Swift Currie
ATTORNEYS AT LAW
Timeless Values. Progressive Solutions.
www.swiftcurrie.com

The 1st Report
A Workers' Compensation Update
Summer 2010

Responsibility for Medical Expenses Under the Georgia Workers' Compensation Act: A Primer

By R. Alex Ficker

The question of an insurer or self-insurer's responsibility for medical expenses under the Georgia Workers' Compensation Act is a topic which generally does not receive the same quantity of analysis as indemnity benefits. However, this topic is of equal importance and significance, as informed decision making regarding medical expense issues immensely impacts virtually all aspects of a workers' compensation claim. With this in mind, please consider the following an elementary discussion of the insurer or self-insurer's responsibility for medical expenses.

To ensure payment of medical expenses is proper, one should always ask three basic questions: Who? What? When? The "who" question concerns whose expenses the insurer or self-insurer should pay. Under the Georgia Workers' Compensation Act, the insurer or self-insurer is responsible for furnishing medical benefits prescribed by a licensed physician. O.C.G.A. § 34-9-200(a). This generally involves providers from the panel of physicians, those agreed upon by the parties, or those designated by the Board to treat the injured employee, although referrals from these providers or other ancillary providers may also be authorized.

The next question is for "what" expenses the insurer or self-insurer is responsible. Under O.C.G.A. § 34-9-200(d) legitimate medical expenses include reasonable and necessary medical, surgical, hospital and rehabilitative services, as well as durable medical supplies and prostheses ordered or prescribed by authorized providers. In some cases, emergency medical services are appropriate when the injured employee requires immediate treatment, such as immediately after an accident, or in cases where the injured employee has a compelling reason which forces he or she to seek temporary care. In the case of an emergency medical expense, it is important to determine whether a genuine medical emergency existed when the employee sought treatment. For example, an employee presenting to an emergency room in order to obtain a refill on his or her medication, despite having a scheduled appointment with her authorized physician the next day, may not qualify as an "emergency."

Pursuant to Board Rule 203, medical expenses also include the reasonable cost of attendant care deemed necessary by the authorized treating physician during an employee's travel and convalescence. The employee is also entitled to reimbursement for the actual cost of meals and lodging for travel outside the employee's home city, although meal expenses are legitimate only where total travel time exceeds four hours and the total cost does not exceed $30.00 per day. Board Rule 203(e).

Mileage incurred by the employee during travel between the employee's home and place of examination or treatment, which includes physical therapy and pharmacies, is also considered a valid medical expense. Board Rule 203(d). Currently, the reimbursement rate is $0.40 per mile, and this amount remains unchanged for 2010. However, before providing reimbursement for submitted expenses, it is advisable to check both the date of the reimbursement request and the amount of mileage sought. The import of the submission date lies in a one-year limit on submissions as discussed below. With regard to the amount of mileage, the advent of direction and mapping websites on the internet allows one to determine if the mileage amount submitted is reasonable given the destination of each trip. One caveat to questioning the amount of medical mileage is the slight discrepancies between websites and the route taken. Therefore, slight discrepancies should generally not serve as a basis for denying the request for reimbursement.

Although O.C.G.A. § 34-9-200 places a limitation on the insurer or self-insurer's responsibility for medical expenses to those reasonably required and likely to effect a cure, give relief or restore the employee to suitable employment, it is important to remember the medical provisions of the Georgia Workers' Compensation Act and their "limitations" are quite broad. Therefore, one should be sure to temper their decisions regarding payment of expenses with this understanding. If any questions arise, be sure to contact counsel.

The next portion of the "what" question concerns what portion of the expense the employer or self-insurer should pay. The amount a provider may charge for a particular medical expense is limited to the usual, customary and reasonable charges, which the employer or insurer can determine by using the Fee Schedule adopted by the State Board. O.C.G.A. § 34-9-205. It is important to note the Fee Schedule also applies to copies of medical records. *See Smart Document Solutions, LLC v. Hall*, 290 Ga. App 483; 659 S.E.2d 838 (2008). Consequently, one should always consult the Fee Schedule before forwarding payment to ensure the proper payment amount.

The final basic question concerning medical expenses is "when" to pay. Under the Board Rules, the insurer or self-insurer must pay submitted expenses within 30 days of receipt of both the charges and the appropriate medical reports documenting the basis for the charges. Board Rule 203(c)

(3). If there is a legitimate reason for questioning the charges, one must provide written notice to the submitter which states why the insurer or self-insurer disputes the charges. One must forward this notice to the provider within the same 30-day window. In the event the provider or employee challenges the amount of the payment provided, they must do so within 120 days of payment. The failure to do so acts as a waiver of the right to additional payment.

The Board Rules also limit the time frame within which an employee or provider can submit the expenses. As noted above, with respect to requests for medical mileage reimbursement, the employee or provider submitting the expense for payment must do so within one year of the date of service, or within one year of the date the claim is accepted or established as compensable if the case was previously controverted. Board Rule 203(b)(1). The failure to make a timely submission acts as a waiver of the right to payment or reimbursement of these expenses. Board Rule 203(b)(1).

The requirements and strategies discussed above provide the basic tools for navigating the general issues concerning payment of medical expenses. However, a basic understanding of how to utilize these tools is essential to containing the expenses incurred in a claim, while also ensuring the legitimacy of the medical expenses submitted.

For more information on this topic contact Alex Ficker at 404.888.6215 or alex.ficker@swiftcurrie.com.

Recent Case Law Update

By M. Ann McElroy

Georgia Institute of Technology v. Hunnicutt, A10A0377 Ga. Ct. App. (April 7, 2010)

In *Hunnicutt*, the Court of Appeals addressed the question of whether the filing of a Request for Catastrophic Designation, Form WC-R1CATEE, constitutes an application for additional Temporary Total Disability (TTD) income benefits under O.C.G.A. § 34-9-104(b). Since the Court of Appeals found that the filing of a Form WC-R1CATEE constitutes an application for a "change in condition" under the plain language of O.C.G.A. § 34-9-104(b), the filing of a Form WC-R1CATEE by the claimant within 2 years of the date of the last payment of TTD income benefits was a timely application under O.C.G.A. § 34-9-104(b). Accordingly, the request for income benefits was not barred by the statute of limitations.

In *Hunnicutt*, the claimant suffered a compensable work injury on May 6, 1996. TTD benefits were paid until February 2, 2004, the maximum 400-week period from the date of injury allowed under O.C.G.A. § 34-9-261. On July 27, 2005, the claimant filed a Form WC-R1CATEE asking for her injury to be classified as catastrophic, but the request did not specifically ask for additional TTD benefits. The appellants objected to the catastrophic designation request and on May 23, 2006, the Managed Care and Rehabilitation Division of the Board issued a decision designating the claimant's injury as catastrophic. However, the decision did not specifically address income benefits.

The appellants timely appealed the decision by requesting a hearing before an Administrative Law Judge, but before a hearing was conducted, the appellants voluntarily dismissed the appeal with prejudice, and agreed to provide the claimant with rehabilitation benefits. On December 17, 2007, the claimant filed a WC-14 request for hearing seeking TTD benefits, as well as payment of outstanding medical expenses. The appellants asserted the claim for additional income benefits was barred by the two-year statute of limitations pursuant to O.C.G.A. § 34-9-104(b). At the hearing, the claimant argued that the Form WC-R1CATEE, filed on July 27, 2005, implicitly incorporated a request for TTD benefits. Alternatively, the claimant argued that the filing of the Form WC-R1CATEE tolled the statute of limitations with respect to a claim for TTD benefits. The ALJ agreed and granted the claimant's request for TTD benefits, which were to recommence as of February 1, 2004. The Appellate Division affirmed the Award.

On appeal, the Court of Appeals found that under the plain language of O.C.G.A. § 34-9-104(b) and O.C.G.A. § 34-9-200.1, a request by a claimant for the designation of her injury as "catastrophic" constitutes an application for a "change of condition" under O.C.G.A. § 34-9-104(b). The basis for this decision is that a claimant who has a catastrophic injury, as defined in O.C.G.A. § 34-9-200.1(g), shall receive weekly benefits until the claimant undergoes a change for the better. A catastrophic designation would constitute a change in condition, pursuant to O.C.G.A. § 34-9-104(b), since this designation would increase or authorize the recovery of income benefits over and beyond the 400-week maximum allotted in O.C.G.A. § 34-9-261. Thus, the Court of Appeals ruled as long as a request for catastrophic designation is filed within two years of the date of the last payment of TTD income benefits, a request for TTD income benefits is not barred by the statute of limitations.

Big Lots v. Kiker, A10A0790 Ga. Ct. App. (May 25, 2010)

The *Kiker* case addresses the question of whether a Consent Order designating a new authorized treating physician can establish a claimant's physical condition for purposes of O.C.G.A. § 34-9-104(a). The Court of Appeals found such a Consent Order did not establish the claimant's physical condition resulting from the injury "by award or otherwise."

In *Kiker*, the claimant alleged an aggravation of a preexisting lumbar condition while working as a cashier for the employer in July of 2002. In a June 2004 award, an Administrative Law Judge agreed, and deemed the claimant's injury a compensable aggravation. In December 2005, the parties entered into a Consent Order, wherein a new authorized treating physician was designated. In March of 2009, an Administrative Law Judge issued an award which ruled the claimant's aggravation of her preexisting lumbar condition had subsided, she had undergone a change in condition for the better, and she therefore was no longer entitled to receive medical benefits. The ALJ, in part, considered medical evidence which predated the 2005 Consent Order in reaching the decision. A June 2009 award of the Appellate Division affirmed.

On appeal, the Superior Court ruled the 2005 Consent Order designating a new authorized treating physician had the effect of *res judicata* (as of the date of the Consent Order), insofar as the July 2002 injury continued to be the cause of her back-related disability. As such, the Superior Court ruled only evidence subsequent to the Consent Order could be considered in determining whether a change in condition for the better had occurred. Further, the Superior Court found there was no evidence subsequent to December 2005 which would support a resolution of the 2002 back injury, and therefore benefits should continue.

The Court of Appeals found that the Superior Court erred in finding that only evidence after the December 2005 Consent Order could be considered in determining whether the claimant underwent a change of condition for the better, as the Consent Order did not establish the claimant's physical condition resulting from the injury. It may have helped that there was evidence through June 2008 showing that the claimant's injury had resolved and that the claimant's preexisting back condition had progressively worsened apart from the July 2002 injury. However, the Court of Appeals was clear in their decision that the Consent Order changing authorized treating physicians did not establish the claimant's physical condition for purposes of O.C.G.A. § 34-9-104(a), "by award or otherwise."

For more information on these cases contact Ann McElroy at 404.888.62102 or ann.mcelroy@swiftcurrie.com.

Early Claim Deadlines and Investigation

By J.C. Hillis

Employers and insurers face tight deadlines and tough decisions as it relates to conducting an initial claim investigation and determining the compensability of an alleged work-related accident. Ideally, an initial claim investigation shall include thorough review of witness statements, interviews and detailed documentation, as well as photographs or video footage. However, in practicality, we are often confronted with questionable accidents, a lack of initial documentation and/or witness testimony, and other issues which prevent a comprehensive preliminary investigation. While the initial claim deadlines are tight, the Georgia Workers' Compensation Act does provide an employer/insurer time to investigate a claim and make a determination of compensability. Familiarizing yourself with these deadlines, and the implications for each, is an important step in ensuring good decisions are made in a timely fashion.

As a preliminary matter, employees are required to provide "notice" of an accident to their employer within 30 days of the occurrence. More specifically, this "notice" must generally be to a supervisor, or someone acting in a supervisory capacity. Notice of an accident at work must only alert the employer to the *possibility* of a job-related injury and must only be such "notice that will put the employer on notice to make an investigation if the employer sees fit to do so." *Fountain v. Georgia Marble Co.*, 95 Ga. App. 21, 96 S.E.2d 656, aff'd, 213 Ga. 352, 99 S.E.2d 144 (1957). Notice of an accident must not necessarily be communicated to the person in charge of handling workers' compensation claims, but rather to a supervisor or an individual acting in a managerial capacity.

An adjuster's investigation into a claim should commence immediately upon "notice" from the employer and may differ dramatically depending on the nature of the incident, the injury and the persons involved. It is generally helpful in all claims to obtain written or verbal statements from any possible witnesses. This is true even for "cumulative" injuries alleged to have developed over a period of time. Some manner of statement from the employee alleging an injury should also be obtained, if possible. Surveillance videos should be reviewed and recordings preserved. Contact information for relevant witnesses should be obtained and communicated.

Once an employer/insurer has received "notice" of a claim, several deadlines become important. The employer and insurer have 21 days from the date of notice of the injury to either controvert the claim, or 21 days from the date of first disability to commence weekly income benefit payments. Notably, "notice" to the employer is deemed notice to the insurer, such that the 21-day timing deadline commences when an employer learns of an alleged accident, regardless of whether the employer has reported the claim to their insurer.

It is well worth your effort to make every attempt to fully investigate the claim and make a determination about compensability during this initial phase of the claim. However, even if a form controverting the claim is not filed within the 21-day limit, the employer and insurer may still deny the claim, but could face penalties for failing to properly file forms. Thus, a claim may be denied completely for an indefinite period so long as the employer or insurer have not voluntarily commenced income benefits.

If the employer and insurer voluntarily commence payment of weekly income benefits, the employer and insurer have 60 days from the *due date* of first payment of compensation to change their minds and deny the claim. Effectively, this places a deadline of 81 days from the date of first disability to deny a claim after weekly benefits have been commenced. After 81 days of paying benefits, the employer and insurer may only controvert a claim based on "newly discovered evidence."

The term "newly discovered evidence" is defined by the Georgia Code and is not intended to allow simply any evidence discovered after 81 days to fulfill the requirement to controvert. Rather, to meet the standard for "newly discovered evidence," the employer and insurer must fulfill each of five detailed elements which include: 1) that the evidence has come to the employer's and insurer's knowledge since the acceptance of the claim, 2) that it was not owing to the want of due diligence that the employer and insurer did not acquire it sooner, 3) that it is so material that it would probably produce a different result, 4) that it is not cumulative only, and 5) that the evidence does something more than only impeach the credit of a witness.

There are few workers' compensation cases which interpret the requirement of newly discovered evidence, though they reveal the standard is not easily overcome. For instance, an employer/insurer's

discovery that an employee lied about several prior back surgeries on his application was not newly discovered evidence, in part because the employer could have discovered these facts through the exercise of due diligence. A thorough review of the claimant's employment application, or discovery of the claimant's surgical scars during a pre-employment physical, should have provided notice to the employer to investigate further. In other cases, the courts have rejected as "newly discovered evidence" the cumulative testimony of witnesses. The difficulty of overcoming the "newly discovered evidence" standard is motivation enough to insure a claim is thoroughly investigated before the 81-day deadline to controvert when benefits are being paid.

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

Highlights from the Legislature

By Robert R. Potter

There were not many substantial changes to the workers' compensation provisions in the latent legislation session, though two new bills were drafted. HB 1101 was the Board sponsored bill that does essentially two things: (1) it allows the Board to publish decisions and leaves the discretion as to when, what type (ALJ or Appellate Decision, all, or select decisions of value to practitioners) and how (internally or subbed out) the decisions are to be published up to the Board and (2) it strengthens the authority of the Self Insurers Guaranty Trust Fund Board to police its own and make sure the members comply with internal protocol and pay when they should. It passed without opposition. It has been signed by the Governor and is effective July 1, 2010.

HB 1364 is the SEUS insolvency bail out bill that had a more tortured path. As originally written, it applied to SEUS and Cornerstone (though written for SEUS) and mandated that the GIIP (Georgia Insurers Insolvency Pool) cover claims by the insureds of these captive insurers if the insured made a one time payment of $5,000 into the Pool. If the insured was worth more than $25,000,000 (like cities, counties and school boards), they would pay $20,000. It passed the House in that manner, but was amended in the Senate to raise the payments ($20,000 and $100,000 respectively) and make them per claim. It also expanded the scope to cover previous claims of future captive insolvencies and remove the $25,000,000 threshold across the board. It passed the Senate 47-2. Back in the House on Day 40, the buy-ins were cut in half ($10,000 per claim and $50,000 per claim) and the other language affecting the Pool was dropped. The bill as amended passed and was agreed to by both Houses. The Governor had considerable input and pressure both to sign this bill and to veto it. He signed it. Whether there is a constitutional legal challenge by an adversely affected insurer or policyholder remains to be seen. The bill has retroactive application, is substantive in nature, and will cost traditional workers' compensation insurers and their policyholders who fund the Pool.

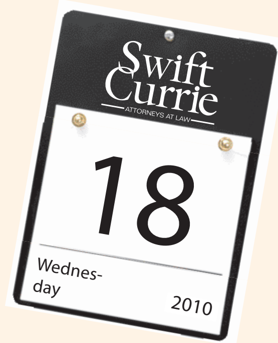
For more information contact Robert Potter at 404.888.6105 or robert.potter@swiftcurrie.com.

E-mail List

Swift Currie
The 1st Report
A Workers' Compensation Update
Summer 2010
Responsibility for Medical Expenses Under the Georgia Workers' Compensation Act: A Primer

If you would like to sign up for the E-Newsletter version of The 1st Report, please send an e-mail to info@swiftcurrie.com with "First Report" in the subject line. In the e-mail, please include your name, title, company name, mailing address, phone and fax.

Save the Date



Multi-State Breakout Session at the Florida WC Convention

Wednesday, August 18, 2010
8:45 am - 3:00 pm
Orlando World Center Marriott
Orlando, FL

Annual WC Seminar

Thursday, September 16, 2010
More details to come
Cobb Energy Performing Arts Centre

Joint Liability Luncheon

Liability luncheon with
McAngus Goudelock & Courie, LLC
Thursday, October 7, 2010
More details to come
Maggiano's Buckhead

© Swift, Currie, McGhee & Hiers, LLP
ALL RIGHTS RESERVED.

1355 Peachtree Street, NE • Suite 300 • Atlanta, Georgia 30309
404.874.8800 • www.swiftcurrie.com

Swift, Currie, McGhee & Hiers, LLP, offers these articles for informational purposes only. These articles are not intended as legal advice or as an opinion that these cases will be applicable to any particular factual issue or type of litigation. If you have a specific legal problem, please contact a Swift Currie attorney.

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 404.888.6108. or Elizabeth at elizabeth.gates@swiftcurrie.com or 404.888.6208.