whether an injury is catastrophic, the board shall give consideration to all relevant factors including, but not limited to, the number of hours for which an employee has been released. A decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act shall be admissible in evidence, and the board shall give the evidence the consideration and deference due under the circumstances regarding the issue of whether the injury is a catastrophic injury; provided, however, that no presumption shall be created by any decision granting or denying disability income benefits under Title II or supplemental security income benefits under Title XVI of the Social Security Act.

(B) Once an employee who is designated as having a catastrophic injury under this subsection has reached the age of eligibility for retirement benefits as defined in 42 U.S.C. § 416(l), as amended March 2, 2004, there shall arise a rebuttable presumption that the injury is no longer a catastrophic injury; provided, however, that this presumption shall not arise upon reaching early retirement age as defined in 42 U.S.C. § 416(1), as amended March 2, 2004. When using this presumption, a determination that the injury is no longer catastrophic can only be made by the Board after it has conducted an evidentiary hearing.

Generally, injuries that fall within the parameters of sub-parts (1) through (5) of the aforementioned statute are self-evident and easily identified. The vast majority of disputed and litigated cases revolve around sub-part (6). In order for an employee to prove that his or her injury is catastrophic, the employee must show that he or she is unable to perform both (a) their prior work duties, and (b) any work available in substantial numbers in the national economy.

The first issue can usually be determined by the employee's authorized treating physician or by the employee's attempts to return to work. The latter issue typically necessitates testimony from a vocational expert who has knowledge of the labor market and the employee's abilities, including education level and vocational training. However, it must be noted that recent court rulings suggest that the use of a vocational expert is not always necessary; sometimes the medical evidence and the employee's testimony are sufficient to meet the burden for catastrophic designation.

If a claim is deemed catastrophic, the 400-week cap on income benefits is removed. Thus, a catastrophically injured worker could theoretically receive TTD benefits for life if he or she is unable to return to work. In the rare event that a catastrophically injured employee returns to work for more than 2 years earning at least his or her average weekly wage, the employee's right to enforce his entitlement to lifetime benefits would be time barred by O.C.G.A. § 34-9-104(b) statute of limitations. Roseburg Forest Prod. Co. v. Barnes, 299 Ga. 167, 787 S.E.2d 232 (2016).

It is important to remember that the employer has only 48 hours to appoint a registered rehabilitation supplier or give reasons why rehabilitation is not necessary once the employer has accepted a claim as catastrophic. If it is deemed catastrophic by the Board, then the employer has 20 days to name a rehabilitation supplier; otherwise the Board will appoint one of its choosing. O.C.G.A. § 34-9-200.1.

6-2. Impact of Social Security Disability Award

According to O.C.G.A. § 34-9-200.1(g)(6), a decision granting or denying disability income benefits under Title II or Supplemental Security Income benefits under Title XVI of the Social Security Act shall be admissible into evidence, and the Board shall give the evidence the consideration and deference due under the circumstances regarding the issue of whether the injury is catastrophic. In simpler words, the current state of the law is that an employee's Social Security award will be considered as evidence by the administrative law judge, but an award granting Social Security benefits to the employee does not automatically result in a determination that the workers' compensation claim is catastrophic. Prior to July 1, 1995, such an award granting Social Security benefits created a presumption that the workers' compensation claim was catastrophic.

6-3. Rehabilitation Supplier

According to O.C.G.A. § 34-9-200.1(a), "[i]n the event of a catastrophic injury, the employer shall furnish the employee entitled to benefits under this chapter with reasonable and necessary rehabilitation services. **The employer either shall appoint a registered rehabilitation supplier or give reasons why rehabilitation is not necessary within 48 hours of the employer's acceptance of the injury as compensable or notification of a final determination of compensability, whichever occurs later.** If it is determined that rehabilitation is required under this Code Section, the employer shall have a period of 20 days from the date of notification of that determination within which to select a rehabilitation supplier. If the employer fails to select a rehabilitation supplier within such time period, a rehabilitation supplier shall be appointed by the Board to provide services at the expense of the employer. The rehabilitation supplier appointed to a catastrophic injury case shall have expertise which, in the

judgment of the Board, is necessary to provide rehabilitation services in such case." (Emphasis added).

CHAPTER 7 - JURISDICTION AND VENUE

7-1. Employers Subject to the Workers' Compensation Act

In order to be subject to the Workers' Compensation Act in Georgia, an employer must have three employees regularly employed in the usual course of their trade, business, occupation or profession within the state. An employer that does not meet these requirements can be subject to the Act if they elect to be covered and purchase workers' compensation insurance. O.C.G.A. § 34-9-2(a)(2).

7-2. Jurisdiction of the State Board

The issue of jurisdiction over workers' compensation claims arising from an injury that occurred in Georgia boils down to whether or not the injury occurred within the territorial limits of the state.

The Board will not deny jurisdiction simply because the employee is not a resident of the state or because the contract for employment was entered into in another state. If the accident occurred within the territorial limits of Georgia, then the State Board of Workers' Compensation has jurisdiction. The Board may also have jurisdiction over claims occurring outside of the territorial limits of Georgia in certain circumstances.

7-3. Dual Jurisdiction

An employee may file a workers' compensation claim in Georgia for an injury that occurred outside the territorial limits of the state if the following conditions are met:

(1) the contract for employment was made in Georgia;

(2) the employee's residence is within the state, or the employer's place of business is within Georgia; and

(3) the contract for employment was not for work done exclusively outside the state. O.C.G.A. § 34-9-242.

If an employee has filed a claim in another state for workers' compensation benefits, he or she may also, in some instances, file a claim in Georgia as well. The Board must have jurisdiction over the claim and may give an employer credit for benefits already paid on the same claim pursuant to another state's workers' compensation laws.

7-4. Venue

The county where an accident occurs determines the place the hearing will occur. There are four venues where a hearing may be held: (1) the county in which the injury occurred; (2) a county contiguous to the county of injury; (3) any other county agreed upon by the parties and authorized by the administrative law judge; or (4) any county within 50 miles of the county of injury or death. O.C.G.A. § 34-9-102(b).

If an accident occurs outside the State of Georgia but the Georgia State Board of Workers' Compensation still has jurisdiction to hear the claim, then the location of the hearing is determined by any of the following: (1) the county of the employer's residence; (2) the county of the employer's place of business; or (3) in any other Georgia county as determined by the administrative law judge. O.C.G.A. § 34-9-102(b).

CHAPTER 8 - NOTICE OF AN INJURY

8-1. Notice Provision

An employee has the burden of proving that he has met the notice requirements under O.C.G.A. § 34-9-80. An employee or his representative must give notice of an injury to the employer immediately or as soon as is practical after the occurrence of the accident. No compensation will be paid to an employee unless either oral or written notice is given to the employer within 30 days after the occurrence of the accident or within 30 days after the death resulting from the accident.

Exceptions to the 30-day requirement do exist. If the employee is prevented from giving notice due to physical or mental incapacity, or if there is fraud or deceit that prevents timely notice, or if the employer had knowledge of the accident, the time limit will be tolled. The administrative law judge can also hear reasonable excuses that might satisfy the Board as to why notice was not timely given and same must not prejudice the employer. The notice rule is designed to protect the employer against fraud, give the employer the opportunity to investigate the accident, and provide prompt medical care for the employee.

The notice provision has been liberally construed by the courts. Notice is sufficient so long as the employer is on notice to make an investigation should they choose to do so. This is typically referred to as "inquiry notice." It is not necessary that the employee himself give notice to the employer. It is sufficient notice if the circumstances surrounding the injury give notice to the employer that an injury may have occurred and same warrants at least an inquiry investigation of the claim. Furthermore, notice may be given to the employer, their agent or representative, or the employee's foreman or immediate supervisor.

CHAPTER 9 – OVERVIEW OF BENEFITS PROVIDED UNDER THE ACT

9-1. Indemnity or Income Benefits

A. Waiting Period

An employee is not entitled to any workers' compensation income benefits for the first seven days of incapacity resulting from an injury. The seven-day waiting period for disability benefits eligibility begins on the first day that the injured employee is unable to work a full day, unless the employee was paid in full for the date on which the injury occurred. In this case, the waiting period begins the next day. The period runs for seven calendar days of disability. Disability ends on the day the injured employee returns to work. According to O.C.G.A. § 34-9-221, the first payment of income benefits is due on the twenty-first day after the Employer has knowledge of the injury or death. At that point, benefits are payable in weekly installments.

When an employee is entitled to income benefits, the income benefits become due on the seventh day of the disability week. If the checks are being mailed from out of state, checks should be mailed from the fourth day of the disability week to ensure timeliness.

B. Temporary Total Disability (TTD)

When a worker is temporarily disabled from working due to a work injury, he will be entitled to TTD benefits. An employee in a non-catastrophic case is only eligible for temporary total disability benefits for 400 weeks from the date of the accident. Disability is often determined by the authorized treating physician. Even if the employee is capable of light duty work, but there is none available with the employer, then the employee may be entitled to TTD benefits. Generally, it is the employee's burden to prove entitlement to TTD benefits. He must prove that he sustained a total loss to his earning capacity because of the work-related injury.

An employee allowed TTD benefits is entitled to a weekly payment of two-thirds of his average weekly wage, up to the current maximum of $575.00 per week if the accident occurred on or after July 1, 2016. The maximum is $550.00 per week if the accident occurred between July 1, 2015 and June 30, 2016, and $525.00 per week if the accident occurred between July 1, 2013 and June 30, 2015. For earlier dates of accident, the maximum was $500.00 per week for injuries occurring between June 30, 2007, and July 1, 2013, $450.00 per week for injuries occurring between July 1, 2005 and June 30, 2007, $425.00 per week for injuries occurring between July 1, 2003 and June 30, 2005, $400.00 per week for injuries occurring between July 1, 2001 and June 30, 2003, and $375.00 per week for injuries occurring between July 1, 2000 and June 30, 2001. The weekly compensation rate is based on the date the employee's accident occurred. See O.C.G.A. § 34-9-261 for the maximum rates for earlier dates of accident.

An employee's TTD benefits may be suspended when he or she returns to work, or where the authorized treating physician has released the employee to full duty work without restrictions. A WC-2 should be filed with the Board reflecting the reason for the suspension. If benefits are suspended based on a full duty work release, then a copy of the supporting medical report from the Claimant's authorized treating physician should be attached to the WC-2 (and the Claimant's authorized treating physician must have examined the Claimant within the previous 60 days of the effective date of full duty release). Further, if benefits are suspended based on a full duty work release, but the employee has not actually returned to work, then the Employer/Insurer must give the Claimant 10 days' notice of the suspension, and allow an additional 10 days of TTD benefits after the full duty release before suspending income benefits.

C. Temporary Partial Disability (TPD)

To be eligible for temporary partial disability benefits, the employee's on-the-job injury must have partially impaired his earning capacity. The employee's average weekly wage after the accident must be less than his average weekly wage before the accident to qualify for TPD benefits. The employee's disability must be both temporary and partial in nature.

The employee has the burden of proving that he is eligible for TPD benefits. He must prove the following:

(1) he suffered a loss of earning power as a result of the on-the-job injury; and

(2) he suffers temporary physical limitations due to that injury. Kissiah at §15.02.

The amount of TPD benefits to which an employee is entitled is determined by comparing the employee's average weekly wage prior to the injury with the average weekly wage after the injury. If there is a wage loss, then the employee may recover two-thirds of the difference between the pre-injury average weekly wage. The maximum weekly amount of TPD benefits allowed by law is $383.00 per week, as of July 1, 2016. For injuries from July 1, 2015 through June 30, 2016, the maximum weekly amount of TPD benefits is $367.00. For injuries from July 1, 2013 through June 30, 2015, the maximum weekly amount of TPD benefits is $350.00. For injuries from July 1, 2007, until June 30, 2013, the maximum weekly amount of TPD benefits is $334.00 per week. An employee is only eligible for TPD benefits for 350 weeks from the date of the accident. A WC-262 should be filed every 13 weeks during which TPD benefits are due documenting TPD payments in 13 week periods and a copy should be sent to the claimant and the claimant's attorney. Board Rule 262.

It should be noted that if the employee has a new job with reduced earnings, he or she must still establish the causal connection between the employee's impaired earning capacity and

the employee's work-related injuries. The reduced earnings must be causally connected to some physical or psychological disability related to the work injury; not the mere fact that the employee obtained a new position or job.

D. Permanent Partial Disability Benefits (PPD)

Permanent partial disability benefits compensate for three types of losses: (1) loss of a specific member; (2) loss of use of a specific member; and (3) impairment to the body as a whole. PPD benefits will not become due so long as the employee is entitled to TTD or TPD benefits. O.C.G.A. § 34-9-263. The employer has 30 days from the date that the employee becomes entitled to PPD benefits to have the injured body member rated according to the *American Medical Association's Guidelines to the Evaluation of Permanent Impairment. 5th Edition*. Once the rating has been obtained, the employer must commence payment of PPD benefits within 21 days of receipt of the permanent partial impairment rating from the authorized treating physician. The employer is presumed to have knowledge of the report 10 days after the report of PPD rating is made.

A condition that will not improve during the employee's lifetime is considered permanent in nature. O.C.G.A. § 34-9-263 lists parts of the anatomy and then sets forth the number of weeks of disability benefits to which the employee is entitled. For example, if an employee with a TTD rate of $325.00 per week is given a 10 percent rating to the arm, then you take the maximum number of weeks for an arm injury (225), multiply it by 10 percent (.10), and then multiply that by the TTD rate (225 x .10 x $325.00 = $7,312.50 in PPD benefits owed).

Where an employee has a pre-existing permanent impairment and he later sustains a subsequent work-related injury, he is entitled to permanent partial disability benefits for the subsequent injury only if the injury increased his permanent impairment. He may only receive

benefits for the amount by which the subsequent injury increased his permanent impairment above and beyond that pre-existing level of impairment

An employee's weekly permanent partial disability benefit is calculated by taking two-thirds of the employee's average weekly wage up to an amount equal to the maximum dollar amount allowed by law. This is the same amount as the employee would be entitled to for temporary total disability benefits under O.C.G.A. § 34-9-261. The maximum dollar amount allowed is determined by the date the accident occurred.

9-2. Medical Benefits

The employee bears the burden of proving that he or she is entitled to medical benefits. An employer is only responsible for medical expenses which are:

(1) reasonably required and appear likely to effect a cure, give relief, or return the employee to suitable employment;

(2) prescribed by an authorized physician (the authorized treating physician or one directly referred by the authorized treating physician);

(3) for the benefit of the employee;

(4) due to the employee's compensable injury; and

(5) the usual and customary charges.

See O.C.G.A. § 34-9-200. There is no monetary limitation on medical benefits. However, for all injuries occurring on or after July 1, 2013, which are not designated as catastrophic, the employee is only entitled to a maximum of 400 weeks of medical benefits from the date of accident. This is notable because for accidents occurring before July 1, 2013, an employee was entitled to medical benefits for the rest of their life, so long as the treatment is reasonably required to effect a cure, provide relief or restore the claimant to suitable

employment. In all catastrophic cases, the employee is entitled, regardless of the date of accident, to medical benefits for life. The State Board publishes an annual Fee Schedule of reasonable charges for all medical services provided for under the Act. The Fee Schedule is organized by the type of service provided. Employees are not to be billed by medical providers once a claim has been accepted or a hearing has been requested regarding compensability. Pursuant to Board Rule 203, peer review is available to review cost and to determine the reasonableness and/or necessity of services already rendered.

An authorized medical provider may request advanced authorization for treatment or testing. Advanced authorization may be requested by completing Section 1 and 2 of Board form WC-205 and faxing or e-mailing same to the adjuster. The insurer should respond by completing Section 3 of the WC-205 within **five (5) business days** of receipt of this form. This response must be by facsimile or e-mail to the requesting authorized treating physician. **A failure to respond within this five-day period renders the requested treatment/testing pre-approved.** However, the treatment/testing must still be related to the injury in order to qualify. For example, wrist or knee surgery would not qualify if submitted for pre-approval for a compensable neck injury. If the insurer still wants to deny the treatment/testing after the five days has expired, then a WC-3 Notice to Controvert should then be filed within 21 days of the WC-205.

An employer is responsible for all expenses incurred for medications prescribed by an authorized physician for the work related injury. Medical expenses also include the reasonable cost of travel to and from the employee's home to the place of treatment or pharmacy.

9-3. Rehabilitation Benefits

Rehabilitation services are only mandatory for individuals who have sustained catastrophic injuries. O.C.G.A. § 34-9-200.1. Parties in a non-catastrophic case may agree to

voluntary rehabilitation services, and if they do, the agreement must be in writing. A catastrophic injury involves a spinal cord injury, multiple amputations, severe brain or closed head injury, second or third-degree burns over 25 percent of the body as a whole or third-degree burns to 5 percent or more of the face and hands, total or industrial blindness, or any other injury determined to be catastrophic by the Board.

Rehabilitation services include the goods and services necessary for vocational assessment and evaluation; guidance and counseling; vocational planning, training and placement. Home or vehicle modifications that are reasonably necessary may also be included. Kissiah at §19.02.

The Workers' Compensation Act specifically states that both the fees of rehabilitation suppliers and the reasonableness and necessity of their services shall be subject to the approval of the Board. Rehabilitation expenses should be limited to the usual, customary, and reasonable charges in Georgia, and they should not exceed the fee schedule listed under O.C.G.A. §34-9-205. The fee schedule allows an hourly rate of $75 per hour for non-catastrophic suppliers and $80 per hour for catastrophic suppliers. The fee schedule also limits the number of hours that can be charged for certain activities.

Rule 200.2, which addresses medical/nurse case management, went into effect on January 1, 2016. Before Rule 200.2 went into effect, third party or independent contractor case managers were prohibited from engaging in nurse case management. Rule 200.2 allows third party or independent contractor case managers not employed directly by the Employer, Insurer, or TPA, to perform case management services including: (1) contracting the treating physician for purposes of assessing, planning, implementing, and evaluating the options and services required to effect a cure or provide relief; and, (2) assist with the approval of job descriptions consistent

with O.C.G.A. § 34-9-240 and Board Rule 240. However, according to Rule 200.2, there are certain requirements that the case managers must meet, including: (1) case managers must possess certification or licensure required by Board Rule 200.1; (2) the consent of the Claimant is required when the case manager attends a medical appointment; and, (3) when consent is required, it may be withdrawn and the Claimant must be informed in writing that consent may be refused. The requirements of Board Rule 200.2 do not apply to a direct employee of the Insurer, TPA, or Employer, or to an attorney representing a party (and the requirements in Board Rule 200.1 are still valid).

9-4. Credits and Offsets

When an employer or insurer takes a credit or makes a reduction to offset a payment, it must report the credit or reduction to the Board on a Form WC-243. The employer/insurer bears the burden of proving entitlement to the credit or reduction.

If benefits have been paid to the employee under the laws of another jurisdiction, then the employer is entitled to a credit for the payments against any Georgia benefits which are due. Where an employer or insurer pays benefits to the employee which are not yet due, it is entitled to credit against any future benefits due until the overpayment is recouped. The employer or insurer is also entitled to credit for salary or wages paid by the employer during the employee's disability when there is no award.

In Georgia, an employer is also allowed credit for salary paid to the injured worker for periods covered by sick leave or vacation, so long as the employer follows a four-step procedure. Kissiah at §20.04. Previously the Georgia Court of Appeals in a 4-3 split decision ruled against an employer that argued for a credit for the sick leave wages paid to an employee while the employee was out for his compensable work injury. However, because this would allow a

claimant the opportunity to recover double wages, the Appellate Division of the State Workers' Compensation Board continues to allow Employers to take a credit if the employer: (1) told the claimant that he had the option to either indemnity benefits or paid leave; (2) allowed the claimant to select between the two; (3) did not require that the selection was irrevocable; (4) presented evidence at the hearing regarding its policies.

Unemployment benefits which an employee receives during his or her disability must be credited against income benefits due under the Workers' Compensation Act. The employer may never credit unemployment benefits received by the employee against any PPD benefits that the employee receives.

The Board is authorized to order the employer or insurer to reimburse a group insurance company or any other disability insurance provider for benefits (medical or indemnity) paid to the injured worker. The employer or insurer is then allowed to take credit for any reimbursements paid.

An employer may not take credit for payments made to the employee pursuant to a disability pension plan. No credit may be taken by the employer for "GI Bill" payments received by the employee.

Finally, there is an interesting twist when the employee goes to jail while receiving or claiming entitlement to benefits. If the employee is incarcerated pursuant to a conviction (or even a parole/probation violation), the courts have held that the employee is not entitled to income benefits. The logic is that while in jail, the employee's inability to earn money is no longer caused by the work injury. **Caveat**: **the employer cannot suspend income benefits before the employee has actually been <u>convicted</u>, even if he is sitting in jail before trial.** Once the employee is convicted, the employer can seek to take a credit for benefits paid during

the entire period for which the employee was incarcerated as well as suspend income benefits. Furthermore, once TTD or TPD benefits have been suspended due to the employee pleading guilty or being convicted of a crime, the employer/insurer has no obligation to commence PPD benefits. Wet Walls Inc. v. Ledezma, 266 Ga. App. 685 (2004). The theory provided by the Court in the above case is that paying PPD benefits under this scenario could provide a windfall to employees in cases where the claims may be designated as catastrophic in the future.

CHAPTER 10 - COMMON DEFENSES

10-1. Rycroft Defense

This defense was judicially created in 1989 by the Georgia Supreme Court in the case of Georgia Elec. Co. v. Rycroft, 259 Ga. 155 (1989). The defense involves an employee's intentional misrepresentation of his prior medical condition to act as a bar to the recovery of workers' compensation benefits. For the employee's misrepresentation to bar recovery of benefits, he must have made a false statement in a post-employment health questionnaire or inquiry regarding his physical condition. The employer must also satisfy three elements for the defense to bar recovery of benefits by the employee:

(1) The employee must have knowingly and willfully made a false representation as to his physical condition;

(2) The employer must have relied upon the false representation, and the reliance must have been a substantial factor in the hiring;

(3) There must have been a causal connection between the false representation and the injury. Kissiah at §11.02.

It is not necessary for the misrepresentation to be in writing; an employee's oral statement is enough to bar recovery if all of the above-mentioned factors are satisfied.

An employee who intentionally makes a false statement as to his physical condition may not use the fact that the employer failed to engage in extensive physical examination and investigation as a defense. An employer is not required to examine an employee's medical history; rather, the employer should be able to rely on the employee's statements regarding his prior health conditions. However, once an employer engages in a pre-employment physical

examination of the employee, it may weaken the argument that the employer actually relied upon the intentional misrepresentation made by the employee in the hiring process.

Usually for the causal connection factor to be satisfied, the employer must merely demonstrate that the work-related injury would not have occurred or was considerably worse than it would have been had the pre-existing condition not been present.

The one caution that arises in raising this defense is if the employer initially accepts liability on the claim, and more than sixty days from the due date for the payment of income benefits has elapsed, then the employer is barred from raising the defense according to O.C.G.A. §34-9-221, unless the employer can meet the threshold for newly discovered evidence.

10-2. Willful Misconduct, Including Drugs and Alcohol

Willful misconduct is an affirmative defense. Therefore, the employer has the burden of proving the employee's willful misconduct so as to bar the workers' compensation benefits. The employer must show that the employee engaged in willful misconduct at the time of the work-related injury and that the misconduct caused the injury. In order for misconduct to be enough to bar workers' compensation benefits, it must be more than mere negligence. The conduct must be quasi-criminal in nature. In a recent opinion, the Supreme Court of Georgia clarified what constitutes "criminal" and "quasi-criminal" conduct in the context of the willful misconduct defense.

In Burdette v. Chandler Telecom, LLC, 335 Ga. App. 190 (2015), an employee was injured after falling a great distance while attempting to lower himself down a cell phone tower in a "controlled descent." Typically, the employer prohibited employees from lowering themselves in a controlled descent fashion because of safety concerns. In Burdette, the employee's supervisor directly instructed the employee to climb down the cell phone tower

before the fall occurred, but the employee disregarded the supervisor's instructions. The Court of Appeals held that the employee's conduct was, "at most, a violation of instructions and/or doing of hazardous act in which danger was obvious, but was not conduct that was criminal or quasi-criminal in nature." As such, because the employee's conduct did not meet the Court of Appeals' definition of criminal or quasi criminal conduct, the Court of Appeals held the willful misconduct defense would not apply and the employee would not be precluded from recovering workers compensation benefits. In February of 2017, the Supreme Court of Georgia unanimously reversed the Court of Appeals' decision and determined "criminal or quasi criminal" simply means "the intentional doing of something either with the knowledge that it is likely to result in serious injury, or with the wanton and reckless disregard of its probable consequences." The Supreme Court of Georgia specifically indicated that this is the standard which should be utilized to determine whether an intentional violation by an employee will bar his or her right to compensation.

According to O.C.G.A. § 34-9-17, "no compensation shall be allowed for an injury or death due to the employee's willful misconduct . . . . or due to intoxication by alcohol or being under the influence of marijuana or controlled substance." The only exception allowed is a controlled substance prescribed by a physician for the employee and taken in accordance with such prescription.

According to O.C.G.A. § 34-9-17(b)(1), if an employee has .08 grams of alcohol or more in his system within three hours of the time of the alleged accident as shown by chemical analysis of the employee's blood, urine, breath, or other bodily substance, there will be a rebuttable presumption that the accident and injury or death was caused by the consumption of alcohol. In this case, the employee could be barred from receiving benefits. If an employee has

any marijuana or other improper (i.e., not prescription) controlled substance in his blood within eight hours of an accident, as shown by chemical analysis of the employee's blood, urine, breath, or other bodily substance, there is a presumption that the accident and injury or death was caused by the ingestion of marijuana or the controlled substance. In this case, the employee could also be barred from receiving benefits.

If an employee unjustifiably refuses to submit to a reliable, scientific test for drugs or alcohol taken pursuant to O.C.G.A. § 34-9-415, then the presumption arises that the accident and injury or death was caused by the employee consuming alcohol or ingesting drugs. The presumption that arises in the drug and alcohol use cases is not absolute. The employee may rebut the presumption by showing that the intoxication or ingested drug use was not the proximate cause of the accident. It is then up to the employer to prove that the intoxication, drug use, or willful misconduct was indeed the proximate cause of the accident to bar the workers' compensation benefits.

10-3. Statute of Limitations

If an award has previously been issued which awarded income benefits, the change in condition statute of limitations rather than the "all issues" statute of limitations applies. When the change in condition statute runs, it bars only the claim for additional income benefits; it does not affect a claim for additional medical benefits. On the other hand, when the "all issues" statute of limitations runs, it bars the claim in its entirety. O.C.G.A. § 34-9-82 is the "all issues" statute of limitation, and O.C.G.A. § 34-9-104(b) outlines the change in condition statute of limitations.

Under O.C.G.A. § 34-9-82, the right to compensation is barred unless a claim is filed within one year after the injury unless payment of weekly benefits has been made or remedial

medical treatment has been furnished by the employer. Under these exceptions, the claim may be filed within one year after the date of the last remedial treatment furnished by the employer, or within two years after the date of the last payment of weekly benefits. Note that payment of permanent partial disability benefits for an impairment rating are considered weekly benefits and can toll the running of the statute of limitations. O.C.G.A. § 34-9-82 controls new accidents.

Under O.C.G.A. § 34-9-104(b), one must look at the date that the accident occurred to determine the appropriate application of the statute. For accidents occurring prior to July 1, 1978, the statute of limitations for assessing a change in condition by an employee to reinstate benefits is two years from the date on which the employer notified the board of its final payment. For accidents occurring between July 1, 1978 and July 1, 1990, the request to reinstate benefits is timely if it is made within two years of the date of final payment of income benefits potentially due. For accidents occurring after July 1, 1990, the request is timely if it is within two years after the last payment of income benefits for temporary total or temporary partial disability. If the claim for a change in condition is claiming entitlement to permanent partial disability (PPD) benefits, then the statute of limitations is four years from the last payment of TTD or TPD benefits.

CHAPTER 11 - AVERAGE WEEKLY WAGE

11-1. Methods of Determination

There are three methods of computing average weekly wage as set forth by O.C.G.A. § 34-9-260. The following is a brief analysis of the three methods for computing average weekly wage.

11-2. Actual Wages for Thirteen Weeks Preceding the Date of Injury

The most commonly used method of computing an employee's average weekly wage is calculated by averaging the employee's earnings for the 13 weeks preceding the injury date. To use this method of calculation, the employee must have worked in the employment at the time of the injury, whether for the same or another employer, during substantially the whole of 13 weeks immediately preceding the injury. If the employee has worked for 13 weeks preceding the compensable injury, one would take the total of the weekly wages for the 13 preceding weeks and divide same by 13 to arrive at the employee's average weekly wage.

The question frequently arises as to what is meant by "substantially the whole of 13 weeks immediately preceding the injury." Georgia case law infers that one cannot use an employee's earnings for 11 weeks preceding the date of accident to compute the employee's average weekly wage. However, some case law has held that the employee worked substantially the whole of 13 weeks when the employee had only worked 12 weeks. Under such circumstances, the question becomes whether the employee actually worked enough hours during the 12 or 13 weeks to meet the threshold requirement of working "substantially the whole" of 13 weeks prior to the accident. O.C.G.A. § 34-9-260. This question is usually a factual issue to be determined by the Administrative Law Judge.

The Court of Appeals has noted the word "substantially," like the word "reasonably," is one of those words that "deliberately leaves a wide area of discretion to commissioners and courts." This test is usually applied liberally to achieve the ultimate objective of reflecting fairly the employee's probable future earning loss. The following are examples where the courts have held that the employee had not worked "substantially the whole of thirteen weeks immediately preceding the injury" Kissiah at §13.06.

1. An employee worked a full 40-hour week during only 2 of the 13 weeks prior to the accident and did not work at all during 2 of the 13 weeks preceding the accident; Id.
2. The Employee had been hired to work a five-day, 40-hour week and during the 13 weeks preceding his injury and the employee had only worked 2 such weeks; Id.
3. The Employee had not worked 3 of the 13 weeks preceding the date of accident and had worked only one day another week and only two days in two other weeks. Under such circumstances, as stated above, the employee could not have been said to have worked "substantially the whole of the 13 weeks preceding the injury." Id.

11-3. Wages of Similarly Situated Employee

If an injured employee has not worked "substantially the whole of 13 weeks immediately preceding the injury," then one must next consider the second method of calculating average weekly wage. This method involves taking the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks, regardless of what the injured employee himself may have earned during those weeks. Specifically, the employer/insurer should not take the employee's earnings for the weeks that the employee

worked and then take the wages of a similar employee for the weeks the employee did not work. The only way to properly utilize this method is to use a similarly-situated employee's earnings for the entire 13 weeks preceding the employee's injury. Kissiah at §13.06.

For the purpose of this method, a similar employee in the same employment need not necessarily be the one who was in the very same job classification or even the exact same pay scale as the injured employee. Rather, it need only be one who at least performs a similar type of job for the same employer. Kissiah at §13.06[3].

11-4. Third Method: Full-Time Weekly Wage (Contract for Hire)

If one cannot utilize either the first or second method as outlined above, the following method should be used:

The third method of computing average weekly wage requires that "the full-time weekly wage of the injured employee be used." This involves taking the employee's hourly wage rate multiplied by the number of hours that constitute the "full time" work week for such an employee, pursuant to his contract of employment with the employer. Specifically, if the employee's contract of employment called for him to work 40 hours per week at five dollars per hour, then his average weekly wage, utilizing this third method, would be $200.00. Conversely, if the employee was hired to work just 20 hours per week at $5.00 per hour, then his average weekly wage would only be one hundred dollars per week. Kissiah at §13.06[4].

Calculating the average weekly wage is necessary in determining the employee's compensation rate for income benefits.

CHAPTER 12 - REPORTING AND FORMS

12-1. Time Deadlines

Once an employee suffers a work-related injury, he must give the employer (or employer's agent, representative, foreman, or employer's own supervisor) notice of the injury immediately upon the occurrence of an accident or as soon thereafter as practical, but it should be no later than thirty (30) days after the occurrence of the accident. The thirty (30) day requirement to provide notice of a work-related accident does not begin to run until the employee first realizes that he has sustained an injury. However, if the injury is gradual in nature the thirty (30) day notice period does not begin to run until the injury has become extensive enough to prevent the employee from working, or to constitute a disability under the Georgia's Workers' Compensation Act. The question of whether the employee gave the employer sufficient notice of an injury is a question of fact to be determined by the State Board of Workers' Compensation. The burden is not upon the employer to prove that they received notice of an injury, but rather the employee carries this burden from the outset.

The notice limitation in essence serves four primary purposes. First, it enables the employer to conduct an investigation concerning the employee's alleged work-related injury. Second, it allows the employer to subject the employee to medical examination and diagnosis of the injury. Third, it allows the employer to engage the employee with early medical treatment in an attempt to mitigate the damages and seriousness of the injury. Fourth, it serves to prevent the delayed report of an injury, which increases the likelihood of fraud or injustice upon the employer.

Once the employer has been provided notice of a work-related injury, the insurer or self-insurer has twenty-one (21) days in which to timely controvert the claim. O.C.G.A. § 34-9-

221(d) The twenty-one (21) day period of time runs not from the date of the accident itself, but from the date of the employer's notice or knowledge of disability. The controvert of a claim can be accomplished by completing the "C" Section of Board Form WC-1 First Report of Injury, filing the original with the State Board, and providing a copy of same to the employee. If a First Report of Injury has already been filed with the State Board, then a Board Form WC-3 should be filed to controvert the claim. In that regard, when controverting a claim, the insurer or self-insurer should state the grounds upon which the rights of compensation is being controverted. Once this has been done, the State Board can not only adjudicate the claim upon the basis of the controvert stated by the insurer, but may determine all issues.

Even where an insurer or self-insurer has voluntarily accepted liability on the claim through the payment of benefits, and when the 60 days from the due date of first payment of compensation statute of limitations has already run, the insurer may not thereafter controvert overall liability on the claim without the existence of newly discovered evidence. In that situation, the insurer/self-insurer should prepare a Form WC-2 Notice of Payment or Suspension of Benefits, and a Form WC-3 Notice to Controvert, and file both with the State Board. Furthermore, copies of both forms should be provided to the employee and any individual financially interested in the claim.

Once the employee has sustained a work-related injury, he then has one year from the date of accident to file a claim (with a WC-14) with the State Board of Workers' Compensation. The failure of an employee to file a claim within the claim limitations period is jurisdictional. Therefore, the failure to timely file a claim deprives the State Board of jurisdiction to hear the case. However, there are exceptions that apply to the one year statute of limitations concerning all issues cases.

If the employer has provided the employee with remedial treatment, the employee then has one year from the last date the employer provided treatment to file a claim. However, any remedial treatment furnished by the employer, must be on account of the injury of the employee. The running of the one year statute of limitations for all issues claims may also be tolled by an employer's payment of weekly benefits on account of the employee's injury. If the claimant is being paid weekly compensation benefits by the employer due to a reported work-related injury, and the employer later controverts this claim, the employee would then have two years from the date of the last payment of those benefits in which to timely file a claim.

In Tara Foods v. Johnson, 297 Ga. App. 16, 676 S.E.2d 418 (2009), the Court of Appeals recently ruled that where a claimant files a WC-14, "Notice of Claim," rather than WC-14, "Request for Hearing," the claimant's filing does not toll the running of the change in condition statute of limitations. The Court also held that, even if a request for hearing is filed with the Board within two years of the last payment of income benefits, it would not toll the running of the change in condition statute of limitations if the hearing request seeks only medical benefits, rather than income benefits.

12-2. Key Board Forms

Note that, according to Board Rule 60(c), a penalty may be incurred for not properly designating documents with the assigned claim number, date of injury, and claimant's name. Failing to include this information may result in the rejection of the filing of any document with the Board.

1. ICMS and Electronic Filing.

Electronic Data Interchange, or EDI, was implemented via ICMS during the fall of 2007. Board Rule 60(f) provides that pleadings, forms, documents, or other filings shall be filed with

the Board electronically through ICMS (now ICMS II), unless otherwise authorized. In the event of an outage preventing electronic submission, the document may be filed in paper or by facsimile with any Board office. Any filing by facsimile must be clearly labeled with the name of the Claimant, claim number, and Board division or employee to whom the facsimile transmission is directed. A certificate of service showing concurrent service upon the opposing party electronically or by facsimile transmission must be a part of any electronic or facsimile transmission, failure to include a certificate of service will invalidate the filing. Pursuant to Board Rule 60(g)(2), any party or attorney challenging the authenticity of an electronically filed document or electronic signature must file an objection to the document within 15 days of receiving notice of the electronic filing. The burden shall be on the party challenging the authenticity of the signature.

Board Rule 62(1)(a) provides that prior to filing in EDI, insurers, self-insurers, group self-insurers, and designated claims offices (TPAs) shall be certified to file via EDI by the Board. Board Rule 62(1)(b) states that insurers, self-insurers, group self-insurers, designated claims offices (TPAs) or their designated vendors shall file Forms WC-1, WC-2, WC-2a, WC-3, and WC-4 via EDI in form of FROIs (First Report of Injury) and SROIs (Subsequent Report of Injury). Insurers, self-insurers, group self-insurers, or designated claims offices (TPAs) shall not file any document or submit any transmission via EDI in any claim created prior to July 1, 2009. For any claim created prior to July 1, 2009, insurers, self-insurers, group self-insurers, or designated claims offices (TPAs) shall file in paper unless and until web filing is available.

The SBWC Electronic Filing Mandate in 2009 required that all new lost time claims with date of injury after June 30, 2009, or new lost time claim be submitted via EDI. The Board granted a final extension to organizations until September 1, 2010. As the extensions expired,

pursuant to Board Rule 62(1)(d), WC-1s, WC-2s, WC-2a, WC-3s, or WC-4s that are filed in paper by an insurer, self-insurer, group self-insurer, or designated claims office (TPA) concerning any claim created on or after July 1, 2009 may be rejected by the Board.

Board Rule 62(1)(e) mandates that when filing via EDI, and whenever an attachment to a filing or submission is required, the employer, insurer, self-insurer, group self-insurer, or designated claims office (TPA) shall simultaneously mail to, or electronically file with, the Board the filed Subsequent Report of Injury (SROI) or Form and a copy of such attachment. Pursuant to Board Rule 60(c), all attachments filed with the Board shall contain the employee's name, date of injury, and Board claim number, or will otherwise be rejected by the Board. Copies of all filings shall be served on the employee and the claimant's attorney, if represented.

Board Rule 62(3) states that if an insurer, self-insurer, group self-insurer, designated claims office (TPA), or their designated vendor files Form WC-1, WC-2, WC-2a, WC-3, or WC-4 via EDI, then all subsequent FROIs (First Report of Injury) and SROI (Subsequent Report of Injury) shall be filed via EDI. Failure to do so may subject the filing party to a penalty. The Board may also grant exceptions to Rule 62.

Georgia's requirements for EDI and a FAQ section are posted at http://sbwc.ga.gov. As indicated on the website, an organization is in violation of the SBWC Electronic Filing Mandate of 2009 if it continues to send paper forms to SBWC and it is registered as an EDI Trading Partner in Production. Paper forms will be returned to file via EDI. In order to create an ICMS file at the Board, a Form WC-1 or Form WC-14 shall be filed with the Board. Only originals may be filed. Service upon a party or attorney of any form, document, or other correspondence shall be by electronic mail, unless unavailable, and then by U.S. mail. An EDI First Report of Injury ("FROI") will have the same reporting requirements as the paper FROI in the jurisdiction.

The jurisdiction is only accepting new reports of injury via EDI.

Effective October 1, 2010, fines and/or penalties may be assessed for noncompliance against organizations which are not participating in EDI or for those who continue to file outside the EDI parameters as defined on the Board website. The initial fine for insurers, self-insured employers, and Group Funds for noncompliance will be $100/day and $25/form received at SBWC. Frivolous filing in EDI (i.e. SROI not received within 48 hours) may also result in a $50/transaction fine. Maintenance of claims with date of injury prior to July 1, 2009 may be continued in paper or by registered users of the Board's online claims filing system. Maintenance of existing claims will continue in paper or by registered users of the Board's web-based claims filing system.

If you have any questions about implementing EDI with Georgia, send your questions to the EDI email address at the Board (EDI@SBWC.GA.GOV). Include EDI Implementation in the subject line of your email.

As of February 16, 2016, the SBWC launched ICMS II, which updated and improved on the original ICMS. Any filing made on EDI will appear simultaneously on ICMS II. This allows ICMS users to accurately see what filings have been made on EDI and when those filings were made. Effective December 1, 2018 the SSN/BTN numbers have been removed from all Board forms, ICMS II. This means you no longer need to request a BTN to file a WC-1 or WC-14. You can now file them via ICMS II or EDI. The new revision of the Board forms reflecting the removal of the SSN/BTN and all other changes are available on the Board's website.

2. Form WC-1 **Employer's First Report of Injury**

Employers shall complete Section A immediately upon knowledge of an injury and submit this form to their insurer. Insurers who receive a Form WC-1 from an employer shall

clearly stamp the date of receipt on the form. Insurers and self-insured employers shall complete Section B or C and mail the original to the Board and a copy to the employee within 21 days of the employer's knowledge of disability. Cases with seven or less days of lost time should be reported on Form WC-26, which is the consolidated yearly report of medical only cases that is filed annually. For previously designated "MEDICAL ONLY" claims, check the appropriate box in Section B or C. In death cases with accident dates before July 1, 1995, a copy of Form WC-1 shall also be filed with the Administrator of the Subsequent Injury Trust Fund at the same time it is mailed to the Board. Further, Form WC-1 shall be filed within 48 hours of the employer's acceptance of a catastrophic injury as compensable. Effective January 1, 2019, the filing of a Form WC-1 will be required in all claims, including all assessed if parties fail to timely file a WC-1 after January 1, 2019, pursuant to the provisions of O.C.G.A. §§ 34-9-12(a), 34-9-18 and Board Rules.

Complete Section B on the form WC-1 when the employer/insurer commences payment of weekly benefits or when the Employer continued to pay salary, and when the employer/insurer suspends benefits for an actual return to work prior to the filing of the Form WC-1. Furnish a copy to the employee.

Complete Section C within 21 days in accordance with subsection (d) of O.C.G.A. §34-9-221 when the employer/insurer controvert payment of compensation. Furnish copies to the employee, and upon request, to any other person with a financial interest in the claim. In addition, complete and file a Case Progress Report Form WC-4, within 90 days of the date of claimed disability.

3. Form WC-2 **Notice of Payment or Suspension of Benefits**

File Form WC-2 to commence, suspend, amend the weekly benefit payment, or when a change in disability status occurs after Form WC-1 has been properly filed with the Board. File a Form WC-2 when suspending O.C.G.A §34-9-261 benefits and commencing O.C.G.A. §34-9-262 benefits pursuant to O.C.G.A. §34-9-104(a)(2). Mail a copy of the Form WC-2 and attachments, if any, to the employee and his attorney, if one has been retained. See Board Rule 221 for suspending with a full duty release from the doctor. If the last payment is intended to close the case, file a final Form WC-4 with the Board and mail a copy to the employee.

4. Form WC-2a **Notice of Payment or Suspension of Death Benefits**

Use in death case in lieu of Form WC-2. Use when change in dependency occurs. Use this form when making a payment to the State of Georgia for no dependents.

5. Form WC-3 **Notice to Controvert**

Complete Form WC-3 to controvert or deny a claim when a Form WC-1 has previously been filed. Furnish copies to employee and any other person with a financial interest in the claim including, but not limited to, the treating physician(s) and attorney(s) in the claim. See subsections (d), (h), and (i) of O.C.G.A. §34-9-221 and Rule 221. In addition, complete and file a final Form WC-4 within 180 days of the controvert.

6. Form WC-4 **Case Progress Report**

The filing requirements are as follows:

(A) In both controverted and accepted claims, within 1 year of the first date of disability;

(B) Within 30 days from last payment for closure;

(C) Upon request of the Board;

(D) Every 12 months from the date of the last filing of a Form WC-4 on all open cases;

(E) To reopen a case;

(F) Within 30 days of final payment made pursuant to an approved stipulated settlement;

(G) Within 90 days of receipt of an open case by the new third party administrator.

7. Form WC-6 **Wage Statement**

File this when the weekly benefit is less than the maximum under O.C.G.A. §34-9-261 or §34-9-262 and furnish a copy to the employee. If a party makes a written request to the employer/insurer, then the employer must send the requesting party a completed Form WC-6 within 30 days, but should not send a copy to the Board.

8. Form WC-7 **Application for Self-Insurance**

This Board form should be completed to obtain and maintain certification for self-insurance. A packet is available through the Licensure and Quality Assurance Division of the State Board of Workers' Compensation. They can be contacted at (404) 656-4893.

9. Form WC-10 **Notice to Elect or Reject Coverage**

A sole proprietor or partner must file this form to elect coverage under the provisions of O.C.G.A. §34-9-2.2.

A corporation must file this form in order for the corporate officer or limited liability company member to be exempt from coverage or to revoke their previously filed exemption.

Rejection becomes effective the date of filing with the insurer, if there is one, and, if none, with the Board.

The farm labor employer must file this form in order to request coverage for farm laborers or to revoke their previously filed request.

10. Form WC-11 **Standard Coverage Form**

This particular Board form should be completed to meet the requirements to establish a group self-insurance fund.

11. Form WC-12 **Request for Copy of Board Records**

Any person requesting a copy of Board records shall file his request on this form. Any person who receives a copy of Board records pursuant to a request shall pay the charges due within 30 days of receipt of an invoice from the Board.

12. Form WC-14 **Notice of Claim/Request for Hearing or Mediation**

File to open a claim, request a hearing, or request a mediation conference. Furnish a copy of Form WC-14 to all other parties. (A request for hearing by an employee will be considered only after the time required of the employer/insurer to make the first payment of income benefits has expired as provided in O.C.G.A.§34-9-221.) The filing of Form WC-14 constitutes an entry of appearance and/or a certification as to the existence of a valid fee contract or notice of representation.

13. Form WC-14a **Request to Change Information on a Previously Filed Form WC-14**

A party or attorney shall file this form with the Board when requesting correction of a mistake concerning the employee's name, social security number, date of injury, or county of injury on a previously filed Form WC-14. A Form WC-14A may also be used to add a hearing issue or dismiss an employer, insurer/self-insured employer, or claims office. A Form WC-14A

shall not be used to change an address of record, add additional parties, or additional date of injury.

14. Form WC-20(a) **Medical Report**

This report shall be completed and filed in the following situations:

(A) The attending physician or other practitioner makes the report and forwards it along with office notes and other narratives to the employer/insurer as follows:

(i) Within seven days of initial treatment;

(ii) Upon the employee's discharge by the attending physician;

(iii) At least every three months until the employee is discharged;

(iv) Upon the employee's release to return to work;

(v) When a permanent partial disability rating is determined; and

(vi) Pursuant to Board Rule 203(b).

(B) The employer/insurer shall file the report including office notes and narratives with the Board within 10 days after receipt in the following situations:

(i) When the report contains a permanent partial disability rating:

(ii) Upon request of the Board; and,

(iii) To comply with other rules and regulations of the Board.

(C) The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with this rule and Rule 200(c).

15. Form WC-24 **Enforcement Division Request for Hearing or Trial Division Intervention**

For use by Enforcement Division only. Board Rule 24 provides the Enforcement Division the authority to request a hearing before an ALJ to seek assessment of civil penalties for not complying with the Georgia Workers' Compensation Act. Form WC-24 is used only by the Enforcement Division to request a hearing.

16. Form WC-25 **Application for Lump Sum/Advance Payment** (See Board Rule 222).

The Board will consider an application for a lump sum payment of all remaining income benefits or of a lump sum advance of a portion of the remaining income benefits, but the Board will not consider any application unless benefits have been continued for at least 26 weeks. The employer/insurer may make a lump sum payment or lump sum advance without communication or interest without an award from the Board.

In lieu of a hearing, the Board will consider application for lump sum advances and lump payments in accordance with the following procedures:

(1) Request for a lump sum advance or a lump sum payment must be submitted on a Form WC-25, and a copy must be sent to the employer/insurer and any other interested parties. The request will not be granted unless the current Form WC-25 is completely filled out with appropriate supporting documents as directed on the form.

(2) The parties have fifteen (15) days from the date of the certificate of service to file objections to the application. Objections to an application must be accompanied by documents in support of the objections, may be accompanied by counter-affidavits, and must be served upon the party or the attorney making the application. A certificate of service must accompany the objections attached.

(3) If any party elects to cross-examine an adverse party, it must notify the Board

within fifteen (15) days of the certificate of service of the Form WC-25 of its intention to submit a deposition. The deposition must be filed with the State Board no later than thirty (30) days from the certificate of service on the Form WC-25 unless an extension is granted by the Board upon a showing of just cause.

(4) If, in the judgment of the Board, there are material and bona fide disputes of fact, the Board may schedule a hearing or assign a case to the Administrative Law Judge for the purposes of receiving evidence or schedule a mediation conference on the issues.

(5) The maximum attorney's fees which will be granted in conjunction with an advance shall be 25 percent of the amount of the advance or $500.00 whichever is less, unless specifically authorized by the Board.

17. Form WC-26 **Yearly Report of Medical Only Cases**

File on or before March 1st following each calendar year in respect to payments for injuries not reported on Form WC-1. File annually even if no reportable injuries or payment occurred during the reporting year.

18. Form WC-100 **Request for Settlement Mediation**

To be used when a party is requesting a settlement mediation at the State Board.

19. Form WC-R1 **Request for Rehabilitation**

The employer/insurer shall file a Form WC-R1:

(A) Within 48 hours of the employer's acceptance of a catastrophic injury as compensable, simultaneously with the Form WC-1, naming a catastrophic supplier;

(B) Within 15 days of notification that rehabilitation is required to request a rehabilitation supplier;

(C) When the employer/insurer requests a supplier for cases with dates of injury prior to July 1, 1992;

(D) When the employer/insurer requests a change of supplier;

(E) To request reopening of rehabilitation; or

(F) Upon request of the Board.

The employee or claimant's attorney shall file a Form WC-R1 to request appointment of a supplier for cases with dates of injury prior to July 1, 1992, for change of supplier, reopening of rehabilitation, or when requesting a catastrophic supplier to be appointed to a claim.

A case party shall file a form WC-R1 when a stipulated settlement provides for rehabilitation and rehabilitation is not already on the case. A case party may file a Form WC-R1 to request an extension of vocational rehabilitation services for cases with dates of injury prior to July 1, 1992.

All required information shall be supplied and shall be legible. The certificate of service must be completed and the date mailed must be indicated.

20. Form WC-R2 **Rehabilitation Transmittal Report**

The principal rehabilitation supplier shall file this form;

(A) To accompany updated narrative progress reports on catastrophic cases every 90 days;

(B) To request a rehabilitation conference or prepare for a rehabilitation conference;

(C) With all progress reports as required by the Board not submitted with a Form WC-R2A and when a stipulation request has been submitted;

(D) Upon request of the Board;

(E) To report medical care coordination services for non-catastrophic cases with dates of injury prior to July 1, 1992.

21. Form WC-R2a **Individualized Rehabilitation Plan**

The principal rehabilitation supplier shall file this form within 60 calendar days from the date of appointment; not later than 30 calendar days prior to the end of the current rehabilitation period to request extension of services; or to amend an approved plan 30 calendar days prior to the date of plan expiration.

22. Form WC-R3 **Request for Rehabilitation Closure**

The principal rehabilitation supplier shall file this form, accompanied by a closure report and any necessary documentation:

(A) Following 60 days of return to work status;

(B) When further services are not needed or feasible;

(C) When a stipulated settlement has been approved by the Board that does not include further rehabilitation services; or

(D) When the Board has closed the case.

23. Form WC-P1 **Panel of Physicians**

24. Form WC-P2 **Conformed Panel of Physicians**

25. Form WC-P3 **WC/MCO Panel**

This Panel is used by employers/insurers contracted with a Board Certified Managed Care Organization. (See Board Rule 201).

26. From WC-102 **Request for Documents from Parties**

Prior to or subsequent to a hearing being requested in a claim, the parties shall be entitled to request copies of documents listed on this form from the opposing parties, and the named documents shall be provided to the requesting party within 30 days of the date of certificate of service, subject to penalties for failure to comply.

27. Form WC-102c **Attorney Leave of Absence**

An attorney who is counsel of record, and wishes to obtain a leave of absence, must file this form with the Atlanta office of the Board. If granted, the leave will cover all cases for which the attorney is counsel of record which are not calendared on the date of approval.

28. Form WC-102d **Motion/Objection to Motion**

A party who files a motion or objects to a motion shall use this form, if no other specific Board form exists for the motion or request, and shall serve a copy on all counsel and unrepresented parties. The filing of Form WC-102d constitutes an entry of appearance or a certification as to the existence of a valid fee contract or notice of representation.

29. Form WC-104 **Notice of Employee of Medical Release to Return to Work with Restrictions of Limitations**

For non-catastrophic accidents occurring on or after July 1, 1992, the employer/insurer must send this form to the employee no later than 60 days from the date the employee was released to work with restrictions with a medical report demonstrating the employee is capable of performing work with restrictions. If the employee is not working but has been capable of working with restrictions for 52 consecutive weeks or 78 aggregate weeks, then the employer shall file a form WC-2 converting the benefits from TTD to TPD. The WC-104 and medical report releasing the Claimant to return to work with restrictions should be attached to the WC-2.

Effective January 1, 2014, Rule 104 was amended to require simultaneous filing of Form 104 with the Board at the time it is served on the employee and the claimant's attorney.

30. Form WC-108a **Attorney Fee Approval**

An attorney shall file this form in order to request approval of a fee contract, an assessed fee by consent, and for resolution of a fee lien dispute by consent, when there is no pending litigation, and shall serve a copy on all counsel and unrepresented parties.

31. Form WC-108b **Withdrawal/Attorney Fee Lien**

An attorney who wishes to withdraw must file this form and follow the procedure set out in Rule 108(b). An attorney of record who chooses to file a lien for services and/or request for reimbursement of expenses after withdrawal from representation or after services are terminated, in writing, by a client, shall file this form with supporting documentation, and serve a copy on all counsel and unrepresented parties.

32. Form WC-121 **Notice of Use of Servicing Agent**

An insurer, self-insurer, or self-insurance fund shall file this form to give notice of the employment of a servicing agent or the termination of services of a servicing agent.

33. Form WC-200a **Change of Physician/Additional Treatment by Consent**

Parties who agree on a change of physician/additional treatment shall file a properly executed Form WC-200a with the Board, with copies provided to the named medical provider(s) and parties to the claim, which form shall be deemed to be approved and made the order of the Board pursuant to O.C.G.A.§34-9-200(b) unless otherwise ordered by the Board.

34. Form WC-200b **Request/Objection for Change of Physician/Additional Treatment**

A party who requests a change of physician or additional treatment without consent, or who objects to a request which has been made, shall file this form with the Board, and serve a

copy on all counsel and unrepresented parties. Objections must be filed within 15 days of the date on the certificate of service on the request. The filing of Form WC-200b constitutes an entry of appearance or a certification as to the existence of a valid fee contract or notice of representation. Additionally, a separate certificate of service identifying the names and addresses of the parties served with the request must be attached to the supporting documentation filed with the Form WC-200b.

35. Form WC-205 **Request for Authorization of Treatment or Testing by Authorized Medical Provider**

This form announces on its face that "advance authorization for the medical treatment or testing of an injured employee is not required by the Georgia Workers' Compensation Act." Furthermore, the treatment or testing will be deemed pre-approved (and the Employer is responsible for payment and the treatment/test requested) if there is a failure to respond to this form within five business days. If the employer or its insurer complies and furnishes a written refusal to authorize within five days, the employer or its insurer still must authorize or controvert the medical care within twenty-one days of the initial request.

36. Form WC-206 **Reimbursement Request of Group Health Insurance Carrier/Healthcare Provider**

A group health insurance carrier or health care provider which requests reimbursement of medical expenses shall file this form during the pendency of a claim, and serve a copy on all counsel and unrepresented parties.

37. Form WC-207 **Authorization and Consent to Release Information**

Employer/Insurers seeking the release of medical information pursuant to O.C.G.A. §34-9-207 may utilize this form to receive consent from the employee. There is disagreement over

whether the WC-207 authorizes procurement of all medical records or only those related to the injury or condition which is the subject matter of the workers' compensation claim. Accordingly, we encourage Employer/Insurers to utilize broad form medical authorizations when possible which can be utilized to obtain all medical records.

38. Form WC-208a **Application for Certification of WC/MCO**

This Board form should be completed to obtain certification as a WC-MCO under the Georgia Workers' Compensation Act. To obtain certification of a plan, the application should be submitted on a Form WC-208(a) accompanied by a non-refundable fee of $1,000.00. Furthermore, all requirements of Board Rule 208 must be complied with.

39. Form WC-240 **Notice to Employee of Offer of Suitable Employment**

The employer/insurer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition as required by O.C.G.A. § 34-9-240, and shall provide it to the employee and his/her attorney at least 10 days prior to the date the employee is scheduled to return to work with a copy of the written approval of the authorized treating physician of the essential job duties to be performed.

Please note the Employer/Insurer must provide claimant and claimant's counsel with a copy of any job description/analysis at the time it is sent to the authorized treating physician.

40. Form WC-240a **Job Analysis**

Employer/Insurer may use this with Form WC-240 to provide a detailed job description with the offer of employment.

41. Form WC-243 **Credit**

An employer/insurer seeking a credit pursuant to O.C.G.A. § 35-9-243 shall file this form with the Board and send a copy to all counsel and unrepresented parties. The employer/insurer

must specify the amount of unemployment compensation and/or income payments made to the employee pursuant to a disability plan, a wage continuation plan, or a disability insurance policy, and shall specify the ratio of the employer's contribution to the total contribution of such plan or policy.

42. Form WC-244 **Reimbursement Request of Group Insurance Carrier/Disability Benefits Provider**

A group insurance carrier or disability benefits provider which requests reimbursement of disability benefits shall file this form during the pendency of a claim, and serve a copy on all counsel and unrepresented parties.

43. Form WC-262 **Wage Documentation of Temporary Partial Disability Payments**

Complete this form if the maximum TPD benefits are not being paid. When paying weekly TPD income benefits, file a form WC-262 with the Board at 13 week intervals or when such benefits are suspended, whichever comes first. When filing a WC-262 with the Board, send a copy to the employee and the employee's counsel, if represented. The maximum weekly amount of TPD benefits allowed by law is $383.00 per week after July 1, 2016.

44. Form WC-Change of Address **Change of Address**

This form is to be used to change an employee's address. This form is also to be used to change an employer's address or an attorney's address.

45. Form WC-PMT **Petition for Medical Treatment**

NEW FORM: This form was created to use when an Employer/Insurer have failed to respond to a request for authorization of treatment/testing by an authorized medical provider within five (5) business days of the request. The Employee and/or the Claimant's attorney may file a WC-PMT to show cause why the recommended treatment/testing has not been authorized.

In lieu of participation in the telephonic conference, the Employer/Insurer and/or the Employer/Insurer's attorney may use this form to authorize or controvert the recommended treatment/testing.

CHAPTER 13 - MODIFICATION OF BENEFITS OR A "CHANGE IN CONDITION"

13-1. Change in Condition - Generally

A change in condition, governed by O.C.G.A. § 34-9-104, is defined as "a change in the wage-earning capacity, physical condition, or status of an employee or other beneficiary covered by this chapter, which change must have occurred after the date on which the wage-earning capacity, physical condition or status of the employee or other beneficiary was last established by award or otherwise." Specifically, the courts in Georgia have defined a change in condition as primarily economic in nature. Additionally, in order for there to be a change in condition, indemnity benefits must have been paid to the employee by order of the board or by agreement.

13-2. Limitations on Change in Condition Claims

While there are no limits to the number of change in condition claims which may be filed by an employee or employer, there is a time limit. For accidents which occurred on or after July 1, 1990, the employee must file a claim for a change in condition within two years of the date of the last payment of income benefits pursuant to O.C.G.A. § 34-9-261 (TTD) or § 34-9-262 (TPD), or within four years of the last payment if the benefits sought are solely PPD benefits. O.C.G.A. § 34-9-104. Payment for remedial medical treatment has no bearing on a change of condition claim.

It should be noted that this statute of limitations only affects the employer/insurer's obligation to pay indemnity benefits, and not medical benefits. In other words, if the change in

condition statute of limitations has run, the employer/insurer still has exposure for medical benefits until the 400 week cap or for the employee's lifetime if the claim has been designated catastrophic.

13-3. Change in Condition for the Better

In situations where the employee has not returned to work, the employer will bear the burden of proving that the employee has undergone a change in condition for the better; thus, allowing the employer to suspend income benefits. Generally, an employer can meet this burden by showing that the employee has actually returned to work, the employee has the ability to return to work, or the disability is not related to the on-the-job injury. The employer can also meet this burden using the incarceration or illegal alien defense.

There is one exception to the employer bearing the burden of proof. When the authorized treating physician has released the employee to return to work with restrictions and the employer offers suitable employment within the restrictions and the employee refuses to attempt the job, then the employer is allowed to suspend benefits unilaterally, and the burden shifts to the employee to prove that he is entitled to recommencement of benefits. O.C.G.A § 34-9-240.

An employer may carry its burden of proving a change in condition for the better if the employer proves:

1. The employee has actually returned to gainful employment;

2. The employee has the ability to return to work and suitable employment is available; or

3. The employee's disability is not causally connected with the on-the-job injury.

Kissiah at §21.04.

When an employee who has received TTD benefits returns to employment, the employee is usually considered to have undergone a change in condition for the better.

Even if an employee does not actually return to work, the employer may be able to show a change in condition for the better.

The employer must have evidence of:

1. A physical change for the better;
2. An ability to return to work as a result of the physical change; and
3. The availability of work to terminate or reduce the loss of income resulting from the disability. Kissiah at §21.04[2].

If the employer can show that the employee is capable of performing normal duty unrestricted work, the employer does not have to show the specific availability of suitable employment in order to carry its burden in proving a change of condition for the better. On the other hand, when the employee has restrictions on his capacity to work, the employer must show the availability of suitable work to carry its burden.

While the Court of Appeals has held that the employer need not show an actual offer of employment, the courts have not provided any guidance of what evidence (short of an actual offer) would be sufficient to meet the employer's burden. However, it is clear that the employee must be made aware of the suitable employment opportunities. The use of vocational experts to conduct labor market surveys within the employee's restrictions, qualifications, and geographic region can be helpful in identifying suitable employment.

13-4. Offers of Suitable Employment

If the employee refuses suitable employment offered to him, then income benefits may be suspended pursuant to O.C.G.A. § 34-9-240. The Supreme Court of Georgia has created a two-prong test to determine whether the employee's income benefits should be suspended:

1. Whether the position made available to the employee was suitable to his capacity; and
2. Whether the employee's refusal of the job was justified.

City of Adel v. Wise, 261 Ga. 53 (1991).

The job is suitable if it is within the employee's physical limitations. The State Board has wide discretion in determining whether the employee's refusal was justified. The Georgia Supreme Court has stated that the refusal must relate to the physical capacity or employee's ability to perform the job for the reason to be considered justified.

If a light-duty job is offered to a claimant via O.C.G.A. § 34-9-240, the claimant is required to attempt the light-duty job for eight (8) cumulative hours or one full workday, whichever is greater. Failure to attempt the job for the required time allows the Employee/Insurer to unilaterally suspend the Claimant's benefits. If the claimant does attempt the light-duty job for eight (8) cumulative hours or one full workday, but refuses the job before fifteen (15) work days, the claimant will be entitled to re-commencement of income benefits. The Employer/Insurer, however, can file a hearing request seeking to suspend the claimant's benefits based on an unjustified refusal of a suitable light-duty job.

13-5. Disability Unrelated to Injury

If an employer can show that the employee's current disability is related to a subsequent non-work related accident or pre-existing condition, a suspension of benefits is possible. Additionally, the employer may be able to show that employee's disability is the result of a

subsequent intervening accident such as a new accident with a different employer or a new accident during employee's personal activities.

Additionally, an aggravation of a pre-existing condition is compensable "but only for so long as the aggravation of the pre-existing condition continues to be the cause of the disability." O.C.G.A. § 34-9-1 (4)

13-6. Incarceration Defense

In cases where the employee is capable of performing light duty work but subsequently becomes incarcerated for a crime for which he is convicted or pleads guilty, the employer may suspend the employee's benefits during the employee's period of post-conviction incarceration, as his incarceration is the cause of his inability to secure employment not his injury. Furthermore, the employer/insurer has no obligation to pay PPD benefits after an employee has been convicted of or pleads guilty to a crime after TTD or TPD benefits have been suspended.

13-7. Change in Condition for the Worse

In situations where the employee has returned to work (except in the WC-240 situation with the employee working less than 8 cumulative hours or one scheduled workday) or where the authorized treating physician has released the employee to work without restrictions, it is the employee who then bears the burden of proof to show that he is entitled to a recommencement of income benefits.

The employee can meet this burden by showing total physical disability or partial physical disability coupled with economic disability. To show that there has been an economic change in condition for the worse, the employee must show that his inability to secure suitable employment was proximately caused by his prior work-related injury. An employee may obtain recommencement of disability benefits even if he has quit, been laid-off for reasons unrelated to

the accident, been terminated for just cause unrelated to the accident, or been terminated due to his own misconduct.

Where an employee seeks to prove an economic change in his condition for the worse as of the date that he stopped working, he must prove the following:

1. That he has a loss of earning power;
2. That he continues to have physical limitations due to the work-related injury;
3. That he diligently, but unsuccessfully, sought employment; and
4. His inability to secure suitable employment elsewhere was proximately caused by his work-related injury. Kissiah at §21.05.

If the employee is capable of normal duty unrestricted work, then lack of suitable employment is irrelevant. The employee would not be allowed to recover additional income benefits.

To carry his burden in proving a change in condition for the worse, the employee must show that he unsuccessfully, but diligently, sought suitable employment. The courts have not clearly defined what actually constitutes a diligent job search. In Maloney v. Gordon County Farms, 265 Ga. 825 (1995), the employee made six attempts to secure employment, and this was deemed a diligent job search.

In situations where the employee: (a) is injured on the job, (b) loses time from work, (c) returns to work, and (d) subsequently is separated from employment for reasons unrelated to his/her injury, the employee will generally be under an obligation to carry the burden of proving that a diligent job search was conducted in an effort to establish a causal link between the work related injury and the employee's worsened economic condition in order to receive disability benefits.

13-8. Change in Condition Versus New Injury

When an employee sustains an initial on-the-job injury and returns to work until his condition diminishes to the point of disability, a question arises as to whether liability should be imposed for the initial injury or for the date of disability. If liability is imposed for the initial injury, it will be imposed based upon a change in condition. If liability is imposed for the date of the disability, then the liability will be imposed based on a new accident (sometimes also referred to as "fictional new injury.").

The above-mentioned distinction is important because if the employee is injured, returns to work, and continues working, then his claim may be barred by the change in condition statute of limitations. The courts have attempted to avoid this by deciding that when an employee is injured, returns to work, and ultimately ceases working because of the aggravation of his preexisting condition through the performance of his post-injury work, then he may be deemed to have suffered from a "new accident" as of the date that he ceased working. The courts have developed this fictional new accident theory to avoid penalizing employees for continuing to work after an injury.

Where an employee sustains a work-related injury, returns to work, and then his or her condition deteriorates to the point of disability, there are three possible results:

1. If the gradual worsening of his condition was at least partially attributable to his physical activity in continuing to work after his injury, then the one year statute of limitations begins to run from the date the employee was forced to stop working. The date of the "new accident" is the date the disability manifests itself.

2. If the employee sustains a second accident as the result of a specific job-related incident which aggravates a pre-existing condition which resulted from a prior accident, then the second accident which aggravated the pre-existing condition is a new injury.

3. If following a compensable injury the employee returns to work performing his normal duties, then as a result of the wear and tear of ordinary life and the activity connected with performing his normal duties, his condition worsens to the point where he can no longer perform his normal work, this scenario is often deemed a change in condition.

There are also situations where an employee with light duty restrictions leaves his employment to secure new employment. Oftentimes the employee becomes disabled sometime after starting his new employment. In these scenarios, both employers are usually named as parties to the case, and they are left to fight whether or not the employee has suffered a new injury or a change in condition. Normally, absent a specific new accident with the new employer, the determination of this issue will rest on which job had more strenuous activities. If the new job has more strenuous activities, the employee will usually be deemed to have suffered from a new accident. These issues typically arise when the insurance companies for the employer change between the date of the initial injury and the date of disability.

13-9. Conversion from TTD to TPD Benefits

Once a claimant has been released to light-duty work, the Employer/Insurer can file a WC-104 that will permit the claimant's benefits to be converted from TTD benefits to TPD benefits after 52 consecutive weeks or 78 aggregate weeks. The WC-104 is intended to encourage claimants to return to work if the Authorized Treating Physician has found he or she is capable of doing so. The WC-104 must be completed within 60 days of the claimant's release to light-duty work, filed with the Board, and served on the claimant and/or his attorney. The WC-

104 must include the doctor's release to light duty. After the 52 consecutive weeks or 78 aggregate weeks, the Employer/Insurer can file a WC-2, along with the previously filed WC-104, to convert the claimant's benefits. Dates that the claimant actually works cannot be counted towards the 52 consecutive or 78 aggregate days. MARTA v. Thompson, 326 Ga.App. 631 (2014).

CHAPTER 14 - EX PARTE COMMUNICATIONS WITH TREATING PHYSICIANS ALLOWED IN GEORGIA

14-1. What are Ex Parte Communications?

Ex parte communications are communications by one side in an adversarial proceeding with a decision maker. Ex parte communications with a judge are prohibited by the Code of Judicial Conduct. This means if the attorney for one side or the other is going to have a conversation with the judge about a pending case, it can only occur in the presence of the attorney for the opposing party. Limitations on communications with treating physicians had been imposed by some states but up until recently, plaintiff's and defense lawyers in Georgia had communicated with a personal injury or workers' comp claimant's treating physicians both formally and informally for decades. That changed with the Moreland v. Austin Supreme Court decision in 2008, where the Court determined that HIPAA precluded defense counsel from informally interviewing treating physicians without first complying with HIPAA procedural safeguards.

Following this ruling, employers, insurers and their representatives were rightfully concerned about the scope of the Court of Appeals' decision, which contained language suggesting that the right to privacy trumped the goals of the workers' compensation system, including the need for the expedient exchange of medical information. In the Arby's V. Mcrae decision in 2012, the Supreme Court found that a workers' compensation claimant waives this right under O.C.G.A. § 34-9-207 once a claim has been filed, or once medical or indemnity benefits have been paid. While the Court recognized HIPAA's privacy provisions, the Court also noted that HIPAA specifically exempts disclosures made in accordance with state workers' compensation laws. Because O.C.G.A. § 34-9-207 allows ex parte communications between the

employer and the claimant's treating physicians, HIPAA does not apply.

With this ruling, the Supreme Court has eliminated any lingering concerns regarding an employer's ability to communicate with a claimant's treating physicians. Perhaps more importantly, the Supreme Court reaffirmed the role and authority of the State Board of Workers' Compensation as gatekeeper and arbiter of issues such as this.

14-2. Governing Authority: Georgia Workers' Compensation Law

Georgia law provides: "When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records **and information related to the claim or history or treatment of the injury arising from the incident**." O.C.G.A. §34-9-207 (Emphasis added). A signed WC-207 is required of all persons asserting a worker's compensation claim or receiving workers' compensation benefits.

HIPAA privacy rule "expressly permits the disclosure of information as authorized by and to the extent necessary to comply with the requirements of workers' compensation laws." *See* 45 C.F.R. § 164.12(1). In other words, HIPAA indicated its procedural safeguards pre-empted State laws with the exception of workers' compensation laws and instead stated HIPAA would yield to State workers' compensation laws which expressly permitted disclosure of information.

14-3. Georgia Policy

The goal of all parties in workers' compensation cases dealing with injured workers should be to: "effect a cure, give relief, or restore the employee to suitable employment." *See*, O.C.G.A § 34-9-200(a) providing accurate information to treating physicians facilitates these

goals. The intent behind the Workers' Compensation act is to promote communication by the parties with treating physicians. Therefore, allowing one side the ability to engage in formal discovery while depriving it to another party is unfair.

Fortunately, in the fall of 2012 the Georgia Supreme Court reversed the Court of Appeal's decision in the McRae v. Arby's Restaurant Group claim and confirmed that the unambiguous language of §34-9-207 does not prevent an employer or its insurance company from conducting ex parte communications with the Claimant's treating physician. According to the Court, once an employee submits a claim for workers' compensation benefits where it's receiving weekly income benefits or in a situation where the employers pay medical expenses, the employee is deemed to have waived any privilege they may have regarding protected medical records and information related to their workers' compensation claim. The Supreme Court disagreed with the Court of Appeals that the phrase "all information and records" in §34-9-207 limited an employer or insurer to obtaining information through anything other than tangible documentation. Instead, the Supreme Court agreed with the dissenting opinion that the word "information" is properly interpreted to include "knowledge or data that is communicated to another regardless of whether the knowledge or data has been memorialized in any tangible medium or exists only in the memory and voice of the person communicating it." Accordingly, the Supreme Court confirmed that the word "information" as used in §34-9-207(a) includes oral communications and the Court indicated that the Court of Appeals erred by interpreting that this code section prohibited oral communications between a treating physician and employer.

The Supreme Court also addressed several policy arguments set forth by the claimant but confirmed that there were no legal grounds for prohibiting ex-parte oral communications between a treating physician and an employer to the extent that confidentiality is waived by an

employee in a workers' compensation claim. The Supreme Court actually indicated that the complete prohibition of all ex-parte communication will be inconsistent with the policy favoring full disclosure in workers' compensation cases as well as the goal of Georgia's workers' compensation statute of providing equal access to relevant information within an efficient and streamlined proceeding as to not delay the payment of benefits to an injured employee.

The Court did note that while an employer or insurer is legally able to have ex parte communications with an injured employee's treating physician, the treating physician does not have to agree to be interviewed ex parte. Instead, the physician may agree to be interviewed only on the condition that their own counsel, or the employee, or her counsel is present, and may also request the interview be audio or video recorded and they share the substance of the interview with the employee and her counsel.

CHAPTER 15 - HANDLING THE UNDOCUMENTED ALIEN'S CLAIM

15-1. Introduction

As practitioners in the field of workers' compensation, we are all aware of the increasing number of claims being filed by undocumented aliens. Estimates place the number of undocumented workers in the Metro Atlanta area at over 100,000, and well over 393,000 state-wide. As explained below, these claims are, for the most part, like any other claim. However, claims by undocumented workers do have some peculiarities of which the claims adjuster and attorney must be aware.

15-2. The Employer's Obligations: I-9 Form and E-Verify

Under the Immigration Reform and Control Act of 1986 (IRCA), it is unlawful for an employer to *knowingly* hire an unauthorized alien or to continue to employ an individual after learning that he or she is not authorized to work in the U.S. The employer's knowledge that the employee is unauthorized will be inferred if he or she reasonably should have known that the person was unauthorized.

The IRCA also requires that the following steps be followed upon hiring any individual:

(1) The employer must attest, under penalty of perjury on an I-9 Form, that he/she has verified that the individual in not an unauthorized alien by examining documents establishing the individual's identity and employment authorization. For instance, the employer can examine a U.S. passport or a resident alien card, either of which establishes identity and employment authorization (List A documents). As an alternative, the employer can examine one document which establishes identity (List B documents*, *i.e.*, a driver's license, a draft card, a military card, voter's registration card) and a second document which establishes work authorization (List C documents, *i.e.*, a social security card or an original or certified birth certificate). The employer must generally examine the documents within 3 days of hiring the individual.

*An employer participating in E-Verify may only accept List B documents that bear a photograph.

(2) The employee must attest, under penalty of perjury on the I-9 Form, that he or she is a citizen or a national of the U.S. or is otherwise authorized to work in the U.S.

(3) The employer must retain the I-9 Form, generally, for 3 years from the date of hire or one year after the individual is terminated whichever occurs later.

Providing a Social Security number on Form I-9 is voluntary for all employees unless the employer with whom they are applying participates in the E-Verify program which requires an employee's Social Security number for employment eligibility verification.

Once the I-9 Form is completed, employers must also ensure that they meet the requirements of the Georgia Illegal Immigration Reform and Enforcement Act of 2011 (IIREA), which imposes requirements on employers to check the immigration status of new hires. The IIREA requires private employers with more than 10 employees to use the U.S. Department of Homeland Security's E-Verify system to verify the employment eligibility of all newly-hired employees.

Additionally, all Georgia public employers, as well as contractors and subcontractors performing services in the state for a public employer, are required to use E-Verify for all new employees. There are certain procedures that employers must follow when using E-Verify that were designed to protect employees from unfair employment practices. E-Verify must be used for all new hires, both U.S. citizens and noncitizens. It cannot be used selectively to prescreen applicants for employment, check employees hired before the company became a participant in E-Verify (except contractors with a federal contract that requires use of E-Verify), or re-verify employees who have temporary employment authorization.

The E-Verify process strengthens the I-9 Form employment eligibility verification process that all employers, by law, must follow. As more and more employers implement the E-Verify process, the "clean hands" defense will become a stronger defensive tool should the employer later be charged with hiring an unauthorized alien. The employer need not, and should

not, inquire further into an individual's work or immigration status as long as the above steps are followed and the employer has no reason to doubt the authenticity of the documents presented or the truthfulness of the employee's statement that he or she is authorized to work in the United States. Demanding further documentation or interrogating the employee without just cause (*i.e.* simply because the employee has an Hispanic name) could subject the employer to a discrimination claim. However, should the employer have reasonable grounds for suspecting that the individual is not authorized to work in the U.S. and there is no intent to discriminate, then further inquiry could be appropriate.

15-3. Claims By Unauthorized Aliens Generally

The Board has taken the position that any injured employee who meets the requirements for establishing a valid claim under the Workers' Compensation Act is entitled to benefits, regardless of whether the employee is authorized to work in the U.S. After all, the Board knowingly awards benefits to unauthorized employees almost on a daily basis. Though the Workers' Compensation Act is silent on this issue, Georgia courts have held that unauthorized workers can receive workers' compensation benefits. See Wet Walls, Inc. v. Ledezma, 266 Ga. App. 685 (2004); Continental PET Technologies,Inc. v. Palacias, 269 Ga. App. 561 (2004). However, while an unauthorized worker may be entitled to workers' compensation benefits, the right to receive ongoing income benefits is not unlimited. (See the "What Does Work" Section below).

15-4. The Adjuster's Obligations

For the most part, a claim in which the employee is suspected to be an unauthorized worker should be handled just like any other claim; the same rules and defenses apply. However, as shown below, there are some situations in which it is important to know whether the claimant is an unauthorized worker. Accordingly, the adjuster should take steps to verify the claimant's work authorization *if appropriate*.

Be forewarned, there are claimant's attorneys lying in wait for the opportunity to file a discrimination suit on behalf of an undocumented worker against an employer or insurer. With this in mind, follow a very simple rule: **do not discriminate. Treat all claimants alike**. For example, all claimants should be asked where they were born. If they answer that they are not from the U.S., then they should be asked whether they are citizens of the U.S. If they are not, then they should be asked whether they are authorized to work in the U.S. Likewise, the adjuster should ask every employer whether they verified the employee's work authorization when they hired the Claimant, and whether the employer has reason to believe the claimant is unauthorized to work in the U.S. Again, this is not discrimination. This is merely part of the standard investigation of every claim.

Although not every situation can be anticipated here, a good rule of thumb is to try to ask the same questions of every employer and claimant in every claim. Where the answers indicate that the claimant may not be authorized, then reasonable follow up questions are appropriate. The adjuster should avoid requesting proof that the employee is an authorized worker where the employer has already done so in the hiring process.

15-5. Successful and Unsuccessful Defense Strategies

As more and more claims are filed by undocumented workers, defense attorneys have become innovative in their attempts to successfully defend these claims. The claimant's Bar seems to suggest that claims by unauthorized workers should be treated exactly like any other claim and that to try to develop unique defenses based on immigration status is discriminatory and/or unethical. However, the defense Bar argues that it has a duty to zealously represent the interests of clients and that fulfilling this duty within the bounds of legal ethics is not only appropriate, but mandatory. The good news is that as the defense and the claimant's Bars continue to lock horns on these issues, decisions by the Board, as well as some state court decisions, are beginning to firm up the law governing these claims. Below you will find some examples of what has worked and what has not worked.

WHAT DOES NOT WORK

First, it is apparent that the State Board of Workers' Compensation will flatly reject the denial of a claim simply on the grounds that the Employee is not legally able to work in the U.S. Such defenses are also likely to result in an assessment of attorney's fees.

Other approaches seem reasonable but have been unsuccessful. For instance, the Board has refused to rule that an unauthorized worker, who has been terminated for reasons unrelated to his work injury, cannot prove that he has performed a diligent yet unsuccessful job search. The following hypothetical illustrates this point:

> An employer unknowingly hires an undocumented worker who presents false identification and employment verification. The employee sustains a compensable accident which is accepted by the insurer. After receiving income benefits for two months, the claimant returns to full-duty work at which point the employer fires the claimant due to its discovery that he is undocumented. The claimant subsequently files a claim seeking a change in condition and alleges that he has not been able to find work due to his work injury. (The legal standard governing whether the employee is entitled to

> a resumption of benefits after being terminated for a reason unrelated to the work injury is known as "the Maloney Burden" and requires that the employee perform a diligent yet unsuccessful job search .) The employer argues that as a matter of law, the Claimant is unable to meet the Maloney Burden because the reason he cannot get a job is that he is undocumented which has nothing to do with his work injury.

The State Board's Appellate Division has rejected the employer's reasoning in the above matter and cited to a Colorado State Court's decision which held that an employee's undocumented status does not create a "legal disability" which prevented the claimant from seeking and finding work. Of course, it still prevents your employer from offering work once they are aware that the claimant is unauthorized.

WHAT DOES WORK

Defense attorneys have been successful in suspending an undocumented claimant's benefits where the claimant has been released to light duty work, <u>but only where certain specific conditions exist</u>. The hypotheticals below will serve to illustrate this situation.

<u>Hypothetical #1</u>:

> Bob's Roofing hires Juan Valdez who immigrates to Georgia after a terrible coffee crop bankrupts his family in Colombia. Juan verifies that he is a documented worker by producing a Green Card. The employer and employee complete the I-9 form, and the employer has no reason to suspect that Juan is illegal. Three months later Juan falls from a roof and breaks his leg. The adjuster receives the first report of injury and investigates the claim. She learns that Mr. Valdez is undocumented and that his "Green Card" was purchased on Buford Highway for $10.00. Nonetheless, she accepts the claim as compensable, and TTD benefits are paid for five months. At that point, Mr. Valdez is released to light-duty work, and Bob has suitable light duty work available. Now what? If Bob puts Juan back to work now that he knows he is illegal, he is violating federal law. If he does not, Juan will sit back and receive TTD indefinitely.

In this case, there is a solution. The adjuster can refer the case to an aggressive defense attorney to file a WC-240 Notice after he or she gets the ATP to approve the light-duty job. When the WC-240 is served on the Claimant, the Claimant is then advised that he will need to produce valid proof that he is able to work in the U.S. before he can return to work. If he cannot

produce such proof (and in the above hypothetical he will not be able to do so), the employer will not be able to return him to work, and the Claimant's benefits will be suspended.

Hypothetical #2:

> Bubba's Roofing hires Manuel Labor and puts him to work on a roof immediately. Bubba does not ask for any proof of immigration status. In fact, he is pretty sure Manuel is an undocumented alien. Manuel falls from a roof at work and tears ligaments in an ankle. The claim is accepted as compensable, and the Claimant receives TTD for three months before he is released to light-duty work. Bubba, who has heard about how Bob resolved his case, is willing to make light-duty work available and pressures the adjuster to cut off Manuel's benefits after he offers him the job. Should the adjuster follow Bubba's advice?

Probably not. In this case, Bubba's roofing does not have "clean hands." In other words, the employer is guilty of some wrongdoing, and the State Board will probably not allow the Claimant's benefits to be suspended following a WC-240 offer. If Bubba could get away with this, then he would have the incentive to hire nothing but undocumented workers in order to minimize his exposure for worker's compensation liability. In this case, Bubba (and his insurer) should seriously consider settling the entire case or getting the Claimant to a doctor who will aggressively treat him and attempt to get a full duty release. When the employer does not have "clean hands," it is very difficult to suspend benefits without a full duty release. The next best course of action is probably to initiate surveillance and possibly send the Claimant to a conservative doctor for an IME. If that doctor releases the Claimant to full duty, your attorney can request a hearing based on a change in condition for the better. After discovery, you can decide whether to go to trial or settle the claim.

In Martines v. Worley & Sons Construction, 278 Ga. App. 26 (2006), the employer offered an undocumented alien claimant a light duty job driving a work truck. The claimant refused the job upon being asked to show a driver's license in order to operate the truck. The

Court of Appeals held that the claimant's inability to accept the job did not relate to his work injury, but rather, the refusal related to the claimant's illegal alien status that prevented him from obtaining a driver's license. As such, the Court of Appeals approved the employer's ability to suspend the claimant's benefits.

While Martines may have raised more questions than it answered, this case provides a strong negotiating tool when managing and settling claims filed by unauthorized workers.

15-6. Conclusion

As can be seen from the above examples, these cases are not very different from the average workers' compensation claim. The adjuster should simply treat a claim involving an unauthorized worker like any other. Perform a non-discriminatory investigation upon receipt of all files to determine whether the Claimant is undocumented, and whether the employer has "clean hands." If the Claimant is unauthorized, and if the employer does have "clean hands," then the adjuster should try to get a light duty release and prepare a WC-240 offering the Claimant suitable light-duty work (after speaking with the employer to explain the importance of offering light duty) contingent upon the Claimant demonstrating that he or she is authorized to work in the U.S. Finally, do not stop thinking about creative solutions to the unique problems presented by claims involving undocumented workers. The law in these cases is still evolving, and it could be worth your time to run your ideas or questions by your defense attorney.

CHAPTER 16 - PANEL OF PHYSICIANS AND BILL OF RIGHTS

16-1. What Makes a Panel Valid

O.C.G.A. § 34-9-201 provides that an employer must maintain a list of at least six reasonably accessible physicians from whom injured employees may obtain treatment. The employer must post this list, which is known as the "Panel of Physicians," in a prominent place upon the business premises and must otherwise take all reasonable measures to ensure that:

1. Employees understand the function of the Panel, and their right to select a physician therefrom in case of an injury, and

2. Employees are given appropriate assistance in contacting Panel physicians when necessary.

Appropriate prominent places for posting the Panel include any general office bulletin board, the employee's break stations, the personnel office, and any other places where employees frequent during a normal work day.

As of July 1, 2015, Board Rule 201 no longer requires all six physicians to be non-associated. The Panel must include at least one physician who is an orthopedic surgeon, and 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. Failure to include a minority does not invalidate the Panel, but it may give the employee the right to select a minority physician of his 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. Hospitals should never be posted on the Panel. Posting a hospital may authorize care by all physicians practicing at that hospital.

Although the law requires six physicians to be posted, it is recommended that an employer post more than the required number. This allows the employee additional choices and insurers the continued validity of the Panel should the status of a posted physician change. Additional specialties should be posted 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 sure that the physician will agree to treat employees for work-related injuries. Additionally, employers should periodically contact their listed panel providers to ensure, among other things, that a) they still accept workers' compensation patients; b) that they still practice in the specialty area for which they are listed, if applicable; and c) that they are still at the same location/phone number listed on the panel. Outdated information on a panel can invalidate a panel, leading to the loss of control over a claimant's medical treatment. It is for this reason that, as mentioned above, employers should be encouraged to list more than the minimum number of physicians.

An injured employee must treat with the physician he/she selects from 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 chosen, the employee may make one change to a second physician who is also posted on the Panel without permission from the employer or insurer. However, effective July 1, 2015, if a Panel physician refuses to treat an employee who has previously received treatment from another Panel physician, the employer/insurer shall increase the Panel for that employee by one physician, per refusal and this must be done within a reasonable time. However, any further changes require the permission of the employer/insurer or an order from 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 posted Panel.

16-2. Employer's Duty

Employers are required to explain the purpose of the Panel to employees, and employees should be reminded of its function once a year. Employers are also required by law to post the "Bill of Rights" in the same location as the Panel of Physicians. This document sets forth an employee's rights under the Workers' Compensation Act, as well as his or her obligations.

Failure to post both a valid Panel of Physicians and the Bill of Rights in prominent places can result in fines from the State Board of Workers' Compensation. More importantly, an employer forfeits the right to control an injured worker's medical treatment and expenses if these documents are not properly posted. In other words, the employee may be allowed to see the physician of his or her choice, and the employer will be required to pay the necessary medical expenses from this treatment.

16-3. Two Types of Panels Allowed in Georgia

1. Standard Panel: This most commonly used Panel must include at least six physicians, at least one must be an orthopedic surgeon, and at least one must be of minority status. No more than two industrial clinics are allowed on the same Panel. The employee may make one change on the Panel without permission from the employer/insurer or the Board.

2. MCO (Managed Care Organization): This type of Panel is usually used by self-insured employers. This Panel is similar to an HMO in that it uses the gatekeeper philosophy. The employee may go to one physician, and he or she will refer the employee to another doctor if

necessary. This list of physicians must be approved by the Board and typically lists hundreds of physicians in the state, similar to a group health insurance plan.

CHAPTER 17 – GUARDIANSHIP

Under Georgia Law, neither a minor nor a legally incompetent person is entitled to bring a claim for benefits, directly receive benefits, or compromise his claim for benefits. Someone legally qualified to act, or receive benefits for that person, referred to as a "guardian" or "conservator," must be appointed by the Probate Court, State Board of Workers' Compensation, or by a court of competent jurisdiction outside the State of Georgia. A minor is defined as a person under the age of 18. An adult may also be legally incapacitated if, "by reason of mental illness, mental retardation, mental disability, physical illness or disability, chronic use of drugs or alcohol, or other cause," that person "lacks sufficient understanding or capacity to make significant responsible decisions or the ability to communicate such decisions regarding his person" or "is incapable of managing his estate."

Once a guardian or conservator is appointed, the minor or incompetent adult is referred to as the "ward." For simplicity, in referring to minors and incompetent adults in this section, they will be referred to as "wards."

17-1. When Guardianship is Required

Generally, in a Workers' Compensation claim setting, guardianship issues arise when:

- a minor is injured in a work-related accident or injury;
- a worker is deceased, and his or her minor children are entitled to benefits; or
- an employee suffers a work-related head injury or other injury resulting in legal incapacity. Kissiah at §35.01.

There are two key issues in dealing with claims involving minors or incompetent adults:

- Who has authority to receive benefits on behalf of the ward?

- Who has authority to bring a claim on behalf of the ward or settle a claim on behalf of the ward?

Generally, the person with authority to receive funds for the proposed ward was formerly called the guardian of the property but is now known as the "conservator." The person with authority to negotiate claims or bring a claim is the "guardian" of the person. In most settings, the guardian and the conservator is the same person. However, individual circumstances will dictate whether or not this is appropriate. The pleadings to be filed with the Probate Court or State Board in any individual circumstances will differ greatly between guardianship of a minor and guardianship of an incapacitated adult. The probate courts of this state use standard forms, much like those used in workers compensation claims, for filing petitions for guardianship and related pleadings.

17-2. Procedure for Determining the Guardian

a) For minors

Where the proposed ward is a minor, the minor's custodial parent generally has authority to negotiate claims and bring claims on behalf of the minor child. Because the law treats the custodial parent as the "natural guardian" of the minor child, that natural guardian can receive funds up to $15,000.00 and no board-appointed conservator is necessary. Keep in mind, the adjuster should get an affidavit stating that no conservator has been appointed and that the affiant is the natural parent under Georgia law.

Whether it is necessary for the natural guardian of a minor child to petition for legal guardianship depends on the amount of benefits being paid to the proposed ward:

- If the sums to be received are $15,000.00 or less, no legal conservatorship is required;

- If the amount defined by law as the "net settlement" (generally, the total entitlement minus legal fees, medical expenses to be paid from the settlement proceeds, and the present value of amounts to be received by minors after they reach 18) is $15,000.00 or less, the natural guardian may seek court approval without becoming court-appointed conservator;
- If the "net settlement" is more than $15,000.00, settlement can only be effective with a court-appointed conservator; and
- Deferred payments to minors (annuities) must be court approved.

If there is no natural guardian of the proposed ward, another family member or other person, including even the county guardian, may become the conservator for such funds or to bring, defend, or settle a claim. Under these circumstances, the guardianship petitions are similar to those used for incompetent adults.

b) For Incapacitated Adults:

In the case of an incapacitated adult, prior to anyone taking action on behalf of the proposed ward, first there must be a determination that the proposed ward is incompetent to handle his or her affairs under the statutory guidelines. That determination requires a hearing before the Probate Court in the county where the proposed ward is located or resides. There is a statutory preference list for who should serve as conservator of the proposed ward. After a conservator is selected, the procedure for obtaining Probate Court approval to compromise the claim is the same whether the proposed ward is a minor or an incompetent.

17-3. Procedure for paying benefits under Guardianship

After a conservator has been appointed to bring, defend, or settle a claim, it is still necessary to obtain approval of any settlement agreement by either the Probate Court or the State Board (depending upon the net settlement amount discussed below). Probate judges in the various Georgia counties treat the authority to approve the settlement in light of the State Board's authority differently. **For claims/settlements within the jurisdiction of the Probate Court, you will need to ensure that a Petition to Compromise a Claim is filed and approved before submitting the stipulated settlement to the State Board.** This is necessary because the conservator is the only person with authority to sign the stipulated settlement on behalf of the proposed ward. The conservator will be responsible for filing inventories, returns, and status reports with the Probate Court or with a court of competent jurisdiction outside the State of Georgia in ongoing claims. **For claims/settlements within the jurisdiction of the State Board, you need to file the Guardianship Petition either prior to or at the time of the filing of the stipulated settlement.**

When a claim has guardianship implications, it is generally advisable to consult with an attorney regarding how to meet the necessary legal requirements for establishing guardianships. It is important to remember that regardless of where the claim originates and what court has jurisdiction over the workers' compensation claim, the jurisdiction that is relevant for the guardianship issue is generally the county where the proposed ward resides. You must ensure that the person receiving the funds for the proposed ward is legally qualified to receive the fund or negotiate the claim in the jurisdiction where the person receiving the benefits resides.

17-4. State Board's Authority Versus Probate Court Authority

For many years, the State Board of Workers' Compensation had authority to appoint a guardian for workers' compensation claims. That provision of the Workers' Compensation Act was revoked in July 1996; however, in 1999 the State Board of Workers' Compensation received limited authority to appoint a guardian to administer Workers' Compensation benefits in claims where the net settlement amount was less than $50,000.00. However, effective July 1, 2012, the State Board of Workers' Compensation's authority to appoint guardians was expanded. At present, the State Board of Workers' Compensation has authority to appoint a guardian to administer Workers' Compensation benefits in claims where the net settlement is less than $100,000.00. However, where the natural parent is the guardian of a minor and the settlement amount is less than $15,000.00, no board appointed conservator is shall be necessary. After the settlement, the board shall retain the ability to resolve all disputes regarding continuing representation of a board appointed conservator of a minor or legally incompetent person. See O.C.G.A. § 34-9-226(b)(2).

In addition, the Board also has authority to appoint a guardian ad litem to bring or defend an action where a minor or a legally incompetent person does not have a duly appointed representative or guardian.

CHAPTER 18 - SUBROGATION

18-1. Purpose

When an employee is injured in an on-the-job accident caused by the negligence of a third party, and the employee receives Workers' Compensation benefits from his employer, the employer/insurer may be entitled to reimbursement from the negligent third party for the workers' compensation benefits paid. O.C.G.A. 34-9-11.1. However, Georgia's subrogation statute heavily favors the claimant, and only permits subrogation recovery when the claimant is "fully compensated" or "made whole" by the recovery in the action against the third party.

18-2. Statute of Limitations

The Georgia Workers' Compensation Subrogation Statute provides that the employee has the exclusive right to file suit against any third party tortfeasor who has caused his on-the-job accident for the first year following the accident's occurrence. When more than one year from the date of the accident has passed, either the employer/insurer or the employee can file suit against the third party at any time prior to the expiration of the applicable statute of limitations. According to the circumstances surrounding the employee's injuries, various statutes of limitations will apply. However, most personal injury law suits involve a two-year statute of limitations. Where the claimant or employer files a tort claim, the other party may intervene in that action.

18-3. Intervening in a Third-Party Claim

A Motion to Intervene is distinguished from a Motion to Add a New Party. An intervener is not seeking any further relief than that already sought in the civil action, but the party is merely trying to have his claim recognized in the already existing litigation and receive a share of the award. A workers' compensation insurer *must* intervene in a claimant's lawsuit if it

wishes to protect its lien. Prior to filing the Motion, the insurer should put all parties on notice via written correspondence of their intent to intervene in the Claimant's lawsuit. Otherwise, the claimant may settle his tort claim before the subrogation lien attaches, leaving the employer/insurer without recourse.

The Georgia Workers' Compensation subrogation Code Section gives the employee and the employer/insurer the right to intervene in certain circumstances. If the employee elects to file suit against the third-party tortfeasor, then he/she must notify the employer/insurer immediately, and the employer/insurer ***must*** intervene if it wishes to protect its lien. Should an employee elect not to file suit against the third party, then, provided that one year has passed, the employer/insurer may file suit. The employer/insurer must immediately notify the employee of its assertion of such cause of action so the employee can intervene.

18-4. Subrogation Trial

The tort trial that includes a subrogation intervention is rather complex. The trial is split so the jury is unaware of the workers' compensation issues. The jury reaches a verdict solely concerning the claims made by the employee against the tortfeasor. If the employee wins, a second phase begins where the subrogation question of "fully compensated" is addressed. If the court determines that the employee's tort recovery plus his workers' compensation recovery make him "fully compensated," then the court shall allow the employer/insurer a subrogation recovery equal to the value of the subrogation lien (all medical, indemnity and death benefits paid to date). However, even after a subrogation recovery, the claimant's attorney then is entitled to present evidence in order to collect an attorney's fee from the employer/insurer's share. Typically, the court will grant the request for the percentage fee agreement, especially if the claimant's attorney did most of the work in seeking the recovery from the tortfeasor.

Therefore, the "best case" scenario for recovery after trial is usually 60 percent of the subrogation lien.

18-5. Conflict of Laws

The Court of Appeals released two opinions that severely limit an employer/insurer's subrogation rights where a resident of Tennessee suffers a work injury in the state of Georgia. In the case of Liberty Mutual Insurance Company v. Roark, the employee, a resident and citizen of Tennessee, suffered a work injury when he was involved in a car accident while driving a company truck in Catoosa County, Georgia. Roark, 297 Ga. App. 612 (2009). The employer's insurance company, Liberty Mutual, paid workers' compensation benefits under Tennessee law. Thereafter, the employee sued the driver of the vehicle that caused the accident in Catoosa County, Georgia and Liberty Mutual filed a petition to enforce its subrogation lien.

The Court held that (1) The Georgia workers' compensation rule of law applies when the injury occurs in Georgia; and (2) Liberty Mutual had no subrogation rights against the employee's potential settlement in Georgia since the employee did not receive workers' compensation benefits under the laws of Georgia. The court affirmed this holding in Performance Food Group, Inc. v. Williams, 300 Ga. App. 831 (2009). Based on the above, under Georgia Law, the employer/insurer have no subrogation rights when a non-resident employee is injured in Georgia, but receives workers' compensation benefits from his/her resident state. *But see*, Paschall Truck Lines, Inc. v. Kirkland, 287 Ga. App. 497 (2007)(leaving unresolved the issue of whether a Georgia employer/insurer may seek subrogation against a Georgia resident who settles a claim for both Georgia workers' compensation benefits and workers' compensation benefits under the law of another State, arising out of a single accident caused by the negligence of a third party).

CHAPTER 19 - HEARINGS AND LITIGATION

19-1. Request for Hearing

The manner for adjudication of disputes in the workers' compensation system is through hearings held before administrative law judges. In order to place a claim into litigation, a party will normally file a Board Form WC-14, "Request for Hearing." The Request for Hearing must outline the issues to be decided by the administrative law judge. Typically, the employer/insurer will request a hearing when the employee is receiving benefits, but the employer/insurer has reason to believe that the employee has experienced a change in condition for the better. For example, this can occur when the employer/insurer have received information that the claimant is working or when the employer/insurer has offered a light duty job that the claimant can perform based on the opinion of the Authorized Treating Physician. On the other hand, the employee usually requests a hearing when a claim has been controverted in whole or in part, or when there is a particular dispute, such as payment of medical bills or a disputed period of disability, in an accepted claim. Once the hearing has been requested, it will be assigned to an administrative law judge in the county which is the appropriate venue for the claim.

The administrative law judge will issue a Notice of Hearing, and the employer/insurer then has 21 days from the date the Notice was sent to have defense counsel file a Notice of Representation. Failure to file a Notice of Representation within 21 days will result in penalties being assessed at the discretion of the administrative law judge. There are approximately twenty administrative law judges in offices throughout the state, approximately eight of which are in Atlanta, and three of which are assigned to the Alternative Dispute Resolution unit.

The following is a list of the administrative law judges in our state with their contact information:

HEARING

Atlanta 270 Peachtree Street NW Atlanta, GA 30303-1299	**Albany** 414 N. Westover Blvd., Ste. C Albany, GA 31707 Fax: 229-430-7825	**Gainesville** 601 Broad St. SE, Ste. D Gainesville, GA 30501 Fax: 770-531-5391
Chief Judge David Imahara 770-531-5625	**Judge Brian Mallow** 229-430-4280	**Chief Judge David Imahara** 770-531-5625
Judge Kimberly S. Boehm 404-656-2978	**Columbus** Heritage Tower, Suite 200 18 9th Street Columbus, GA 31901 Fax: 706-649-1544	**Judge Warren Massey** 770-531-5625
Judge Viola Drew 404-232-1195	**Judge Melodie Belcher** 478-471-2052	**Macon** 110 Holiday Drive N, Suite A Macon, GA 31210-1802 Fax: 478-471-5314
Judge Meg T. Hartin 404-656-2930	**Judge William "Bill" S. Cain** 706-649-7520	**Judge Sharon H. Reeves** 478-471-2051
Judge Elizabeth Lammers 404-656-2996	**Judge Tasca Hagler** 706-649-7372	**Judge Melodie Belcher** 478-471-2052
Judge Johnny Mason 404-656-2971	**Dalton/Rome** (Temporarily Relocated to Atlanta Office)	**Savannah** Seven East Congress St., Suite 601 Savannah, GA 31401 Fax: 912-651-6226
Judge Andrea Mitchell 404-656-2996	**Judge Richard Sapp, III** 706-272-2284 404-656-2947	**Judge Jerome "Jerry" Stenger** 912-651-6223
Judge Charles Spalding 404-656-7772		**Judge Nicole Tifverman** 912-651-6222

ALTERNATIVE DISPUTE RESOLUTION (ADR)

270 Peachtree Street NW
Atlanta, GA 30303-1299

Judge Janice Askin, Director
404-656-2939

Judge Liesa Gholson
404-656-3327

Judge Barbara Lynn Howell
404-656-3327

MISCELLANEOUS

Settlement Division
David Kay
404-656-2929

Catastrophic Disability
Deborah Krotenberg
404-651-7831

ICMS Assistance
404-656-3818

Trial Division
Chief Judge David Imahara
770-531-5625

Appellate Division Director
Patricia Taylor-Smith
404-656-2937

Superior Court Appeals
Jennifer Payne
404-656-7667

Most of the judges will travel to several different counties to hear cases. It is critical that before any hearing, the attorney has all the necessary information to adequately represent the employer/insurer, which involves several steps which are detailed below.

19-2. Discovery

A. Interrogatories

Interrogatories are questions which each side asks the other to learn their reasons for prosecuting or defending the claim, and the evidence each side has to support its contentions. The Interrogatories should include requests for the names of all potential witnesses, information about medical treatment, the type of benefits being sought, the employee's work history, medical history, whether or not he or she has worked since the injury, and other background questions. The purpose of these questions is to help the attorney develop any potential defenses which may not be apparent at first glance. Each party is required to answer Interrogatories within thirty (30) days under the Georgia Civil Practice Act. Perhaps the most critical reason for serving

Interrogatories on the employee is that it helps prevent the employee from entering any surprise testimony or evidence at the hearing.

B. Requests for Production of Documents

Like Interrogatories, Requests for Production of Documents are designed to give the attorney more information about the claim. The documents requested are normally medical records, employment records, and generally any records which support or refute the claim for benefits. Again, if these have been served on the employee properly, he or she will have to give copies of these documents to the employer/insurer before they can be entered into evidence at a hearing. This also helps prevent the employee from producing any surprise documents at hearing as well.

C. Requests for Admissions

Requests for Admissions are often used by both parties to ask the other side to admit certain facts so they will not have to spend extra time trying to prove these facts. The employee usually asks the employer/insurer to admit that an accident took place, that the employee was acting in the course and scope of employment, and that the employer is subject to the Workers' Compensation Act. The responding party has 30 days from the date on the Certificate of Service to respond to these Requests or else they are deemed admitted. Therefore, when served with discovery, and especially with Requests for Admissions, it is critical that adjusters and/or employers send them to defense counsel as soon as possible so that he or she can file timely answers on their behalf.

D. Claimant's Deposition

The most important discovery tool is the claimant's deposition. Not only does it give you basic information about the claim and the claimant's background, it also gives the attorney a

chance to evaluate the claimant's credibility and determine how he or she will appear on the witness stand. This can often be as important as the actual hearing in the case simply because defense counsel is able to pin down the claimant's story early in a claim which prevents a claimant from later changing the facts.

It is often necessary to take witness depositions as well. Sometimes witnesses will be leaving the state or are already out of state, so the parties can agree to take the witnesses deposition and have the transcript entered into evidence at the hearing. Sometimes, if a witness is not willing to speak to counsel for either side, it may be necessary to schedule a discovery deposition to simply find out what that witness knows about the claim or the claimant, and then subpoena that witness to attend the hearing if his or her testimony proves useful.

E. Doctors' Depositions

Most of the time, the parties in a workers' compensation case are able to obtain all of the medical records before the hearing, and each side tenders the records it deems important into evidence. Unlike many other civil suits, medical records are admissible at a workers' compensation hearing without having live testimony from the doctors. Normally, these records will be admissible only when accompanied by the signature of the examining or treating physician. However, there are occasions when either a doctor is uncooperative and will not provide medical records, or when the medical records are ambiguous. In those cases, you should consider taking the doctor's deposition. However, you should attempt to determine the likelihood that the doctor will provide helpful testimony before scheduling the deposition. It is generally not a good idea to depose a doctor when you have no idea what he or she is going to say. In those cases, the attorney should try to contact the doctor before taking a deposition, and possibly even schedule an office visit, to discuss the claim.

Even when the doctor's opinion is against you, you may want to consider taking his deposition. If the doctor is taking a particularly hard line stand with very little objective medical evidence to support it (e.g. he is one of the doctors everyone knows to be a favorite of claimant's attorneys), you may be able to expose his or her bias through a deposition. Occasionally, you may want to depose a doctor who clearly supports your side simply to put more emphasis on his or her opinion. However, you should be careful in doing so because the claimant's attorney will be doing everything in his or her power to attack your doctor's credibility and/or opinions.

19-3. Adjuster Deposition Do's and Don'ts

A. Pre-deposition conference

A defense attorney should allow adequate time to meet with the adjuster in order to properly prepare the adjuster for his or her deposition. If the adjuster's file has been requested, arrange to have the file picked up and reviewed by your defense attorney with privileged and objectionable documents placed in a separate file.

B. Determine issues prior to adjuster's deposition

Carefully review the form WC-14 "Notice of Claim/Request for Hearing" to identify hearing issues, relief sought, and all potential defenses. It is imperative that the adjuster has a clear understanding of the claimant's and the employer's respective theories of the case. Obviously, this cannot occur unless the defense counsel develops the theory and conducts enough discovery to determine the claimant's theory prior to the adjuster's deposition. For this reason, medical records should be gathered and the claimant's deposition should be taken when possible prior to allowing the adjuster to be deposed.

C. Freeze Claimant's testimony prior to the adjuster's deposition

This is especially true when the adjuster has obtained an investigator for the purpose of conducting surveillance. Claimants tend to be much more open and forthcoming regarding their activities and post-accident employment when they suspect they have been under surveillance, but are uncertain as to the results. Furthermore, most administrative law judges will allow the claimant to be deposed prior to educating the claimant as to the results of surveillance. However, if a defense attorney allows the adjuster to be deposed before freezing the claimant's testimony as to post-accident activity and employment, then the claimant's motivation for candor and honesty may be limited to conceding his or her involvement in post-accident activities and employment uncovered by the investigator and revealed during any deposition. The claimant should always be given the opportunity to damage his or her own credibility by misrepresenting the nature of the post-accident activity and employment before they are educated regarding the results of surveillance.

D. Review adjuster's relevant conduct and decisions

An adjuster's conduct and activity leading up to a decision to controvert a claim or to raise certain defenses is a legitimate scope of inquiry by the claimant's counsel. However, because of the narrow time frames within which adjusters often make decisions only limited information may be available to the adjuster when a decision is made to controvert a claim or to raise certain defenses. An adjuster should determine the information which was available at the time a decision was made to pursue a challenged position or defense. The reasonableness of the adjuster's activity or decision will usually turn on the information available to the adjuster at the time the activity was performed or the decision was made.

If a defense asserted by the adjuster was appropriate when first raised but inappropriate in light of subsequently acquired information, then do not be reluctant to abandon the defense and

to take corrective action. Nothing is more uncomfortable for the adjuster and defense counsel than to try and defend an indefensible decision or position taken early in a file when subsequently developed facts demonstrate the defense is no longer viable.

When mistakes are uncovered, be cautious about volunteering information regarding the mistakes, but be prepared to admit to the mistake if questioned during the deposition. If mistakes are identified during the pre-deposition conference, explain why the mistake was made and what corrective action was taken once the mistake was fully appreciated. Begin corrective action prior to the deposition if at all possible. For example, if benefits were improperly suspended, or authorization was not given for appropriate medical treatment, the adjuster may want to recommence the benefits with payment of appropriate penalties or authorize appropriate medical treatment so the matter is cleared up and communicated to the claimant's attorney prior to the adjuster's deposition. This may eliminate the need for the adjuster's deposition, and if it does not, it may enable the adjuster to avoid paying assessed attorney's fees for the claimant's attorney's time in preparing for and conducting the deposition of the adjuster.

E. Standard deposition "do's and don'ts"

1. Tell the truth;
2. Do not volunteer information;
3. Avoid exaggerations;
4. Avoid generalizations regarding the claimant and/or his or her activity;
5. Be sure to understand each question before answering;
6. Feel free to ask the claimant's attorney to repeat or rephrase a question if the question is unclear;
7. Do not guess or speculate;

8. Do not allow the claimant's attorney to put words in your mouth or to put an inaccurate spin on your testimony by allowing him or her to improperly summarize your testimony;

9. Do not agree to provide documents during the course of the deposition which were not previously requested or produced. This would prevent defense counsel from having adequate time to review and discuss such documents and to assert appropriate objections. Allow the defense attorney to respond to any such inquiries;

10. Be cautious about responding from memory with specific dates and times;

11. Be sure to qualify answers when appropriate by prefacing answer with "To the best of my recollection . . .";

12. Defense counsel should discuss the attorney-client privilege regarding information obtained, and the fact that this privilege may be waived in certain instances to explain the adjuster's decisions or course of conduct;

13. Defense counsel should also explain the purpose of the adjuster's deposition, and to the extent possible, the goal of the claimant's attorney in taking the adjuster's deposition.

F. Consider potential cross-examination questions and identify any unfavorable documents

There is no better way to prepare for cross-examination by the claimant's attorney than to anticipate the tough questions and documents which will be used in questioning the adjuster and to review them prior to the deposition. This serves several purposes including putting the adjuster at ease by allowing the adjuster to better anticipate the types of questions he or she will

be asked, and it provides defense counsel with the opportunity to assist the adjuster in understanding how the wording of certain answers can be misconstrued and taken out of context.

G. Location of the Adjuster's Deposition

Never conduct depositions at an adjuster's office. The claimant's attorney should not be given an opportunity to conduct the deposition where the adjuster has complete access to all files, computer, etc., so as to allow access to information not requested by the claimant's attorney prior to the deposition. The claimant's attorney should be required to request desired documents prior to the deposition even if done informally with a letter. Thus, only bring to the deposition what the claimant's attorney has requested.

Furthermore, the claimant's attorney should not be provided with the opportunity to see or overhear conversations and activity at the insurance company or the third party administrator's offices which could be misconstrued as improper or inappropriate.

19-4. Developing Favorable Medical Evidence

(1) Pre-Accident Medical Evidence

There are three ways that employers can create favorable medical evidence before an accident occurs. The first way is with a Post-Employment Medical Questionnaire. The Americans with Disabilities Act (ADA) prohibits most employers from asking medical questions of job applicants until after an offer of employment has been extended to the applicant. These questionnaires can set up a Rycroft defense to defeat an otherwise valid workers' compensation claim by documenting an employee's representations regarding pre-existing conditions (See Section 10-1 for additional information on the Rycroft defense).

Another way to create favorable medical evidence, prior to any accident, is through a physical examination at time of hiring. Physical examinations are useful in that they establish a

baseline on the employee's medical condition and can uncover medical problems which the employee fails to disclose. Accompanying drug screens can be performed during examinations in an effort to screen applicants who abuse controlled substances.

As discussed previously, employers can create favorable medical evidence before the accident by maintaining a valid Panel of Physicians that allows the employer to control medical treatment and medical evidence. A valid Panel must have six physicians and, there can be no more than two industrial clinics on the Panel. Furthermore, there must be at least one orthopedic surgeon and one minority physician on the Panel. Using a hospital on a Panel is a bad idea as some judges believe that all of the doctors who have rights at the hospital are authorized to treat the employee, and other judges believe that it invalidates the Panel.

The employer must post the Panel in a prominent place upon business premises (e.g., near the time clock, in the break room, or an employee gathering place). The employer must also take reasonable measures to ensure employees understand the function of the Panel and the right to select a physician off of the Panel if injured at work. Employees must receive appropriate assistance in contacting Panel physicians and should sign a workers' compensation acknowledgment form.

It is also very important to maintain open channels of communication with physicians on a Panel in order to minimize negative surprises. For example, an employer may want to schedule an appointment with the physician and discuss his or her treatment protocols, light duty work releases, etc., before placing him or her on the posted Panel. It is important to encourage physicians to call the employer contact person if an employee says something regarding the employer which the doctor questions. Also, make sure the physicians are willing to review surveillance videos in evaluating the employee's medical condition and work restrictions and

that the physician understands the employer's desire for drug testing upon an initial examination of any employee following a work-related accident. Finally, make sure that the doctor's bills are paid timely even if the claim is subsequently controverted.

(2) Post-Accident Medical Evidence

The first step in acquiring post-accident medical evidence is to obtain a medical authorization from the employee. Some argue a Form WC-207 limits one to the procurement of medical records for treatment of the work accident. This interpretation appears to conflict with O.C.G.A. § 34-9-207. However, because there is uncertainty regarding the scope of the Form 207, we encourage adjusters to ask claimants to sign a broad medical authorization which makes it clear that all medical records may be obtained with the authorization.

The next step is to gather all of the medical records. In addition to requesting medical records from known providers, it may be beneficial to send a request to hospitals and clinics near the claimant's residence to see if any helpful information surfaces. Also, defense attorneys can send Request for Production of Documents to prior employers seeking the identity of other medical providers and information on prior accidents or injuries. If possible, obtain a recorded statement of the employee which should include a medical history and a listing of previous medical providers. Should a claimant refuse to provide a medical authorization, a hearing should be requested and Request for Production of Documents can be sent to medical providers without a medical authorization at that time.

Once medical records are received, all the records should be reviewed in search for other causes for the claimant's injuries and disabilities and for inconsistencies in the description of the accident, medical history, and symptoms. Also, be aware of references to other healthcare

providers and activities inconsistent with the claimant's alleged injuries. Finally, be on the lookout for a history of other accidents or injuries before or after the work accident.

(3) Post-Compensability Medical Evidence

Once a claim has been deemed compensable, efforts to develop favorable medical evidence must continue in order to push the claim towards a resolution. At this stage, it is important to identify medical non-compliance issues including: missed medical appointments, missed physical therapy appointments, non-cooperation with functional capacity evaluations, non-cooperation with work hardening programs and/or the failure to follow the orders of the authorized treating physician regarding use of prescription medication, weight loss, and smoking cessation.

It is always advantageous to try and develop evidence with the help of the authorized treating physician (ATP). Initially, the "nice guy" approach should be used by requesting a treatment plan. Then, escalate involvement with the ATP by requiring accountability in following the treatment plan. In addition, "level the playing field" with the ATP by providing a complete picture for the physician including a history of prior personal injuries and workers' compensation claims, pre-existing medical conditions, and inconsistencies in the claimant's deposition testimony.

There are many options to choose from in order to get a stale case moving again. For example, many times a bad ATP will need to be pressured with a second opinion. If a claimant is not improving with current treatment, the ATP can be asked to order physical therapy for the claimant. Also, when the claimant is totally disabled, an order for a Functional Capacity Evaluation can be sought from the ATP in order to obtain a light duty release**.** A light duty release permits the filing of a WC-104 "Notice to Employee of Medical Release to Return to

Work with Restrictions or Limitations" which allows conversion from TTD benefits to TPD benefits after the claimant has been released to light duty work for 52 consecutive weeks or 78 aggregate weeks. If a claimant has already been released to light duty, then a full duty release could be sought from the ATP. Once the ATP gives a projected full duty release date, the employer has leverage in settlement negotiations, and the doctor has self-imposed pressure to stick to the projected release date.

Sometimes the most effective way to get a stale case moving is by requesting a change of physician or by obtaining an independent medical examination (IME). Reasons to request a change of physician include: proximity of physician's office to employee's residence, necessity for specialized care, existence of a language barrier between claimant and current ATP, referral by the ATP, duration of treatment without appreciable improvement, current physician has nothing more to offer, and evidence of excessive treatment with prescription medication. With regard to an independent medical examination, an employer has the right to insist on one. IME physicians many times can recommend treatment plans on stalled cases. The adjuster should communicate with physicians regarding why an IME is being requested and only physicians respected by the Board should be selected in conducting IMEs as "hired gun" physicians have little credibility with the Board.

19-5. Appeals

Pursuant to O.C.G.A. §34-9-103, the losing party to an administrative law judge's Award/Order has twenty (20) days after the administrative law judge's order to file an appeal to the Appellate Division of the State Board. **NOTE: Failure to pay an Award or file an appeal within 20 days results in a 20 percent penalty.** The Appellate Division has the authority to re-weigh the evidence, so an appeal to this level is almost automatic. If the appellant wants to have

oral arguments before the Appellate Division, his written requests for oral argument must be made with the appeal. The appellant also has twenty (20) days from the Certificate of Service on the appeal to file a new brief to the Appellate Division showing how the administrative law judge erred. The appellee then has twenty (20) days to file a response brief. Generally, if you are appealing a decision, oral argument is a good idea because it lets you emphasize parts of the case which might not be apparent in a written brief.

While the Appellate Division does have authority to re-weigh the evidence, they will generally affirm the decision if there is a preponderance of the credible evidence supporting the judge's decision. The Appellate Division will usually issue an order within thirty (30) to sixty (60) days after the oral argument. After receiving the order from the Appellate Division, the losing party has an automatic right to appeal to the Superior Court in the county where the injury occurred. That appeal must also be filed within twenty (20) days of the Appellate Division's award. At that point, the State Board will forward its entire file with the transcript of the hearing testimony and evidence to the Superior Court. A Superior Court argument must be scheduled within sixty (60) days of the date of docketing at the Superior Court. Otherwise, a decision will be affirmed by operation of law.

The Superior Court does not have authority to re-weigh the evidence, but it must affirm the decision if it is supported by <u>any evidence</u>. It is extremely difficult to have a case reversed at the Superior Court level. Generally, that will only occur when the State Board has made an error of law. The Superior Court is the last level at which the appellant has an automatic right of appeal. Once the Superior Court has issued an order, the losing party may file an application for discretionary review at the Court of Appeals within thirty (30) days.

The Court of Appeals very rarely grants these applications for review and usually only when there is a new issue of law or interpretation to be decided. If the Court of Appeals denies the discretionary appeal, then the appellant can file for certiorari, which is another appeal, to the Supreme Court of Georgia. For all practical purposes, if the award has been affirmed all the way through the Court of Appeals, the Supreme Court will virtually never agree to even hear the appeal.

19-6. Mediation

Several years ago, the State Board set up a separate mediation unit (ADR Unit) to help resolve issues which might not require a full evidentiary hearing. These issues include disputes over payment of medical bills, attorney fee disputes, and settlement negotiations. The State Board has specially trained mediators who will sit down with both parties (and the adjuster) in an informal proceeding to see if the parties can reach an agreement. The parties are free to speak openly because nothing said in the mediation will be kept in the Board file. Mediation has proven very successful in resolving many of these issues, especially settlement.

As we all know, there are many cases in which an employee continues to receive benefits for years with no end in sight. In such cases, a mediation is often helpful because it brings the sides together to see if the case can be resolved. Generally, the mediators can help each side understand the other side's arguments a little better to aid in reaching an agreement.

CHAPTER 20 – ATTORNEY'S FEES/ATTORNEY FEE CONTRACTS

There are three general areas related to the topic of attorney's fees: (a) Board approval of attorney's fees, (b) assessment of attorney's fees, and (c) attorney advertising and division of fees. In addition, in order for a Stipulation to be approved by the Board, even where the claimant's attorney has waived his fee, the claimant's attorney must file his or her fee contract with the Board or the Board will not approve the Stipulation.

20-1. Approval of Attorney's Fees

Pursuant to O.C.G.A. § 34-9-108(a):

> The fee of an attorney for service to a claimant in an amount of more than $100.00 shall be subject to the approval of the Board, and no attorney shall be entitled to collect any fee or gratuity in excess of $100.00 without the approval of the Board. The Board shall approve no fee of an attorney for services to a claimant in excess of 25 percent of the claimant's award of weekly benefits or settlement.

Sometimes claimants' attorneys simply forget that they need to have their fees contract approved by the Board. The only action required by the claimant's attorney is the completion and submission of a WC-108(a) form, which includes a certification that all counsel and unrepresented parties have been served with a copy of the form. If the claimant's attorney receives a fee in excess of $100.00 and fails to file a WC-108(a), he or she will be in violation of O.C.G.A. § 34-9-108(a) and Board Rule 108. One caveat is that the approval of a settlement which indicates the amount of the fee for the claimant's attorney is generally considered authorized.

Often, the claimant's attorney will request that 25 percent of the claimant's weekly indemnity benefit be issued directly to them. However, **you cannot do so <u>unless</u> you have received an Order from the Board** approving the attorney's fee contract and confirming their entitlement to 25 percent of the claimant's weekly indemnity payments. Additionally, it is important to carefully read the language of the Order, as the judge may not permit the claimant's attorney to receive 25 percent of all of the indemnity benefits to which the claimant is entitled.

20-2. Assessment of Attorney's Fees

O.C.G.A. § 34-9-108(b) provides:

(1) Upon a determination that proceedings have been brought, prosecuted, or defended in whole or in part without reasonable grounds, the administrative law judge or the board may assess the adverse attorney's fee against the offending party.

(2) If any provision of Code Section 34-9-221, without reasonable grounds is not complied with, and an claimant engages the services of an attorney to enforce his or her rights under that code section, and the claimant prevails the reasonable *quantum meruit* fee of the attorney, as determined by the board, and the costs of the proceeding may be assessed against the employer/insurer.

(3) Any assessment of attorney's fees made under this subsection shall be in addition to the compensation ordered.

(4) Upon a determination that proceedings have been brought, prosecuted, or defended in whole or in part without reasonable grounds, the administrative law judge or the board may, in addition to reasonable

> attorney's fees, award to the adverse party in whole or in part reasonable litigation expenses against the offending party. Reasonable litigation expenses under this subsection are limited to witness fees and mileage pursuant to Code Section 24-13-25; reasonable expert witness fees subject to the fee schedule; reasonable deposition transcript costs; and the cost of the hearing transcript.

Allowance of attorney's fees under this section is predicated upon a determination by the administrative law judge that a party has acted without reasonable grounds. Please note that this code section applies to proceedings that have been brought, prosecuted, or defended in whole *or in part* without reasonable grounds. A claimant's attorney will often seek assessed fees when they file a WC-14 Hearing Request, despite the existence of reasonable defenses to the claim. Arguably, such a request for assessed fees could be construed as bringing or prosecuting a claim without reasonable grounds.

An appeal to the Appellate Division, if brought without reasonable grounds, can also lead to the assessment of attorney's fees under this code section. However, a frivolous appeal to the Superior Court, Court of Appeals, or Supreme Court could result in fees being assessed pursuant to O.C.G.A. § 9-15-14 of the Civil Practice Act.

20-3. Restrictions on Attorney Advertisement and Division of Fees

O.C.G.A. § 34-9-108(c) states as follows:

> An attorney shall not advertise to render services to a potential claimant when he or she or his or her firm does not intend to render said services and shall not divide a fee for legal services with another attorney who is not a partner in or associate of his or her law firm or law office, unless:

(1) The client consents to the employment of the other attorney after a full disclosure that a fee division will be made;

(2) The division is made in proportion to the services performed and the responsibility assumed by each; and

(3) The total fee of the attorneys does not clearly exceed reasonable compensation for all legal services such as the attorneys rendered to the client.

A violation of this code section generally results in a response by the State Bar of Georgia rather than other parties to the claim. Nonetheless, when taking a recorded statement from a claimant who is not yet represented by an attorney, questions about whether he has been contacted by an attorney or someone who claims to work for an attorney can often result in interesting responses. Often such questioning can provide valuable information for the State Bar of Georgia in the prevention of "runners" who solicit business through unscrupulous means.

CHAPTER 21 - SETTLEMENTS AND ADVANCES

21-1. Settlements

The State Board of Workers' Compensation encourages the settlement of claims, via a liability stipulation or a no-liability stipulation. In a liability stipulation, the employer/insurer accepts responsibility for the claim if they have not already so agreed. In contrast, a no-liability stipulation is entered into with the agreement that the employer/insurer is not responsible for the claim, but desires to conclude the claim with the payment of an agreed-upon sum of money.

A liability stipulation requires parties to state the following: (a) with specificity, the legal and/or factual matters about which the parties disagree; (b) that all medical expenses which were reasonable and necessary have been or will be paid by the employer/insurer; (c) that all parties are in agreement to the settlement; (d) whether future medical benefits will be paid by the employer/insurer, and if so, whether the treatment will be limited to certain providers; and (e) that the State Board of Workers' Compensation has jurisdiction to determine issues regarding medical treatment.

A no-liability stipulation may only be utilized if the employer/insurer has not already accepted liability for the claim, and the State Board has not issued an award finding the claim compensable. A no-liability stipulation should state the following: (a) the employee's employment history with the employer; (b) that all parties agree that the employee did not sustain a compensable accident; and (c) which party will be responsible for payment of medical bills. The no-liability stipulation should be accompanied by an "Agreement Covenant and Release", a separate document which essentially states that the employee will not pursue a claim against the employer in exchange for an agreed upon amount of money.

Both types of Stipulations should include the following: (a) social security language (Hartman language) if the settlement is for more than $5,000.00, (b) whether the employee has an outstanding child support lien, (c) whether a health care provider has an outstanding lien, and (d) an itemization of the expenses for which the claimant's attorney seeks reimbursement.

Please remember that if a claimant has applied for or is receiving Social Security Disability benefits or is a Medicare beneficiary, you will need to obtain a Medicare Set Aside as part of any settlement. If the claimant is a Medicare beneficiary and the claim settles for over $25,000.00, including the MSA costs, the MSA will be eligible for CMS review. The review threshold increases to $250,000.00 when the claimant is not a Medicare recipient but has a reasonable expectation of Medicare enrollment within 30 months of the settlement date. This situation may occur when dealing with a non-Medicare beneficiary who has applied for Social Security Disability benefits or is appealing a Social Security Disability denial.

21-2. Advances

An advance of future income benefits may be requested by the employee via a form WC-25, provided that at least 26 weeks of income benefits have already been paid. The WC-25 must be accompanied by documentation or affidavits supporting the employee's need for the advance. Once the application for an advance is filed with the Board and served on the employer/insurer, the employer/insurer has 15 days to file an objection to the application. The Board may, in its discretion, hold a hearing on the issue, or it may simply rule on the pleadings. Specific findings of fact to support the ruling are not required. If the request for an advance is granted, the employer/insurer may reduce the advance to the present value at 5 percent per annum. They may also recover the advance payment by a proportional reduction of the weekly benefits or by reducing the number of weeks of payments.

Once a Stipulation and Agreement is approved by the Board, payment must be made within twenty (20) days, or a 20 percent penalty may be assessed. Note: if mailing from out of state, payment must be made within seventeen days (17).

CHAPTER 22 - MANAGING WORKERS' COMPENSATION COSTS

22-1. Introduction

There are many ways in which employers can help manage the cost of workers' compensation claims. It is important to be proactive and aggressive with each claim to keep costs at a minimum. Although the suggestions outlined in this chapter require time and/or expense, the efforts will often pay dividends by pushing an employee back to work or promoting settlement.

This chapter will discuss three ways in which worker's compensation costs can be controlled. The first and most effective tool for reducing or controlling costs is placing an employee in a light duty job. Offering each employee a light duty assignment, once he or she obtains a light duty release from the authorized treating physician (hereinafter "ATP"), can significantly decrease costs. Employees who do not want to return to work, or disagree with the ATP's opinion about their ability to perform light duty work, will generally attempt the job before quitting and alleging that the injuries prevent their continued performance. If the employer believes the employee did not make a good faith effort to perform light duty work, it can request a hearing on the matter to suspend benefits. Second, vocational rehabilitation, in certain cases, can also aid in reducing costs. If the employer can get the employee back to some type of suitable employment, then the benefits can be reduced, or possibly suspended. Finally, the employer can argue that the employee has undergone a change in condition for the better, by demonstrating that the employee is able to return to unrestricted work duties or that suitable employment is available. Similarly, employers can also dispute an employee's efforts to reinstate suspended benefits, when the employee is alleging a change in condition for the worse, by proving that the employee failed to conduct a diligent job search.

These are just a few of the ways in which an employer can attempt to control workers' compensation costs, all of which are discussed in detail below. Employers should never believe there is nothing they can do to control workers' compensation costs after a claim is found compensable.

22-2. Light Duty Assignments

A. Introduction

The most effective tool to reduce exposure for workers' compensation disability benefits is O.C.G.A. §34-9-240. This statute requires employees to make a good faith effort to return to work when a suitable job, that has been approved by the ATP within 60 days of the last examination date, is offered. This statute states:

> If an injured employee refuses employment procured for him or her and suitable to his or her capacity, such employee shall not be entitled to any compensation, except benefits pursuant to Code Section 34-9-263, at any time during the continuance of such refusal unless in the opinion of the Board such refusal was justified. O.C.G.A. §34-9-240(a).

The Workers' Compensation Act has always envisioned that employers should be able to suspend disability benefits to an injured employee when the employer has light duty work, consistent with the injured employee's medical restrictions, available. However, prior to July 1, 1994, employers had no statutory tool available to force an injured employee to at least attempt suitable employment. Before O.C.G.A. §34-9-240 was enacted on July 1, 1994, employers had to hire a lawyer and proceed to a hearing on whether the light duty job was in fact suitable for the injured employee based upon their medical restrictions.

Under O.C.G.A. §34-9-240 and Board Rule 240, employers are given the authority to unilaterally suspend disability benefits, under limited circumstances, when the employee fails to attempt the offered and suitable light duty work. If an employee refuses employment that the ATP has approved and deemed suitable to the employee's medical restrictions, and where the light duty job was offered pursuant to the requirements of the statute and the Board Rule, the employer can automatically suspend the benefits without the need to hire an attorney or proceed with a hearing. The change in Georgia law eliminated the requirement that the employer first obtain a court order before being able to suspend the employee's disability benefits.

Employers should take advantage of Board Rule 240, and create and offer light duty work, whenever possible. Numerous studies have shown that the longer a non-catastrophically injured employee stays out of work receiving disability benefits, the more likely it is that they will not return to work. The Board Form 240 Light Duty Job Offer enables the employer to accelerate the injured employee's return to work, thereby helping to prevent an injured employee from becoming comfortable with their disabled status.

A. Employer Requirements under O.C.G.A. §34-9-240 and Board Rule 240.

1. Create a light duty job.

The employer should create a light duty job for the injured employee any time it is practical to do so. If the employer is unsure as to what job duties are appropriate, then the employer should consider having a job analysis prepared by a vocational rehabilitation counselor. The light duty job can be developed by using a WC-240A. Alternatively, the ATP may have the employee undergo a Functional Capacities Evaluation (hereinafter "FCE") which will clearly specify what job duties the employee is physically capable of performing. Board Rule 202 specifically authorizes FCE's as part of an Independent Medical Examination

(hereinafter "IME"), however the Board's interpretation of this Rule does not allow adjusters to request FCEs. Accordingly, an FCE must be ordered by the ATP.

2. Approval of a light duty job by the ATP

Once a light duty job is created by the employer, with specific job duties, it should then be presented to the employee's ATP, in writing, for approval. The ATP's signature approving the light duty job is required and the approval must be within 60 days of the last examination of the employee. Furthermore, Rule 240 requires that a request for approval of a light duty job presented to the ATP must be sent to the claimant's attorney and the employee at the same time it is sent to the physician. It should also be noted that Board Rule 200.1 prevents the rehabilitation counselor or case manager from communicating with the ATP without notice and consent of the claimant's attorney. This Rule, which was proposed by the claimant's bar, requires defense attorneys to perform tasks which formerly were performed by rehab counselors.

3. Preparation of Board Form WC-240

The next step in complying with Board Rule 240 is to prepare a Board Form WC-240. Close attention should be paid to answer all the specific questions on the Board Form and to attach the light duty approval signed by the ATP. The employer should also make sure that Board Form WC-240 is completed in full within 60 days of the ATP's written approval of the light duty job. It is important to note that all blanks on the Board Form WC-240 should be completed or answered by reference to an attachment. Furthermore, the ATP's light duty job approval must be attached to the WC-240 when filing with the Board.

To set up a unilateral suspension of the injured employee's disability benefits based upon a Form WC-240 job offer, the form must include the following information as outlined in Board Rule 240(b)(3):

(i) a description of the essential job duties to be performed, including the hours to be worked, the rate of payment, and a description of the essential tasks to be performed;

(ii) the written approval of the authorized treating physician(s) of the essential job duties to be performed;

(iii) the location of the job, with the date and time that the employee is to report to work."

Once Board Form WC-240 is completed, it should then be submitted to both the employee and the claimant's attorney. This requirement is often overlooked and astute employees' attorneys are aware of this requirement, and will use it to prevent an employer from suspending benefits if the employee fails to return to work.

4. Return to work date

When determining the date and time for the employee to report to work, as required on the Board Form WC-240, the employer should make sure the report date gives the employee at least ten (10) days advance notice. In other words, the employee must receive notice of the approved light duty offer by way of the Board Form WC-240 at least ten days before the employee is required to report to work. If ten days advance notice is not given, then the employer loses its right to unilaterally suspend benefits if the employee does not report for work, in which case it will be necessary to request a hearing to determine a change in condition and/or file a Motion to Suspend Benefits on a Board Form WC-102(d).

5. Employee's failure to report to light duty work

If all of the Board Rule 240 requirements are satisfied and the employee fails to show for work, or attempts the proffered job for less than eight cumulative hours or one scheduled workday (whichever is greater), the employer may then unilaterally suspend the employee's

benefits by filing, with the State Board, a WC-2 "Notice of Suspension of Benefits". When the WC-2 is filed, the completed WC-240 must be attached along with the physician's signed job approval, as proof that at least ten (10) days before the employee was required to report for work, the employee was notified of the job offer, the completed Board Form WC-240 mailed to the employee and the claimant's attorney, and all of the requirements of O.C.G.A. §34-9-240 and Board Rule 240 were met.

6. Employee's unsuccessful attempt to return to work

If the employee attempts the light duty job for eight cumulative hours or one workday (whichever is greater), but is unable to perform the job for more than fifteen (15) working days or less, and is allegedly unable to continue performing the job for any reason, income benefits must be automatically reinstated by the employer effective the date the employee ceased working by filing a WC-2 "Notice of Recommencement of Benefits." In such case, it is necessary to either request a hearing to determine a change in condition or file a Motion to Suspend Benefits on a Board Form WC-102(d). Where a Motion to Suspend Benefits is filed because the employee does not continue working for 15 scheduled work days, the motion must also be accompanied by an affidavit from the employer setting forth the suitable employment that has been offered to the employee as set forth on Board Form WC-240. This affidavit must state that the offer is continuing and a description of the job and approval must be attached. The employee must also have been examined by the ATP within sixty (60) days prior to filing a motion for suspension of income benefits. The employee may object to the Motion to Suspend Benefits for failure to accept suitable employment by filing a Board Form WC-102(d) with the Board within fifteen (15) days of the date of the certificate of service attached to the Motion.

If the employee attempts the projected job for less than eight cumulative hours or refuses to attempt the job, then the employer may voluntarily suspend benefits by filing a WC-2, suspending benefits with the Board with supporting documents that the employee has been released to return to work by a physician.

In cases where either a Motion to Suspend Benefits is filed or a hearing is requested based on the employee's unjustified refusal of suitable employment, the employer may also want to consider having the approved light duty job filmed by video tape. A co-worker can be filmed performing the essential job duties that have been approved by the ATP. Once the essential job duties have been videotaped, same should then be presented to the ATP for his or her approval. This type of video tape is usually very persuasive as it gives the administrative law judge and the ATP an opportunity to see the job, and it eliminates a common argument by the claimant's attorney that the ATP approved the job without fully understanding what it required.

It is also a good idea for the employer's attorney to depose the employee after the employee refuses to continue with the approved light duty job in order to pin the employee down regarding the reasons he or she is allegedly unable to perform same. The deposition cannot be scheduled until a hearing is requested. Often, the employer's attorney can "poke holes" in the employee's reasons with the assistance of the ATP's report and the video tape.

–In sum, it is always a good idea to attempt to create a light duty job pursuant to Board Rule 240 in order to push cases toward a resolution. Employees who are forced by way of Board Rule 240 to "work for their check" will be more inclined to reasonably resolve their workers' compensation claims. Otherwise, the employee can continue to draw income benefit checks without any effort on his or her part and no apparent end in sight for catastrophic cases and with only a 400-week cap for non-catastrophic cases. Therefore, it is advisable for the employer to

pay close attention and monitor an employee's medical status and keep in close contact with the ATP to ensure that the employee's work status is continuously addressed. Board Rule 240 is an effective tool which should be used every opportunity by the employer. However, close attention should be paid to all requirements as set forth above to ensure proper compliance.

7. How to Deal with Employees You Do Not Want Back on the Job.

All too often, employees who are injured on the job are also those employees whose job performance was marginal or barely satisfactory before the injury. Furthermore, many times the employees pursuing questionable workers' compensation claims are problem employees who should have never been hired by the employer. Nonetheless, once these problem employees (who are often not seriously injured) file workers' compensation claims, the claims professionals are expected to perform miracles by inexpensively resolving the claim without ever offering light duty work to the injured employee. The best way to resolve questionable injury claims (where malingering is suspected) is to offer light duty work to the employee, who many times has no desire to return to work. Such an offer significantly reduces the value of the workers' compensation claim because if the employee is capable of performing the light duty job, then the employer should ultimately be able to suspend disability benefits to the employee.

Employers should resist the temptation to terminate problem employees once they file workers' compensation claims regarding questionable injuries simply as a means of eliminating problem employees. Employers create much less exposure for themselves by dealing with the personnel issues surrounding a problem employee before a contested workers' compensation claim is pending. Employers need to understand that they can be penalized in the workers' compensation system for terminating employees when they have not fully recovered from their injuries. If an employee is fired for reasons related to his injury or work restrictions when the

employee still has not recovered from his work injury, the employer must then pay the employee temporary total disability benefits until the employee is fully recovered or returns to work with another employer earning as much as he or she did prior to the injury. However, the employee has no burden to go out and look for work with a different employer. If the employee is fired for reasons unrelated to his injury while still not recovered, then he may be entitled to payment of temporary total disability benefits if he can show that he has looked for work, but he has not been able to find other suitable light duty work because of his injury or restrictions. Thus, terminating an employee before a full recovery may mean he or she gets paid workers' compensation benefits for not working at all.

If the employee is fired for reasons relating to his or her injury or restrictions, then the employer may also be exposed to lawsuits and penalties under the Americans with Disabilities Act. One should encourage employers to make light duty jobs available even if the employer does not want to take the employee back. Light duty job offers made to suspected malingerers rarely result in long-term sustained return to work. Rather, it usually promotes settlement of the claim.

22-3. Vocational Rehabilitation

A. Introduction

Vocational Rehabilitation can be an effective tool for getting the employee back to work by assisting in modifying jobs or work stations, or in retraining or educating the employee in alternative jobs. It may also provide an impetus for settling a claim. While it is not an option for every claim, when used appropriately and effectively, vocational rehabilitation can serve to reduce workers' compensation costs by returning employees to suitable employment or promoting settlement.

Rehabilitation services are only mandatory for individuals who have sustained catastrophic injuries. O.C.G.A. §34-9-200.1. A catastrophic injury involves a spinal cord injury, multiple amputations, severe brain or closed head injury, second or third degree burns over 25 percent of the body as a whole or third degree burns to 5 percent or more of the face and hands, total or industrial blindness, or any other serious injury determined to be catastrophic by the Board. If an employee refuses to accept or cooperate with authorized rehabilitation services, benefits may be suspended only by order of the Board. See Board Rule 200.1 (e)(1). Moreover, a party or an attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services. The failure to cooperate can include (1) interference with services outlined in a Board approved rehabilitation plan; (2) failure to permit an interview between the employee and supplier within ten (10) days of a request by the supplier or other obstruction of the interview process without reasonable grounds; (3) interference with any party's or the supplier's attempts to obtain medical information; (4) failure to sign and return or object to a proposed rehabilitation plan within twenty days; or (5) the failure to attend a rehabilitation conference without good cause.

In claims involving non-catastrophic injuries, employers/insurers may voluntarily utilize qualified medical case managers to provide telephonic or field medical case management services. Qualified medical case managers must possess certification or licensure of at least one licensing agency contained in Board Rule 200.1 (I) (A). Such medical case management services may be provided at the expense of the employer/insurer. Consent of the employee or the claimant's attorney shall be required for any medical case manager to work with the injured worker. Consent shall be in writing when attending any medical appointment. Where consent is required, it may be withdrawn and the employee shall be informed in writing that such consent

may be refused. Consent of the employee shall not be required for such qualified medical case manager to contact the treating physician for purposes of assessing, planning, implementing and evaluating the options and services required to affect a cure or provide relief. All communications are subject to the provisions of Rule 200.1(II) (D). Nothing in this rule shall be construed to allow or promote utilization review on the part of the medical case manager. The medical case manager may assist with approval of job descriptions only as consistent with O.C.G.A. § 34-9-240 and Board Rule 240. Violations of this rule may be referred to the Rehabilitation Division for peer review as contemplated by Rule 200.1 (IV). Case managers may be involved in cases where the employer/insurer has contracted with a certified workers' compensation managed care organization (WC-MCO). These case managers shall operate pursuant to the provisions of O.C.G.A. §34-9-208 and Board Rule 208. Nothing contained in this Rule shall apply to a direct employee of the insurer, third party administrator or employer, or to an attorney representing a party, provided that their specific role is identified.

Board Rule 200.2.

Rehabilitation services include the goods and services necessary for vocational assessment and evaluation, guidance and counseling, vocational planning, training and placement. They also may include home or vehicle modifications that are reasonably necessary.

The Workers' Compensation Act specifically states that both the fees of rehabilitation suppliers and the reasonableness and necessity of their services shall be subject to the approval of the Board. Rehabilitation expenses should be limited to the usual, customary, and reasonable charges in Georgia, and they should not exceed the fee schedule listed under O.C.G.A. §34-9-205. The fee schedule allows an hourly rate of $75 per hour for non-catastrophic suppliers and $80 per hour for catastrophic suppliers. The fee schedule also limits the number of hours that

can be charged for certain activities. 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, then rehabilitation services may be appropriate.

Injured employees are now divided into three different groups, and their vocational rehabilitation services depend 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 rehabilitation services to those employees whose injuries are not "catastrophic" but is not required to do so.
>
> (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.

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.

B. Vocational Rehabilitation with the Employee's Agreement

Employees injured after July 1, 1992, but not catastrophically, do not have to agree to vocational rehabilitation and often do not. However, if the employee will agree to vocational rehabilitation in situations where the employer simply has no suitable work or will not take the employee back to work, vocational rehabilitation is often helpful in finding suitable work for the employee with another employer. Vocational rehabilitation suppliers can help the employee to search different sources for available jobs within the employee's restrictions. The rehabilitation supplier can also coach the employee in interviewing skills, go with the employee to job interviews, and help coordinate retraining of the employee in a new field, if necessary, thereby maximizing the employee's chances of returning to the workforce as quickly as possible.

C. Vocational Rehabilitation without the Employee's Agreement

Because employees and their attorneys sometimes do not want a successful return to the workforce since it reduces the value of the workers' compensation claim, many employees refuse to cooperate with vocational rehabilitation. When the employee will not agree to vocational rehabilitation, the employer can still employ the services of a vocational rehabilitation supplier, but the supplier cannot have any direct contact with the employee or treating physicians. The rehabilitation supplier can conduct labor market surveys and find specific jobs that are available within the employee's restrictions given by the treating physician. The rehabilitation supplier can also work with the employer to create jobs or modify existing jobs so that they are suitable for the employee's medical limitations. The rehabilitation supplier can then submit the information to the employer's attorney who conveys the information to the claimant's attorney or employee if he or she has no attorney. If the employee refuses to even apply for any of the available jobs, then the employer may request a hearing to suspend the employee's benefits

based on the availability of suitable light duty work. However, these hearings are extremely difficult to win because the Workers' Compensation administrative law judges often interpret the law in such a way that the employee has no burden to look for suitable work with other employers if the employer at the time of the accident has no light duty work available. Nevertheless, labor market surveys are often worth the risk if for no other reason than to put pressure on the employee to settle his or her claim.

If the employee does pursue and apply for the available jobs found by the vocational rehabilitation supplier, then he or she may actually get hired, thereby reducing or eliminating the employer's liability for income benefits. If the employee does not obtain a job out of those provided, additional job information can be provided periodically based on the vocational rehabilitation supplier's findings until the employee successfully obtains employment elsewhere or the case is settled.