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The 1st Report

A Workers' Compensation Update

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Assessed Attorney Fees Under the Georgia Workers' Compensation Act

By J. David Garner

As part of the regulatory scheme of the Georgia Workers' Compensation Act, assessed attorneys' fees and costs of litigation may be awarded in appropriate cases. Such assessments are designed to prevent overreaching and fraud, and encourage the parties to proceed carefully and in accordance with the statutes and Board rules.

A party may have attorneys' fees assessed against the opposing party in two circumstances. First, assessed attorneys' fees may be imposed where proceedings have been brought, prosecuted or defended in whole or in part without reasonable grounds. Second, assessed attorneys' fees may be imposed for noncompliance with any provision of Code Section 34-9-221, where noncompliance was without reasonable grounds. In addition, costs of litigation may be imposed for unreasonable prosecution or defense of a claim. Costs of litigation are statutorily limited to witness fees and mileage, reasonable expert witness fees subject to the fee schedule, reasonable deposition transcript costs and the cost of the hearing transcript. Pursuant to Rule 108, assessed attorneys' fees may only be imposed for a maximum period of 400 weeks, unless the Board in its discretion approves a period exceeding 400 weeks, in which case the fee still may not exceed 25% of the claimant's weekly benefits.

Perhaps the most common ground for assessment of attorneys' fees involves cases where one side has "unreasonably prosecuted or defended" a claim. Typically, attorneys' fees under this section are awarded where the Board finds the defense of an employer or insurer was unreasonable. Less often, but still possible, are attorneys' fee awards against claimants, where the Board finds the claimant was unreasonable in bringing or prosecuting the claim. In either event, since an assessment of attorneys' fees is largely within the discretion of the State Board, determining what is "unreasonable" is somewhat of an exercise in guesswork. However, the courts have given some guidance as to the parameters the Board must use in awarding assessed attorneys' fees.

Attorneys' fees may not be awarded where the matter is closely contested on reasonable grounds. Obviously, this standard is hardly a bright line rule. However, in the event of a close case, it is always prudent to argue to the Administrative Law Judge that the matter has been closely contested, and the factual disputes between the parties do not rise to the level of unreasonable conduct. Conflicting medical evidence is often a basis for arguing a matter is closely contested on reasonable grounds.

Since the State Board is the entity that assesses fees and litigation costs, the State Board has the burden of demonstrating to the appellate courts that the defense or prosecution was unreasonable. The State Board does not satisfy this burden merely by setting forth its own separate basis for the award, but instead must demonstrate by the record that there is "evidence upon which to base a finding of unreasonableness with respect to the employer's defense of a claim." *Pet, Inc. v. Ward*, 219 Ga. App. 525; 466 S.E.2d 46 (1995) (citations omitted). This means the State Board must render findings of fact defending the Award and these findings of fact must be based upon the record before the Board.

However, this rule requires only that the State Board demonstrate there is evidence upon which to base a finding of unreasonableness. The case law traditionally shows if the evidence as a whole demonstrates there is sufficient evidence to support a finding, such an Award will probably not be overturned on appeal.

Where a request for assessed attorneys' fees is based upon an alleged violation of, or noncompliance with, O.C.G.A. § 34-9-221, the Award must be predicated upon a determination the noncompliance was without reasonable grounds. *Union Carbide Corporation v. Coffman*, 158 Ga. App. 360, 280 S.E.2d 140. Merely engaging an attorney to enforce rights under O.C.G.A. § 34-9-221 does not entitle a party to an award of attorney's fees unless the noncompliance with O.C.G.A. § 34-9-221 was "without reasonable grounds." *Id.*

Experience demonstrates that Administrative Law Judges are not nearly so lenient with regard to violations of O.C.G.A. § 34-9-221. One example of this is failure to controvert a claim where benefits were in dispute. In such a case, it is not a great leap for the judge to rule benefits should have been paid, and even if the defense to payment of benefits was "reasonable," the failure to controvert the claim was not. Similarly, the late commencement of income benefits, even if they are ultimately paid voluntarily, is ripe for a finding that the actions of the employer and insurer were unreasonable. The Board is also likely to deem the behavior of the employer and insurer unreasonable when income benefits are suspended, but no WC-2 is filed to notify the claimant of the suspension.

Regarding the manner and amount of fees to be assessed, the Act gives the State Board discretion pursuant to O.C.G.A. § 34-9-108(b)(1) to award either *quantum meruit* fees or so-called "add-on fees." The former

is merely the reasonable value of the attorney's services, and the latter is where the Board orders the employer and insurer to pay 25% of the claimant's weekly benefit directly to the claimant's attorney, in addition to paying the entire income benefit check to the claimant. Obviously, add-on fees are typically reserved for cases involving the misconduct of an employer and insurer. The Board has discretion to assess either type of fee in any case where the facts warrant it.

Proper attention to claims handling and form filing will assist in limiting claims for assessed attorneys' fees. While assessed fees and litigation costs are almost always requested by claimant's attorneys, competent handling of the file, proper attention to detail and proper form filing will alleviate this concern in most cases. In addition, the closer the handling of the file is to "reasonable" versus "unreasonable," the more likely counsel for the employer and insurer will be able to negotiate the cost of any requested fee assessment downward.

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The Ever-Evolving Definition of "Change in Condition"

By Elizabeth L. Gates

In general, Georgia case law shows a claimant can establish a "fictional new accident" rather than a "change in condition" if there is no previous agreement or award to pay income benefits. But, in the five years since the Court of Appeals' decision in *Footstar Inc. v. Stevens*, what constitutes an "award or otherwise" so as to trigger a "change in condition" has been an ever-evolving concept, and is still not well defined by the Board and the current case law. *See* 275 Ga. App. 329 (2005), aff'd *Footstar, Inc. v. Liberty Mut. Ins. Co*., 281 Ga. 448 (2006).

In *Footstar*, the claimant had an injury while working for Footstar, Inc., on November 8, 1999. Travelers, the carrier at the time of the injury, accepted the claim as medical only. On January 1, 2001, Liberty Mutual Insurance Company replaced Travelers as the workers' compensation carrier. In August 2001, Travelers requested a hearing to determine which insurer was responsible for the cost of her continued medical care. Therefore, the Administrative Law Judge issued an Award which essentially stated the claimant sustained a compensable injury on November 8, 1999; that she was not disabled; and that the claimant had not sustained a new injury or had a new accident during Liberty Mutual's coverage. Therefore, Travelers was still responsible for her continuing medical care.

The claimant went out of work in January 2002, at which time a hearing was requested to determine whether she was entitled to income benefits, and if so, which carrier was responsible. The Administrative Law Judge found the change in condition, two-year statute of limitations under O.C.G.A. § 34-9-104(b) did not apply because Travelers never paid income benefits to Stevens. The judge concluded that if the claim was not a change in condition then a fictional new accident must be established. Accordingly, the judge determined January 5, 2002, the date Stevens left work, was a fictional date of accident. Because Liberty Mutual was the insurance carrier on that date, it was responsible for any benefits due to the injured worker.

However, the Appellate Division reversed, finding the claimant suffered a change in condition for the worse rather than a new injury. The Appellate Division reasoned the change in condition statute applies to "medical only" cases such as this, where a compensable injury had been established by award (the Administrative Law Judge's December 18, 2001 Award finding the injury was compensable.) The Appellate Division held Travelers was responsible for paying the disability and ongoing medical benefits to the claimant because it was the carrier at the time of the original injury.

Travelers argued O.C.G.A. § 34-9-104(b) (the change in condition statute) should not apply because the claimant was awarded only medical benefits. The Court of Appeals disagreed because the statutory definition of a change in condition made no reference to what type of compensation must have been awarded. Instead, only the wage earning capacity, physical condition or status of an employee that was last established by an "award or otherwise" is mentioned under O.C.G.A. § 34-9-104(a)(1). The Court of Appeals also found "an award of medical expenses is an award of compensation within the meaning of the act." Thus, the change in condition statute could apply.

In the five years since the *Footstar* decision, what constitutes a "change in condition" has evolved to possibly encompass claims to which it did not previously apply. Prior to *Footstar* it was generally accepted the change in condition statute could not apply to medical only claims because no income benefits had been paid. Now, in a medical only claim, it is certainly possible for a change in condition rather than a fictional new accident to occur where there has been an "award or otherwise." The real question that has arisen in the wake of *Footstar* is what constitutes an "award" so as to trigger a change in condition.

Since the *Footstar* decision, the higher courts in Georgia have not shed any additional light as to what constitutes an "award or otherwise." However, this is an issue the Board grapples with often in hearing claims involving a possible "change in condition" as opposed to a "fictional new accident." Given the uncertainty of what will be considered an "award or otherwise" by the Board, one must view with caution any action taken on a claim which could be construed as establishing the wage earning capacity, physical condition or status of the employee.

It is clear "award or otherwise" encompasses the payment of temporary total or temporary partial disability benefits. However, it is not clear as to whether payment of permanent partial disability benefits would constitute an "award or otherwise" so as to trigger the change in condition statute. The payment of a permanent partial disability rating is often associated with the medical portion of a claim, to which the change in condition statute does not traditionally apply. However, the *Footstar* decision leaves open the possibility a change in condition could occur in a case where permanent partial disability benefits have been

paid, but no temporary total or temporary partial disability benefits have ever been paid.

Another area of concern when dealing with the change in condition statute is consent orders. Consent orders are often used in both compensable and medical only claims to reflect the resolution of issues between the parties. However, even if a claim is medical only, a consent order would be a perfect vehicle by which a judge could find a change in condition occurred, as the consent order would act as the "award or otherwise" needed to establish the change in condition. For that reason alone, employers and insurers are cautioned about entering into consent orders.

Given the uncertainty surrounding what actions for employers and insurers will constitute an "award or otherwise" and trigger the change in condition statute, it is wise to monitor a claim closely any time there is an actual file created with the State Board. According to the current case law, merely paying medical expenses (without creating a Board record) on behalf of an employee would not constitute an "award or otherwise." But, it is certainly possible that a documented (via filing of Board forms) payment of medical expenses or permanent partial disability benefits with the Board could later constitute an "award or otherwise" sufficient to establish a change in condition for the worse.

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

Case Law Update

By Richard A. Phillips

Selective HR Solutions, Inc., et al. v. Mulligan, A10A008 Ga. Ct. App. (July 12, 2010)

In *Mulligan*, the Court of Appeals addressed Board Rule 205 and the related Form WC-205. More specifically, it addressed whether an employer's failure to timely respond to a WC-205 and the authorized treating physician's request for authorization of treatment automatically triggers a right to payment for medical care, regardless of whether or not the underlying injury is work-related. The court held insofar as Rule 205 precludes an employer from contesting compensability of treatment, it is invalid as substantive rule-making which would impermissibly shift the claimant's burden of proof to show that an injury is work-related and invades the province of the legislature.

The claimant injured her back while at work in September 2005. The claim was accepted, the claimant received medical care, recovered from her injury and returned to work in July 2006. Then, in May 2007, she re-injured her back in a fall at home, wholly unrelated to her employment. She treated with a primary care physician and explained that she had fallen through her floor. She then sought a second opinion from an orthopedist, complaining of back pain which had developed over several months. The claimant submitted the bills from that treatment to her husband's group health insurance. She later returned to her authorized treating physician for her workers' compensation claim. That physician concluded a lumbar surgery was necessary and sent a Board Form WC-205 to the insurer requesting advanced authorization pursuant to Board Rule 205 on October 26, 2007. On December 7, 2007, the insurer sent a note to the authorized treating physician stating that it would not authorize the procedure and returned the Form WC-205 on December 11, 2007, refusing to authorize the surgery absent a second opinion. The physician operated three days later.

An Administrative Law Judge denied the claimant's request for additional income benefits, finding that she had not shown a change in condition as to her September 2005 injury, and her December 2007 surgery was not compensable. The Appellate Division affirmed the decision, and on January 9, 2009, the superior court affirmed the Award of the Board by denying the change of condition claim, but reversed the Board's denial of the claimant's request for medical treatment pursuant to Rule 205. The superior court effectively ruled that while the condition may be unrelated, the employers failure to timely respond to the WC-205 made the surgery compensable

The Court of Appeals found that the superior court erred in interpreting Rule 205 as providing that an employer's failure to respond within five days to an authorized treating physician's request for advance authorization of treatment automatically triggers a right to payment for medical care whether or not the underlying injury is work-related. The court reasoned that Rule 205 had the effect of shifting the burden of proof as to compensability in favor of the claimant, and the Board did not have the power to institute such a rule. Therefore, the court reasoned, insofar as Rule 205 precludes an employer from contesting compensability of treatment, the Rule is invalid as substantive rule-making which impermissibly shifts the claimant's burden of proof to show that an injury is work-related.

S&B Engineers & Constructors, Ltd. et al. v. Bolden, A10A0226 Ga. Ct. App. (June 22, 2010)

This case in part highlights the importance of filing the WC-2 when suspending income benefits. In *Bolden*, the Court of Appeals addressed the question of whether the Board may order reinstatement of temporary total disability benefits from the date benefits were stopped based on a regular duty work release, to the date of hearing where the employer/insurer failed to properly file a WC-2. The court held this to be the case; however, where the claimant amended her request at the hearing to seek only temporary total disability benefits until the date she returned to work for a different employer, it was not proper to order payment of benefits past the date requested.

Following a compensable injury to the claimant's left hand in June 2006, the employer/insurer commenced temporary total disability benefits in November 2006. On April 9, 2007, the claimant's authorized treating physician reported she had no work-related restrictions. On April 24, 2007, the employer/insurer stopped temporary total disability benefits without filing or serving a WC-2 or otherwise notifying the claimant of the reason for the suspension of benefits. On May 9, 2008, the claimant began working for a different employer. The claimant requested a hearing seeking temporary total disability benefits from the date of

suspension forward. At the hearing, the claimant amended her request to seek temporary total disability benefits only until her May 9, 2008 return to work.

The Administrative Law Judge found that as of April 9, 2007, the claimant had no restrictions related to her work accident. However, the Administrative Law Judge also found the employer/insurer violated O.C.G.A. § 34-9-221 by failing to properly file and serve a WC- 2 reflecting the earlier suspension of benefits. Therefore, the Administrative Law Judge awarded payment of only ten additional days of benefits beyond April 9, 2007, to satisfy the notice requirement, plus a 15% late payment penalty and assessed attorney fees.

On appeal, the Appellate Division directed the employer/insurer to pay temporary total disability benefits from the date of termination until the hearing date, citing the required ten days notice. The superior court affirmed the Appellate Division. Although the Court of Appeals acknowledged the fact that the claimant had returned to work for a different employer, it did not address the issue and held that because the claimant amended her request at the hearing to seek benefits only until May 9, 2008, no evidence supported the Appellate Division's award of temporary total disability benefits up to the hearing date. Therefore, the Court of Appeals determined that because the employer/insurer did not file a WC-2, thereby failing to give ten days notice before ending its payment of income benefits, the claimant was entitled to temporary total disability benefits from the date of termination until May 9, 2008, as requested by the claimant at the hearing. Had the claimant not amended her hearing request, this case could have been decided differently.

Medical Office Management et al. v. Hardee, A09A2381 Ga. Ct. App. (March 23, 2010)

In *Hardee*, the Court of Appeals addressed the question of whether a claimant's spouse is entitled to reimbursement for attendant care provided to the claimant. The court held there is no express prohibition in the Workers' Compensation Act against attendant care services provided by a family member, including a spouse, and the Board did not err in awarding attendant care services provided by the claimant's spouse. The court noted that, as found by the appellate division, the fee schedule promulgated by the Board, pursuant to O.C.G.A. § 34-9-205, contemplates reimbursement for home health services provided by family members.

Historically, some employers and insurers have attempted to point to precedent from a 1939 case which held that an individual is not entitled to compensation for services furnished to a spouse. The *Hardee* decision reflects the more modern approach to this issue, and employers and insurers should be cognizant of this factor in their serious claims. Notably, however, the fee schedule does limit the maximum for family members providing attendant care services to $9.87 per hour (for a maximum of 12 hours daily), far less than the fee scheduled rate for an outside vendor.

For more information on these cases contact Richard Phillips at 404.888.6218 or richard.phillips@swiftcurrie.com.

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Liability Luncheon with
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Thursday, October 7, 2010
11:30 am - 2:00 pm
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Friday, November 5, 2010
More details to come
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