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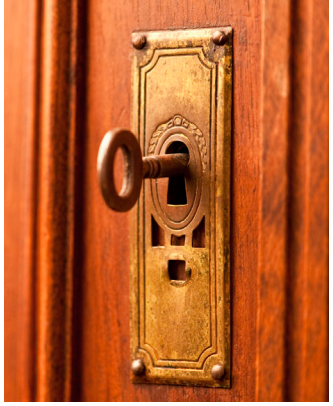

The 1st Report

A Workers' Compensation Update

Fall 2011

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Recent Board Rule Changes and Filing Procedures for ICMS/WC Online

By: Katie M. Kelley

The State Board of Workers' Compensation implemented the Integrated Claims Management System (ICMS) and Electronic Data Interchange (EDI) system in 2008. Since the system was implemented, the procedures and policies regarding form filing continue to be updated. Effective July 1, 2011, various Rules and Regulations of the State Board of Workers' Compensation were amended with respect to filing procedures applicable to ICMS and the EDI system.

The Board made the following changes with respect to EDI procedures.

1. For claims created after July 1, 2009, the filing of Board Forms WC-1, WC-2, WC-2a, WC-3 and WC-4 in paper may be rejected by the Board and may subject the filing party to a penalty.
2. When suspending benefits via EDI, the required attachments must be mailed or electronically filed with the Board prior to or simultaneously with the filing of the EDI suspension.
3. Board Rule 60(c) provides all attachments filed with the Board must contain the employee's name, date of injury and Board claim number, or the attachment will be rejected by the Board.

Thus, when a Board Form requires attachments, the attachments need to be mailed or electronically filed and must include the identifying information required by Board Rule 60(c).

In addition to EDI filings, ICMS has now been amended to allow attorneys to file Board Forms WC-1, WC-2, WC-2a, WC-3 and WC-4 via ICMS when necessary. **However, the Board has emphasized that insurers and claim offices are still required to file the forms via EDI even when attorneys have already filed the forms via ICMS.**

The Board has also implemented a new policy for assigning identification numbers to claimants. Specifically, when a valid Social Security number is not available, the WC-14 or WC-1 required to initiate a claim must be filed in paper. Once the WC-1 or WC-14 is received by the Board, a Board Tracking Number (BTN) will be assigned as an identification number in addition to the Board claim number. When a BTN is assigned, the claim number will be automatically generated in ICMS. The party filing the paper WC-14 or WC-1 will then be able to search for the BTN by using the claim number. The Board has also indicated that they can be contacted at (404) 656-3818 or 800-522-0682 with any questions or in order to obtain the BTN.

Once it has been determined that a valid Social Security number is not available, the identification number will be assigned and shown as BTN-xx-xxxx. (Previously, the first three letters of the BTN contained zeros.) Once the claim number and BTN have been assigned, then all forms may be filed and should be filed online via ICMS or EDI. In the event that a valid Social Security number is not available when a claim is originated, but then subsequently becomes available, it should be provided to the Board who will replace the BTN with the Social Security number. With respect to existing claims that have been assigned an identification number due to the unavailability of a valid Social Security number, the three zeros located at the beginning of the identification number will be replaced with the letters BTN.

In summary, these recent amendments and changes appear to address some of the ongoing issues employers and insurers have had with filing forms via EDI. The Board is now accepting mailed attachments when necessary, and this will be useful in cases where technical problems arise in trying to file the attachments electronically. Another helpful change is that counsel will now be able to file certain forms online where EDI was already established. However, it is prudent to maintain communications with counsel, if there is one assigned, to be sure that all forms are properly filed and reflected on ICMS.

For more information on this topic, contact Katie Kelley at katie.kelley@swiftcurrie.com or 404.888.6222.

O.C.G.A. § 34-9-206: *What's Going On?*

By: Matthew C. Jordan

Admittedly, when Marvin Gaye released his 1971 opus "What's Going On," he was addressing more serious issues than those presented in this article. When considering the issues that arise under the guise of O.C.G.A. § 34-9-206, however, the song's infectious chorus comes instantly to mind. Occasionally, providers in workers' compensation claims, including authorized treating physicians, utilize the provisions of O.C.G.A. § 34-9-206 when a dispute arises about the costs of medical services rendered or overdue bills. This lesser-known statute provides that:

> any party to a claim under [the Workers' Compensation Act], a group insurance company, or other health care provider who covers the costs of medical treatment for a person who subsequently files a claim under [the Workers' Compensation Act] may give notice in writing to the Board at any time during the pendency of the claim that such provider is or should be a party at interest as a result of the payments made on the employee's behalf for medical treatment.

Those seeking to become a "party at interest" must simply complete and file a Form WC-206 with supporting documentation attached. The filing must be made during the pendency of the litigation in order to be valid.

When reading the statute logically, it seems the parties that are intended protection are group health insurance carriers or other similar providers who have paid for medical treatment for what either has or may become a compensable work-related injury. At times, however, it is an *authorized treating physician* (ATP) in an accepted workers' compensation claim that seeks to become a party to a claim.

The reason most ATPs give for filing a Form WC-206 in an accepted claim is:

1. There is a dispute regarding the amount actually paid by the insurer, which could be at odds with the Georgia Workers' Compensation Fee Schedule; and/or
2. There are unpaid medical bills for treatment rendered for a compensable workers' compensation claim.

Frankly, there is scant guidance provided by the statutes or by case law regarding what impact the ATP becoming a party in the litigation has on the underlying workers' compensation claim. Such a situation, however, is cause for concern. For instance, how can the ATP remain impartial in rendering care when he has become a party to the *pending litigation*? Should that physician be removed as the ATP in this situation? It is arguable that he should. At the core of the workers' compensation system is the notion that both the employer and claimant are to be treated fairly. If the ATP, who is *supposed to be* neutral, becomes a party to the litigation, the notion of fairness fails. The only logical remedy, arguably, is the appointment of a new ATP who does not have a stake in the litigation. This can be accomplished by agreement of the parties or by a Motion filed with the Board.

Regardless of who files the Form WC-206, another issue of concern is the *amount* asserted. The form itself requires the party who seeks to become involved in the litigation to notify the Board of the specific amount it has expended on the employee's behalf for medical treatment with supporting documentation. Therefore, the amount of the interested party's reimbursement will be anchored to the information in the form. In other words, an interested party cannot place the Board on

Swift Currie Spotlight

By: R. Briggs Peery and J.C. Hillis

As a concept, the "burden of proof" is straightforward enough – it is the duty on one party to prove or disprove a matter in dispute. In workers' compensation change in condition cases, the party that alleges a change generally has the burden of proof to show the change in condition for the better or worse as the case may be. Either way, the party with the burden of proof usually has the tougher job of prevailing before the State Board.

Briggs Peery and J.C. Hillis recently prevailed in a case before the Georgia Court of Appeals that clarified who carried the burden of proof in a complicated change in condition case. *Veolia Envt. Servs. v. Vick,* 711 S.E.2d 40 (Ga. Ct. App. 2011). In the case argued by Mr. Peery and Mr. Hillis, the employee injured his left ankle in a compensable injury at work in April 2007. The employer and insurer provided medical treatment including surgery and paid income benefits when the employee was out of work. After a few months, the employee returned to light duty work whereupon the employer and insurer suspended the payment of income benefits. While working light duty, the employee was terminated in March 2008 for reasons unrelated to his work injury (he failed to advise the employer he was taking narcotic pain medicine from his personal physician, and he then failed to provide a release to return to work from that physician). The employee alleged he should have been receiving temporary partial disability during the several months that he worked light duty, and temporary total disability after his termination in March 2008.

The administrative law judge (ALJ) awarded the employee temporary partial disability benefits for the several months he worked before his termination because he met his burden to show that he

notice of one amount, then seek reimbursement for a *higher* amount after the fact. If the provider appears at a hearing with bills that are greater than they have claimed on their WC-206, they may be disappointed.

Yet another consideration is the impact on settlement if a provider is made a party to the claim. After all, closure of the file is the ultimate goal. The Board will not likely approve a settlement with a claimant while there is still an unresolved lien. The best remedy is to address and close all billing issues prior to settlement of the underlying claim.

Why is this relevant to employers and insurers? Here are some points to consider when faced with a provider intervening in the claim:

1. Were you notified *in writing* by the party at interest that a WC-206 was filed?
2. Was the WC-206 filed during pendency of the claim? If not, the Board no longer has jurisdiction to add the party or consider the dispute.
3. If the notice is timely filed, verify who is trying to become a party. If it is the ATP, find out the nature of the dispute. Have them send you the medical bills in question and have your billing department or provider "run the numbers" again to make sure the payments are correct per the Georgia Fee Schedule. You may be able to resolve it without litigation.
4. If the dispute is regarding bills from the ATP, consider trying to obtain a new ATP who is not a party to the litigation through agreement with the claimant or by filing a Motion with the Board.
5. Is settlement on the horizon? Talk with the provider and work through the dispute, if possible.

Until this issue is fully explored through litigation, the implications, particularly with regard to authorized doctors filing a WC-206, will remain unaddressed and ambiguous. With regard to this statute and its application, Mr. Gaye's poignant question shall, for the time being, remain unanswered.

For more information on this topic, contact Matt Jordan at matthew.jordan@swiftcurrie.com or 404.888.6207.

Diligent Job Search Under *Maloney v. Gordon County Farms*

By: Crystal Stevens McElrath

Maloney v. Gordon Farms, 265 Ga. 825 (1995), is a well-known and often-cited case wherein the Georgia Supreme Court relaxed part of the burden of proof which an employee bears in order to claim entitlement to indemnity benefits after being terminated from the job of injury. Prior to *Maloney,* the Supreme Court in *Hartford Accident & Indemnity Co. v. Bristol*, 242 Ga. 287 (1978), required that an employee show his inability to secure subsequent suitable employment was proximately caused by his work injury even though the prospective employer would not likely testify on the employees behalf. Even more stringent was the additional requirement under *Aden's Minit Market v. Landon*, 202 Ga. App. 219 (1991), that the employee show the uncooperative prospective employer's reasons, i.e. state of mind and motive, for not hiring him. *Maloney* overruled *Aden's*. In *Maloney*, the employee was offered a job and the offer was rescinded after the prospective employer learned of the employee's injury. Where the employee would previously have had to provide direct evidence of a connection between the timing of her rescinded job offer and her injury, had reduced income related to his work injury. The ALJ, however, found the employee did not meet his burden of proof to show entitlement to temporary total disability benefits after his termination because he was fired for reasons unrelated to his injury and did not perform an adequate job search. The ALJ, then, surprisingly, found the employer and insurer had the burden of proof to show that the employee's temporary partial disability benefits should be suspended after his termination. Furthermore, the ALJ ruled the employer and insurer failed to meet their burden of proof even though the employee's condition as partially disabled had not been established prior to hearing. The ALJ therefore awarded the employee ongoing temporary partial disability benefits after his termination.

The Appellate Division of the State Board overturned the decision of the ALJ finding the employee was not entitled to any income benefits after his termination. The Superior Court remanded the case with instructions to place the burden of proof upon the employer and insurer to prove a change in condition after the employee's termination. The employer and insurer appealed to the Georgia Court of Appeals where the decision of the Superior Court was reversed. The Court of Appeals found the employee had the burden of proving that his inability to find suitable employment elsewhere was proximately caused by his work injury in order for the award of temporary partial disability benefits to continue after his termination. Because the lower courts all agreed that the employee failed to make a sincere and diligent effort to secure employment after his termination, the Court of Appeals concluded the employee failed to meet his burden of proof and was not entitled to ongoing temporary partial disability benefits.

The employee has applied to the Supreme Court to review the decision of the Court of Appeals which was still pending as of the printing of this article.

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the Court in *Maloney* allowed for an inference to be drawn from these facts.

Maloney's relaxed burden allows the Board to use its discretion and draw reasonable inferences regarding causation from the evidence presented. That is, where an employee presents evidence of a loss of earning power resulting from a compensable injury, ongoing physical limitations and a diligent but unsuccessful job search since his or her termination, an administrative law judge may draw a reasonable inference depending on the evidence that the employee's inability to secure new employment was caused by the injury. The employee's burden of proof regarding the job search itself must still be met and there must be evidence upon which the reasonable inference is based before the employee can benefit from this relaxed standard of causation.

Since 1995, many of the cases which have applied the elements of *Maloney's* diligent job search have looked primarily, if not exclusively, at the number and timing of the job inquiries in order to determine the diligence of the employee's efforts. For instance, applying for "several" jobs in the employee's previous industry was adequate, but only sporadically applying for work on a few days over a couple of years was inadequate. There have been other cases where courts have considered factors beyond the number and timing of an employee's job, such as the types of jobs the employees have applied for, but they have been far less common.

Recently, the Appellate Division of the State Board of Workers' Compensation issued a particularly instructive decision addressing an employee's burden to prove a diligent job search. This case seems to suggest a shift toward considering a wider range of factors, many of which may benefit employers and insurers. In the unreported decision, the Appellate Division held that an employee failed to conduct a diligent job search where he alleged 110 searches over a period of 144 days. Engaging in a job search on average, of less than one a day, was less than diligent in the eyes of the Board. However, in *Maloney*, the employee alleged only six job searches, far less than the 110 alleged by the employee in the case at hand. The Board acknowledged as much and, after defining "diligent" as "steady, earnest, energetic" and "in good faith," pointed to other factors which suggested that the employee's job search was none of these.

The Appellate Division articulated a number of factors which may assist employers and insurers in defending *Maloney* claims. While it is the employee's burden to prove his or her diligent job search, an employer or insurer may argue that an employee has failed to carry this burden where the totality of the evidence does not show a diligent job search. Based on the Appellate Division's latest ruling, the employer and insurer would be wise to pay particular attention to:

1. the number of job inquiries made;
2. the timing of the employee's job inquiries;
3. the physical demands of the jobs which the employee pursued; and
4. whether the employee applied for jobs which fit his/her qualifications.

Employers and insurers should always investigate the validity of an employee's alleged job search, including confirming that the employee actually contacted the alleged employers. By investigating the alleged job search, the employer and insurer can determine if the employee accurately reported his medical condition to prospective employers.

An employer and insurer can potentially mitigate exposure by closely scrutinizing the details of an employee's alleged job search and not take it at face value. Certainly, it would be easy to assume that 110 job inquiries constituted a diligent job search, but when considered in light of other factors, this may not be the case. The employee still bears the burden to prove a diligent but unsuccessful job search, and employers and insurers ought not let an employee off the hook with anything less.

For more information, contact Crystal Stevens McElrath at 404.888.6116 or at crystal.mcelrath@swiftcurrie.com.

Events

Annual WC Seminar
"Swift Currie Film Festival"
Thursday, September 15, 2011
9:00 am - 3:00 pm
Cobb Energy Performing Arts Centre
Atlanta, GA
*4 CE Hours Offered (includes 1 ethics hour and 3 property & casualty hours)

Joint Liability Luncheon with McAngus Goudelock & Courie and Manier & Herod
Thursday, October 6, 2011
11:00 am - 2:00 pm
Hilton Garden Inn Nashville/Vanderbilt
Nashville, TN

Annual Property & Coverage Insurance Seminar
Friday, November 4, 2011
More Details to Come
Cobb Energy Performing Arts Centre
Atlanta, GA

For more information on these programs or to RSVP, visit www.swiftcurrie.com/events.

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