

Summary of Workers' Compensation Provisions

Income Benefits

Temporary Total Disability (TTD) Benefits (O.C.G.A. § 34-9-261)

There is a seven-day "waiting period" before an employee is entitled to income benefits. The employee is entitled to income benefits for the "waiting period" if he or she is disabled for a period of 21 consecutive days.

Effective Date	7/1/01	7/1/03	7/1/05	7/1/07	7/1/13	7/1/15	7/1/16	7/1/19	7/1/22
Maximum weekly benefit	\$400	\$425	\$450	\$500	\$525	\$550	\$575	\$675	\$725
Minimum weekly benefit*	\$40	\$42.50	\$45	\$50	\$50	\$50	\$50	\$50	\$50
Total maximum benefits	\$160,000	\$170,000	\$180,000	\$200,000	\$210,000	\$220,000	\$230,000	\$270,000	\$290,000

The maximum duration of weekly benefits is 400 weeks from the date of accident except for catastrophic cases, in which there is no cap on income benefits. There is no cap on weekly benefits for accidents occurring before July 1, 1992.

*The minimum weekly benefit is the average weekly wage if the average weekly wage is less than \$50.

Temporary Partial Disability (TPD) Benefits (O.C.G.A. § 34-9-262)

Calculated by determining the difference between the employee's pre-injury average weekly wage and his post-injury earnings and multiplying that difference by two-thirds.

Effective Date	7/1/01	7/1/03	7/1/05	7/1/07	7/1/13	7/1/15	7/1/16	7/1/19	7/1/22
Maximum weekly benefit	\$268	\$284	\$300	\$334	\$350	\$367	\$383	\$450	\$483
Total maximum benefits	\$93,800	\$99,400	\$105,000	\$116,900	\$122,500	\$128,450	\$134,050	\$157,500	\$169,050

The maximum duration for TPD benefits is 350 weeks. The time period runs from date of accident.

Permanent Partial Disability (PPD) Benefits (O.C.G.A. § 34-9-263)

Permanent partial disability benefits are not due to an injured employee so long as the employee is receiving TTD or TPD benefits. Once the employee's entitlement to TTD or TPD benefits ceases, the employer/insurer have 30 days within which to have the injured employee rated for a permanent partial impairment. The employer/insurer are presumed to have knowledge of the rating not more than 10 days after the date of the report establishing the rating. Once the employer/insurer has knowledge of the rating, it must initiate payment of PPD benefits within 21 days. PPD benefits may be paid in lump sum or weekly and the method of payment is within the discretion of the employer/insurer.

Effective Date	7/1/01	7/1/03	7/1/05	7/1/07	7/1/13	7/1/15	7/1/16	7/1/19	7/1/22
Maximum weekly benefit	\$400	\$425	\$450	\$500	\$525	\$550	\$575	\$675	\$725

Maximum weekly benefits for loss of or loss of use of specific members

Member	Weeks	Member	Weeks
Arm	225	Little Finger	25
Leg	225	Great toe	30
Hand	160	Other toes	20
Foot	135	Loss of Hearing: One ear	75
Thumb	60	Loss of Hearing: Both ears	150
Index Finger	40	Loss of vision: One eye	150
Middle Finger	35	Body as a whole	300
Ring Finger	30		

Death Benefits-Payable Only to Dependents (O.C.G.A. § 34-9-265)

Dependents who are wholly dependent upon the deceased employee for income are entitled to 100 percent benefits. Income benefits to partial dependents are calculated by comparing the deceased employee's average weekly wage to contributions paid by the deceased to the partial dependents.

Effective Date	7/1/01	7/1/03	7/1/05	7/1/07	7/1/13	7/1/15	7/1/16	7/1/19	7/1/22
Maximum weekly benefit	\$400	\$425	\$450	\$500	\$525	\$550	\$575	\$675	\$725
Burial Expense	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500

\$290,000 cap for a surviving spouse without dependents within one year of death for injuries on or after 7/1/22.

Calculating an Employee's Pre-injury Average Weekly Wage (AWW)

1. The employee's earnings during the 13 weeks immediately preceding the week of the accident. This method must be utilized first if the employee worked "substantially the whole" of 13 weeks preceding the week of the accident. The 13 weeks of wages are added and then divided by 13.
2. A similarly situated employee. If the employee's AWW cannot be calculated based on the 13 week method, the employer/insurer must take the wages of a similar employee in the same employment who has worked "substantially the whole" of the 13 weeks immediately preceding the injured employee's accident.
3. Contract wage. If neither of the first two methods can be used, the employer/insurer must calculate the employee's AWW by multiplying the hourly rate by the number of hours constituting full-time employment.
4. The computation of an AWW includes hourly pay/salary, tips, food and housing furnished by the employer, bonuses and operational expenses. It does NOT include fringe benefits.

Statute of Limitations and Other Time Limits

1. File initial claim: One year from date of injury or last remedial medical treatment, unless statute is tolled.
2. Change in condition: Two years from the date of last payment of income benefits.
3. Claims for PPD benefits: Four years from date of last payment of either temporary total or temporary partial disability benefits.
4. Appeal to Appellate Division: Twenty days from date of administrative law judge (ALJ) award.
5. Appeal to Superior Court: Twenty days from date of Appellate Division award.
6. Subrogation: If an injured employee does not file suit against a third-party tortfeasor within one year, the employer/insurer may file suit and must notify the employee who then has a right to intervene. Employer/insurer's recovery limited by compensation and medical expenses actually paid and only after claimant has been "fully and completely compensated" for economic and non-economic losses. O.C.G.A. § 34-9-11.1. If employee does file suit, protect lien by intervening prior to entry of judgment.
7. Reimbursement: The Board is now empowered to order reimbursement of the overpayment of income benefits to a claimant. The request for reimbursement must be made within two years of the date the overpayment was made. O.C.G.A. § 34-9-245.
8. Peer review: Submit disputed charges to peer review within 60 days of receipt.

Notice to Controvert, Payment of Compensation and Awards, Penalties (O.C.G.A. § 34-9-221)

1. The employer/insurer must accept claim or file controvert within 21 days.
2. For accepted claims, employer/insurer must controvert within 81 days.
3. The employer/insurer may controvert a claim based on "newly discovered evidence" at any time. Based on review of certain statutory requirements, it is within the discretion of the administrative law judge to determine what constitutes "newly discovered evidence."
4. If an award is issued granting income benefits, the employer/insurer has 20 days in which to issue payment (17 days if funds are from outside Georgia). Failure to timely pay subjects the employer/insurer to a 20 percent penalty. The same rule applies to approved settlements.

Payment of Medical and Other Expenses; Returning Employee to the Doctor/Suspension of Benefits

1. For all injuries occurring on or before June 30, 2013, and for all injuries occurring on or after July 1, 2013, which are designated as catastrophic injuries pursuant to subsection (g) of Code Section 34-9-200.1, the employer shall 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.

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 that are prescribed by a licensed physician, 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. The 400-week cap does not apply to the maintenance, repair, revision, replacement or removal of any prosthetic device, spinal cord stimulator, intrathecal pain pump device, durable medical equipment, orthotics, corrective eyeglasses or hearing aids, provided that such items were originally furnished within 400 weeks of the date of injury or occupational disease arising out of and in the course of employment.

2. Properly submitted medical expenses (excluding mileage) must be paid to the provider (or to the employee if paid out of pocket) within 30 days. Failure to pay after 30 days results in a 10 percent penalty. Failure to pay after 60 days results in a 20 percent penalty. Failure to pay within 90 days results in a 20 percent penalty plus interest.
3. O.C.G.A. § 34-9-203 was amended, effective July 1, 2013, to require reimbursement for any charges for mileage incurred by the employee be paid within 15 days from the date the employer or insurer receives the charges and reports required by the Board.
4. O.C.G.A. § 34-9-203 was amended, effective July 1, 2003, to include penalties for expenses incurred "out of pocket." This section includes employee requests for mileage reimbursements. The employee has one year from the date of service to submit a request for reimbursement.
5. O.C.G.A. § 34-9-200 was amended, effective July 1, 2003, to make it abundantly clear that an employee receiving compensation has an obligation to submit to examination by the authorized treating physician. If the employee unjustifiably refuses to attend or otherwise obstructs an examination, the Board may order a suspension of benefits.

Request for Pre-authorization of Treatment or Testing

1. If pre-authorization is requested on a WC-205
 - a. Action required: Either pre-authorize or deny on WC-205 and, if denying, file Form WC-3.
 - b. Deadline: Respond to requesting medical provider by facsimile or email within five business days from date of receipt of WC-205 and file WC-3 within 21 days if denying treatment or testing.
 - c. If deadline is not met: Treatment or testing deemed pre-authorized.
2. If pre-authorization is requested by filing of WC – Petition For Medical Treatment (WC-PMT): Notice of Telephonic Conference with an ALJ is issued for a date within five days
 - a. Action required: Either pre-authorize treatment or controvert it on WC-PMT Section C or D. If one of these is done, telephonic conference with ALJ will be cancelled. If not done, parties required to participate in telephonic conference.
 - b. Following conference with ALJ: Interlocutory order may be issued addressing authorization. If it is determined authorization should be provided, the treatment may then be authorized or a hearing request objecting to interlocutory order must be filed within 20 days. If so, the hearing request will operate as a supersedeas of the order.
 - c. Where a hearing request is not timely filed: The Board will construe such non-action as consent to payment of requested medical treatment or testing.

Change in Condition: Release to Light Duty (O.C.G.A. § 34-9-104 (a)(2))

1. Send to employee and file with the State Board within 60 days of light duty release by authorized doctor
 - a. Form WC-104
 - b. Copy of medical report providing light duty restrictions
2. After 52 consecutive weeks or 78 aggregate weeks of light duty release, to reduce benefits send to employee and State Board
 - a. Form WC-2
 - b. Copy of Form WC-104
 - c. Copy of medical report

Offering a 240 Light Duty Job (O.C.G.A. § 34-9-240, Rule 240)

1. Send to employee at least 10 days before scheduled to return to work
 - a. WC-240 (send a copy of job description to employee and their counsel at time description is provided to treating physician)
 - b. Description of job, duties, hours, rate of pay
 - c. Physician approval (within 60 days)
 - d. Location, date, time of job commencement
 - e. Attaching a properly completed form WC-240 (a) will satisfy the requirements for making a proper offer of employment.
2. File with Board after refusal to return to work
 - a. WC-240 and documents sent to employee
 - b. WC-2: suspension of benefits
 - c. Statement that employee did not try job
3. Effective July 1, 2013, employer/insurer must recommence TTD if employee returns to work and attempts the job for eight cumulative hours or one scheduled workday, whichever is greater, but is unable to work 15 working days; file form WC-2 memorializing commencement with the State Board. Must also send employee copy of WC-2 reflecting commencement of benefits. Failure to immediately reinstate benefits per 240(c) shall result in waiver of employer's defense of suitability of employment for period of time the employer did not pay the weekly income benefits when due.
4. If the employee fails to attempt the proffered job, the employer/insurer may unilaterally suspend the employee's income benefits.

Georgia Workers' Compensation Forms

FORM	WHEN/WHY FILED	WHERE FILED	SUPPORTING DOCUMENTATION NEEDED
WC-1 Employer's First Report of Injury	<p>"File the 1 in every one"</p> <ul style="list-style-type: none"> Effective Jan. 1, 2019, must be filed in all claims within 10 days of employer's notice of accident Failure to file form could result in the assessment of attorneys' fees 	SBWC	Potentially a WC-6
WC-2 Notice of Payment or Suspension of Benefits	<p>"Whatever you do, file a 2"</p> <ul style="list-style-type: none"> Filed when commencing, converting, modifying or suspending benefits 	SBWC	<ul style="list-style-type: none"> Potential attachments include: full duty release, WC-104 with light duty release, WC-6 Can potentially be filed simultaneously with WC-240 and attached doctor-approved light duty job description or WC-240a
WC-3 Notice to Controvert	<ul style="list-style-type: none"> File a controvert when any portion of a claim is denied or controverted Should be filed within 21 days of notice of disability or request for medical benefits in question Failure to file form could result in the assessment of attorneys' fees 	SBWC and any other party with financial interest, including treating physician and attorneys in the claim	Medical records may be attached
WC-4 Case Progress Report	<ul style="list-style-type: none"> Must be filed annually Must be filed when case is settled or closed Basis for form is for Board to be able to monitor claim 	SBWC	None
WC-6 Wage Statement	<ul style="list-style-type: none"> Must be completed when a claimant is entitled to indemnity benefits that are less than maximum allowable rate 	SBWC	Potentially filed simultaneously with WC-1 or WC-2
WC-12 Request for Copy of Board Records	<ul style="list-style-type: none"> Filed when requesting copy of Board records to determine documents filed in current claim or any prior claims Any party who receives a copy of Board records pursuant to WC-12 shall pay invoice within 30 days of receipt 	SBWC (cannot be filed on ICMS)	None
WC-14 Notice of Claim/ Request for Hearing	<ul style="list-style-type: none"> Notice of claim can be filed to toll statute of limitations by claimant Either party may file to request a hearing on any issue at any juncture of claim 	SBWC; all parties to claim	None
WC-25 Application for Lump Sum/ Advance Payment	<ul style="list-style-type: none"> When benefits have been paid for at least 26 weeks, claimant can request lump sum or advance payment pursuant to this form Objecting party has 15 days from date of certificate of service to file objection to application for advance 	Filed at SBWC by claimant; claimant must send copy to employer/ insurer or any other interested party	Objection can be accompanied by supporting documentation
WC-100 Request for Mediation	<ul style="list-style-type: none"> To be used when party is requesting mediation Must have agreement of all parties to file 	SBWC	None
WC-102 Request Documents from Parties	<ul style="list-style-type: none"> Mechanism to request documents from parties even when claim not in litigation Must respond within 30 days of date of certificate of service; subject to penalties for failure to comply 	SBWC; opposing party from whom documents sought	None
WC-102b Notice of Representation	<ul style="list-style-type: none"> Filed by attorney for employer/insurer to indicate representation 	SBWC	None
WC-102d Motion/Objection to Motion	<ul style="list-style-type: none"> Document used to file a motion or objection to motion Response must be filed within 15 days of the date listed on the certificate of service 	SBWC; all parties to claim	Supporting written objection and/or supporting documentation including medical records
WC-104 Notice to Employee of Light Duty Release	<ul style="list-style-type: none"> Tendered to notify claimant of light duty work release and potential change in benefits Sent to claimant by employer/insurer no later than 60 days from the date of a light duty work release Results in conversion by ATP of benefits from TTD to TPD after 52 consecutive or 78 aggregate weeks of light duty releases Reduces cap from 400 weeks to 350 weeks 	Effective Jan. 1, 2014, file with the Board at the same time it is initially served on claimant and claimant's attorney. Attach to WC-2 and file with SBWC and all parties at the time of conversion.	<ul style="list-style-type: none"> Medical record reflecting light duty release Filed simultaneously with WC-2 when converting from TTD to TPD

WC-200a Change of Physician/ Additional Treatment by Consent	<ul style="list-style-type: none"> Memorializes mutual consent by the parties to a change in treating physician or agreement to additional treatment 	SBWC	None
WC-200b Request/Objection for Change of Physician/ Additional Treatment	<ul style="list-style-type: none"> Filed when one party seeks a change in physician Filed when the opposing party objects to the change in physician request Must respond within 15 days of the date on the certificate of service 	SBWC; all parties to claim	Supporting written objection and/or supporting documentation including medical records
WC-205 Request for Authorization of Treatment or Testing by Authorized Medical Provider	<ul style="list-style-type: none"> Form typically sent via fax or email by a medical provider directly to insurer/self-insurer to request specified treatment and/or procedure Insurer/self-insurer must fax or email response within five business days or the treatment or procedure is deemed approved If denying the requested treatment, a WC-3 controvert must also be filed within 21 days of the date of the WC-205 	Neither the request nor the response should be filed with the Board unless otherwise requested	None
WC-240 Notice to Employee of Offer of Suitable Employment	<ul style="list-style-type: none"> Outlines an offer of suitable light duty employment to an employee on disability benefits (not necessary if they voluntarily return to work) Follows approval of a light duty job description by the ATP (job description must be sent to claimant and claimant's attorney at time it is tendered to the treating physician) Must be sent to employee at least 10 days prior to return to work date and to attorney if represented Should include essential duties of job, pay rate, hours/days to be worked, location and date/time to report to work 	WC-2 and WC-240 should be filed with Board when benefits actually suspended; also send to all parties to claim	<ul style="list-style-type: none"> Should be sent to the employee with a copy of the job description and a copy of the physician's approval of the light duty job When suspending, a WC-2 should be filed with the WC-240 and physician's approval of the light duty job attached
WC-240a Job Analysis	<ul style="list-style-type: none"> To be completed by an employer providing specific information about a light duty job Not required, but recommended 	SBWC; all parties to claim	Can be attached to a WC-240 job offer
WC-243 Credit	<ul style="list-style-type: none"> Employer/insurer is entitled to a dollar-for-dollar credit for benefits paid unemployment, disability plan, wage continuation plan or disability insurance Must be filed with SBWC no less than 10 days prior to hearing 	SBWC; all parties to claim	None
WC-PMT	<ul style="list-style-type: none"> Filed by claimant to force employer/insurer to show cause as to why a particular treatment/testing recommended by an authorized medical provider has not been authorized Telephonic "show cause" conference is set with ALJ not more than five business days from date of filing Employer/insurer can authorize or controvert treatment/testing by filing a response and completing Section C or D, which cancels telephonic conference 	SBWC; all parties to claim	None
WC-PMT(b)	<ul style="list-style-type: none"> Filed by employer/insurer to force the employee to show cause as to why an order should not be issued directing him/her to attend an appointment with an authorized medical provider Telephonic "show cause" conference is set with ALJ not more than five business days from date of filing Employee can agree to attend appointment and file response, completing Section C If employee fails to attend, employer/insurer can file Section D of the WC-PMT(b), which sets additional conference for employee to show cause as to why benefits should not be suspended 	SBWC; all parties to claim	Attached documentation showing the employer/insurer <u>or</u> ATP gave the employee notice of the appointment
WC-R1 Request for Rehabilitation	Employer/insurer shall file in the following instances: <ul style="list-style-type: none"> Within 48 hours of catastrophic acceptance designating catastrophic supplier To request a rehab supplier To request reopening of rehabilitation Upon request of the SBWC 	SBWC	WC-1 naming catastrophic supplier
WC-RICATEE Employee Request for Catastrophic Designation	<ul style="list-style-type: none"> Filed by employee when employer/insurer will not voluntarily accept request for catastrophic designation Objection must be filed within 15 days of the date listed on the certificate of service 	Objection filed with SBWC and all parties to claim	Supporting medical and/or written documentation should be filed with objection

WC-240 Process

Swift Currie's Step-by-Step Guide to Returning Employees to Light Duty Work Through the WC-240 Process

O.C.G.A. § 34-9-240 and Board Rule 240 provide the method for returning employees back to work when released to light duty in Georgia. Completing every procedural step is imperative to have a successful and enforceable light duty job offer. The following 10-step guide can help you navigate the common pitfalls.

1 Verify the claimant is capable of performing light duty work by the authorized treating physicians.

2 Contact the employer and verify the availability of work under the specific restrictions assigned.

3 Secure a description of the available light duty job from the employer either on a WC-240A form **or** a clearly worded and detailed job description.

4 Send the executed WC-240A form or detailed job description to the authorized treating physicians, providing at the same time, a copy to the claimant and the claimant's attorney (if represented). Ensure the authorized treating physicians approve the light duty job within 60 days of their last examination.

5 Upon receipt of the signed WC-240A or written approval of the detailed job description from the authorized doctor(s), contact the employer to verify the date and time of the claimant's return to work, as well as the rate of hourly pay and supervisor contact information.

6 Prepare a WC-240 form containing the information verified in step 5, attach the WC-240A or job description and doctor's written approval and forward a copy to the claimant and the claimant's attorney at least 10 days prior to the date of the return to work.

7 Contact the employer representative a few days before the return to work date to confirm readiness for claimant's return to work.

8 On the date of the scheduled return to work, confirm the claimant actually returned to work. Once confirmed, or if the claimant refuses to/does not return to work, immediately file a WC-2 with the State Board of Workers' Compensation to document the suspension of the claimant's income benefits. Be sure to attach the WC-240 and WC-240A. Be sure to commence permanent partial disability benefits if applicable.

9 If the claimant works more than eight cumulative hours or one scheduled workday, **whichever is greater**, but less than 15 days, income benefits must be reinstated immediately (**FAILURE TO REINSTATE INCOME BENEFITS, REGARDLESS OF THE REASON, RESULTS IN THE WAIVER OF THE "SUITABLE EMPLOYMENT" DEFENSE**). A WC-2 should be filed reflecting the recommencement of income benefits.

10 Seeking further suspension of income benefits for failure to accept suitable light duty work should be considered. Contact a Swift Currie attorney to discuss your options as there is further action we can take if we have to reinstate benefits that can help bring the claim to a resolution.

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Having represented clients in Georgia and throughout the country for over 60 years, Swift, Currie, McGhee & Hiers, LLP, has evolved into a law firm capable of handling all areas of civil law and litigation. With approximately 160 attorneys, Swift Currie possesses the resources and abilities to tackle the most complex legal problems, while at the same time, providing its clients with individualized, prompt and cost-effective service. Our law firm has a wealth of experience across numerous practice areas, and our depth of legal talent allows us to tailor such strengths to individual cases.

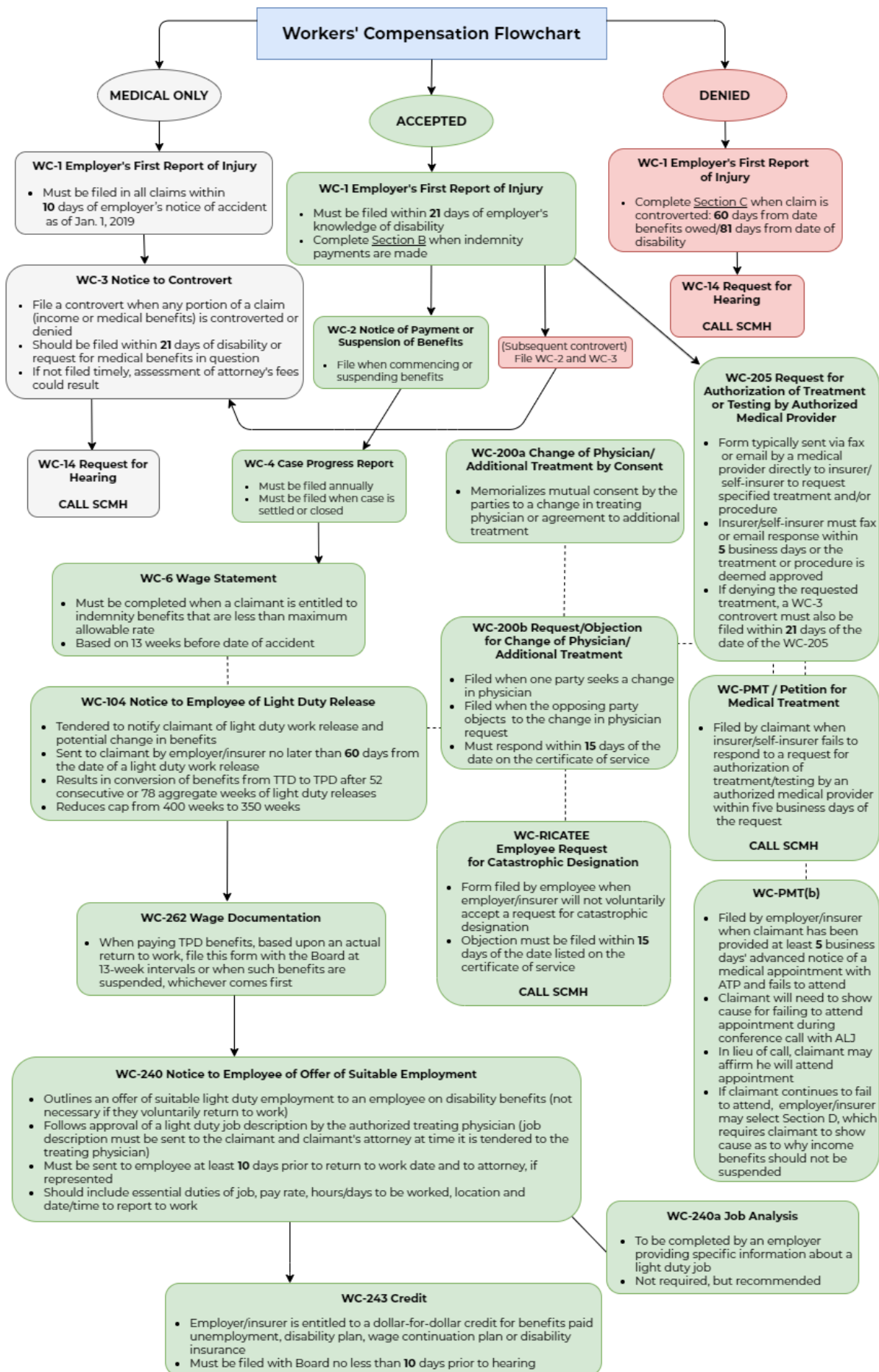
Our firm's philosophy is to provide our clients with creative, aggressive and professional representation of their interests. We also strive to conduct ourselves in a manner consistent with the legacy of our four founding partners.

No matter what the issue is in dispute, Swift Currie has attorneys ready to assist you. We believe we have a well-deserved reputation for high-quality legal services and dedicated attorneys.

Finding creative solutions to complex problems – that is our commitment to our clients.

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Panel of Physicians Quick Tips

The Basics of a Valid Panel

Under O.C.G.A. § 34-9-201(b)(1), a “valid traditional panel of physicians” must include:

1. at least six physicians or professional associations or corporations of physicians who are reasonably accessible to employee;
2. at least one physician that is an orthopaedic surgeon;
3. no more than two industrial clinics; and
4. where feasible, at least one minority physician.

Pursuant to Board Rule 201, should a physician on the panel of physicians refuse to provide treatment to an employee who previously has received treatment from another panel physician, the employer/insurer, as soon as practicable, shall increase the panel for that employee by one physician for each such refusal.

Under O.C.G.A. § 34-9-208 and Board Rule 208, a self-insured employer or insurer of an employer may contract with a managed care organization (MCO) provided that the employees who are subject to the contract receive medical services in a manner described in the contract, and that each contract complies with the certification standards provided under O.C.G.A. § 34-9-208.

The requirement that physicians, professional associations or corporations on a panel be “non-associated” has been removed.

What Employers Should Know

Employers are involved in the procedural requirements that must be followed in maintaining the validity and integrity of a valid panel of physicians. O.C.G.A. § 34-9-201(f) provides that if an employer fails to provide any procedures set forth under this section, the employee may select any physician to render services at the expense of the employer. Employers are required to:

1. post the panel of physicians in a prominent place upon the business premises;
2. take all reasonable measures to ensure that the employees understand the function of the panel;
3. take reasonable measures to ensure that the employees understand their rights to select a physician from the panel in case of injury; and
4. assure that the employees are given appropriate assistance in contacting panel physicians.

TIPS FOR EMPLOYERS

- Provide a copy of and explain the purpose of the panel of physicians to employees at the time of hire and again at the time an on-the-job injury occurs.
- Post a copy of the panel of physicians in more than one location reasonably accessible to employees.
- At the time of an injury, allow the employee to select a physician from the panel and document this selection by having the employee circle his choice and sign a copy of the panel.

What Insurers Should Know

Insurers should work with employers in maintaining the validity of the panel of physicians. In conjunction with employers, insurers should regularly review the panel to be sure all physicians listed are currently valid and are practicing at their listed locations. If possible, insurers should know as much as possible about all physicians listed on their employer's panel and ensure those physicians are within a reasonable distance from the workplace.

TIPS FOR INSURERS

- Consider having more than six providers listed on a panel, if possible, as long as the panel meets the requirements under O.C.G.A. § 34-9-201(b)(1).
- Establish an open dialogue and relationship with the physicians on your employer's panel.
- At the time an injury is reported by an employer, take that time to coach your employer about the status, validity and function of their panel.

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Petitions for Medical Treatment

WC-PMT

Petition to Show Cause:

Medical Treatment/Testing Recommended by Authorized Medical Provider

1. The WC-PMT provides the claimant with an option to request a conference call with an administrative law judge (ALJ) in order to seek authorization of medical treatment or testing recommended by an authorized medical provider.
2. The WC-PMT requires the claimant to provide the medical request to the employer/insurer at least five business days before filing for a PMT conference call.
3. Once the Board receives the form, a conference call will be scheduled with an ALJ and a Notice of Telephonic Conference will be emailed to all parties.
4. In response to receiving the WC-PMT notification, the employer/insurer has the option of filing a reply to the PMT and choosing to authorize or deny the requested treatment.
5. If the treatment is denied, the employer/insurer must explain the reason for the controvert. If the employer/insurer authorizes or controverts the treatment, the telephone conference with the ALJ will be canceled.
6. In the event the employer/insurer needs more information prior to authorizing or controverting the medical treatment, both parties must participate in the conference call with the ALJ in order for the employer/insurer to show cause for why the treatment has not been authorized as of the conference call.
7. During the conference call, the ALJ may deny or authorize the requested treatment. If the ALJ authorizes treatment over the employer/insurer's objection, the employer/insurer must file a WC-14 Request for Hearing objecting to the ALJ's interlocutory order within 20 days. Failure to file a WC-14 will be construed as consent to payment in accordance with the fee schedule for the requested treatment/testing.

WC-PMT(b)

Petition to Show Cause:

Medical Treatment/Employee's Failure to Attend Medical Appointment With ATP

1. The WC-PMT(b) allows the employer/insurer to request a conference call with the ALJ so the claimant can explain why they failed to attend a medical appointment with an authorized treating physician (ATP).
2. The employer/insurer must affirm the claimant or claimant's attorney was given at least five business days' advanced notice of the medical appointment. At the time the WC-PMT(b) is filed, the claimant must have failed to attend the appointment and supporting documentation must be attached.
3. In lieu of a conference call, the claimant may affirm they will attend the rescheduled, at-issue appointment and provide the physician's name and time and date of the appointment.
4. Once the claimant affirms they will attend the at-issue appointment, the conference call will be canceled.
5. Failure to attend the at-issue appointment may result in the suspension of income benefits. If the claimant fails to attend the appointment in accordance with a Board order or agreement by the claimant, the employer/insurer can submit a WC-PMT(b) with a completed Section D: Petition to Suspend Benefits for Failure to Attend Medical Appointment with an ATP. Section D requests a conference call with the ALJ in which the claimant or claimant's attorney must show cause why income benefits should not be suspended.
6. If a claimant is not attending medical appointments, utilize the PMT(b) to attempt to obtain a Board order directing the employee to attend the appointment or face a potential suspension of income benefits.
7. This process should not be used when a claimant misses a scheduled independent medical examination (IME).

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Having represented clients in Georgia and throughout the country for over 60 years, Swift, Currie, McGhee & Hiers, LLP, has evolved into a law firm capable of handling all areas of civil law and litigation. With approximately 170 attorneys, Swift Currie possesses the resources and abilities to tackle the most complex legal problems, while at the same time, providing its clients with individualized, prompt and cost-effective service. Our law firm has a wealth of experience across numerous practice areas, and our depth of legal talent allows us to tailor such strengths to individual cases.

Our firm's philosophy is to provide our clients with creative, aggressive and professional representation of their interests. We also strive to conduct ourselves in a manner consistent with the legacy of our four founding partners.

No matter what the issue is in dispute, Swift Currie has attorneys ready to assist you. We believe we have a well-deserved reputation for high-quality legal services and dedicated attorneys.

Finding creative solutions to complex problems – that is our commitment to our clients.

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Standard Diagnostic Tests

Arthroscopy

Arthroscopy is a diagnostic and surgical technique in which the provider manipulates a small, lighted camera called an arthroscope that has been inserted into the joint through a small incision in the joint. Images of the inside of the joint are projected onto a monitor.

Arthrogram

An arthrogram provides a diagnostic record that can be seen on an X-ray after the injection of a contrast fluid into the joint to outline structures of the joint. If disease or an injury is present, this contrast fluid may either leak into an area where it does not belong, indicating a tear or opening, or be blocked from entering an area where there normally is an opening.

Bone Scan

Two different kinds of tests may be called bone scans. One type tests the density of the bone and is used to diagnose osteoporosis. This type of bone scan uses narrow X-ray beams or ultrasound to see how solid the bone is. The second type of bone scan is used to identify areas where there is unusually active bone formation. It is frequently used to pinpoint stress fracture sites or the presence of arthritis, infection, or cancer. The patient is given a dose of a mildly radioactive substance through an intravenous line (IV). A special nuclear camera takes a picture of the entire body. Areas of abnormal bone formation activity will appear brighter than the rest of the skeleton.

Computed Tomography (CT Scan)

A CT scan (computed tomography) combines X-rays with computer technology to produce a more detailed, cross-sectional image of the body. It may be ordered if the doctor suspects a tumor or a fracture that doesn't appear on X-rays (such as in your collarbone or pelvis) or if the patient had severe trauma to the chest, abdomen, pelvis or spinal cord. An X-ray tube slowly rotates around the patient, taking pictures from all directions. A computer combines the images to produce a clear, two-dimensional view.

Discography

Discography is a test used to determine whether the discs, the cushioning pads that separate the bones of the spine, are the source of back pain. It may be performed before surgery to positively identify the painful disc(s). During the procedure, the doctor inserts a needle into one or more discs and injects a contrast dye. A CT scan will then show any changes in the disc size or shape.

Doppler Ultrasound

If a blockage in the blood vessels of the legs or arms is suspected, the doctor may prescribe an ultrasound test. An ultrasound uses high-frequency sound waves that echo off the body. This creates a picture of the blood vessels. The Doppler audio system transmits the "swishing" sound of the blood flow. The technician uses a sensor that looks like a microphone. The sensor is placed against the skin and moved up and down across the area being tested. The technician will apply pressure every few inches to see if the blood vessels change their shape.

Echocardiogram

Often referred to as a cardiac ECHO, an echocardiogram is a sonogram of the heart. It uses standard ultrasound techniques to image two-dimensional slices of the heart. The latest ultrasound systems now employ 3D real-time imaging.

Electrocardiogram (ECG or EKG)

An ECG or EKG is a non-invasive test that records the electrical activity of the heart. It is used to measure the rate and regularity of heartbeats, as well as the size and position of the chambers, the presence of any damage to the heart, and the effects of drugs or devices used to regulate the heart, such as a pacemaker. Sensors are applied to the torso and extremities, and readings of the heart's electrical activity are taken.

Electromyography

An electromyography (EMG) records and analyzes the electrical activity in your muscles. It is used to learn more about the functioning of nerves in the arms and legs. During an EMG, small, thin needles are placed in the muscle to record the electrical activity.

Contrast Enhanced CT Scan

This test uses contrast dye to better visualize the spinal canal and nerve roots in the spine. It may be used to help diagnose back problems such as spinal stenosis, particularly in patients with pacemakers or others who cannot have an MRI. The doctor uses X-ray guidance to inject a very low dose of contrast fluid (dye) into the spinal fluid. The CT scan is then administered.

Magnetic Resonance Imaging (MRI)

An MRI (magnetic resonance image) uses magnetic fields and a sophisticated computer to take high-resolution pictures of bones and soft tissues, resulting in a cross-sectional image of the body. It can be used to help diagnose torn muscles, ligaments and cartilage, herniated disks, hip or pelvic problems and other conditions. As with a CT scan, the patient lies on a table that slides into the tube-shaped MRI scanner. The MRI creates a magnetic field around the patient, then pulses radio waves to the areas of the body to be pictured. The radio waves cause tissues to resonate. A computer records the rate at which the body's various parts (tendons, ligaments, nerves) give off these vibrations, and translates the data into a detailed, two-dimensional picture.

Nerve Conduction Study (NCS)

Nerve conduction studies are often done along with an electromyogram to determine if a nerve is functioning normally. The doctor will tape wires (electrodes) to the skin in various places along the nerve pathway. Then the doctor stimulates the nerve with an electric current. As the current travels down the nerve pathway, the electrodes placed along the way capture the signal and measure its speed. In healthy nerves, electrical signals can travel at speeds of up to 120 miles per hour. If the nerve is damaged, however, the signal will be slower and weaker. By stimulating the nerve at various places, the doctor can determine the specific site of the injury.

Quantitative Computed Tomography

Quantitative computed tomography (QCT) is used to measure bone mineral density (BMD) for osteoporosis. It is similar to a normal CT scan, but uses a computer software package that determines bone density in the hip or spine. This technique provides for true three-dimensional imaging and reports BMD as true volume density measurements.

Radiographs (X-rays)

X-rays (radiographs) are the most common and widely available diagnostic imaging technique. X-rays are always used for fractures and joint dislocations, and may also be recommended if the doctor suspects damage to a bone or joint from other conditions such as arthritis.

Stress Tests

A treadmill stress test measures the effectiveness of the cardiovascular system (heart, lungs and blood vessels).

Venography

Venography is used to determine the presence of a blood clot in the leg, a condition called deep vein thrombosis. In this test, a contrast solution (or dye) is slowly injected into the leg. X-rays are taken to identify the location of the clot.

Neurological and Orthopedic Office Tests

Adson's Test

The patient is asked to take and hold a deep breath, the neck is extended, then the patient is asked to turn his head from one side to the other side. Downward pressure on the patient's arm will cause an obliteration of the pulse, in which case the test is positive, and indicates a thoracic outlet syndrome.

Anterior Drawer

With the knee flexed approximately 90 degrees, the proximal tibia is pulled forward. If excessive movement is found, the test is an indication of a tear of the anterior cruciate ligament.

Apley Test

The patient is placed prone on the examining table and the knee is flexed 90 degrees. While compressing the knee, the lower leg is rotated in both directions. If this maneuver elicits pain, it is probable that a meniscal tear is present.

Axial Compression

The patient is either sitting or lying and the examiner presses down upon the top of the patient's head. Narrowing of the neural foramen, pressure on the facet joints, or muscle spasm can cause increased pain and the test may indicate pressure upon a nerve and the neurologic level of existing pathology.

Babinski's Test

Normally, when the lateral aspect of the sole of the relaxed foot is stroked, the great toe is flexed. If the toe extends instead of flexes and the other toes spread out, the test is positive and would indicate upper motor (brain or spinal cord) involvement.

Impingement Test

The shoulder is forcefully abducted or adducted and internally rotated causing the greater tuberosity to press against the undersurface of the acromion. A positive test indicates an impingement syndrome.

Lachman Test

With the knee flexed approximately 20 degrees, the proximal tibia is pulled forward. Excessive motion of the tibia anteriorly is indicative of a tear of the anterior cruciate ligament. Considered the most accurate clinical test for tear of the anterior cruciate ligament.

Lasegue's Test (a.k.a. Bragard's Test)

Flexion of the affected limb's hip is not painful, but extension of the knee while the hip is flexed is painful. Such pain would indicate sciatica and spinal cord nerve root compression.

McMurray's Test

As the patient lies supine with knee fully flexed, the examiner rotates the patient's foot fully outward and the knee is slowly extended; a painful "click" indicates a tear of the medial meniscus of the knee joint. Inward rotation of the foot with pain indicates a tear in the lateral meniscus.

Phalen's Sign

Flexion of the wrist reproduces the paraesthesias and pain of median nerve compression at the wrist (carpal tunnel syndrome). The reverse Phalen maneuver involves hyperextension of the wrist with the resultant median nerve paraesthesias.

Quadriceps Inhibition Test

Pressure is placed over the superior aspect of the patella and the patient is asked to perform a straight leg raising maneuver. Pain and grinding with this maneuver is indicative of chondromalacia of the patella.

Slocum Test

With the knee flexed approximately 90 degrees, the foot is placed in both internal and external rotation for separate tests. The proximal tibia is then pulled forward. Excessive anterior motion of the tibia indicates rotatory instability of the knee, either anteromedial or anterolateral, depending upon the direction of rotation of the foot.

Straight Leg Raising

With the knee extended and the patient supine or seated, the hip is flexed (with the leg straight). A positive test results in pain in the sciatic nerve distribution and suggests a disc herniation.

Supraspinatus Isolation

Strength of abduction of the shoulder is tested by abducting and forward flexing the arm with the forearms in internal rotation. This isolates the supraspinatus muscle, the most common area of weakness in a rotator cuff tear. If weakness is demonstrated, this test is very suggestive for a rotator cuff tear.

Tinel's Sign

A tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or the beginning of regeneration of the nerve.

Waddell Test

The patient is tested for appropriateness of response to tenderness, axial loading, rotation, straight leg raising in the seated position, regional disturbances and overreaction. Inappropriate responses in three of the five areas is very suggestive of functional overlay in patients with back problems.

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“Dog” File Checklist

I. Determine Present Status

1. Review file – beginning and end
2. Review medical billing – year-to-year cost
3. Outline medical referral chain
4. Surgeries?
5. Doctor – how long treated?

II. Obtain Surveillance

1. Consider weekend/weeknight surveillance
2. Adequate budget
3. Criminal/court records
4. “Telephone” surveillance

III. Gather Updated Medical

1. Obtain medical authorization from claimant
2. Recent medical visits?
3. Consider independent medical examination (IME)
4. Send IME report to present authorized doctor

IV. Fact Finding: IMEs, Medical Conferences, Etc.

1. IME by internist, cardiologist, etc.
2. Medical conference at doctor’s office
3. Canvass medical facilities near claimant’s home
4. Other medical conditions or social problems

V. Investigate Other Sources of Information

1. Contact employer
2. Obtain employer’s file, if necessary
3. Past vocational rehabilitation counselors?
4. Doctor’s office – talk to medical secretary
5. Social security file?

VI. Look at Your Options: Change in Condition, Mediation, Etc.

1. Is vocational rehabilitation realistic? Ask for an updated or initial evaluation
2. Discovery – deposition of claimant, medical request for production of documents
3. Change in condition worth pursuing!
4. SITF fund claim – status/can a claim still be filed?
5. Request change in physicians – consider requesting a mediation

VII. Evaluation for Settlement

1. Look at three-to-five-year exposure
2. Conference with claimant if unrepresented
3. Create an issue: window of opportunity to settle
4. Medicare Set Aside issues?
5. Creative settlement ideas (medical trust with a reversion to the employee)
6. Mediation settlement conferences: valuable tool
7. Consider private mediation, if possible

VIII. Settle?

1. How much leverage do you have?
2. Realistic timetable and plan of attack!

10 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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Reasons to Controvert

One of the questions most often asked of our attorneys is “What wording should I use and what reason should I list on my notice to controvert?” We have compiled a reference list of possible reasons to controvert a claim. This is not an exhaustive list, but this should give you some ideas when making sure you have addressed all possible defenses in a claim.

Possible justifications for a controvert include:

1. The present injury/disability/death did not arise out of and in the course of employment.
2. Employer/Insurer reserves the right to controvert the above claim on any other or further grounds that may be or become available.
3. The condition complained of is not the result of an injury as defined by the Georgia Workers' Compensation Act. See O.C.G.A. § 34-9-1 (covers heart attack, stroke and disability due to alcoholism or drug addiction).
4. The injury complained of is the result of a willful act of a third person for reasons personal to employee. See O.C.G.A. § 34-9-1.
5. The disability complained of is no longer causally related to an injury or aggravation arising out of and in the course of employment. See O.C.G.A. § 34-9-1 (when a work-related disability has resolved but claimant still alleges disability due to unrelated condition.)
6. Employee failed to give proper notice as required under the Georgia Workers' Compensation Act. See O.C.G.A. § 34-9-80.
7. Claim barred by the statute of limitations. See O.C.G.A. § 34-9-82.
8. Accident did not occur in this state and the Georgia State Board of Workers' Compensation has no jurisdiction to hear this claim under O.C.G.A. § 34-9-242 (for cases where contract not made in Georgia, employee does not reside in Georgia and employer has no place of business in Georgia).
9. Claimant was not employed on the alleged date of accident.
10. Claimant is an independent contractor and not entitled to benefits under the Georgia Workers' Compensation Act.
11. Claimant does not qualify for benefits sought. See O.C.G.A. § 34-9-8 (for owners of premises, employers who are not statutory employers and for injuries occurring on premises where statutory employer has no control).
12. Employee is a farm laborer domestic servant/ railroad employee and not subject to the Georgia Workers' Compensation Act. See O.C.G.A. § 34-9-2.
13. Accident is a result of misconduct, intentionally self-inflicted injury or willful failure or refusal to use a safety appliance or perform a duty required by statute. See O.C.G.A. § 34-9-17.
14. Employee was under the influence of alcohol or a controlled substance at the time of injury. See O.C.G.A. § 34-9-17.
15. Death did not result from the injury to which employee was entitled to compensation. See O.C.G.A. § 34-9-265 (when controverting death benefits after a compensable injury).
16. Claimant is not a dependent as defined under O.C.G.A. § 34-9-13 and is not entitled to benefits pursuant to O.C.G.A. § 34-9-265 (directed at alleged dependents in death claim).
17. Employee has no physical injury or physical disability arising out of and in the course of employment (for employees who allege psychological injury without physical injury).
18. All compensation due under the Act has already been paid to claimant for injury date in question (to cover claims where all 400/350 weeks of disability have been paid).
19. Any claim for benefits stemming from this injury date has already been settled by stipulation and this stipulation has been approved by the State Board.



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No matter what the issue is in dispute, Swift Currie has attorneys ready to assist you. We believe we have a well-deserved reputation for high-quality legal services and dedicated attorneys.

Finding creative solutions to complex problems – that is our commitment to our clients.

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The Red Flags of Workers' Compensation:

25 Warning Signs

1. News of layoffs/terminations/transfers
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 the 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

swift/currie

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