



WORKERS' COMPENSATION LAW

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Preparing the Record for Appeal and Tips for Appellate Practice at the Board

By Judge Melodie Belcher & Delece Brooks

1. Think about the appeal process when you are creating the record. Keep the record clean. State the issues clearly at the beginning of the hearing so that there is no doubt that all issues have been raised at the appropriate time. At the appellate level, reframe your issues to focus on the ALJ's error.
2. Do not interrupt each other or the witnesses. When two attorneys are talking over each other or an attorney and a witness are talking at the same time, not only does the ALJ become frustrated, but the court reporter may not capture the exact conversation either. When you (or your associate) read the transcript to write the brief, it will be a jumbled mess. Most significantly, when the appellate courts look at the transcript, they will be frustrated with the inability to read a complete and intact question and answer. Without the face to face interaction that occurs at the hearing level, the significance of the evidence presented may be lost in the frustration of reading a messy and confusing transcript. So, avoid this problem through witness preparation. Explain to the witness that both your question and his answer are important and that the judge needs to hear everything clearly. Explain that the risk of speaking prematurely is that he will not understand or answer the question you intended. Finally, despite your unending desire to speak, hold your tongue and wait until your witness completes his answer before continuing. Keep your questions simple. Do not use words that your witness may not know. Ask only one question at a time.
3. Present your case in an orderly fashion at the hearing so that the ALJ and appellate courts understand your position. Keep in mind that while you have been living with the claim and know the sequence of events all too well, the ALJ and appellate courts do not even know what type of work the Employee performed. It is easier to understand a novel if you start at the beginning and work to the end. The same is true with a claim. Present the sequence of events in a logical fashion, telling the Employee's story from the beginning.
4. Anticipate evidentiary objections and be prepared with a legal basis for your position as to the admissibility of evidence. Bring copies of supporting case law for the ALJ to review. Offer to brief the issue and ask that a ruling on the admissibility be deferred. If you offer to brief the issue, be sure to do so. Make an offer of proof if an evidentiary ruling does not go your way. This is the only way the appellate courts will be able to consider the admissibility (and the substance if admissible) of the evidence. Ensure that all appropriate witnesses (including those necessary to the introduction of documentary evidence) attend the hearing and that you will be able to close the record (other than briefs) at the end of the hearing. Write out your questions or important points to cover. It is too easy to get caught up in an evidentiary issue and to forget to prove a crucial element without a reference sheet.
5. If you want the ALJ to take judicial notice of a Board form, be sure that all applicable information on the form is read into the record by either you or the judge. Remember, the form will not travel as part of the record.
6. Do not lead your own witnesses. The ALJ and appellate courts are not issuing rulings based on the testimony of the attorneys. The testimony is less persuasive if it comes from you rather than from the witness.
7. Do not make assumptions. Do not assume that something that seems like it should be common knowledge does not have to be proved at a hearing. Think about everything the ALJ/appellate

courts must know for you to win and consider how to prove it.

8. Hire competent interpreters. Make sure that they are experienced in the language that needs to be translated and that they have courtroom experience. If you do not trust the interpreter the opposing party is providing, bring your own interpreter and pose objections if necessary. Instruct witnesses to speak in one language only



and to wait until the interpreter finishes interpreting before answering the question. Again, constant interruptions make for a sloppy record.

9. Organize your exhibits and mark each page with both the exhibit number and the page number. Do not duplicate exhibits. Do not tender irrelevant medical documentation such as hospital instructions. Do not tender illegible records. If you cannot read them, chances are the ALJ cannot read them either. Ten pages of extremely relevant medical evidence are much more persuasive than one hundred pages of nurses' notes, cardiac graphs, EMG graphs and treatment notes for unrelated illnesses. If you have a stack of medical that is so large that you do not want to be bothered going through it to weed out the irrelevant stuff, it is a good bet that the ALJ and appellate courts are not going to want to go through it either, and they may end up missing something you believe is important. Include a cover sheet delineating the outstanding medical bills.
10. When appealing to the higher courts, the appealing party pays for the transmittal of the record and it must be done within 30 days. The cost is \$10.00 for the first 10 pages and .50 for every page thereafter. Pursuant to Board Rule 105(f), you may request a waiver. Upon good cause shown, the Board may waive the copying and transmittal costs. Only the trial record is sent – not the entire Board file. This would include the transcript, exhibits, briefs, WC-14, ALJ award and Appellate decision. The record is sent in paper via certified mail. The appealing party must request that it be sent to the county where the injury occurred and if out of state, it is generally sent to Fulton County.
11. When appealing to the Appellate Division, be specific with your enumerations of error. State exactly how you think the ALJ was incorrect in his or her award.
12. Briefs to the Appellate Division should not rehash the same information that is in the ALJ brief. If you do not have any new arguments, just indicate to the Appellate Division that you are relying on the ALJ brief. It is certainly acceptable and often persuasive for the briefs to be short and to focus on a specific issue that you contend the ALJ got wrong.
13. Effective July 1, 2010, a party scheduled for oral argument is required to notify the Appellate Division no later than 48 (business) hours before the scheduled appearance if the party does not intend to appear. The Appellate Division allows only one reset and it must be for a higher court conflict or a very good reason (death in the family, serious illness). You must fax a request to the

Appellate Division 48 business hours prior to the hearing. Keep in mind that oral argument is not a right and if the reset is not granted, the Appellate Division may decide the case on the argument of the party who appears and the briefs.

14. Briefs at the Appellate Division are due 20 days from the day the appeal is filed and are limited to 20 pages unless otherwise approved by the Board. Board Rule 103 (b) (4). The appellee has 20 days to respond. If you need an extension, it must be requested in writing even if all parties agree. If an extension is granted, it will likely be for one week only.
15. If you would like the Appellate Division to hold the ruling on an appeal, because you are trying to settle the claim, they will do so for 30 days only. Then they will rule on the appeal.
16. When making your oral argument, focus on the strongest points. Be prepared to answer questions from the judges. You may make an oral motion for assessed attorney's fees, but you must provide evidence of your time and expertise.
17. If you are appealing an interlocutory issue, remember to properly request the ALJ to certify his or her order for appeal. Otherwise, your appeal will be dismissed for lack of jurisdiction. Board Rule 103 (d).
18. If you are appealing a claim involving multiple accident dates, be specific as to what dates of accident you are in fact appealing.
19. If you would like to file a Motion for Reconsideration of an ALJ award, file your appeal at the same time. The 20 day clock runs simultaneously on both. You can always dismiss your appeal if the ALJ grants the requested change. Also, if you file Motions for Reconsideration do not use a WC-102(d). There is not a form for a Motion for Reconsideration, but there is a doc type in ICMS. This applies at the ALJ level and at the Appellate Division. Be sure to call the ALJ or the Appellate Division if you file a Motion for Reconsideration to make them aware of it, and the Appellate Division would like a courtesy copy faxed to them as well. File Motions for Reconsideration as soon as possible to allow the ALJs or the Appellate Division time to rule on them.
20. Finally, there is now security at the Appellate Division courtroom. Plan ahead and arrive early. You won't want to be late!

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Understanding CMS' WC-MSA Review Thresholds & Addressing "Non-Threshold" Cases

By Mark Popolizio, Esquire, NuQuest/Bridge Pointe

It has been almost ten years since the Centers for Medicare and Medicaid Services (CMS) released its seminal policy memorandum in July, 2001, (known as the "Patel Memo")¹ formally introducing the Medicare Set-Aside (MSA) in relation to workers' compensation (WC) settlements. The WC-MSA is the agency's recommended compliance mechanism to protect Medicare's "future interests" under the Medicare Secondary Payer Statute (MSP).²

On many levels, the WC-MSA has revolutionized claims practices and opened new fronts of potential exposure. In addition to adding a challenging layer of complexity to claims handling, the WC-MSA has significantly increased case values and has complicated (and, in some instances, even prevented) claim settlement.

While the industry has certainly made strides in becoming better familiarized with CMS' ever changing policies and procedures, there still remains a good deal of confusion, misunderstanding and misapplication of CMS' WC-MSA review thresholds. Likewise, how to handle "non-threshold" cases (those cases that do *not* meet CMS' WC-MSA review thresholds) continues to present formidable challenges for practitioners and the claims industry in general.

This article dissects CMS' WC-MSA review thresholds, highlights potential pitfalls regarding certain definitional components of the review thresholds (e.g. the popular \$24,999.99 settlement), and addresses the troubling area of MSP compliance in non-threshold cases.³

Part I

CMS' WC-MSA Review Thresholds: *Understanding the Criteria & Avoiding the Pitfalls*

A. Commutation v. Compromise Settlements

42 C.F.R. § 411.46 is the regulation often cited by CMS as the primary basis for the WC-MSA. Subsection (a) of this regulation states as follows:

Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded

until medical expenses related to the injury or disease equal the amount of the lump sum payment.

Furthermore, subsection (b)(2) of this regulation provides that if a settlement "*appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work related condition, the settlement will not be recognized.*"

Under CMS' WC-MSA framework, the initial screening test in determining whether the agency deems a MSA appropriate requires an assessment of the *type* of settlement at issue. In this respect, CMS classifies WC settlements as *commutation* or *compromise* settlements.⁴

CMS provides a lengthy overview of *commutation* vs. *compromise* cases in its July 23, 2001 and April 23, 2003 policy memoranda which the author suggests the reader carefully review in their entirety. Understanding the agency's approach in this respect is important as it dictates whether or not consideration of a WC-MSA is necessary.

Per CMS, a MSA is appropriate only in relation to settlements that possess a *commutation* aspect.⁵ In general, CMS views a *commutation settlement* as one that compensates workers for *future* medical expenses related to the work injury; while a *compromise settlement* is viewed as a settlement that compensates only *current* or *past* medical expenses.⁶ A settlement could possess both a commutation and compromise aspect.⁷

CMS indicates that admission of liability is *not* the sole determining factor of whether or not a settlement is considered a commutation or compromise.⁸ Along these lines, CMS states that a settlement which does not provide for future medicals could still possess a commutation aspect if the facts indicate a need for future medical care in relation to the WC injury.⁹

Once it is determined that a particular settlement is a *commutation*, contains a *commutation* component, or could possibly be viewed by CMS as possessing a *commutation* aspect, the focus shifts to determining whether or not the case meets CMS' WC-MSA review thresholds.

B. CMS' Current WC-MSA Review Thresholds

CMS has established two specific "review thresholds" for WC cases. If a WC settlement meets either one of the below thresholds, CMS deems submission of a WC-MSA proposal for its review and approval appropriate.¹⁰

CMS' current WC-MSA review thresholds are as follows:

Threshold #1 → Medicare Beneficiaries

The claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than \$25,000; or

Threshold #2 → Non-Medicare Beneficiaries

The claimant is *not* a Medicare beneficiary at the time of the settlement, but has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the total settlement amount is greater than \$250,000.¹¹

In order to determine potential applicability of the review thresholds, it is imperative to understand how CMS defines (a) *total settlement amount* and (b) *reasonable expectation of Medicare enrollment*.

CMS' Definition of Total Settlement Amount

The concept of *total settlement amount* relates to how CMS calculates the monetary component of its review thresholds.

CMS defines the term ***total settlement amount*** as follows:

Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement.¹²

CMS' definition of *total settlement amount* should be carefully examined to make sure that *all* relevant factors are being considered.

For example, close attention should be paid to how the agency calculates the *total settlement amount* when annuities are used. In this context, CMS states that the total payout to the claimant should be used in the calculation -- not the cost or present day value of the annuity.¹³

Furthermore, "*any previously settled portion of the WC claim*" is included in calculating the *total settlement amount*. Unfortunately, the agency has not provided any further guidance as to exactly what may be considered to fall within this concept. As such, this could very likely create uncertainty in particular situations in light of the wide array of payment arrangements and options commonly used in WC practice.

Notwithstanding, this factor would at least seem to have specific application in those jurisdictions where it is common practice to settle out indemnity (leaving medicals open) at one point, followed by a settlement of future medicals at some subsequent point in time. Per CMS' definition, the amount of the prior indemnity settlement would seemingly need to be added to the amount of the

subsequent medical settlement amount to determine if said sum exceeds the applicable monetary thresholds.

Another area of caution concerns the "*repayment of any Medicare conditional payments*" aspect of the *total settlement amount* definition.¹⁴ This calls into particular focus the popular \$24,999.99 settlement (or a settlement for some other amount that is close to, but does not exceed, CMS' \$25,000 monetary threshold) in relation to settlements involving Medicare beneficiaries (Threshold #1). This approach is often utilized in an attempt to keep the claim below CMS' WC-MSA review thresholds.

However, despite the parties' intentions, it is possible that the case could end up meeting CMS' WC-MSA review thresholds when conditional payments are taken into account. Unfortunately, CMS has not provided much by way of interpretational guidance on exactly *how* conditional payments should actually be factored for *total settlement amount* calculation purposes, and, thus, has left key questions unanswered regarding the practical application of this definitional component.

For example, CMS' use of the word "*repayment*" is interesting in that taken literally this could be interpreted to mean that the includable conditional payment amount is the "final" conditional payment amount that is ultimately determined to be reimbursable to CMS. However, under CMS' current policy, the parties generally cannot obtain



CMS' "final" conditional payment amount until *after* the claim is settled and the executed settlement agreement is sent to the agency's contractor.¹⁵

This would raise the question of how determining the actual amount of conditional payments to be *repaid* could be ascertained without the parties first *settling* the case. This would seemingly create an impractical and, perhaps, unworkable scenario on many levels, and would likely inject additional delay and complication to the process.

Absent clarification from CMS, practitioners are left to wrestle with how best to address the "*repayment of any Medicare conditional payments*" component of CMS' definition from a practical standpoint.

Along these lines, addressing this issue would at least seem to entail considering CMS' claimed conditional payment amount at the time of settlement, or perhaps from some other logical and acceptable measuring point short of actually obtaining CMS' "final" conditional payment amount. In doing so, it may be discovered that this figure by itself, when added to the actual settlement amount to be paid to the claimant, could end up yielding a *total settlement amount* greater than the \$25,000 threshold amount.

However, these practical approaches (assuming that CMS would even permit same) raise their own questions and issues. For instance, the first question that surfaces is how would the concept of "at the time of settlement" be defined? This could prove particularly problematic given that under the current process it could take a few months to obtain a conditional payment figure from CMS. Thus, should the parties be permitted to use the interim conditional payment amount that they may have received from CMS during the course of the claim? If so, how recent should this figure be?¹⁶

Assuming an acceptable measuring point could be established, additional questions arise. Should the *gross* figure of the claimed conditional payment amount be used? Depending on the specific facts, using the *gross* figure may very well increase the prospects that the monetary threshold could end up being pierced. Or, should the includable amount be limited to the amount that would be (or could be) actually reimbursable under the regulatory reimbursement provisions contained in 42 C.F.R. § 411.24 and 42 C.F.R. § 411.37?

Limiting the includable amount of conditional payments in this manner could prevent a claim in certain circumstances from exceeding the monetary threshold.¹⁷

(Caveat: The above approaches are presented for illustrative discussion purposes only. In presenting same, the author is not stating or otherwise suggesting that these approaches represent, or could represent, a proper interpretation of CMS' policy, or that same would necessarily be accepted by the agency).

While legitimate interpretational questions remain, it is important to recognize the larger issues: (1) That the "*repayment of conditional payments*" component of the *total settlement amount* definition must be considered, and (2) That in doing so, a settlement that is seemingly *below* (and intended to be below) the \$25,000 monetary threshold could actually end up getting tipped over and into CMS' WC-MSA review thresholds.

CMS' Definition of Reasonable Expectation of Medicare

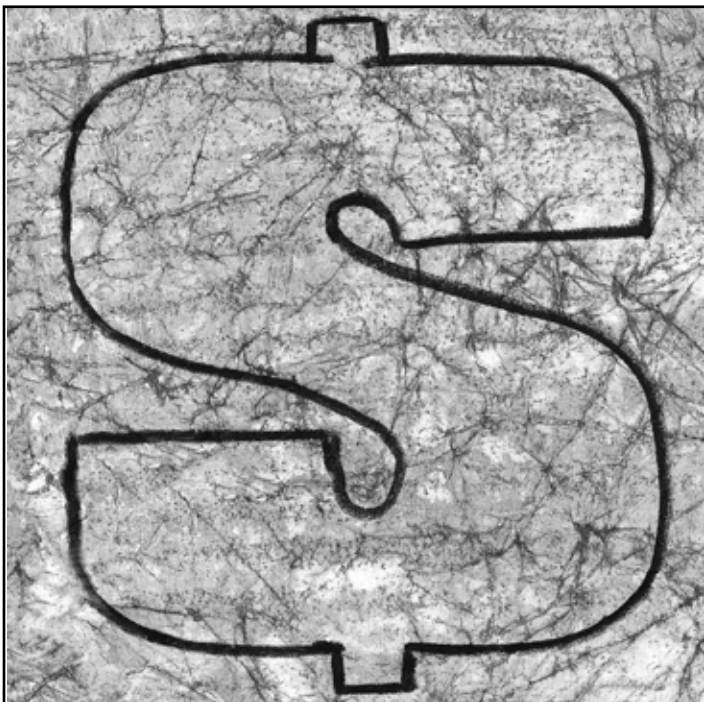
The concept of *reasonable expectation of Medicare enrollment* deals with those claimants who are *not* Medicare beneficiaries at the time of settlement. This relates directly to CMS' WC-MSA review threshold pertaining to *non-Medicare* beneficiaries (Threshold # 2).

CMS defines ***reasonable expectation*** in its April 23, 2003, memorandum as follows:

When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?

Answer: Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:

- a) The individual has applied for Social Security Disability Benefits;
- b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
- c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
- d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
- e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.



As will be noted, three of the factors (a-c) revolve around the claimant's social security disability (SSD) status. To determine whether (a-c) could be applicable, direct measures need to be taken to determine the claimant's SSD status. From the author's viewpoint, best practices would dictate that this determination be made via direct inquiry to the social security administration (SSA) for a variety of reasons. Importantly, it should be noted that CMS' Query Function process established to determine a claimant's Medicare status in the context of Medicare's new notice and reporting law (Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007)¹⁸ will *not* provide any information related to the claimant's social security status.

In addition, special attention to factors (b) and (c) is also in order. Specifically, it should be noted the ultimate applicability of these factors could hinge on the claimant's intentions and representations. For example, assume the SSA provides confirmation that the claimant's application for SSD was denied, and that he/she has not appealed or re-filed for SSD. This information is indeed important, but it is only part of the analysis.

Per CMS' definition, if the claimant in this situation "*anticipates appealing that decision*" or is "*in the process of appealing and/or re-filing*" for SSD, CMS considers him/her to have a *reasonable expectation of Medicare enrollment*. Thus, as part of claims practice, practitioners should develop the necessary practical approaches to properly address this aspect of CMS' definition in terms of documenting (as best as possible) a claimant's intentions and representations. Defense practitioners should consult with their clients to determine if they have any specific protocols to be followed in this situation.

Part II

Non-Threshold Cases:

Addressing Settlements That Do Not Meet CMS' WC-MSA Review Thresholds

If it is determined that the settlement does *not* meet CMS' WC-MSA review thresholds, the focus shifts to what obligations the parties may have from CMS' perspective to consider Medicare's interests in "non-threshold" cases.

On this point, CMS states as follows in its July 11, 2005 memo:

Q1 Clarification of WCMSA Review Thresholds

– Should I establish a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) even if I am not yet a Medicare beneficiary and/or even if I do not meet the CMS thresholds for review of a WCMSA proposal?

A1 The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds

for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered. (Emphasis by CMS).

CMS revisited the issue in its April 25, 2006, stating, in pertinent part, as follows:

The CMS wishes to stress [that the \$25,000 monetary threshold related to Medicare beneficiaries] is a CMS **workload review** threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases. (Emphasis by CMS).

From these statements, important (and troubling) pieces of the puzzle fall into place: First, CMS does *not* consider its WC-MSA review thresholds to be safe harbors. Second, CMS expects its interests to be considered and protected in *all* WC settlements, regardless of whether or not the settlement meets the review thresholds. But what does this mean exactly?

Unfortunately, CMS has not really provided much by way of guidance. As a result, CMS has essentially placed the industry in the very peculiar position of having to develop its own practice protocols regarding when, and how, to consider and protect Medicare's interests in relation to non-threshold settlements.

In response, many primary payers have developed specific *internal* protocols regarding how non-threshold cases will be addressed. These protocols typically involve including some form of future medical allocation or projection as part of the settlement. A common mechanism used in this context is a "non-threshold MSA." (For purposes of this analysis, the author will discuss the issue in terms of using a non-threshold MSA). It is important to note that a non-threshold MSA (or whatever other mechanism that may be used) is *not* submitted to CMS for review and approval as the claim in this context does *not* meet the agency's review thresholds.¹⁹

Determining exactly *when* to include a non-threshold MSA involves consideration of many different factors that differ from primary payer to primary payer, and practitioner to practitioner. From the author's experience and observation, some factors commonly considered by the industry weighing in favor of including a non-threshold MSA are:

1. A case involving a Medicare beneficiary where the total settlement is \$25,000, or less. In this instance, the rationale to include a non-threshold MSA is that Medicare's interests are already implicated as the claimant is a Medicare beneficiary. (CMS' April 25,

2006 memorandum could be viewed as supporting this rationale).

2. A settlement involving a non-Medicare beneficiary where one, but *not* both, of CMS' WC-MSA review thresholds for non-Medicare beneficiaries is met.

For example, the settlement is below the \$250,000 monetary threshold, but the facts indicate that the claimant has a *reasonable expectation of Medicare enrollment*; or it has been determined that the claimant will in fact become a Medicare beneficiary at some point after the settlement (e.g. the claimant who is a SSD beneficiary at the time of the settlement, but whose Medicare benefits in connection to the SSD award are not scheduled to commence until some point after settlement). The rationale to include a non-threshold MSA in these instances is premised upon the fact that Medicare's interests *could be, or will in fact be, implicated* after the settlement.

3. A decision may be made to include a non-threshold MSA in relation to a settlement that exceeds the \$250,000 monetary threshold, even though the claimant does *not* have a *reasonable expectation of Medicare enrollment*. There could be several different rationales or concerns at play prompting this decision based upon the specific factual situation.

The above considerations are by no means inclusive, and each non-threshold case should be closely analyzed to determine if taking affirmative steps to consider and protect Medicare's interests would be appropriate.

In addressing this issue, defense practitioners should contact their clients to determine if they have in fact established specific non-threshold protocols. If so, the defense practitioner should become familiar with the client's protocols to ensure that he/she is properly complying with same as part of his/her claims handling and settlement practice. If the client has not established non-threshold criteria, the defense practitioner should consult with the client to confirm that they have a complete and proper understanding of the issue.

As for claimant practitioners, it would be prudent to inquire as to whether or not the primary payer involved in your case will require a non-threshold MSA. Additionally, claimant practitioners should independently address this issue and consider developing their own non-threshold protocols and practice parameters.

Conclusion

In many respects, there is certainly more than meets the eye when assessing possible applicability of CMS' WC-MSA review thresholds. Determining whether or not a settlement meets (or may meet) a review threshold requires careful examination of the various definitional components established by CMS. This analysis can be complicated in particular situations in light of the fact there remain several questions and uncertainties regarding how specific components of the review thresholds are to be interpreted

(or could be interpreted).

When the dust settles, it is imperative that the practitioner has a firm understanding of CMS' WC-MSA review thresholds and recognizes the issues presented by non-threshold cases in relation to effective claims handling, protecting client interests, and minimizing potential exposure (for both their clients and themselves).

Mark Popolizio, Esquire, is the Vice President of Customer Relations for NuQuest/Bridge Pointe

Prior to joining NuQuest, he practiced workers' compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included MSA and Medicare Compliance. Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations.

Popolizio served as vice president of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters. Mark is also involved with current MSP reform efforts in Congress (H.R. 4796). Mark has also published numerous articles on MSA/Medicare issues.

He is licensed to practice law in Florida and Connecticut and can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

(Endnotes)

1. Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001.
2. The Medicare Secondary Payer Statute (MSP) is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent provisions related to MSP compliance are contained in Subparts B, C and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.)
3. The author understands the larger arguments raised in some quarters questioning the underlying validity and legal authority of CMS' WC-MSA process, administrative framework (or lack thereof), and policy memoranda in regard to the issue of whatever "legal" obligations may exist, or which may be considered appropriate under the MSP. While the author acknowledges these issues and arguments, that larger debate is not the focus of this article.
4. Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 2-5 and Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 2-3 (FAQ No. 4).
5. Patel, at p. 2 and Grissom, at p. 2.
6. Patel, at p. 3 and Grissom, at p. 2
7. Id.

8. Patel, at p. 2-3 and Grissom, at p. 2.
9. Patel, at p. 2-3 and Grissom, at p. 2-3.
The following statement and example contained in CMS' April 23, 2003, memorandum highlights the agency's position on this point:
Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.
Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.
10. As stated, the WC-MSA and CMS' review process regarding same is the agency's recommended method to protect its future interests under the MSP. In this regard, CMS has stated that its review procedure is a voluntary compliance process. While CMS' WC-MSA process is technically a voluntary process, from the author's experience a significant segment (if not the majority) of the claims industry has been, and is, complying with the agency's WC-MSA review process. Industry compliance with CMS' review process is based primarily upon the belief that obtaining CMS approval provides a degree of security from future liability. The thought being that the parties would be in a far better position to defend any future claim by CMS if the agency was afforded the opportunity to review the settlement and approve the proposed WC-MSA.
11. CMS sets forth and discusses its WC-MSA review thresholds in the following agency policy memoranda: Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 4-6; Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 1-2 (FAQ Nos. 2 and 17); Gerald Walters, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions, July 11, 2005, p. 2 (FAQ Nos. 1 and 2); and Gerald Walters, CMS Memorandum to All Regional Administrators, Workers' Compensation Medicare Set-Aside Arrangement (WC-MSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, April 25, 2006. It should be noted that CMS has reserved the right to adjust, modify or even eliminate the review thresholds.
12. Gerald Walters, CMS Memorandum to All Regional Administrators, Workers' Compensation Medicare Set-Aside Arrangement (WC-MSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, April 25, 2006.
13. See also, Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 6 (FAQ No. 17).
14. A "conditional payment" can be defined as "a Medicare payment for services for which another payer is responsible." See, 42 C.F.R. § 411.21.
15. For further information regarding Medicare conditional payments, CMS' current conditional payment process, and recent reform legislation introduced in Congress that would revise certain current agency practices in relation thereto, see the author's article as contained in *Settlement News*, April 2010 entitled: *The Medicare Secondary Payer Enhancement Act of 2010 (H.R. 4796) Proposes Amendments to the Medicare Secondary Payer Statute: Major Changes Are Proposed to the Medicare Conditional Payment Process*, Section 111 of the MMSEA & Other General MSP Compliance Matters This article can be obtained by logging onto www.NQBP.com (select "Resource Library" and then choose "Settlement News").
16. Another possible consideration in this regard is how and to what extent (if at all) conditional information that may be obtained from MyMedicare.gov could possibly be used. Through this site, it may be possible to obtain conditional payment information. However, from a few accounts received by the author, this site may not always contain the most current information. Furthermore, there may be issues regarding informational accuracy and system access in particular situations.
17. The following examples may help better illustrate the questions and possible issues being raised by the author:
Example #1:
The parties reach a settlement agreement (SA) involving a Medicare beneficiary in the amount of \$20,000. At the time of the settlement, it has been determined that Medicare is asserting conditional payments (CP) in the amount of \$5,000.01. (Note: For purposes of the foregoing examples, it is assumed that the CP amount could in fact be obtained as of the time of the settlement or, alternatively, that same is based on an interim conditional payment amount that the parties may have obtained from CMS during the course of the claim. Furthermore, the examples assume that CMS would in fact be agreeable to even consider said approaches.)
In this example, if CMS took the position that it is the gross amount of conditional payments being claimed at the time of settlement that should be included in calculating the total settlement amount, the settlement in this instance would meet CMS' WC-MSA review threshold as the combined total of these figures would equal \$25,000.01 [\$20,000 SA + \$5,000.01 CP = \$25,000.01] which exceeds the \$25,000 monetary threshold under Threshold #1.
Example #2:
The parties reach a settlement agreement (SA) involving a Medicare beneficiary in the amount of \$12,000.00. At the time of the settlement, Medicare is asserting conditional payments (CP) in the amount of \$14,000.
If, as in Example #1, CMS took the position that it is the gross amount of conditional payments being claimed at the time of the settlement that should be included in calculating the total settlement amount, the settlement in this instance would meet the review thresholds as the combined total of these figures equals \$26,000 [\$12,000 SA + \$14,000 CP = \$26,000] which exceeds the \$25,000 monetary threshold under Threshold #1.
However, a different result could seemingly be reached employing 42 C.F.R. § 411.24(c). Under this section, if CMS does not need to take legal action to recover its conditional

payment claim, the amount of recoverable conditional payments is the lesser of either (a) the Medicare primary payment, or (b) the amount of the full primary payment that the primary payer is obligated to pay.

Assuming that CMS would permit application of this formula at this juncture of the claim, then Medicare's conditional payment recovery would be limited to \$12,000. This amount represents the lesser of factors (a) and (b) above. Thus, in this instance, the settlement would not meet the WC-MSA review thresholds as the combined figures would only total \$24,000 [\$12,000 SA + \$12,000 CP = \$24,000] which is below the \$25,000 threshold.

By way of note, an interesting question that could arise using these approaches involves how, if at all, should conditional payment amounts that the parties may question or dispute be taken into account? Also, to what extent (if at all) would CMS permit the determination to be reduced by "procurement costs" which, per 42 C.F.R. § 411.37, are permitted in reducing a parties' ultimate reimbursement obligation?

(Note: The above are presented for illustrative discussion

purposes only. In presenting same, the author is not stating or otherwise suggesting these approaches represent, or could represent, a proper interpretation of CMS' policy on this point, or would otherwise be accepted by the agency).

18. Section 111 of the MMSEA is codified at 42 U.S.C. § 1395y(b)(7) and (8).
19. As a supplement to the author's discussion of non-threshold cases herein, the reader may also wish to review the excellent overview of this topic (which includes a review of various options for consideration) as prepared by Patty Meifert contained in *Settlement News*, March, 2007 entitled: *MSP Compliance in Settlements NOT Meeting the CMS Review Thresholds: Options for Primary Payers*. This article can be obtained by logging onto www.NQBP.com (select "Resource Library" and then choose "Articles").

Message from the Chairman

By Richard S. Thompson
Chairman, State Board of Workers' Compensation

As we close in on the first year of my tenure as Chairman of the State Board of Workers' Compensation, I am pleased to report that we at the Board continue to make every effort to serve our customers in a fair, impartial, and efficient manner in every Division. It is my pleasure to update you on several initiatives that Directors Warren Massey, Steve Farrow and I have implemented and/or will have completed in the very near future.

First, the Georgia General Assembly recently passed legislation, which the Governor signed, allowing, for the first time in history, the publication of Awards issued at both the trial and appellate levels. This innovation has been long requested by the workers' compensation community, and it is now available. We have begun by publishing Awards from October, 2009 forward. We are starting with those cases heard by the current Appellate Division. Thus, if a case was appealed in or after October, 2009, both the Administrative Law Judge and Appellate Awards will be published. We will be adding additional awards as our resources allow us.

The 2010 session of the General Assembly also saw the passage of legislation, signed by the Governor, which essentially rewrote and strengthened the ability of the Georgia Self-Insurer Guaranty Trust Fund Board of Trustees to pursue a non-compliant member which fails to fulfill its obligations to continue payment on compensable claims filed by injured workers.

In addition, during the past year, we have seen territory changes for administrative law judges, which the Appellate Division believes will enhance the decision-making process at the trial level. As has been mentioned previously, the turnaround time for approval of Stipulations and Agreements by the Settlement Division has improved dramatically. Nowadays, approximately 90 to 95% of stipulations submitted for approval will be approved within 10 days of submission. Also, Awards at both the trial and appellate levels continue to be issued in a timely manner so as to expedite the decision-making process for all parties with regard to handling of a claim.

The most thorough and far reaching change presently taking place is the ICMS II "refresh" project which will, among other things, see a replacement of both software and hardware in the present ICMS system and an upgrade and improvement in those areas which were found to be deficient through the ICMS I process.

Finally, I would like to take this opportunity to thank all of the wonderful people who work with me and the other Directors at the State Board of Workers' Compensation and who devote a great deal of time and effort to improving our workers' compensation delivery services to you, our customer base. I would also like to thank the members of the Chairman's Advisory Council who devote untold numbers of hours of unpaid time to the care and nurturing of the Georgia workers' compensation system. Without their help and assistance in guiding the system, Georgia's workers' compensation system would not be a shining example for other states to emulate.

Message from the Chair

By Cliff Perkins
Chair, Workers' Compensation Section

In this day of upside down mortgages and "201ks", it is easy to get a negative attitude. Our training and work as lawyers increases that risk, since it is our job to fly speck documents and adverse testimony. It's no wonder that lawyers experience a high level of depression and burnout. So what can we do to make it better?

The answer is simple—do what matters. Both the doing and the mattering are important. I've noticed I'm my grumpiest right before I begin preparing for trial—at the time when I am not yet doing it—I am just dreading it. Once I start actually doing it, the dread goes away. I've also noticed that I am much happier doing the work if the work matters. Winning on a technicality is not nearly as satisfying as winning on the merits.

But why am I writing about this in our trade journal? How does all this apply to workers' compensation law? It applies because doing what matters will make our system work. Making our system work is worthwhile. Doing worthwhile work is fulfilling.

In a recent case, opposing counsel caught up with me after the hearing and said: "You know that IME I just put in evidence—it is on a different claimant." We agreed to substitute the correct IME. Later that same client was receiving TTD but found a job. There was nothing new or different about the new employer. My client tried the job for several weeks, but couldn't do it. When I provided information showing those facts, the defense attorney and insurer voluntarily recommenced TTD without forcing my client through another hearing.

Both substituting the IME and avoiding an unnecessary

hearing were the right things to do because they mattered. It matters that the judge gets the correct information, even though it might have been kept out on a technicality. It matters that the injured worker gets prompt payment of benefits even though the delay of a hearing might have given the defense a strategic advantage. That defense attorney and I will continue to zealously represent those clients and others. He will kick my tail some, and hopefully I will kick his some too. But regardless of who kicks whose, we will both enjoy the fight more because it was a fair one.

I know I am mainly preaching to the choir when I write this. It has been said over and over again what a pleasure it is to practice in this section of the bar because the lawyers do practice what I am preaching. But preaching happens every Sunday for a reason—we humans are terribly forgetful of lessons we have learned. It never hurts to be reminded of what matters. So I take this opportunity to get up on my soapbox and preach.

Remember to do what matters. Devote your time to the justice system as well as to your particular clients. Encourage your clients and others who work in our system to do the same. Make your fights about the merits of the case. Don't appeal every case – not even to the appellate division. As the appellate division directors made clear at the seminar, they want to review only the cases that involve obvious errors of fact and focus more on the few cases that involve real issues of law. Give your opponent the benefit of the doubt. Remember he or she, like you, is trying to do the right thing, and that both of you will occasionally need a gentle assist when you fall short of that goal. The more we focus on these things, the more we will love our work.

A special thanks to the 2010-11 Workers' Compensation Law Section Officers:

Clifford C. Perkins Jr.
Perkins Law Firm LLP

Kelly Alyne Benedict
Benedict & Torpey P.C.

John G. Blackmon Jr.
Drew Eckl & Farnham, LLP

John Douglas Christy
John D. Christy P.C.

Gary M. Kazin

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Carlock Copeland & Stair LLP

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Jo H. Stegall III
McRae Stegall Peek Harman Smith Manning

ICMS Update

By Stan Carter

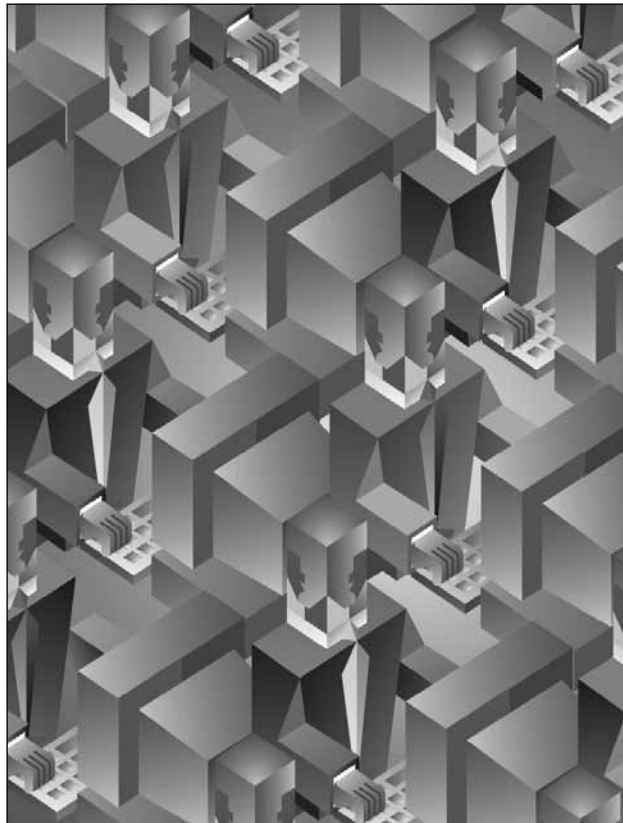
ICMS-2: We've just about got this thing figured out as it is – why change anything?

Issues: We are highly dependent upon the ICMS and WCONLINE systems.

- Software must be upgraded to take advantage of new functionality.
- Existing software is highly customized and not easily upgradeable.
- Access for additional users without affecting current system performance.
- Existing hardware is nearing end of life and core software is at end of support.
- Project Scope: SBWC is partnering with IBM and GTA (Georgia Technology Authority) for:
 - The implementation of new infrastructure environments (hardware and software).
 - Application upgrades and Implementation services.
 - Security for the system at GTA's North Atlanta Data Center.

Project Objectives:

- New classes of users – Rehab Suppliers, Claims Offices/TPAs, Self-Insured Employers, and Carriers.
- Hardware and Software upgrades – newer, faster, more reliable.
- Upgraded applications with flexible design, which are easier to maintain and enhance.
- More robust systems – able to support 1500 new users.
- SBWC should be able to stand on our own for maintenance and enhancements.
- Maintain current system functionality
- Scalable system – create the ability to add more users as needed.



Some Items on SBWC's Enhancement "Wish List":

- Provide a consistent look to all forms viewed by all classes of users.
- Improve the settlement approval notification process for enhanced reliability and verifiability.

What Will Users Need?

- The new system, like the current system, will be windows-based.
 - Accommodate multiple browsers.
 - HIPAA/HITECH Compliant (security, privacy, access, etc.)
 - Intuitive experience without extensive re-training.

What is SBWC doing now, and when will ICMS-2 "Go Live"?

- SBWC's IT staff is training to enhance and broaden their existing skills; critical skills have been added as needed to fulfill additional roles including Project Manager.
- A Project Team of key SBWC staff from various divisions has been meeting to get the project underway.
 - Development will occur in an isolated secure environment without risk to the current system.
 - Requirements and design details are being captured; this process will continue through sequential refinements called "iterations".
 - The current target for switchover is July 2012.
 - As you can see, this is a long-term project for SBWC. Our goal is to create a system that will provide all the same capabilities present in the current system, but to make it more secure, more robust, and faster, friendlier, and easier to use.

Idiopathic Injuries and the Harris Test

By Robert Hendricks

Recent decisions in the Court of Appeals have clouded rather than clarified the compensability of idiopathic injuries. Without clear guidance on this issue, employers, insurers, and employees will continue to litigate compensation for these types of injuries. To date, the clearest and most practical test has been the one laid out in *Harris v. Peach County*, 296 Ga. App. 225, 674 S.E.2d 36 (2009). In that case, a custodian bent over to pick a pill off the floor, as required by the conditions of her employment. In the process of picking up the pill, her own body weight caused her knee to dislocate. She did not come into contact with anything in the process. The Court of Appeals held that this injury was compensable because the activity the employee was engaged in was in furtherance of her job duties. This test of whether the activity constitutes an employment function is a clear and easy distillation of the relevant language from applicable case law.

This language was originally imported into Georgia case law in 1923. The Court of Appeals in *New Amsterdam Casualty Co. v. Sumrell* 30 Ga. App. 682, 118 S.E. 786 (1923) addressed the issue of whether an injury “arose out of” the employment. This language was then adopted by the Georgia Supreme Court in *Fried v. United States Fidelity and Guaranty Co.*, 192 Ga. 492, 15 S.E.2d 704 (1941). Specifically, in citing *New Amsterdam Casualty Co. v. Sumrell*, the Court in *Fried* stated:

The Court of Appeals of Georgia has very aptly defined the term “arising out of” the employment, as follows: “It ‘arises out of’ the employment, when there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is required to be performed and the resulting injury. Under this test, if the injury can be seen to have followed as a natural incident of the work, and to have been contemplated by a reasonable person familiar with the whole situation as a result of the exposure occasioned by the nature of the employment, then it arises ‘out of’ the employment. But it excludes an injury which can not fairly be traced to the employment as a contributing proximate cause, and which comes from a hazard to which the workmen would have been equally exposed apart from the employment. The causative danger must be peculiar to the work. . . It must be incidental to the character of the business, and not independent of the relation of master and servant.

Four years later, the Georgia Supreme Court in *Thornton v. Hartford Accident and Indemnity Co.*, 198 Ga. 786 792, 32 S.E.2d 816 (1945) gave a slightly reworded definition:

The words “arising out of” mean that there must be some causal connection between the conditions

under which the employee worked and the injury which he received. The causative danger must be incidental to the character of the employment, and not independent of the relation of master and servant. The accident must be one resulting from a risk reasonably incident to the employment. And a risk is incident to the employment when it belongs to, or is connected with, what a workman has to do in fulfilling his contract of service. “A risk may be incidental to the employment when it is either an ordinary risk directly connected with the employment or an extraordinary risk which is only indirectly connected with the employment owing to the special nature of the employment.

This language is cited in the majority of the major cases addressing idiopathic injuries and has formed the basis for determining whether an idiopathic injury is compensable.

After *Thornton*, two cases dealing with idiopathic injuries were addressed by the Court of Appeals: *United States Casualty Company v. Richardson*, 75 Ga. App. 496, 43 S.E.2d 793 (1947) and *Orkin v. Wright*, 92 Ga. App. 224, 88 S.E.2d 205 (1955). *U.S. Casualty Co.* dealt with an employee who suffered an epileptic seizure and struck his head on a table, while *Orkin* dealt with an employee who suffered a heart attack. There was evidence in both cases that the employees’ conditions (seizure and heart attack) had been induced by work related exertion. This work related exertion was enough of a causal connection to sustain the award in both cases. However, in addressing the issue of whether the award was legally sustainable in *U.S. Casualty Co.*, the Court of Appeals noted that the award would be sustainable under either one of two theories. The first was that the work related exertion was a causal connection to the epileptic seizure. The second was that “if the fall is on a stairway or into a machine or against anything except the bare floor, and especially if the fall is from a height, as the risk of injury is increased, or is a ‘special danger of the employment’” it arises out of the employment. This addition has caused some confusion in the case law.

In *Prudential Bank v. Moore*, 219 Ga. App. 847, 467 S.E.2d 7 (1996), a computer clerk apparently fainted and struck her head on the baseboard as she fell. She claimed that under *U.S. Casualty Co.* her injury arose out of her employment. The Court of Appeals in *Prudential Bank* distinguished between a structural hazard (such as the baseboard or a wall) and an increased risk (an object specifically related to the work place). The Court also distinguished this case from *U.S. Casualty Co.* in a footnote stating that the injury suffered by the employee in *U.S. Casualty Co.* was due to work related exertion and not an idiopathic fall, as was the case here. This distinction

highlights the necessity of a causal connection between the employment and the injury. In both *U.S. Casualty Co.* and *Orkin*, the employee's injury was brought about by the performance of a job function. In *Prudential Bank*, there was no evidence of a causal connection between the computer clerk's job and her injury.

Prudential Bank was subsequently overruled by *Johnson v. Publix*, 256 Ga. App. 540, 568 S.E.2d 827 (2002) and then reinstated by *Chaparral Boats v. Heath*, 269 Ga. App. 339, 606 S.E.2d 567 (2004). The Court in *Johnson* opined that *Prudential Bank* had misinterpreted *U.S. Casualty Co.* in that *Prudential Bank* stated that *U.S. Casualty Co.* stands for the proposition that an idiopathic fall is compensable only when the claimant strikes a work-related object. While the Court in *Prudential Bank* did base its decision on the fact that the employee did not strike a work-related object, it also noted that the employee's fall was not brought on by work-related exertion as it had been in *U.S. Casualty Co.* Thus, the Court in *Prudential Bank* seems to distinguish between an injury from an idiopathic condition and an injury from an idiopathic fall.

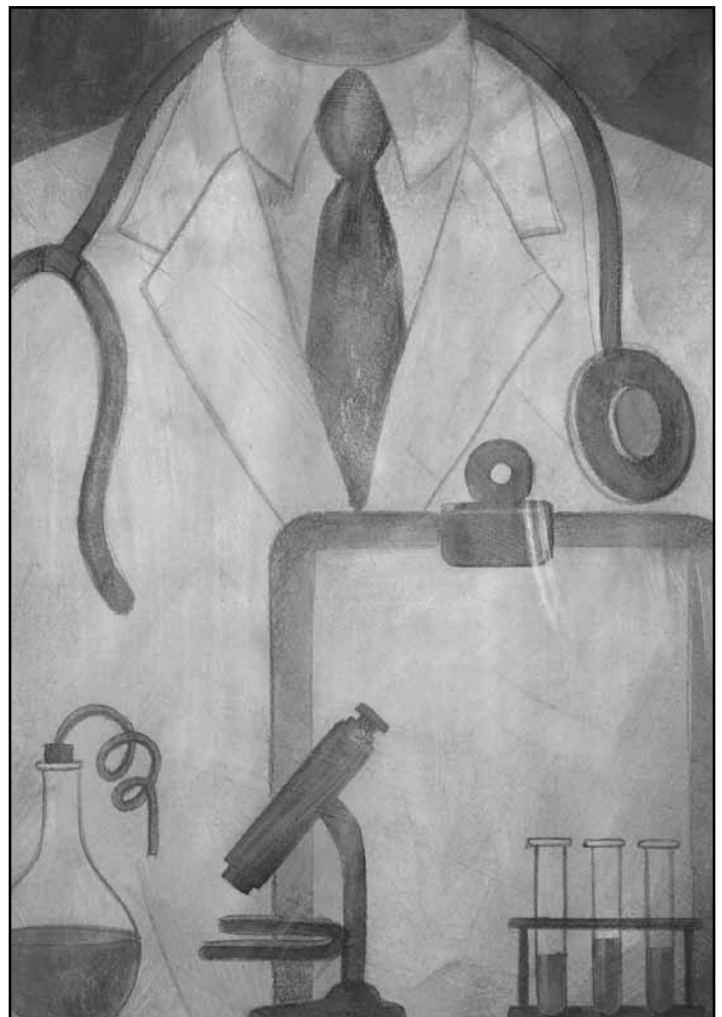
If an employee has some sort of idiopathic condition that is in some way exacerbated or activated by something incidental to his or her work, that injury would be causally connected to the employment, thus falling in line with *U.S. Casualty Co.* However, if the employee is injured in a fall caused by purely idiopathic reasons, there is no causal connection to the employment and the injury would not be compensable, as was the case in *Prudential Bank*. The dissent in *Johnson* pointed out that "there was no evidence to show that [the employee's] injuries were the result of anything other than an idiopathic fall." Additionally, there was no evidence to connect the cause of the fall to any aspect of the employee's employment. Thus, the Court of Appeals' disapproval of *Johnson* in *Chaparral* was appropriate.

Despite its efforts to the contrary, the Court in *Chaparral* did little to clarify the issue. In dicta, the Court distinguished between situations in which the application of the positional risk doctrine would be appropriate to establish a causal connection and situations in which it would not.¹ In situations where the application of the positional risk doctrine would be inappropriate, the general rule as laid out in *Fried*, *supra*, would apply². The Court went on to say that the "peculiar to the employment" analysis is not a replacement for "analyzing compensability in terms of whether there was a causal connection between the employment and the injury." The Court further explained that the "peculiar to the employment" analysis is essentially an analysis of whether the employee would be equally exposed to the risk apart from the employment. This analysis contemplates whether some condition of the employment was related to the injury.

Citing *Davis v. Houston*, 141 Ga. App. 385, 233 S.E.2d 479 (1977), the Court attempted to illustrate this point. In *Davis*, a nurse's aide was denied compensation after injuring her back while putting on her coat to leave work.

The Court affirmed the finding of the ALJ and the appellate division that "the risk of incurring such a back injury while putting on a coat 'was a hazard to which she was equally exposed apart from her employment.' In other words, the risk was not 'peculiar' to the employment, but common to the employee and the public at large." The Court in *Chaparral* further explained that "[b]ecause the causative risk was not peculiar or incidental to the character of the employment, and there was no evidence of a causal connection between a condition of the employment and the injury, *Davis* held that the injury did not arise out of the employment and was not compensable." Thus indicating that had the causative risk been peculiar or incidental to the character of the employment or had there been evidence of a causal connection between a condition of the employment and her injury, the injury would have arisen out of her employment and been compensable.

Although *Chaparral* presented a lengthy discussion of the law regarding idiopathic injuries, it did little to cut back on or really clarify the language addressing the issue of whether an injury arises out of employment. That step was taken by the Court of Appeals in *Harris v. Peach County*. The facts of that case, *supra*, would exclude the application of the positional risk doctrine and the increased risk doctrine. Thus for the employee's injury to be compensable,



it must fall within the requirements of the general rule as laid out in *Fried*. The Court in *Harris* distilled the general rule to a clear and easy to apply test: Did the activity constitute an employment function? This distillation looks directly at whether there was a causal connection between the injury and a condition of the employment. Because the employee in *Harris* was required by a condition of her employment to pick the pill off the ground and because she was injured while doing so, the Court of Appeals found that there was a causal connection between the conditions of her employment and her injury.

The Court of Appeals in *Harris* also addressed the issue of whether the employee must suffer an injury that he or she would not suffer outside of work to be compensable. The Court explained that “the fact that [the employee] could have been injured in a similar manner away from work does not require a different result ... [because] she was carrying out job duties when she was injured in that way.” This falls in line with the discussion of the meaning of “peculiar to the employment” in *Chaparral*. The Court in *Chaparral* used the injury suffered by the employee in *Davis* as an example of an injury that was not “peculiar to the employment” because there was no nexus between a condition of her employment and her injury. In *Harris*, the Court provides the other side of that analysis by explaining that an injury is “peculiar to the employment” if there is a nexus between a condition of the employment and the injury.

Applying the test laid out in *Harris* to *U.S. Casualty Co., Orkin, Prudential Bank, Davis, and Chaparral*, one would see the same results. In the cases where evidence of an employment function contributing to injury was presented, the courts found a causal connection (*U.S. Casualty Co. and Orkin*). In cases that lacked that evidence, no causal connection was found (*Prudential Bank, Davis, and Chaparral*). Under this analysis, only *Johnson* might have been decided differently.

Unfortunately, the case at issue in *St. Joseph's Hospital v. Ward*, 300 Ga. App. 845, 686 S.E.2d 443 (2009) was presented to the Appellate Division after the publication of *Chaparral* but before the publication of *Harris*. Without the guidance of *Harris*, the Appellate Division framed the activity the employee was engaged in at the time of her injury (turning to get a patient a glass of water so he could take medicine) in its most basic sense: simply turning. The Appellate Division found that this was a hazard the general public was exposed to, thus it was not a compensable injury. That decision was appealed to the Superior Court and reversed. The Superior Court held that the appellate division misapplied *Chaparral* by not considering the causal connection between the conditions of the nurse's employment and her injury. The Court of Appeals, however, noted that according to the sufficiency of the evidence rule the Appellate Division's finding that she “was not exposed to any risk unique to her employment by standing and turning” was supported by some evidence, and thus the Superior Court and the Court of Appeals were required to defer to that finding.

The decision in *St. Joseph's* emphasized the “peculiar to the employment” language discussed in *Chaparral*, but seems to have missed the instruction that the “peculiar to the employment” analysis is not “a good substitute for analyzing compensability in terms of whether there was a causal connection between the employment and the injury.” Ironically, the three judge panel deciding *St. Joseph's* note in nonbinding dicta that “any statements in *Harris, supra*, that might be construed as contrary to our whole court decision in *Chaparral, supra*, are nonbinding dicta.” This was not only unnecessary to decide the issue at hand, but was also unnecessary since *Harris* simply distilled the test that was laid out in *Chaparral* and is, in fact, consistent with *Chaparral*.

While it is unclear how the Court of Appeals will address this issue in the future. It seems that the reasoning applied in *St. Joseph's* is unlikely to stand for two reasons. First, if it did, then when a warehouse worker lifts a fifty pound box and suffers a back injury, it would not be compensable because the injury would be a result of lifting which would be a risk the employee would have been equally exposed apart from the employment. Second, the decision in *St. Joseph's* also cites *Chaparral* out of context in regard to its understanding of the “peculiar to the employment” analysis. *St. Joseph's* saw the “peculiar to the employment” analysis as requiring that the work activity be an activity that the public does not generally engage in. However, *Chaparral* explained that the “peculiar to the employment” analysis is simply an analysis of whether the injury was related to or caused by the peculiar nature of a condition of the employment. Ultimately, the most likely result seems to be an affirmation of the principles laid out in *Chaparral*, which can be applied effectively through the *Harris* test.

A special thanks to Justin Lowery, a law student at Emory, for his assistance with this article.

(Endnotes)

1. Essentially, the positional risk doctrine was meant to extend protection to employees if a duty related to the employment places the employee in a locale which exposes the employee to a risk, even if it is not peculiar to the employment. However, it does not apply where the risk which causes the employee's injury would occur independently of place, employment, or pursuit.
2. [An injury] ‘arises out of’ the employment, when there is . . . a causal connection between the conditions under which the work is required to be performed and the resulting injury. . . . But it excludes an injury which can not fairly be traced to the employment as a contributing proximate cause, and which comes from a hazard to which the workmen would have been equally exposed apart from the employment. The causative danger must be peculiar to the work. . . It must be incidental to the character of the business, and not independent of the relation of master and servant.

Distinguished Service Award

By John G. Blackmon Jr.
Drew Eckl & Farnham, LLP

The Workers' Compensation Law Institute in October marked the ten year anniversary of the first Distinguished Service Award to a workers' compensation practitioner. The list of recipients reads like a who's who, and includes Bill George, Charlie Drew, Earl Mallard, Jim Hiers, John Williams, John Sweet, Lamar Gammage, Curtis Farrar, Joe Sartain, Lavinia George, Carolyn Hall, Don Hartman, Bobby Potter, Lee Southwell and John Ross. Criteria for the award are that the nominee must: (1) be at least 50 years old, (2) has been working in the workers' compensation area for 20 years and (3) has been working for the good of the system in particular and the community in general.

As you might expect, it is a difficult decision to make considering the nominees submitted. John Ross was given the award this year and was a statesman if there ever was one. For those of you who could not attend the seminar, John Ferguson, Carolyn Hall, Stan Carter and John Sweet spoke on his behalf. John passed away a year ago and practiced law in Georgia for almost 30 years. He was counsel for CW Matthews Contracting Company, an "asphalt man" as he described himself and a long-term member of the Chairman's Advisory Committee. His specialty was bringing two sides to the middle and he was as skilled as anyone in doing so. John was a problem solver, and devoted a great deal of his time working to resolve issues in manner that benefitted both injured workers and employers. If there is one thing I remember about John, it came from a speech he gave several years ago at an ICLE seminar. He talked about his love of Georgia, the green pines, the red clay and the blue sky. Never having been a fan of red clay, he changed my mind that day and was a master at getting you to view something in a different light. John Ross never sought the limelight, was genuine and his contributions will be with us for a long time.

One of the other individuals nominated this year was Marvin Price, and if there was an example of going above and beyond the call of duty in recent years, it was Marvin. After being told that one of his clients would no longer receive benefits because the insurer went out of business, Marvin fought tirelessly to right that wrong and restore benefits to a gentleman who had suffered a severe brain injury. While zealously representing his other clients, and trying to keep his practice afloat, Marvin worked pro bono

to get legislation passed that would ensure that his client, as well as several others similarly situated, received lost time and medical benefits. These were catastrophically injured workers who, for lack of a better description, were about to be turned out into the cold. For those who know Marvin, the fact that he would undertake such an endeavor would come as no surprise.

Perhaps the best way to describe what qualities a recipient should possess is to look at the criteria for the Algernon Sydney Sullivan National Award. It provides for recognition of an individual who has "fine spiritual qualities, practically applied to daily living... the object of each of the Awards is not so much to encourage any one individual as it is to reach and influence many." Competency, integrity, compassion, dedication and service. Those qualities should be possessed by every individual who is nominated and who receives the Distinguished Service Award.

Over the last several years there has been quite a bit of discussion about whether we should have one or two recipients. Suggestion has been made that there should be at least two each year, one who represents injured workers and the other from the defense and perhaps a third from the State Board. The Executive Committee, at least this past year, did not lean strongly either way. Instead, the focus was on giving the award to an individual who met the criteria, and it was not a decision hastily made. The fact of the matter is that we are all in this together, and the side you practice on is irrelevant in the grand scheme of things. If a person is deserving of the award, he or she should receive it without regard to his or her clients. However, there is much room for discussion on this subject and if you would like give us your ideas, send it to a member of the Executive Committee, which currently consists of Cliff Perkins, Lynn Olmert, Gary Kazin, John Christy, Jo Stegall, Kelly Benedict, Gregg Porter and John Blackmon.

While all of the past recipients were unique in their own right, their contributions to the workers' compensation practice and to their community were extraordinary, which is why they deserved the Distinguished Service Award. Because it is given at the annual seminar in late September or October, nominations should be submitted to the Executive Committee no later than May 31. If you decide to submit a name, please tell us why that person should be honored. The more information you provide, the better.

*As you might expect,
it is a difficult decision
to make considering
the nominees
submitted.*

This and That in Discovery

By Jason Perkins

Discovering What Is In The Adjuster's File

The Injured Worker's Perspective

Are the adjuster's file and the adjuster's notes discoverable? The scope of discovery is set out in O.C.G.A. §9-11-26(b)(1). "Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence."

Based on the statute, the first question is whether the files and/or notes are relevant. While the hearing issues are going to determine whether the discovery request is "relevant to the pending action", there are a number of situations where information contained in the adjuster's file, including the adjuster notes, are relevant. The file and notes should contain information about whether the adjuster received a certain document or documents, such as a Form WC-205, if that is at issue. If assessed attorney's fees are an issue, the file and notes will document the adjuster's investigation and/or handling of the claim and whether it was reasonable or unreasonable. If O.C.G.A. §34-9-18 civil penalties are an issue, the file and notes will likely provide documentation of violation of board rules and/or false or misleading statements made for the purpose of denying benefits.

The second question is whether the adjuster's file and notes are admissible or, if not admissible, reasonably calculated to lead to the discovery of admissible evidence. While the adjuster notes are most likely reasonably calculated to lead to the discovery of admissible evidence, the analysis should not even need to go that far because the electronic "adjuster notes" should be admitted at a hearing as a business record pursuant to O.C.G.A. §24-3-14. Under that code section, "Any writing or record ... made as a memorandum or record of any act, transaction, occurrence, or event shall be admissible ... if the trial judge shall find that it was made in the regular course of any business and that it was the regular course of such business to make the memorandum or record at the time of the act, transaction, occurrence, or event or within a reasonable time thereafter." Electronic adjuster notes clearly fit within this definition. They routinely document the actions of the adjuster from review of a medical record to assignment of case management to unreasonable actions and failure to file Board Rules. They are created and

maintained in the ordinary course of an insurer's business of claims management.¹

So, what about those two words: not privileged? The most commonly asserted objection to the files and/or notes is that they are privileged because they were prepared in anticipation of litigation and are the work product of the adjuster. The insurer, as the party asserting this privilege, will have the burden of showing that the documents were prepared in anticipation of litigation.² It is not sufficient that the party making the assertion of privilege simply object on the grounds that the material requested was prepared in anticipation of litigation. The party must present some evidence to show why the information is privileged.

The proper way to begin addressing the issue of an assertion of privilege with regard to the adjuster's file and/or notes is with a privilege log. Within the Requests for Production of Documents, the party seeking discovery can include instructions that request a privilege log with regard to any document claimed to be privileged. Also, the party seeking discovery can request a privilege log after receiving the responses.

The privilege log should provide a general description of the document, the date of creation of the document, the identity of the person creating the document, the subject matter within the document which is contended to be privileged, the specific privilege asserted, and the legal and/or factual basis for the privilege. The point is that a reasonable determination cannot be made as to whether the information is actually privileged without this information. The information provided in a privilege log allows the party seeking discovery to make reasonable arguments regarding why the information is not privileged without requiring the party seeking to protect the documents to actually reveal those documents.

There is scarce Georgia law, especially with regard to Workers' Compensation claims, about if and when electronic adjuster notes are prepared in anticipation of litigation. The evaluation of claims of policyholders is part of the ordinary business of an insurance company and such evaluation does not take place in anticipation of litigation just because litigation often results from a denied claim.³ Activities routinely handled by the adjuster as part of adjusting a workers' compensation claim will be documented in the adjuster notes. Because most of the adjuster notes document routine activities, they should be discoverable when otherwise relevant.⁴ If there is disagreement over whether certain adjuster notes were prepared in anticipation of litigation after a privilege log has been provided, the administrative law judge will likely need to conduct an in camera review of the adjuster notes.

The employer/insurer may demonstrate that some adjuster notes or other portions of the adjuster's file were prepared in anticipation of litigation. However, even if the employer/insurer demonstrates that certain documents/notes within the insurer's file were prepared in anticipation of litigation, the injured worker can still obtain those documents if it can show that he or she has substantial need for the materials in preparation of its case and is unable without undue hardship to obtain the substantial equivalent of the materials by other means. O.C.G.A. §9-11-26(b)(3). The injured worker, as the party seeking discovery, would have the burden on this issue.⁵ If the administrative law judge determines that the injured worker has satisfied this burden, the court should still order removal of the mental impressions, conclusions, opinions or legal theories of the employer/insurer.⁶

What about surveillance? Georgia law addressing surveillance has held that private investigators that are providing evidence about their observations, as opposed to investigative techniques, are testifying as fact witnesses instead of experts. As such, the observations made by an investigator are not privileged and only the investigator's conclusions or other work product should be protected from discovery.⁷ A surveillance tape should simply be a recording of what happened on a particular day or days.⁸ Assuming that it is surveillance of the injured worker, it is really just a statement of that injured worker's actions. As a result, it is discoverable just like any other statement of the injured worker or recording of how the injured worker was feeling on a particular day.

On the other hand, the actual report of the investigator could certainly contain work product in addition to the reporting of the investigator's observations. If work product, including mental impressions and

conclusion, is present in the report, then the analysis of the investigator's report becomes a different issue from providing the tape. However, when interrogatories are sent to the employer/insurer seeking facts about what the investigator observed, the employer/insurer should answer those interrogatories to the extent that it does not require them to reveal work product (and may need to use information from the report to do so).

Should the employer/insurer be able to withhold the otherwise discoverable information until they have taken the injured worker's deposition? The employer/insurer will argue that they will not be able to impeach the injured worker if the surveillance information has to be produced in discovery prior to the deposition. First of all, the litigation process is not an effort to win the case by trickery or concealment. It is an effort to arrive at the truth. Second, there is a statutorily enacted process for serving and responding to discovery. If discovery has been served by the injured worker and the answers to that discovery are due prior to the injured worker's deposition, it is not proper for the employer/insurer to violate the discovery rules and withhold discovery until after the deposition.

Parties should not be encouraged to benefit strategically from improper objections and the failure to comply with discovery requirements. In fact, Georgia courts have recognized that discovery of otherwise discoverable information should not be preconditioned on a party first submitting to a deposition.⁹ This rule supports the policy of full and timely disclosure that is the basis of our discovery statutes. If it were otherwise, parties would simply withhold all discoverable information¹⁰ from the opposing party until after a deposition was taken. On the other hand, if the deposition has been properly scheduled before the employer/insurer's responses to discovery are due, then the deposition should certainly take place before the discovery has to be provided.

The Employer/Insurer's Perspective

Often, I receive requests for an **entire** adjuster's file. While some materials in the file are certainly discoverable (for example, medical records), others clearly are not. For example, requests are often specifically made for adjuster file notes prepared by the adjuster regarding the case. As discussed below, there is no Georgia case law directly on point regarding the discoverability of some of these materials, however, when objections are made to the production of such materials, the assertion should be that they are privileged under the attorney/client privilege and/or the attorney work product doctrine. In the same vein, it should be pointed out that adjuster's file contents vary from insurer to insurer,



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and this is a very broad approach to the most common elements and contents of these files.

Georgia has not been as clear as other states in defining what is and is not governed by the attorney/client privilege (“the privilege”), but generally speaking, the privilege in Georgia includes agents and employees of the attorney and his/her client, acting under the direction of either the client or the attorney, in furtherance/to facilitate the legal representation. OCGA § 24-9-24; Eglin *Fed. Credit Union v. Cantor, Fitzgerald Securities Corp.*, 91 F.R.D. 414 (N.D.Ga 1981). The privileged network of the attorney would include people such as administrative assistants and legal assistants, the latter category being anyone from law clerks to secretaries. *In re Fulton County Grand Jury Proceedings*, 244 Ga. App. 380, 535 SE2d 340 (2000). The privilege is not necessarily a tool to be used to exclude facts, but rather, it merely bars the use of communications by one party to prove facts not yet in evidence. *Gilbert v. State*, 169 Ga. App. 383, 313 SE2d 107 (1983). In Georgia, the privilege is most broadly construed when an expert or consultant is hired by the attorney; when this is done communications between the expert and client are privileged because they are between the attorney’s agent and the client. *G.M.C. v. Moseley*, 213 Ga. App. 875, 447 SE2d 302 (1994). However, it is important to remember that when the expert is hired by the client, the expert becomes the agent of the client, not the attorney, and thus the privilege will not apply, even to sensitive matters involving legal strategy. *Id.*

The attorney work product doctrine (“the doctrine”) is more clearly defined in Georgia. The purpose of the doctrine is simple; it is in place to protect against the use of discovery methods to obtain another party’s trial preparation materials. *Sturgill v. Garrison*, 219 Ga. App. 306, 464 SE2d 902 (1995). The application of the doctrine, however, isn’t as simple. The doctrine is only waived when an opposite party can prove substantial need of the otherwise undiscoverable materials, and the same party must also prove that there will be undue hardship in acquiring substantially equivalent materials (which are discoverable) by other means. OCGA § 9-11-26(b)(3). It is only after successfully arguing both substantial need and undue hardship that the movant will be granted access to these materials, but even if the movant can prove these two elements, the Court must guard against disclosure of mental impressions, conclusions, opinions and/or legal theories of an attorney/other representative concerning the litigation at issue. *McKesson HBOC, Inc. v. Adler*, 254 Ga. App. 500, 562 SE2d 809 (2002). Even after such an argument is successful by the movant, the trial court will almost always perform an in camera inspection of the materials to safeguard against the disclosure of any of the aforementioned categories of information which could give the movant an unfair advantage in the litigation. *Id.*

The claimant’s recorded statement, when given, is discoverable. It is not a statement by an agent or employee of the attorney; it should not contain any mental

impressions or trial strategy of the attorney. As such, neither the privilege nor the doctrine will bar it from being discoverable. Whether it has been transcribed or it is the original recording, the statement itself is a discoverable portion of the file as it is the claimant’s own words. Since the statement is not taken under oath it has limited trial use for anyone once it is obtained, however, it could be a useful discovery tool for either side. I always take the position that this is a discoverable portion of the adjuster’s file material as it is no different than the claimant’s discovery deposition transcript and testimony except for the fact that it is not taken under oath and cannot be used as such in a hearing or trial. It can, however, be used as evidence as far as there is a prior inconsistent statement made by the claimant as to a material fact or relevant matter to the issue in litigation. O.C.G.A. § 24-9-83. It should be noted that before contradictory statements may be proven against the claimant, unless such statements are written and made under oath with some judicial proceedings, the circumstances (time, manner, place, and persons stated to) attending the formal statement must be called to the claimant’s mind with as much certainty as possible. This usually means that a recorded statement must be shown to the declarant or read at the claimant’s hearing.

Surveillance is another topic for which there is no case law directly on point in the state of Georgia. Generally speaking, the State Board has taken the position that when there is a dispute over the discoverability of surveillance, the employer and insurer are entitled to take a discovery deposition, and following that, the surveillance must be produced. This seems to be a compromise between the positions some defense counsel take, that the surveillance is attorney work product, therefore, privileged, or conversely, the position that the claimant’s attorney sometimes takes, that the surveillance is another recorded statement of the claimant, and as such, is completely discoverable.

The majority of jurisdictions that have determined the issue as to whether or not video surveillance is discoverable hold that it is. 19 ALR 4th 1236. Most of the jurisdictions favoring disclosure place a limit upon it, and this is similar to the position that the State Board has taken in the past, that the production of the surveillance tape will not be required until after the employer and insurer has had a reasonable opportunity to conduct a deposition (post-surveillance) of the claimant. There are two cases directly on point which outline the intersection between surveillance and work product doctrine. *Ranft v Lyons*, 163 Wis. 2d 282 (Wisc. App. 1991) and *Hikel v Abousy*, 41 FRD 152(d) Md. (1966). The Court in *Ranft* reasoned there had to be a balance between the work product doctrine and the need to conduct discovery in an open manner, finding that the “strategic decision to invest a client’s resources on ... video surveillance is protected work product. The decision not only reflects the lawyer’s evaluation of the strengths or weaknesses of the opponent’s case, but also the lawyer’s instructions to the person or persons conducting the surveillance also reveals the lawyer’s analysis of potentially fruitful areas of investigation.” *Ranft*, 163 Wis. 2d 301.

Interestingly, the *Ranft* Court rejected the compromise position of allowing post-surveillance/pre-production deposition testimony from the claimant (the position the State Board has adopted). Conversely, the *Hikel* Court found the surveillance materials to be non-discoverable insofar as revealing their existence in response to an interrogatory would prevent effective cross-examination.

On the opposite end of the spectrum, several states have taken the position that such materials are discoverable despite the fact they are work product. For example, in *Cabral v Arruda*, 556 A. 2d 47 (R.I. 1989), the Supreme Court of Rhode Island held surveillance material, while work product, was discoverable upon a showing of undue hardship. The Court reasoned that these materials being used to surprise a plaintiff or defendant at trial potentially created undue hardship, and as such, the materials would be discoverable under the undue hardship doctrine. A similar conclusion by different reasoning was arrived at by the New Jersey Supreme Court in *Jenkins v. Rainer*, 69 N.J. 50 (1976). The *Jenkins* Court reasoned that while the materials were work product, the inability of the movant to film his prior activities created undue hardship in acquiring substantially the same materials, therefore, the exemption created by the doctrine would be lifted.

Medical records for the injury/accident in question in the adjuster's files are always discoverable under Board Rule 200, and barely deserve mention in this article other than to state that all medical records should be produced as soon as possible, again, to prevent undue hardship. This seems implicit in the Rule and in the Georgia Civil Practice Act. This is especially so in workers' compensation claims since physicians are not compelled to testify as witnesses at hearings, therefore, the reliance upon these records is even greater by both parties. Thus said, however, a different approach might be taken with respect to medical records which do not pertain to the work accident/injury in question. Certainly this is a topic which remains "in play" in terms of the scope of a medical records request by insurers for a claimant's medical records, and the same privacy concerns must be given consideration when an adjuster's file is requested. Certainly any requesting claimant who seeks to limit the medical records by date and injury of origin cannot, at the same time, demand all the medical records in the adjuster's file outside of that limitation. Such a request might, in fact, open the claimant up for the discovery of his or her own entire medical history as he or she has suddenly "opened the door" in terms of waiving a supposed privilege.

There, of course, will be multiple correspondences from attorneys and other agents in the adjuster's file. These materials are clearly protected under the attorney work product doctrine. While the attorney/client privilege is often invoked as a privilege to these materials, it should be remembered that the attorney/client privilege only applies to testimony. *Tenet Healthcare Corp. v Louisiana Forum Corp.*, 273 Ga. 206, 538 S.E. 2d 441 (2000); Georgia Rules of Professional Conduct, Rule 1.6(a). While no party or witness should be required to make discovery of the

advice of his professional advisors or consultation with them [O.C.G.A. §24-9-27(c)], because the communications are written and produced with strategy usually in mind, the work product doctrine is the more proper objection to assert, and indeed, such correspondence should be protected under the same. Of course the attorney/client privilege would likely bar the production of these materials as well. Thus said, attorney correspondence in the adjuster's file clearly is work product and not discoverable without undue hardship, and even then, portions of such materials will likely be redacted by the Court after an *in camera* inspection.

Last, but certainly not least, are the adjuster's notes. There is a lot of confusion and controversy surrounding their discoverability, and Georgia courts have not determined one way or the other whether or not they are discoverable (not unlike surveillance). Adjuster's notes generally contain a broad variety of topics including, but not limited to, notes of conversations with their counsel, excerpts of correspondence from counsel and communications with employer representatives concerning the facts of the claim in dispute. It would certainly seem, therefore, that at least parts these notes are being kept in preparation for trial use by the attorney involved, and therefore fall under the work product doctrine.

While many counsel seeking these materials would point out that this is not "product" prepared by defense counsel, trial preparation materials falling under the privilege also include reports prepared by those working for the attorney or the client *related to anticipated or pending litigation*. In *Tobacco Road, Inc. v Callaghan*, 174 Ga. App. 539, 330 S.E. 2d 768 (1985) (emphasis added), the investigator's report of a witness' statement was deemed privileged [See, also, *Copher v Mackey*, 220 Ga. App. 43, 467 S.E. 2d 362 (1996)] and statements taken by an insurance investigator in anticipation of litigation were part of protected work product. Adjuster's notes are certainly part of the process for preparing for litigation and/or trial, and document evidence, strategy and information to be used in the same. Again, if the movant party can prove both substantial need and undue hardship in acquiring the equivalent materials elsewhere, it is possible that the notes might have to be produced, but even then, the trial judge will likely perform an *in camera* inspection to exclude all otherwise privileged and protected materials within the notes. Such an inspection might make the notes worthless to the movant after redaction by the judge.

It would certainly seem under the *Callaghan* and *Copher* cases adjuster notes would be work product. Thus, without a showing of undue hardship by the counsel for the plaintiff, the notes would be deemed non-discoverable. Even if undue hardship were shown, the work product notes, not unlike attorney correspondence as outlined above, would likely first be subject to an *en camera* inspection by the Court under the same mandates cited above in that the Court shall protect from disclosure all mental impressions, etc., in the generation of the product. In other words, and

in sum and substance, Georgia courts have not been very generous with requests for such reports or materials, and likely, an Administrative Law Judge would not be either without showing of undue hardship by the requesting party.

The Interaction of the Right to Discovery and the Right to Privacy

How much information about her private life is an injured worker required to reveal simply because she got injured at work? The standard for a deposition is set by O.C.G.A. §9-11-26 the same as it is for other discovery matters. It is essentially a three pronged test in that the matter must be “relevant to the subject matter involved in the pending action”, “reasonably calculated to lead to the discovery of admissible evidence” and “not privileged.” The issue of privilege will not be discussed specifically in this portion of this article, but it is obviously important to consider whether information is privileged in depositions or other forms of discovery.

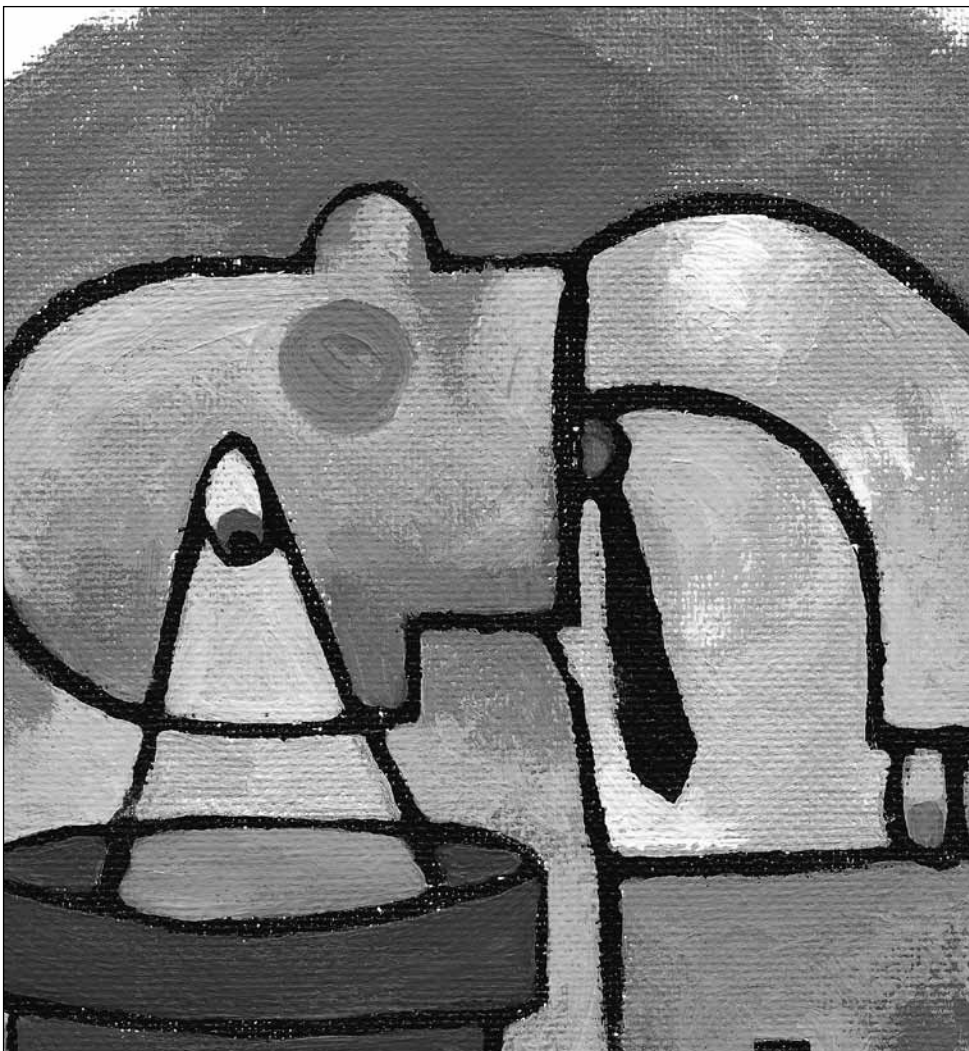
It is often difficult to determine whether something is both relevant and reasonably calculated to lead to the discovery of admissible evidence. However, it is important to remember that “relevance” and “reasonably calculated

to lead to the discovery of admissible evidence” are two separate standards. Under O.C.G.A. §9-11-26, the information sought must be relevant **and** admissible or reasonably calculated to lead to the discovery of admissible evidence. “The most acceptable test for relevancy is whether the evidence offered renders the desired inference more probable than it would be without the evidence.”¹¹ Of course, one must start with the current litigation issues to determine what is relevant. Too often, discovery is not narrowly tailored to the pending issues. While the Claimant’s previous injuries to the same part of the body and functional capacity are certainly relevant in a deposition in an all issues claim, they are not relevant in a claim where the determination of the correct average weekly wage is the only hearing issue.

Even if the information sought is relevant, admissible (or reasonably calculated to lead to the discovery of admissible evidence) and not privileged, the information still may not be discoverable. The State of Georgia recognizes the right to privacy. In fact, the Supreme Court of Georgia was the first court of highest resort in the country to recognize the right to privacy. The right of privacy in Georgia “is far more extensive than the right of privacy protected by the U.S. Constitution...”¹² This right to privacy affects discovery because “the competing interests in an individual’s right to privacy must be accommodated in the discovery process.”¹³

How should the competing interests in an individual’s right to privacy be accommodated? There must be a balancing test between the need for the information of the party seeking discovery and the privacy interests of the party providing the information. With regard to workers’ compensation, the filing of a workers’ compensation claim does not force someone to make her entire life an open book. If the employee’s interest in keeping the information private outweighs the employer’s interest in discovering the information, then the information should not be discoverable. Injured workers are often stigmatized by employers, co-workers and others for filing Workers’ Compensation claims. They are sometimes made to feel like it is their fault that they got hurt. They have a strong interest in keeping private information that may only be marginally relevant.

That privacy interest is especially important in discovery. When an



injured worker reveals potentially embarrassing information to her attorney, that information will not be revealed elsewhere. When potentially embarrassing information is revealed in a deposition, the injured worker must reveal that information to the other attorney, someone she knows is hired to work against her. That information is also revealed to the court reporter. It will likely to be revealed to employees of the employer and the insurer as clients of the attorney, and it can certainly go even further than that. The strong right to privacy in Georgia should protect injured workers from having to reveal marginally relevant information when they have an interest in keeping that information private.

Proper Subpoena Use

Generally speaking, subpoenas are an order from a court compelling an individual to provide testimony on a matter before it. As officers of the court(s), it is incumbent upon us as such to use the subpoena power of the court(s) in a manner that is just and will aid in the furtherance of the cases before it. Unfortunately there are a number of attorneys in Georgia who issue subpoenas in an abusive manner and certainly do not issue them properly. Outlined below are the proper procedures for the utilization of



subpoenas to secure the attendance of witnesses, to procure and to preserve evidence.

Title 24, Chapter 10, of the Code of Georgia sets forth the procedures by which to use a subpoena for litigation purposes. O.C.G.A. § 24-10-20(a) mandates that every subpoena shall be issued by the Clerk under seal of the Court whose power it is issued from. In workers' compensation, we, of course, have our own subpoenas in form that can be acquired from the State Board/ICMS. When served, it is important to note that for witnesses, the power of the subpoena to compel their attendance *only* extends to the lines of the state of Georgia. O.C.G.A. § 24-10-21. In other words, out-of-state witnesses cannot be compelled by use of a State Board subpoena. Subpoenas for production of documentary evidence are governed by § 24-10-22, and under section (a), a subpoena issued to a person for witness' testimony may also direct such person to produce books, papers, documents, or other tangible things designated on the subpoena. Section (b) of the Statute notes that the Court issuing the subpoena, upon written motion filed by the opposing party before the time specified in the subpoena, may quash or modify the subpoena if it is "unreasonable and oppressive," or conditionally deny the motion upon the advancement by the person in whose behalf the subpoena is issued the reasonable cost of the materials requested.

A subpoena may be served by any sheriff, deputy, or by any other person not less than 18 years of age, proof of which may be shown by return or certificate endorsed on a copy of the subpoena. O.C.G.A. § 24-10-23. Subpoenas may also be served by registered or certified mail or statutory overnight delivery, and the return receipt shall constitute *prima facie* proof of service. *Id.* It is important to note that service upon a party may be made by serving his counsel of record. *Id.*

Where subpoenas are often not served properly is when fees and mileage are not paid. Under O.C.G.A § 24-10-24, a witness fee shall be **\$25 per day**. The payment of the fee shall not be demanded as a condition precedent to the attendance of a witness residing within the county where testimony is to be given. When a witness resides outside the county where the testimony is to be given, however, the service of the subpoena, in order to be valid, **must** be accompanied by the tender of the fee for one day's attendance (\$25) plus mileage of \$0.20 per mile for traveling expenses for going to or from the witness' place of residence by the nearest practical route. In other words, unless the witness lives within the county where his or her attendance is compelled by the subpoena, non-payment of both one day's witness fee and mileage will deem the service of the subpoena to be invalid.

Finally, practitioners must consider the enforcement mechanism under Title 24, Chapter 10. Under O.C.G.A. § 24-10-25, subpoenas may be enforced by an attachment for contempt which can result in a fine not exceeding

\$300.00 and imprisonment of no more than 20 days if the witness, after being properly served, fails to attend. However, a caveat to this subsection (Section A) is that in all cases under this section of the Code, the Court will consider whether under the circumstances of the case the subpoena was served within “a reasonable time.” While this varies from case to case, in no event shall a reasonable time be less than 24 hours prior to the time that appearance was required by service of the subpoena.

In sum, practitioners should use subpoenas sparingly and only in clear furtherance their client’s case. For example, subpoenas should not be issued to the entire staff of an employer or insurer to “scare” them into settlement, nor should they be issued to the entire family of an employee for the same purposes. The discovery process leading up to a hearing or trial should give both sides ample opportunity to examine any witnesses under oath, and determine who can best advance their client’s interests at a hearing or trial. Surprising the other side with subpoenas which are not issued with this purpose in mind, or even served properly, doesn’t do either side any good, and risks angering the sitting judge.

(Endnotes)

1. See *Burch v. Tioga Manor Nursing Home*, 649 So. 2d 545 (La. Ct. of Appeals, 3rd Cir. 1994) (adjuster notes in hearing on issue of assessed attorney’s fees for unreasonable defense and penalties);
2. *General Motors Corp. v. Conkle*, 226 Ga. App. 34 (1997).
3. *Atlanta Coca-Cola Bottling Co. v. Transamerica Ins. Co.*, 61 F.R.D. 115 (ND Ga. 1972).
4. See *Department of Transp. v. Hardaway Co.*, 216 Ga. App. 262 (1995) (discussing *Lowe’s of Ga. v. Webb*, 180 Ga. App. 755 (1986) and explaining that routine activities were not done in anticipation of litigation but activities in response to unusual circumstances or threats of litigation qualified as anticipation of litigation)
5. *Lowe’s of Georgia, Inc. v. Webb*, 180 Ga. App. 755 (1986).
6. *Tobacco Road, Inc. v. Callaghan*, 174 Ga. App. 539 (1985).
7. *Jones v. Scarborough*, 194 Ga. App. 468 (1990).
8. If it has been modified or enhanced to be something other than just a recording of the injured worker’s activities, then this is a completely different problem.
9. See *Truitt v. Mason*, 189 Ga. App. 24 (1988) (it was improper for trial court to enter order requiring defendant to first be deposed by plaintiff before plaintiff produced transcript of traffic court proceedings).
10. Examples of such information that could be withheld could include recorded statements of any party, medical records, correspondence seeking payment of medical bills, etc.
11. *Southern Ry. Co. v. Lawson*, 256 Ga. 798, 802 (1987).
12. *Powell v. State*, 270 Ga. 327 (1998).
13. *Southern Outdoor Promotions, Inc. v. National Banner, Inc.*, 215 Ga. App. 133 (1994).

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