



# WORKERS' COMPENSATION LAW

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SECTION NEWSLETTER

## ***Ray Bell Construction Company, et. al v. King: A Perspective***

By Timothy V. Hanofee  
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On April 10, 2007, the Supreme Court of Georgia denied the Motion for Reconsideration filed relative to the decision the Court rendered on March 26, 2007, wherein they awarded death benefits to the minor child of Howard King. The denial concluded the litigation that commenced on Sept. 5, 2002, when I filed the WC-14 and requested a hearing, some four years and seven months earlier.

The Supreme Court, in a splintered 4-3 decision, affirmed the Court of Appeals, the Superior Court of Monroe County, the Appellate Division and the administrative law judge, all tribunals having found the vehicular accident and subsequent death of Howard King arose out of and in the course of his employment with Ray Bell Construction Company.

The evidence adduced at this fact-sensitive and fact-driven hearing demonstrated that King was a construction superintendent working for Ray Bell Construction Company at a construction site at the Georgia

Diagnostic and Classification Center in Jackson, Ga., (Butts County). The employer provided King with a company truck, an expense account for gas and maintenance of said truck and further provided and paid for an apartment for King in Fayetteville, Ga. King was a resident of Florida.

At the time of the vehicular accident, King was returning to either the job site in Jackson, Ga., or to the company apartment in Fayetteville, Ga. He was traveling northbound on I-75 near Forsyth, Ga., which was on a direct route to both the job site and the company apartment. He had dropped off personal belongings in a storage shed in South Georgia.

There was testimony presented at hearing that suggested King had actually picked up tools at the storage shed in

South Georgia and was bringing them back to the job site. A large toolbox in the back of the truck was removed after the accident and did indeed have tools belonging to Ray Bell Construction Company. Ray Bell Construction Company representatives took the tools back.

There was conflicting evidence as to whether King was actually returning to the job site or the company apartment in Fayetteville. King did have access to the construc-

tion site and did have keys to the construction trailer. King had worked at the job site on weekends in the past.

The administrative law judge and the Appellate Division concluded that on the day of vehicular accident resulting in King's death, King had been on a personal mission, but, had completed that mission, had turned around and was driving back to the company apartment or job site. As such, King was brought back into the scope of workers' compensation coverage.

The Supreme Court, in granting certiorari, wanted to explore whether or not "the Court of Appeals improperly

extended the continuous employment doctrine by not requiring that the employee's injury arise out of the employee's employment thereby failing to apply the two-prong test set forth in *Mayor and Aldermen vs. Stevens*, 270 Ga. 166 (598 SE 2d 456) (2004)".

The Supreme Court majority found that King was injured after he had concluded a personal mission and returned to an employment status. Further, since King was in the general proximity of the place he was employed (either the job site or company apartment), his accident and injury therefore arose both out of and in the course of his employment, thereby authorizing an award of work-

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# Comments From the Chairman

By Timothy V. Hanofee  
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As I close out my year as chair of the Workers' Compensation Law Section of the State Bar of Georgia, let me reiterate what I have stated on numerous occasions. It is a privilege and honor to have served as section chair. Frankly, it is hard to believe that "my year" is coming to an end.

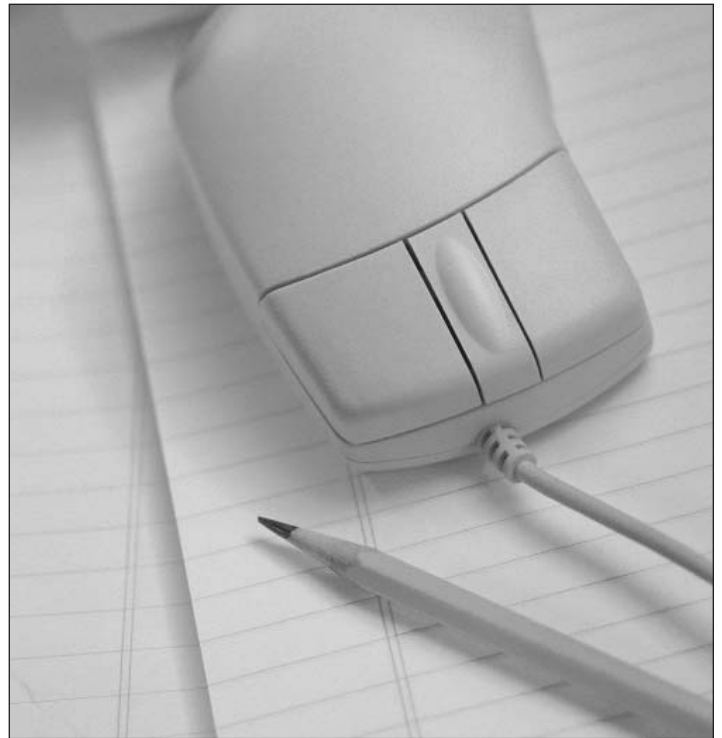
Our section continues to grow and prosper. Our membership is at an all-time high of 953, up some 34 members from just a year ago. My hope and desire is that the seasoned and grizzled veterans will assist the newer members and demonstrate to these new members that the practice of worker's compensation law, while competitive and demanding, can be civil, respectful and, most of all, ethical.

The entire frame of reference for a new lawyer is what he sees and learns from his mentors and older, more experienced adversaries. It is incumbent upon each and every one of us to respect the Bar in general, and the workers' compensation bar in particular.

The State Board of Workers' Compensation continues to make progress towards a completely paperless system. The diligence and hard work of Chairman Hall and all employees of the Board is so greatly appreciated.

Our section's continued involvement and participation in helping raise monies for Kids' Chance, and the great work Kids' Chance does towards scholarships for children of seriously injured or deceased workers in Georgia, is truly remarkable.

On June 15, 2007, I will have practiced law in the State of Georgia for 30 years. During that time, I have practiced almost exclusively in the area of workers' compensation. While my practice has changed in many ways over the years, the enthusiasm I have for the practice of law, the friendship of the claimant and defense bar and the over-



whelming willingness of the participants of our section to work together to help our system work continues to amaze me. I am fortunate to have found this area of law to practice.

As I say farewell as chair, I can state to you that the Workers' Compensation Law Section has been turned over to a capable and talented workers' compensation practitioner. Ann Bishop will take the reins of our section and I am sure lead us to new plateaus.

I thank the Workers' Compensation Law Section for allowing me to serve as its chair. **WC**

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# ICMS Update

By Liesa Gholson, Director of Process Improvement & Oversight and  
Judge David K. Imahara, Director of ADR

The State Board of Workers' Compensation (SBWC) successfully implemented the ICMS electronic document management system on Oct. 1, 2005. Great progress has been made, and close to one million documents have been scanned in the past 18 months.

## Phase 2

On Aug. 21, 2006, the Board successfully implemented ICMS Phase 2. Some of the functions for Board staff are:

- Electronic processing of mediation/hearing requests
- Automated case assignment to judges
- Electronic calendars for ADR, Hearing, and Appellate Division
- Automated scheduling of hearings/mediations
- Electronic generation of judicial orders/awards with electronic signature
- Notices of Hearing/Mediation/Oral Argument and awards/orders are being sent out by e-mail. All of these documents are sent as PDFs. In addition, as many of you have seen, we are now using electronic signatures. If an e-mail containing an order, award, notice, etc. fails, the sender at the Board is notified that such e-mail containing the order, award, notice, etc. failed. In such circumstances, the Board will mail a copy of such document.

The Board continues to work to improve the e-mail notifications going to parties of the claim and to submitters. For now, we are able to notify only the primary e-mail address submitted to the Board. Eventually, we will be able to notify alternate addressees. When Phase 3 is implemented later this year, if you are a party to a claim and are a registered user, you will be able to view the file online. E-mail addresses are required for registered users.

## The New Claim Number

The automated system generates a 10-digit Claim Number for each new claim. (e.g. 2005-001522, 2006-001523). The first four digits identify the year the claim is created at the Board (not the year of the injury), (i.e. when a Form WC-1 or WC-14 is filed). Only a Form WC-1 or Form WC-14 will actually create a new electronic file. This number is a unique identifier for the claim. The Board no longer uses Social Security numbers on notices or awards/orders. This Board claim number must appear on every form or document filed by the parties/attorneys. See Board Rule 60(c).

## Living in Two Worlds

If you have a claim file that was created prior to Oct. 1, 2005, your claim is living most likely in two worlds (paper and electronic). The Board continues to process files that

are primarily paper. Over time, we are scanning the paper files into ICMS. The data for claims created prior to Oct. 1, 2005, was migrated from the Georgia Online (GO) main-frame system to ICMS. However, that data was minimal and does not include all the information ICMS will have. If you are party to a claim created prior to Oct. 1, 2005, you may not receive e-mail notifications when documents are filed, because the parties or attorneys or record have not been recorded in ICMS.

## Format and Accuracy

Board forms have been revised to work with the new system. Every form was reviewed and revised July 1, 2005, and again July 1, 2006. ICMS uses specific data to identify the claim and process the information. The claim information must be submitted on current forms! The correct forms are those issued in July 2006, printed with "7-2006." Effective Jan. 1, 2007, the Board will return your form if it is not current. You must refile on the correct version of the form (which can be found on the SBWC website, [www.sbwc.ga.gov](http://www.sbwc.ga.gov)). One key addition to most forms is a space to enter the insurer/self-insurer's SBWC ID number. The Board issues updates to the current forms every July, so be aware that new form changes will arrive soon! It is imperative that you stay current with the Board forms. Do NOT alter the Board forms. See Board Rule 61(b)(64); Board Rule 102(A)(3). Do not change fields to reflect something other than what is on the form.

If you are not sure which form to use, refer to the forms and Board Rules, and in particular Board Rule 61(b), at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov). You must use the proper form to report the information. If sufficient space does not exist on a form, do not alter the form. Instead, attach a supporting document. For example, if more parties exist than is possible to list on a Form WC-14, attach a piece of paper showing all the correct parties to a claim.

If the information is not completed sufficiently for processing on a form, it will be returned. The WC-1 is the most critical. The form must identify the employer, the insurance carrier or self-insured entity, as well as the claims office handling the claim. Please always complete the section for SBWC ID number that identifies the carrier or self-insured entity. See Board Rule 61(b)(1). This number can be located in an alphabetical listing at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov). Please note that the Board is rejecting Form WC-1s if sections B, C, or D are not filled out. Finally, when paper forms are sent to the Board, they are scanned into the ICMS system. Data on the form must be printed clearly and must be dark enough to be scanned correctly. (Faxes do not scan well!) If the information is not clear and dark, effective Jan. 1, 2007, the form will be returned.

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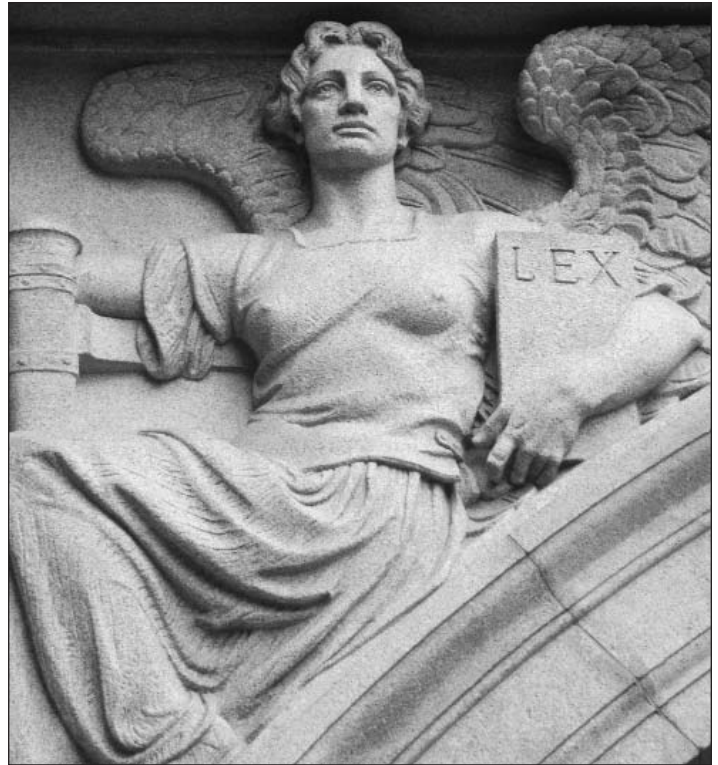
# Case Law Update

By E. Lee Southwell  
Chief Staff Attorney, State Board of Workers' Compensation

***Korner v. Education Management Corporation*,  
281 Ga. App. 322 (2006)**

The case of *Korner v. Education Management Corporation*, 281 Ga. App. 322 (2006), deals with an issue of whether suitable employment was available. In that case, the employee worked as a counselor at a youth development center. She was assaulted by one of the students and suffered physical and psychological injuries. The physical injuries healed quickly, but the psychological affects of these injuries lingered. The employee received temporary total disability benefits. The employer/insurer sought to suspend those benefits based on a change in condition. They contended that the employee was able to perform some work and that work suitable to her condition was available. At the initial hearing, both sides presented vocational experts. The employee's expert testified that, although employee was able to do some work, there was no work suitable to her condition available and reasonably accessible to her. The expert based the opinion on a review of the employee's medical records, a labor market survey, and a personal interview with the employee. The employer/insurer's expert testified that suitable work was available. This expert also reviewed medical records and performed a labor market survey, but did not speak personally with the employee. One of the jobs which was identified as suitable to employee's condition was counseling foreign students, although employer/insurer's expert did not know that the assault that gave rise to this claim was committed by a foreign student. Most of the other jobs that were identified as suitable were in the sales and marketing fields and required background and experience that the employee did not possess. Nevertheless, the administrative law judge gave more credence to the employer/insurer's expert and found that a change in condition for the better had occurred because suitable work was available.

The Appellate Division reversed, holding that the employer/insurer's expert was not persuasive. This finding was based on the fact that the employer/insurer's expert had not spoken with the employee, did not know that a foreign student had committed the assault, and identified as suitable-for-the-employee jobs that required background and experience that she did not possess. On appeal, the Superior Court reversed and reinstated the administrative law judge's decision. The Court of Appeals granted discretionary appeal and reversed the Superior Court. The Court of Appeals ruled that the Appellate Division's decision should have been affirmed based on the any evidence rule. The Appellate Division was authorized to find that employer/insurer's expert was not persuasive, even though the administrative law judge had found otherwise. The employer/insurer complained that their expert could not



conduct a personal interview with the employee, because that expert was not a principal rehabilitation supplier, medical case manager, or direct employee of the employer or insurer and was thus prohibited by Board rules from making direct contact with a person who was represented by counsel. The Court of Appeals responded that the employer/insurer chose their witness and brought any problems that choice created on themselves.

***Vought Aircraft Industries v. Faluds*,  
281 Ga. App. 338 (2006)**

The case of *Vought Aircraft Industries v. Faluds*, 281 Ga. App. 338 (2006), involves a credit issue pursuant to § 34-9-243 and *res judicata*. In that case, there was an initial hearing in 2002 to determine whether Faluds suffered a compensable injury. At the beginning of that hearing, the first administrative law judge stated that she would not rule on employer/insurer's request for a credit for 20 weeks of disability benefits previously paid to Faluds, because the request was not timely filed pursuant to Board Rule 243. This action was interpreted as a refusal to rule by the majority of subsequent courts. For the most part, the allegation that the credit issue was specifically reserved for decision at a later time was not recognized. After the initial hearing, the first administrative law judge found that Faluds had suffered a compensable injury to his right elbow. No appeal was taken from that award, and it became final. This claim was subsequently designated as catastrophic.

In 2005, Vought requested a hearing to determine a change in condition, a redesignation with regard to catastrophic status, and a determination of the credit issue. The second administrative law judge denied all requests. That judge interpreted the first judge's action as a refusal, not a reservation, and found that her ruling on the credit issue, i.e., no credit was due, was *res judicata*. The Appellate Division reversed only on the credit issue. The Appellate Division found that the first administrative law judge's action was a reservation of the issue, not a refusal to rule and a ruling on the merits. In all other respects, the Appellate Division adopted the award of the second administrative law judge. On appeal, the Superior Court affirmed the Appellate Division decision on all issues except credit. On that issue, the Superior Court reversed and ruled that no credit was due. The Court of Appeals granted discretionary appeal, and ruled only on the credit issue. The Court of Appeals also interpreted the first administrative law judge's action as a refusal and ruling on the merits, although the court did not specifically so state, and ruled that the decision not to grant credit in the first award was *res judicata*. Because the court did not speak to the issue of whether or not the credit question was specifically reserved for decision later, this case cannot be interpreted as approving or disapproving that procedure. The decision of the Court of Appeals is based strictly on its interpretation of the first administrative law judge's actions. It also puts more teeth in the decision of *City of Atlanta v. Webb*, 228 Ga. App. 278 (1997), and once again demonstrates that a final award is a powerful thing.

***Goswick v. Murray County Board of Education*, 281 Ga. App. 442 (2006)**

It had long been believed that Code § 34-9-200 only dealt with the consequences of failure or refusal to cooperate with authorized medical treatment while Code § 34-9-202 dealt only with the scheduling of and refusal to cooperate with independent medical examinations. As the case of *Goswick v. Murray County Board of Education*, 281 Ga. App. 442 (2006), points out, the word "independent" does not appear anywhere in Code § 34-9-202.

In that case, the employee suffered a compensable injury and received benefits. He also received medical treatment for an extended period but had not attended any medical appointment for a substantial length of time. The employer/insurer, wishing to obtain current medical information, scheduled an examination with the authorized treating physician. This examination was scheduled pursuant to Code § 34-9-202. The employee, based on the advice of counsel that Code § 34-9-202 did not apply to authorized treating physicians, refused to attend. An administrative law judge, following a hearing, ordered him to attend the examination. He again refused, still contending that Code § 34-9-202 did not apply to authorized treating physicians. At a second hearing, the same administrative law judge who had conducted the first hearing ordered a suspension of income benefits for failure to attend an independent medical examination. The Appellate Division adopted the second award. The Superior Court and the Court of Appeals affirmed. The Court of Appeals pointed out that

Code § 34-9-202 did not limit itself, by its terms, to independent medical examinations. It referred to examinations by duly licensed physicians. The court pointed out that the authorized treating physician would fall into this category. Therefore, the so-called independent medical examination contemplated by Code § 34-9-202 can be performed by the authorized treating physician. This authority is in addition to the authority pursuant to Code § 34-9-200 to order employees to cooperate with medical treatment from authorized treating physicians. The Court of Appeals found it irrelevant that the employee's injury occurred before a 2003 amendment to Code § 34-9-200(c) became effective. The court pointed out that amendments regarding ongoing medical treatment were procedural, and that it made no sense to lock in the rules in effect at the time of the original injury when the changes only dealt with the method by which treatment was delivered. The court rejected employee's argument that he had to refuse to comply with the administrative law judge's first order in order to be able to litigate the issue of whether Code § 34-9-202 applied to authorized treating physicians. The court pointed out that this question could have been raised on an appeal from that order.

***Cypress Insurance Company v. Duncan*, 281 Ga. App. 469 (2006)**

The greatest significance of *Cypress Insurance Company v. Duncan*, 281 Ga. App. 469 (2006), is procedural. In that case, Duncan began working at a restaurant owned by a family member. Later business arrangements, including a lease of the premises with option to buy, created confusion as to whether Duncan was an employee or an owner. After she suffered what would have been a compensable injury if she were an employee, the issue was raised that she was part of a partnership and was therefore an owner. As a partner, she could not have been an employee. After a period of disability, Duncan allegedly returned to work.

At the initial hearing, the administrative law judge made several rulings. First, he ruled that Duncan was not a member of a partnership, was not an owner, and was an employee. He further found that she had indeed returned to work and thus had been overpaid temporary total disability benefits. He found the employer/insurer were entitled to reimbursement or credit for this overpayment. Even though the issue of permanent partial disability had not been stated as an issue to be tried at the hearing, the administrative law judge found that a permanent partial disability existed, and ordered the credit for overpaid temporary total disability benefits be taken against permanent partial disability benefits. The Appellate Division adopted the award, and the Superior Court affirmed. On appeal, the Court of Appeals affirmed for the most part. The Court of Appeals agreed that Duncan was an employee and not a partner/owner. The court also ruled, pursuant to the any evidence rule, that she had returned to work and been overpaid temporary total disability benefits. Because employer/insurer had no notice that the issue of permanent partial disability would be tried at the initial hearing, the administrative law judge's ruling on this issue was a violation of due process. The Court of Appeals reversed on this issue and remanded the case for a

hearing on the issue of the existence and extent of permanent partial disability and credit.

***Metropolitan Atlanta Rapid Transit Authority v. Reid*, 282 Ga. App. 877 (2006)**

If an employer chooses to provide medical treatment for compensable injuries through a Workers' Compensation Managed Care Organization (WC/MCO), Board Rule 208 provides that questions with regard to change of physician within the organization will be initially handled through the organization's internal dispute resolution procedures. Code § 34-9-200(b), which contains the general authority of the Board to order a change of physician, does not contain an exception for WC/MCO's. This fact became critical in *Metropolitan Atlanta Rapid Transit Authority v. Reid*, 282 Ga. App. 877 (2006). In that case, the employee suffered a compensable injury and received treatment through his employer's WC/MCO. He became dissatisfied with the treatment he was receiving, and applied to the Board for a change of physician. He did not first proceed through the WC/MCO's internal dispute resolution procedures. The documents the employee filed with the Board consisted of a motion, one page of argument, and more than 200 pages of medical documents. (It is possible that this case inspired the 50-page limit on motions for change of physician and responses now found in Board Rule 200(b).) MARTA was only served the motion and argument pages. For reasons unknown, they did not receive the medical records. MARTA objected to the request, and filed a copy of the WC/MCO's internal dispute resolution procedures with its response. The administrative law judge granted the request for change of physician. In his decision, the administrative law judge referenced some of the medical records which MARTA had not received. MARTA filed a motion for reconsideration based on inadequate service and violation of due process, and filed an appeal to the Appellate Division at the same time. The administrative law judge did not rule on the motion for reconsideration. The Appellate Division adopted the administrative law judge's decision. In doing so, the Appellate Division rejected MARTA's arguments with regard to the controlling nature of the WC/MCO's internal dispute resolution procedures. MARTA appealed to the Superior Court. When the Board's record was transmitted, it was discovered that the medical records attached to the initial motion had disappeared. These records were reconstructed, and the record on appeal was supplemented. The Superior Court affirmed, rejecting MARTA's due process argument and their contention as to the controlling nature of the WC/MCO's internal dispute resolution procedures. MARTA also complained about a statement in the Appellate Division's award that the administrative law judge did not rule on the motion for reconsideration based on an unwritten internal Board policy that once an appeal was filed, the administrative law judge lost jurisdiction to reconsider the award.

On appeal, the Court of Appeals affirmed, and made a statement with regard to the conflict between rules, written or unwritten, and statutes. First, the conflict which the court addressed was that between Board Rule 208 and

Code § 34-9-200(b). Although the rule does provide that the issue of change of physician within a managed care organization is first dealt with through that organization's internal dispute resolution procedures, the court pointed out that Code § 34-9-200(b) is controlling. That code section gives the Board general authority to order a change of physician in any case, subject to certain procedural requirements. It does not contain an exception for managed care organizations. Thus, the written rule is in conflict with a statute. When a rule is in conflict with a statute, the statute controls. With regard to the unwritten Board policy on motions for reconsideration, the outcome was the same. The court pointed out that Code § 34-9-103(b) allows the Board or any administrative law judge to amend an award to correct apparent errors. (Case law has held that this correction must be accomplished within the time allowed for appeal.) The code section also provides that the administrative law judge may amend an award to correct an apparent error, even if an appeal from the original award has already been filed. Thus, the unwritten policy is in conflict with a statute. When an unwritten policy is in conflict with a statute, the statute controls.

***Bayer Corporation v. Lassiter*, 282 Ga. App. 346 (2006)**

The case of *Bayer Corporation v. Lassiter*, 282 Ga. App. 346 (2006), involves a tragic situation. In that case, the employee initially suffered injuries in a compensable automobile accident. These injuries included back and leg injuries. The employee also developed severe tinnitus (ringing in the ears) following the accident. It was ultimately found that this condition was also caused by the accident. The tinnitus eventually became so severe that the employee told his wife not to let him make any decisions because he did not trust his judgment. There were also times when he would step outside the house and start his leaf blower in order to find something which would make enough noise to drown out the ringing in his ears. A hearing had been requested with regard to compensability of the accident, but before the hearing could take place, Lassiter committed suicide. His wife substituted herself as the claiming party both on behalf of his estate for temporary total disability benefits due prior to his death, and for death benefits for herself. The hearing record contained evidence from a psychiatrist who normally testifies on behalf of employers and insurers. This psychiatrist testified that the tinnitus was related to the original accident and injuries resulting therefrom. He further testified that Lassiter's judgment was so impaired that at the time he committed suicide, it could not be said that the act, although purposeful, was intentional. He further testified that the tinnitus caused the impaired judgment and led directly to the suicide. Based on this evidence, the administrative law judge found the original accident and the death both compensable. The Appellate Division adopted, and the Superior Court and the Court of Appeals affirmed. The Court of Appeals pointed out that, based on the evidence presented, it was correct to say that the act of committing suicide in this case was not intentional and was not willful misconduct. The court specifically stated that the stricter standard which applies in tort cases, and which employer/insurer argued

required denial of this death claim, was irrelevant in the workers' compensation field.

***Freeman v. Barnes*, 282 Ga. App. 895 (2006)**

The case of *Freeman v. Barnes*, 282 Ga. App. 895 (2006), arose out of the Fulton County courthouse shooting in 2005. The widow of the Superior Court judge who was one of the victims filed a wrongful death action against the county sheriff and a number of his deputies, alleging negligent security practices. The sheriff moved to dismiss on a number of grounds, including the exclusive remedy of workers' compensation. The trial court rejected the exclusive-remedy claim. On appeal, the Court of Appeals affirmed, but on a split decision. Two judges ruled that according to the state constitution, a Superior Court judge is an employee of the state, not of the county in which his or her court is situated. These judges also treated the terms "employee" and "official" as interchangeable. Also based on the state constitution, they ruled that the sheriff is an employee of the county in which he or she serves. Therefore, the judge and the sheriff were not employees of the same employer and the exclusive remedy of workers' compensation did not apply. It was pointed out that the widow was receiving death benefits under the workers' compensation law from the State of Georgia. It was further pointed out that Fulton County had attempted to pay the funeral expenses and treat this case as a workers' compensation claim, but these efforts had been rejected. These two judges stated that an employer cannot, by its actions, convert a claim that is not a workers' compensation claim into such a claim merely by attempting to pay benefits. One judge concurred in the result, but for different reasons. He did not treat the terms "employee" and "official" as interchangeable. He stated that the definition of "employee" in Code § 34-9-1(2) included state employees, but not state officials, and further stated that the two were not the same. He also stated that a Superior Court judge is not subject to the right of anyone to control the time, manner, and method of his or her performance of duties. Therefore, it is difficult to say that a Superior Court judge is an employee of anyone. For this reason, the exclusive-remedy provision of the workers' compensation law did not apply in this case. Because of the division in the panel, this case is physical precedent only and is only as persuasive as a future court wants it to be.

***Putzel Electrical Contractors v. Jones*, 282 Ga. App. 539 (2006)**

Code § 34-9-281 contains a special provision regarding the time limit for filing claims based on asbestos-related occupational diseases. According to that provision, a claim for asbestosis, mesothelioma, or asbestos-related cancer must be filed within one year after the first date of disability following diagnosis. The case of *Putzel Electrical Contractors v. Jones*, 282 Ga. App. 539 (2006), holds that both of these events must occur before the time limit begins to run, and that it does not matter in which order they occur. In that case, the employee was performing building renovation work in 1992. In the process of doing this work, he discovered what he believed was asbestos.

He reported this discovery, and an asbestos-abatement team was called in. The suspicious material was removed. There was testimony from the employee and from other people who had seen the material and who would recognize asbestos when they saw it that the material was indeed asbestos. Scientific testing to confirm this sighting was not done. The employee began suffering lung problems. As early as 1994, doctors began to be suspicious that he might have been exposed to asbestos. No definitive diagnosis was made in 1994 or at anytime prior to May 2003. The employee became disabled in 1994. He filed his claim in September 2003. The employer disputed the claim on a number of grounds. First, they contended that there was no proof that the material was asbestos. Second, they contended that the claim was time-barred. Following a hearing, the administrative law judge found the testimony that the material was asbestos sufficient to establish this fact. The administrative law judge also ruled that the time limit did not begin to run until July 2003 because the two events of diagnosis and disability did not come together until that time. On appeal, the Appellate Division basically adopted, but made a slight amendment. The Appellate Division found that the first diagnosis was in May 2003 and that the two events, disability and diagnosis came together at that time. The time limit for filing the claim began to run in May 2003, and the claim filed in September 2003 was timely. The Superior Court affirmed, as did the Court of Appeals. The Court of Appeals quickly disposed of the issue of whether the material was asbestos based on the any evidence rule. The Court of Appeals spent the rest of an extensive opinion ruling on the issue of when the time limit began to run. The court ruled that the word "diagnosis" in Code § 34-9-281 meant a definitive diagnosis, not a mere suspicion. The Court of Appeals also ruled that the two events, disability and diagnosis, had to be in existence at the same time in order for the time limit to begin to run. It did not matter which event occurred first. Although the Court of Appeals did not speak to this issue, it appears that the limitation contained in Code § 34-9-281 that disability from an occupational disease must manifest itself within seven years of the last injurious exposure to the hazard of the disease does not apply in asbestos cases, because the language with regard to asbestos is placed after the seven-year language.

***Cook v. Prehistoric Ponds, Inc.*, 282 Ga. App. 904 (2006)/*Gill v. Prehistoric Ponds, Inc.*, 280 Ga. App. 629 (2006)**

The case of *Cook v. Prehistoric Ponds, Inc.*, 282 Ga. App. 904 (2006), is a companion to *Gill v. Prehistoric Ponds, Inc.*, 280 Ga. App. 629 (2006). Both cases involved the same issue of whether an alligator farm is a farm so that the workers' compensation law does not cover workers there. The Court of Appeals ruled in both cases that alligators are not livestock subject to regulation by the Department of Agriculture, but are game animals subject to regulation by the Department of Natural Resources. Both cases hold that an alligator farm is not a farm for workers' compensation purposes and that people who work there are covered under the workers' compensation law.

***Fallin v. Merritt Maintenance & Welding, Inc.*, 283 Ga. App. 485 (2007)**

The case of *Fallin v. Merritt Maintenance & Welding, Inc.*, 283 Ga. App. 485 (2007), dealt with the issue of whether a notice to controvert which was invalid as to compensability of a claim could allow an employer/insurer to raise the issue of a change in condition for the better. In that case, the employee suffered a compensable back injury on Nov. 13, 1998. The employer/insurer accepted this claim as compensable and began paying income benefits on Dec. 17, 1998. Although late payment penalties were due at that time, none were paid. Payment of benefits continued until the employer/insurer suspended them and filed a notice to controvert based on their allegation that the employee had undergone a change in condition for the better as of Nov. 1, 1999. The employee contended that the employer/insurer were legally barred from making this contention because they had not paid all income benefits due at the time they filed their notice to controvert. Following a hearing, the administrative law judge ruled that the notice to controvert was invalid pursuant to O.C.G.A. § 34-9-221 (h) with respect to the issue of whether the employee had suffered a compensable injury. This invalidity resulted from the fact that all income benefits due, including penalties, had not been paid at the time the notice to controvert was filed. The administrative law judge further ruled that the fact that the employer/insurer were barred from contesting compensability of the original claim did not mean that they were not allowed to contend that a change in condition for the better had occurred. The administrative law judge further ruled that employer/insurer had proved that such a change had indeed taken place. The Appellate Division, the Superior Court, and the Court of Appeals affirmed. The Court of Appeals noted that because income benefits had been paid for more than 60 days from the due date of the first payment, the employer/insurer could only controvert compensability of the original claim on the grounds of change in condition or newly discovered evidence pursuant to O.C.G.A. § 34-9-221 (h). According to the case of *Cartersville Ready Mix v. Hamby*, 224 Ga. App. 116 (1996), the employer/insurer were not allowed to controvert liability for the original claim on the basis of newly discovered evidence because all income benefits, including penalties, had not been paid at the time the notice to controvert was filed. No such issue was presented in this case, because no one was contending that newly discovered evidence existed. The Court of Appeals pointed out that O.C.G.A. § 34-9-221 (i) applied when an employer/insurer were not controverting the compensability of an original claim but were controverting continued liability for payment of income benefits based on a change in condition. The *Hamby* case, *supra*, did not apply to O.C.G.A. § 34-9-221 (i). Therefore, even though the employer/insurer in this case could not controvert compensability of the original claim, they were allowed to present evidence to show that a change in condition for the better had occurred.

***Reid v. Georgia Building Authority*, 283 Ga. App. 413 (2007)**

The case of *Reid v. Georgia Building Authority*, 283 Ga.

App. 413 (2007), dealt with the issue of whether a claim was catastrophic. In that case, the employee was a custodian employed by the Georgia Building Authority. She suffered a compensable injury to two fingers of her dominant right hand. She sought to have her injury designated catastrophic. Following a hearing, an administrative law judge designated the claim catastrophic and the Appellate Division agreed. On appeal, the Superior Court reversed based on a total lack of evidence in the record to support a determination that the claim was catastrophic. The Court of Appeals granted discretionary appeal and affirmed the Superior Court. The Court of Appeals acknowledged that findings of fact in a Board award must be affirmed if there is any evidence in the record to support them.

Nevertheless, the court found that there was no such evidence in this case. First, the court pointed out that the employee violated Court of Appeals rules by failing to cite the portions of the record that supported his statement of facts in his brief. The Court of Appeals pointed out that this failure alone could have led to dismissal of the appeal, but because the record was short, the court exercised its discretion and made its own review of the record to determine whether evidence existed. The court pointed out that employee was attempting to prove that she could not return to her former employment and that she could not return to work which was available in substantial numbers in the national economy. The court stated that she did prove that she could not return to her former employment. There was nothing in the record to indicate that she could not return to work that was available in substantial numbers in the national economy. The only testimony in the record from the employee was that she had looked for work. She did not testify at the hearing as to where she looked for work, how many places she looked for work, and the nature of the work she sought. The employee's attorney argued that she had testified that she looked for work within her restrictions at at least six places and was not hired, but that evidence was in deposition transcripts that were not part of the record before the Court of Appeals. Therefore, the Court of Appeals could not consider this "evidence." The employee did not present a vocational expert to testify as to the unavailability of work in substantial numbers in the national economy for which she was otherwise qualified. The administrative law judge found that because of the employee's advanced age, limited education, lack of other skills, and the fact that she had done custodial work for virtually all of her working life demonstrated that there was not work available in substantial numbers in the national economy for which she was otherwise qualified. The Court of Appeals pointed out that there was no testimony or other opinion evidence in the record to support this conclusion, and found that the administrative law judge used his own personal experience in reaching this conclusion. The court ruled that the Board did not have the authority to use personal knowledge and experience in deciding a case. This last holding is probably the most important aspect of this case. This case also raises, but does not answer, the interesting question of whether evidence of a diligent but unsuccessful job search which would allow an inference of total disability to be



drawn pursuant to *Maloney v. Gordon County Farms*, 265 Ga. 825 (1995) in order to establish a change in condition for the worse, would also be sufficient to establish that an employee is not able to perform jobs available in substantial numbers in the national economy for which he or she is otherwise qualified. That determination awaits further litigation.

***TIG Specialty Insurance Company v. Brown.*, 283 Ga. App. 445 (2007)**

The case of *TIG Specialty Insurance Company v. Brown.*, 283 Ga. App. 445 (2007), involves the issue of whether a fictional new accident occurred when insurance coverage changed after the date of the original accident but before the date of the fictional accident. In that case, the original accident occurred in December 2000 when TIG was providing workers' compensation insurance coverage. Zenith Insurance Company assumed workers' compensation coverage in February 2002. The employee did not miss any time from work as a result of the December 2000 accident until May 2002. Despite the fact that coverage had changed by that time, TIG began paying income benefits in May 2002. In February 2004, TIG requested a hearing to determine whether Zenith should reimburse it for payments made after the effective date of Zenith's coverage. Both Zenith and the employee moved to dismiss the hearing request pursuant to O.C.G.A. § 34-9-221 (h), contending that payment had continued for too long to allow TIG to contest liability. The administrative law judge denied the motions, but the Appellate Division found that O.C.G.A. § 34-9-221 (h) prohibited TIG from contesting liability. The Superior Court affirmed, and the Court of Appeals granted discretionary appeal. The Court of Appeals reversed. The Court of Appeals found that there was no issue in this case as to whether someone owed benefits to the employee. The only issue was which insurer should pay those benefits. The court of appeals found that this case was controlled by *Columbus Intermediate Care Home v. Johnston*, 196 Ga. App. 516 (1990). In that case, as in this one, the first insurer began paying income benefits as if a change in condition for the worse had occurred, but later determined that a fictional new accident had occurred at a time when a subsequent insurer was on the risk. The only difference between the two cases was that the erroneous payment continued for only six months in *Johnston*, *supra*, before the error was discovered and a hearing was requested, while in this case the erroneous payment continued for nearly two years. This distinction did not make a difference. The Court of Appeals ruled that in both cases the only issue was which insurer was responsible for the claim. There was no issue that there was a compensable claim. When there was no issue that there was a compensable claim for which someone was responsible, the time limit in O.C.G.A. § 34-9-221 (h) did not apply. As long as all parties agreed that someone owes benefits, the issue of who owes the benefits can be raised at anytime. The Court of Appeals remanded this case to the Board so that the administrative law judge could hold a hearing and determine which insurer owes benefits to the employee.

## Certiorari

There is some news on the certiorari front. The Supreme Court has denied certiorari in *Gill v. Prehistoric Ponds, Inc.*, 280 Ga. App. 629 (2006); *Caswell, Inc. v. Spencer*, 280 Ga. App. 141 (2006); *Korner v. Education Management Corporation*, 281 Ga. App. 322 (2006); *Goswick v. Murray County Board of Education*, 281 Ga. App. 442 (2006); *Freeman v. Barnes*, 282 Ga. App. 895 (2006), and, probably most surprisingly, *Rite-Aid Corporation v. Davis*, 280 Ga. App. 522 (2006).

***Reliance Electric Company v. Brightwell*, Ct. App. No. A06A1665, decided Feb. 19, 2007**

O.C.G.A. § 34-9-221(i) provides that when an employer/insurer suspend payment of income benefits on the basis of a change in condition, they must give the employee 10 days' advance notice of their intent to do so. The Court of Appeals has now spoken to the issue of the consequences of failure to give a full 10 days' notice. In *Reliance Electric Company v. Brightwell*, Ct. App. No. A06A1665, decided Feb. 19, 2007, the employee suffered a carpal tunnel injury that the employer/insurer accepted as compensable. They began paying income benefits and medical expenses. Based on a medical opinion that employee was able to return to work without restrictions as of July 25, 2003, the employer/insurer issued a Form WC-2 dated July 29, 2003, that stated that employee's income benefits would be suspended as of Aug. 10, 2003. This form was not filed with the Board until Aug. 4, 2003. Therefore, the employee received only six days' notice of employer/insurer's intent to suspend her income benefits, not the 10 days required by O.C.G.A. § 34-9-221(i) and Board Rule 221(i). The employee did not request a hearing to challenge the suspension of her income benefits until May 2004. The hearing was held in January 2005, and the administrative law judge issued an award in March 2005. That award determined that employee had indeed undergone a change in condition for the better and was able to return to work without restrictions as of July 25, 2003. Nevertheless, because of employer/insurer's failure to give a full 10 days' notice of suspension of employee's income benefits, the administrative law judge ordered them to reinstate income benefits as of Aug. 11, 2003, and continue paying them until the date of his award in March 2005.

On appeal, the Appellate Division basically agreed with the administrative law judge, but found that suspension of payment of income benefits was authorized as of the date of the hearing in January 2005 rather than the date of the administrative law judge's award. The Superior Court affirmed, but the Court of Appeals reversed. The Court of Appeals noted that Board Rule 221(i) provides that the employer/insurer must file notice with the Board that they intend to suspend payment of income benefits and serve a copy of that notice on the employee. That rule further provides that, in the absence of compelling evidence to the contrary, the date the form is filed with the Board is the date the Board marks it "Received" and the date the form is filed with the Board is the date notice is served on the employee. The Court of Appeals held that the 10-day notice period begins to run on the day the form is filed

with the Board, not the day it is sent out by the employer/insurer. In this case, notice of intent to suspend payment of income benefits was only given six days in advance of the event. There were no other defects in the notice. Under these circumstances, the Court of Appeals held that the only income benefits the employee was entitled to receive were those which covered the four days necessary to complete the notice period. There were other possible consequences, however. If the employee requested a hearing to challenge the premature suspension of income benefits, the employee could also seek late payment penalties and assessed attorney's fees if it was determined that the failure to give proper notice was without reasonable grounds. The court based this holding on *Sadie G. Mays Memorial Nursing Home v. Freeman*, 163 Ga. App. 557 (1982). The notice in the *Brightwell* case was actually better than the notice given in the *Freeman* case. In *Freeman*, the notice gave the wrong reason for a suspension based on a change in condition for the better "actual return to work [which did not happen] as opposed to ability to return to work without restrictions" in addition to suspending payment of income benefits prematurely. The *Freeman* court held that this failure did not deprive the employer/insurer of the right to prove a change in condition for the better on the merits if their action was challenged at a hearing. In *Brightwell*, the notice gave the right reason for suspension based on a change in condition and the only defect was the premature suspension of payment of income benefits. The Court of Appeals in *Brightwell* distinguished *Russell Morgan Landscape Management v. Velez-Ochoa*, 252 Ga. App. 549 (2002). In that case, in addition to suspending income benefits prematurely, the notice gave a reason (failure to cooperate with medical treatment) which had nothing to do with a change in condition for the better. It was not until the hearing before the administrative law judge that the employee knew that the real reason the employer/insurer sought to suspend payment of income benefits was an alleged change in condition for the better. Under these circumstances, the employee could not fairly be said to know the reason why employer/insurer was seeking to suspend his benefits until the hearing. Due process required that employee know the real reason. Under these circumstances, the Board (administrative law judge and Appellate Division) was correct in requiring that income benefits be paid from the date of suspension to the date of the hearing even though the employer/insurer were able to prove at the hearing that a change in condition for the better had actually occurred as of the date of the original suspension of income benefits. Inasmuch as the notice in *Brightwell* was based on the right reason, and the only defect was a failure to give a full 10 days' notice, the employee was only entitled to payment of four additional days of income benefits and was allowed to request a hearing to seek imposition of penalties and assessed attorney's fees if she could prove entitlement to them. The Court of Appeals therefore reversed the judgment of the Superior Court and remanded the case to the Board for further proceedings.

***Wal-Mart Stores, Inc. v. Parker*,  
283 Ga. Sapp. 708 (2007)**

The case of *Wal-Mart Stores, Inc. v. Parker*, 283 Ga. Sapp. 708 (2007), deals with procedural aspects of appeals pursuant to O.C.G.A. 34-9-105. That code section requires that the Superior Court hold a hearing on a workers' compensation appeal within 60 days after the appeal is docketed with the court, unless the original hearing is continued by order of the court to a date certain beyond the 60-day period and the order is entered within the 60-day period. After a hearing is held, the Superior Court must issue an order disposing of the appeal within 20 days of the hearing. If the court fails to meet any of these deadlines, the Board's decision stands affirmed by operation of law. In addition to the duties imposed by O.C.G.A. § 34-9-105(b) the Superior Court judge has other duties. O.C.G.A. § 15-6-21 requires the trial judge to send notice of his or her decision to the losing party so that that party might prepare an appeal if it sees fit to do so. If the judge fails to meet the requirements of O.C.G.A. § 15-6-21, there is a remedy for the losing party. That remedy is to have the original judgment set aside pursuant to O.C.G.A. § 9-11-60(g) and then reentered with proper notice given so that the losing party might prepare an appeal. *Cameron v. Canal Insurance Company*, 246 Ga. 147 (1980). In the *Parker* case, the employee filed a claim for benefits and was originally awarded income and medical benefits by an administrative law judge. The Appellate Division adopted and amended the administrative law judge's award, and did not grant as many benefits as the administrative law judge did. The employee appealed to the Superior Court. The appeal was docketed on Aug. 5, 2005. The Superior Court heard oral argument on Sept. 6, 2005. The Superior Court entered an order reversing the decision of the Appellate Division and reinstating the decision of the administrative law judge on Sept. 26, 2005. The Superior Court judge did not, personally or through the clerk's office, give the employer/insurer notice of this decision. The employee's attorney discovered that judgment had been entered less than thirty days after Sept. 26, 2005, but did not inform employer/insurer's attorney of this fact until more than thirty days after Sept. 26, 2005. The employer/insurer filed a motion with the Superior Court pursuant to O.C.G.A. §§ 15-6-21 and 9-11-60(g) to have the Sept. 26, 2005, order vacated and reentered with proper notice so that they might prepare an application for discretionary appeal to the Court of Appeals. The Superior Court ruled that if it vacated the Sept. 26, 2005 order, the Board's decision would become affirmed by operation of law pursuant to O.C.G.A. § 34-9-105(b) and denied the motion. The Court of Appeals granted employer/insurer's application for discretionary appeal from the denial of their motion. On appeal, the Court of Appeals reversed. The Court of Appeals stated that O.C.G.A. § 34-9-105(b) needed to be strictly construed. Under a strict construction, that section provided for an affirmance by operation of law only if at least one of its deadlines was not met. It did not speak to the situation in which all deadlines were met, but other notice requirements were not. The Court of Appeals held that if all of the deadlines in O.C.G.A. § 34-9-105(b) were

met, but the requirements of O.C.G.A. § 15-6-21 were not met, the losing party was not left without a remedy. The Superior Court was authorized to set aside the original order pursuant to O.C.G.A. § 9-11-60(g) and then reenter it with proper notice given so that the losing party could prepare an appeal. If all of the deadlines set forth in O.C.G.A. § 34-9-105(b) had been met, but the notice requirements of O.C.G.A. § 15-6-21 had not, the Superior Court could set aside the original order and reenter it without losing jurisdiction over the appeal. The time for filing an application for discretionary appeal would begin to run upon reentry of the judgment.

***Caremore, Inc./Woodhill Nursing Home v. Hollis*, 283 Ga. App. 681 (2007)**

The case of *Caremore, Inc./Woodhill Nursing Home v. Hollis*, 283 Ga. App. 681 (2007), decided Feb. 22, 2007, contains a number of rulings. The most interesting one probably deals with Board Rule 205, while the most important one probably deals with the calculation of average weekly wage. In that case, the employee sustained a low back injury that the employer/insurer accepted as compensable. They began paying income benefits and medical expenses, although they did not file any forms with the Board (First Report of Injury, Notice of Payment, or Wage Statement). The employee contended that she also injured her hip in the same accident. Her treating physician wanted to refer her to another doctor for evaluation to determine whether the hip problems were related to the back injury. He sent a Form WC-205 to the employer/insurer requesting pre-approval of this referral. The employer/insurer did not respond within five days, as required by Board Rule 205, but did respond after 14 days and denied authorization. These events occurred in March 2004. In August 2004, the employer/insurer did authorize the referral. A hearing was scheduled in January 2005. In lieu of a hearing, the parties submitted stipulated facts and briefs to the administrative law judge. The issues before the administrative law judge were the employer/insurer's liability for civil penalties and the correct amount of the employee's average weekly wage. With respect to the average weekly wage issue, the parties stipulated that the employer provided meals to the employee at a subsidized rate. The employee was required to pay \$1 for each meal, while the meals were valued at \$4, resulting in a net benefit of \$3 per day and \$15 per week. The employer/insurer also challenged the validity of the time limit contained in Board Rule 205 as being beyond the rule-making power of the Board. The administrative law judge imposed civil penalties for employer/insurer's failure to file any forms with the Board and their failure to make a timely response pursuant to Board Rule 205. The administrative law judge also increased the employee's average weekly wage by the amount of the meal subsidy. The Appellate Division, the Superior Court, and the Court of Appeals affirmed. The Court of Appeals refused to rule on the challenge to the validity of Board Rule 205 because the employer/insurer's authorization of the evaluation of employee's hip injury prior to the hearing before the administrative law judge rendered that issue moot. The Court of Appeals then went on to rule on the issue of

whether civil penalties were properly imposed. The court ruled that they were. The court held that the imposition of civil penalties was proper for employer/insurer's multiple procedural violations in this case. It is interesting to note that the Court of Appeals included failure to make a timely response to the Form WC-205 as one (although by no means the only one) of these violations. On the average weekly wage issue, the employer/insurer argued that, because Board Rule 260(a) only mentions housing, food, and other benefits furnished to an employee without charge which represents a real economic gain to the employee and is capable of pecuniary calculation as items to be included in the average weekly wage, the value of a partially rather than a fully subsidized meal could not be included. The Court of Appeals disagreed. The Court of Appeals cited the definition of wages in *Atlanta Journal & Constitution v. Sims*, 200 Ga. App. 236 (1991) as any payment for services rendered which represents a real economic gain to the employee. According to this definition, the value of the partially subsidized meals represented a real economic gain to the employee and that value was properly included in her average weekly wage. Thus, the value of partially subsidized meals is as much a part of an employee's average weekly wage as the value of fully subsidized meals would be. The Court of Appeals cited in a footnote cases from other jurisdictions, which appear to reach the same result. *Anello v. Friendship Village Convalescent Home*, 546 So.2d1119 (Fla. 1989) (deals with the value of meals provided by the employer, cannot tell from the court's citation whether the meals were fully or partially subsidized); *Bananno v. Employers Mutual Liability Insurance Company of Wisconsin*, 299 So.2d 923 (La. 1974) (deals with "subsidized" meals).

***Royal Insurance Company v. Georgia Insurers Insolvency Pool*, Ct. App. No. A06A2454**

The case of *Royal Insurance Company v. Georgia Insurers Insolvency Pool*, Ct. App. No. A06A2454, decided Feb. 23, 2007, deals with the proper forum for determining the liability of employers and insurers to pay workers' compensation benefits. In that case, the employee suffered an injury in 1990. He filed the claim in December 1990 against his immediate employer, a temporary service, the employer client of the temporary service, and their respective insurers. No hearing was ever held on this claim, because the immediate employer and its insurer began paying benefits before a hearing was requested. In 2003, the immediate employer's insurer became insolvent, and the Georgia Insurers Insolvency Pool began paying benefits to the employee. In 2005, the Pool filed a declaratory judgment action in Superior Court, contending that the client employer and its insurer became responsible for the claim when the immediate employer's insurer became insolvent. The Pool requested that the other employer/insurer be ordered to reimburse it for all benefits it had paid. The Superior Court entered an order finding that the second employer/insurer became responsible for the claim when the first insurer became insolvent and ordered them to reimburse the Pool for all benefits the Pool had paid. The second employer/insurer appealed to the Court of

Appeals. The Court of Appeals vacated the judgment of the Superior Court. The Court of Appeals held that the parties were in the wrong forum. The Court of Appeals held that this case was not a proper one for resolution by declaratory judgment. The proper forum for determining which employer/insurer is responsible for payment of workers' compensation benefits to the employee is the State Board of Workers' Compensation. (There was no statute of limitation problem in the workers' compensation claim, because a timely claim had been filed against both employers and benefits had been paid for many years.) The Superior Court was directed to dismiss the Pool's motion without prejudice. Though the court did not so state, the parties are free to request a hearing before the Board to determine who is responsible for paying workers' compensation benefits to the employee in this case. On motion for rehearing, the court found the fact that the employee's lawsuit against the statutory employer and its insurer had been dismissed in federal court on the ground of the exclusive-remedy provisions of the workers' compensation law was irrelevant. Because the statutory employer had exclusive-remedy protection based on a potential, not necessarily actual liability for workers' compensation benefits, the fact that that employer was granted exclusive-remedy protection did not automatically mean that that employer was liable for payment of benefits to the employee. This ruling also did not confer jurisdiction on the trial court to rule on the effect of this ruling. The proper entity to determine what effect, if any, the federal ruling had on the workers' compensation claim was the State Board of Workers' Compensation, not the trial court.

***Winnersville Roofing Company v. Cottington*,  
283 Ga. App. 95 (2006)**

The case of *Winnersville Roofing Company v. Cottington*, 283 Ga. App. 95 (2006) deals with the issues that a defendant may raise in an action to enforce a Board award pursuant to O.C.G.A. § 34-9-106. In that case, Cottington suffered a compensable injury while working for Winnersville Roofing Company, a sole proprietorship. Cottington requested a hearing to determine the validity of his claim. Winnersville Roofing Company was sent at least three hearing notices which it admitted receiving. There was also a show-cause order to show whether workers' compensation insurance was in effect or was not needed. Although there was a workers' compensation insurance policy in effect at the time of Mr. Cottington's injury, there was no response to this order. The hearing notices advised Winnersville Roofing Company to notify its insurer of the pendency of the hearing. Winnersville Roofing Company did not do so. At the hearing, no one appeared to represent the employer or insurer, although it was impossible to tell from the record that an insurer existed. The administrative law judge found Cottington's claim compensable and ordered Winnersville Roofing Company to pay income benefits and medical expenses as well as late payment penalties, penalties for failure to have workers' compensation insurance and assessed attorney's fees for unreasonable defense and failure to have workers' compensation insurance. No appeal was taken from the administrative

law judge's award. Cottington took a certified copy of the administrative law judge's award to the appropriate Superior Court and sought to have judgment entered pursuant to O.C.G.A. § 34-9-106. Winnersville Roofing Company sought to have the Superior Court vacate the administrative law judge's award because it was entered against the wrong entity and because workers' compensation insurance existed at the time of Cottington's injury. The Superior Court denied Winnersville Roofing Company's motions and entered judgment in favor of Cottington. On appeal, the Court of Appeals affirmed. The Court of Appeals pointed out that the request to have the original award vacated for the errors alleged could not be granted if the errors were caused, at least in part, by the negligence of the moving party, which was the case here. Winnersville Roofing Company had notice of the hearing and admitted receiving the show-cause order. There was no excuse for that entity's failure to respond to the show-cause order or to appear at the hearing. The errors alleged could have been raised at the hearing or on an appeal to the Appellate Division from the administrative law judge's award. According to the Court of Appeals, even the insurer was aware of the existence of the administrative law judge's award at a time when an appeal could have been filed, even though that awareness may have been gained on the last or next-to-last day of the appeal period. The Court of Appeals also pointed out that if a proprietorship is operating under a trade name, as Winnersville Roofing Company was, then an action against the trade name is the same as an action against the owner. Because the grounds for opposing Cottington's attempt to have judgment entered were the result, at least in part, of the defendant's own negligence, they did not form the basis of a valid defense.

***Foot Star, Inc. v. Liberty Mutual Insurance Company*,  
281 Ga. 448 (2006)**

The Supreme Court of Georgia has been more active in the workers' compensation field recently than it frequently is. The court has handed down two recent decisions, both of which affirm the action of the Board as affirmed by the Court of Appeals. In *Foot Star, Inc. v. Liberty Mutual Insurance Company*, 281 Ga. 448 (2006), the Supreme Court affirmed the decision of the Court of Appeals in *Foot Star, Inc. v. Stevens*, 275 Ga. App. 329 (2005). That case involved the effect of a previous final award on a determination as to whether a change in condition or a fictional new accident had occurred. In that case, the original award determined that the employee had sustained a compensable accident but had incurred medical expenses only and had not suffered any disability as of the time of the award. (This situation resulted from the fact that the employee had continued to attempt to work much longer than she probably should have.) There was no appeal from the original award, and it became final. Insurance coverage for the employer changed, and after that change, the employee finally had to stop working. Had the previous award not existed, the case would have been a classic fictional new accident. Because of the definition in O.C.G.A. § 34-9-104(a)(1) of a change in condition as a change in the wage-earning capacity, physical condition, or status of the

employee since the wage-earning capacity, physical condition, or status was last determined by award or otherwise, and because of the existence of the previous final award, the Appellate Division found that a change in condition had occurred. The Court of Appeals and a majority of the Supreme Court agreed. The Supreme Court majority based their decision strictly on O.C.G.A. § 34-9-104(a)(1), which made no reference to income benefits or to time limits for filing claims. They held that the provisions of O.C.G.A. § 34-9-104(b) with regard to the time limit for filing claims based upon change in condition, which specifically referenced claims for income benefits and based its limitations on the dates income benefits were paid, were irrelevant to the discussion of the definition of a change in condition found in O.C.G.A. § 34-9-104(a)(1). Two dissenters disagreed. They contended that O.C.G.A. §§ 34-9-104(b) and 34-9-104(a)(1) needed to be construed together. When construed together, the result was that O.C.G.A. § 34-9-104(a)(1) only applied to claims that had been established by the award or voluntary payment of income benefits.

***Ray Bell Construction Company v. King*,  
S. Ct. No. S06G0891, decided March 26, 2007**

The case of *Ray Bell Construction Company v. King*, S. Ct. No. S06G0891, decided March 26, 2007, deals with the doctrine of continuous employment. In the process, it makes a significant limitation of the scope of *Mayor & Aldermen of the City of Savannah v. Stevens*, 278 Ga. App. 166 (2004). In the *King* case, the employee, a Florida resident, was working as a supervisor at one of the employer's work sites in Griffin, Butts County, Ga. During this time, he was required by his employer to live in a company-owned apartment in Fayetteville, Ga. He was given a company truck to drive, and was required to use it to travel between his temporary residence and the job site. On the day on which his ultimately fatal accident occurred, a Sunday, he had used the company truck to perform the personal mission of delivering furniture to a storage location in Alamo, Ga., a location far from his job site or temporary residence. This personal mission had been completed and he was returning to either the job site or his temporary residence when the collision occurred. The collision occurred in Monroe County, which is contiguous to Butts County and a great distance from Alamo, Ga. Although the administrative law judge and the Appellate Division did not make a specific finding of the parameters of King's scope of employment, they did make a specific finding that his deviation from employment for personal reasons was clearly at an end at the time of the ultimately fatal collision and that he had resumed the performance of his employment duties at that time. The Superior Court, the Court of Appeals, and a majority of the Supreme Court affirmed. The Supreme Court majority viewed this case the same way the Court of Appeals did. When an employee is required by his or her employment to lodge and work away from home or headquarters and to stay in an area defined by the need to be available to perform employment duties, that employee is said to be in continuous employment and has a much broader scope of employment than a person who is limited to one specific work

location. Nevertheless, even an employee who is in continuous employment can deviate from the performance of his or her work duties in order to engage in a purely personal mission. Injuries that occur while the employee is performing such a personal mission do not arise out of and in the course of employment. If, however, the personal mission is completed so that the deviation is over and the employee has resumed the performance of his or her work duties, an injury which occurs after the deviation ends does arise out of and in the course of employment. The Supreme Court majority viewed the *King* case as a deviation-and-resumption case. The majority made only passing reference to *Mayor & Aldermen of the City of Savannah v. Stevens*, *supra*. The majority did not so state, but they apparently treated *Stevens* as a going-to-and-coming-from work case that had little relevance or significance in a deviation-and-resumption case. Three justices vigorously dissented. They believed that *Stevens*, *supra*, was of great relevance and significance in this case. They did not view the *King* case as a deviation-and-resumption case but, like *Stevens*, found that it involved an injury which occurred at a time when the employee was performing no duties on behalf of the employer. In order to reach this conclusion, the dissenters had to engage in judicial fact finding to point out that King was on sick leave from his employer at the time of his ultimately fatal collision and that he had not resumed the performance of his duties of employment because he intended to pick up and deliver another load of furniture to the same storage location in Alamo, Ga., at a future time. (These facts were not found by any lower court.) Accordingly, the dissenters believed that the majority had given the doctrine of continuous employment an overly broad application and would have reversed the judgment of the Court of Appeals. **WC**

### Filings Where No Board Form Exists

When filing anything with the Board, place the Board claim number on each page of your document. This is especially important where no Board form exists. If filing correspondence with the Board, please place the Board claim number in the top left corner of each page.

### What Causes Delay and How You Can Help

Generally, the manner and method in which the Board processes any filing is still the same. However, with a paperless system, exact precision is required in order for the documents to be correctly processed efficiently.

Several things can cause a delay in the processing of forms. Inaccurate or incomplete forms go to research and are not processed into workflow. For example, employee name, date of injury, and Social Security number must correctly match what is on file with the Board or else the ICMS system will not be able to recognize the filing and associate it with the correct file. If the name is off by one letter, the Social Security number off by one digit, or the date of injury off by one digit, this may create a new claim, and will delay getting your document into its correct claim file.

Generally, these problems cause such filing to go to research for a Board employee to determine which file the document is associated with. This one issue causes thousands of documents to be taken out of workflow (essentially suspended) until a proper determination can be made.

It is also important to know that the type of document or form that is filed triggers the processing path of all documents and forms. It is imperative that the mail reception staff be able to identify the type of document so that the automated system will send it to the correct process. How to help:

- If a Form is available for the document you are filing, always use the form (e.g. Form WC-102d for motions and Form WC-200b for change of physicians), even when you are including attachments.
- Never alter a Board Form to change the data or information fields.
- If a Form is not available for the document you are filing, clearly identify and name the document on the first page. E.g. Claimant's Brief, Employer/Insurer Brief for Trial and ADR Divisions, Appellant's Brief, etc. Additionally, make sure the first page includes the new Board claim number and other claim-identifying information and your Bar number.
- Except for Stipulated Settlements, Board Rules require that only one copy of a document is to be filed. If a judge or other Board personnel request a courtesy copy of a document be sure to clearly mark the document as a "courtesy copy" so that duplicates are not scanned into the electronic claim file.

- Include the Board Claim Number!
- In our current system the Board does not need written confirmation from the attorneys on resets, unless specifically instructed by the judge's office.
- A claimant's attorney should file an attorney fee contract, and for defense attorneys a notice of representation (Form WC-102b), for every claim.

### Claims Offices

ICMS was designed to create a relationship between the insurer/self-insurer/group self-insurer and their designated TPAs. The claims offices designated by an insurer, self-insurer, or group self-insurer and their respective addresses and contact information shall only be submitted by the insurer/self-insurer/group self-insurer on the Form WC-121 or Forms WC-131A-Insurers only. (See Board Rule 61; Board Rule 126.) Only the entity identified by the insurer/self-insurer/group self-insurer as the legitimate administrator of their claims is recognized by the system. On the defense side, please be sure to encourage your clients to use updated, accurate information when submitting this information.

Progress Note: In the early days of ICMS, it was possible to designate only one claims office per carrier or self-insurer; that is no longer the case. The insurer/self-insurer/group self-insurer can designate multiple claims offices by filing the proper form.

### Phase 3 now in 2 parts

The Board split Phase 3 into two parts. Phase 3A integrates Managed Care and Rehabilitation functions into ICMS. These functions are now being tested internally. Phase 3B will deploy the web-based submission of forms and electronic viewing capabilities of files. The web-based functions are still going through design review and will go through extensive testing prior to implementation. Look for implementation this fall.

### New Help Desk

Planning has begun on the development of a new Board Help Desk, which will integrate the existing Information & Referral (I & R) Department and offer support for ICMS. The new Help Desk is expected to be included in the implementation of the web-based functions in Phase 3B.

### A look to the future with Phase 3 and EDI

Coming soon, the Board will implement Phase 3 where in ICMS will permit Web-based submission of forms as well as file review over the Internet. Documents that supplement claim forms can be submitted as attachments over the Internet. Once registered, you will be able to submit forms and to view electronic claim files to which you are a party or attorney of record. Remember that many active claim documents filed prior to Oct. 1, 2005, will still be in paper format and thus, not viewable over the Internet.

The Board will offer training on the new Internet-based capabilities later this year. We are excited about our progress and hope you are too. Liesa Gholson will be coordinating the training. **WC**

# Medicare in Workers' Compensation

By Michael R. Merlino II  
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In recent years, Medicare has become a necessary party in workers' compensation settlements. In 1980, a collection of statutory provisions known as the Medicare Secondary Payer (MSP) statute was enacted to reduce Medicare costs.<sup>1</sup> The MSP states that Medicare should be a secondary insurance provider when another source of primary coverage exists. As a result, Congress mandated that it was no longer permissible to shift the responsibility for medical expenses to Medicare. A few years ago, Workers' Compensation Medicare Set-aside Arrangement (WCMSA or MSA) was created to satisfy the mandate.<sup>2</sup>

In 2003, the federal government enacted the Medicare Prescription Drug Improvement and Modernization Act that furthered the objectives of the MSP by clarifying and expanding Medicare enforcement powers. The Centers for Medicare and Medicaid Services (CMS), the entity that enforces the MSP, was given the right to seek recovery "against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third-party payment directly or indirectly" if those funds were part of a settlement involving a primary insurer such as a workers' compensation carrier.<sup>3</sup> CMS would be entitled to double damages if it brought an action to enforce its right.<sup>4</sup> This expansion of powers lead insurers, employers and attorneys to seriously consider Medicare's interests because they did not want to be exposed to future claims (and double damages) by CMS.

CMS is currently focusing on workers' compensation claims because it is common for an employer to settle a workers' compensation case and leave it up to the employee to deal with any future medical expenses. In many instances the employee would pocket the money and then rely on his or her Medicare benefits to pick up the tab for any remaining medical treatment related to his or her on-the-job injury. The aim of the MSP was to curtail this practice of intentionally (or negligently) shifting medical expenses to Medicare.

The following advises attorneys how to address Medicare issues in settlement documents and satisfy the provisions of the MSP. Discussed in further detail are two issues that need to be addressed: past medical expenses (conditional payments) and future medical expenses (Medicare set-asides).

## Conditional Payments

The first issue involves making sure that Medicare has not already made payments on behalf of the employee/claimant before the case settles. CMS refers to these as "conditional payments."<sup>5</sup> Usually in a workers' compensation case the employer is already paying for the treatment associated with the job-related injury. In some cases, though, the employee, for a variety of reasons, seeks

treatment from another provider and uses his or her Medicare benefits to pay for the treatment. Medicare will pay the physician, but the payment is *conditioned* on the primary insurer reimbursing Medicare in the future.

Conditional payment information can be obtained by sending a basic request to CMS. Once CMS processes the request (six to eight weeks), it will provide a list of the conditional payments that Medicare has made on behalf of the employee/Medicare recipient. This correspondence should be scrutinized to make sure it is accurate. If it is not, a letter to CMS should be sent advising it of the errors.

CMS will only provide an *estimated* conditional payment amount *before* the case settles. CMS will not provide a *final* amount until *after* it receives a copy of the board-approved settlement documents from the parties. In some instances, the final amount can be significantly higher than the estimated amount due to Medicare's system of reporting and tracking its charges.

This system frustrates the settlement process because the parties cannot determine the total conditional payment amount until after the case settles. This issue should be addressed at the time of settlement. The settlement document should contain language that indicates which party is responsible for paying the *final* conditional payment amount, regardless of the estimated amount provided by CMS prior to settlement.

## The Medicare set-aside

The CMS website provides the following explanation:

All parties in a Workers' Compensation (WC) case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses. The recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS approved set aside amount is exhausted and accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury.<sup>6</sup>

In other words, the parties must determine how much Medicare could be expected to *reasonably* pay out in benefits to the employee for his or her work-related injury (based on the employee's current medical condition).<sup>7</sup> The ambiguous process of projecting health care costs for the duration of someone's life based on current medical records is a little like predicting the weather for next

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## Medicare

### Continued from page 15

month by looking out the window today.

Obtaining an accurate projection is essential because CMS retains a third-party company comprised of physicians and nurses (reviewers) to analyze all WCMSAs submitted to CMS. These reviewers have unfettered authority to increase the WCMSA amount if they deem the medical records support their position. Unfortunately, the parties are left with very limited recourse if they do not agree with the reviewers' assessment.

To complicate matters further, CMS has provided very little guidance as to what it considers a "reasonable" WCMSA.<sup>8</sup> Accordingly, one with little experience in evaluating medical records or knowledge of CMS' interpretation of what is reasonable could have a difficult time getting a WCMSA approved by CMS.

### The CMS Review Process

The CMS review process usually takes between two to five months. The process begins in New York City at the Coordination of Benefits Contractor (COBC), where all WCMSAs and related correspondence are submitted.<sup>9</sup> The COBC transfers materials into an electronic file for further handling.<sup>10</sup> Once this is completed, the file is transferred to a third-party contractor in Baltimore to do the "heavy lifting" by reviewing the medical records and analyzing the MSA projection. At this stage, the WCMSA goes through a five-step review process that includes a quality control component. Then the third-party contractor makes a recommendation concerning the total amount of the WCMSA.

The recommended MSA amount is forwarded to a regional CMS office for final processing.<sup>11</sup> All parties to the WCMSA receive a formal letter from the CMS regional office indicating the final WCMSA amount.

If, at any stage of the process, more information is requested (e.g. additional medical information), the supplemental information must be sent to the COBC in New York; direct submission to any entity other than the COBC is prohibited. Therefore, submitting an incomplete WCMSA can severely delay the process (by 60 days or more) because the information has to go through the COBC for distribution to the requesting entity.

### Should the WCMSA be submitted to CMS?

The only sure way to protect all parties of a workers' compensation claim is to obtain CMS approval of the WCMSA amount. Once approval is acquired, all parties are absolved from further liability. However, CMS will not review all WCMSA proposals:

It is not in Medicare's best interest to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. (Ref: 7/23/01 Memo QI (c)). A WCMSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

A WCMSA may be submitted to CMS for review in the following situations:

- (1) The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000; OR
- (2) The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.<sup>12</sup>

This is commonly referred to as the "review threshold." If the case does not meet one of the two listed criteria, CMS will not review the WCMSA. While it is easy to confuse the CMS refusal to review to mean that a WCMSA is not necessary, that is not the case:

The CMS wishes to stress that this 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.<sup>13</sup>

In other words, just because CMS is trying to reduce its workload does not mean that the parties do not need to complete a WCMSA. Therefore, if the case does not meet the review threshold requirement it still may be advisable to establish an unapproved WCMSA at the time of settlement.

### Practice Considerations

Here are a few recommendations for those handling WC cases:

- Find out early in the process if the claimant/employee is a Medicare recipient;
- Make a request for conditional payment information as soon as possible;
- Take Medicare's interests into account and make sure that there is language in the settlement agreement that reflects that;
- The settlement document should also address which party is responsible for the final conditional payment amount; and
- If the case meets CMS review threshold requirements, obtain CMS approval. If not, consider establishing an unapproved Medicare set-aside trust.

### Conclusion

Dealing with Medicare issues and the CMS can be a time-consuming, thorny process. Taking Medicare's interests into account early will pay off because the parties will know all (or most) Medicare issues that must be addressed in the settlement documents. The end result should be a settlement that leaves all parties knowing where they stand regarding Medicare and as comfortable as possible that CMS will not be making any future claims. **WC**

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If you have any questions about Medicare Set-asides you



can contact the author, Michael R. Merlino II, a Georgia lawyer, at The Ramos Law Firm, 678-904-5516 or michael@ramoslawfirm.com.

## Endnotes

1. 42 U.S.C. 8 1595y(b)(5); applicable regulations are found at 42 C.F.R. Part 41 1; see also Medicare Secondary Payer and You at [www.cms.hhs.gov/MedicareSecondPayerandYou](http://www.cms.hhs.gov/MedicareSecondPayerandYou).
2. For a general overview see Workers' Compensation Agency Services at [www.cms.hhs.gov/WorkersCompAgencyServices/](http://www.cms.hhs.gov/WorkersCompAgencyServices/).
3. CMS Memorandum dated April 22, 2003 (Answer to Question 13) citing, for example, 42 C.F.R. 411.24(b), (e), and (g) and 42 C.F.R. 411.26. Available at [www.cms.hhs.gov/WorkersCompAgencyServices/01\\_overview.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp).
4. 42 USC 1395y(b)(2)(B)(iii).
5. Go to [www.cms.hhs.gov/WorkersCompAgencyServices/03\\_reportingwc.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/03_reportingwc.asp) to learn more.
6. [www.cms.hhs.gov/WorkersCompAgencyServices/04\\_wcsetaside.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp).
7. Keep in mind that as of Jan. 1, 2006, Medicare covers prescription drugs, so those must be added to any WCMSA.
8. As the CMS Web site states, "[T]he amount of the set aside is determined on a case-by-case basis."
9. [www.cms.hhs.gov/WorkersCompAgencyServices/05\\_wcmsasubmission.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp).
10. You may be able to speed up this process if the WCMSA is submitted electronically. See [www.cms.hhs.gov/WorkersCompAgencyServices/05\\_wcmsasubmission.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp) for further information regarding electronic submissions.
11. For a list of regional offices go to [www.cms.hhs.gov/RegionalOffices](http://www.cms.hhs.gov/RegionalOffices).
12. [www.cms.hhs.gov/WorkersCompAgencyServices/04\\_wcsetaside.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp).
13. CMS Memorandum dated April 25, 2006. Available at [www.cms.hhs.gov/WorkersCompAgencyServices/01\\_overview.asp](http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp).

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# Revenge of the Stips

By R. Craig Henderson  
Division Director, Settlement Unit

**M**ay you live in interesting times, is a phrase that is often quoted as an English translation of a Chinese proverb or curse. In reality, and in keeping with the science fiction flavor of the title of this article, the phrase actually originated around April 1950, when it was included in a story in the magazine *Astounding Science Fiction*. The story was written by Eric Frank Russell. (Wikipedia.org) While I have no idea what Mr. Russell's story was about, the idea of interesting times certainly captures the spirit in the Settlement Unit these days.

Now that I have established fully my science fiction/literary-geek credentials, I would like to explore some of our interesting times here at the Board. Our interesting times reside in the matrix of three different elements intersecting at the State Board of Workers' Compensation this year. The first element is the business flow for attorneys of stipulations through our office. The second element is the emphasis on customer service through Gov. Purdue's TeamGeorgia initiative. Our third axis is the opportunity presented by the conversion to ICMS. For clarity's sake, these concepts are presented as distinct elements. However, in reality there is substantial congruence among these elements, so that rather than a three pronged approach we see three facets of a single concept. That unifying theory is that the Settlement Unit actively seeks out ways of making our services more responsive and helpful to the attorneys and parties we serve.

Statistically, the Settlement Unit remains consistent in approving more than 95 percent of the stipulations submitted. Of the less than 4.5 percent of the rejected stipulations, the vast majority relate to unaddressed child support or attorney liens. Our volume can vary from week to

week, from a high in 2007 of 394 approvals to a low of 129. We are on track to approve in excess of 16,000 stipulations this year.

Much of the credit for the relatively smooth flow of work through our unit goes to the attorneys submitting documents to us. On Feb. 1, 2007, I published a brief memo regarding stipulations, and I was gratified by how quickly it was taken to heart. We have enjoyed as spirit of cooperation and ease in communication that has allowed us to work toward our goal of faster, friendlier, easier stipulation approval.

After such a great response from the practitioners, it is appropriate to look to the future, and with apologies to history, we should now ask what we of the Settlement Division can do for you. The following comments are designed to outline the Division's concerns. This list is by no means exhaustive, and I welcome suggestions, comments, criticisms and corrections from everyone.

**Speed.** A quickly approved Stipulation and Agreement creates happy clients, less stressed support staff, and satisfied attorneys. In our current hybrid state of approving stips both on paper and electronically, our goal is for conventional stips to be approved in less than three weeks. Currently, stips that have structured settlements, MSAs, are death claims, or are otherwise required to be examined by me take somewhat longer. My goal is to be consistently under 30 days for those claims. A good rule of thumb to follow if you believe we somehow hold up a stip is that most holdups and delays are my fault. Please feel free to call me and I will do what I can to resolve any problems.

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# Tightening the Belt:

## The Compensability of Gastric Bypass Surgery Under the Georgia Workers' Compensation Act

By Michael Memberg, Mercer Law, Class of 2008  
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With the possible exception of a circus sideshow, morbid obesity will likely never be a work-related condition. Nevertheless, injured employees who are morbidly obese often request payment by their employer for medical treatment of their weight condition. This article focuses on the compensability of gastric bypass surgery as part of the treatment of back injuries for a morbidly obese employee.

It should come as no surprise that it is typically more difficult to treat someone's back injuries if they are morbidly obese. Many of the back treatment options, especially surgery, are limited by weight-related health conditions, including hypertension and diabetes, and the excess fatty tissue often limits accessibility to the injured areas. In fact, morbidly obese people are often too large to fit in standard MRI machines to allow a proper diagnosis in the first place, and the weight itself often exacerbates the injuries. Thus, drastic weight loss is often necessary to diagnose and treat a morbidly obese person's back injuries, and gastric bypass surgery (GBS) is an option often requested by employees.

The Georgia Workers' Compensation Act is not clear on whether GBS is compensable. Under the Act, employers are required to furnish such surgical treatment, which shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment. See O.C.G.A. § 34-9-200(a). The employee has the burden of proving that the surgery will directly give relief to his work-related injury. See *Jarallah v. Pickett Suite Hotel*, 204 Ga. App. 684 (1992). Additionally, any award issued in a workers' compensation case must make a definitive determination as to whether the injured employee's treatment expenses were reasonable and necessary. *Edwards v. Firemans Fund Ins. Co.*, 147 Ga. App. 27 (1978). Therefore, an employee would have to prove that GBS was reasonable and necessary to be compensable.

Generally speaking, there are three scenarios where an injured employee may request the employer to pay for GBS:

1. where the weight decrease following GBS will enable the employee to undergo a reasonable and necessary treatment of their work injury that was precluded by the obesity;
2. where the employee's obesity is the result of a compensable injury; or
3. where the GBS is a reasonable and necessary treat-

ment of the work injury. As of this writing, the Georgia Court of Appeals has yet to address the issue of whether GBS may be considered reasonable and necessary. Until such a decision is made, employers and employees will continue to fight over every request for GBS. For now, it may be helpful to look to how these requests have been treated in other states.

The first scenario has been addressed in Arkansas and Nebraska, where compensation judges denied GBS to claimants who could not otherwise have surgery for their compensable injuries because of their obesity. See *Rodriguez v. Hirschbach Motor Lines*, 707 N.W.2d 232 (Neb. 2005); *Oliver v. Guardsmark, Inc.*, 3 S.W.2d 336 (Ark. App. 1999). In *Rodriguez*, the court denying the claim found little evidence showing that GBS would directly relieve Rodriguez's injury, and the opinion noted the speculative nature of GBS, which was only intended to make Rodriguez more amenable to other surgeries. 797 N.W.2d at 766-767. Similarly, the court in *Oliver* found insufficient evidence to allow GBS where it would serve only to make the claimant more amenable to the underlying back surgery (especially in light of medical evidence the surgery probably would not be necessary if the employee lost weight naturally). See 3 S.W.2d at 338-39. These two cases may indicate a trend that GBS should not be approved where its primary intended purpose is to make an obese claimant more amenable to more direct treatment.

The second scenario is addressed in an Oregon case, where a claimant needed to lose a significant amount of weight for a compensable knee replacement to be successful. See *Sprague v. U.S. Bakery*, 116 P.3d 251 (Or. App. 2005). There, the court essentially deferred, by way of a dense interpretation of the Oregon workers' compensation code, to a lower court's determination of whether the employee's obesity was a consequential and combined condition with respect to the compensable injury (the employee's obesity was found not to be related to his compensable knee injury in a separate proceeding). *Id.* Essentially, the Oregon rule states that the claimant must prove that the obesity is a consequence of the compensable injury before GBS will be compensable. In other words, morbid obesity must develop post-injury before GBS is compensable.

The third scenario, where GBS is likely to be found compensable, was addressed in Minnesota. Minnesota has clearly stated that GBS is compensable in cases where it is a reasonable direct treatment of a compensable injury, especially where other non-surgical alternatives have been

exhausted. See *Hopp v. Grist Mill*, 499 N.W.2d 812 (Minn. 1993). In *Hopp*, GBS was allowed as treatment for a compensable thrombosis, and only after other treatments were unsuccessful. See *id.* In this situation, there likely would be no legitimate challenge to the reasonableness and necessity of GBS.

The above cases have all been appellate level decisions; however, compensation judges around the country have often been strict in requiring employees to carry their burden of proving that GBS is reasonable and necessary. See *Geraldine Fortune v. U.S.A. Healthcare/Iowa Long Term Care Risk*, 2006 IA Wrk. Comp. LEXIS 809 (Oct. 31, 2006) (denying claim because claimant failed to prove that GBS was reasonable and necessary, as no doctor opined that GBS was reasonable and necessary treatment resulting from the work injury); *Santana Rodriguez v. Hirschbach Motor Lines/Dakota Truck Underwriters*, 2005 NE Wrk. Comp. LEXIS 44 (Jan. 19, 2005) (affirming finding that GBS was not reasonable and necessary treatment as its reasonableness and necessity were never addressed); *Edith M. Taylor v. City of Little Rock/Risk Management Resources*, 2004 AR Wrk. Comp. LEXIS 87 (Mar. 15, 2004) (finding GBS not reason-

ably necessary and that perceived need for GBS was not a natural and probable result of work injury); *Danny Smith v. City of Hamburg/Municipal League WCT*, 1998 AR Wrk. Comp. LEXIS 789 (Feb. 23, 1998) (finding that evidence fails to support a finding that GBS is reasonably necessary). In Georgia, administrative law judges would have the same gatekeeper role under *Edwards* in requests for GBS as with any other requested surgery, i.e. evaluating the introduced evidence to determine whether the surgery is reasonable and necessary treatment for the work injury.

In conclusion, it is quite clear that the Court of Appeals, or even the General Assembly, needs to clarify the law on the compensability of GBS. Obviously, employees are entitled to reasonable and necessary treatment of work-related injuries and aggravations of pre-existing conditions. Nevertheless, employers are not just going to accept the compensability of GBS when the employee likely needed it regardless of the injury, especially if GBS is only requested as an indirect treatment intended to make the employee more amenable to direct treatment, such as back surgery. Until the law is clarified, both employers and employees in Georgia are left in a gray area that benefits no one. **WC**

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## See Ray Bell Continued from page 1

ers' compensation dependency benefits to the minor child.

The Supreme Court opinion authored by Justice Benham supported the findings of fact as established by the Appellate Division of the State Board of Workers' Compensation and determined that King had suffered a compensable injury because at the time the injury, King was in continuous employment; he was driving the employer-provided vehicle, had concluded his personal mission and resumed the employer's business by driving to the job site or the company provided housing.

The majority in further dicta went on to describe Georgia's doctrine of continuous employment, or what is sometimes referred to as "the traveling employee" doctrine, which affords broader coverage when an employee is required by his employment situation to lodge and work within a geographic area limited by the necessity of being available for work on his employer's job site. The majority followed existing Georgia law in finding for King's minor son and seemed to be concluding that it is essential that traveling employees be afforded worker's compensation coverage when they are in areas that they would otherwise not be in, but for their employment situation.

It was my observation, and was stated at Oral Argument before the Supreme Court, that for the Court to reverse or modify the decision of the Court of Appeals, the Supreme Court would have had to substitute themselves as finders of fact and force themselves to reconstrue the facts developed at hearing. The Supreme Court did not do that and concluded there was ample evidence in the record to support the prior decisions rendered.

There has been some speculation that the *Ray Bell* deci-

sion will somehow open up a "Pandora's box" and any traveling employee driving a company vehicle or being out-of-state on assignment will be covered for workers' compensation, regardless of the circumstances involved in any type of accident sustained. I simply do not believe this to be true nor does my interpretation of the Supreme Court's decision suggest same.

My view of the Supreme Court decision is that they have reiterated and recommitted to the continuous employment doctrine in Georgia. A traveling employee is to be afforded broader coverage than a regular employee, and unless that traveling employee is performing an act that is outrageous to the general conduct of one simply existing in a foreign locale, they are afforded workers' compensation coverage under the Act.

Had the Supreme Court reversed the Court of Appeals, it is my belief that no traveling employee or employee in a continuous employment situation would have been protected and/or safe from having his case routinely and regularly controverted. That would have been onerous, unfair and an illogical decision.

I am thankful the *Ray Bell* decision does not do that. What *Ray Bell* does is demonstrate that a traveling employee, under general circumstances, will be covered and protected under the Workers' Compensation Laws of Georgia. **WC**

## Stips

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**Efficiency.** The Settlement Division is committed to providing good service to our customers. That means we want to be responsive to our customers' needs. As we discuss internally, we are in the business of approving stips. Every rejected stip creates an impediment to our workflow, so we really, really want to approve them. However, our ability to approve stips is directly related to what we are presented. Utilization of the checklists on our website, standard language, and streamlining your exhibits to represent the basis of the agreement are easy steps that can be taken that greatly enhance the likelihood of a particular stip's approval.

**Communication.** As noted in the Feb. 1, 2007 memo, the examiners have the discretion to call the attorneys regarding a question that they might have regarding a stip. I encourage attorneys to reciprocate. Feel free to call about a stip, or even before a stip is filed to ask questions or give us warning about some quirk in a document. By addressing potential problems before they arise, we create the commonality of purpose and goals that add to our efficiency and result in a faster and simpler approval process.

**Emergencies.** Occasionally, attorneys will ask to "walk through" a stip. As a practice, we hesitate to do this, because taking stips out of turn does impede the efficient flow of documents for processing. The practice also feels like breaking in line to me. But there are real emergencies that do require special service. Naturally, we want to be as helpful as we can when those rare circumstances arise. I just want us to have a common definition of emergency. For instance, an imminent foreclosure or mandated exit from the country, are legitimate emergencies. Really wanting to "wrap this up" before your vacation is not.

**Liens.** We will not hold a stip for more than 48 hours for the parties to resolve an unaddressed lien. My observation is that when the Settlement Division held stips, the sense of urgency dissipated very quickly. Rather than clutter up our offices and hallways with paper as we wait for a resolution that may come someday, we are sending stips back so that the parties will not have a false sense of comfort

that the stip is at the Board and we will resolve the problem for you.

Gov. Purdue announced his commitment to raising the level of customer service by state agencies. Under that direction, we have measurable goals to meet that, demonstrate and track our commitment to customer service. I want our service to be such that in the not-too-distant future, you can reasonably expect stips to be approved in a week. Stan Carter has been very gracious and enthusiastic in his support of this goal, encouraging the cross-training of four Board employees to examine stips during those predictable times when volume increases.

Additionally, we want to ensure that our customers perceive the Settlement Division as a resource to be used, not an obstacle to be negotiated. We want you to call us with your questions, problems and requests. In return, we offer you fast, friendly, polite and knowledgeable assistance. Our commitment to our customers is the workability of our system. If we cannot address your concern, we will find someone who can.

ICMS is going to be a great boon to the settlement process. As we look to the future, the totally paperless filing of stips will allow practitioners more flexibility and ease in the approval process. The examination of the stip will allow for nearly instantaneous revision and correction, and our goal is to have the approval time ultimately measured in hours instead of weeks.

What these measures are designed to do is to allow correct documents to flow quickly through the approval process. I have spoken before about my model of a meritocracy, where correct documents are rewarded by speedy approval. One of the unintended consequences of ICMS is that it will also create an environment where errors and omissions can be rectified quickly as well. This technology will afford us the opportunity to obviate the delays of the past created by the necessary handling and documenting paper files.

My staff and I enjoy our work with "our" attorneys. If we can answer any questions, or help anyone, please let us know. My phone number is 404-651-5078. **WC**

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