



WORKERS' COMPENSATION LAW

Spring 2010

John D. Christy, editor

Section Newsletter

How Did We Get Here?

By Lee Southwell

This will be somewhat of a personal memoir of my time at the State Board of Workers' Compensation.

I first worked at the Board in the summer of 1974. It was between my second and third years of law school. I was a part of the first group of Governor's interns. We worked on a project to completely edit and revise the Board rules and regulations. The first thing we did was edit the rules to make them refer to the Code sections that they dealt with. (There had been 32 rules, none of which referred to a particular Code section.) We also made some changes in the substance of the rules (this is where the statement that a plea of the statute of limitation was an affirmative defense which had to be raised before the first hearing in a claim or be considered waived came from.) We didn't have a final document when the summer project was over, but we did have a working document from which other people could work. I later found out that this project was part of an attempt by Earl Mallard and John Andy Smith to produce a complete revision of the law and rules. The rule revision was much more successful. When I returned to the Board in November of 1975, I saw the rules that had become effective in June of that year and recognized things that we had originated the summer before.

The attempt to revise the Code was much more difficult. Before the effective date of the 1975 amendments, total disability income benefits were only payable for a period of 400 weeks. (the original 1920 law provided a cap of 350 weeks, which became 400 in 1955.) The 1975 amendment removed the 400-week cap. Temporary partial disability benefits were payable for 350 weeks from the date of injury (300 in 1920, change to 350 in 1955 and still in effect today). In cases with what were called specific member injuries (i.e., arms, hands, feet, legs, vision, hearing, etc.), total or temporary partial disability benefits resulting from these injuries were only for a maximum of 75 weeks from the date of injury. (This was known as the healing period.) There was no category for loss of use of the body as a whole. The argument was once presented inside the office that if a "specific member injury" made a person totally or partially unable to work, that class of benefits should continue after 75 weeks, rather than being automatically converted to benefits for loss or loss of use of the member. I won't embarrass the person who presented this argument by naming that person. I agreed as a matter of what should be, but not as a matter of what legally was. Unfortunately, the Court of Appeals issued a decision which said I was right (even though I wished I

Comments From the Chairman

By Joseph T. Leman

The Section has had a full schedule in recent months. The Workers' Compensation Institute enjoyed as good an attendance as we have ever had. I am delighted to say this includes attendance by Administrative Law Judges as well as practitioners. We hope to keep up this tradition of good fellowship and excellent educational opportunities. Many thanks to Judge Tasca Hagler, Kelly Benedict, Kevin Gaulke and all those who gave of their time to be on the faculty. The hard work that went into the program was apparent.

The Kid's Chance dance was once again a success. This is a program of great worth which benefits deserving young people and their families. Ann Bishop did her usual good job of organizing the event this year.

The amount of change recently at the Board has been

remarkable. The members of the Section, as always, endeavor to support the directors, the judges and the staff as these changes occur.

The Section's ICLE program for general practitioners will be headed by Lynn Olmert this spring. We know it will be well done.

The Section is strong and active. The Section needs your help to continue to grow. We need to support the existing programs and work on adding new ones. My request is that each member encourage participation by younger lawyers. Please take the time to discuss with them the Section's activities and ask them to join with us in these. The future is bright. **WC**

wasn't). In 1975, we were only a few years away from a strict dollar limit on medical expenses (which first changed in 1971). The 1971 limit was \$5000 plus whatever else the Board found was reasonable and necessary. (Can you imagine what it would be like now if there was a strict limit, no matter what it would be? As medical costs are going, that limit would have to be changed every year and it would be hard to keep up.) There was a time in the early 1970's (before 1978) when one large self-insurer was threatening to request Board approval of additional medical expenses every time the amount in a particular claim approached or reached \$5,000. John Andy Smith's response was "Fine. Go ahead and ask. We can put out more orders than you can ask for." The fiction of a limit on medical expenses was finally removed in 1985.

It was against this backdrop that Earl Mallard formed a Code revision commission to revise the workers' compensation law from beginning to end. (John Andy Smith didn't think it would succeed because it put everything that anybody could oppose in one place so that opposition to one thing could potentially produce a "no" vote, but being a good soldier, he supported his chairman's/commanding officer's efforts.) The first draft of a complete revision came up for a vote in 1976, but was tabled for more study. A new revision came back in 1977 in the form of a proposed bill to be presented to the legislature. That proposal passed the commission by one vote and went on to the legislature. It didn't get out of committee. In fact, the revision included a whole article establishing the Subsequent Injury Trust Fund. The Fund was only saved by separating that article from the revision bill and passing it as a separate and distinct bill. (it had taken passage of a state constitutional amendment to allow the Fund to be established.)

After 1977, Earl Mallard and John Andy Smith got representatives of various interest groups together and convinced them that something had to be done. The agreement reached produced the 1978 amendments. Those amendments streamlined the

payment of benefits. The previous system had been payment or suspension by agreements signed by all parties and approved by the Board. The new system provided for immediate payment (or suspension with advance notice) and the filing of forms giving notice of what had been done. (The rules were later changed to allow immediate suspension if the employee actually returned to work.) The statute of limitation on an original all-issues was liberalized. As of July 1, 1978, claims could be filed within one year of the injury (or death), within one year of the last remedial medical treatment furnished by the employer, or within two years of the last payment of income benefits in a claim. (A whole body of case law has developed in this area.) There was a major change in income benefits for permanent partial disability. For the first time, this class of benefits was available for loss of use of the body as a whole. The original belief was that this change was made for back injuries, but it was worded so broadly that it takes in any disability not otherwise covered in the schedule. There was also another major change in this area. The so-called healing period was eliminated so that temporary total and temporary partial disability benefits were payable as long as entitlement to them lasted. When I saw a draft of the bill which eventually passed, I pointed out to John Andy Smith that the healing period was done away with (which I for one was glad to see). His response was "I know, but don't tell anybody until it passes." The 1978 changes also put in a different limit on the time for filing claims for additional benefits based on a change in condition. The old limit had been two years after the Board was notified of final payment of benefits in a claim. With the enactment of the direct payment system, the former notice of final payment form ceased to exist. The 1978 limit was two years after the last payment of income benefits due under the workers' compensation law. (Once again, this apparently simple statutory language led to the development of a whole body of case law.) It came to be believed in some quarters that this language and case law led to outrageous results which allowed some

claims to stay open too long. There was another change in 1990 which put in a new limit. This limit is the current one - two years after the last payment of income benefits for temporary total or temporary partial disability was actually made for claims for additional benefits for temporary total or partial disability; four years after temporary total or temporary partial disability benefits were actually paid for claims for benefits for permanent partial disability. This change, in attempting to solve the problems created by the former language and case law, created problems of its own. People who returned to work and continued to work for more than two years were left out in the cold if they later had a change in condition for the worse. This change became a bigger issue with the 1992

law changes, which will be discussed later.

The next change was a complete recodification of all Georgia law. This change resulted in a whole new renumbered Code (and coordinated Board rules). We all had to cease to think of the old Code section numbers and begin to think of the new numbers. We also had to remember both numbers so that we could translate references in old cases into new numbers. When I say "we", I include everybody - practitioners, Board people, and the courts all the way up to the Court of Appeals and Supreme Court.

The next big change came in 1985. Rehabilitation (which was mandatory [at least in the form of assessment of need] in every claim), was separated from the Code section regarding medical expenses and given a whole Code section of its own. There was also a major change in income benefits for death. Death benefits had been payable for a maximum of 400 weeks from the date of injury causing death for all dependents. There was a deduction for income benefits paid to the injured worker between injury and death if such benefits were paid. The new limits were age 65 or receipt

of 400 weeks of income benefits, whichever was greater. Dependency for children lasted until age 18, or age 22 if the child remained enrolled in a postsecondary educational institution. The dependency of a spouse was presumed total unless the spouse had been employed for at least three months prior to the injury causing death. (The former law had been that a widow was always presumed totally dependent while a widower had to prove dependency. This rule was unofficially recognized as unconstitutionally discriminatory long before the Georgia Supreme Court had the argument presented to it and so ruled.) The law developed around this definition of dependency to the point that ALJ's were finding that if a working couple needed both incomes to maintain their household and lifestyle, they were totally dependent on each other. The loss of either income was a financial disaster. In 2000, the legislature recognized the reality of modern life that most couples are working and producing two incomes. A new definition was enacted which provides that if a couple is living together at the time of the injury causing death, they are presumed mutually totally dependent on each other. The 1985 presumption was rebuttable if the surviving spouse had been employed for at least three months prior to the injury causing death. The current (2000) presumption is rebuttable if the couple had been living separately for at least three months prior to the injury causing death.

In 1988, a major change occurred which had nothing to do with the workers' compensation law or Board rules. That change was the creation of Kids' Chance. This is a scholarship program for children of catastrophically injured or deceased workers. The Workers' Compensation Section of the State Bar of Georgia, with the active participation of representatives of labor, employers, insurance companies, self-insurers, and both employees' and defense attorneys, is one thing which everybody can agree on. If there are innocent victims of workers' compensation injuries, they are these children. Kids' Chance conducts a number of fund-raising events throughout every year. There are more inspiring stories resulting from Kids' Chance participation in financing education than can be told in this space. Suffice it to say that there are doctors, lawyers, and other professionals realizing their dreams (and many times giving back to the community) who would be working in a warehouse somewhere (important and valuable work in itself) were it not for Kids' Chance. I'm proud to say that this concept, which now exists in a majority of states and is adding more all the time, had its origin in Georgia. I wasn't one of the founding fathers, although I wholeheartedly support the goals of the organization. The founding father (although he will tell you that God gave him the idea and had him implement it) was Bob Clyatt. An early and enthusiastic supporter was Jim Oxendine, who contributed greatly in getting Kids' Chance off the ground.

It's time to get back to the actual law. Between 1920 and 1946, Georgia law had provided no workers' compensation coverage for diseases which did not flow naturally and unavoidably from an injury arising out of and in the course of employment. In 1946, the legislature enacted an amendment to the workers' compensation statute

which purported to add coverage for occupational diseases which arose out of and in the course of employment. This amendment contained so many limits and restrictions that John Andy Smith once called it the Employers and Insurers Occupational Disease Liability Protection Act. (This was done strictly in-house, never in public). The 1946 law had a specific list of conditions which were covered. In 1971, a catch-all definition was added to cover diseases not specifically listed if certain things could be proved. They amounted to three different ways of saying that that the employee's working conditions caused the disease, a requirement that the disease not be an ordinary disease of life to which the general public is exposed, and that the disease not be one to which the employee had a substantial risk of exposure outside of employment. (In my humble opinion, this definition is still too tight. Diseases should be covered if the employee has a substantially greater risk of exposure because of his or her employment than the general public would. I know this idea would be extremely controversial if it were ever proposed for enactment by the legislature. From my dual membership in both bars and both workers' compensation sections, I have become aware that Florida has a definition of occupational disease very much like the one I propose and has apparently learned to live with it.) The 1985 amendments said nothing about occupational diseases because it was that the 1985 amendments represented the non-controversial proposals. Because the 1985 amendments called for a medical fee schedule, they were more controversial than they were believed to be. In fact, they were so controversial that Sen Hal Dawkins stood in front of the assemblage at the fall St. Simons seminar and begged us collectively not to put him and his committee through that fight again the next year. The occupational disease amendments did not come up until they were enacted in 1987. The 1987 amendments removed almost all the limits and restrictions from the 1946 amendment. The did leave the 1971 catch-all five-part definition in place, and applied it to all occupational diseases. (As stated above, I think

the definition is still too tight, but it is a big improvement over what existed before.)

Although it may not seem to be a big addition, the Self-Insurers' Guaranty Trust Fund was established in 1989. Too many self-insurers were going bankrupt, using up their surety bonds, and leaving people with valid claims nowhere to go. There had been too many times in the 1980's that we had to divide up bond proceeds among claimants entitled to benefits and too many people paid cents on the dollar. The current setup is better for all concerned.

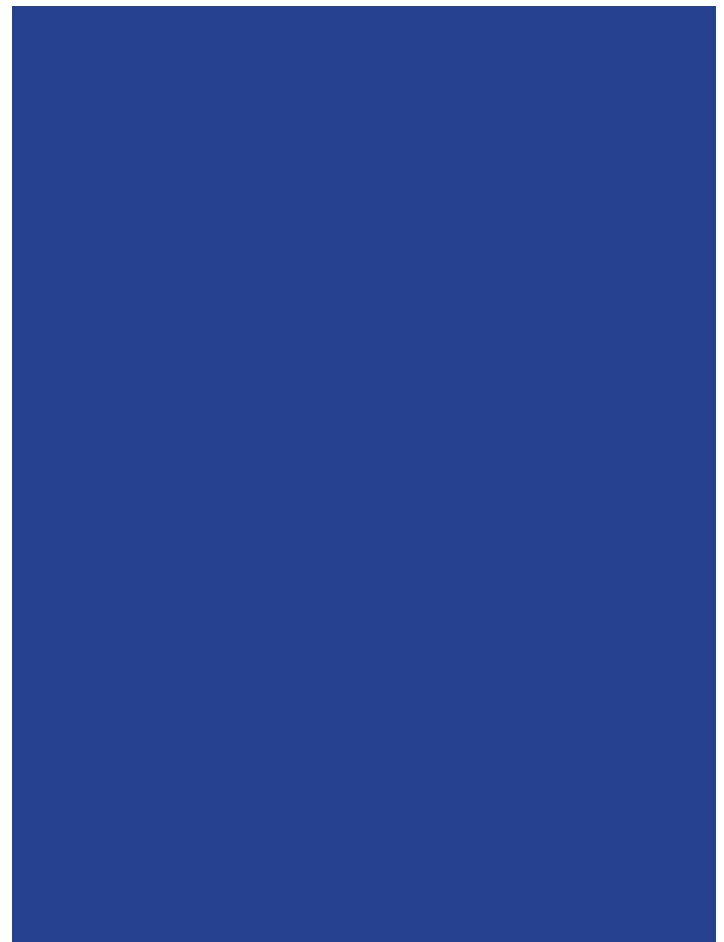
The 1990 amendments were big, but could have been bigger. As previously stated, the time limit for requesting additional benefits based on a change in condition was changed. For additional benefits based on temporary total disability (the current name - the word "temporary" had not been necessary since at least 1975) or partial disability was changed to two years after the last payment for "temporary" total or temporary partial disability were last actually paid. Additional benefits for permanent disability had to be requested within four years after benefits for temporary total or temporary partial disability were last actually paid. The concept of "due under [the workers' compensation law]" was done away with. We've found out from 2009 court decisions that a change to catastrophic designation must be requested within the two-year time limit. Merely filing a claim without requesting a hearing or administrative determination is not enough. There was also a big controversy at the time about who was allowed to make the first choice of rehabilitation suppliers. This process was known as "jump ball rehab." The 1990 amendment gave the employer/insurer the exclusive opportunity to name the supplier within certain time limits. If these time limits passed with no appointment made, either party could request a supplier. Those who think that the "jump ball rehab" issue was controversial haven't seen controversial. Then-Sen. Hal Dawkins brought representatives of all interest groups into a room and attempted to hammer out some

reforms. This meeting resulted in the 1990 amendments. Sen Dawkins wanted more. He wanted a retaliatory discharge statute which would have allowed employees who filed a workers' compensation claim in good faith and were fired for that reason (assuming they could prove or convince the jury to see it) to recover tort damages despite the general exclusive remedy of workers' compensation benefits against the employer/insurer. This had been tried in 1988 when the Georgia Trial Lawyers Association had a bill introduced which provided for just such a remedy. The committee substitute that passed enacted a penalty if a fatal injury resulted from the employer's willful misconduct, which was defined in such a way that an individual employer might almost have to be in line for the death penalty if the acts were done. Sen. Dawkins was no more successful. There was too much controversy, and there was no consensus on acceptable language. No one has proposed such a change since.

If we thought 1990 was a big year for change, we hadn't seen anything yet. The 1992 amendments were a watershed. Almost anything that could be changed was changed, mostly in the direction of lesser benefits. (Don't tell the Atlanta TV newscasters. They only mentioned that weekly income benefits were increased in reporting on legislation that passed the last day of the 1992 session.) The concept of temporary total disability came into official existence for most claims. Temporary total disability income benefits was capped at 400 weeks from the date of injury. From 1975 to 1992, there had been no cap. From 1920 to 1955, the limit had been 350 weeks. Between 1955 and 1975, it had been 400 weeks. The 1992 cap was more severe than the 1920-1975 cap had been. The words "From the date of injury" did not appear in the total disability benefits section. The legislature did recognize that some claims would result in to "temporary" total disability benefits for more than 400 weeks and made provision for these cases. The concept of catastrophic injuries was brought into the law in 1992. (It had been in the

Board rules for a period of time before that, but wasn't as important because of the absence of a limit on the duration of total disability benefits between 1975 and 1992.) Catastrophic injuries were originally defined as five specified conditions and a sixth, catch-all clause. This catch-all clause has produced the most controversy. It has existed in several forms. Between 1992 and 1995, it was any injury of a nature or severity which does or would qualify the employee for Social Security disability benefits. There was an argument that this definition was unconstitutional because it denied the employer/insurer any input in the determination of entitlement to Social Security disability benefits. The Georgia Supreme Court eventually ruled that the definition was constitutional because it required a two-step process. The first step was determining whether the employee had a severe disability. The employer/insurer had no input in this step. The second step was determining whether the severe disability was related to the compensable injury so that it could be designated catastrophic. All parties had input into this determination, which the Board made after all parties had notice and an opportunity to be heard. The next definition came in 1995. It included any injury of a nature or severity that it rendered the employee incapable of returning to his or her former employment or performing work available in substantial numbers in the national economy. The word "or" is crucial. In the one case which has reached the Court of Appeals, the court ruled that "or" means "or." Proof of either of the two conditions is enough to establish an injury as catastrophic. The vote at the Court of Appeals was three concurring in the majority opinion, one concurring in the judgment only, and three dissenting. This obviously doesn't add up to 12, the number of judges on the Court of Appeals at the time and now. Five judges, for whatever reason, did not vote. This decision is physical precedent only, and as persuasive as a future court wants it to be. The issue has not come up again. One possible reason is that in 1997, the definition was changed again to define an injury which falls under the catch-all definition is catastrophic if it renders the employee incapable of returning to his or her former employment and any employment available in substantial numbers in the national economy. There have since been small amendments to presume that an injury is not catastrophic for the first 130 weeks from the date of injury (no big problem since 130 is less than 400) and to allow an injury to be presumed no longer catastrophic after the employee reaches age 65. This determination can only be made by the Board after a hearing at which all parties have notice and an opportunity to be heard. (inasmuch as most if not all of the conditions which qualify for catastrophic designation don't miraculously get better when the employee reaches a certain age, this change may not produce much litigation.) The provision that any party may apply at any time to have a determination that an injury is or is not catastrophic once the determination is first made that it is or is not has not been tested. The 1992 amendments also limited the scope of rehabilitation to vocational rehabilitation and made it mandatory only in catastrophic cases. Voluntary rehabilitation in noncatastrophic cases as long as all parties consented became effective in 1996. (The Board rules require voluntary

rehabilitation agreements to be in writing.) The other watershed was in the area of attorney's fees. (This portion of the law applies to employees' attorneys. Employer/insurer attorneys have hourly fee arrangements with their clients with which the Board does not become involved. Employees' attorneys generally take cases on a contingent fee basis. It is these fees that the Board regulates.) I've heard that fees were once routinely one-third of benefits paid regardless of circumstances (this was before my time). At some point after he came to the Board, John Andy Smith instituted a sliding scale of 25 percent without a hearing, 30 percent after extensive discovery, and 33 1/3 percent after a hearing. This sliding scale remained in effect until 1992. At that time, the statutory limit became 25 percent regardless of circumstances. Assessed attorney's fees had also been controversial for years. Ever since 1920, attorney's fees could be assessed against any party which brought, prosecuted, or defended a claim without reasonable grounds. In 1978, the concept of "without reasonable grounds" was expanded to "in whole or in part without reasonable grounds". Also in 1978, an additional ground for assessment of attorney's fees was added. If any employer or insurer violated the provisions of the direct payment system without reasonable grounds, the employee/claimant employed an attorney to enforce his/her rights, and the employee/claimant prevailed. Unlike the concept which had been in effect in some form since 1920, this second category did not even give the appearance of being even-handed. (Even though there were cases where fees could have been assessed



against employees/claimants, they rarely were because they would have been uncollectible. John Andy Smith did say [at a Workers' Compensation Section luncheon at one State Bar convention] that he had assessed attorney's fees in favor of of a well-known defense attorney, but didn't know whether the defense attorney collected. (The assessment was against a claimant who had four children. One "wise" person in the audience shouted that, knowing the defense attorney in question, he probably levied on and sold one of the children to collect. The second ground was not even-handed in that it could only apply to employers and insurers (unless failure to keep an address current is a violation of the direct payment system - a problem which can

be addressed in other ways [such as a motion for a protective order]). The 1992 amendments introduced the concept of "quantum meruit" into this second category. There is still controversy as to whether quantum meruit is limited to hourly rate times hours worked or can be something larger if the Board finds that the services are worth more. The controversy still bubbles, but there are court cases which approve the determination of the value of services based on a contingent fee. It looks like this controversy isn't dead, but only asleep. It will still wake up and manifest itself from time to time.) The 1992 amendments also brought the concept of subrogation of the employer and/or workers' compensation insurer to the employee's (or employee's estate in the event of a fatal injury according to a 1995 amendment) against a third party whose negligence was proved to have caused the compensable injury. This right had been eliminated in 1972, and then-House Speaker Tom Murphy was alleged to have said that subrogation would come back ten years after he was dead. Speaker Murphy was still alive and in the Speaker's chair when the 1992 amendments passed. Current subrogation applies only if the employee or estate has been fully and completely compensated for all damages, economic and noneconomic. This subrogation has produced a great deal of litigation and probably will continue to do so.

The 1992 amendments produced the establishment of the Chairman's (the name didn't change when Carolyn Hall became Board Chair although the name was shortened) Advisory Committee. This committee has representatives of all interest groups (business, labor, insurance, self-insurers, lawyers representing all parties, and legislators) and is divided into subcommittees, each of which deals with one aspect of the workers' compensation system. This committee produces proposals for statutory amendments to present to the legislature and Board rules to present to the Board for approval. This committee has been instrumental in producing changes in the law and

rules basically without controversy in the legislature. This is not to say that there hasn't been controversy. The bills that have produced the most controversy have been those introduced independent of the Advisory Committee's recommendation. It's hard to imagine how much controversy there would be if the main bills hadn't been debated and worked out to the point that everyone could live with them, even if no one loved every part of them.

The next big change came in 1994. The two main aspects were in the areas of willful misconduct and refusal of suitable employment. The allegation, if proved, that the injury was caused by the employee's willful misconduct had been a defense since 1920. In 1990 intoxication by alcohol or marijuana were added as specific (but not exclusive) forms of willful misconduct. The employer/insurer still had the burden (which they had had since 1920) of proving that willful misconduct was the proximate cause of the injury. In 1994, the employers/insurers were aided in their ability to prove proximate cause in some areas. If the employee's blood alcohol level was shown to be .08 grams percent or higher within three hours of the injury or marijuana or a controlled substance was found in the employee's body within eight hours of the injury, there was a rebuttable presumption that alcohol intoxication or marijuana or drug use caused the injury. There was an exception for controlled substances taken pursuant to a valid medical prescription and in accordance with the prescription. Subsequent court decisions have held that the presumption can only be rebutted by clear and unrebutted evidence. Based on the cases I've seen at the Board, the ALJ's will find the presumption rebutted only if the circumstances of the case and the way the accident happened make it clear that alcohol intoxication or drug use had nothing to do with causing the accident. The other big change was in the area of refusal of suitable employment. After July 1, 1994, if an employee returns to a job procured for him or her by the employer which is allegedly suitable to the employee's injury-impaired condition and is unable to work for more than 15 working days,

an automatic change in condition for the worse occurs and income benefits must be reinstated. I always thought this was a good concept, but feared the possibility of abuse on all sides. People can count. Employees can count to 14 while employers can count to 16. Over the years, I haven't heard that my fears have been realized. I'm glad to have been wrong.

There was a change in 1996 in permanent partial disability. From 1978 until 1985 there had been a coordination of permanent partial disability benefits for loss of use of the body as a whole and benefits for temporary partial disability. An employee could not could not collect benefits for these classes of disability in excess of 350 weeks. In 1985, the number was lowered to 300. Permanent partial disability benefits for loss of use of the body as a whole were based on physical impairment or wage loss, whichever was greater. (I always use the term loss of use here because there's no such thing as 100 percent loss of use of the body as a whole. As John Andy Smith once put it, "If you have 100 percent loss of use of the body as a whole, you're totally disabled or dead, and we have other provisions for that".) This coordination was eliminated in 1996. The 1996 amendment also limited the source of permanent partial disability ratings in all cases regardless of the date of injury (the legislature left no doubt - they included that specific language in the statute) to the American Medical Association's Guides to the Evaluation of Physical Impairment. (The AMA Guides had been one source since 1992, but other recognized medical books or guides were also recognized in the 1992 legislation. The limitation to the AMA Guides alone came in 1996.) Over the years, the law has been amended as new editions of the Guides have been published. The current law lists the Fifth Edition. (I've heard that there is a sixth edition, but it hasn't been incorporated into the law so far.)

Later changes have not included any other watersheds other than the ones I've talked about (probably ad infinitum). Benefit increases have been enacted periodically, raising temporary total disability benefits to 2/3 of the employee's average weekly wage not to exceed \$500, temporary partial disability to 2/3 of the difference between the employee's pre-injury average weekly wage and the amount he/she is able to earn if he/she returns to work after the injury, not to exceed \$350, and death benefits payable to a surviving spouse or partial dependent until age 65 or 400 weeks, whichever is greater (unless the spouse remarries or cohabits in a meretricious relationship) and to children until age 18 or 22 if still in postsecondary school. (One lawyer once raised an interesting question. The definition of a meretricious relationship limits to persons of the opposite sex. His question was whether that was unconstitutional discrimination against heterosexuals on an equal protection basis. That question was only raised in conversation. There hasn't been a case, and it would be extremely controversial if it came up.) There is one aspect of death benefits which appears to be unusual. The total benefits payable to a surviving spouse if she/he is at the time of the employee's death or becomes within one year of death the sole dependent. That limit first came in

1974 and was \$27,500. It was raised to \$32,500 in 1975, \$65,000 in 1985, \$100,000 in 1994 and the current \$125,000 in \$2000 I've served under Board Chairs Earl Mallard, Herb Greenholtz, Jim Oxendine, Hal Dawkins, and Carolyn Hall. It's been a long and winding road, and sometimes a bumpy ride to get to where we are now. We may not be what we should be or what we will be, but I hope you now have some perspective on where we were..

Addendum:

There are a couple of afterthoughts. I've only heard about the founding of the Workers' Compensation Section of the State Bar of Georgia. It happened in 1975. Two of the original organizers were Al Wall from Roswell and John Andy Smith (that name again). The original plan was that the Section chairmanship (forgive the political incorrectness would rotate between claimants' and defense attorneys. There have been times when two representatives of one side or the other have served consecutively, but the rotation has been maintained for the most part. The Executive Committee appears to be balanced evenly now. John Andy Smith was the charter Section secretary, and served until he retired in 1983. I took over at that time and served until I became unable to continue in 2007. Notice that I refer to the Section as the Workers' Compensation Section. The name of the system was not changed from workmen's compensation until 1978. I've always been of the opinion that the name of the system ceased to make a difference when the first claim involving a female worker was accepted and paid without any objection from the employer/insurer. In this case, political correctness and factual correctness/modern reality match.

One of the best stories I ever heard came from then-Sen Hal Dawkins. It was told in public from the speakers' platform at a St. Simons seminar. (Judge Dawkins probably regrets telling this one in public while I was listening.) He's told a junior version several times, but only told the whole thing once - the time at St. Simons. At the time, Ludlow Porch had a morning talk show on an Atlanta radio station. One day during a legislative session, a caller called in and complained about what he called the "pinko liberal slugs" in the General Assembly. He went on to say that the worst one was his State Senator - Hal Dawkins. An enterprising reporter heard the comment and called Sen. Dawkins' home in Conyers to get a reaction. Sen Dawkins' wife answered the phone. When told of the caller's comments, her reaction was "I don't know about the other things, but he got the slug part right." In the halls of the State Capitol, Sen Dawkins was known as Sen. Slug thereafter. (The junior version of the story ends here.) Sen. Dawkins went on to explain that the Sen Slug name was a reaction to the fact that he, as Chairman of the Senate Industry & Labor Committee, had uncomplimentary nicknames for some Senators who attempted to obstruct legislation (of various kinds) which he wanted passed. The Sen. Slug name became so well known that one morning when he came to work, he found a piece of mail on his desk addressed to Sen Slug. The nickname was so well known that somebody at the Capitol knew where to send it.) **WC**

Recent Appellate Court Decisions in Workers' Compensation

By Neil C. Tom

A. B. Bishop & Associates, LLC

Since the cases summarized in the last newsletter, the Court of Appeals has heard only three cases of interest to the Workers' Compensation practitioner. Two deal with subrogation, and one with whether an injury arose out of employment.

Butts v. Thomas, 300

Ga.App. 639, 686 S.E.2d 262 (2009)

Decided Sept. 22, 2009, reconsideration denied Oct. 28, 2009.

In the first of the two cases dealing with the rights of an employer who has paid workers' compensation benefits to subrogate against a third-party tort claim arising out of the same incident, an employee sustained injuries in a car accident that occurred in Georgia on 18 August 2005. He was acting in the scope of his Tennessee employment at the time, so the employer paid benefits pursuant to Tennessee workers' compensation law.

The claimant did not pursue a tort action against the other driver. Seeking

to recover workers' compensation benefits it had paid to the employee, the employer filed suit in the employee's name on 13 February 2008 under a Tennessee statute that assigns the cause of action against the tortfeasor to the employer by operation of law if the employee does not file suit within one year of the injury. That statute further provides that the employer has six months to file suit against the tortfeasor after the cause is assigned.

The tort defendant moved for summary judgment on the grounds that the claim was barred by the two-year statute of limitations in O.C.G.A. § 9-3-33. The trial court granted the defendant's motion. On appeal, the Court of Appeals rejected the employer's argument that, since Georgia law gave the employee the right to sue for two years after the accident compared to Tennessee's one year, and since the Georgia statute of limitation applies to the cause of action that arose in Georgia, the employer had an additional six months after the employee's right to sue had expired. Citing *Taylor v. Murray*, 231 Ga. 852

(1974), the Court held that a foreign statute cannot extend an applicable Georgia statute of limitations.

Performance Good Group, Inc. v. Williams, et al., 300 Ga.App. 831, 686 S.E.2d 437 (2009)

Decided Nov. 6, 2009.

In the second subrogation case, again dealing with the Tennessee-Georgia line, the employee was injured in a car accident while performing his work duties. His employer paid benefits under Tennessee workers' compensation law. The employer then brought suit against the driver and the owner of the other vehicle seeking to recover benefits paid. The trial court granted the defendants' motion for summary judgment, and the employer appealed.

Because the employee had a right to recover benefits pursuant to Georgia workers' compensation law (even though his actual recovery was

pursuant to Tennessee law), the Court held that Georgia law of subrogation, provided in O.C.G.A. § 34-9-11.1, applied. The Georgia subrogation statute clearly states that an employee as a right of subrogation limited to “benefits paid under the Georgia Workers’ Compensation Act.” Because no such benefits had been paid, the employer did not have a valid claim.

The Court of Appeals rejected the employer’s argument that it was denied due process. Noting that the right to subrogation was created by statute, there was no violation of due process by the Georgia General Assembly’s not having provided for the recovery of benefits paid pursuant to another state’s workers’ compensation laws. The Court of Appeals appeared to acknowledge the harshness of the result, but noted that, at least in this case, the harshness was somewhat mitigated by the fact that the employer could pursue its subrogation rights against the employee, a Tennessee resident, in a Tennessee court if the employee recovered an award in the Georgia action.

St. Joseph’s Hospital, et al. v. Ward, 300 Ga.App. 845, 686 S.E.2d 443 (2009)

Decided Nov. 9, 2009.

A hospital nurse claimed injuries to her knees occurring on various dates. Following a hearing, the administrative law judge (ALJ) found that she sustained a compensable injury to her right knee on 23 June 2005 when she twisted the knee while turning to get some water for a patient. The employee returned to work in a sedentary position in August 2005, where she remained until September 2005, when she stopped working to undergo right total knee replacement. The ALJ found that the employee sustained a fictional new accident on 16 September 2005 when she became unable to work due to a gradual worsening of her condition at least partially attributable to her continued work. There were no findings regarding the compensability of the alleged injuries to the left knee.

The employer appealed to the State Board’s Appellate Division, which found that a claim for a 2003 left knee injury was barred by the statute of limitations. It further found that the 23 June 2005 injury was not compensable because the “standing and turning” that caused the injury was not associated with any peculiar employment risk and did not bring her into contact with “any object or hazard of employment.” The Appellate Division reversed the ALJ’s finding that she sustained a fictional new accident on 16 September 2005, finding that the employee had failed to establish that any worsening of her knee had resulted from the performance of her job duties.

The employee appealed to the superior court, which reversed the Appellate Division’s finding on the compensability of the June 2005 injury, noting that the “standing and turning” to get water was part of her work duties of assisting a patient. The superior court further reversed the Appellate Division and found that as of 16

September 2005, the employee had compensable claims for both knees because the continued work at least partially caused a gradual worsening of the conditions of both. The employer’s application for discretionary appeal was granted by the Court of Appeals.

In *Chapparral Boats v. Heath*, 269 Ga.App. 339 (2004), the Court of Appeals had held that a knee injury sustained while walking at work was not compensable, because the activity of walking was a risk to which the employee was equally exposed apart from employment. In the present case, the Court of Appeals held that whether the employee’s “standing and turning” was a risk to which the employee was equally exposed apart from employment was a factual finding to which the superior court and the Court of Appeals must defer.

The Court acknowledged its having affirmed a different Board conclusion in the factually similar case of *Harris v. Peach County Board of Commissioners*, 296 Ga.App. 225 (2009), wherein a knee injury resulting from a custodial worker’s bending down to pick up her own dropped pill was found compensable. Picking things up off the floor was part of the Harris claimant’s duties, so there was evidence from which the State Board could conclude that she was engaged in activity presenting a risk to which she might not have been equally exposed apart from work.

Is it not true, however, that turning to retrieve water for a patient was part of the nurse’s duties? And may we not assume that some employees are required to walk from one location to another on the employer’s premises to perform their job duties? It seems to your humble author that “walking” (*Chapparral*), “bending” (*Harris*), and “standing and turning” (*Ward*), can always go either way, as long as there is some element of work duty involved. In *Harris*, why the employee was bending was important, but in *Ward*, the reason for standing and turning was irrelevant. If what matters is the degree to which the job duty plays a part in the activity, it is difficult if not impossible to discern from these cases where the dividing line may be. People bend whether at work or not, but not necessarily in furtherance of their job duty to clear objects from the floor. Likewise, people stand and turn whether at work or not, but not necessarily in furtherance of their job duty to provide water to a hospital patient. Because the Court of Appeals appears to review these cases under an “any evidence” standard, it highlights the importance of winning at the Board level. But they offer little guidance as to what evidence is needed.

Much less confusing was the Court of Appeals’ holding regarding the superior court’s reversal of the Appellate Division’s finding that the employee had not sustained compensable fictional new injuries to both knees in September 2005 when she stopped working. Noting there was evidence on both sides of the issue of whether the employee’s continuing work duties contributed to her gradual worsening resulting in disability, the Court held that it was improper for the superior court to reverse the Appellate Division where there was any evidence to support the Appellate Division’s finding.

New Circumstances, New Injury?

Defining the conceptual limits of the “fictional” new accident

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When does the intervention of new circumstances warrant the finding of a “fictional” new accident? With considerable expansion in its definition and application in recent years, the concept of a fictional new accident is expanding. Without clearly defining the conceptual limits of a fictional new accident, its current application threatens to expand the concept beyond the original rationale for its existence and into a device used to obtain the most financial benefit to the parties.

The original concept of the “fictional new accident” arose out the equitable need to escape the harsh effects of the statute of limitations on a change of condition claim. *Beers Constr. Co. v. Stephens*, 162 Ga. App. 87, 290 S.E.2d 181 (1982). Previously, the statute of limitations might bar an employee’s recovery of workers’ compensation disability benefits for a disability that was clearly employment-related simply because the employee continued to work after his initial injury even though he was hurt to some extent. *Aetna Cas. & Sur. Co. v. Cagle*, 106 Ga. App. 440, 126 S.E.2d 907, 908 (1962). Rather than allowing a result that would penalize an employee for returning to work after an initial injury, but who ultimately ceased work due to the worsening of his condition after the statute of limitations had run, the concept of the fictional new injury date was created, allowing the statute of limitations to run from the date that the employee ceased work, not the date of the employee’s actual injury.

However, the concept of the fictional new accident evolved further to alleviate similar harsh effects that occurred as a result of the employee’s original date of injury working an injustice on the outcome of a claim. *Zurich Ins. Co. v. Cheshire*, 178 Ga. App. 539, 343 S.E.2d 753 (1986). For example, a fictional new injury date has been

used in situations where an employee goes to work for another employer after his initial injury, and due to the new circumstances, subsequently sustains an aggravation or worsening of his condition. *Slattery Assoc. v. Hufstetler*, 161 Ga. App. 389, 288 S.E.2d 654 (1982). As the original employer has no ability to control the work activities of its employee who leaves its employ to work elsewhere, the Court was reluctant to assign liability to the original employer as would otherwise be required under a change of condition. *Beers Constr. Co. v. Stephens*, 162 Ga. App. 87, 89, 290 S.E.2d 181, 183 (1982). Consequently, in circumstances where

liability between successive employers is at issue, the Court has applied the concept of a fictional new accident to relieve the claimant’s original employer from liability for the claimant’s worsening condition while employed by a subsequent employer.

For example, in *Certain v. United States Fid. & Guar. Co.*, 153 Ga. App. 571, 266 S.E.2d 263 (1980), an employee was injured after performing strenuous work with his employer. He received compensation and later returned to light duty work. The employee quit and subsequently went to work for a second employer

performing the same type of strenuous work that he had been medically prohibited from doing before. Although the employee did not experience a specific new accident, his condition continued to worsen to the point that he became totally disabled. The Court held that the new circumstances of his employment with the second employer warranted the finding of a new accident as of the date of his inability to work for the second employer.

The concept of a fictional new accident date has also been used when the injured employee eventually stops working for the same employer, but the employer has been subsequently insured by a different insurance carrier in the meantime. For example, in *Guarantee Mut. Ins. Co. v. Wade Investments*, 232 Ga. App. 328, 499 S.E.2d 925 (1998), the concept of a fictional new accident was used when an injured employee was subsequently forced to stop working due to her worsening condition, but whose employer was by that time insured by another carrier. In this case, the employee developed carpal tunnel and received appropriate medical treatment. Although her physician recommended a surgical release, she declined to consider the procedure and continued to work for her employer. During this time, her employer became insured by another workers' compensation carrier. The employee's condition worsened and she subsequently became unable to work due to the pain. The issue arose as to which insurer was liable for her temporary total disability benefits. The Court held that the second insurer was liable as the claimant sustained a fictional new accident on the date her disability manifested itself and she was unable to continue her employment.

In both of these situations, the court has carved out exceptions justifying the finding of a fictional new injury to relieve the original employer when the claimant subsequently goes to work elsewhere, or to relieve the original insurance carrier when the claimant later stops working for same employer with a new insurance provider. However, all of the situations discussed above involve the finding of a fictional new injury under certain limited exceptions in order to avoid the unfair or unjust result that would otherwise occur by application of the claimant's original date of injury.

The concept of the fictional new accident has continued to expand beyond the original reasoning underlying the rule. Instead of a narrow application to particular circumstances where applying the concept of change of condition serves to work an injustice on the parties, the concept of fictional new accident is now used to seek the advantages of a different accident date, to which newer, substantive changes apply, even though there have been no statute of limitations issues or any change in the employer or insurer.

An example of this conceptual expansion is when a claimant seeks the imposition of a fictional new accident date to take advantage of a new maximum benefit cap that has subsequently gone into effect after his initial date of injury, even though he has had no additional accidents or injuries, no intervening or aggravating events, no change in his employment, compensation, or medical care, and no running of the statute of limitations. This seems to have been

the situation in *Georgia Subsequent Injury Trust Fund v. ITT-Rayonier*, 198 Ga. App. 467, 402 S.E.2d 54 (1991), although the case was appealed on other grounds. Although the facts underlying the claimant's accident and injury are sparse, and it there is some factually ambiguity as to whether the claimant sustained an actual new accident or a fictional new accident, the Court of Appeals notes that in the underlying claim, the claimant successfully contended that she had sustained a new accident, so as to secure an increase in her weekly disability benefits, since the maximum compensation rate for her new accident was higher than it was for her original accident.

In *Cypress Companies v. Brown*, 246 Ga. App. 804 (2000), Ms. Brown was injured on July 20, 1997 while working at a restaurant. She began experiencing pain and swelling in her right knee and obtained medical treatment. Den America Corporation was the employer at that time. Ms. Brown continued working. Approximately 10 days later, Den America sold the restaurant to Cypress. Brown continued working as the condition of her right knee worsened. By January 19, 1998 she needed crutches and ultimately ceased working on April 3, 1998 after arthroscopy surgery. She began to work again in June 5, 1998 but later underwent a right knee replacement procedure in November, 1998 and returned to work on January 29, 1999. A dispute arose between the different employers and insurers as to who was responsible.

The Court stated that as no agreement or award had been entered as a result of the 1997 incident, "...an initial claim for compensation based upon a gradual worsening of an employee's pre-existing and previously uncompensated work-related injury may be classified as a new accident". The date of the new accident is the date that the injury manifested itself, that is, the date the claimant was forced to cease her employment " p. 807.

Recently, the Appellate Division was faced with this issue. A claimant injured his ankle on April 11, 2007. He continued working until August 15, 2007. He went out of work to have surgery on the same ankle. He has, because of some post-surgical problems, continued to be disabled. The insurer picked up the claim and paid \$450/wk., the maximum on April 11, 2007. The claimant requested a hearing, asking that benefits be increased to \$500/wk. as that was the maximum allowed on Aug. 15, 2007.

The Appellate Division ruled in favor of the claimant, following the rationale of both *Cypress Companies* and the seminal case of *Central State Hospital v. James*, 146 Ga. App. 308 (1978). The Appellate Division determined that it is the date when the disability first manifests itself that should be the date of injury.

Thus, a fictional new accident was found where there was no question as to whom would be responsible for a claim nor was there a Statute of Limitations issue. This expansion of the use of fictional new accidents in workers' compensation could provide the basis for more cases in the years to come and all attorneys should be prepared for the ramifications.

WC

Let the Good Times Roll – Just Not To The Workplace: An Analysis of the Intoxication Defense and The Development Of Employer Presumptions

Gregory T. Presmanes and Seth R. Eisenberg

The summer blockbuster movie smash hit *The Hangover* features three men throwing a bachelor party in Las Vegas for their best friend who is set to be married that weekend. The four men proceed to indulge themselves to all the drugs and alcohol they can find in Las Vegas. After a night of wild partying, the three men awaken, still feeling the effects of the drugs from the night before, with no recollection of the wild events and worse, no groom. Luckily, the three men are able to spend their whole next day piecing together the prior evening's events, locate the groom, and return home in time for the wedding and a happy ending for all.

Now imagine an employee has a similar wild night, but instead of waking up on vacation, the employee goes to work still hungover. The likelihood of such a scenario is no laughing matter. All employers are at risk for workers' compensation claims for workplace accidents involving the use of drugs or alcohol, and the intoxication defense can be a valuable tool for employers in preventing payment of benefits to an injured worker who suffers a workplace injury while intoxicated.

Background on the Intoxication Defense

Workers' compensation is an administrative remedy requiring employers to compensate employees for injuries arising out of and in the course of employment.¹ Although workers' compensation does not look to the negligence or the fault of the parties as a factor in determining an award of benefits, an employee's benefits can be limited or even denied if an employee causes their injury due to their own intoxication.² The intoxication defense is an affirmative defense, and employers have the burden of proof to prove the employee's intoxication caused their injury.³

Proving the Defense and the Effect of Varying Degrees of Causation Requirements

First, an employer must show the employee was intoxicated in order to carry its burden of proof.⁴ In addition to proving the employee was intoxicated, an employer must satisfy a timing requirement and prove that the intoxication was present at the time of the employee's on-the-job injury.⁵ Finally, even if the employer can prove that the employee was intoxicated at the time of the employee's on-the-job injury, absent proof that the intoxication caused the accident the employee will still be entitled to benefits.⁶

The toughest and most strict intoxication defense statutes to satisfy require that the work-related injury be the sole cause of the employee's intoxication.⁷ On the opposite side of the spectrum, some statutes only require that the on-the-job injury be "caused by" or "caused, in whole or in part," by the employee's intoxication in order for the employer to properly deny benefits.⁸ In between these two tentpoles exist the majority of statutes utilizing the more familiar *proximate cause* standard.⁹

The "sole cause" and similar high degree of causation jurisdictions represent the most stringent intoxication defense statutes.¹⁰ The "sole cause" jurisdictions best serve the remedial purpose of the workers' compensation statutes which is to award benefits without determining the fault of the parties.¹¹ However, considering almost all jurisdictions recognize an employee's intentional intoxication as a bar or reduction to benefits, it would appear that public policy would discourage "sole cause" jurisdictions from watering down the intoxication defense statutes.¹²

The Development of Statutory Presumptions To Ease the Employer's Burden

Although the continued existence of "sole cause" jurisdictions would seem to warn practitioners that the intoxication defense is not a realistic way for employers to defend against benefit payments, many states have developed provisions in their intoxication defense statutes that create a presumption in favor of applying the defense to deny benefits.¹³ Georgia is one jurisdiction that enacted a statutory presumption of intoxication under their workers' compensation scheme.¹⁴ Georgia law provides for a presumption to arise in favor of a finding of employee' intoxication when an employee tests positive for drugs or alcohol following a work-related injury.¹⁵

The benefit to the employer of these statutory presumptions is best exemplified by a comparison of Georgia cases before and after the enactment of the statutory presumptions.¹⁶ In a pre-presumption case, the employer

in *Thomas v. Helen's Roofing Co.*, 199 Ga. App. 161, 404 S.E.2d 331 (1991) submitted a positive laboratory result confirming the presence of cocaine in the employee's system, but the court held the employer failed to prove that the employee was intoxicated at the time of the accident.

In *Lastinger v. Mill & Machinery, Inc.*, 236 Ga. App. 430, 512 S.E.2d 327 (1999), decided after the enactment of the statutory presumptions, the employee was injured at work due to a fall from detaching a conveyor belt. A urine sample was taken from the employee shortly after the accident which revealed the employee had ingested marijuana and cocaine.¹⁷ The employer submitted the positive drug test to raise the statutory presumption.¹⁸ The court stated that based on the positive urine sample taken within eight hours of the accident, it was undisputed the presumption arose in the case even though the employee stated that he used drugs five days before the injury but denied being impaired by drugs on the day of his injury.¹⁹ The court further reasoned that once the presumption was met, the employee had the burden of showing by clear and uncontradicted evidence that the drugs were not the cause of the injury.²⁰

In both *Thomas* and *Lastinger*, the employee admitted using drugs in the past but not to using drugs on the day of the accident. Also, the employer in both cases submitted a positive drug test. However, as a result of the statutory presumption and the employer acting in accordance with said presumption, the employer in *Lastinger* was able to shift the burden to the employee to rebut the defense by clear and uncontradicted evidence.²¹

Recognizing the immense benefit of these statutory presumptions in favor of establishing the intoxication defense, an important aspect of establishing these presumptions is the drug or alcohol test must be conducted to comply with state statutes regulating workplace drug testing.²² An employer trying to establish a statutory presumption must show that

it complied with the procedures of proper workplace drug testing as set forth by state legislatures.²³ If an employer fails to conduct drug testing by statutory standards, a presumption will not arise even if the employee tests positive for drugs or alcohol.²⁴

For example, a proper drug test requires that an employer be able to prove chain of custody of the drug test.²⁵ A chain of custody requirement is standard for any drug test to be admissible in court because the employer must be able to confirm that the sample test had been taken from the worker.²⁶ Evidence indicating proper chain of custody includes evidence that the test sample was drawn from the employee, properly marked with employee's name, and a technician or doctor on hand for the test is available to testify that the proper procedures were followed.²⁷

Further promoting drug-free workplace programs, a statutory presumption in favor of intoxication can arise even where no positive drug test is conducted on the employee. If an employer has implemented a drug-free workplace program and notified its employees of the potential for drug-testing, many intoxication statutes will presume an employee was intoxicated at the time of the work injury where the employee refuses a drug test after the accident.²⁸ In Georgia, the unjustified refusal of an employee to submit to a drug test after an accident will give rise to a rebuttable presumption in favor of intoxication, even absent proof of compliance with the drug testing statute.²⁹

Conclusion

To best establish the defense, practitioners and employers should implement certain procedures to better enhance the chances of successfully asserting the defense. Prior to an accident, there should be a written and promulgated drug-testing policy in place. All employees must be made aware of it and the impact of refusing said test. At the time of the accident, interview the injured employee, co-workers, and any other witnesses regarding intoxication and impairment at the time of the accident. Further, a request must be made for the employee to take a drug test immediately after the accident, not days later. Finally, hire any necessary expert witness, particularly an experienced toxicologist, in order to explain to the court any test results and other evidence showing intoxication and impairment at the time of the accident. **WC**

(Endnotes)

- 1 See MARJORIE A. SHIELDS, Annotation, *Application of Workers' Compensation Laws to Illegal Aliens*, 121 A.L.R. 5th 523 (2004).
- 2 See, e.g., O.C.G.A. § 34-9-17. See also 82 AM. JUR. WORKERS § 225 (2009)
- 3 See DONALD T. DECARLO, *Drugs in the Workplace*, RISK & INSURANCE, July 1999, available at http://findarticles.com/p/articles/mi_m0BJK/is_1999_July/ai_56029984/; See MARJORIE A. SHIELDS, Annotation, *Workers' Compensation: Validity, Construction, and Application of Statutes Providing that Worker Who Suffers Workplace Injury*

- and Subsequently Tests Positive for Alcohol Impairment or Illegal Drug Use is Not Eligible for Workers' Compensation Benefits*, 22 A.L.R. 6th 329 (2007).
- 4 *Parks v. Maryland Casualty Co.*, 69 Ga. App. 720, 26 S.E.2d 562 (1943). Intoxication "is a condition where one is under the influence of intoxicating liquors to the extent that he is not entirely himself, or his judgment is impaired, and his acts or words or conduct are visibly and noticeably affected." *Id.*
 - 5 See JAMES B. HIERS, JR. & ROBERT R. POTTER, *GEORGIA WORKERS' COMPENSATION LAW AND PRACTICE* § 7-7 (5th ed.)
 - 6 KENT M. SMITH ET AL., *The Intoxication Defense in Workers' Compensation*, For The Defense, September 2009, at p. 70; James B. Hiers, supra note 5. Generally, evidence that an employee was intoxicated at the time of the accident is not enough standing alone to justify a denial of benefits. See Am. jur. Workers, supra note 2, at § 225.
 - 7 See V.I. Code R. tit. 24 § 252; D.C. Code § 32-1503; Md. Code Ann., Lab. & Empl. § 9-506; N.Y. Workers' Comp. Law § 10.
 - 8 Tex. Lab. Code Ann. § 406.032; S.D. Codified Laws § 62-4-37; N.H. Rev. Stat. Ann. § 281-A:14.
 - 9 See, e.g., O.C.G.A. § 34-9-17; N.M. Stat. § 52-1-11; Idaho Code Ann. § 72-208; Miss. Code Ann. § 71-3-7; Me. Rev. Stat. Ann. tit. 39-A § 202; Fla. Stat. Ann. § 440.09; Nev. Rev. Stat. Ann. § 616C.230; It is imperative that practitioners research these causation standards to best determine if the courts analyze these standards as strict or lenient causation standards relative to the general proximate cause standard. For example, some courts treat a causation standard with the word "primary" closer to the "sole cause" standard. See Travis M. Wheeler, Note, *Grammatico v. Industrial Commission: Invalidating Statutes Making Alcohol or Drug Use a Bar to Workers' Compensation Claims in Arizona*, 48 Ariz. L. Rev. 211, 213 (2006).
 - 10 Donald T. DeCarlo, supra note 3.
 - 11 See *id.*; Marjorie A. Shields, supra note 3.
 - 12 See Robert J. Fitzgerald, Comment, *A Watered Down Intoxication Defense*, 186 N.J.L.J. 581 (2006).
 - 13 See Kent M. Smith Et Al., supra note 6, at 71.
 - 14 O.C.G.A. § 34-9-17. Georgia is also a proximate cause causation standard jurisdiction.
 - 15 O.C.G.A. § 34-9-17.
 - 16 Compare *Thomas v. Helen's Roofing Co.*, 199 Ga. App. 161, 404 S.E.2d 331 (1991) with *Lastinger v. Mill & Machinery, Inc.*, 236 Ga. App. 430, 512 S.E.2d 327 (1999).
 - 17 *Lastinger*, 236 Ga. App. at 430.
 - 18 *Id.*
 - 19 *Id.* at 431.
 - 20 *Id.* In Georgia jurisprudence, there is no reported appellate case ruling on the evidence necessary to rebut the statutory presumption in favor of the intoxication defense.
 - 21 *Id.* Although the appellate court found that the presumption was successfully established by the employer, the case was remanded to the State Board of Workers' Compensation because of improper impeachment evidence admitted by the ALJ. *Id.*
 - 22 See, e.g., O.C.G.A. § 34-9-17(3) ("If the employee unjustifiably refuses to submit to a reliable, scientific test to be performed in the manner set forth in O.C.G.A. § 34-9-415 . . . then there shall be a rebuttable presumption that the accident . . . caused by the consumption of alcohol or the ingestion of marijuana or a controlled substance").
 - 23 James B. Hiers, supra note 5.
 - 24 *Id.*
 - 25 See *Estate of Mitchum v. Triple S Trucking*, 113 N.M. 85, 92, 823 P.2d 327 (1991).
 - 26 See *Unigard Insurance Co. v. Elmore*, 137 Ga. App. 665, 224 S.E.2d 762 (1976).
 - 27 See *Mitchum*, 113 N.M. at 92.
 - 28 See Paul J. Siegel, *The Dangers of "Post-Injury Drug and Alcohol Testing"* <http://www.irmi.com/Expert/Articles/2003/Siegel102.aspx>
 - 29 See *Marine Port Terminals, Inc. v. Dixon*, 252 Ga. App. 340, 556 S.E.2d 246 (2001).

Effective Use of Paralegals in a Workers' Compensation Practice

By Andrew B. Roper
The Gammage Firm

Workers' Compensation is an area of practice that requires regular interaction with your clients, whether they are claimants or employer/insurers. Regular interaction with your clients requires an enormous amount of time; time there seems to be so little of. This article will highlight many of the ways that we at The Gammage Firm attempt to manage our time more efficiently through the effective use of paralegals. If it is not evident by the end of the article, there is no way to adequately measure the importance of the paralegal's role in a Workers' Compensation claimants' practice.

At The Gammage Firm, paralegals are the front line; the first into battle, if you will, beginning with client intake. Our method is to simply alternate new client intakes amongst the paralegals and they, in turn:

- 1) speak with the potential client regarding the facts of his/her case,
- 2) schedule an appointment for the potential client to come in and speak directly with us, and
- 3) are responsible for greeting the potential client and seeing that he/she is comfortable.

In the meantime, the paralegal has typically summarized the facts as the potential client relayed them and discussed same, along with possible issues that need to be resolved with the attorney. When one of our attorneys meets with a potential client for the first time, he already has a pretty good understanding of the facts surrounding his/her case as well as identified most of the issues that need to be addressed. Not only does the client usually appreciate the fact that the attorney has been briefed regarding his/her particular situation prior to even stepping in the door, but this method allows the attorney to spend more time establishing a rapport with the potential client on a personal basis because most of the "bottom-line" information has already been exchanged. As part of our initial consultation, we make it clear to the new client that his/her paralegal is the "go to" person in our office regarding the case. The paralegal acts as a "client manager." Whether the attorney is in court, on the road for depositions or mediations, or simply busy with telephone calls or the like, the paralegal is available to speak with the client when he/she has any questions or concerns. Of course, all legal questions are taken and discussed appropriately. It is important to remember to stress to your staff not to provide legal opinions to clients without consulting the supervising attorney. Although 9 times out of 10 the paralegal will be correct in his/her analysis, it is imperative that the paralegal ALWAYS consult with his/her supervising attorney before rendering any legal advice.

After initial consultation and once the attorney-client relationship has been established, the attorney typically holds a brief meeting with the paralegal to go over the case

again and specify issues for any requests for hearings that need to be filed. Appropriate forms are filed through ICMS and the paralegal then begins to organize and maintain the actual physical file within the office. Most, if not all, client telephone calls are sent by the receptionist directly to the client's paralegal. As alluded to earlier, this eliminates the client from having to speak to a machine, and provides immediate assistance regardless of where the attorney is or what he is doing. Many times, the inquiries need no legal analysis and can be easily resolved with a 5-minute phone call. Certainly, if the client would like to speak to his/her attorney, that desire should be granted, but we have found that most clients are completely satisfied and know that the paralegal is a part of their "legal team" and can competently gauge the nature of the question. In order to maintain good client relations, incoming telephone calls must be handled appropriately. This method allows every client to speak with a live person immediately, and if not immediately, certainly on the same day as the initial call. Also, it prevents the client from being "shuffled" from person to person within the office. We have found that clients truly appreciate meeting and getting to know everyone on their team from day one.

In a workers' compensation claimants' practice, tasks arise on a daily basis involving late TTD/TPD checks, mileage reimbursements, authorization for doctors' visits, and telephone calls with general questions only natural of someone who has never had a case before, never hired an attorney before, and is somewhat skeptical of the entire process. All of these issues can be resolved by a competent, well trained paralegal with little to no supervision. Jack Welch once said:

If you pick the right people and give them the opportunity to spread their wings and put compensation as a carrier behind it you almost don't have to manage them.

We have found this statement to be so true. With the obvious exception of making legal decisions or giving legal advice, we encourage the paralegals at our firm to take on new tasks, brainstorm along with us in difficult cases, and certainly to share their ideas with us.

Your paralegal is an essential part of your team, and there absolutely must be a mutual understanding and respect of that fact. Never make the mistake of thinking that he/she just loves working with you so much that you take a productive situation for granted. No matter how much you think your paralegal enjoys spending every waking hour with you, if you stop issuing paychecks, you better plan on spending a lot more time at the office. To quote Warren Buffet, "Price is what you pay. Value is what you get." A competent, well trained paralegal is invaluable. Find a way to save somewhere else; if you have the right people in place, compensate them accordingly.

Hopefully, the vital importance that paralegals have in a workers' compensation claimants' practice has been adequately expressed. If one were to ask our paralegals to describe their job, they would likely answer, "We run this place." Of course, that is not far from the truth, and if you have a paralegal who can manage your time more efficiently and help retain good client relations all the while, then in a way, they do run the place. **WC**

A special thanks
to the
2008-09 Workers'
Compensation Law
Section Officers:

Cliff Perkins

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Use It Or Lose It

By John F. Sweet

A couple of years ago, a colleague whom I love dearly, called and asked if I would do a professional courtesy, and assist, meaning take over representation on a comp case, because he was no longer able to continue for unrelated reasons. No problem.

He explained that the employee had stippled out the income benefits, as well as any right to VR, leaving only the medicals. The employee is in a wheelchair, CAT designated, a meds only case. This new client has been a pleasure to work with. He is helpful, and appreciative, although, unless the E/I steps out of line, this is a pro bono case.

Well technically not, since a pro bono case is, by definition, a case which you take knowing, at the inception, that whether or not attorney fees might be potentially available for your work, you are agreeing to represent without a fee, no matter how successful your representation may be. Arguably, then, as long as the possibility of unreasonable denial may be the response from the E/I, arguably again, if you were to find an ALJ that believed that assessed attorney fees were still within his or her discretion, there is the remote possibility of an attorney fee, so comp can never technically be pro bono.

Then, of course, this “medicals only” case might settle, from which arguably I would be due a fee. This is another area of contention: some ALJ's in this circumstance take the position that any agreement, where the remaining cause of action is exclusively medical, such agreement could only be a payment for medical care, and for that reason attorney fees are not allowed.

Some ALJ's, in the alternative, take the position that payment for medical care in the future is not payment for medical care, but rather payment for the right to a compromised portion of the future medical care. This argument, which not compelling, rests in the reality that there is a significant difference between payment directly to a medical provider by the insurance company, as distinguished from a payment of money made to the employee in contemplation of the possibility of future medical care, understanding that on receipt, the employee is free to use the money to buy a car.

All of which needs to be considered in light of the famous Goya, in Museo Del Prado in Madrid, the scary giant, holding

the remains of a man in his prehensile grip, while tearing off the man's head. As I confessed in a mediation last week, I am a leftist, and I do not hate the federal government, but we are about to be eaten by the giant. Quietly, we all seem to sense the danger, and while I have been known to grouse about the impending doom, up through and including this expression of opinion, there does not appear, yet, to be a clear escape. I am talking about the MSA process, CMS, and the shadow of the Secondary Payor Act.

Step back just a second. Two-thirds of the cost of the workers' compensation program in the State of Georgia is expended on medical care. The other four (4) rights, TTD, PPD, TPD and VR, aggregate to the remaining one-third of the annual cost of the system. Put another way: workers'



compensation is primarily a medical delivery system. The primary difference between workers' comp and group health and MEDICARE, is the inclusion of the “return to work” component of the comp.

Put another way, the social reality of our score card, the ultimate evaluation of our contribution will be the assessment of how well we distribute medical care. That assessment includes a measure of the quality of the care we deliver; the speed at which it is delivered; the speed at which the authorization is given, or the remuneration for the service is made; and a critical look at whether or not W/C can eradicate redundancy

and fraud, and even a myriad of other maladies and inefficiencies that seem to be woven into the fabric of our system, slowing it up.

Against, that backdrop is the yawning maw of MEDICARE. You know them: you get letters from CMS telling you about your duties to them. It fascinates me that the employee is generally “stuck with the law that was in existence on the date of the accident, as in the amount of TTD that can be received, and at the same time, I can get such directions from CMS on cases where the DOA, and indeed my contract, pre-date the passage of the Secondary Payor Act.

Please understand. I know the Secondary Payor Act is righteous, and makes good sense. But if it is accompanied by the implicit arrogance of one-sided conversation, it hardly smacks of due process, either intellectual or legal.

So here is the problem: the MSA regulations now require that the prescription medication must be included at the market rate, as opposed to the fee schedule, which is absolutely correct, since the e/e will purchase as a fair market buyer after the stip is approved. But the regs go on to require that the present medications be protected for life, which is absolutely not correct. Many of the medications either become toxic, or the body accommodates them out of effectiveness, when used over prolonged periods.

The requirement for cost projection for life has, simply stated, bloated the MSA's, creating a growing impediment to settlement. CMS, of course, has an interest in this upward drift, because, considering its effect in the aggregate, it slowly eases the burden of the accrued un-funded liability of MEDICARE for future medical care. This upward drift in the cost of the MSA's has commensurately resulted in a reduction of the portion of the pot set aside for settlement that would be paid to the employee. There is increasingly less individual incentive to settle. The system is slowing up, holding on to cases for a longer time. And as to a system assessment, this growing

procedural lethargy is helping no one.

So a new and creative mushroom has begun to sprout in the dark and creative recesses of the industry: how about a partial stipulation to settle everything, leaving the medicals open? Wow, that is a stipulation with a twist. Historically the primary function of a stip was to turn the variables into constants, to fix the costs, which allowed the losses to be liquidated, and therefore the insurance company could be more assured of its profit when fixing rates. This new proposal would do just the opposite, it would dispose of the fixed costs of 261, 262, and 263, and leave the poor unprotected E/I to the ravages and vagaries of whatever is necessary to effectuate a cure.

So if leaving the medicals open is not optimal for the insurance industry, that is profoundly in control of the system, why would such an instrument come into being? There are a couple of guesses I would posit:

First, the insurance industry may want to settle what they can, even if it is only a partial stipulation. Sounds like a compromise, so that would be a suspect category.

Second, and more probably, once the income benefits are settled, counsel for the employee is fairly effectively precluded from making a living representing people who only have medical care left. The effect would be a substantial diminution of medical care delivered under the w/c system.

Please allow my personal opinion that this new method was not designed by the insurance industry because it is innately greedy. Rather I believe it was designed to accommodate to the unremitting, and unrelenting growing power of the federal government to nationalize the state system. Again, as a progressive, from time to time I have looked to the federal government to protect individual rights, but as a Jeffersonian, I think we should look for help only when the state system is broken. As a relative term, here I mean “broken” as the belief or experiential reality that the federal response to a challenge, like delivery of medical care to the injured worker, is effectively

better than the system currently in effect.

So can the federal government deliver medical care better? I am open to such a possibility, but in the thirty-five years that I have practiced comp, there is no sustained evidence that the federal government would improve medical delivery for injured workers. OWCP would not be an improvement; the VA is spotty, and while we have a good to great VA in Atlanta, that is not consistently the case nation-wide. MEDICARE is a decent competitor, with lower administrative costs, and a faster remuneration system, but the fee schedule for it is so Damoclean that a significant number of physicians in Georgia, will not take Medicare patients. By my estimates, even though the fee schedule in w/c is a barrier to some physicians, Medicare's fee schedule would significantly and further constrict the pool from which injured workers could access treatment.

All of which is to say that I think settling everything except the medicals is a dangerous mushroom, although it may taste good initially, it is toxic, perhaps fatal. It is bad news for everyone. It will ultimately abandon the injured worker without representation on the most important aspect of the claim. It will leave the E/I with the most variable cost. But most of all it will constitute an abdication of our jurisdiction which will reward the Federal government for its arrogant abrogation of the fundamentals of due process when it sets a property right, without a hearing, without the chance to cross examine, without evidence. The present process in effect with CMS would be changed: they should either come into court, like the rest of us, or the State Board should wrest back its power, its jurisdiction, and assert its right, absent some direct statutory preemption, to control the benefits of its dominion.

In the alternative to reward CMS with a de facto control, can only encourage an increase in the corrosive, however unintended effect, of increased Federal intervention is the process to which the Workers' Compensation system lays claim. **WC**

State of the State Board of Workers' Compensation

By Gary Kazin

First, I wish to thank Gov. Perdue for the opportunity to become the 13th Chairperson of the State Board of Workers' Compensation, effective Oct. 1, 2009. My immediate predecessor, Carolyn Coberly Hall, was appointed and reappointed by both a Democratic and Republican Governor, a first for the state of Georgia and a real tribute to the unwavering fairness and dignity which are the embodiment of Carolyn Hall. As a tribute to her, I made the decision to name the Appellate Division Courtroom in her honor, and there is a plaque on the outside courtroom door signifying this fact. She is truly a friend to everyone in the workers' compensation world in Georgia and will never be forgotten by any of us.

I also want to take this opportunity to thank the members of the Workers' Compensation Section who hosted a welcome reception for my wife, Jenni, and me just before the end of the year. It was very heartwarming for us to see members of the Section, some of whom traveled from out of town, to join with us at the inception of the new administration. Thanks to my 12 predecessors in this position as Chairman of the State Board of Workers' Compensation, I am pleased to report the State of the Board has never been better. My charge, as well as that of Judges Massey and Farrow, is to continue to find ways to improve upon a very stable model and one which has served employers and employees well in the state of Georgia over time.

I would also like to welcome to the Appellate Division a new member, Hon. Stephen Farrow, former State Senator and longtime trial lawyer in northwest Georgia, who practiced in Dalton for 27 years prior to his appointment to the Appellate Division concurrently with me, effective Oct. 1, 2009.

As I have said on several occasions, the Workers' Compensation Bar is the most collegial section of the State Bar of Georgia. That truism continues to prove itself as our first several weeks as a newly constituted Appellate Division have shown. The lawyers who have appeared before us in oral arguments and who have presented excellent briefs for our consideration have only reinforced my prior opinion as a workers' comp practitioner myself that we have more professionals in our section than any other section of the Bar, and I truly appreciate the respect for our system which we all nurture on a daily basis in ways that are both tangible and intangible.

When I was asked to prepare this paper, I thought long and hard about this initial opportunity to share with the workers' compensation section, via the written word, my vision for the State Board of Workers' Compensation.

Above all, we at the Board intend to continue to provide "customer service" at a level which will only continue to improve over time. It is important to me for all

employees at the State Board of Workers' Compensation to understand we are not in place to serve ourselves; instead, our mission must always be to implement the Workers' Compensation Act in a fast, efficient, and qualitative manner which benefits all citizens of the State of Georgia, especially employers and employees.

As a preliminary and objective indicator that we will continue to improve our customer service, we have taken steps to vastly improve the "turnaround" time for the approval of stipulations in the Stipulation Unit. As one who recently left a practice specializing in workers' compensation litigation and mediations, I am keenly aware that most, if not all, settlements represent a finely tuned balancing of interest of all parties which can only remain so for a finite period of time before the inevitable collapse. We at the Board continue to be sensitive to the ever-changing dynamics in each and every instance in a settlement situation. Our role is to assist in helping you to resolve claims; the Board should not, and will not, be an impediment to the settlement of claims. O.C.G.A. §34-9-15.

Second, pursuant to O.C.G.A. §34-9-102(f), Awards issued by Administrative Law Judges shall be issued within 60 days after the date of hearing. On occasion and, due to unforeseen circumstances, Awards may be issued slightly outside that deadline. However, I am pleased to report that on the very date I am preparing this paper, all ALJ Awards are up to date, with one exception. The reasons for the late Award are quite appropriate under the circumstances, well known and approved by me. The days of waiting months and months for ALJ Awards are over.

Third, at the Appellate Division level, Awards should be and will be issued within 90 days after oral argument or within 90 days after submission on briefs only without oral argument unless, again, unforeseen circumstances prevent such issuance.

Finally, I would like to let the workers' compensation section know my goal as Chairman during my tenure is to provide as much transparency and accountability as possible for those of us who hold the privileged title of "public servant." Doing so is vital, in my opinion, to the accomplishment of our mission here at the State Board of Workers' Compensation to provide a fair, neutral, and hard-working environment for the resolution of workers' compensation claims affecting practically each and every employee and employer in the state of Georgia. If we accomplish that goal, we will be successful in our mission. **WC**

Case Summaries

BY GARY KAZIN

Case 1 (Issued 12/15/09)

The issues before the ALJ in this catastrophic claim were the employer/self-insurer's liability to pay for housing modifications and assessed attorney fees and expenses. In his award, the ALJ ordered the employer/self-insurer to comply with the independent living rehabilitation plan developed by the employee's designated rehabilitation supplier, providing for the building of a handicapped-accessible home as approved by the employee, on the property the employee already owns. Additionally, the ALJ did not find that the employer/self-insurer defended this claim without reasonable grounds and therefore declined to assess attorney fees or litigation expenses against the employer/self-insurer.

On appeal, the employer/self-insurer disputed that construction of accessible housing on the employee's property, as opposed to construction of accessible housing on land owned

by the employer/self-insurer, would provide the employee the least restrictive lifestyle possible. See Board Rule 200.1(a)(5)(ii). The employer/self-insurer also argued that the ALJ acted in excess of his authority in determining the employee's least restrictive lifestyle and in ordering that the employer/self-insurer pay to the employee the cost of building a handicapped-accessible home, as opposed to ordering construction of the home.

Following an unsuccessful Board-ordered mediation between the parties, the Appellate Division found that the employer/self-insurer could comply with its obligations under the Act and Board Rules by providing the employee a life estate interest in an appropriate, handicapped-accessible home. In doing so, the Appellate Division did not find that the approved house necessarily must exist on the property the employee owns, and the Appellate Division further found that a life estate interest in the house would provide the

employee reasonable and necessary housing to return him to the least restrictive lifestyle possible. Although the employee had expressed a desire to remain on his own property and to have the employer/self-insurer build him a new house, with a design and building contractor he has chosen, and grant the employee a full ownership interest in the new house, the Appellate Division did not find that those stipulations are mandated by the Act or Board Rules in order for the employer/self-insurer to provide housing reasonably necessary for the employee to return to the least restrictive lifestyle possible. Finally, with respect to the life estate, the Appellate Division granted the employee the option: (i) for the employer/self-insurer to build the house, based on the housing plan submitted by the employee, on a suitable parcel of property the employer/self-insurer selects and owns; or (ii) for the employer/self-insurer to build the house on a portion of the employee's existing acreage.

Case 2 (Issued 01/04/10)

This case involved issues regarding an offer of suitable employment and compliance with O.C.G.A. § 34-9-240 and Board Rule 240. The employee's ATP for his physical injury, but not his ATP for his psychological condition, had approved a light duty job description within 60 days of a September 2008 job offer. Without complying with the provisions of O.C.G.A. § 34-9-240 and Board Rule 240, the employer nevertheless offered the restricted duty position. The employee appeared on two consecutive days, but on both days left early, complaining that he could not perform the work activity. Subsequently, the employer reinstated benefits pursuant to O.C.G.A. § 34-9-240 (b)(1) and requested a hearing for a determination that the employee had undergone a change in condition for the better and for authorization to suspend benefits. The ALJ found that because it had not complied with the requirements for unilateral suspension of benefits required by O.C.G.A. § 34-

9-240 and Board Rule 240, the employer was not authorized to suspend benefits in September 2008 (the date of the job offer.) Nevertheless, the employer had proven at hearing that the proffered job was suitable and had carried its burden to show a change in condition for the better. Therefore, the award authorized suspension of benefits as of the date of the hearing and authorized a credit against PPD benefits for TTD benefits paid between that date and issuance of the award.

The employee appealed the award, arguing that the suspension as of the date of the hearing was precluded because the employer had never complied with O.C.G.A. § 34-9-240 or Board Rule 240.

The Appellate Division agreed with the ALJ that though the employer had not strictly complied with the examination and notice provisions of the statute and rule, the employer met its the burden of proof to show a change in condition for the better and was justified to suspend the employee's TTD as of the hearing date. The Appellate Division also agreed that, while strict compliance with the examination and notice provisions of the statute and board rule was required for unilateral termination of benefits, failure to comply with the requirements did not preclude a later determination at hearing that the employee had unjustifiably refused the job and was no longer entitled to compensation. See *City of Adel v. Wise*, 261 Ga. 53, 401 S.E.2d 522 (1991); See, e.g. *Wal-Mart Stores, Inc. v. Harris*, 234 Ga. App. 401, 506 S.E.2d 908 (1998).

Case 3 (Issued 11/30/09)

In this case, the employer/insurer argued that the ALJ erred on multiple grounds in assessing certain attorney fees, litigation expenses, and civil penalties. On cross-appeal, the employee also argued that the ALJ erred on multiple grounds in making his award.

In his award, the ALJ directed the employer/insurer to pay: (1) to the Board, a civil penalty, pursuant to O.C.G.A. § 34-9-18, in the amount of \$4,000.00; (2) to the employee's attorney, an assessed attorney fee in the amount of \$28,730.00; and (3) to the employee's attorney, litigation expenses in the amount of \$1,202.70. In making his award, the ALJ generally concluded that the insurer inappropriately sought to apply restrictions and provisions to the ATP's recommended treatment and surgery, outside the bounds of and not permissible under the Act, and that the insurer violated Board Rules 200(a)(1), 201(a), 205(b)(2), and 200.1(a)(1)(iii). The ALJ noted that an insurer may use internal "utilization review" processes to handle its portion of a particular claim, and that such processes are not per se prohibited by the Act as long as they are internal – that is, not imposed on any other participant -- and do not violate any right or obligation it or any other participant may have under the Act or Board Rules. Thus, the ALJ found justification for assessing civil penalties against the employer/insurer pursuant to O.C.G.A. § 34-9-18(a). Furthermore, the ALJ concluded that the insurer's delay, denial, and failure to

authorize the ATP's requested surgery for over nine (9) months was without reasonable grounds, thereby justifying assessed attorney fees and litigation expenses pursuant to O.C.G.A. § 34-9-108.

On appeal, the employer/insurer contended, among other contentions, that the ALJ erred in assessing attorney fees and litigation expenses of \$28,730.00 and \$1,202.70, respectively, in favor of the employee's counsel. The employer/insurer asserted that the employee's counsel failed to plead properly and prove a case for assessed attorney fees and litigation expenses, and that the ALJ had no basis for making those assessments. The employer/insurer argued that the employee's allegations of certain "unreasonable acts" committed by the employer/insurer with respect to their management of the medical aspects of this claim, even if proven to be true, would not subject the employer/insurer to the assessment of attorney fees or expenses under the Act. The employer/insurer further argued that, given that the employer/insurer had authorized surgery for the employee over one (1) year before the hearing of this case, and that the employee had not raised a request for authorization of surgery in his Form WC-14 filing prior to the surgery's being authorized, the employer/insurer could not have "defended" against this matter without reasonable grounds.

Upon review, the Appellate Division agreed with the ALJ that the employer/insurer's failure to authorize the ATP's requested surgery for over nine (9) months was without reasonable grounds, in a manner justifying the assessment of attorney fees and litigation expenses in favor of the employee's counsel. However, the Appellate Division did not agree with the ALJ's conclusion that the appropriate value of the services rendered by the employee's counsel in this matter was \$28,730.00. Instead, the Appellate Division found that the reasonable value of the services the employee's counsel rendered in this matter was \$4,662.50. After the employer/insurer, through counsel, made the employee's counsel specifically aware, in writing, of their readiness to authorize the recommended knee surgery, and to offer choices of doctors to perform the surgery after the ATP had left his practice, the employer/insurer ceased to act unreasonably in defending this matter. Therefore, the attorney fees awarded to the employee's counsel were adjusted to correlate more accurately with the attorney's work performed, the benefits gained for the employee, and the unreasonableness of the employer/insurer's actions.

Case 4 (Issued 10/30/09)

The employee who, significantly, spoke no English, had suffered extensive injuries in a violent chemical explosion at her workplace and the injury had been accepted as compensable. Subsequently, her physical injuries had become stabilized, but she continued to suffer significant emotional and social limitations. The employee's ATP for her physical injuries had referred her to a psychiatrist who had been treating her with medication under a diagnosis of post traumatic stress disorder. The psychiatrist had recommended that the employee be referred to a Spanish

speaking psychotherapist for “talk therapy” to address her anxiety and panic issues.

The employer/insurer had procured an independent medical examination (IME) by another psychiatrist, who had opined that he could expedite the employee’s recovery by offering both medication management and talk therapy. Unlike the current psychiatrist and proposed psychotherapist, the IME psychiatrist spoke no Spanish, but he opined that the language barrier posed no impediment to psychotherapy. The ATP recommended that the employee remain with her current psychiatrist and be afforded an opportunity of treatment with that psychiatrist’s choice of therapist. At issue before the ALJ was the employer/insurer’s request of change in physician from the current psychiatrist and proposed psychotherapist to the IME psychiatrist. The request was denied by the ALJ.

On appeal the Appellate Division, with one dissent, agreed with the ATP that the therapist’s ability to directly communicate with the employee is central to successful talk therapy. The award elaborated that:

While the use of an interpreter may suffice in treating physical symptoms where injuries can be visually examined, psychotherapy depends exclusively on the ability to accurately communicate and understand the cultural context within a language. The intimate conversation fundamental to talk therapy involves the fostering of trust and understanding between the therapist and patient. By the nature of psychotherapy, a third person in the room would potentially thwart the free exchange of information and interpersonal communication. We find the presence of assigned interpreters at such therapy sessions would greatly inhibit, if not prevent, the opportunity for successful treatment. In fact, the independent medical examination with [the IME psychiatrist], in which numerous errors in the employee’s personal history were recorded with the use of an interpreter, demonstrates the potential ineffectiveness of talk therapy where direct communication is

not possible.

The Appellate Division found, as did the ALJ, that the employer/insurer did not provide a credible basis either for refusing to authorize the treatment requested by the ATP or for a change in physician to provide the same treatment through an interpreter. The award of the ALJ was affirmed.

Case 5 (Issued 10/29/09)

In this two-employer claim, the employee had developed what the ALJ characterized as “insidious” neck pain which eventually took him out of work and was diagnosed as a significant cervical injury. At all times relevant to the development of his symptoms, the employee was working alternating 24-hour shifts between two employers: for one as an emergency medical technician and for the other as a firefighter. From a functional standpoint, the employee’s activities in each job were equivalent to those in the other. Medical evidence of causation was accordingly equivocal, with physician testimony that the injury could have been caused by either job or as a cumulative effect from both.

The ALJ’s award found both employers liable for both indemnity and medical benefits pursuant to O.C.G.A. § 34-9-224. Both employers appealed, with both arguing the equivocal nature of the medical testimony, and both challenging the characterization of the employment as “joint” under the statute. (In his award, the ALJ used both “joint” and “concurrent” in characterizing the work activity.)

Regarding the equivocal nature of the evidence of causation, the Appellate Division found no abuse of the ALJ’s discretion in attributing causation to both. Each employer had skillfully presented a case for causation against the other. Otherwise equivocal medical evidence relating the injury to each employer, “...in conjunction with other evidence, non-expert in nature, indicating that such a relation exists, although likewise not sufficient by itself to establish the relation, or in conjunction with admitted or obvious facts and circumstances of

the case showing that death or physical disability would naturally and probably result from the injury, is sufficient to establish the causal relation.” Estate of Patterson v. Fulton Dekalb Hospital Authority, 233 Ga. App. 706, 708; 505 SE2d 232 (1998).

Regarding the argued distinction between joint and current employment, the Appellate Division found that regardless of such a distinction, the award was a correct application of O.C.G.A. § 34-9-224. The Georgia courts have found that a worker who, like the employee in this claim, alternated between two employers with similar pertinent work activity, that employee “...was accordingly in the service of both employers within the purview of Code § 114-419 [O.C.G.A. § 34-9-224].” Georgia Casualty & Surety Co. v. Moore, 142 Ga. App. 191, 192; 235 S.E.2d 591 (1977). Regarding the distinction that the two employers in Moore were functionally identical in the work activity involved, the Appellate Division found that medical and other evidence in the claim established the pertinent work activity for each employer as it impacted upon the specific cervical injury to be mechanically equivalent. The award was upheld.

Case 6 (Issued 10/30/09)

In this change in condition case, the employee’s ATP had previously approved a light duty “returns processor” job and the employee had attempted the work. After the work attempt was unsuccessful, the employer/insurer did not suspend TTD benefits. Two months later, the physician again authorized the same job description, after which employer strictly complied with the examination, medical release and notice requirements of O.C.G.A. § 34-9-240 and Board Rule 240 in again offering the light duty position to the employee. After this second offer, the employee did not attempt the work. In reliance on the statute and board rule, the employer unilaterally suspended benefits as of the date of the second job offer. The employee requested a hearing seeking, in part, reinstatement of TTD benefits as of the date of the

unilateral suspension. The ALJ found that the second job offer was in compliance with O.C.G.A. § 34-9-240 and Board Rule 240, the employee had unjustifiably refused the work, and therefore, the employer/insurer's unilateral suspension of TTD benefits was proper.

On appeal, the employer's technical compliance with the statute and board rule was not at issue. Rather, the employee argued that due to his previous failed work attempt, O.C.G.A. § 34-9-240 and Board Rule 240 did not require the employee again to attempt the same work. The Appellate Division disagreed, finding that the prior offer's lack of success did not prevent the employer/insurer from subsequently complying with the WC-240 process and again attempting to return the employee to suitable work. Because the employee did not attempt the proffered, suitable job, the employer/insurer properly suspended the employee's TTD benefits in accordance with O.C.G.A. § 34-9-240 and Board Rule 240.

Case 7 (Issued 11/30/09)

The employee in this case had submitted to an independent medical examination, and the IME physician had recommended a functional capacity evaluation ("FCE"). When the employee failed to attend the scheduled evaluation, the employer filed a motion to compel attendance at the FCE. The ALJ denied the employer's motion, then granted a certificate of immediate review.

The Appellate Division noted that O.C.G.A. § 34-9-202 and Board Rule 202, taken together, generally require that as long as an employee is claiming compensation, she shall submit herself to examinations, at reasonable times and places, ordered by a duly-qualified physician or surgeon designated and paid by the employer or the Board. Examinations shall include physical, psychiatric, and psychological examinations, as well as reasonable and necessary testing ordered by the examining physician. See Board Rule 202(a). If an employee refuses to submit herself to or in any way obstructs such examination requested and provided for by the employer, her right to compensation and her right to take or prosecute any proceedings under the Act shall be suspended until such refusal or objection ceases. O.C.G.A. § 34-9-202 (c).

Here, at issue before the Appellate Division was the effect of a July 1, 2006, change in Board Rule 202, which deleted the specific reference to functional capacity evaluations. On review, the Appellate Division found that although the revision to Board Rule 202 eliminated direct reference to "functional capacity evaluations," it does not exclude an FCE from "reasonable and necessary testing" that may be ordered by an examining physician. Further, Board Rule 202 does not prohibit FCEs or provide that an employee would be excused from an FCE ordered by an examining physician. The award below denying the employer's motion to compel was thus reversed. **WC**



When Is It the Ideal Time to Settle the Cat and Non-Cat Medicare Non-Medicare Claims in 2010

By Luanne Clarke
Attorney, Mediator, Arbitrator

Settlement of workers' compensation cases is beneficial for a wide variety of reasons for all parties and has traditionally been accomplished over the phone after an exchange of analysis, demands, offers and determination of "the" figure. Financial changes in our world economy resulted in a more careful analysis of exposure and a "tightening" of the belt. Alternatively, claimants are feeling the financial pinch and wish to settle their files to obtain the money for the car payment, the house mortgage, the non-work related medicals—even the grocery bills. The desire to settle remains for all but the "common ground" found in a few telephone calls between opposing parties is not now as easily reached. Thus, the parties are turning to neutrals who have extensive experience in handling workers' compensation claims and who can provide an independent analysis to help everyone recognize the common ground and exposure and risks for each. The parties remain the decision makers but an honest confidential dialogue now may need to be exchanged so the appropriate compromise is reached.

According to the National Council on Compensation Insurance (NCCI), permanent total cases are up in the last four years. These cases have traditionally been the most difficult to evaluate, reserve, and settle. But workers' compensation benefits are statutory in design and experts could still provide reasonable analysis of medical costs related to work injuries, lost wages and permanency for the loss of use of a portion of the body.

In Georgia, the highest cost driver in the system is medical expenses. Medical expenses available in 2010 were never even options in years past. The creation of a whole new category of brand specific drugs and surgical procedures such (pain management specialists and spinal cord stimulators

for example) presented options for claimants that had not heretofore been routine options. Even a simple carpal tunnel release can result in a prescription for oxycotin—a highly effective highly addictive drug. Thus, all parties found themselves second guessing the physician's recommendations for injections, long term use of narcotics, stimulants, etc. in even the simple cases.

Most workers' compensation claims do not involve catastrophic injuries and are excellent candidates for settlement. I believe that all parties acknowledge that the compensation rate for Georgia's injured workers is hardly a wage a claimant can live on long term without suffering financial consequences. Thus, settlements of the non-cat claims have occurred when all parties are of the opinion that the employee's treatment and physical restrictions are stable. In those instances, an experienced attorney and experienced adjuster can usually reach a settlement figure that is acceptable to all. However, even in non-cat cases there are occasions when an independent third party is a valuable "set of eyes" to review, analyze and recommend a range of acceptable figures. This neutral has no financial interest in the resolution of the claim but rather has the goal of helping the parties find the common value given the totality of the circumstances. Whether it is a claimant who is getting a "second opinion" or an adjuster who needs to consider the long term picture, a neutral can identify the impediments to settlement of claims. With patience and a true analysis of exposure even the most difficult cat case can be analyzed and settled to the satisfaction of all.

It is the Medicare or soon to be Medicare eligible claimant that now requires thoughtful, specific analysis and a careful consideration of the timing of the settlement and procurement of

the Medicare Set Aside (MSA).

Whether settlement is quickly pending or not, the Medicare beneficiary status of a workers' compensation claimant needs to be determined as quickly as possible. Releases should be obtained (and given) so all parties know the Medicare status of the claimant and know if there are any conditional payments that have been made by Medicare and reimbursement may be a future issue. If the claimant is on Medicare (Class I) or is reasonably expected to be enrolled in Medicare (NOT SSDI) within 30 months (Class II) a MSA or CSA comes into play.

In short, if you have a Class I claimant and the settlement is greater than \$25,000 a MSA needs CMS approval. If the settlement of a Class I claimant is less than \$25,000 a CSA or MSA is needed but is not submitted to CMS as they will not review the Medical Set Aside.

If the Claimant falls under Class II, and does NOT have a reasonable expectation of Medicare enrollment within 30 months NO MSA is needed. If yes, this claimant DOES have a reasonable expectation of enrollment in Medicare within 30 months then if the settlement is \$250,000 or less no CMS approval is needed but a Medical Set Aside is needed to protect Medicare's interests. If the Class II settlement is greater than \$250,000 the MSA must be approved by CMS. Reasonable expectation for Class II claimants usually means has applied for, on appeal for, or is receiving SSDI, is 62.5 years old or older, or has an end stage renal disease.

Even in Cat cases, the parties DO NOT have to consider Medicare's interests unless the cat claimant is Class I or Class II. In these non-Medicare cat cases the standard cat analysis applies and the negotiation of needed future medical treatment is a

part of the settlement process. Often a mediator can assist in reaching a consensus and compromise of the value of the future expenses for settlement purposes.

Yet some cat cases are also Class I or Class II and settlement is still the desire of all parties. Fortunately, CMS has given us distinct guidelines to follow to ensure that we “take into consideration the interests of Medicare.” Remember, the MSA is a document that is based on past medical history, diagnoses codes, and standards of care to be used in determining reasonable consideration of Medicare’s interests for the future treatment of the workers’ compensation claimant. CMS allows certain discounting factors like rated age, wholesale drug prices, generic drugs where appropriate. There are vendors who specialize in obtaining this MSA cost and I strongly recommend that you retain an expert in this MSA analysis. CMS is returning MSA’s that are significantly higher than those submitted. Therefore, an expert’s assistance in the reconsideration process is available should this occur in your claim.

After obtaining the MSA, the parties need to determine what, if any, non- Medicare covered expenses exist and need to be taken into consideration in the settlement. CMS does not address non Medicare covered drugs, transportation or mileage, non-covered costs such as home attendant care, certain durable medical equipment, dental and vision care. Workers’ compensation is required to pay this expense as “medical”, IF , and ONLY IF it is prescribed or reasonably expected to be prescribed and related to the work injury. Workers’ compensation is NOT required to “pre-pay” medical expenses unless as a compromise which is part of a settlement or under a CMS guideline. Hence, the need for “timing” of the settlement and the possible need for an experienced mediator who understands the complexities of your claim and non MSA expenses. What is or is not determined as a non- MSA reasonable “pre-payment” and why the insurance company should consider pre-payment in settlement is one of the common “sticking points” and obstructions to settlement.

Even with Medicare or no Medicare requirements it is clear that expensive drug or procedural prescriptions for a work injury are key to the driving costs of a MSA or non-MSA claim so the timing of the settlement is imperative to ALL parties IF THERE IS GOING TO BE A REASONABLE SETTLEMENT OF THE CLAIM. Failure to recognize the appropriate time to settle can result in a carrier’s financial inability to settle the claim – it is just too expensive to “pre-pay”.

Federal law requires stiff sanctions to those who fail to “take into consideration” Medicare’s interests. See *United States vs. Stricker* and *United States vs. Harris*. – parties are being sued for their failure to take into consideration Medicare’s interests. Medicare’s interests cannot, and should not be avoided. However, given that settlement of a workers’ compensation claim is voluntary in Georgia for all parties, the facts and medical stability of a claim is critical if the claimant attorney is confident the employee’s future needs are going to be met and if the insurance company is willing to pre-pay for anticipated medical treatment that may or may not come to pass.

Claimant’s attorneys must understand that generally the claimant must manage the Medicare Set Aside account and be prepared to be questioned by federal authorities as to the use of these funds. These funds, as agreed upon by CMS, must be exhausted before Medicare will step in and pay for its required portion of medical expenses. CMS can require professional administration of the MSA in certain cases. This is another expense to the insurance company that may benefit the claimant but that the claimant does not have the authority to spend as he or she wishes.

Bottom line, monitor you claims closely to determine the optimum time to settle the file. **WC**

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Workers' Compensation Claims and MSA Pitfalls We All Need to Avoid

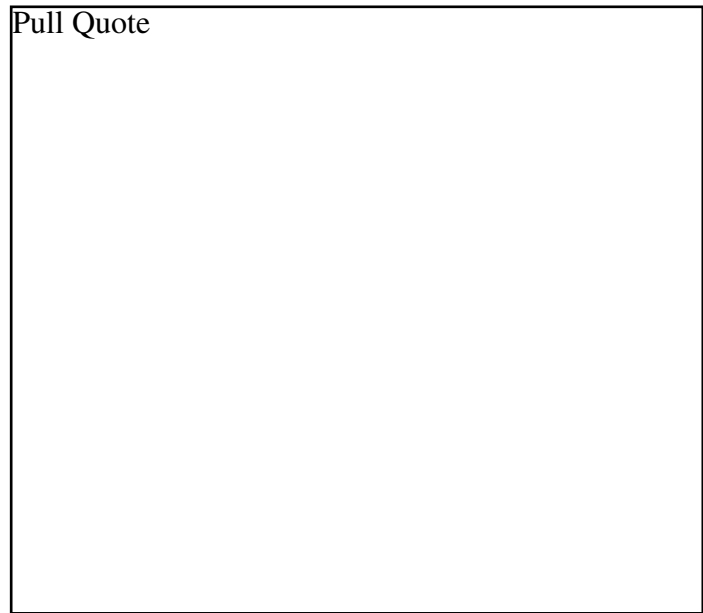
By G. Robert Ryan, Jr. Partner
Moore, Clarke, DuVall & Rodgers, P.C.

By now all workers' compensation practitioners should understand when an issue of the necessity of a Medicare Set Aside (MSA) is raised in a workers' compensation case and must be addressed. The penalties for failure to adequately consider Medicare's interests as required by federal law may be severe and have already resulted in lawsuits being filed. The Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(2), and the regulations implementing it, 42 C.F.R. §411.20 et. seq., mandate that Medicare's interests must be taken into consideration. The Federal government is aggressively enforcing the requirements as they relate to workers' compensation settlements, through the Centers for Medicare and Medicaid Services (CMS).

In *United States of America v. Stricker, et.al.*, CMS and the Secretary of Health and Human Services filed suit seeking reimbursement for conditional payments made by Medicare against various parties, including individual plaintiffs' attorneys and law firms. This suit arose out of a liability claim, not a workers' compensation claim, however, the Medicare Secondary Payer Act provides similar remedies to the United States to recover from a primary payer, whether a liability insurer or a workers' compensation insurer. *Stricker* arose out of consolidated lawsuits alleging injuries related to production of PCBs in the Anniston, Alabama area. A global settlement agreement was reached in the amount of \$300,000,000. Of this amount, approximately \$171,000,000 was payable to the plaintiffs and \$129,000,000 to the various plaintiffs' attorneys involved in the complex litigation. CMS brought suit against: the

underlying defendants; their insurers; and individual attorneys and law firms representing the plaintiffs. The attorneys and their firms were named pursuant to 42 U.S.C. § 1395y(b)(2) (B)(iii) which gives the United States a right of action against "any entity" that "has received payment from a primary plan." "Any entity" is in turn defined in the C.F.R. to include an attorney. 42 C.F.R. § 411.24(h). The United States alleged that 907 of the plaintiffs in the

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underlying lawsuits were Medicare beneficiaries on whose behalf Medicare had made payment for treatment for injuries or illness. See, *United States of America v. Stricker et.al.*, CAF # CV-09-PT-2423-E (USDC Northern District of Alabama, Eastern Division, filed December 1, 2009).

A prior lawsuit, *United States of America v. Harris*, 2009 U.S. Dist. LEXIS 23956 (USDC Northern District of West Virginia, CAF # 5:08CV102) sought reimbursement from plaintiff's attorney, individually. In *Harris*, the evidence showed that the plaintiff and his attorney settled a products liability case resulting from a fall from a ladder

for \$25,000.00. The plaintiff was a Medicare beneficiary and Medicare paid \$22,549.67 in benefits. Medicare sought reimbursement from the settlement funds in the total amount of \$10,253.59 and notified plaintiff's attorney. Nevertheless, the plaintiff and his attorney failed to either pay the reimbursement or to follow the CMS administrative appeals process. The United States brought suit against *Harris*, individually, and the district court granted summary judgment for the United States on March 26, 2009.

To avoid the pitfalls of settlement without taking into account Medicare's interests, first check eligibility status of the claimant. This is essential and many insurers are now requiring execution of Medicare releases, such as the Form 3288, that will allow the insurer to independently verify (through a vendor or directly with Social Security) the claimant's Medicare status. The claimant also has the ability to go to his local Social Security office and obtain a statement, on Social Security letterhead,

confirming his Medicare status. This provides protection to both the insurer as well as the claimant and claimant's counsel. Attorneys and parties should cooperate with such requests and provide such releases, that is, if they want to settle their claims. Any required releases and confirmation of Medicare eligibility status will ideally be obtained and completed before mediation or final agreement on a settlement amount.

If the claimant is enrolled in Medicare (Class I) then Medicare's interests must be considered in all cases and an MSA must be prepared and approved by CMS if the total settlement amount is over \$25,000.00.

If the claimant has a reasonable expectation of enrollment in Medicare within 30 months of the settlement (Class II) then Medicare's interests must also be considered, and an MSA prepared and approved by CMS if the total settlement amount is over \$250,000.00. CMS has made it crystal clear that the review threshold amounts do not constitute safe harbors and instead are merely based on CMS workload levels and the reality that CMS does not have the resources to review every settlement. Medicare's interests must still be taken into account in every settlement where the claimant is a Medicare beneficiary or has a reasonable expectation of becoming Medicare eligible within 30 months, regardless of whether CMS approval is required. The normal method of doing this is to prepare a MSA, or a so-called Claim Settlement Allocation (CSA) which will be included as part of the settlement but will not be submitted to CMS for approval.

CMS provides guidelines for when and how its interests must be taken into consideration, including definitions of "reasonable expectation". This information can be obtained electronically or manually. CMS maintains a website and an overview of its policies with links to policy memorandums issued from July 23, 2001, through May 2008 can be found at: <http://www.cms.hhs.gov/WorkersCompAgencyServices/>. (Link current as of January 28, 2010) All workers' compensation practitioners should review each policy memorandum and regularly visit this site for the latest in CMS updates. These policy memoranda determine what information CMS will require and how they will analyze your effort to "take into consideration Medicare's interests."

Visit the CMS site to get the current memorandum on when a Medicare Set Aside (MSA) will be required, when an MSA will be reviewed by CMS, what must be included in a MSA, and other issues of relevance to settlement of a workers' compensation claim. These policy memorandums, which essentially clarify and implement the C.F.R. (which in turn implements the statute) are our guidelines until the courts decide specific issues of compliance.

Determining who is currently eligible for Medicare is a fairly straightforward process and any questions concerning status can be resolved through the use of a properly completed SSA Form 3288 or similar release. "Reasonable expectation" is more complex. A claimant may have a reasonable expectation of eligibility within 30 months based on age (if a claimant is at least 62.5 years old – Medicare eligibility begins at age 65) or he may have a reasonable expectation of eligibility based on a disability which qualifies for Social Security Disability Insurance (SSDI). Medicare eligibility begins after a beneficiary has received SSDI for 24 months. Social Security benefits begin 6 months after the date of disability for SSDI, so a claimant has a reasonable expectation of being Medicare eligible 30 months from his date of disability for SSDI.

If a claimant is already enrolled in Medicare, there may be an issue of conditional payments. These are payments already made by Medicare for past medical treatment, for which Medicare is entitled to reimbursement. Any claim for repayment of conditional payments must be addressed and

resolved.

The manner in which the interests of Medicare in future medical payments are considered has traditionally been by obtaining a Medicare Set Aside. This MSA may be self administered or professionally administered.

The MSA is a document that is based on past medical history, diagnoses codes, and standards of care among other things. A huge consideration is the future prescription drug treatment. This projection often results in exorbitant MSA projections, sometimes rendering settlement impractical. CMS currently requires lifetime allocations for the full panoply of prescriptions that a claimant is receiving from his or her pain management provider. The opinion of the authorized treating physician(s) is needed ON HIS OR HER LETTERHEAD to address the future treatment, and attempt to obtain CMS approval of tapering of future medications. A pre-prepared questionnaire is not acceptable to CMS nor is an affidavit from the claimant that he or she will not now or ever have a procedure sufficient. An IME or peer review opinion indicating future tapering of prescription medications is not typically accepted by CMS, but, again, the authorized treating physician's written opinion on letterhead may be accepted by CMS and may be utilized to obtain significant reductions in the future prescription set aside. A meeting between counsel for both parties and the authorized treating physician may be very useful in explaining the MSA process to the physician and obtaining an accurate opinion from the treating physician regarding future medical needs for the MSA. Although the physician may typically charge \$500 to \$1,000 for his time in such a meeting, this could be the best money you ever spend on your case if it results in the physician preparing an accurate and thoughtful opinion regarding future medical needs that saves you tens or even hundreds of thousands of dollars on the MSA.

Once the MSA is obtained there are numerous issues that may arise such as: 1) how will the MSA be funded- lump sum or annuity?; 2) will the MSA be self or professionally administered?; 3) will the Stipulated Settlement be submitted to the State Board of Workers' Compensation before or after CMS approval of the MSA allocation?; 4) will the Stipulation be held and therefore either party can "back out" of the settlement?; 5) how will the carrier deal with an increase requested by CMS?; 6) if CMS determines the MSA is too high, how will the carrier collect the overpayment?; 7) when is the seed money to be paid and how does the carrier collect an overpayment, if any?; 8) is SITF involved and are SITF MSA requirements being met?

These and other questions can and must be successfully addressed. To do so requires an understanding of CMS requirements by the parties and the drafting of documentation that addresses these issues. Communication and cooperation between the parties and their attorneys is essential in order to successfully complete such a settlement. Careful analysis of the need and desire for settlement leads to careful analysis of the answers to the issues raised above. If you have any questions for which I can offer assistance please feel free to contact me. Ryan@mcd-r-law.com. **WC**

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