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The 1st Report
A Workers' Compensation Update
Fall 2008

The Posted Panel of Physicians: Common Pitfalls

By Elizabeth L. Gates

By properly maintaining a posted panel of physicians, employers and insurers are able to avoid some common problems in litigated claims. The most common problems are an undesirable authorized treating physician or losing control of the injured worker's medical care completely. By simply maintaining a valid posted panel of physicians and following some simple guidelines in utilizing the panel, employers and insurers have a much better chance of maintaining control of an injured workers' medical care and more effectively moving claims towards closure. The failure to properly maintain or explain the panel of physicians to an employee invalidates the panel and allows an injured worker to treat with any physician they select at the employer's and insurer's expense; therefore, maintaining a proper panel is of great importance.

O.C.G.A. § 34-9-201 requires employers to maintain a posted panel of physicians. Specifically, O.C.G.A. § 34-9-201(b)(1) states "the employer shall maintain a list of at least six physicians or professional associations or corporations of physicians who are reasonably accessible to the employees… ." According to the Act, an employee may accept the services of a physician selected by the employer from the panel or may select another physician from the panel. The physician selected from the panel may arrange for any consultation, referral and extraordinary or other specialized medical services as the nature of the injury shall require without prior authorization from the Board; provided, however, that any medical practitioner providing services as arranged by a primary authorized treating physician under this subsection shall not be permitted to arrange for any additional referrals. *See* O.C.G.A. § 34-9-201(b)(1).

First and foremost, we must ensure employers are in conformity with the basic requirements regarding the posted panel of physicians. The most basic requirement is that a list of six physicians or professional associations must be posted somewhere on the employer's premises. Also, pursuant to O.C.G.A. § 34-9-201 (b)(1), at least one of the physicians must practice the specialty of orthopedic surgery, not more than two industrial clinics shall be included on the panel and one of the six physicians must be a minority physician. Each physician listed must also be a separate entity. Accordingly, problems often arise when two physicians in the same practice are separately listed on a panel, as they are considered to be only one physician under the Act. When two panel physicians share a physical address, it essentially serves to invalidate the panel. Also, it is important to regularly review the physicians and professional associations listed on the panel to ensure that the physicians and professional associations still practice at the address listed on the panel, and that no other circumstances have changed, such as a telephone number, which would invalidate the panel. It is also important to ensure that all of the physicians listed on the panel still accept workers' compensation patients and are willing to accept care of patients from the employer. By simply ensuring that a valid panel is in place, many potential issues can be avoided.

The second obstacle comes in properly maintaining the panel at the actual premises of the employer. O.C.G.A. § 34-9-201(c) mandates that the employer shall post the panel of physicians in prominent places upon the business premises and otherwise take all reasonable measures to ensure that employees understand the function of the panel, and are given appropriate assistance in contacting physicians off the panel. Problems often arise when the employer has a valid panel, but the panel is not actually posted in a prominent place at the employer's location. Examples of prominent places at the employer's location where a panel could be appropriately posted are a break room, on a bulletin board where announcements are posted, or any other conspicuous place where all employees are likely to look or pass by on a daily basis. If the panel is posted in a conspicuous place at the employer's location, the likelihood is that most employees will have seen the panel.

Furthermore, it is important for employers to ensure their employees are familiar with how the panel operates. An easy way to ensure that the panel is properly explained to employees is to include this process in new-hire orientation. A recommended practice for employers is to have all new employees sign a form acknowledging they have received and were explained the purpose of the panel and return that documentation to the employee's personnel file. Also, if the validity of the panel becomes the subject of litigation, a supervisor or human resources employee who conducts orientation is usually available to testify regarding how the panel was explained and where the panel is actually posted. In any event, all employers need to have some system in place to ensure that all employees are aware of the function of the posted panel of physicians.

When an injury occurs, it is important that the individual in the supervisory role who is dealing with the injury shows the panel of physicians to the injured employee and allows the employee to choose a physician from the list. In short, we need to ensure that the employee is given a choice of physicians from the panel. It is also important to offer the employee their one-time change off the panel if they inquire about a new doctor. This is usually best accomplished by having an employee circle their selection, sign and date the panel and place the document in the injured worker's personnel file.

By maintaining a properly posted panel of physicians and utilizing the panel in the proper manner, we can avoid undesirable physicians treating injured workers. We can also keep the employees with physicians we are familiar with and with whom we have a good relationship. In general, this helps move claims towards closure in a more streamlined manner. It also helps us build a relationship with the physicians on our panel and most importantly, maintaining a proper panel helps us retain control of the claimant's medical care.

For more information on this topic, please contact Elizabeth Gates at 404.888.6208 or via email at elizabeth.gates@swiftcurrie.com.

ICMS: Where We Are and Looking Ahead to the Future

By James A. Robson

On December 17, 2007, the State Board of Workers' Compensation officially implemented Phase III of the Integrated Claims Management System (ICMS). As many are aware, the purpose of ICMS is electronic document management. By using the WCONLINE interface, a registered user who is a party to the workers' compensation claim (e.g., attorneys and insurers) can not only view files that have been previously submitted online, but can now submit documents online as well. Of course, accessing documents online only applies to claims that have been placed into electronic format. For those claims filed prior to October 1, 2005, the State Board is still in the process of scanning paper files into the ICMS system. Some of these older files may never become completely electronic due to the inability to scan some of the papers that comprise a file. However, those claims filed after October 1, 2005, are exclusively electronic and are readily available for online viewing.

To initiate a new claim through online filing, an insurer/self-insurer will first file the WC-1 First Report of Injury, while a claimant will file a WC-14 Notice of Claim. After completing the appropriate fields and listing the parties to the matter, a Board Claim Number is generated and transmitted to the parties via e-mail. All subsequent filings will utilize this Claim Number so it is important for it to be included in all subsequent Board filings.

After the initial filings are made, parties are free to submit briefs, motions and Board Forms online. Of course, Board Rules still apply to filings. Therefore, a party cannot submit a brief to the Trial Division beyond 50 pages, while a Brief to the Appellate Division is still limited to 20 pages. *See* Board Rules 102(d)(1) and 103(b)(4), respectively. Should one attempt to submit a document that exceeds the maximum page limit, the document will not be accepted by the system.

Fortunately, those experiencing trouble with the new ICMS system have access to help should they encounter problems. The Division of Process Improvement & Oversight has created a Help Desk to provide information and support with functions of the WCONLINE interface. In August 2008, the Board is scheduled to implement a call management center to assist with individual questions.

Over the next few months, the Board will permit users to submit data through the Electronic Data Interchange (EDI), which will enable insurers and self-insurers to submit volumes of data electronically instead of by individual forms. In fact, the Board's intention is to make electronic submissions of the WC-1, WC-2, WC-3 and WC-4 mandatory within 18 months following the completion of the pilot program. By the second quarter of 2009, electronic filing will be mandatory for all insurers, self-insurers and group insurers, and paper forms will no longer be accepted.

These changes to form filing and document submission are certainly drastic. However, they will improve efficiency and accessibility in the long-run, which is sure to be a boon to both attorneys and insurers alike.

2008 CMS Fee Schedule

With the passage of the Medicare Improvements for Patient and Providers Act of 2008 on July 14, 2008, the Medicare Physician Fee Schedule (MPFS) has replaced the -10.6 percent rate with a .5 percent rate. Importantly, the Act is effective retroactively to July 1, 2008. Providers under the MPFS can expect to receive payment under the new .5 percent update rate in 10 business days or less.

The Medicare statute provides that Medicare will pay either a charge submitted according to the Medicare fee schedule or the submitted charges, whichever is lower. Those claims where the date of service falls on July 1 or later, with a charge at least at the level of the January 1, 2008, to July 1, 2008, the fee schedule amount will be reprocessed automatically. However, a provider submitting a lesser amount will be required to contact their local contractor for assistance in obtaining adjustments. This is also the case with non-participating physicians who submit unassigned claims at the reduced non-participation amount.

For more information on either of these topics, contact James Robson at 404.888.6231 or via email at james.robson@swiftcurrie.com.

Managing Pain Management

By S. Elizabeth Wilson

The Journal of the American Medical Association (2008) describes pain as "an unpleasant sensory and emotional experience usually arising from actual or potential tissue damage." For many, the pain associated with tissue damage or inflammation is "acute" lasting up to several weeks. "Chronic pain," or the other pain, is pain lasting more than several weeks. Chronic pain consists of pain associated with chronic medical conditions, neuropathic pain and psychogenic pain. Historically, the conventional therapy for pain was a prescription for opioids. Opioid use to manage pain associated with life shortening diseases, like cancer, has never been questioned. However, the problem arising with opioids in non-cancerous chronic pain, is the addiction and tendency for overuse. Opioid medications reduce pain by binding a variety of pain receptors in the central nervous system, including the brain and spinal cord, as well as the receptors in other parts of the body. Different types of opioids bind to different receptors causing various results in addition to the reduction of pain. Because responses to opioids can vary from person to person, and because development of tolerance can be addressed by changing a specific type of opioid, it is common for physicians to prescribe more than one opioid during a course of treatment for any given individual. The existence of multiple opioid substances, each interacting with more than one receptor, makes the prescription and management of opioids a challenge. There are several schools of thought as to the administration of these opioids. This has become a controversial subject in the workers' compensation arena as chronic, long-term use of opioids tends to be detrimental to the basic premise of workers' compensation, that is, returning the injured worker to employment. *See* Laura B. Gardner, MD, MPH, PhD, et al., *Pain Management and the Use of Opioids in the Treatment of Back Conditions in the California Workers' Compensation System* (June 2008).

It has become a priority in our business to attempt to "manage" long-term chronic pain management. Doctors are often discovering alternative methods of treating a person with a chronic acute condition who is not a surgical candidate. It is imperative the doctor not only reduce the amount of medications and/or opioids prescribed to a claimant, but address alternative methods such as physical therapy, work hardening and simple exercise. A main problem throughout chronic pain management cases is claimants may lose their ability, or will, to return to work. A claimant may become dependent on pain management drugs and develop a mindset that they will not be able to survive without them. It is imperative in cases where addiction is clearly a factor, that all parties involved rally around the ultimate goal of returning the person to work and, if possible, weaning the claimant off his/her medications.

Thus, in order to "manage" pain management cases, the employer/insurer must be cognizant from day one of the circumstances surrounding the claim. If the claimant is not a surgical candidate and has been referred for chronic pain management, the first step is to meet with the doctor and discuss a treatment plan with a reasonable end date in sight. Second, assign a nurse case manager to monitor and report all appointments and steps toward recovery. Third, always encourage the claimant to return to suitable employment. Often claimants become dependent upon not only the medications, but the actual "claim" itself. The workers' compensation claim takes on a life of its own, and once this occurs, the claimant truly believes they cannot live without the drugs. Although this is always going to be a controversial topic, pain management is one treatment area that is spiraling out of control. Often doctors will simply prescribe opioids without taking into account the long-term effects. Therefore, in order to facilitate a change, the employer/insurer must be aware of the long-term effects of overuse and be cognizant of how long each claimant has been receiving opioids in order to truly and effectively "manage" pain management.

For more information on this topic, please contact Beth Wilson at 404.888.6211 or via email at beth.wilson@swiftcurrie.com.

Recent Case Law Update

By J. David Garner

Three recent cases from the Georgia Court of Appeals have a potentially significant impact on future workers' compensation claims. Those cases are:

- *Keystone Automotive, et al. v. Hall*, 2008 GACA A08A0086 (Ga. Ct. App. 2008)
- *United Grocery Outlet, et al. v. Bennett*, 2208 GACA A08A0677 (Ga. Ct. App. June 27, 2008)
- *Parham v. Swift Transportation Co., Inc.* GACA A08A0472 (Ga. Ct. App. June 2008)

Keystone Automotive v. Hall

Keystone addresses the presumption in death cases, that the employee's job caused the death when the employee is found in a place where he might reasonably have been expected to be while in the performance of his duties, as contrasted against the requirement of medical evidence connecting the death in heart attack cases. The claimant in *Keystone* was found unconscious outside a warehouse bay door beside his truck on the employer's premises and died three weeks later, having never regained consciousness. Some medical evidence indicated that the "likely" precipitating cause of death was a heart attack while other medical evidence indicated that the claimant had "a normal heart" during his three-week hospitalization post-injury. The Court found

that because the precipitating cause of death was "far from conclusive," as a matter of law the cause of death was therefore "unknown" such that the presumption applied. It upheld the reversal of the State Board's determination of non-compensability. Certiorari to the Georgia Supreme Court has been requested in this case.

United Grocery Outlet v. Bennett

The *Bennett* case dealt with the two-year limitation period under O.C.G.A. 34-9-104(b). It has long been argued by the claimants' bar that an improper suspension of benefits tolls or suspends the two-year limitation period. It has been as strenuously argued by the defense bar that the statute runs from the last date of actual payment of TTD or TPD benefits to the claimant, regardless of whether form-filing requirements were properly complied. The *Bennett* Court held that the latter was true. The real issue, per the Court, was not whether the employer properly notified the claimant of her suspension of benefits, but whether the claimant timely brought her claim for additional benefits based on a change in condition. The Court based this holding in part on the fact that the claimant had actual knowledge of the date of the last payment of TTD/TPD benefits, and therefore no due process violation existed. Since in all such cases, actual or constructive knowledge should be rather easily established, the *Bennett* decision, for all intents and purposes, solidifies the two-year change in condition statute as running from the last date of actual payment of TTD/TPD benefits. Obviously, caution should be taken when designating payment of income benefits on Board forms, since any question as to whether payments rendered were actually TTD/TPD versus PPD may result in a different outcome. Certiorari to the Georgia Supreme Court has been requested in this case.

Parham v. Swift Transportation

The *Parham* case dealt with the evidentiary standards for medical causation. The claimant in *Parham* was working in hot, humid weather when he began feeling ill. He was taken to the emergency room where he was diagnosed with a urinary tract infection, acute renal failure and a fever of 102 degrees. The medical evidence was inconclusive as to causation. However, the claimant testified as to his level of exertion and the timing of the onset of his symptoms. The Board held the claimant's testimony as to medical causation was sufficient to establish the work conditions caused the claimant's injury. The Superior Court reversed, indicating that the Board relied on "equivocal" evidence from the claimant's physicians. The Court of Appeals reversed, stating that "[t]he ALJ and board may choose to believe the testimony of the claimant as opposed to the testimony of an expert witness." The Court therefore held the claimant was entitled to benefits.

For more information on any of the cases addressed in this article, please contact David Garner at 404.888.6213 or via email at david.garner@swiftcurrie.com.

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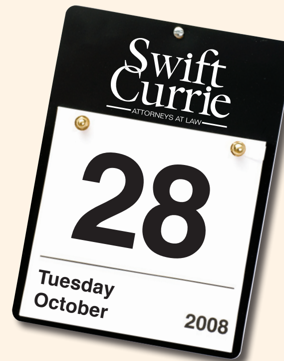

Save the Date

Fall Roadshow Luncheon
Tuesday, October 28, 2008
11:00 am - 1:15 pm
Maggiano's Buckhead

Swift Currie's Annual Property and Liability Seminar
Friday, November 7, 2008
9:30 am - 3:30 pm
Villa Christina

Joint WC Seminar with Peachtree Orthopaedic Clinic
Tuesday, November 11, 2008
11:00 am - 1:30 pm
Maggiano's Buckhead

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1355 Peachtree Street, NE • Suite 300 • Atlanta, Georgia 30309
404.874.8800 • www.swiftcurrie.com

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The First Report is edited by Charles E. Harris, IV and K. Martine Nelson. If you have any comments or suggestions for our next newsletter, please contact Chad at chad.harris@swiftcurrie.com or at 404.888.6108. You can also contact Martine at martine.nelson@swiftcurrie.com or at 404.888.6224.