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The 1st Report

A Workers' Compensation Update

Spring 2009

Recent Developments Regarding the Subsequent Injury Trust Fund

By M. Ann McElroy

We are rapidly approaching a very important date with regard to requests for reimbursement from the Subsequent Injury Trust Fund (SITF). According to O.C.G.A. § 34-9-362(d), an employer or insurer only has until June 30, 2009, to obtain a reimbursement agreement from the Fund for notices of claims filed with the Fund on or before July 1, 2006, or the claim for reimbursement will be automatically denied. However, an employer or insurer has three years from the date the notice of claim was received by the Fund, if the notice of claim was filed after July 1, 2006, to obtain a reimbursement agreement before the claim for reimbursement is automatically denied. O.C.G.A. § 34-9-362(e). In addition to those provisions, if compensability of the workers' compensation claim is being decided by the State Board of Workers' Compensation, then the employer or insurer has 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 will be automatically denied. O.C.G.A. § 34-9-362(f).

An employer or insurer has 20 days from the date of the Fund's denial of the claim of reimbursement to request a hearing with the State Board of Workers' Compensation appealing the Fund's determination. O.C.G.A. § 34-9-362(g). An employer or insurer therefore has until July 20, 2009, to file a hearing request in situations where the notice of claim was filed with the Fund on or before July 1, 2006, and no reimbursement agreement has been obtained. If a hearing request is not filed, recovery from the Fund will be completely barred.

The SITF is responsible for repaying employers based on the availability of money for reimbursement. In light of the eventual elimination of the SITF, there is presently a backlog with regard to reimbursements. The number of claims has increased significantly due to the above referenced June 30, 2009 deadline, causing the reimbursement backlog to likewise increase, from $60 million on June 30, 2006, to $135 million recently. The Fund is cognizant of this issue and is working to eliminate this backlog, which was historically resolved through increased annual assessments placed upon insurers and self-insurers. However, given the phasing out of the Fund, these annual assessments have been decreased. Beginning in 2010, the annual assessments will be capped at $100 million, and this assessment level will continue until all eligible workers' compensation claims have been paid for which the Fund is responsible. O.C.G.A. § 34-9-358.

Richard McGee (SITF Administrator), David Taylor (SITF Deputy Administrator), and Luanne Clarke (Moore, Clarke, DuVall & Rodgers) comprise the Fund Advisory Committee and have devised a plan for addressing the increasing demand for settlements and reducing the current backlog. They have expressed their desire to share this information with all employers and insurers to help create a common understanding. The SITF is utilizing a new installment reimbursement program for settlements as follows:

1) A settlement of up to $75,000.00 will be reimbursed in full as the current backlog allows.

2) Settlements from $75,000.00 to $150,000.00 will be paid under an installment process with the first $75,000.00 being paid within seven (7) to eight (8) months (depending on the backlog), and the remaining installment will be automatically reimbursed on the payment anniversary date twelve (12) months later. The SITF will not require additional filing seeking reimbursement of settlement funds since the Fund will automatically issue the payment on the anniversary date of the initial installment payment.

3) Settlements of $150,000.00 to $225,000.00 will be paid at $75,000.00 per 12-month period with the second and third payments being automatically issued on the anniversary date of the prior payment.

4) Any settlements above $250,000.00 will be reimbursed in three (3) equal, annual installments.

The SITF believes that this program will help minimize costs to the insurer and self-insurer in preparing and monitoring reimbursement requests. In a case which has been approved for settlement by the SITF, any insurer or self-insurer objecting to the installment program outlined above will be invited to attend a meeting with management of the SITF to discuss the reasons behind the objection.

The good news is the annual assessments insurers and self-insurers face can be reduced or suspended by the SITF Administrator when further assessments are no longer needed. At present, there is a projected elimination of the backlog by 2015. Although they have been clear in their statements that this is only a projected date, the SITF has expressed its intent to cease assessments as soon as possible.

For more information on this topic, please contact Ann McElroy at ann.mcelroy@swiftcurrie.com or 404.888.6212.

Using Independent Medical Evaluations and Record Reviews to Move Claims

By Heidi M. Hosmer

Everyone has those pesky files that drag on and on and just will not go away. These "dog" files continue to linger with us, month after month, despite our suggestions of settlement to the claimant, attempts at surveillance and wishes for a full duty release, or even a light duty release. So what is one to do when a claim grows stagnant and just will not move?

When utilized properly, an independent medical evaluation or a records review can often help to jump-start a previously stagnant file, whether the goal is to set the stage to redirect medical treatment with a motion for a new authorized treating physician, dispute the reasonableness or necessity of a particular recommended treatment, posture the claim for a change in condition or ultimately settle the file.

An independent medical evaluation is often a great tool to help move a claim. Employers/insurers have the benefit of utilizing independent medical evaluations at their discretion, within reason, pursuant to the provisions of O.C.G.A. § 34-9-202(a), which states: "After an injury and as long as he claims compensation, the employee, if so requested by his or her employer, shall submit himself or herself to examination, at reasonable times and places, by a duly qualified physician or surgeon designated and paid by the employer or the board. Such examination may include physical, psychiatric, and psychological examinations." However, it must be noted that the provisions of O.C.G.A. § 34-9-202(a) do not extend to include functional capacity evaluations, which must be ordered by the authorized treating physician.

The employer/insurer must very carefully select the independent medical evaluator whom they will utilize to assist in moving the claim. First, one must consider what is to be gained by an independent medical evaluation: Is the employer/insurer looking for a new treating physician for the claim? Is the employer/insurer seeking an opinion regarding the necessity of a particular procedure or treatment? Is the employer/insurer seeking a full duty release and statement of maximum medical improvement for settlement or change in condition purposes? Thus, special attention must be given to the independent medical evaluator's specialty, reputation and experience. Further, the evaluator must be provided with all relevant records for review prior to the scheduled evaluation, as well as a comprehensive letter detailing the reason for the evaluation and the position which the employer/insurer is seeking to support with the evaluation. If the employer/insurer intends to propose the evaluator as the new treating doctor in an upcoming motion for change of physician, then it should also be asked of the evaluator whether he or she would be willing to assume treatment for the claimant. Notably attention must also be paid to the location of the evaluator's office in relation to the claimant's residence, as this could also become an issue in a change of physician request.

In addition to an independent medical evaluation, a records review can be utilized to assist in moving a previously stagnant claim forward. In some cases, a records review may be preferable to an independent medical evaluation, as it does not require the claimant and opposing counsel be involved, or aware, of the activity on the file. Further, if the claimant is located in another state, where the providers for independent evaluations are not as well known, or where expensive travel accommodations would be required to bring the claimant to the area for a local independent medical evaluation, a records review might be more cost effective. Particularly in cases where the question may be whether the care the claimant is currently receiving from the authorized treating physician is necessary and appropriate, a records review may be preferable. However, it must be noted that the State Board would fail to give as much weight to the opinion of a physician performing a records review when considered against a physician, or authorized treating physician, who has not only reviewed the records, but has met with a patient face-to-face, conducted an examination and made his or her own findings.

Both independent medical evaluations and records reviews can be useful tools for moving a claim in a more favorable direction. However, careful attention must also be paid to the ultimate goal as there are many factors to consider when choosing a physician for the task.

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

A Properly Timed Controvert and Deadlines Under the Act

By J.C. Hillis

Georgia statutes and case law provide two basic methods to controvert a workers' compensation claim in its entirety. Generally, one method of denying a claim applies to instances prior to the employer and insurer having commenced indemnity or weekly benefits, as set forth in O.C.G.A. § 34-9-221(d), while the other method applies to instances after the employer and insurer have commenced indemnity benefits, as set forth in O.C.G.A. § 34-9-221(h).

With respect to the first manner of controverting a claim, O.C.G.A. § 34-9-221 (d) provides "[i]f the employer controverts the right to compensation, it shall file with the board, on or before the twenty-first day after knowledge of the alleged injury or death, a notice in

accordance with the form prescribed by the board, stating that the right of compensation is controverted and stating the name of the claimant, the name of the employer, the date of the alleged injury or death, and the ground upon which the right to compensation is controverted." Ideally, the employer or insurer would file and serve form WC-1 and WC-3 stating their intention to controvert a claim within 21-days of knowledge of the alleged injury. Thoroughly filling out the WC-1 and WC-3 should fulfill the employer's and insurer's obligation to provide the information set forth in the statute.

What happens if you miss the 21-day deadline to file the WC-3 notice to controvert? The employer and insurer may be subject to monetary penalties or attorney's fees for failing to file the notice in a timely fashion. However, as long as the employer and insurer have not started paying weekly benefits, the employer and insurer do not lose their right to controvert or defend the claim on substantive grounds.

When the employer and insurer have started paying weekly benefits, generally, the second method to controvert an entire claim applies. O.C.G.A. § 34-9-221(h) provides, "[w]here compensation is being paid without an award, the right to compensation shall not be controverted except upon the grounds of change in condition or newly discovered evidence unless notice to controvert is filed with the board within 60 days of the due date of first payment of compensation." This method is more complicated and comes with several pitfalls created by case law interpreting this statute.

"Where compensation is being paid without an award," refers to instances where the employer and insurer have voluntarily started paying weekly benefits. Generally, an employer and insurer are obligated to start paying benefits within 21 days of the date of first disability when an employee has been disabled for more than seven days. Usually, O.C.G.A. § 34-9-221(h) applies when the employer and insurer start properly paying benefits within the 21-day period, but a more detailed investigation may reveal questionable circumstances surrounding the accident after the 21-day period elapses.

What if you make the decision to controvert after you have started paying weekly benefits without an award? First, you need to determine the deadline to file a notice to controvert under O.C.G.A. § 34-9-221(h). As a general rule, it is still safest to mark your calendar for 81 days after the date of accident to investigate a claim and make a determination about compensability.

Second, you should prepare a WC-3 providing notice of your reason for controverting and a WC-2 providing notice to the employee that you are going to stop paying weekly benefits because the claim is being controverted. Next, you should file and serve the WC-3 and WC-2 forms simultaneously within 60 days of the due date of first payment of compensation. This is where the real complexity with case law interpreting O.C.G.A. § 34-9-221(h) arises. In *Cartersville Ready Mix Co. v. Hamby*, the Georgia Court of Appeals ruled that for an employer and insurer to be in the position to file a valid WC-3 controverting a claim after compensation has been paid without an award, it is essential that all benefits, including penalties, be properly paid prior to the filing of the controvert. *Cartersville Ready Mix Co. v. Hamby*, 224 Ga. App. 116, 479 S.E.2d 767 (1996). Therefore, if benefits owed are not paid through the time of the filing of the WC-3 and WC-2 under O.C.G.A. § 34-9-221(h), the employer and insurer lose their right to controvert the claim except upon the grounds of change in condition or newly discovered evidence. You should insure that you have paid all of the benefits owed through the time of the filing of the WC-3 and WC-2 to protect your right to controvert the claim because the newly discovered evidence standard is high and generally difficult to overcome.

As you can imagine, not all circumstances fit neatly within the general rules above. Be sure to review your deadlines closely and fill out all forms thoroughly. Also, make sure you have investigated the claim before you make any weekly benefit payments, as the process for controverting the claim following commencement of income benefits becomes much more complicated.

For more information on this topic contact J.C. Hillis at 404.888.6209 or jc.hillis@swiftcurrie.com.

Recent Case Law Update

By Robert D. Johnson

Clarke v. Country Home Bakers, et al

In *Clarke v. Country Home Bakers, et al*, the Court of Appeals addressed whether a work release participant should be considered an "employee" as defined in O.C.G.A. § 34-9-1. A08A2032 (Ga. Ct. App. October 17, 2008). The claimant was halfway through a prison sentence when he volunteered to participate in a work release program with Country Home Bakers. While working, he suffered a significant fall resulting in hospitalization. Thereafter, he stayed in the prison infirmary until he was paroled. The insurer paid workers' compensation benefits until notified by the Department of Corrections the claimant was incarcerated. When the claimant was paroled, he filed a hearing request seeking temporary total disability benefits. The ALJ denied his claim, finding the claimant was not an "employee" who is entitled to workers' compensation benefits as defined by O.C.G.A. § 34-9-1. The Superior Court affirmed. The Court of Appeals also affirmed relying on the specific language of O.C.G.A. § 34-9-1(s), which states inmates or persons participating in work release programs are not considered an "employee" as defined under the Act while participating in work or training, or while going to and from the work or training site.

Williams v. Conagra Poultry of Athens

The Court of Appeals addressed whether a request for a catastrophic designation was a "change in condition" and thus subject to the statute of limitations in O.C.G.A. § 34-9-104(b) in *Williams v. Conagra Poultry of Athens*. A08A1854 (Ga. Ct. App. January 28, 2009). The claimant was injured in 1992 and received TTD benefits from the employer for the maximum 400 weeks which expired in April 2001. She then applied for catastrophic designation twice, in August 2002 and April 2003, and was denied both times. She applied for the third time in September 2003 and was approved. The employer requested a hearing appealing the administrative designation and the ALJ ruled the claimant was not entitled to additional income benefits because she did not submit her request within the two-year statute of limitations in O.C.G.A. § 34-9-104(b). The Court of Appeals upheld the ALJ's findings, confirming a catastrophic designation is a "change in condition" within the meaning of O.C.G.A. § 34-9-104(a) and thus, a request for additional income benefits, by catastrophic designation or otherwise, must be brought within two years of the last payment of TTD or TPD benefits.

Dekalb Board of Education v. Singleton

The Court of Appeals in *Dekalb Board of Education v. Singleton* addressed the compensability of a psychological injury triggered by asthma. A08A1181 (Ga. Ct. App. October 17, 2008). The claimant worked as a bus driver and on August 8, 2005, she suffered an asthma attack after exposure to fire extinguisher residue and cleaning products on her bus. She received medical treatment for an exacerbation of her pre-existing asthma. In December 2005, after she had been released to return to work, she complained of fears for her safety and the childrens' if she returned to work as a bus driver. She was diagnosed with adjustment disorder, anxiety and depression by several psychologists and she was terminated by the school board for abandonment of her job. She was awarded workers' compensation benefits based on a psychological injury by the ALJ, which was upheld by the Full Board and the Superior Court. The ALJ found the psychological condition compensable based on the holding of *Southwire v. George*, 266 Ga. 739, 741 (1996) finding the asthma attack contributed to the continuation of the psychic trauma and also precipitated the psychic trauma.

The School Board appealed contending the Board and Superior Court failed to apply the correct legal standard for determining whether a superadded psychic injury is compensable when there is no major psychic disability, the original psychic injury quickly resolved and there were no subsequent consistent complaints of major psychic trauma. The School Board relied on the Court's decision in *ITT Continental Baking v. Comes*, 165 Ga. App. 598, 599 (1983) that the claimant only suffered from mild depression, such that her psychological condition was not compensable. The Court of Appeals upheld the Board and the Superior Court's decision reasoning there was evidence the psychic problems were not "mild" but constituted real fears based on medical evidence in the record.

For more information on these cases contact Bobby Johnson at 404.888.6207 or bobby.johnson@swiftcurrie.com.

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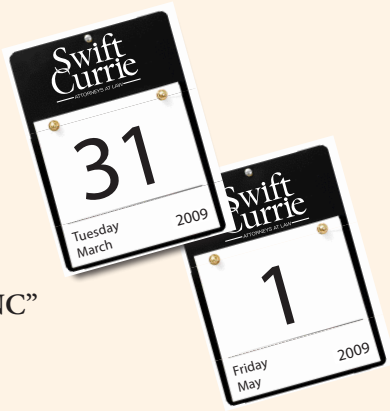
Save the Date

"WC for the Employer: How to Save $$$ and Troubles"
Thursday, March 26, 2009
8:15 am - 12:30 pm
Merry Acres, Albany, GA

"Repetitive Use Injuries"
Joint WC Program with Peachtree Orthopaedic Clinic
Tuesday, March 31, 2009
11:00 am - 2:00 pm
Maggiano's Buckhead



"You Think You've Got It Bad: Examining WC in GA, SC & NC"
Joint WC Seminar with McAngus, Goudelock & Courie, LLC
Friday, May 1, 2009
9:00 am - 3:00 pm
Cobb Energy Performing Arts Centre

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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.