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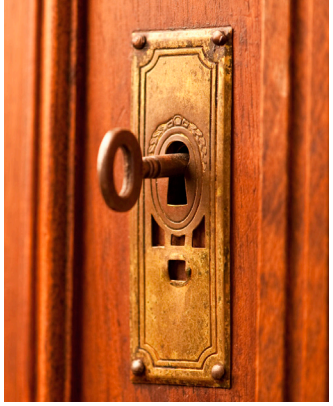

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Staring Down the Rabbit Hole of Presumption: Death Claims and the "Presumption" in WC Claims

By: Crystal Stevens McElrath

Over the years, death claims have become misleadingly synonymous with "the presumption." At times, the courts have even confused themselves when trying to determine whether the presumption of causation applies to a death claim. Frankly, distinguishing between an "immediate cause of death" and a "precipitating cause of death" can feel like trying to navigate a chaotic maze. Or perhaps, like the Lewis Carroll story which gave rise to the "rabbit hole" expression, it is better compared to a bad trip!

When an employee dies, from unknown causes, in a place and at a time where (s)he might reasonably be expected to be performing his /her job, there is a presumption that the death arose out of and in the course of the employment. Once the presumption is applied, the burden of proof shifts from the claimant to the insurer. The insurer must then show the decedent's death *did not* arise out of the employment, and this burden cannot be met by simply suggesting *possible* causes of death. *Southern Bell Telephone Company v. Hodges,* 164 Ga. App. 757 (1982).

The rationale behind the presumption—and the burden placed on the insurer—is that the death itself removes the witness best able to show causation. *General Accident Fire & Life Insurance Company v. Sturgis*, 136 Ga. App. 260 (1975). Thus, the presumption does not apply when a claimant sustains a compensable, nonfatal accident for which (s)he received disability benefits, before later dying. *Fowler v. City of Atlanta*, 116 Ga. App. 352 (1967). On the other hand, the presumption does apply where a decedent is found alive but dying, comatose or otherwise unresponsive. *General Accident Fire & Life Insurance Company v. Sturgis*, 136 Ga. App. 260 (1975); *Hartford Accident & Indemnity Company v. Trigg*, 144 Ga. App. 74 (1977).

In *Trigg*, the employee, a salesman, was found dead in his burning car. The Court of Appeals found evidence that the deceased died by an explosion of the gasoline can in his automobile. Thus, the death was not unknown or unexplained. In *Odom v. Transamerica Insurance Group*, the Court again found the presumption did not apply in the case of an employee maid found dead in a hotel room she was supposed to have cleaned. 148 Ga. App. 156 (1978). Her death certificate stated the cause of death was "cerebral vascular accident due to hypertension." Again, the death was not unexplained, but the Court acknowledged it had confused itself with its own precedents on when a death was unexplained.

In 1982, the Court of Appeals attempted to undo some confusion by parsing the term "cause of death" into "immediate" and "precipitating." *Zamora v. Coffee General Hospital*, 162 Ga. App. 82 (1982). The Court reasoned that modern medicine often determines the immediate cause of death, but may not provide answers as to what led to, or precipitated, the immediate cause of death. In *Zamora*, a maintenance engineer was found dead and it was determined he was strangled (the immediate cause of death), but the evidence did not show a precipitating cause. Ultimately, the Court determined the presumption on causation applied because it was unclear why the decedent was strangled.

For defense counsel and insurance adjusters, the precipitating cause of death is perhaps the most difficult hurdle to overcome when trying to avoid the presumption. It can be as hard to explain to our insured employers as it is to explain to the Board. Employers often want to believe that when the immediate cause of death is natural, it is the end of the claim: Case Closed, We Win! Unfortunately, this is almost never the case in reality. On the other end of the spectrum, some claimant's attorneys want to complicate cases where both the immediate and precipitating causes are known so the Board will apply the presumption. This only confuses and abuses the presumption.

Recently, Swift Currie attorneys argued just such a death claim before the Court of Appeals. The decedent was not found dead or non-communicative at his job, but rather became increasingly ill and died several days later after undergoing emergency surgery to repair an aortic dissection. The decedent's autopsy determined he died from an ischemic bowel as a

complication of, and precipitated by, an aortic dissection. The defense was straight forward: the employee's immediate and precipitating causes of death were clear based on the medical evidence; thus, the death was not unknown or unexplained and the presumption ought not apply. In this case, the death had not removed the only witness who could attest to the cause. The decedent was able to advise his doctors that he had not taken his blood pressure medications consistently. One of the claimant's theories of the case asserted that both the ischemic bowel and aortic dissection were immediate causes of death, so there was no precipitating cause of death to truly explain or establish causation. After an evidentiary hearing, the administrative law judge (ALJ) and Appellate Division of the State Board agreed with the employer/insurer. The Superior Court reversed, holding "the incident that resulted in [the decedent's] death did, in fact, occur at a time and place when he was in performance of his job duties," and thus the claimant was entitled to the presumption. The Court of Appeals reversed. Though it recognized the ALJ came to the correct conclusion, it remanded the case so the ALJ could clarify whether the precipitating cause of death was explained such that the presumption should not apply.

While recent trends in death claims seem to be moving toward very liberal applications of the presumption, a definitive, non-compensable explanation is always the best defense to death claims and the best rebuttal to the presumption. Through appropriate research, diligent discovery—including a thorough investigation of the decedent's medical background, lifestyle and relationships—and effective follow-up with the doctors, defense counsel can help insurers and employers avoid getting lost in the rabbit hole.

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

Finishing the Drill: How to Avoid Paying Additional Income Benefits Following a Full Duty Release

By: Norman L. Barnett

In workers' compensation claims where the injured worker is disabled and receiving income benefits, a major goal in the claim is to obtain a full duty release so indemnity benefits can be suspended. Adjusters and attorneys spend a great deal of time, energy and resources trying to bring injured workers back to work and the reasons why are obvious: getting an employee back on the job generally reduces exposure by ending the employer/insurer's responsibility to pay income benefits.

While getting an injured worker back to full duty work and suspending benefits is extremely important, it is also important to remember proper procedures must be followed in doing so. Otherwise, all the work done on the front end to get a favorable work status is for naught. In fact, failing to follow the proper procedures in suspending a claimant's benefits can result in the claimant being entitled to additional income benefits, even after he is considered able to return to full duty work.

An example of this can be seen in *Morgan Landscape Management v. Velez-Ochoa*, 252 Ga. App. 549 (2001), where, following a full duty work release from the claimant's authorized treating physician, the employer and insurer sus-

Computing Average Weekly Wage: Not Always Your Average Math

By: Ann M. Joiner

Effective July 1, 2013, the maximum workers' compensation rate will increase from $500.00 to $525.00 per week. Of course, before payment of any workers' compensation benefits, the computation of a claimant's average weekly wage must be performed. A claimant's workers' compensation rate is 2/3 of the average weekly wage, not to exceed the maximum rate for the claimant's date of accident.

O.C.G.A. § 34-9-260 delineates the three methods for calculating a claimant's average weekly wage and the basis for each.

The first and preferred method should be used when a claimant has worked substantially the whole of 13 weeks preceding his injury. Wages for the week of the accident are not included in the 13 weeks. The total wages are added and then divided by 13 to arrive at the claimant's average weekly wage. The Court of Appeals held 11 weeks does not constitute substantially the whole of 13 weeks. *American Fire and Casualty Company v. Davidson*, 116 Ga. App.255, 157 S.E.2d 55 (1967). If your claimant has not worked for 13 weeks immediately preceding the injury, you will need to use the second method for calculating average weekly wage.

The second method for computing average weekly wage is using 13 weeks of a similarly situated employee. This will need to be an employee who performs similar job duties as the claimant and is paid at a similar rate. Preferably, it will be an employee who has the same job title as the claimant.

If neither of the first two methods are possible, you must use the full-time weekly wage. This involves a multiplication of the hourly rate paid to the claimant under the contract of

pended the claimant's benefits by filing a WC-2, but the WC-2 did not state the correct reason why the claimant's benefits were suspended. Because the employer/insurer failed to properly notify the claimant of the reason for the suspension, they were ultimately ordered to retroactively pay income benefits to the claimant from the date of suspension through the date of the hearing, which took place many months later. The consequences of failing to file the WC-2 correctly were significant.

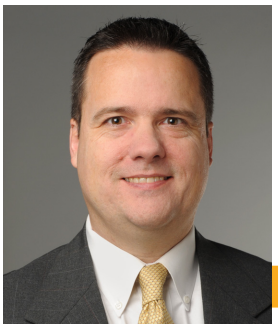
Although the employer/insurer in *Velez-Ochoa* was in a difficult position, preventing this scenario is a relatively straightforward task. The employer/insurer must take the following steps to finish the drill when suspending the claimant's benefits following a full duty work release:

* **Step 1 – Reason for suspension: Fully complete a WC-2, including the reason for the suspension of the claimant's benefits.** O.C.G.A. § 34-9-221(i); Board Rule 221(i).
* **Step 2 - Medical records: Attach medical records supporting the release without restrictions.** It is important to note the medical records accompanying the WC-2 must be from the employee's authorized treating physician, who must have examined the employee within 60 days of the date of the release. Board Rule 221(i).
* **Step 3 – File with the Board: File the WC-2 with the State Board of Workers' Compensation.** O.C.G.A. § 34-9-221(c), (h); Board Rule 221(h).
* **Step 4 - Notice: Provide notice to the claimant of the suspension of benefits at least 13 days prior to the date of the suspension by mailing the WC-2 to the claimant.** It is best to send notice by certified and regular mail. Board Rule 221 (i), O.C.G.A. § 34-9-221(i).

There have been several cases recently which have reduced the sting of the holding of *Velez-Ochoa*. However, it is not necessary to even invoke such defenses if proper procedures are followed on the front end.

Following the above steps when suspending a claimant's benefits serves to prevent multiple problems that may arise later in a claim, whether at a hearing or otherwise, and can substantially reduce overall claim exposure.

For more information on this topic, contact Norman Barnett at 404.888.6173 or norman.barnett@swiftcurrie.com.



Summary of Proposed Legislative Changes

By: J. David Garner

The 2013 legislative session of the Georgia General Assembly has passed House Bill 154, which revises portions of the Georgia Workers' Compensation Act. What follows is a brief summary of these proposed changes and their likely impact on workers' compensation claims in Georgia. The most notable change would cap medical exposure at 400 weeks for non-catastrophic injuries. O.C.G.A. § 34-9-

hire by the number of hours he was normally scheduled to work in a full-time work week. Under Rule 260(b), it is assumed that a normal work week is five days, that a normal work day is eight hours and the employee's daily wage is 1/5 of the weekly pay.

Board Rule 260(a) lists other elements to include when computing a claimant's average weekly wage. It states that salary, hourly pay, tips, bonuses, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee should all be included in the average weekly wage calculation. These additional items are included because they constitute a financial benefit to the employee and are capable of pecuniary calculation.

A WC-6 must be completed and filed with the Board when a claimant's average weekly wage results in a temporary total disability (TTD) or temporary partial disability (TPD) rate less than that of the maximum for the date of injury. The form must also be provided upon written request from the claimant and/or his counsel of record. You can file the WC-6, along with the WC-1, at the inception of the claim, or you can file it once a claimant becomes entitled to income benefits.

In order to avoid confusion, potential underpayment and the possibility for penalties later in the claim, it is best to perform the computation of an employee's average weekly wage and complete the WC-6 at the inception of a claim, even if the employee is not immediately entitled to any indemnity benefits.

It is also important to consider whether the claimant has a second or third job in addition to working for the insured. Under Board Rule 260(c), the wages paid by all similar concurrent employers shall be included in calculating a claimant's average weekly wage. As far as what concurrent employment is considered similar, that is determined on a case by case basis.

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200(a) would provide a firm cap on medical, surgical and hospital care and other treatment as contemplated in newly drafted O.C.G.A. § 34-9-200(a)(2), which provides:

> For all injuries occurring on or after July 1, 2013, that are not designated as catastrophic injuries pursuant to subsection (g) of Code Section 34-9-200.1, the employer shall, for a maximum period of 400 weeks from the date of injury, furnish the employee entitled to benefits under this chapter such medical, surgical, and hospital care and other treatment, items, and services which are prescribed by a licensed physician, including medical and surgical supplies, artificial members, and prosthetic devices and aids damaged or destroyed in a compensable accident, which in the judgment of the State Board of Workers' Compensation shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment.

While this is an obvious benefit to employers and insurers, particularly in those claims that have not yet been designated catastrophic but which have significant medical exposure, in practical terms it is unlikely to significantly affect the vast majority of claims. Under the present law, most non-catastrophic claims settle prior to the expiration of the 400-week cap, and most claims with extremely significant medical exposure eventually end up being designated catastrophic. However, for the limited number of claims that are not catastrophic, but have significant medical exposure, the 400-week cap will provide a measure of limitation on the claim value. Even for those claims that do not have significant medical exposure, the inability of the claimant to extrapolate medical costs over the life of the claim will help to limit settlement costs. Finally, the effect of this change on Medicare Set-Aside allocations could be significant. It may be possible to settle the indemnity exposure prior to a catastrophic designation, and thereby limit the Medicare Set-Aside exposure since the 400-week cap would then apply to that claim. It will remain to be seen how the Centers for Medicare and Medicaid Services will treat such cases under the new law.

Another significant proposal attempts to define a "good faith attempt" to work pursuant to O.C.G.A. § 34-9-240. Under current law, so long as an employee "attempts" a proffered light duty job for any length of time, however minimal, the employer must immediately recommence benefits and request a hearing to seek supervision. The proposed change would require that an employee attempt the light duty job for eight hours or one scheduled work day, whichever is greater. The obvious benefit of this proposed change is that it places a reasonable time period on light duty job attendance before it is considered an actual "attempt" to perform light duty work. While this does not change significantly the landscape for employers and insurers offering light duty work, since the claimant can simply work the one day and then stop working, it at least requires a minimal good faith effort of the employee before the employer and insurer are required to recommence benefits pending a hearing.

Another change constitutes the first increase in maximum income benefits allowable under the Act in six years. Under the proposed changes, the new maximum temporary total disability (TTD) rate would be $525.00 per week, and the new maximum temporary partial disability (TPD) rate would be $350.00 per week. In addition, mileage reimbursements would be due within 15 days of receipt instead of 30 under a change to O.C.G.A. § 34-9-203. This is a relatively minor change, but should be noted by claims handlers and attorneys to avoid late payment penalties. Finally, O.C.G.A. § 34-9-222 would be altered under the proposed changes to allow the Board to order lump sum payment of future benefits reduced to present value at five percent per annum, rather than seven percent.

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

Events

Joint WC Luncheons Presented with McAngus Goudelock & Courie
May 9, 2013 — Atlanta, GA
May 21, 2013 — Charlotte, NC
11:00 am - 2:15 pm

"Code-A-Palooza" — GA's New Evidence Code and Updates on Additional Litigation Topics
May 14, 2013 — Atlanta, GA
Cobb Energy Performing Arts Centre
11:00 am - 3:30 pm

Joint Coverage Luncheon Presented with McAngus Goudelock & Courie
June 4, 2013 — Charlotte, NC
Stay tuned for more information.

Catastrophic Claims Luncheon
June 21, 2013 — Atlanta, GA
Villa Christina
11:00 am - 1:30 pm

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

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