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Ex-Parte Communications with Treating Physicians After Moreland v. Austin

By Jarome E. Gautreaux
O'Neal, Brown & Clark, P.C.

In personal injury and workers' compensation matters, the injured person's medical treatment is often the focus of the entire case. Even when the liability situation is clear, disputes arise over whether the medical treatment that a person received was related to the incident giving rise to the claim. Thus, treating physicians are routinely called upon to offer opinions on the issue of causation.

Often, opposing attorneys will seek to meet with treating physicians to discuss a patient's medical condition, history and treatment. It is not unusual for these meetings to occur on an ex parte basis. These ex parte meetings have come under increased criticism due to privacy concerns, especially with the enactment of the Health Insurance Portability and Accountability Act (HIPAA). Recently, in *Moreland v. Austin*, 284 Ga. 730 (2008), the Supreme Court of Georgia addressed the issue of of how Georgia law and HIPAA affected the propriety of ex parte discussions with treating physicians.

The Moreland Case

The Moreland case was a medical malpractice case. The defense lawyers sought permission from the trial court to permit ex parte meetings with several physicians who had treated the patient/plaintiff in the case.

The Court of Appeals held that the ex parte meetings were permissible because the defense lawyers had served a formal request for production of the medical records in the litigation. The Supreme Court disagreed with this analysis and the conclusion of the Court of Appeals.

The Supreme Court held that under HIPAA, ex parte meetings to discuss a patient's medical information are permissible in two situations – if the patient consents, or the court issues an order allowing such ex parte contact. Moreland, at 734. Since neither of those occurred in Moreland, ex parte contact was not proper. The request for medical records from the defendants was not sufficient to go further and allow ex parte conversations after the request for medical records was provided.

Issues after Moreland

While the Moreland case resolves some issues, it also leaves several questions unanswered. For example, if one way to comply with HIPAA is to obtain an order allowing ex parte contact, when should such an order be issued? What

In Memory of David Bartlett Higdon Sr.
Nov. 17, 1946 –June 24, 2009

Chambless, Higdon, Richardson, Katz & Griggs, LLP regretfully announces the passing of David Higdon. David was a wonderful mentor, partner, and friend to all in the firm. David dedicated his career to representing injured workers, teaching Workers' Compensation to future attorneys, and giving a voice to those who could not otherwise afford representation. David touched the clients he represented, attorneys and staff with whom he worked, and the community in which he lived. All those who had the pleasure of knowing him will deeply miss him.

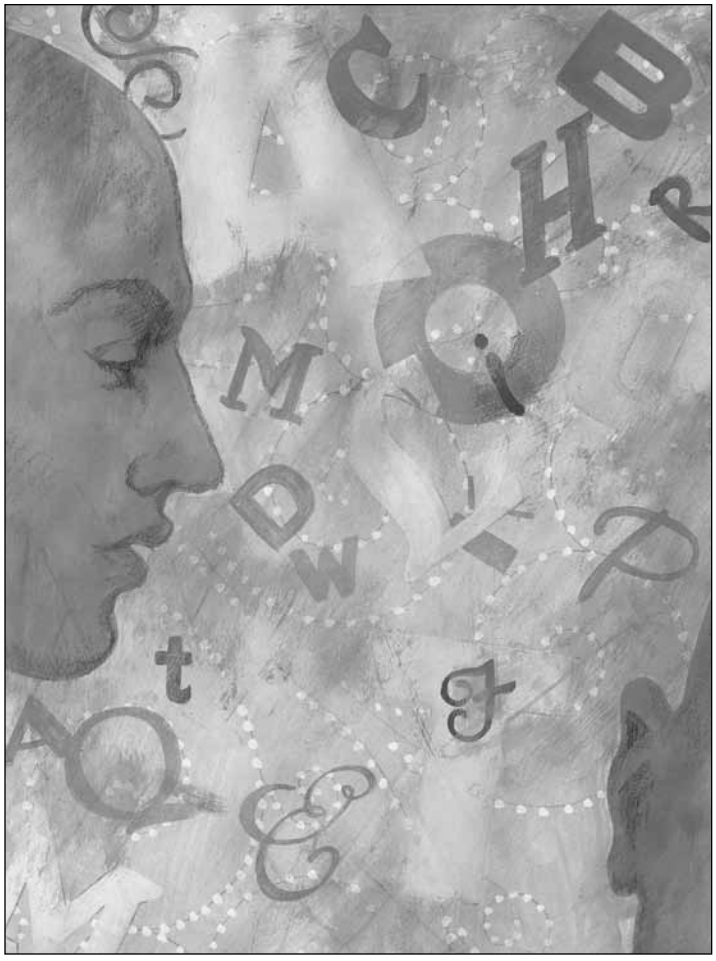
factors are important to consider? Or should such ex parte meetings be barred entirely since there are other discovery methods available, such as depositions? One of the issues that will have to be resolved is how the Moreland decision affects the permissibility of ex parte meetings in workers' compensation cases.

The starting point for the analysis is with the HIPAA regulations themselves. In 45 C.F.R. §164.512, disclosures of protected health information are permitted in workers compensation cases. The HIPAA privacy rule permits disclosures of protected health information as follows:

> A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
>
> 45 C.F.R. § 164.512(l).

Thus, the HIPAA regulations allow disclosures authorized under states' workers' compensation laws. The issue thus becomes whether Georgia's workers compensation laws authorizes ex parte communications. This certainly seems to be a controversial area in many workers' compensation cases.

The provisions of O.C.G.A. § 34-9-207 include waivers



of privileges and confidentiality regarding communications "related to the claim or history or treatment of injury arising from the incident …." (emphasis added). It also requires an injured employee to sign a release for medical records related to the claim. There is no express mention of ex parte meetings with treating physicians or health care providers in this code section.

Under similar statutes, courts have held that ex parte communications are prohibited. For example, in *Overstreet v. TRW Commercial Steering Division*, 256 S.W.3d 626 (Tn., 2008), the Court considered whether ex parte communications were permissible in the context of a workers' compensation claim. The relevant statute provided for physicians to provide a complete medical report about the injury and the claimant's employment and for physicians and hospitals to provide medical records upon request. Tenn. Code Ann. § 50-6-204(a)(1). Because the terms of this statutory provision did not permit ex parte communications, the Court held that the rules of statutory construction required the conclusion that such ex parte communications were prohibited. The court recognized the policy of protecting physicians and patients from inadvertent disclosures of private health information. Overstreet, at p. 634. Further, the court in Overstreet recognized that HIPAA would permit disclosures permitted under states' workers' compensation statutes, so the decision turned on the application of state law.

Other courts have analyzed the issue similarly, holding that ex parte communications were prohibited in the context of workers' compensation cases. See *Brown v. Bi-Lo, Inc*., 354 S.C. 436 (2003)(statute requiring provision of "all existing information" and records did not extend to allowing ex parte communications with treating physicians); *Salaam v. North Carolina Dept. of Trans.*, 122 N.C. App. 83 (1996); *Hydrauics, Inc. v. Industrial Commission*, 329 Ill. App. 3d 166 (2002); *Sorenson v. Barbuto, et al*, 2008 UT 8 (2008).

If O.C.G.A. § 34-9-207 does not address ex parte meetings, which by its terms appears to be the case, then it would seem that the general analysis in Moreland would apply and would permit ex parte communications only in cases in which a court issues an order allowing such meetings or the patient/claimant consents to the meetings.

Since presumably most patients will not provide consent for such meetings, the question becomes whether courts should issue orders allowing ex parte meetings. While the decisions are not in agreement on this point, some of the more important factors to consider can be identified.

Perhaps the most important factor from the few decisions on this issue is the danger that a physician's ex parte meeting with counsel for the defendants could veer off into privileged areas or areas that are completely irrelevant to the claim at issue. This type of concern seemed to be the primary factor in Judge Bessen's opinion in *Lazzara v. Northside Hospital*, State Court of Fulton County, Georgia, Case No. 2007EV002408-J (Aug. 5, 2008).

Another factor that is often prominent in the decisions is the danger that the healthcare provider, who is often untrained in the law, will inadvertently disclose protected health information beyond the proper scope of disclosure. For example, in Judge Purdom's recent decision denying ex parte discussions, he specifically mentioned the danger of a physician being lured into improper disclosures. See *Delbridge v. Suchdev*, State Court of DeKalb County, Georgia, Case No. 09A02363-3 (June 15, 2009).

The most important factor mentioned in favor of allowing ex parte discussions is the contention that allowing ex parte interviews makes discovery of relevant information easier and less costly. See Lazarra, at p. 3 (addressing this argument).

Other factors often considered in the context of ex parte meetings include the medical profession's ethical obligations to their patients and the privacy expectations of patients. *Petrillo v. Syntex*, 499 N.E.2d 952 (Ill., 1986) (listing numerous factors); See also *Doe v. City of Chicago*, File No. 96 C 5739, 1998 U.S. Dist. LEXIS 10302 (N.D. Ill., 1998)(citing numerous cases on both sides of this issue).

While the issue of ex parte meetings under HIPAA is still relatively new, Moreland gives some needed guidance on the interplay of Georgia and federal law on this issue. If the analysis in Moreland governs this issue in workers' compensation cases, then the next battleground will likely be the question of whether such meetings should be allowed, given the numerous privacy and policy concerns relating to this issue.

The author is thankful for the numerous helpful suggestions for improvement that he received from the Editor and from Justin D. Studstill, who has recently joined O'Neal, Brown & Clark as an associate in the firm. ***WC***

List of Citations

1. Moreland v. Austin, 284 Ga. 730 (2008).
2. 45 C.F.R. §16 4.512
3. O.C.G.A. § 34-9-207
4. Lazzara v. Northside Hospital, State Court of Fulton County, Georgia, Case No. 2007EV002408-J (Aug. 5, 2008).
5. Delbridge v. Suchdev, State Court of DeKalb County, Georgia, Case No. 09A02363-3 (June 15, 2009).
6. Petrillo v. Syntex, 499 N.E.2d 952 (Ill., 1986).

Jarome E. Gautreaux is a partner in the firm of O'Neal, Brown & Clark in Macon, Georgia. He represents individuals and families in cases involving serious injuries or death arising out of medical negligence, trucking/ roadway collisions, and defective products, including workplace injuries related to defective products. He is an adjunct professor at Mercer Law School and serves on the Amicus Curiae committee of the Georgia Trial Lawyers Association (GTLA). He participated, with Lee Wallace, in the drafting of the Amicus brief submitted in the Moreland case by GTLA.

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Whither the "WC-205" Process

By Thomas M. Finn

Currently pending in the Court of Appeals is Selective *HR Solutions, Inc., et al. v. Mulligan*, A09D0304, Discretionary Application Granted 7 April 2009, the final appellate decision in which is likely to seal the fate of the present advance authorization process – one way or the other. Whatever that ultimate legal outcome, most would agree that some uniform, rapid response process must exist to expedite approval of delivery of healthcare to Georgia's injured workers – approval which is not a statutory prerequisite. This article will discuss briefly the history of the current advance authorization process, the bases of recent legal attacks on the process and will conclude with some recommendations.

FIRST, SOME HISTORY

Georgia's current medical delivery model, used by the vast majority of Georgia's employers, is the so-called traditional panel of physicians, adopted in 1978 as part of that year's comprehensive amendments to the Act. Originally, the panel required only three or more physicians or group of physicians. The current statutory provision and composition requirement of the traditional panel is found in O.C.G.A. § 34-9-201(b)(1).

Readers should be aware that the 1978 enactment of the panel healthcare delivery model took place toward the end of the era during which fee for service/indemnity was the prevailing health plan model in both group health and in the workers' compensation programs of most states. By 1978 some health care policy analysts were already contending that ". . . the inflationary fee-for-service payment system rewards providers for rendering more, not less, health care." As cost sharing devices such as deductibles and co-payments, used increasingly in group health, whether or not effective in controlling the growth of health care costs, were traditionally not allowed in workers' compensation healthcare, the structural design of Georgia's medical care delivery model in both medical only and lost time claims provided no statutory prospective or concurrent review method by which employers and insurers could challenge medical care before it was furnished by an authorized treating physician.

The premise of Georgia's panel system was explained in *ITT-Continental Baking Company v. Powell*, 182 Ga. App. 533, 356 S.E. 2d 267 (1987):

> "A distinction must be recognized between income benefits and medical expenses. Income benefits are to be paid automatically once the employer is notified of the injury, unless the employer in return informs the employee by means of a notice to controvert that in its view the injury is not compensable – not arising out of and in the course of the employment, etc. O.C.G.A. §34-9-221.

Employer-liable medical expenses, on the other hand, initiate with the services of a physician selected from the approved list. . . as required by O.C.G.A. §34-9-201(c)." (emphasis supplied)

The Powell decision continues, adding:

> "Rule 221(d) of the Workers' Compensation Board provides: 'To controvert in whole or in part the right to income benefits or other compensation, use Forms WC1 or WC3.' Even if an employer is required to notify the board of its refusal to pay medical expenses, it is not a statutory requirement as the statutory scheme regarding time constraints for a 'notice to controvert' -- . . . relates solely to income benefits." (emphasis supplied)

See, also, *NuSkin International v. Baxter*, 211 Ga. App. 32, 438 S.E. 2d 130 (1993).

THE EMERGENCE OF "PRE-AUTHORIZATION" IN TRADITIONAL PANEL CLAIMS

For purposes of this article, the writer assumes that readers understand the medical and legal distinction between pre-authorization and pre-certification.

In the late 80s and early 90s, components of the Managed Care Model, already being applied regularly in group health, began infiltrating Georgia workers' compensation claims.

"The managed care model of health care delivery contains several key characteristics which set it apart from traditional (indemnity) insurance. One of the main differences in that the service delivery and financing functions are integrated under managed care. Managed care organizations (MCOs) employ various techniques to control costs and manage health service use prospectively. Among those techniques are restricting enrollee access to certain providers (in-network providers); requiring primary-care physician approval for access to specialty care (gatekeeping); coordinating care for persons with certain conditions (disease management or case management); and requiring prior authorization for routine hospital inpatient care (pre-certification). MCOs may offer different types of health plans that vary in the degree to which cost and medical decision-making is controlled."

In 1994, to create a statutory provision to authorize the use of and to regulate WC/MCOs, present O.C.G.A. §34-9-201(b)(3) was enacted. Unfortunately by 1997, the pre-authorization prospective utilization review device of the managed care model had become such an impediment to delivery of authorized treatment that the predecessor to the present WC-205 process was promulgated by Board Rule. The former rule did not require use of any particular vehicle, format or content for communication of a request for advance authorization as such request could be submitted by a provider, by a claimant or claimant's attorney. While the primary flaw in the earlier advance authorization process was the 30 day period provided for response by the employer or insurer, nevertheless, the process did work, albeit too slowly.

THE CREATION OF THE PRESENT WC-205 PROCESS

By Executive Order dated 10 Jan. 2000, Gov. Roy Barnes created the Governor's Workers' Compensation Advisory Commission. Appointed to co-chair the Medical Committee of that commission were Mark Gannon of Atlanta and the author hereof. The Governor's charge to the commission was to address the increasing problems in health care delivery that were reducing the number of providers willing to accept and treat Georgia's injured workers. That commission set to work in May 2000, debating and agreeing upon several substantive statutory changes which were then incorporated into H.B. 497:

1. Amendment of O.C.G.A. §34-9-201 to expand the traditional panel to six (6) or more physicians or groups of physicians;
2. Amendment of O.C.G.A. §34-9-108 to add (b)(4), an entirely new subsection providing a means for the Board to award specific litigation expenses;
3. Complete revision of O.C.G.A. §34-9-203 to create a self-activating, graduated penalty provision to encourage prompt payment of provider's bills.

The Medical Committee also devoted considerable time to revising and streamlining the existing advance authorization process. Attorneys on the Medical Committee were careful to be sure that the process was not inconsistent with existing statutory and case law. For example, the provisions of Board Rule 205(b)(c)(d) are applied only in a claim that has already been found to be compensable for purposes of authorized treatment and the only purpose for which those rule provisions were created was to assist the authorized treating physician in expediting the delivery of medical care – medical care that the employer is already statutorily required to provide by O.C.G.A. §34-9-200(a) through a physician selected by the process established by O.C.G.A. §34-9-201.

Rule 205(b)(1)(a) and (b)(1-3) essentially track O.C.G.A. §34-9-200(a) and invoke the fee schedule provisions of O.C.G.A. §§34-9-203 and 205 (". . . shall be paid in accordance with the Act, where the treatment/tests are: . . . ."

The basis for Board Rule 205(b)(1)(b)(4) may be traced directly to O.C.G.A. §34-9-201(b) and to Appellate decisions such as *Woodgrain Millwork/Windsor Wood Windows v. Millende*r, 250 Ga. App. 204, 551 S.E. 2d 78 (2001) (specifically citing Board Rule 205(b); *Old Dominion Freight Line v. Anthony*, 216 Ga. App. 267, 454 S.E. 2d 574 (1995); *Hensel Phelps Const. Co. v. Manigault*, 167 Ga. App. 599, 307 S.E. 2d 79 (1983); *Roberson v. Hartford Accident & Cas. Co.*, 141 Ga. App. 588, 234 S.E. 2d 145 (1977).

Subsection (b)(2) of Rule 205 is also a correct statement of the law and was lifted directly from O.C.G.A. §34-9-200(a), 201(b) as the concepts of authorized vs. unauthorized treatment are explained by Powell and NuSkin, supra.

As the Commission and members of the Board recognized that the revised process would be available for use in only compensable lost-time claims and accepted medical only claims in which authorized treatment was being provided by an ATP, revision of the existing Board Rule was considered to be sufficient when each of the following objectives was met:

1. Create a non-mandatory simple process by which authorized treating physicians could obtain advance authorization if/when those physicians so desired;
2. Create a rapid turn around between request and response by reducing the 1997 30 day response time to five business days;
3. Create a process which, itself, would provide proof of service of the request in order to satisfy due process by requiring that the request be either e-mailed or faxed, creating a paper trail to prove the date and time of submission of the request for advance authorization and the adjuster to whom the request had been faxed or e-mailed;
4. Create a uniform process by permitting use of only one specific form which would contain the exact wording, punctuation and format [since altered to accommodate ICMS]. To prevent obstructive or spurious bases for denial, an exact set of pre-listed check-off reasons for denial – and only those reasons – were included in the section of the form in which the employer's response would be made;
5. Create finality so that physicians wouldn't be left hanging. To that end, the committee agreed to add a final step to conclude the stage of the process where all communications and interaction had been between the physician and the party

responsible for payment; i.e., Form WC-3 would be filed and served within 21 days of initial receipt of the new form WC-205 if there had been an initial refusal to convey advance authorization.

ATTACKS ON THE WC-205 PROCESS

Between 2000 and 2005, use of the revised WC-205 Process increased slowly among medical providers as it was not as heavily promoted as it could have been. However, in some geographic pockets of the state, use increased rapidly as claimant attorneys familiar with the process encouraged its use by ATPs to expedite delivery of medical care to the clients of those claimant attorneys.

Unfortunately, by late 2005, legal attacks on the WC-205 Process coincided with the expansion of use of managed care utilization review, surgical second opinions, PPOs, pre-certification, case management and treatment and practice guidelines to screen treatment ordered by ATPs in traditional panel claims. The first case to reach the Court of Appeals in which a specific attack was made on Board Rule 205(b)(3)(a) was *Caremore, Inc./Wooddale Nursing Home v. Hollis*, 283 Ga. App. 681, 642 S.E.2d 375 (2007). The attack in Caremore was still-born since the employer had actually approved the Dalton ATP referral of Hollis to an Atlanta orthopedic specialist before an order enforcing the rule had been entered.

Since *Caremore v. Hollis*, supra, the cross hairs have been placed squarely on subsections (b)(3)(a) and (b)(3)(b) of Rule 205. The author has analyzed three (3) recent Appellate Division decisions.

In one case, the employer/insurer had apparently made a timely initial denial of surgery, advance authorization for which had been requested by WC-205 submitted by the ATP. The ALJ ordered the surgery and assessed attorney fees against the employer/insurer for failure to file the WC-3 required by Board Rule 205(b)(3)(b). By Award dated 29 May 2009, the Appellate Division affirmed the assessment of attorney fees. Neither the ALJ nor the Appellate Division addressed the alternate requirement of Rule 205 (b)(3)(b); that is, "(a) authorize the requested treatment or testing in writing. . . ."

In another very recent case, the ATP had submitted a WC-205 to the adjuster who had timely denied the treatment on the sole basis that the ATP had not first submitted to that insurer's treatment criteria/protocol in a claim in which medical was not delivered via a WC/MCO. Forty-five days after initial receipt of the WC-205, the employer/insurer finally controverted, raising for the first time that the proposed treatment was not reasonably necessary. The Appellate Division's language is puzzling and alarming in its implication that substantial compliance is sufficient:

> ". . . the failure to comply strictly with Board Rule 205(b)(3)(b) does not in this case, estop the employer/insurer from raising defense to controvert the requested treatment or testing." (emphasis supplied)

The 24 June 2009 Appellate Division decision in this second case appears to be based upon this legal reasoning, ". . .the Board Rule 205 advance authorization provision cannot be read without reference to other provisions of the Act and to Board Rules. As this decision relies upon *Raines & Milam v. Milam*, 161 Ga. App. 860, 289 S.E. 2d 785 (1985) and *Holt Service Co., V. Modlin*, 163 Ga. App. 283, 293 S.E. 2d 741 (1982), it is not difficult to understand the source of the Appellate Division's concern. The author and many others believe that Raines & Milam and Modlin can easily be distinguished factually and legally. Both cases were all issues claims in which the employers disputed the compensability of the claims – even as to provision of authorized medical care!

In *Raines & Milam v. Milam*, the Court of Appeals held that the failure of an employer/insurer to file a notice to controvert a claim within 21 days after knowledge of the alleged injury or death as required by O.C.G.A. §34-9-221(d) did not prevent a controversion of the compensability of a claim more than 21 days after the employer's notice or knowledge.

In *Holt Service Company v. Modlin*, the issue was the effect of former Board Rule 705(d), which provided: "If Form No. WC3 is not filed on or before the 21st day after knowledge of the injury or death, the accident will be presumed to be compensable, subject to rebuttal." The Court of Appeals in Modlin noted that "the claimant in a workers' compensation proceeding has the burden of proof to show that his injury is compensable" and that the "effect of Rule 705(d) is to shift the burden of proof on the main point that claimant would otherwise have to prove." (Emphasis supplied). The Court of Appeals held in Modlin that Rule 705(b) was in excess of the Board's authority because it provided that, upon an employer/insurer's failure to controvert a claim within 21 days of knowledge of the injury or death, the burden was shifted to the employer/insurer to prove an injury was not compensable. Both Milam and Modlin are concerned with O.C.G.A. §34-9-221(d) [predecessor §114-705(d)], which is directed at the issue of the compensability of a claim. The Board Rule at issue in Modlin granted claimant a "rebuttable presumption of compensability" and was, therefore, invalid as substantive rule-making. The substantive right at issue in Modlin was the right of an employer/insurer not to be required to prove the noncompensability of an alleged work injury. An injured employee has the burden to prove the underlying compensability of an alleged work injury.

In contrast, Board Rule 205 is not concerned with the underlying compensability of a claim or the compensability of any part of a claim, including medical treatment or testing for which the authorized treating physician is seeking advance authorization. Board Rule 205 also is not concerned with an employer/insurer's substantive right not to be required to prove the noncompensability

of a claim. Board Rule 205 is concerned only with an injured employee's right to receive prompt medical care from authorized treating physician(s). The concept of a compensable injury is quite different than the concept of authorized treatment. *ITT-Continental Baking Company v. Powell*, supra.

Board Rule 205 is applicable when advance authorization is requested, regardless whether a claim is a medical only claim or a lost time claim. A claimant has a right/entitlement to authorized medical care immediately following the work-related injury; unless, of course, the employer/insurer controverts the underlying compensability of the claim pursuant to O.C.G.A. §34-9-221(d) and requires the injured employee to prove the compensability of an alleged work injury. But once it is accepted (or once it is proven) that a compensable claim exists, the injured employee is entitled to authorized medical treatment.

Cases such as Milam and Modlin are concerned with compensability in the sense of an employee's right/entitlement to any benefits as dependent upon whether the employee suffered a compensable injury. Board Rule 205, on the other hand, is concerned only with an employee's right to receive promptly the medical care recommended/ordered by authorized treating physician(s).

Recognizing that, on average, less than 20 percent of injured workers are represented, that medical providers are not attorneys, the contention that Board Rule 205 "is burden shifting/works a forfeiture" despite a two-step process that amply provides due process, written notice that provides to respondents more than enough information to make an initial decision within 5 business days, that gives respondents nearly three weeks to decide whether to adhere to the basis for denial made within 5 business days and to prepare, file and serve a WC-3 seems entirely misplaced.

The emergence of pre-authorization in traditional panel claims is, at least, partly the result of complaints that the fee-for-service model for the delivery of healthcare is inflationary and encourages excessive treatment. Board Rule 205(b) has always been an attempt to create symbiosis with pre-authorization while ensuring that medical care provided by ATPs is not delayed or denied by payers without Board regulatory oversight that prevents medical necessity decisions from being motivated predominantly by financial rather than medical interests.

SOME RECOMMENDATIONS

Regardless the outcome of Mulligan, Georgia's traditional panel healthcare model is a policy anachronism.

Even if the Court of Appeals affirms the Superior Court's reversal of the Appellate Division, the present advance authorization process remains a metaphorical temporary tire awaiting legislative modernization of the Act. The tension between the medical necessity review techniques used by national insurers and TPAs to determine prospectively/concurrently medical necessity is irreconcilable with the present WC-205 process. We would be wise to begin reviewing and comparing the solutions to expedite healthcare delivery other states have adopted recently. We would be wise to consider carefully the explanation given by the Office of the Chair, New York State Workers' Compensation Board regarding the draft treatment guidelines specific to the five work injuries found to occur frequently and to consume the most healthcare dollars:

> "In the absence of medical treatment guidelines, New York practitioners do not have easily accessible up-to-date standards for care. Similarly, claims examiners at the insurance carriers and self-insureds (carriers) do not have agreed upon standards by which to assess the medical necessity of care. One result is the generation of substantial disputes about medical care that is harmful to both employee and employer, as delivery of care is delayed and frictional costs increase.
>
> Carriers (and their administrative third-party payors) use a variety of tools to assess appropriateness of care in an effort to control costs and ensure quality, a process that is called utilization management or review (UR). There is no requirement that carriers employ the same UR standards or processes and this lack of uniformity may cause injured worker-patients with the same conditions to be treated differently. This lack of standardization may lead to variations in the treatment of injured workers that are not explained by the nature of their injuries, so that some workers may receive lower quality of care than others. Lack of standardization also adds to frictional costs by producing needless disputes."

We would also be wise to monitor carefully national healthcare reform efforts to incorporate the scholarship of (e.g.) National Academies' Institute of Medicine which released on 30 June 2009 its four quartile Initial National Priorities for Comparative Effectiveness Research, at least five of which are injuries/health conditions we see regularly in Georgia Workers' Compensation claims. By the time sufficient interest and political will coalesce in Georgia, the body of credible research findings will enable Georgia to avoid the mistakes made by states such as California and Texas in adopting one size fits all comprehensive sets of treatment/practice guidelines as part of integrated UR. The research to be developed in accordance with the Patient-Centered Outcomes Research Act of 2009, SB 1213, introduced 9 June 2009 should also be available.

We should avoid using code terms such as healthcare rationing since use of valid evidence based medicine will enable us to incorporate statutorily the findings of research organizations such as The Dartmouth Institute for Health Policy & Clinical Practice; which, with a grant from The Robert Wood Johnson Foundation, has produced widely acclaimed studies such as the landmark analysis of Medicare spending released jointly on 2/26/09 by The New England Journal of Medicine and the Dartmouth Atlas of Healthcare, confirming that more utilization does not necessarily produce better medical outcomes.

Finally, an integrated medical care delivery system relying upon evidence based medicine, if constructed carefully, could eliminate some of the shortcomings of the current statutory medical delivery system and incorporate processes which create a uniform and scientifically valid system by which medical necessity is determined. But, until then, the WC-205 process must be enforced exactly as written. ***WC***

1 Perhaps the heterograph, "wither" might be a more appropriate choice of words.
2 Ga. Laws 1978, p. 2220. § 9.
3 Health Affairs, The Policy Journal of the Health Sphere, Iglehart, "Low-Cost, High Quality Care in America" 7/28/09. (visited 6 Aug. 2009); "Health Insurance: A Primer," Fernandez, Congressional Research Service #R632237 Feb. 3, 2005.
4 Restraining the Health Care Consumer, The History of Deductible and Co-Payments in the U.S. Health Insurance, Social Science History 2006 30(4):501-528. Duke University Press.
5 Note that "peer review" enacted in 1985 is available only retrospectively. See O.C.G.A. §34-9-205(b). The "fee schedule" was also adopted that year.
6 Managed Health Care: A primer, CRS Report for Congress #97-913 EPW, Sept. 30, 1997, at Congressional Research Service, The Library of Congress.
7 Present O.C.G.A.§34-9-208/Board Rule 208.
8 See 2001 Annual Survey of Georgia Law, Workers' Compensation, Bagley, et al, 53 Mercer Law Review 521-526.
9 To this day, there is very little guidance to medical providers and their staffs on the Board's website. For example, there are publications specifically directed to medical providers. Best Practices: Guidelines for Medical Providers does not mention the WC-205 process. And, while the 7/1/2009 Procedure Manual does contain two brief paragraphs at p. 7-7 stating that ". . . an authorized medical provider may request advance authorization . . . by utilizing Board Form WC-205. . ." The "fee schedule" actually states at p.7, "In the event that an authorized treating physician requests preauthorization or precertification. . .the procedures provided in Board Rule 205 shall be followed. If mandatory, one would expect the Board website to provide step-by-step directions – something as simple as 10 minute "Utube" clip – for medical providers and their staffs. The author notes the recent creation of the "MFWCP" Medical Provider Training Program, Section 11-1-4 of the 7/1/09 Procedure Manual; however, it is unlikely that many providers will have the time to undergo that training program – assuming they ever learn of its existence in the first place.
10 The Appellate Division's Award in Selection HR Solutions, Inc. v. Mulligan, contains this exact sentence – and legal reasoning. However, in "Mulligan", there was neither timely "initial deny" nor timely WC-3. And, to make matters worse, in reliance upon the employer/insurer's admitted receipt of the WC-205, admitted failure to deny the "requested" surgery by timely "initial denial" and timely WC-3, the surgery was performed, the surgeon "left hanging." There is no question that the "WC-205 process", itself, is in jeopardy. See, www.mag.org/generalcounsel/legal-news.
11 Smith v. Mr. Sweeper Stores, Inc., 247 Ga. App. 726, 544 S.E. 2d 758 (2001).
12 It was intended by the Commission that all communication would be between providers and payers until a decision was made "to controvert." Only then would the Board [possibly] become involved.
13 "Proposed Medical Treatment Guidelines," New York State Workers' Compensation Board, Office of the Chair, Sub. #046-270 1/22/09. http;//www.ins.state.ny.us/press/2007/p07012032cov.pdf.
14 Iomwww@nas.edu
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16 www.dartmouthatlas.org.

Finn has represented injured workers and Social Security disability applicants for over three decades. He has served as presiding officer of the Workers' Compensation Sections of both the State Bar of Georgia and Georgia Trial Lawyers Association. A frequent lecturer, he has authored and presented papers at 25 seminars and legal symposiums in Georgia and surrounding states. His service as co-chair of the Medical Committee of Governor Barnes' Workers' Compensation Advisory Commission in 2000 – 2001, resulted in expanding the panel of physicians, rewriting OCGA 34-9-203, enacting a provision to authorize award of "litigation expenses" and the revision of the "advance authorization" process. His subsequent service on the data committee of the Workers' Compensation Review Commission produced the first ever in-depth analysis of Georgia's Workers' Compensation, cited as authoritative in Davis v Carter Mechanical, Inc. 272 Ga. App. 773. As lead or Amicus attorney, he has been involved in numerous reported appellate decisions affecting workers' compensation law and practice, such as Padgett v Waffle House, Inc., 269 Ga. 825; Maloney v Gordon County Farms, 265 Ga. 825. Tom presently serves as a member of the Board of Directors of the Georgia Legal Foundation, Inc., a 501(c)(3) non-profit which reviews significant workers' compensation cases for amicus curiae assistance.

Compensability of Idiopathic Falls in the Workplace

By Kellye C. Moore
Walker Hulbert Gray & Byrd, LLP

In order for a workplace injury to be compensable, it must arise out of and in the course of employment. There must be some causal connection between the conditions under which the employee worked and the injury he received. Yet, how is compensability affected when an employee is injured in the workplace as the result of an idiopathic fall? Idiopathic means (1)arising spontaneously or from an obscure or unknown cause or (2) peculiar to the individual. As with most workers' compensation issues, the answer to this question lies in the facts surrounding the fall.

The general rule is that injuries from idiopathic falls in the workplace are not compensable since they do not arise out of employment, although they occur in the course of employment. However, there is an exception to the general rule. When an employee is injured in an idiopathic fall in the workplace and the employee comes into contact with something specifically related to the workplace, such as a work bench, machinery, or equipment, or the employee falls from a height, which increases the risk of injury, the injury is compensable.

For example, in *United States Casualty Co. v. Richardson*, the claimant had an epileptic condition which had previously caused epileptic attacks at work without injury. The claimant worked selling men's apparel in a department store. At the time of the accident, no one saw the claimant fall, but several employees heard two bumps in quick succession and went to investigate. The claimant was found unconscious on the floor near a table with a sharp corner. The table was part of the equipment used in the department store. The claimant was bleeding from a head wound and suffered a severe fracture of the skull. In finding that the claimant's injuries were compensable, the Court of Appeals of Georgia determined that irrespective of whether or not excessive exertion from claimant's job duties brought about his epileptic seizure, the seizure of the claimant caused him to fall on the sharp corner of the table which caused the skull fracture and the injury to his brain. This table with a sharp corner was a hazard of the employment to which the claimant was subjected. In reaching its conclusion, the Court reviewed cases from other jurisdictions and found that awards are upheld in most States, if the fall is on a stairway or into a machine or against anything except the bare floor, and especially if the fall is from a height, as the risk of injury is increased, or is a special danger of employment.

Where the idiopathic fall does not result in contact with something specifically related to the employment, the injury is not compensable because the injury sustained is no different that it would have been had the employee suffered a similar fall at any place other than on the employer's premises. In *Prudential Bank v. Moore*, the claimant had a fall at work, apparently from fainting, and hit her head on a baseboard. In determining that the claimant's injury was not compensable, the Court of Appeals reasoned that a baseboard, like a floor, is a structural hazard that an employee is equally exposed to apart from her employment. A wall and baseboard is not peculiar to the employment and thus does not fit the exception to non-coverage.

In *Johnson v. Publix Supermarkets*, however, the Court of Appeals overruled Prudential Bank v. Moore, and departed from the narrow exception to non-coverage for idiopathic falls by broadly declaring that if a workers' compensation claimant's injury was due to a fall, the employer is liable, even though the fall was caused by an idiopathic condition. In *Johnson v. Publix Supermarkets*, the Court found the claimant's injury compensable when she broke her leg while hurrying down a store aisle. The Court of Appeals later disapproved *Johnson v. Publix Supermarkets* finding that it had misconstrued prior decisions when it declared that an idiopathic fall is compensable even if no work-related object is involved. Thus, the narrow exception to non-coverage for idiopathic falls still stands today.

Consequently, whether an idiopathic fall is compensable will depend on the facts surrounding the fall. "When the cause of the fall is personal to the worker (as a non-industrial heart attack, dizzy or epileptic spells, or any idiopathic condition) the fact that the floor is rough cement instead of wood and hence more dangerous, is not ground for an award. . . . But awards are upheld . . . if the fall is on a stairway or into a machine or against anything except the bare floor, and especially if the fall is from a height, as the risk of injury is increased, or is a special danger of the employment." ***WC***

Notes From The Chair

By N. Staten Bitting, Jr., Esq

The Workers' Compensation Section offers best wishes to Judge Carolyn Hall as she concludes her service as Chairman of the State Board. By any measure Judge Hall has done an outstanding job in a difficult office. The chairman must be an administrator, appellate judge, political liaison, good will ambassador and more. Her omnicompetent leadership has placed Georgia among the best run systems in the country while planning and executing significant changes, such as ICMS, which will keep us in the front ranks. Well done, Your Honor.

The Section will host an event to Honor Judge Hall on Sept. 29 in Buckhead. Details will be sent by e-mail. Join other section members and guests for the special evening.

Mark you calendar for the annual Workers' Compensation Institute in October. Judge Tasca Hagler, Kelly Benedict and Kevin Gaulke have planned an excellent program with an outstanding faculty. We who are veterans of the annual pilgrimage to St. Simons Island know there is no finer way to spend an autumn weekend.

Finally, the Section welcomes the incoming Chairman, Richard Thompson. Judge Thompson is a long-time member of the Comp Section. He has served as an advocate, a trial judge, an appellate judge and a mediator. His varied experience should serve him well. As they say in the theater, break a leg. ***WC***

Editor's Corner

By John D. Christy

I hope that our Section Members and other readers find the Summer Edition of the Workers' Compensation Law Section Newsletter worth the wait. I am grateful to and wish to say a special thanks to Jarome E. Gautreaux; Thomas M. Finn; Kellye C. Moore; Dennis L. Duncan; J. Travis Hall; Christina Beville; Benjamin I. Jordan; Teri Zarrillo; Jeffrey Stinson; Jason C. Logan; and Neil C. Thom for the time and effort that they put into preparing their articles for the newsletter.

The Memorial to David Higdon is a testament to a most valued past member of our Section. I had the honor and the privilege to know and work with David for many years and found him to always be a professional in the truest sense of the word in his approach to the practice of law and in how he treated fellow members of the Bar. ***WC***

A special thanks to the
2008-09 Workers' Compensation Law
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The Perkins Law Firm

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Attention State Bar Members! Please Note!

check your information

www.gabar.org/member_essentials/address_change/

The State Bar is in the process of implementing its new database. This implementation will affect how a few things work on Bar's website. To be ready for this change, we ask that you please make sure we have up-to-date information in your membership record. Please go to www.gabar.org/member_essentials/address_change/ and check your information. Also note what e-mail address the Bar lists as your official e-mail address, as you will need this to log in for the first time once the database change takes place. We will keep you updated as we move forward with this project.

CIVIL UNREST: Incivility and Its Consequences Upon the Profession

By Dennis L. Duncan and J. Travis Hall
Chambless, Higdon, Richardson, Katz & Griggs, LLP

"We make ready with nervousness to scale the final slope, the assent which was the goal of all the earlier advances forward."

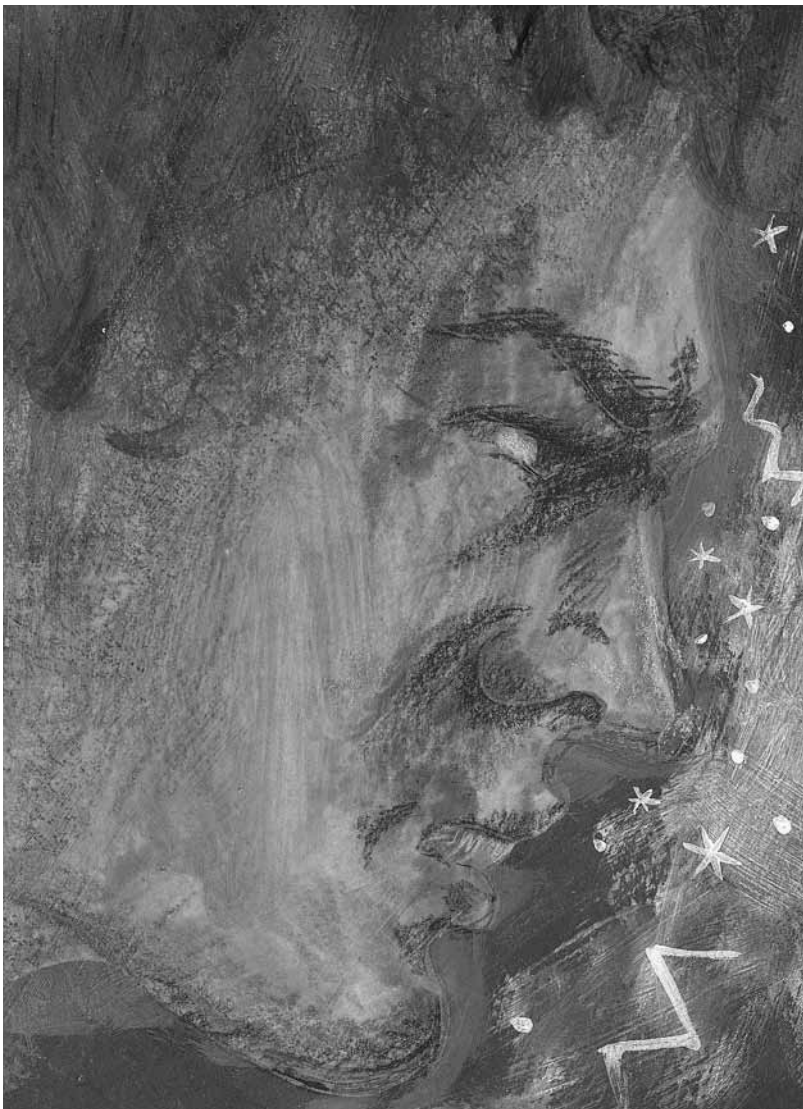
-Hans Urs von Balthasar

Lawyers are good people and the law a noble profession. Attorneys love their families, they respect their clients, and they give back to their communities. Unfortunately, all too often in the modern era the courtesy and respect that these good individuals once showed to one another have been replaced by a deep seeded mistrust and animosity. An adversarial legal system, such as the one in which we practice, is not dependant on unfettered aggression and self righteous zeal for the client's interest, but on honest civility. Passionate advocacy on behalf of one's client can be constructive; but conversely, it can become destructive if it is allowed to roam the legal landscape unchecked. The emotions that a lawyer brings to bear on his client's behalf should be tempered and reigned in by the primary duty to honor the court and one's fellow professionals.

What constitutes civil misconduct may sometimes be difficult to clearly define. Incivility manifests itself in a variety of behaviors: the attorney who chronically refuses to return phone calls or respond to correspondence in an intentional effort to frustrate opposing counsel; or the attorney, who automatically files a motion before picking up the phone to attempt an informal resolution of a dispute; or the attorney who refuses to treat his colleague with even a modicum of respect for fear that his or her client may deem that courtesy a weakness. For many attorneys, this uncharitable conduct is the rule not the exception. In the legal profession, the trend appears to be a shift in focus away from service to our society, and instead a shift of service to one's firm and/or its super clients. When this happens, a premium is placed on winning at all costs, and little regard is given to our primary duties as officers of the court: to seek the truth, vindicate those who have been wronged, and facilitate the administration of justice.

Historically, our adversarial system has presumed that attorneys will zealously advocate for their clients within the bounds of the law, while providing the finder of fact with competent and credible evidence relevant to the legal issues to be adjudicated. Hence, justice, in whatever form it takes, is the goal of litigation. Victory, which is obtained through deceit, obstinacy and an unwillingness to cooperate with opposing counsel and the court, is a distorted product of an overtly manipulated legal system, it is a disservice to clients, and it unfortunately, raises many profound ethical questions.

When asked, attorneys often mention incivility in the legal profession as their primary reason for discontent with their career. Yet, the trend toward increased incivility not only persists but according to recent statistics is rapidly escalating. Obviously, most attorneys do not enter the practice of law with the intent to be incivil. It is a learned behavior. So what has caused this modern trend toward incivility? There are two primary answers to that question: one is cause for concern for defense attorneys, and the other is cause for concern for plaintiff attorneys. First, incivility has the primary effect of prolonging litigation at all levels and thereby increasing litigation costs. While it is nice to imagine that some of these attorneys are just diligently pursuing justice on behalf of their clients, more often than not, the real focus is on generating higher fees. Second, by filing unnecessary motions and exhibiting displays of arrogance and uncooperativeness with opposing counsel, many lawyers think that they are delivering in some manner on what are more likely than not unrealistic promises they made to their clients either through exaggerated advertisements or during initial consultations. When a lawyer tells a client that he or she will "fight" for their victory,



or that he or she will not let the other party "push them around," that lawyer paints himself or herself into a corner and is often forced to resort to quasi-theatrics to save face at the cost of authentic, productive representation for their uninitiated client.

In both scenarios, the usual motivating factor generating incivility is monetary gain. A defense attorney, representing sophisticated corporate clients, who is usually commensurated by a hefty retainer and bills against it by the hour, can easily be tempted to premium bill for costly motions as opposed to simply arranging a teleconference with the judge and opposing counsel. Moreover, a defense attorney may be inclined to unnecessarily prolong litigation in an effort to keep a steady revenue stream flowing. While this strategy may seem to work in the short term, in the long run, these manipulated clients will be lost to firms that, to the contrary, provide a quality legal product in a timely manner and for a reasonable fee. The myopic, short term strategy actually tends to perpetuate itself. Rather than stemming the tide of incivility, it encourages this conduct in an effort to replenish the constant loss of disillusioned clients. Thus, it actually perpetuates itself by forcing attorneys to bill as much and as quickly as possible in order to compensate for the inevitable, foreseeable loss of dissatisfied clients.

On the flip side of the coin, a plaintiff attorney, who attracts clients by promising to be unrealistically aggressive and relentless in pursuit of his or her client's interests, is often tempted to act upon that promise by being uncouth, uncooperative, and obstinate toward opposing counsel. Again, this behavior has the effect of drawing out the litigation process and obscuring the real issues of the case. Therefore, rarely does this type of histrionics achieve the desired results of a clear and decisive victory for the plaintiff.

Clients ultimately desire a fair and speedy resolution of their legal problems. But this cannot possibly happen if the strategy of the attorneys is to squander the court's time squabbling over collateral disputes that shed little light on the issues needing to be decided by the judge or jury. Some lawyers are tempted to argue these de minimus matters because they have explicitly promised their clients that they would do so at the outset of the litigation. Nevertheless, just as in the case with defense attorneys, plaintiff attorneys can find that instead of increasing their business through incivility, their business actually declines. If it becomes apparent to the courts, as well as other attorneys, that the actions of a particular lawyer are contumacious or disordered with respect to their handling of a law suit, their credibility suffers greatly and favorable results for their hapless clients are bound to decline.

All attorneys have a duty to their clients, but also to their profession. True duty to one's profession includes conducting oneself in a civil manner and treating fellow officers of the court with respect at all times. Opposing counsel will not always be one's best friend; oftentimes, they are far from it. But all attorneys, as trusted servants of society, should strive to promote genuine civility among their fellow members of the bar. Incivility erodes the historic prestige, the common trust, and what it truly means to be an attorney. For the sake of justice, in reverence for our rule of law, for our clients' best interests, and the legal profession as a whole, we should at all times endeavor to uphold the integrity of our American Court System by imparting to each and every one of its members sincere civility and respect. ***WC***

Dennis Duncan focuses his practice on workers' compensation law and general insurance defense.

Travis Hall is a an Associate with the law firm of Chambless, Higdon, Richardson, Katz & Griggs, LLP in Macon, Georgia. He concentrates his law practice in the area of civil litigation. He specializes in representing insurers, self-insured employers, and state and local governments in the defense of workers' compensation claims. His practice areas also include civil rights defense litigation, defense of automobile liability claims, general liability matters, and general insurance defense. Mr. Hall was admitted to the State Bar of Georgia in 2008. He graduated from Florida State University in 2003 with a Bachelor of Science Degree in Political Science and in 2005 with a Master's Degree in Political Science. He attended law school at Mercer University's Walter F. George School law where he graduated in 2008.

The Effect Weekly Benefits, Remedial Treatment and Estoppel Have on the All Issues Statute of Limitation

By: Christina J. Bevill and Benjamin I. Jordan
David & Rosetti, LLP

O.C.G.A. § 34-9-82(a) states "[t]he right to compensation shall be barred unless a claim therefor is filed within one year after injury, except that if payment of weekly benefits has been made or remedial treatment has been furnished by the employer on account of the injury the claim may be filed within one year after the date of the last remedial treatment furnished by the employer or within two years after the date of the last payment of weekly benefits." If no income benefits are paid or remedial treatment provided, the application of the rule is straight forward. However, when medical benefits are furnished or income benefits paid, issues arise concerning the date the clock begins running for a claimant to file a timely claim. Those issues include what constitutes remedial treatment and weekly benefits. This article addresses and evaluates these issues and the related case law.

Pre-July 1, 1978 Statute

For accidents prior to July 1, 1978 the employee had one year from the date of the accident to file a claim. Former Ga. Code Ann. § 114-305; C*otton States Ins. Co. v. Studdard*, 126 Ga.App. 217, 190 S.E.2d 549 (1972). The time period for filing a claim was not extended if medical treatment was provided or weekly benefits paid. However, the Court of Appeals applied an estoppel theory barring the employer from asserting a statute of limitation defense, although there was confusion regarding exactly how the theory should be applied.

In *Cotton States Ins. Co. v. Studdard* the employee experienced a Nov. 17, 1969 work-related accident, which resulted in a broken hip and subsequent surgery. 126 Ga. App. 217, 190 S.E.2d 549 (1972). An agent of the employer and insurer investigated the claim and informed the employee she should not file a workers' compensation claim because the company would take care of everything. Id. at 218. The parties entered into settlement negotiations and, by August or September 1970, an agreement appeared imminent. Id. However, after realizing another operation would be required, the employee informed the insurer she could not sign the agreement because there would be additional medical bills. Id. On Nov. 19, 1970, three days after the statute of limitation had lapsed, the insurer informed the employee that unless she took the amount previously offered she would receive nothing as the statute had run. Id. at 219.

The Board held the employee had the right to rely on her insurer. Cotton States, 126 Ga. App. at 219. Because the insurer led her to believe it was still planning to settle the claim until shortly after the statute had lapsed, it had waived its right to assert a statute of limitation defense. Id. In affirming the decision, the Court of Appeals held, "[t]he conduct of defendant and its insurance carrier may be such as to estop them from presenting the statutory limitation as a defense in bar of the claim for compensation if the effect of such conduct was to mislead or deceive claimant, whether intentional or not, and induce [her] to withhold or postpone filing [her] claim petition until more than a year had elapsed from the occurrence of the accident." Cotton States, 126 Ga. App. at 220, 221. (emphasis added).

This rule was not applied consistently and led to conflicting results. The Court of Appeals sometimes required evidence of an intentional misrepresentation by the employer made to influence the employee not to file a workers' compensation claim. For example, in *Hartford Acc. & Indem. Co. v. Snyder* the employee experienced a work-related accident on Jan. 9, 1969, but did not file a claim until Oct. 10, 1970. 126 Ga.App. 31, 189 S.E.2d 919 (1972). There was evidence the employee, who could neither read nor write, was assured by his employer, or agents acting on behalf of his employer, that his medical bills would be paid and that he would also receive a compromise settlement. Id. at 32. The employee testified he had received no payments and none of his medical bills had been paid. Id. at 32, 33.

The court held, "the bar of the statute was not removed by the fact that a claimant may have continued in the service of his employer, receiving wages, or the making of gratuitous contributions by the employer to the employee and his family, or by the making of a purported settlement of his claim, or by the payment of his medical expenses, or by the payment of wages and the hospital and doctor bills, or by treatment by the employer's physician." Id. at 36. The court further held, "a statement by an employer or his agent to an employee to the effect that he or she 'would be taken care of' or by an insurer's physician that 'the company will take care of you' does not constitute fraud that will toll the statute as to the time for filing claims." Id. Although the court recognized fraud could toll the statute, it placed a very high burden on an employee.

Between 1972 and 1979 there was continued confusion over exactly how the estoppel theory should be applied. In Employers Ins. of *Wausau v. Nolen* the employee, acting on advice from the insurer, failed to file a claim causing the statute of limitation to lapse. 137 Ga.App. 205, 223 S.E.2d 250 (1976). The Court of Appeals held the actions of the insurer misled the employee and caused him to postpone the filing of his claim until more than a year had elapsed from the occurrence of the accident. Id. at 206. As a result, the employer or insurer were barred from asserting

a statute of limitation defense. Id. at 207. In doing so, the Court cited the rule from Cotton States which did not require intent. Id.

Conversely, in *Day v. Bituminous Cas. Corp.* the court once again required evidence of intent. 141 Ga. App. 555, 234 S.E.2d 142 (1977). In Day, there was evidence the insurer told the employee she could visit the insurer's doctor again, her claim would be reopened, and that she did not need to sign anything as her medical expenses would be paid, which in fact they were throughout 1973 and 1974. Id. at 556. The Court refused to apply the estoppel theory and reasoned these statements did not constitute intentional acts of concealment or misrepresentation. Id.

In 1979, the Georgia Supreme Court addressed this conflict in *Brown Transport Corp. v. James.* 243 Ga. 701, 257 S.E.2d 242 (1979) In Brown Transport, the Supreme Court overruled both Day and Snyder holding, "that where an employee relies on the statements of his employer or insurance carrier, who are in a position of authority, that he will be taken care of, that all is well and he needn't worry, it is going too far then to allow them to raise as a bar to his claim the employee's failure to file within one year." Id. at 701. The ruling focused purely on the employer's conduct and the employee's reliance. There was no longer a requirement that the employer made statements with the intent to mislead the employee.

Current Statute

In recognition of the problems caused by the strict language of the pre-July 1978 provision, the statute was amended to include tolling provisions for the receipt of "weekly benefits" as well as "remedial medical treatment" furnished by the employer. The payment of weekly benefits or furnishing of remedial treatment by the employer might have previously justified the use of the estoppel theory. Now, however, no estoppel is required for these acts as they have been specifically included in the statute.

Estoppel Theory Still Viable

There are situations when neither weekly benefits have been paid nor remedial treatment furnished by the employer, but the use of the estoppel theory is warranted by the circumstances. For example, in the Court of Appeals held the employer and insurer were estopped from asserting the statute of limitation as a defense after the insurer incorrectly informed the claimant, who had a 1998 date of accident, they were not the insurer on the date of the accident. 257 Ga. App. 700, 572 S.E.2d 45 (2002). The claimant was referred to another insurer who denied his claim. Id. at 701. By the time he filed his claim with the original insurer, the one year limitation period had lapsed. Id. In ruling the estoppel theory applied, the Court of Appeals again cited the rule from Cotton States. Id. at 703. Thus, although the amended version of the statute added new exceptions, the estoppel theory remains viable.

Defining "Weekly Benefits" Under O.C.G.A. § 34-9-82(a)

Payment of temporary total disability (TTD) or temporary partial disability (TPD) to an employee establishes his or her claim as a compensable claim by award or otherwise.

Hartford Ins. Group v. Stewart, 147 Ga.App. 733, 250 S.E.2d 184 (1978). Once a claim is compensable, O.C.G.A. § 34-9-82(a) is no longer applicable. Instead, the claim has been accepted and there is no obligation to file a notice of claim.

PPD Benefits

If the employee has received permanent partial disability (PPD) benefits, he or she has two years from the last date of such payments in which to file a claim for that particular accident date. *Mickens v. Western Probation Detention Center*, 244 Ga. App. 268, 534 S.E. 2d 927 (2000). The Court in Mickens reasoned the General Assembly could have included specified benefits in the statute; however, it did not. Mickens, 244 Ga.App. at 270. In addition, the court noted O.C.G.A. § 34-9-263 expressly refers to permanent partial benefits as weekly income benefits. Id. Thus, the Court concluded PPD benefits constitute weekly benefits for purposes of tolling the statute of limitation under O.C.G.A. § 34-9-82(a). Id.

It is worth noting the employer in Mickens controverted overall liability, pursuant to O.C.G.A. § 34-9-221(h), after paying PPD benefits. The Court applied the all issues statute of limitation seemingly because the claim was controverted. Thus, if a claim is not controverted, it is an open question whether the payment of PPD benefits would render the claim compensable, or merely toll the statute under O.C.G.A. § 34-9-82(a).

Payments from Insurers other than Georgia Workers' Compensation Insurers

The employee may have received weekly benefit payments from an insurer that is not subject to the Georgia Workers' Compensation Act. In *Sprayberry v. Commercial Union Ins. Co*. the Georgia Court of Appeals indicated that weekly benefit payments made under the Tennessee Workers' Compensation Statute did not toll the running of the statute of limitation under Georgia law. 140 Ga.App. 758, 232 S.E.2d 111 (1976). That was, however, before the July 1, 1978 amendment to the Act.

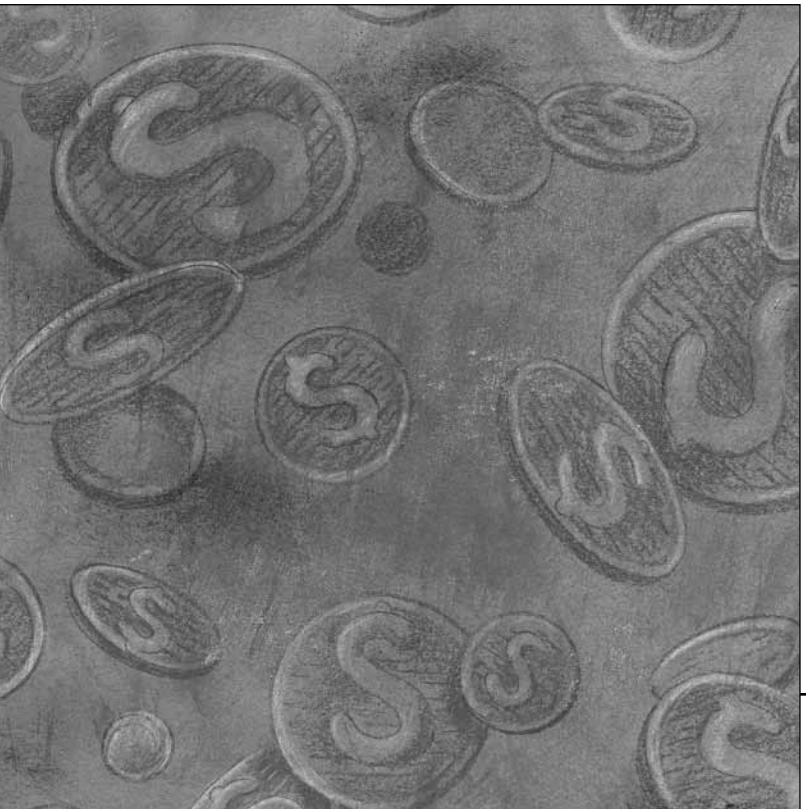
Since the 1978 amendment, the Court of Appeals has been far more liberal in allowing a variety of payments to toll the statute of limitation. As such, the result in Sprayberry might be different under the present wording of the statute. In Atlantic Container Services v. Godbee the employee filed a claim more than one year after his accident date. 218 Ga.App. 594, 462 S.E.2d 465 (1995). He had never received any workers' compensation

benefits, but he had received weekly benefit payments pursuant to the Longshoremen's & Harbor Workers' Compensation Act, 33 U.S.C. 901, et seq. (LHWCA). The Court of Appeals held although funded by a different insurance carrier under the LHWCA, the employer provided income benefits for the injury. Atlantic Container Services, 218 Ga.App. at 595. Income benefit payments made pursuant to the LHWCA constituted weekly benefit payments for purposes of tolling the statute of limitation under § 34-9-82(a). Id. In so holding, the Court emphasized the plain language of § 34-9-82(a) and reasoned the term weekly benefits as used in the statute should not be confined merely to benefits paid pursuant to the Georgia Workers' Compensation Act. Id.

Payment of Regular Salary, Vacation Pay, or Sick Leave

Each of the previously cited circumstances involves situations in which an insurer, workers' compensation or otherwise, pays weekly benefits to the injured employee. In other cases, the employer might pay the employee regular salary, vacation pay, or sick leave while he or she is out of work recovering from a compensable injury. In such a situation, the question may arise whether these payments constitute weekly benefits for purposes of tolling the statute of limitation under O.C.G.A. § 34-9-82(a).

In *Harper v. L & M Granite Co.*, Inc. the Court of Appeals held where an employer did not pay the employee under the Workers' Compensation Act but instead paid the employee's regular salary while the employee missed time from work because of an on-the-job injury, and where the employer was found to have encouraged the employee to accept the regular salary rather than file a workers' compensation claim, the payments made were in lieu of workers' compensation income benefits, and a claim filed within two years of the last payment of such salary was not barred by O.C.G.A. § 34-9-82(a). 197 Ga. App. 157, 397 S.E.2d 739 (1990). The employee in Harper notified his employer he wanted to receive workers' compensation benefits within thirty days of experiencing a compensable accident; however, the employer actively persuaded the employee not to file a workers' compensation claim. Harper, 197 Ga. App. at 158, 159. Instead, the employer paid him for two weeks (70 hours) of work. Id. Ultimately, the employee was terminated before he could return to work. Id. at 159.



The Georgia Court of Appeals held these payments did constitute weekly benefits under O.C.G.A. § 34-9-82(a), thus tolling the statute of limitation, because they were made by the employer in an effort to avoid a workers' compensation claim from being filed. Harper, 197 Ga. App. at 160. As a result, they were made in lieu of workers' compensation benefits. Id. Although Harper specifically involved payment of regular salary, the Court of Appeals' focus was not so much on the fact that salary was paid, but that benefits, of any sort, were paid with the intent to avoid a workers' compensation claim. Id. It is worth noting the Court in Harper determined the evidence presented by the claimant was "barely" enough to support the Board's holding. Id. Nevertheless, the same reasoning should apply to other types of benefits paid in lieu of workers' compensation benefits, including sick leave and vacation pay.

Based on the holding in Harper, the door is left open for situations in which salary is paid after a compensable accident, but there is no evidence the employer made the payments to avoid payment of workers' compensation benefits. Where there is no evidence the employer continued to pay salary to avoid a workers' compensation claim, a good argument can be made that the employer did not make the payments in lieu of workers' compensation. This is likely to occur when, pursuant to its own policy, a company pays the employee his or her salary while the employee is out of work either treating for or recovering from the injury especially when there is evidence it is done as a matter of convenience for the employee.

Remedial Treatment

O.C.G.A. § 34-9-82(a) extends the statute of limitation for one year from the date of the last remedial treatment provided by the employer on account of the injury. The Court of Appeals has addressed issues relating to the meaning of remedial treatment and what is considered treatment furnished by the employer. In A*merican Intern. Adjusting Co. v. Davis* the employee underwent diagnostic testing with three different physicians two of which agreed he was totally disabled as a result of work related kaolin dust exposure. 202 Ga.App. 276, 414 S.E.2d 292 (1991). He did not file his claim within a year of being taken out of work because of the exposure nor did he receive weekly benefits during that time. Id. The Court of Appeals held diagnostic testing provided

by the doctors did not constitute remedial treatment. Id. at 279. As a result, an MRI scan or CT scan should not toll the statute of limitations. However, in a recent decision, the Appellate Division of the State Board of Workers' Compensation has distinguished the Court of Appeals decision by determining there are some cases where CT and MRI tests constitute remedial medical treatment under O.C.G.A § 34-9-82 (a), thereby tolling the statute. This issue is currently on appeal to the Superior Court.

In addition, the statute is only tolled from the date the treatment was actually rendered, as opposed to when payment for the treatment was received. In *Queen Carpet, Inc. v. Moynihan* the employee sustained a compensable accident and the employer subsequently provided remedial treatment. 221 Ga.App. 797, 472 S.E.2d 489 (1996). The last bill for remedial treatment paid for by the employer was dated November 30, 1992 for treatment dates of Sept. 2, 1992, and Oct. 14, 1992. Id. at 798. The court held because the claim was not filed until Nov. 9, 1993, more than one year after the last remedial treatment was actually rendered, the claim was barred by the statute of limitation found in O.C.G.A. § 34-9-82(a). Id. at 799.

The manner in which the treatment is carried out may determine whether it is remedial. In *Weir v. Skyline Messenger Serv*. the employee argued her exercise regimen was remedial treatment. 203 Ga. App. 673, 417 S.E.2d 693 (1992). Although the doctor suggested this treatment, the Board disagreed with the employee's argument it constituted remedial treatment. Id. at 675. In upholding the Board's decision, the Court of Appeals pointed out there was no medical supervision of the exercise regimen and the employee did not adhere to her appointment schedule with her physician. Id.

To toll the statute of limitation, the remedial treatment must generally be provided by the employer. However, in some circumstances, even if the payment for treatment did not come from the insurer or employer, the treatment may be deemed remedial. In Georgia Institute of Technology v. Gore the Georgia Court of Appeals held where an employer failed to maintain a valid panel of physicians readily accessible to the employees, medical treatment received elsewhere by an employee on account of a work-related injury could be deemed, for statute of limitations purposes, to be remedial treatment furnished by the employer thus tolling the statute of limitation. 167 Ga. App. 359, 306 S.E.2d 338 (1983). There was no dispute as to the compensability of the claim in Gore. Id. As such, there was no dispute about whether the treatment would be the responsibility of the employer and insurer since they did not have a valid panel. Id. By contrast, the employer and insurer might argue that if a valid controvert was filed to the substantive merits, the Gore case would not allow for an extension of the time in which to file since there would be no underlying obligations to provide the treatment.

Once the statute of limitation has lapsed, it cannot be revived. Thus, although an invalid panel authorizes an employee to seek treatment with a provider of their choice, he or she must still do so within one year of the job-related injury or of previous employer-furnished treatment. *Poissonnier v. Better Business Bureau of West Georgia-East Alabama, Inc*. 180 Ga.App. 588, 349 S.E.2d 813 (1986). The employee in Poissonnier was injured on the job and received medical treatment for which her employer paid. Id. at 588. For the next 30 months she received no medical treatment. Id. She then consulted a chiropractor and two other doctors for symptoms which were associated with her work injury. Id. The employee argued any treatment she received for her work related injuries should be considered furnished by the employer because the employer's panel was invalid. Id. The ALJ, citing Gore, agreed with the employee but the Appellate Division reversed. Poissonnier, 180 Ga. App. at 588. The Court of Appeals agreed with the Appellate Division because there was no ongoing course of medical treatment. Id. In doing so, the Court held "medical treatment which is deemed, for statute of limitation purposes, to be remedial treatment furnished by the employer must be commenced within the original period of limitation, i.e., within one year of the job-related injury or of previous employer-furnished treatment." Id.

The statute is not tolled if the employee seeks treatment, without any input from the employer or insurer, from a non-panel physician when there is a valid panel. In *Paideia Sch. v. Geiger* the employee sustained a compensable head injury on October 11, 1985. 192 Ga. App. 723, 386 S.E.2d 381 (1989). The next day, he went to a hospital emergency room complaining of severe headaches; however, he returned to his normal work duties immediately after being examined and made no claim for workers' compensation benefits during the course of the following year. Id. at 723. On November 10, 1986, he sought medical treatment for these symptoms from a non-panel physician without consulting or notifying his employer. Id. Because the employer's panel was valid, the employee was not authorized to unilaterally choose his own physician and the employee's treatment with the non-panel physician was not deemed to have been furnished by the employer. Id.

Conclusion

The 1978 revisions to O.C.G.A. § 34-9-82(a) create more issues regarding when the statute is tolled. When considering weekly benefits, if the employee has received permanent partial disability (PPD) benefits, he or she has two years from the last date of such payments in which to file a claim for that particular accident date. Mickens, 244 Ga.App. at 268. However, the Court of Appeals has emphasized the plain language of O.C.G.A. § 34-9-82(a) and reasoned the term weekly benefits as used in the statute should not be confined merely to benefits paid pursuant to the Georgia Workers' Compensation Act. Atlantic Container

Services, 218 Ga.App. at 595. Thus, the payments do not necessarily need to be derived from or funded by any workers' compensation related entity. Id. In fact, where an employer continues to pay an employee's regular salary while the employee misses time from work because of an on-the-job injury, and encourages the employee to accept the regular salary rather than file a workers' compensation claim, the payments made are in lieu of workers' compensation income benefits, and a claim filed within two years of the last payment of such salary is not barred by O.C.G.A. § 34-9-82(a). Harper, 197 Ga. App. at 160.

The Court of Appeals has addressed several issues related to the "remedial treatment" clause. The Court has held remedial treatment is more than a mere evaluation. American Intern. Adjusting Co., 202 Ga.App. at 276. In addition, the statute is only tolled from the date the last treatment was actually rendered, as opposed to when payment for the treatment was received. Queen Carpet, Inc, 221 Ga.App. at 797. The manner in which the treatment is carried out is also important in determining whether the treatment is remedial. Weir, 203 Ga. App. at 673.

The validity of the panel of physicians may also be a critical factor. If the panel is invalid, medical treatment received elsewhere by an employee on account of a work-related injury would be deemed, for statute of limitations purposes, to be remedial treatment furnished by the employer. Georgia Institute of Technology, 167 Ga. App. at 359. However, while an invalid panel authorizes an employee to seek treatment with a provider of his or her choice, he or she must still do so within one year of the job-related injury or of previous employer-furnished treatment. Poissonnier, 180 Ga.App. at 588. Determining whether the statute of limitation is tolled is fact intensive. However, a basic understanding of the cases discussed in this article will assist the attorney in evaluating whether there is a claim to pursue or a good statue of limitation defense to a claim. ***WC***

Christina J. Bevill is a founding member and partner at David & Rosetti and practices primarily in the area of workers' compensation defense. She is a member of the State Bar of Georgia and the State Bar Workers' Compensation Section.

She has concentrated her practice in workers' compensation on behalf of employers and insurance companies. She has spoken throughout the Southeast on a variety of topics including psychiatric injuries and workers' compensation claims, drugs in the workplace, undocumented workers and strategies to reduce exposure in workers' compensation claims. She received her J.D. from the Walter F. George School of Law at Mercer University in 2000.

Benjamin I. Jordan is an associate at David & Rosetti, LLP. He practices in the area of workers' compensation defense. Ben received his J.D. from Georgia State University in 2006.

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Should Maloney Apply in Today's Economic Environment

By Teri Zarrillo, Esq. and Jeffrey Stinson, Esq.
Goodman McGuffey Lindsey & Johnson, LLP

There is little doubt that claimants, employers, insurers and counsel for all in the workers' compensation legal community have seen changes in practice as the economy has fallen. Statistics show that claims actually should decline during bad economic times. As a practical matter, however, it seems that workers' compensation litigation actually has increased.

Whatever the reasons for the changes in the frequency and/or type of workers' compensation claim and/or litigation, we, as attorneys, rely on the consistent application of case law precedent in our practices. At the same time, we must realize that the realities of our times will inevitably affect the judges' decisions in cases. Perhaps there is a fine line between accepting facts to support an award of benefits and failing to require claimants to satisfy legal requirements for entitlement to benefits? In practice, it seems that this fine line is being blurred to extinction when looking for a claimant to meet their burden of proof for entitlement to income benefits in certain cases.

Georgia workers' compensation law is well settled that a claimant who has work restrictions or limitations due to his on-the-job injuries and who is terminated for cause and for reasons unrelated to his on-the-job injuries has the burden of proving an inability to find suitable employment due to his injuries despite a diligent job search before he will be entitled to weekly temporary total disability (TTD) benefits. *Maloney v. Gordon County Farms*, 265 Ga 825 (1995). What constitutes a diligent job search has been the subject of much litigation over the years, although Georgia courts have never really given a clear standard as to what qualifies as a diligent job search. In Maloney, the claimant's job search with six different employers was found to be diligent. In other cases where the job search was limited to only two fields of work, the Court of Appeals concluded the job search was not diligent. *Harrell v. City of Albany Police Dep't,* 219 Ga. App. 810 (1996). Although these cases give some guidance as to what qualifies as diligent, in practice, the outcome depends on the ALJ and the facts of each specific case.

Initially, it seemed that the Maloney burden would be difficult for a claimant to meet. Not only was the claimant to be taxed with going out and looking for work within their restrictions and capabilities, but also they seemed to be required to prove that their inability to find work was due to their injuries, an approach advocated by the Court in Aden's Minit Market. *Aden's Minit Mkt. v. Landon*, 202 Ga. App. 219 (1991). However, over time, the courts clarified that a claimant would be presumed to have been denied work due to his injuries once he established that he performed a diligent job search. Maloney, *T.V. Minority v. Chaffins*, 223 Ga.App. 495 (1996). The claimant is not required to prove why he was not offered employment. *Sadeghi v. Suad*, Inc., 219 Ga. App. 92 (1995). In practice, this presumption results in a shifting of the burden of proof back to the employer and insurer to show that the claimant was, in fact, denied work for reasons other than his injuries. Often times, employers and insurers are left to expend significant resources to produce testimony from the prospective employers of their reasons for denying a claimant employment. The employers' failure to produce this direct evidence would preclude them from proving that the claimant was denied employment for reasons other than their on-the-job injuries.

This apparent shifting of the burden of proof has seemed to erode the very purpose of the requirement that the claimant perform a diligent job search and show that his inability to find alternative employment was due to his injuries. Still, having the burden of proof forces claimants to show, at a minimum, that they are trying to find other work. With the changes in the economy, there is little doubt that a claimant today is going to have a more difficult time finding work than a claimant of just over a year or 2 ago. However, without any change in the case law, it seems that the unfavorable economy may be leading to the practical effect of eliminating the requirement that a claimant look for work at all before awarding income benefits, regardless of the reason for their termination from the employer.

The claimant's bar may argue that it is a waste of time for claimants to look for work when even able-bodied workers cannot find work. In fact, statistics show that the unemployment rates are near an all-time high, and certainly the highest in recent memory, with no ceiling in sight. The U.S. Department of Labor Bureau of Labor Statistics currently projects the national unemployment rate to be 9.5 percent. In Georgia, over the past year, the unemployment rate has risen from 5.9 percent in May 2008 to 9.7 percent as of May this year. We do not need to look far to find reasons for the unemployment rate, as companies ranging in size from large plants to small businesses are closing.

Such a narrow view is clearly misplaced. Focusing on only unemployment rates or the probability of claimants in general finding work ignores the specific capabilities of the individual workers. Furthermore, there is little doubt that the claimant's bar would object to eliminating the obligation to provide income benefits to an injured worker who is capable of working with restrictions anytime the economy is strong. The employer and insurer's argument would be that the claimant certainly should find work if he looked since the economy is so good, so he should not get benefits under any circumstances. How would we

judge when the economy was at a state that called for application of the Maloney burden? When would we apply the burden of proof at all?

Although Maloney and the line of cases following it indicate that the economy should not have any impact on whether an injured worker who was terminated for cause should be required to conduct a diligent job search, recent decisions from the Board appear to question this well accepted principle. Specifically, in at least one recent case, (and there is some concern in the Defense bar that this may be more widespread), an ALJ did not require a claimant to even look for work and instead summarily found that "dire economic circumstances" at least partially resulted in an employee's inability to find work. Notably, the decisions upon which the ALJ relied pre-dated Maloney and the requirements for the job search the decision helped establish. See *Gilmer v. Atlanta Housing Auth.,* 170 Ga. App. 326 (1984) and *King v. Piedmont-Warner Development et al*, 177 Ga. App. 176 (1985). Certainly, dire economic circumstances may make it more difficult to find work, but such circumstances should not eliminate an employee's obligation to perform a diligent job search.

Additionally, looking only at the odds of a claimant finding work is ignoring other practical considerations for the Maloney burden. We should remember that the workers' compensation system in Georgia is a no fault system. It was not designed to indefinitely support an injured worker, particularly one capable of returning to alternative employment. You do not need to look far to see clear examples of the legislature's attempt to motivate a claimant to return to the work force by limiting their entitlement to benefits: the 400 weeks statutory cap on entitlement to TTD benefits without a catastrophic designation (O.C.G.A. §34-9-261), stringent requirements before a claim is designated catastrophic (OC.G.A. §34-9-200.1), and the statutory change in condition OC.G.A. §34-9-104).

The Georgia Workers' Compensation Act was designed to ensure injured workers resources for medical care while at the same time ensuring that they would have income until they returned to the workforce. At the same time, the Act provided employers and insurers limitations on medical care and income benefits and eliminated suits in tort together with any claim for general damages. The court's decision in Maloney was consistent with the overall purpose of the Act. That is, since the Maloney burden only applies when the claimant is capable of some form of gainful employment, an employer and its insurer should not be required to keep that employee at work or provide them income benefits so long as the reason they are out of work is unrelated to their work-accident. If the claimant can otherwise work, the purpose of the Act is fulfilled and the claimant should not be due additional benefits.

Practically, reliance on the Maloney burden is even more important in a bad economy. The reality is that many employers are having an extremely difficult time keeping all of their employees employed. If the injured worker and his non-injured coworker are both terminated, they should both be required to look for work. Not requiring the injured worker to look for work, actually results in preferential treatment, possibly even arguable discrimination against the non-injured employee. Furthermore, there would be a very real concern that more frivolous workers' compensation claims would be made just to level the playing field so that workers' could guarantee some income to their families even without any need for them to look for work.

As with any issue, the parties, their counsel, judges and legislatures need to be cognizant of the impact of the changing economic times. At the same time, we must recognize the impact of the economy on legal issues for all. There is no question that employers and insurers are feeling the impact of the economic decline, as are employees. Legal precedent should be followed now as in good economic times to make sure we continue to pursue outcomes that support the purpose of the Workers' Compensation Act. ***WC***

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Goodman McGuffey Lindsey & Johnson LLP, founded in 1990, is a mid-sized civil and commercial litigation firm with offices in Atlanta, Georgia and Orlando, Florida. With substantial experience in a wide array of corporate and business litigation, our expertise includes commercial matters, products and tort liability, construction, insurance, class action, and employment disputes. We are currently active in several states throughout the Southeast.

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TERI ALPERT ZARRILLO

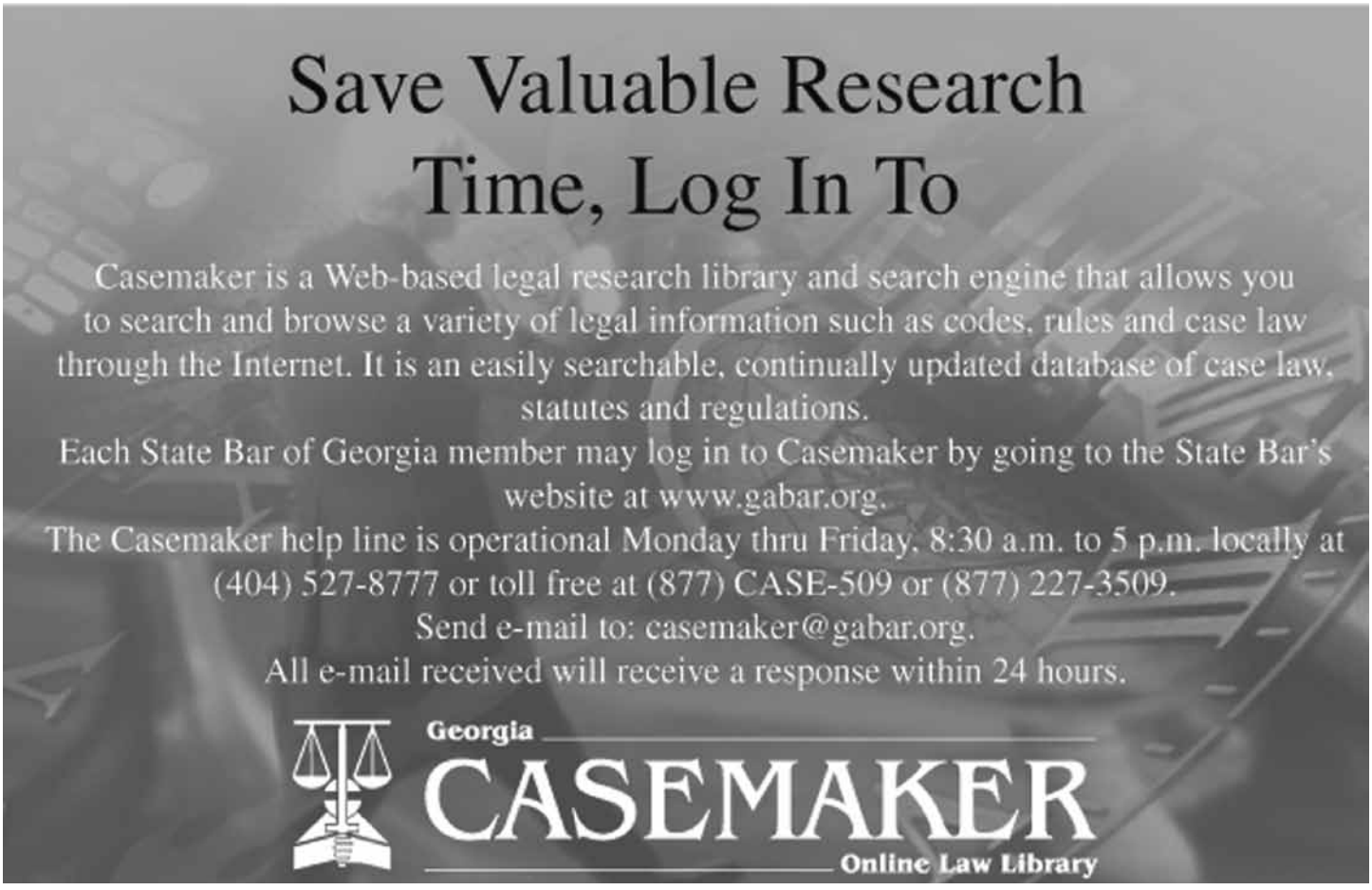
Teri Zarrillo is a partner in Goodman McGuffey Lindsey & Johnson, LLP and primarily represents self-insured and commercially insured employers in workers' compensation matters.

Zarrillo was admitted to the State Bar of Georgia and The Florida Bar in 1993. She earned both her undergraduate and graduate degrees from Emory University (B.A. in 1990 and J.D. in 1993). She is also a member of the Atlanta Lawyers Club and the Atlanta Claims Association. Zarrillo has been privileged to speak at numerous seminars regarding various workers' compensation issues. Her experience also includes representing clients in general litigation of civil cases and insurance coverage. She was born in Brooklyn, N.Y. and was raised in Miami, Fla.

JEFF K. STINSON

Jeff Stinson joined Goodman McGuffey Lindsey & Johnson, LLP in 2006. Having previous experience, he primarily represents employers and insurers in defending workers' compensation matters.

Jeff received his bachelor's degree in Public Relations and also minored in Sociology and Criminal Justice at the University of Georgia and obtained his J.D. from Georgia State University. While at Georgia State, he practiced under the Third Year Practice Act at the United State's Attorney's Office and with the Solicitor General's Office in Douglas County.



The Changing Winds of the Bermuda Triangle

By Jason C. Logan
Constangy, Brooks & Smith, LLP

As the story goes, many pilots, sailors and crewman have mysteriously been lost when navigating the waters of the infamous Bermuda Triangle. Likewise, the so-called Bermuda Triangle of employment law causes employers, attorneys and scholars alike to struggle with the competing requirements while avoiding the common pitfalls associated with the Americans with Disabilities Act (ADA), the Family Medical Leave Act (FMLA) and state workers' compensation laws (WCA). With recent changes to the ADA and FMLA (and others proposed), the waters of the mysterious Bermuda Triangle are more hazardous than ever.

Workers' compensation injuries can trigger application of the ADA and/or the FMLA. In Georgia, a non-exempt employer with three or more employees is required to maintain workers' compensation coverage. Fifteen is the magic number of employees that triggers the ADA's application, while fifty employees is needed to trigger FMLA. Therefore, it is paramount that attorneys and employers alike pay close attention to which laws are in play. Many employers triple their exposure by mishandling what was mistakenly considered just a workers' compensation claim. For example, an employee with a compensable workers' compensation injury may be disabled for ADA purposes and suffer from a qualifying serious health condition for FMLA purposes. This situation can present a host of human resource and legal concerns. Unfortunately, the best approach to handling these types of claims is not always clear, and there may be occasions where the three sets of laws cannot be harmonized to achieve a common goal. In these situations, it is often necessary to adjust the litigation strategy.

The threshold question of which laws apply to the employer is often followed by the more complicated process of deciding whether the employee is a qualified individual with a disability under the ADA or whether the injured employee's condition qualifies as a serious health condition under FMLA begins. To better understand the relationship, the following sections will discuss how the WCA interacts with the ADA and the FMLA.

Workers' Compensation and the ADA

As alluded to above, employers with at least 15 employees must not discriminate against individuals with qualifying disabilities. Not surprisingly, the term disability is a legal term of art and refers to a physical or mental impairment that substantially limits one or more of the major life activities of such individual, a record of such impairment or being regarding as having an impairment. An employee with a disability qualifies for protection under the ADA if he or she can perform the essential functions of the position, either with or without a reasonable accommodation. Although easier said than done, once notified of a disability, the employer should engage in an interactive process with the employee to determine whether any reasonable accommodations exist for that particular employee that would not cause an undue hardship on the employer. An employer's failure to accommodate a qualified individual with a disability is a violation of ADA and can subject the employer to litigation in Federal court.

On Sept. 25, 2008, President Bush signed the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), previously known as the ADA Restoration Act. Prior to the ADAAA, the employer could reasonably defend against ADA claims by arguing that the injury or condition was not a disabilty under the ADA. Prior to Jan. 1, 2009, the term major life activities encompassed things such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. However, the ADAAA drastically expanded the definition of major life activity and created a new category called major bodily functions. Now, a major life activity also includes eating, sleeping, standing, lifting, bending, reading, concentrating, thinking and communicating. The newly created list of major bodily functions include the immune, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive systems. With such an expanded list, most employees will be able to show that they are disabled for ADA purposes, virtually eliminating what was once a primary defense. Moreover, under the ADAAA, employers can no longer consider ameliorative mitigating measures in determining whether an employee is disabled, a decision which legislatively overturned the landmark decision in *Sutton v. United Air Lines*. Accordingly, an employer can no longer consider the employee's ability to take medication to control the condition when determining whether the condition/injury qualifies as a disability. Fortunately, the ADAAA did not contain any significant changes to the reasonable accommodation and anti-discrimination components to the ADA. Rather, the changes effectively broadened the scope of the ADA, such that more people than ever are considered disabled.

Now more than ever, injuries that arise out of and in the course of their employment may also qualify the employee for ADA protection. A work injury that triggers ADA will likely change how the informed employer handles the file. Unlike many states, the Georgia workers' compensation laws

do not specifically prohibit employers from terminating employees who file a workers' compensation claim. Accordingly, an employee does not have a specific retaliatory remedy against her employer when such a termination occurs, except for the potential entitlement to income benefits. Notwithstanding, the employer may be prevented from terminating the employee (for reasons related to the resulting disability) without first engaging in the interactive process to determine whether a reasonable accommodation exists for that employee. Although tailored to the specific employer, a reasonable accommodation could include things such as modifications or adjustments to the work environment, including an adjustment of hours, altering the manner in which the position is typically performed, providing physical aids or providing access to additional training. Thus, not only may the employer be prevented from immediately terminating the employee, but the employee may be entitled to a light-duty position following a workers' compensation accident if it is reasonable.

The Equal Employment Opportunity Commission's (EEOC) recommended reasonable accommodation priority would be to first try to accommodate the employee in his or her regular job. If unable to accommodate the employee in his prior job, the employer should next try to move the employee to a different job that is similar to his regular job in terms of duties, pay, and status. Next, the employer should try to move the employee to different job, including part-time job. If this does not work, the employer should consider offering medical leave before the last resort – termination. Under the circumstances, a recommended first step toward claim avoidance would be to implement an effective transitional light-duty work program that will accommodate the physical needs of the employee without jeopardizing the financial and business needs of the employer.

Now more than ever, there is considerable overlap between ADA and workers' compensation. Under this new era of the ADA, workers' compensation claimants will increasingly qualify for ADA protection. A fundamental understanding of both sets of laws is paramount for claim avoidance and complete representation.

Workers' Compensation and the FMLA

Generally speaking, the FMLA allows eligible employees to take up to 12 weeks of unpaid leave and protects the employee's position (or their right to a similar one) during the leave. Because many workers' compensation injuries/conditions also qualify as a serious health condition under the FMLA, covered employers must be careful not to violate an employee's FMLA rights while defending a workers' compensation claim. The inherent and often deliberate overlap of workers' compensation and FMLA can complicate claim handling and increase an employer's exposure for certain injuries. The new changes to FMLA will make it even more difficult to juggle the overlapping requirements.

FMLA currently applies to employers with 50 or more employees for each working day during each of 20 or more calendar work-weeks in the current or preceding year. To be eligible for FMLA leave, an employee must have been employed for at least 12 months by the employer and worked for the employer at least 1250 hours during the twelve months preceding the commencement of the leave. Covered employers must allow eligible employees to take up to 12 weeks of unpaid leave during any 12

month period for, among other things, a serious health condition that renders the employee unable to perform the essential functions of their position (as defined by the ADA). A serious health condition refers to an illness, injury, impairment or physical or mental condition which involves (1) inpatient care in a hospital, hospice or other medical facility or (2) continuing treatment by a health care provider. Employers must maintain coverage under any group health plan for the duration of the employee's leave at the level and under the conditions coverage would have been provided if the employee had continued working. With few exceptions, the employee must be returned to his or her prior position or a substantially similar position.

On Jan. 28, 2008, the National Defense Authorization Act for FY 2008 (NDAA) was signed by President Bush, which made several changes to FMLA. However, many of the changes were not implemented until Jan. 16, 2009, when the final regulations became effective. Many of the NDAA changes are outside the scope of this article, such as the creation of leave for military situations. Despite these changes, NDAA did give employers something to smile about— employees who fail to qualify for attendance bonuses due to FMLA leave are no longer entitled to those bonuses provided the employer treats employees on other types of leave the same way.

In addition to creating the new categories of FMLA leave, NDAA made some changes to and provided clarification for existing types of leave. In this regard, the new regulations clarified that inpatient treatment for any reason qualifies as a serious health condition. Clearly, many workers' compensation injuries will now automatically qualify as a serious health condition for FMLA purposes. In addition, an employer can require employees who need intermittent leave for scheduled medical treatment to make a reasonable effort to schedule treatment at a time that does not unduly disrupt the employer's operations, such as the beginning or end of a work day. Moreover, the employer may now contact the employee's health care provider directly to seek clarification on a fitness for duty certification. Not surprisingly, several of the forms have been modified, which are available on the U.S. Department of Labor's website. In addition, the time periods for requesting and providing a medical certification have been adjusted in favor of the employee. Unfortunately, NDAA also provides that light-duty work cannot be counted against the employee's available FMLA leave, a change that will require many employers to revise their leave policies.

In accordance with 29 C.F.R. Part 825.702(d), many employers have policies that require an injured worker to utilize their available FMLA concurrent with lost time as a result of a workers' compensation injury. While this is a beneficial tool for employers, this particular sword can cut both ways. Informed claimants will look for violations under all applicable laws. Consider a situation where an aggressive employer involved in a workers' compensation claim decides to offer a light-duty position to the employee, pursuant to O.C.G.A. § 34-9-240. Let's assume this employee is also utilizing FMLA leave and still suffers from a serious health condition, which is the subject of the workers' compensation claim. The question becomes, what should the employer do if the employee fails to attempt the offered position. Can the employee be terminated for failure to show up under a no-call, no-show policy? What about the fitness for duty certification form—should the employer also obtain this form prior to offering the position? Does waiving the rules in a workers' compensation claim jeopardize the validity of the employer's FMLA policy in other instances? These are questions that should be considered ahead of time, but are rarely even contemplated.

While there is not a specific anti-retaliation prohibition for terminating an employee that misses work due to a compensable workers' compensation claim in Georgia, employers are reminded that the employee's position may still be protected under the FMLA. Thus, a decision to terminate an employee could have consequences that extend beyond the obligation to pay TTD benefits. In a compulsory return to work scenario, employers may be within their rights to suspend TTD benefits but should refrain from terminating the employee as long as he or she remains on FMLA protected leave. Of course, this begs the question – would suspending the employee's TTD benefits be grounds for a retaliation claim under FMLA? The outcome would likely hinge on the employer's ability to show that the decision to suspend benefits was unrelated to the FMLA leave. In fact, an employer could probably defeat such a claim on summary judgment by showing that all prior claimant's also had their income benefits suspended when they failed to return to work, regardless of their FMLA status. The bottom line, the FMLA can drastically complicate an otherwise simple WC-240 return to work process and create additional exposure for the uninformed employer.

Employers are also encouraged to use the fitness for duty certification form and provide the physician a copy of the job description ahead of time. Note, the physician that certifies the serious health condition and fitness for duty certification forms may or may not be the authorized treating physician for workers' compensation purposes. Either way, the FMLA regulations require the fitness for duty physical to relate to the offered job and be consistent with business necessity, as required by the ADA. See 29 CFR § 825.702(e).

It should be noted that FMLA and ADA may share some overlap even absent a workers' compensation claim. As addressed in §825.702(d) of the FMLA regulations, FMLA may prevent an employer from requiring an employee to take a light-duty job as an accommodation, but the ADA may require that the employer offer the light-duty position as a reasonable accommodation for his or her disability. This is similar to the scenario discussed above but demonstrates how these laws may be triggered independent of a work injury.

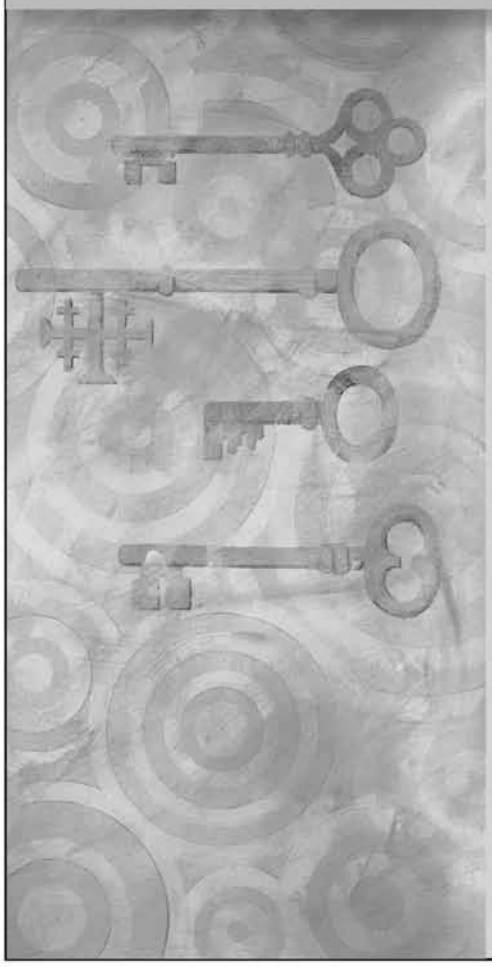
The bottom line, employers should be encouraged to utilize all available defenses and strategies to reduce their workers' compensation exposure but should remain

cognizant of the impact certain decisions may have on an employee's rights under FMLA. Generally speaking, employers are encouraged to run FMLA leave concurrent with lost time due to a workers' compensation leave, but cautioned about the easy-to-make but avoidable violations inherent with such a policy. As before, the first step in avoiding an FMLA violation is to keep and maintain accurate records of FMLA leave for all eligible employees.

Conclusion

Many defense attorneys have learned the hard way that their strategy for efficiently resolving a workers' compensation claim has created exposure for the employer under the ADA and/or FMLA. Likewise, many claimant attorneys lack the expertise necessary to advise their clients about possible ADA or FMLA violations. Unfortunately, the interplay of the ADA, FMLA and WC varies on a case-by-case basis. Even more vexing than simply knowing the laws is the challenging task of balancing the often competing interests. For this reason, the responsibilities/entitlements under these laws are often ignored by the parties on both sides. However, case law has shown that this approach can prove costly. In this new era of ADA and FMLA, attorneys should take caution before heading into these murky waters. ***WC***

Resources for Unemployed Attorneys



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- Lawyers Assistance Program
- Georgia Law Schools' Careers Centers
- Court Appointed Work by County
- Links to Many Other Online Resources

For more information, visit www.gabar.org/news/resources_for_unemployed_attorneys/

Recent Appellate Court Decisions in Workers' Compensation

By Neil C. Thom
A.B. Bishop & Associates, LLC

United Grocery Outlet et al. v. Bennett, Case No. A08A0677

(Ga. Ct. App. 2008). Decided 27 June 2008.

The claimant received temporary total disability benefits (TTD) following a work-related injury in August 2001. The last payment of TTD was in November 2001. In October 2004, the claimant requested a hearing seeking additional TTD based on a change in condition. She argued that the two-year statute of limitations in O.C.G.A. § 34-9-104 had been tolled by the employer's failure to serve forms required by Board Rules. The ALJ and State Board Appellate Division disagreed and denied her claim for benefits. The superior court reversed.

On appeal, the Court of Appeals reversed, holding that the plain language of O.C.G.A. § 34-9-104 provided that the two-year period of limitation on a change in condition claim began as of the last payment of benefits without regard to whether required forms were served. Non-compliance with the rules regarding forms can subject an employer to civil penalties, but cannot extend the statute of limitation.

McLendon v. Advertising That Works, Case No. A08A0768 (Ga. Ct. App. 2008). Decided 10 July 2008.

The claimant filed a hearing request on 14 March 2005, identifying an accident date of 16 July 2004. He later filed another hearing request in July 2005 purporting to amend the first accident date to 8 June 2004. He filed additional hearing requests identifying legal disability dates in October 2004. At the hearing, the claimant dismissed with prejudice the January, July, and October 2004 accident dates, leaving only the June 2004 date. The employer moved to dismiss this claim, arguing it was barred by the one-year statute of limitations in O.C.G.A. § 34-9-82. The claimant argued that the July 2004 hearing request first identifying the June 2004 date was an amendment to the earlier hearing request and, therefore, related back to the date of filing of that earlier request, which was within a year of the June 2004 accident date. He explained that when the claim was first filed for a July 2004 accident, he was not sure of when his accident happened and amended after medical records showed that 8 June 2004 was more likely the correct date. He further argued that because both the March 2004 and July 2004 filings arose out of the same occurrence, the July filing should relate back.

The Court of Appeals was not persuaded by the claimant's argument that the various filings arose out of the same occurrence. It noted that portions of the hearing record cited by the claimant in support of his appeal were not part of the appellate record. The Court of Appeals noted further that all of the various accident dates were distinctly identified in attorney fee contracts dated 8 March 2005. Additionally, the claimant sought different types of relief in his hearing requests for the different accident dates. Because distinct occurrences were at least suggested in the available record, the Court of Appeals held that there was at least some evidence to support the State Board's finding that the 8 June 2004 claim was first asserted in July 2005 and was, therefore outside the limitation period.

Keystone Automotive v. Hall, Case No. A080086 (Ga. Ct. App. 2008). Decided 17 November 2008.

The claimant sought workers' compensation survivor benefits after her husband, a route salesman for the employer, passed away. Co-workers discovered him unconscious next to his truck at the warehouse, and he died after three weeks of hospitalization. Various medical reports regarding the cause of death were offered into evidence, each offering an opinion of what the most likely cause of death was. One report stated that it was not clear exactly what caused the employee's collapse, but further stated that none of the plausible causes had any relationship to the employment. The ALJ found that the employee was discovered in a place where he would reasonably be expected to be while on the job and further found that his death was unexplained. Accordingly, the ALJ found the widow was entitled to a presumption, set forth in *Zamora v. Coffee Gen. Hosp.*, 162 Ga.App. 82, 290 S.E.2d 192 (1982), that the death arose out of employment. The Appellate Division reversed, holding that the causation presumption did not arise because all of the medical evidence indicated that the cause of death was a naturally occurring event unrelated to work activities. The Appellate Division further held that even if the presumption applied, it was overcome by the medical evidence. The superior court reversed, finding that the Appellate Division failed to distinguish between the immediate cause of death and the precipitating cause of death, and that it was the precipitating cause that remained unexplained, justifying the application of the presumption.

Considering the matter in a de novo review of whether the Board applied the correct legal standard, the Court of Appeals affirmed the superior court's reversal. The Court agreed that the evidence was insufficient to establish the precipitating cause of death, so the presumption applied.

DeKalb County Board of Education v. Singleton, Case No. A08A1181 (Ga. S. Ct. 2008). Decided 17 Oct. 2008.

The claimant school bus driver, with a history of asthma, was diagnosed with an asthma attack after becoming ill while cleaning a white powdery residue from the inside of her bus. Although she was eventually released to regular duty work, medical evidence showed that exposure to cold, strong odors or fumes, might precipitate another attack. The claimant was thereafter diagnosed with adjustment disorder and depression and was deemed by a psychologist to be unable to drive a bus due to anxiety. The ALJ found that the claimant sustained a work-related inhalation injury that aggravated her preexisting asthma and that her psychological conditions were compensable, as well, having been precipitated by the asthma attack. The Appellate Division and superior court affirmed. Applying the any evidence standard and noting the medical evidence that the psychic condition originated with the accident, the Court of Appeals affirmed the award below.

Clarke v. Country Home Bakers, et al., Case No. A08A2032 (Ga. Ct. App. 2008). Decided 30 October 2008.

The claimant, a participant in a prison work release program, sustained serious injuries in a fall while working for the named employer. The employer/insurer paid benefits, initially, but was directed by the Department of Corrections to discontinue all benefits when the claimant was released from the hospital and transferred to a prison infirmary. After his parole during the year after the accident, the claimant requested a hearing seeking temporary total disability benefits (TTD). In its definition of employee, the Workers' Compensation Act provides that "inmates participating in a work release program … as part of the punishment" shall not be deemed to be an employee. The claimant argued that his participation in the program was voluntary and was not part of [his] punishment. The ALJ disagreed with the claimant's argument, holding that the ability to choose to participate in the program did not mean the program was not part of the punishment. The Appellate Division, superior court, and Court of Appeals all affirmed.

Holder v. City of Atlanta, Case No. A08A1776 (Ga. Ct. App. 2008). Decided 14 November 2008.

The State Board approved a stipulated settlement between the claimant and the employer on 25 Jan. 2007. Arguing that a nearly identical agreement had already been approved on 23 Jan., the employer challenged the 25 Jan. approval. A hearing was held in the superior court on 25 May 2007. On 25 June 2007, the court entered an order remanding the case to the State Board to resolve the factual dispute over which of the two approved agreements governed. The Court of Appeals granted the employer's petition for discretionary review of the 25 June order, but the appeal was later dismissed when the employer did not file an appellate brief. On 21 Dec. 2007, the claimant petitioned the superior court for a judgment to enforce the 25 Jan. settlement agreement. The superior court denied the petition, citing its earlier remand order. O.C.G.A. § 34-9-105(b) provides that, on appeal to the superior court, the Board's order is affirmed by operation of law if an order disposing of the appeal is not entered within 20 days of the appellate hearing. The Court of Appeals found that the superior court lost jurisdiction after 20 days from 25 May, and the court's having purported to issue the 25 June order nunc pro tunc could not overcome the jurisdiction loss. The superior court's denial of the claimant's petition for a judgment to enforce the settlement agreement was reversed.

Williams v. Conagra Poultry of Athens, Inc., et al., Case No. A08A1854 (Ga. Ct. App. 2009). Decided 28 Jan. 2009.

The claimant sustained compensable injuries in November 1992 and received temporary total disability benefits (TTD) until 400 weeks from her injury date. The last TTD payment was made in April 2001. In March 2002 and April 2003, the claimant filed requests for catastrophic designation, both of which were denied. A third request, filed in September 2003, was granted. The employer accepted the catastrophic designation for medical benefits only and requested a hearing challenging the claimant's entitlement to additional income benefits. The ALJ ruled that the claim for additional income benefits was barred by the two-year statute of limitations in O.C.G.A. § 34-9-104. The Appellate Division and superior court affirmed. Referring to the plain language of the statute ("[a]ny party may apply under this Code section for another decision because of a change in condition ending, decreasing, increasing, or authorizing the recovery of income benefits …, provided … that at the time of the application not more than two years have elapsed since the date of the last payment of income benefits pursuant to Code section 34-9-261 or 34-9-262 was actually made under this chapter") the Court of Appeals affirmed the denial of income benefits.

Harris v. Peach County Board of Commissioners, Case No. A08A1846 (Ga. Ct. App. 2009). Decided 20 Feb. 2009.

The claimant, while working as a custodian, was discussing work issues with her supervisor when she realized a diuretic pill she had placed in her pocket was missing. The supervisor saw the pill on the floor, and as the claimant bent to pick it up, she "heard something pop" in her left knee and collapsed. She subsequently had two surgeries for an anterior dislocation. Medical evidence showed that the dislocation was caused by the extreme weight placed on the knee when the markedly obese claimant reached down to pick up the pill. The ALJ awarded benefits, and the Appellate Division affirmed. The superior court reversed, ruling that the injury was caused by her obesity, and she was equally exposed to that risk of injury both on and off the job.

The Court of Appeals reversed the superior court, holding there was evidence to support the Board's

award that the act of bending to pick up an object on the floor (one of her job duties, whether that object was her personal belonging or not) caused or contributed to the injury. Accordingly, even if the claimant's obesity made her predisposed to such an injury, it was compensable.

Laurens County Board of Education v. Dewberry, Case No. A08A1503 (Ga. Ct. App. 2009). Decided 19 Feb. 2009.

The claimant, a school custodian, injured his right knee on 1 Aug. 2000 while using a machine to strip a floor. He was diagnosed with a medial meniscus tear and degenerative arthritis but continued to work until undergoing arthroscopic surgery in September 2001. The employer's insurer at the time paid medical benefits. It did not pay, and the claimant did not request, any income benefits for the six weeks the claimant was out of work. In 2004, after the employer changed insurers, the claimant sought additional medical treatment. Following two doctor visits in 2004, the first insurer controverted the claim but resumed medical benefits after agreeing with the claimant to a change of physicians. In 2005, a new doctor recommended knee replacement surgery, relating it to the August 2000 injury. The first insurer discontinued medical benefits, and the claimant was forced to stop working in November 2005. The ALJ found the claimant suffered a fictional new accident in November 2005 and ordered the second insurer to pay benefits. The Appellate Division and superior court affirmed.

The Court of Appeals likewise affirmed, rejecting the second insurer's argument that the claimant had experienced a change in condition from the August 2000 accident, which would place the responsibility for continuing benefits with the first insurer. The Court held that even though the claimant missed time from work with his 2005 surgery, the fact that he returned to work "without any agreement or award as to that injury having been approved or issued by the State Board of Workers' Compensation." Because the injury's compensability had not been established by award or otherwise (where otherwise typically means the payment of income benefits), a change in condition could not be found, as a matter of law. That the first insurer arguably should have paid some benefits was of no consequence, since that it "arguably should have" did not establish the compensability of the claim.

Tara Foods v. Johnson, Case No. A08A1628 (Ga. Ct. App. 2009). Decided 26 March 2009.

The claimant sustained a compensable injury in 1992 and was paid weekly benefits until August 2001, when benefits were suspended after the exhaustion of 400 weeks from the date of injury. In November 2002, the claimant filed a WC-14, marking as an issue her entitlement to temporary total disability benefits (TTD) from 8/28/2001 for catastrophic designation. The WC-14 was not marked as a hearing request, however, but as a notice of claim only. In August 2005, the claimant requested a hearing for payment of certain medical expenses. Those issues were resolved by the parties without a hearing, and the matter was removed from the calendar. In an associated consent order, the parties agreed that there were no additional issues before the court. In September 2006, the claimant requested a hearing seeking catastrophic designation and continued TTD. According to the Court of Appeals decision, the ALJ found that the hearing request was untimely and that the statute of limitations had expired on the request for catastrophic designation. The Appellate Division affirmed, and the superior court reversed.

The Court of Appeals reversed the superior court, reinstating the Board's denial of benefits, agreeing with the finding that the application was barred by the statute of limitations applicable to a change in condition claim. Curiously, the Court stated that it was "undisputed that [the claimant's] request for catastrophic designation is governed by the two-year statute of limitation set forth in O.C.G.A. § 34-9-104(b)." In its decision, the Court of Appeals makes no distinction between a request for catastrophic designation and a request for additional income benefits. Because it is possible for an injury to be designated catastrophic without an entitlement to income benefits, it is unclear why the distinction was not made. In *Williams v. Conagra Poultry of Athens,* Case No. A08A1854 (Ga. Ct. App. 2009), decided just a few months earlier, the employer voluntarily accepted the claimant's catastrophic designation, challenging only the entitlement to indemnity benefits. A few months later (*Kroger Company v. Wilson*, Case No. A09A1226 (Ga. Ct. App. 2009)), the court appeared to reinforce its position that the two-year statute of limitations applies to requests for catastrophic designation, but perhaps only where additional indemnity is sought. It remains to be seen whether the court will clarify its position in the future should a case arise where non-indemnity benefits are sought in connection with a request for catastrophic designation filed more than two years after the last receipt of TTD or TPD.

City of Atlanta v. Roach, Case No. A09A0456 (Ga. Ct. App. 2009). Decided 8 April 2009.

The claimant sustained compensable injuries to his hip. To alleviate soreness, he put a heating pad on his hip but fell asleep, resulting in third-degree burns to his hip. The heating pad had not been prescribed by a physician, but the claimant testified he often used it to alleviate his symptoms. The ALJ found that the claimant suffered a superadded injury and that the burn was related to the compensable injuries. The ALJ found that the heating pad use was reasonable and necessary for the compensable injury and awarded payment of medical expenses ad $3,000 in assessed attorney fees. The Appellate Division reversed, finding that the burn did not arise as a natural consequence of the compensable hip fracture and that the burn was not the result of reasonably required medical treatment. The superior court reversed the Appellate Division. The superior court

concluded that the Appellate Division incorrectly required a direct causal relationship between the original injury and the superadded injury. The superior court further found that, where injury results from treatment for a compensable injury, it is not necessary that the treatment be prescribed or authorized in order for the resulting injury to be covered as superadded.

The Court of Appeals reversed, reinstating the Appellate Division's denial of benefits based on a superadded injury. It pointed out that the Appellate Division was authorized to find that "the prolonged use of a heating [pad] together with falling asleep while using the pad is not 'reasonable treatment' as contemplated by the [Workers' Compensation] Act." Further, the Appellate Division and the Court of Appeals pointed out that the Workers' Compensation Act calls for an employer to furnish injured employees medical treatment prescribed by a licensed physician. The Appellate Division was, therefore, authorized to find that the burn was not a superadded injury.

Home Depot v. Pettigrew, Case No. A09A0119 (Ga. Ct. App. 2009). Decided 2 June 2009.

The claimant sustained a compensable ankle injury. She later developed back problems that she contended was a superadded injury resulting from her altered gait. She requested that her injuries be deemed catastrophic. The ALJ determined that the ankle injury was catastrophic, but found that the back problems were not due to the ankle injury or its sequelae. The employer did not appeal, but the claimant appealed the finding that the back problems were not part of the compensable injury. The Appellate Division affirmed. The superior court struck the factual finding regarding the back problems, holding that the issue was not properly before the ALJ for determination due to lack of notice to the claimant that the back's compensability was in question.

The Court of Appeals agreed that the back issue was not properly before the Board and that the factual finding related thereto was improper. However, it ruled that the superior court was not authorized to strike the finding. The appropriate course, because evidence at the original hearing raised the issue of the back's compensability, was to remand the matter back to the State Board for further proceedings in which the claimant would have the opportunity to be heard on the issue.

Strickland v. Crossmark, Case No. A09A0491 (Ga. Ct. App. 2009). Decided 26 June 2009.

The claimant's claim for workers' compensation benefits in an all-issues case was denied by the ALJ and denied her request for assessed attorney fees, finding that the employer/insurer properly controverted the claim. The Appellate Division vacated the ALJ decision and remanded the case for additional proceedings as to the validity of the notice to controvert, which the claimant contended for the first time before the Appellate Division was invalid because the employer had voluntarily commenced benefits but failed to pay all compensation due at the time of its notice to controvert. The employer/insurer appealed to the superior court which reversed and remanded with direction that the Appellate Division review only those issues raised before the ALJ. The Court of Appeals found that the superior court did not have jurisdiction, because the Appellate Division's decision was not a final order.

The Kroger Company v. Wilson, Case No. A09A1226 (Ga. Ct. App. 2009). Decided 8 July 2009.

The claimant sustained a compensable back injury in 1994 and was paid temporary total disability benefits (TTD). He eventually returned to work for the same employer in a light duty capacity. After a second surgery, he again returned to work in August 1998 in a sedentary job. He worked fewer hours and was paid temporary partial disability benefits (TPD). The last TPD payment was made in September 2001 after the exhaustion of 350 weeks from the accident date. In August 2003, the claimant requested a hearing seeking TTD and/or TTD from September 2001 and continuing, but then withdrew the request, which was silent as to catastrophic designation. In May 2004, he stopped working altogether. In April 2006, the claimant filed a request for catastrophic designation. An ALJ issued an order finding that the claim for additional income benefits was time-barred under O.C.G.A. § 34-9-104. The Appellate Division reversed, and the superior court affirmed the reversal.

The Court of Appeals reversed. It held that the request for catastrophic designation constituted a request for a change in condition and, since he sought additional benefits, he had two years from the last payment of TTD or TPD to file the request. The Court held that the August 2003 hearing request was insufficient to toll the statute, because it sought income benefits only and not catastrophic designation.

The decision suggests but does not clearly state that, because additional indemnity benefits would be available if and only if the injury were deemed catastrophic, the August 2003 hearing request seeking indemnity only was meaningless. The decision also suggests that all requests for catastrophic designation are governed by the two-year statute of limitations on change in condition cases. Again, additional clarification might be forthcoming if the Court is called upon to address a case where catastrophic designation is requested in connection with only non-indemnity benefits more than two years from the last receipt of TTD or TPD. ***WC***

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AGENDA

Co-Chairs: ***Kelly A. Benedict,*** Benedict & Torpey, P.C., Marietta
Kevin C. Gaulke, Moore, Clarke, DuVall & Rodgers, P.C., Atlanta
Hon. Tasca B. Hagler, Judge, State Board of Workers' Compensation, Columbus

THURSDAY, OCTOBER 15, 2009

8:00 **REGISTRATION** (All attendees must check in upon arrival.)

8:25 **WELCOME**

8:30 **INTRODUCTION**

8:45 **STATE OF THE BOARD**
Hon. Carolyn C. Hall, Chair, State Board of Workers' Compensation, Atlanta

9:15 **THE IMPACT OF TODAY'S ECONOMY ON INSURANCE COMPANIES**
C. Wade McGuffey, Jr., Goodman McGuffey Lindsey & Johnson, LLP, Atlanta

9:45 **CASE LAW UPDATE**
John A. Ferguson, Jr., Drew, Eckl & Farnham, LLP, Atlanta

10:15 **BREAK**

10:30 **BAD PRACTICE HABITS**
Hon. Melodie L. Belcher, State Board of Workers' Compensation, Columbus
Hon. Vicki L. Snow, State Board of Workers' Compensation, Atlanta
Hon. William S. Cain, Jr., Chief Judge, Trial Division, State Board of Workers' Compensation, Columbus

11:30 **DEPOSITIONS—BACK TO BASICS**
Robert L. Hendrix, III, J. Franklin Burns, P.C., Atlanta
Mary E. Wilson, Savell & Williams LLP, Atlanta

12:00 **DEPOSING THE DOCTOR**
Steven A. Westby, Hamilton, Westby, Antonowich & Anderson, Atlanta

12:30 **ICMS BLOOPERS**
Hon. David K. Imahara, Deputy Chief, Trial Division, State Board of Workers' Compensation, Atlanta
Frances Finegan, Director, Settlement Division, State Board of Workers' Compensation, Atlanta
Stacey Anne Torpey, Benedict & Torpey, P.C., Marietta

1:00 **RECESS**

2:00 **TENNIS TOURNAMENT**

6:30 **SOCIAL HOUR**

7:30 **KIDS' CHANCE DINNER AND ENTERTAINMENT**

FRIDAY, OCTOBER 16, 2009

8:30 **LEGISLATIVE UPDATE**
Hon. Warren Massey, Director, State Board of Workers' Compensation, Atlanta

8:45 **PROFESSIONALISM PANEL**
James T. McDonald, Jr., Swift, Currie, McGhee & Hiers, LLP, Atlanta
George T. Talley, Coleman, Talley, Newbern, Kurrie, Preston & Holland, Valdosta
John F. Sweet, Clements & Sweet, P.C., Atlanta
Michael R. Eddings, Collins & Eddings, Calhoun

9:45 **BREAK**

10:00 **ATTORNEY'S FEES—ASSESSED AND OTHERWISE**
Hon. Meg T. Hartin, State Board of Workers' Compensation, Atlanta
Brian J. Buckelew, Brian J. Buckelew, P.C., Atlanta
Neil C. Thom, AB Bishop & Associates, LLC, Marietta

10:45 **RECENT DECISIONS OF THE APPELLATE DIVISION**
Hon. Viola Drew, Director, State Board of Workers' Compensation, Atlanta
Douglas J. Witten, Deputy Division Director, Appellate Division, State Board of Workers' Compensation, Atlanta
Thomas L. Holder, Long & Holder LLP, Atlanta
Benjamin A. Leonard, Bovis, Kyle & Burch, LLC, Atlanta

11:45 **MAXIMIZING MEDIATION**
David A. Smith, Drew, Eckl & Farnham, LLP, Atlanta
Samuel W. Oates, Jr., Oates & Courville, Columbus
Luanne Clarke, Moore, Clarke, Duvall & Rodgers, P.C., Atlanta

12:30 **RECESS**

1:00 **DICK RICE MEMORIAL GOLF TOURNAMENT**

SATURDAY, OCTOBER 17, 2009

8:00 **MALONEY AND THE JOB SEARCH TODAY**
Hon. Jerome "Jerry" Stenger, State Board of Workers' Compensation, Savannah
Miles L. Gammage, The Gammage Firm, Cedartown
Sharon Hurt Reeves, Jones, Cork & Miller, LLP, Macon

8:45 **ETHICS DURING HEARINGS**
Burton L. Tillman, Jr, Tillman & York, LLC, Atlanta
Michael Rosetti, David & Rosetti, LLP, Atlanta

9:45 **BREAK**

10:00 **BACK ISSUES PANEL**
Erik T. Bendiks, MD, Southern Orthopaedic Specialists, LLC, Atlanta
Hal Silcox, III, MD, Peachtree Orthopaedic Clinic, Atlanta
E. Scott Slappey, Slappey & Sadd, LLC, Atlanta
Robert R. Potter, Swift, Currie, McGhee & Hiers, LLP, Atlanta
Hon. Leesa A. Bohler, State Board of Workers' Compensation, Savannah

11:00 **CATASTROPHIC DESIGNATION HOT TOPICS**
Deborah G. Krotenberg, Division Director, Managed Care and Rehabilitation, State Board of Workers' Compensation, Atlanta
John D. Christy, John D. Christy, P.C., Perry
Lynn Blasingame Olmert, Carlock, Copeland & Stair, LLP, Atlanta

11:30 **CURRENT MSA ISSUES**
Laurence L. Christensen, Laurence L. Christensen, P.C., Marietta
G. Robert Ryan, Jr., Moore, Clarke, Duvall & Rodgers, P.C., Valdosta

12:00 **THE NUMBERS GAME—104, 240, 207 & 205**
Joseph T. Leman, Harriss & Hartman Law Firm, P.C., Dalton
James W. Richter, Richter, Head, Shinall & White, LLP, Atlanta

12:30 **QUESTIONS AND ANSWERS**

1:00 **ADJOURN**

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