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The 1st Report

A Workers' Compensation Update

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Use of the Intoxication Defense in a Death Case

By Edwina M. Watkins

The Basics of the Rebuttable Presumption

Generally, O.C.G.A. § 34-9-17(b) bars the recovery of workers' compensation benefits to an employee's surviving spouse or dependents when the employee's death is caused by intoxication due to: 1) alcohol, 2) marijuana, or 3) a controlled substance which is not legally prescribed by a physician or not taken in accordance with that prescription. This creates a rebuttable presumption (in favor of the employer) that the death was caused by the employee's ingestion of alcohol, marijuana or the controlled substance, if the following can be shown:

- 0.08 grams or more of alcohol in the employees body within three (3) hours of the time of accident; or
- Any amount of marijuana or a controlled substance in the employee's body within eight (8) hours of the time of accident.

Of course, once the employer has the rebuttable presumption, the burden then shifts to the claimant (i.e., dependents and/or surviving spouse) to prove the employee's intoxication was not the proximate cause of the employee's death.

What to do When the Rebuttable Presumption is Not Available

Even without the rebuttable presumption, the employer can still assert the affirmative defense of intoxication. However, in this situation, the employer must now prove (by a preponderance of the evidence) that the employee was intoxicated at the time of the death and the intoxication was the proximate cause of the employee's death. In a death case, the key to successfully asserting the affirmative defense of intoxication will be witness testimony and will often involve the combination of both lay and expert witnesses. When available, lay witnesses can testify about the employee's demeanor, speech and behavior just prior to death. This evidence will be beneficial in assessing and ultimately proving the employee's intoxication. However, in death cases, there is a very good possibility there will be few, if any, lay witnesses to testify about the circumstances surrounding the claimant's death, or his demeanor, speech and behavior just prior to death. In addition to valuable lay witness testimony, an expert witness will be imperative. The expert witness should be someone licensed and credentialed to analyze the drug testing procedure and its results (e.g., forensic toxicology) and also be able to testify about the negative effects of the alcohol, marijuana or controlled substance (e.g., pharmacology) on the employee at the time of death.

For example, if the employer's defense is based upon a positive drug test for cocaine just after a fatal car crash, the expert will need to discuss the impact cocaine would have had on the employee's decision-making abilities, hand-eye coordination, reaction time, alertness and overall ability to operate a vehicle safely. Factors such as the employee's height, weight and level of tolerance for the controlled substance (i.e., whether a "casual" or "chronic" user of marijuana or some other illicit drug) will also be important. Even in regards to prescription medications, knowing the exact dosage of the prescription and whether the employee has been taking the prescription for an extended period of time can influence the expert's opinion on intoxication. Your expert witness may even be able to testify that intoxication resulted from a combination of one or more prescription medications with the ingestion of alcohol or some other illicit drug.

In deaths where a drug test demonstrates an excessively high level of a prescription medication, it may be necessary to obtain copies of the employee's pharmacy records. A deposition of the pharmacist or the staff may also help determine what safeguards, if any, the pharmacy has to verify the authenticity of prescriptions. A deposition may also help determine whether the employee exhibited "drug-seeking behavior," such as attempting to have prescriptions re-filled ahead of schedule or attempting to obtain a higher or more frequent dosage of medication than is indicated on the prescription.

Depending on when the autopsy was performed and the levels of alcohol, marijuana or other controlled substances found in the employee's body, testimony from the expert witness may also address how and at what temperature the employee's body was stored and transported prior to the autopsy; the location from where the bodily fluid or tissue samples were taken; and the quality or fluidity of the samples used for chemical analysis. For example, in the case of a fatal automobile accident, the employee may have suffered severe, bodily injuries causing the blood in the employee's lungs, heart or chest cavity to be exposed to air, which may result in clotting of the blood. Depending on the type of substance being tested for, clotted blood from the employee's chest cavity may produce inaccurate test results when compared to non-clotted blood from the employee's arm or

leg. Additionally, test results could be inaccurate if the body was not properly refrigerated while being transported or stored prior to the autopsy.

In summation, how can we increase the chances of a successful intoxication defense in a death case? Most importantly, retain a qualified expert witness early in the case. If possible, retain the individual who actually performed the drug testing and produced the toxicology reports. This will ease the burden of authenticating the documents and tendering them into evidence at a hearing. If the expert witness did not personally perform the chemical analysis, make sure he/she reviews all of the reports and is intimately familiar with the chemical analysis procedures used in your case. Finally, provide your expert witness with as much information as possible regarding the employee's medical history, prescription medications and dosage and history of alcohol and illicit drug use. Following some of the above guidelines in the defense of a death claim will assist in avoiding the potentially exponential cost of death benefits.

For more information on this topic, please contact Edwina Watkins at edwina.watkins@swiftcurrie.com or by phone at 404.888.6175.

Filing a Request/ Objection to a Change of Physician

By T. Elizabeth Fry

Generally speaking, a claimant has one authorized treating physician, chosen in the manner outlined in § O.C.G.A. 34-9-201. The treating physician may be changed by the Board, by agreement of the parties or by the employee (who is entitled to make one change of panel doctors). Either party may also request a change of physicians.

There are a number of reasons we may want to file a Request for Change of Physician: (1) to transfer a malingering claimant to a doctor who will address the problem; (2) to avoid surgery when conservative treatment may effectuate a cure; or (3) to move along a case after years of ineffective treatment with no appreciable improvement.

Presumably, both the employer/insurer and the claimant share a common goal to accomplish the Act's purpose, which is to ensure that the claimant obtains treatment "reasonably required to effect a cure, give relief or restore the employee to suitable employment." So when making a request to change doctors, there are a number of factors to which we can point, in order to demonstrate that a new doctor will more effectively achieve those goals.

Board Rule 200 outlines specific factors the Board considers when evaluating a Request:

(1) Proximity of physician's office to employee's residence
(2) Accessibility of physician to employee
(3) Excessive/redundant performance of medical procedures
(4) Necessity for specialized medical care
(5) Language barrier
(6) Referral by authorized physician
(7) Noncompliance of physician with Board Rules and procedures
(8) Panel of physicians
(9) Duration of treatment without appreciable improvement
(10) Number of prior treating physicians
(11) Prior requests for change of physician/treatment
(12) Employee released to normal duty work by current authorized treating physician
(13) Current physician indicates nothing more to offer

We should keep these factors in mind when attempting to persuade a judge that a change in physician is necessary. For example, if it is our position that a foot specialist could treat the claimant's foot injury more effectively than a general orthopedist, we should argue that the claimant would be better served by treating with a doctor who is more qualified to treat the specific injury involved in the claim.

A common obstacle for us is a claimant whose lengthy course of treatment has led to no appreciable improvement and has not returned him to work. In such cases, we should obtain a different treatment plan from a doctor (perhaps through an Independent Medical Evaluation) that we can argue is more likely to accomplish the Act's purpose of returning the claimant to work.

Claimants often file a Request for Change of Physician after the treating physician releases them to return to work. The reality is that it is very difficult to argue a successful Objection when the treating physician has released the claimant or has indicated there is nothing left to offer, and the claimant's proposed doctor recommends additional treatment. However, when this occurs, we should highlight the medical evidence which supports the treating doctor's conclusion and emphasize that the claimant's non-medical, self-serving opinion should not override that evidence. Obtaining an independent medical opinion would also be helpful in such a scenario. The claimant's preference to treat with a doctor who will keep him disabled is not a valid reason to order a change in physicians.

A claimant may also request a change to a doctor who recommends surgery, as opposed to conservative care. Under such circumstances, we should point out the current doctor's unique position to evaluate the claimant's condition. Although the proposed doctor recommends surgery, he is not as familiar with the claimant's condition as the authorized treating doctor, who has provided a course of treatment spanning numerous visits. We should then compare the current doctor's qualifications with the proposed doctor's, if this will strengthen our case. The Georgia Composite State Board of Medical Examiners website provides potentially helpful information, such as whether action has been taken against a physician's license. (http://www.medicalboard.state.ga.us/bdsearch/index.html)

One final option allows a party to request a hearing before an Administrative Law Judge on the issue of a change of physician, allowing an evidentiary hearing to be held on the matter. This may assist in obtaining additional testimony from a claimant in support of, or in objection to a change in doctors. Further, this course of action would allow for a medical deposition of the doctor, and an opportunity to obtain an independent medical opinion, if necessary.

Finally, Board Rule 200 requires that "if there has been no hearing requested, the party making the request shall make a good faith effort to reach an agreement on the change." Accordingly, we should attempt to reach an agreement with the claimant before filing a Request for Change of Physician with the Board. Likewise, if the claimant files a Request without attempting to reach an agreement with his employer, we should point that out to the Administrative Law Judge.

For more information on this topic, please contact Lisa Fry at lisa.fry@swiftcurrie.com or by phone at 404.888.6201.

Medicare Secondary Payer Enforcement: New Legislation and What it Could Mean for You

By Heidi M. Hosmer

For a long time, many considered it the general rule that Medicare's interests must only be considered in workers' compensation settlements where: 1) the Claimant is already a Medicare beneficiary; 2) the Claimant is receiving Social Security benefits (and will be eligible for Medicare within two years of receiving Social Security); or 3) where the settlement amount exceeds $250,000 and the Claimant is reasonably expected to become Medicare eligible within thirty (30) months of the date the settlement is approved. However, on July 11, 2005, CMS issued a memorandum clarifying their position concerning when Medicare's interests must be considered. Therein, CMS stated, "[t]he thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or 'safe harbor' thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and Claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered."[1]

Most recently, on December 29, 2007, President Bush signed the "Medicare, Medicaid and SCHIP Extension Act of 2007." Section 111 of the bill deals specifically with the Medicare Secondary Payer (MSP) provisions, and Paragraph eight (8) applies the MSP to Liability Insurance (including Self-Insurance), No Fault Insurance and Workers' Compensation Laws and Plans. The bill provides that beginning July 1, 2009, workers' compensation insurers and self-insurers, as well as liability insurers and self-insurers, must determine the Medicare beneficiary status on all claims. This includes unresolved (i.e. pending and litigated) claims, rather than only claims which are settled or being considered for settlement. If the claimant is entitled to Medicare benefits and/or is a Medicare beneficiary, then the insurer or self-insurer must report the identity of the claimant, along with other relevant claim identifying information, to enable a determination by CMS as to the coordination of benefits and any potential recovery. Notably, the exact reporting requirements for claim information have yet to be determined. This claim information must be submitted within a specific time frame, also yet to be determined by the Secretary, after the claim has been resolved through settlement, judgment, award or other payment. Of key importance in this legislation is the enforcement provision, which provides that failure to comply with timely reporting of the required information may result in a civil penalty of $1,000 for each day of non-compliance with respect to each claimant.

Clearly, the MSP legislation could have a substantial impact on workers' compensation and the way that claims are handled, in addition to its affect on liability and no fault claims. First, the reporting requirements apply not only to cases which are settled, or are approaching settlement, but to all pending and/or litigated claims. The timing requirements will be based on times of settlement, judgment, award and other payment, rather than only based on settlement. This could create a great deal more work for both insurers and CMS. Accordingly, this raises the question of how CMS will handle the vast influx of new claims and additional identifying information, including the tracking of timing requirements, as CMS is already slow to review and approve Medicare Set Aside proposals. It does not seem feasible that CMS, in its present structure, could handle the volume and enforcement requirements of the new MSP legislation.

The bill leaves several open-ended and unanswered questions, including the exact claim information which will be required for submission to the Secretary, as well as the time frame for submission of this information before civil penalties will be assessed. Before the Medicare, Medicaid and SCHIP Extension Act of 2007 goes into effect, these points must be clarified. However, it is clear that a greatly increased reporting burden potentially exists, on an even wider range of workers' compensation claims should this recent MSP legislation be enacted as written. In anticipation of this legislation, some insurers are taking steps to be prepared for the additional reporting requirements and are now beginning to actively assess all their pending claims for MSA potential at the outset. This course of action may be prudent if this Act goes into effect as is. We can certainly anticipate further clarification and memorandums from CMS clarifying the reporting and timing requirements as we approach the July 1, 2009, deadline.

For more information on this topic, please contact Heidi Hosmer at heidi.hosmer@swiftcurrie.com or by phone at 404.888.6143.

[1] CMS Memorandum of July 11, 2005, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions."

SWIFT TIPS

The Red Flags of Workers' Compensation
25 Warning Signs

1. News of layoffs/termination/transfer.
2. Unwitnessed accident.
3. Accident reported after a holiday, weekend or vacation.
4. Short-term employee.
5. Lack of cooperation with medical suppliers.
6. Instant lawyer retention.
7. Disciplined shortly before the accident.
8. Employee is not a "happy camper."
9. Family-owned business/family member injury.
10. Invalid documentation of eligibility to work in United States.
11. Checkered work history.
12. Grapevine news.
13. Use of doctor/chiropractor across town.
14. Attorney/chiropractor/M.D. cross-referral.
15. Lies on employment application.
16. Gap in follow-up of medical care.
17. Subjective medical history totally inconsistent with story.
18. Recent personal disability policy.
19. Prior workers' compensation claims.
20. Dirty hands (literally) at medical or rehabilitation appointment.
21. Family plan (multiple family members out on W/C, disability, etc.).
22. Longer than reasonable subjective complaints unsupported by objective tests.
23. Anonymous call.
24. Arrest record.
25. Never at home.

Ten Reasons to Close a "Dog" File

1. The claimant loves to chat with you personally – for extended periods of time.
2. Your co-workers laugh when you mention the name of the file.
3. The doctor's nurse curses you when you call.
4. It takes a hand cart to move the file.
5. Your defense attorney has retired.
6. You've been promoted – but must keep the file.
7. The employer's First Report of Injury has turned yellow.
8. It's hard to find a 1977 Code revision.
9. Vocational rehabilitation hangs up when you call.
10. Your supervisor wants updates weekly.

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Save the Date

Swift Currie's Annual Workers' Compensation Seminar
September 12, 2008
9:30 AM - 3:00 PM
Villa Christina

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

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