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The 1st Report

A Workers' Compensation Update

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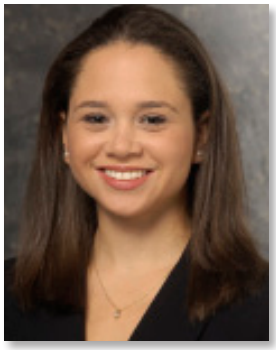
Out-of-State Accidents: When Does Georgia Have Jurisdiction?



By Ashley D. Alfonso

As a rule, Georgia retains jurisdiction for a work injury occurring within the limits of the state. However, there are cases in which the Board may exercise jurisdiction over accidents that occur outside the state, thereby enabling the employee to seek entitlement to indemnity and medical benefits under the Workers' Compensation Act. Georgia is in the majority of states which recognizes an employee may choose to file a workers' compensation claim where jurisdiction may be in one of three possible places: (1) where the injury actually occurred, (2) where the employment was primarily located, or (3) where the contract of employment was entered.

When a question arises as to whether the Georgia State Board of Workers' Compensation has jurisdiction over a claim where an accident occurred outside of the state, the Court will look to whether the facts of the claim meet the prerequisites outlined in O.C.G.A. § 34-9-242. Under O.C.G.A. § 34-9-242, the Georgia State Board of Workers' Compensation has jurisdiction over an accident which occurs outside the state if all three of the following prerequisites are met: (1) the contract of employment was made in Georgia, (2) the contract of employment was *not expressly* for services outside the state of Georgia, and (3) the employer's place of business is in Georgia *or* the claimant's residence is in Georgia. If all three of these prerequisites are present, the Board retains jurisdiction over the claim even though the injury occurred outside of Georgia.

In order to meet the first prerequisite, i.e. whether the employment contract was made in Georgia, it must first be determined whether the principle location of the employment relationship is in Georgia. *Guinn v. Conwood Corp.*, 185 Ga. App. 41, 363 S.E.2d 271 (1987). If it is, the employee is not considered "employed elsewhere than in the state" as stated in O.C.G.A. § 34-9-242, and the Court need not apply the prerequisites outlined in O.C.G.A. § 34-9-242. In contrast, if the principle location of employment is outside the state, the prerequisite of a made-in Georgia contract of employment must be satisfied. To determine whether a contract meets this prerequisite, one must look to where the contract itself was made rather than where the services were intended by the parties to take place. So, if the employer and the employee were in Georgia when the contract was executed, the employment contract is determined to be "made" in Georgia with some limited exceptions. One of those exceptions is if the employer and the employee were in different states when the contract was made. The Board will have jurisdiction over the claim if the employee tendered his acceptance of the employment contract in Georgia.

Also, the contract itself must not be for work exclusively outside of Georgia in order to meet the second prerequisite of O.C.G.A. § 34-9-242. The Board does not have jurisdiction over a contract if it was for work outside the state and if the employee did not actually engage in work within the state under the contract. O.C.G.A. § 34-9-7. In *Roadway Express, Inc. v. Warren*, 163 Ga. App. 759, 295 S.E.2d 743 (1982), the Court of Appeals noted that an employee's work was not exclusively outside the state for purposes of meeting this requirement even if "nearly" all of the employee's work occurred outside of Georgia. Moreover, Georgia properly retains jurisdiction over a claim where the original employment contract was for services exclusively outside the state, but later modified when the employee begins performing work within the state. *New Amsterdam Cas. Co. v. Thompson*, 100 Ga. App. 677, 112 S.E.2d 273 (1959).

To determine whether an employer has a place of business in Georgia, the Court will consider any place of business the employer may have in Georgia even if it is a non-resident corporation or partnership. For example, in *Aetna Cas. & Sur. Co. v. Suits*, 150 Ga. App., 256 S.E.2d 645 (1979), the Court of Appeals found the employer had a "place of business" within Georgia to satisfy O.C.G.A. § 34-9-242 based on evidence the employer operated out of a trailer in Cohutta, Georgia, where it issued paychecks to Georgia drivers and retained business records. Moreover, the employer also owned four trucks based in Georgia.

Dual Jurisdiction: Taking Two Bites of the Apple?

Although a claim may be subject to Georgia law, it does not preclude another state from also exercising jurisdiction over the same claim. An employee may file a claim for benefits in two different states, where one is the state in which he was actually injured and the other where the employment relationship was primarily located. In some instances, more than one state may have jurisdiction over the accident. *Home Insurance Co. v. Burnett*, 146 Ga. App. 355, 246 S.E.2d 394 (1978). The Georgia Workers' Compensation Act does not bar an employee from pursuing a workers' compensation claim in Georgia even if he has already pursued a claim for the same injury under the workers' compensation laws of another state. However, any benefits paid by the employer or insurer in another state are offset against any benefits that may be payable under the Georgia Workers' Compensation Act. Although the employee may pursue his claim concurrently in two states, the Board will only apply Georgia workers' compensation law when adjudicating the claim in Georgia.

For more information on this topic, contact Ashley Alfonso at 404.888.6230 or ashley.alfonso@swiftcurrie.com.

Case Law Update

By C.L. Parker

Liberty Mutual Ins. Co., v. Roark, A09A0550 Ga. Ct. App. (April 23, 2009)

In *Roark*, the Court of Appeals addressed whether Georgia's subrogation law can apply when the claimant receives workers' compensation benefits under the law of another state. The claimant was a resident of Tennessee and was working for a Tennessee corporation when he sustained compensable injuries in a car accident in Georgia. The claimant received workers' compensation benefits under Tennessee law, but subsequently filed a tort claim against the at-fault driver in the Georgia county where the accident occurred.

The insurer filed a motion to intervene in the tort suit, arguing a right to protect its subrogation lien under O.C.G.A. § 34-9-11.1. The claimant, however, argued Tennessee subrogation law applied, and under Tennessee law, the insurer did not have a right of subrogation. The Court of Appeals, in confronting this conflict of law issue, noted as the claimant was injured in Georgia, he was entitled to receive benefits under Georgia as well as Tennessee law. Under these circumstances the subrogation law of the state where the tort occurred applies. Thus, the insurer in *Roark* had a right to protect its subrogation lien under Georgia law even though the claimant received benefits under Tennessee law.

Home Depot v. Pettigrew, A09A0119 Ga. Ct. App. (June 2, 2009)

The *Pettigrew* case addresses the extent of both the Board and the Superior Court's authority. In *Pettigrew*, the claimant sustained a compensable ankle injury. Additionally, she began experiencing back pain which the treating physician attributed to changes in her gait due to her ankle injury. As a result of these conditions, she filed a request for a catastrophic designation.

After a hearing, the Administrative Law Judge issued an order finding the claimant's injury was catastrophic within the meaning of O.C.G.A. § 34-9-200.1, and that the claimant's back problems were degenerative in nature and unrelated to her compensable ankle injury. The claimant appealed the ALJ's ruling on the compensability of her back injury arguing she was not given sufficient notice this would be an issue at hearing. The Appellate Division upheld the ALJ's award finding the claimant raised the back issue in requesting a catastrophic designation and both parties were given adequate opportunity to present evidence on the compensability of her back condition.

On appeal, the Superior Court agreed with the claimant finding she did not have sufficient notice with respect to the compensability of the back injury, and she had not consented to trying the issue before the ALJ. The Court of Appeals held the Superior Court only has authority to affirm, reverse or remand for further factual findings. The Superior Court does not have authority to strike findings of fact made by the ALJ. As the evidence at hearing raised the issue of the compensability of the back condition, the Court of Appeals held the Superior Court should have remanded the issue for a further evidentiary hearing.

Strickland v. Crossmark, A09A0491 Ga. Ct. App. (June 26, 2009)

In *Strickland*, the Court of Appeals confronted the issue of the scope of the Superior Court's review. Following a hearing on compensability, the ALJ denied the claimant benefits, finding she failed to sustain her burden of proving her injury arouse out of and in the course of her employment. The ALJ further denied the claimant's request for attorney fees reasoning the employer/insurer properly controverted the claim. In response, the claimant appealed to the Appellate Division arguing, for the first time, the employer/insurer's notice to controvert was invalid under Board Rule 221. The Appellate Division vacated the ALJ's decision and remanded the case for additional proceedings on the validity of the notice to controvert. The employer/insurer appealed the Appellate Division's decision to the Superior Court. The Superior Court ruled on the issue remanding the proceedings to the Appellate Division.

Upon review, the Court of Appeals held the Superior Court lacked jurisdiction. Under the Workers' Compensation Act, only a "final" award, order, judgment or decision of the Appellate Division is subject to appeal to the Superior Court. The Court of Appeals held the Appellate Division's decision was not "final" as the Appellate Division did not make a decision on the merits, but rather remanded for additional findings, leaving the proceeding pending before the trial division.

Kroger v. Wilson, A09A1226 Ga. Ct. App. (July 8, 2009)

In *Wilson*, the Court of Appeals addressed the issue of whether the filing of a WC-14 Request for Hearing tolls the statute of limitations applicable to a request for catastrophic designation. The claimant suffered a back injury, and following surgical intervention, he received indemnity benefits. He continued to receive benefits until September 2001, when the statutory cap on benefits expired. Just under two years later, in August 2003, the claimant filed a WC-14 Request for Hearing seeking indemnity benefits from September 2001 and continuing. Subsequently, he withdrew the hearing request, and took no further action until April 2006 when he filed an Employee's Request for Catastrophic Designation form, or WC-R1CATEE, requesting that his condition be designated catastrophic. The ALJ held his request was barred by the statute of limitations O.C.G.A. § 34-9-104(b).

Upon review, the Court of Appeals noted pursuant to the recent decision of *Tara Foods v. Johnson*, 297 Ga. App. 16 (2009), the statute of limitations set forth in O.C.G.A. § 34-9-104(b) applies to requests for catastrophic designation. Thus, as a request for catastrophic designation constitutes a request for change in condition within the meaning of O.C.G.A. § 34-9-104(b), a claimant has two years from the date of his last actual payment of income benefits in which to file his claim for a catastrophic designation.

Although the claimant argued his August 2003 WC-14 Request for Hearing was sufficient to toll this statute of limitations, the Court of Appeals disagreed. The Court held the claimant's WC-14, which contained no mention of a request for catastrophic designation, merely constituted a request for indemnity benefits and did not evidence an intent to file for a catastrophic designation. Furthermore, in failing to

file a WC-R1CATEE, the form specifically-designed for such a request, he did not provide the employer and insurer the requisite notice of the issue prior to the expiration of the two-year statute of limitations. Thus, the claimant's failure to specifically request a catastrophic designation within two years of the last actual payment of benefits bars any subsequent claim for such a designation.

For more information on these cases, contact C.L. Parker at 404.888.6219 or cl.parker@swiftcurrie.com.

Practical Considerations for Optimum Handling of Claims from the Outset

By J. David Garner

There are some steps that can be taken with every claim to ensure optimum handling. Every decision made on a file, from controverting a claim to approving a medical procedure, has a cost-benefit analysis associated with it. Some decisions are difficult – whether to controvert a questionable claim and lose control of the medical, versus accepting a potentially expensive claim that is suspicious. There are simple steps that can be taken at the outset of a claim which can both reduce overall costs and ensure employers/insurers maintain control over the claim. This article will touch on a few such decisions that can help reduce costs and better manage claims.

As noted above, whether to controvert a claim at the outset is always a difficult decision. Filing a WC-3 actually controverting the claim (or noting the controvert on the WC-1) is much easier. Once a decision to controvert has been made, a WC-3 should always be filed or the WC-1 should note the claim is controverted. Timely filing the notice of controvert will help avoid penalties and attorneys' fees. Even if the decision to controvert was not made timely, filing a WC-3 is still advised. It is much easier to explain to an Administrative Law Judge why a WC-3 was filed late than to explain why one was not filed at all. If controverting a claim after first accepting it as compensable, it is important to always ensure the claimant's benefits are up-to-date and all penalties due have been paid prior to the controvert. If a claim is initially accepted and later controverted, but the claimant was not paid all benefits due (including penalties) at the time of the controvert, the controvert is invalid. 224 *Cartersville Ready Mix Co. v. Hamby*, Ga. App. 116, 479 S.E.2d 767 (1996).

Another area where unnecessary costs can be avoided is in pre-litigation discovery. Failure to respond to a WC-102 in a timely fashion is a regular occurrence. When this happens, the claimant's attorney will often file a Request for Hearing with formal discovery. Timely responding to a request for pre-hearing discovery not only avoids the potential for attorneys' fees or penalties for failing to comply with Board Rule 102(F)(1), it can avoid the costs of litigation altogether. Similarly, when a hearing is requested, ensuring a timely response is made to discovery propounded under the Civil Practice Act, and to any WC-102s previously filed will avoid the potential for sanctions for non-compliance with discovery.

Finally, in accepted claims, steps can be taken to ensure the employer/insurer maintain control of the medical. If there is a valid panel, it is important to ensure the panel was properly utilized. If the claimant expresses a desire to see another physician, offering the claimant his/her one time change of physician off the panel is essential. If the claimant is not allowed to use his/her right to a one time change off the panel, the claimant will have a stronger argument before the Board that he/she is entitled to a change of physician of their choice. As always, it is also important to keep lines of communication open with treating physicians, which can prevent claimants from engineering unwanted referrals and can also ensure treating physicians are apprised of available light duty work opportunities.

Taking certain precautions at the outset of a claim can significantly reduce costs down the road.

For more information on this topic, contact David Garner at 404.888.6213 or david.garner@swiftcurrie.com.

Subsequent Injury Trust Fund: Any Chance of Reimbursement?

By Jon W. Spencer

In Georgia, the deadline recently passed regarding requests for reimbursements from the Subsequent Injury Trust Fund (SITF). Under O.C.G.A. § 34-9-362(d), a reimbursement agreement must be obtained from the Fund by June 30, 2009, for any Notice of Claim filed with the Fund before July 1, 2006, or the claim will be statutorily denied. Thereafter, employers had 20 days to file an appeal, with the 20 days ending on July 20, 2009. Therefore, if an appeal was not filed by July 20, 2009, reimbursement is no longer a possibility. For claims on which a timely appeal was filed, there are still three ways to possibly obtain a reimbursement agreement on a claim.

The first involves claims on which a Notice of Claim was filed after July 1, 2006. For those claims, employers/insurers have three years from the date the Notice of Claim was filed in order to obtain a reimbursement agreement. O.C.G.A. § 34-9-362(e). Second, no matter when the Notice of Claim was filed, if the compensability of the workers' compensation claim is being decided by the State Board of Workers' Compensation, then employers/insurers have three years from the date of the final decision regarding compensability by the State Board of Workers' Compensation or an Appellate Court to obtain a reimbursement agreement from the Fund. Otherwise the claim for reimbursement

is statutorily denied. O.C.G.A. § 34-9-362(f). Third, although increasingly rare, there are some claims with a date of accident on or before June 30, 2006, for which a Notice of Claim has never been filed, yet may still qualify for reimbursement. According to the statute of limitation, a Notice of Claim must be filed within the later of 78 calendar weeks following the injury (this will have run in the above scenario) or **the payment of an amount equivalent to 78 weeks of income or death benefits, which ever occurs last.** O.C.G.A. § 34-9-362(a).

If an employer/insurer filed a WC-14 requesting a hearing on a claim that has been statutorily denied, there may be a five-year limitation on proving the claim under O.C.G.A. § 34-9-100. Therefore, obtaining a reimbursement agreement as soon as possible is the recommended strategy. The Subsequent Injury Trust Fund will be dissolved upon the completion of all matters provided for in its statutory resolutions, but not later than December 31, 2020.

Additionally, many questions have arisen about when the SITF will issue reimbursement checks. Because of the statutory elimination of the SITF, there has been an increase in the number of claims. The increase in claims has caused a back-log with the Fund and the Fund is working through the requests for reimbursement as they are received. Unfortunately, according to the most recent information obtained from the Fund, they are approximately nine months behind on reviewing reimbursements requests. Therefore, if an employer/insurer filed a request for reimbursement in January 2009, a reimbursement check will not likely be issued before September or October 2009.

Finally, the SITF is using an installment reimbursement program for settlements which they consider "large." While there is nothing in the old reimbursement agreements about an installment payment, the statute requires the SITF's approval of any settlement. Therefore, the Fund has decided they will reimburse in full any settlement up to $75,000 as the current back log allows (currently between 7 and 9 months). For settlements between $75,000 and $150,000, they will reimburse the first $75,000 as the current back log allows and the remaining amount will be reimbursed on the payment anniversary date 12 months later. The SITF does not require an additional filing seeking reimbursement of that amount since they will automatically issue the payment on the anniversary date of the initial installment payment. Additionally, settlements between $150,000 and $225,000 will be paid out at $75,000 for the first two years and the remainder paid on the third anniversary date. Finally, any settlement that exceeds $225,000 will be reimbursed in three equal annual installments. Again, the filing of additional requests seeking reimbursement of these settlement funds is not required beyond the initial request. However, it is advisable to calendar the dates for reimbursement of settlement funds to ensure payments are reimbursed in a timely manner.

For more information on this topic, contact Jon Spencer at 404.888.6240 or jon.spencer@swiftcurrie.com

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Swift Currie 2009 WC Seminar
"Swift Currie Night Live"
Friday, September 18, 2009
9:00 am - 3:00 pm
Cobb Energy Performing Arts Centre

Joint Litigation Seminar with McAngus, Goudelock & Courie, LLC
"A Peek in our Playbook: The Xs & Os of a Solid Defense"
Friday, October 2, 2009
8:30 am - 3:30 pm
Cobb Energy Performing Arts Centre

Swift Currie 2009 Property Seminar
Friday, November 6, 2009
More details coming soon
Villa Christina

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The First Report is edited by Charles E. Harris, IV and Elizabeth L. Gates. 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 may also contact Elizabeth at elizabeth.gates@swiftcurrie.com or at 404.888.6208.