



WORKERS' COMPENSATION LAW

Section Newsletter

Winter 2016

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Willful Misconduct Defense Under Attack From Many Fronts

In This Issue

Chairman’s Corner.....	3
From the Chair.....	4
2015–16 Workers’ Compensation Law Executive Committee.....	4
Fodder for Thought – or Not.....	5
Willful Misconduct Defense Under Attack From Many Fronts.....	8
Georgia Case Law Update	11
Jurisdictional Issues on the Waterfront	19
Transportation in Workers’ Comp Claims.....	23
Odyssey From Sturgess I to Sturgess II	24
Medicare Set-Asides in 2016.....	26
Bringing Problems Home	29
Motions Practice at the Board	31
An Examination of <i>Roseburg v. Barnes</i> and the Overarching Legal Implications on Catastrophic Cases	34
Timing Is Everything in Applying the Continuous Employment Doctrine.....	37
Why does Carpal Tunnel Surgery in Workers’ Comp Frequently Fail?.....	39

Chairman's Corner

By Hon. Frank R. McKay, Chairman State Board of Workers' Compensation

Not a day goes by that we don't hear a story about the prescription opioid epidemic in the United States. Earlier this year the Board participated in the National Prescription Drug Abuse and Heroin Summit held in Atlanta which explored the breadth and depth of the opioid problem. According to CDC data from 2007, unintentional drug overdose deaths in the United States occurred once every 19 minutes. Fueled by the growing use of prescription opioid analgesics, the problem has tripled in the 15 years leading up to 2014, culminating in 28,000 opioid-related overdose deaths. According to data collected by health care information company IMS Health, doctors wrote 7.8 million opioid prescriptions in Georgia in 2015. Between 2006 and 2014, more than 9,100 drug overdose deaths have been reported in Georgia, increasing 45 percent during that time span. Georgia participated in a recent study by the Workers' Compensation Research Institute (WCRI) examining longer term opioid use over a two-year time period ending March 2012. According to that study, Georgia showed a slight decrease in longer term use of opioids (0.2 percentage point change over the study period). That decrease, however, was not statistically significant and we remain concerned about the level of opioid use in Georgia, especially in non-surgical and longer term situations.

The Summit unveiled several initiatives aimed to curb the opioid problem. One such initiative is the CDC's guideline for prescribing opioids for chronic pain released in March. (See www.cdc.gov/drugoverdose/prescribing/guideline.html) Both the American Academy of Orthopaedic Surgeons and the American Academy of Neurology have also issued position statements on the risks of prescribing opioids. Among other recommendations, the CDC guideline states that opioids should not be used as first-line or routine therapy for chronic pain. The guideline advises clinicians to consider opioid therapy only if clinically meaningful benefits for both pain and function are expected to outweigh risks to the patient. Further, the guideline emphasizes the importance of counseling patients on the risks of opioid therapy to help facilitate an informed risk/benefit assessment. When opioid therapy is considered, the guideline specifies opioid selection, duration, follow up and discontinuation.

While recognizing that opioids have a place in medicine, we see far too many instances in Georgia's workers' compensation system where their prolonged use has ended in tragedy for injured workers and their families, and more commonly, where it has unnecessarily delayed getting injured workers better and back on the job, to the detriment of both the workers and their employers. We are working with stakeholders (including several doctors) on the Chairman's Medical Advisory Committee to vet potential solutions to target inappropriate and overuse of opioids. Options discussed have ranged from physician education to a drug formulary. We rely upon

the advisory committee to help us assess the advantages and disadvantages of various approaches and in finding a solution to the opioid problem.

On the judicial side, the Board is mindful of cases in which opioids appear to be used inappropriately, particularly for long term use. The Board has the authority to order a change in treatment or change in physician when situations warrant. While the Board prefers those decisions be made between the parties, often these issues are litigated. When these matters come before us, one of many factors we consider is the impact and propriety of the drug regimen in place under the current treating physician. While the Board lacks treatment guidelines, we do consider prescribing practices (and their effectiveness toward better worker health outcomes) when exercising Board discretion over medical authorization and change in physician decisions.

Regarding other medical treatment, the Board reminds that treatment and tests prescribed by an authorized treating physician shall be paid, in accordance with the Act, where the treatment or tests are: (a) Related to the on the job injury; (b) Reasonably required and appear likely to accomplish any of the following: (1) Effect a cure; (2) Give relief; (3) Restore the employee to suitable employment; or (4) Establish whether or not the medical condition of the employee is causally related to the compensable accident. Board Rule 205. Also, advance authorization for the medical treatment or testing of an injured employee is not required as a condition for payment of services rendered. *Id.* However, when pre-authorization is requested by the medical treatment provider it shall promptly be provided or controverted. *Id.*

The Board is working on creating a physician registry linked to the Board's website that will allow any physician interested in workers' compensation to register by name and specialty and provide contact information. This will allow users of the website to search for physicians by specialty who accept workers' compensation patients and allow the Board to send notices of items of interest and changes in rules and statutes germane to physicians. The site will also have a section of frequently asked questions that will be of interest to physicians.

Georgia continues to lead the nation in economic development and business expansion. Hardly a day goes by without an announcement of a new business locating to Georgia or an expansion project by an existing business. Under Gov. Nathan Deal's initiatives Georgia is a leader in many industries including healthcare, technology, national cyber security defense, manufacturing, film and movie production, agriculture, tourism, logistics & transportation and many others. The stability, balance, and fairness of our workers' compensation system continue to earn it high marks and it is held in high regard by employers and employees alike.

From the Chair

By James J. Long, Long & Holder, LLP

I am pleased to report that the Workers' Compensation Section of the State Bar of Georgia had a very successful year for the fiscal year ending June 30, 2016.

At the current time we have nearly 1000 members of this section and are the 5th largest section. 467 members attended the annual Workers' Compensation Law Institute in October, 2015. We were treated to a terrific three day seminar organized by co-chairs Fred Green, Stephen Hasner, and the Hon. Johnny Mason.

At the 2015 Institute, the section was honored to award the Annual Distinguished Service Award to Richard C. Kissiah who had recently retired but who has rendered an incalculable service to all section members through the publication of his comprehensive treatise.

In April, the section sponsored the annual Workers' Compensation for the General Practitioner Seminar under the leadership of Executive Committee member Kelly Benedict. This seminar was well attended both by section members and others and received rave reviews by all of the attendees.

It has come to the attention to the Executive Committee that, due to fiscal prudence following the large expense required for the publication of the book on the history of Georgia workers' compensation many years ago, we have accumulated quite a bit in the section's treasury. The section looks forward to expanding its outreach for the use of these funds in the coming year.

The members of our Executive Committee for 2015-16 have been Kelly Benedict, Gregg Porter, Elizabeth Costner, Kevin Gaulke, Lee Bennett, and Julie John. As usual, we alternate claimant lawyers and defense lawyers. I am rotating off and Jason Perkins is our new member. Our chair of the section for the coming year will be the Kelly Benedict. I am pleased that I am leaving the Section in the good hands of Kelly who no doubt will provide excellent leadership and energy for the Executive Committee and the section as a whole.

What a pleasure and privilege it is to practice workers' compensation law in Georgia.

Chairman McKay, members of the Appellate Division, the Administrative Law Judges, all of the employees of the board render tireless service to the injured workers of our state.

After 35 years of practicing workers' compensation law in Georgia, I can truly say that our section is a great section. We get along with each other. Litigation, for the most part is collegial and civilized. Thanks to each member of the section for establishing and maintaining this high standard.

I hope that all of you enjoy this year's newsletter. The authors of the articles and the members of the committee who have worked to put together the newsletter for the Section this year deserve a lot of credit for publishing an informative and reliable source of information.

Thanks very much for the opportunity to serve. I encourage everyone to get involved in the section. You and your practice will be greatly rewarded.

2015–16 Workers' Compensation Law Executive Committee

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*The Workers' Compensation Law Section Newsletter is looking for authors
of new content for publication.*

*If you would like to contribute an article or have an idea for content,
please contact Julie John at jjohn@deflaw.com*

Fodder for Thought – or Not

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

Several months ago I arrived early for an Appellate Division argument. After being greeted by Stan Bexley and Sgt. Steve Dawson, I went inside and found a nice seat on the back bench. There were at least four lawyers who had already arrived and who were discussing – debating – what changes they would make to the workers' compensation system. Some of the suggestions were pretty good, some fair and some I disagreed with. One fellow talked at length about fairness, which brought to mind Garrison Keillor's Lake Wobegon. That place where "all of the women are strong, all of the men are good looking, and all the children are above average." There is no Lake Wobegon – life is not fair or perfect. That said, and while our workers' compensation system is pretty good, especially when compared to some other states, there are some things we might want to discuss.

Subrogation

In the February/March 2016 edition of a magazine published by the Claims and Litigation Alliance, a lawyer from South Carolina ranked states by best to worst in terms of subrogation. He placed Georgia in the number one position - unfortunately in the "worst" category. In doing, so he wrote that "Georgia is hands down the worst state for workers' compensation subrogation, which is all but impossible to handle successfully." A tad strong, but he might be on to something. When subrogation was reintroduced in 1992, rumor had it that Speaker Tom Murphy said it would return "over his dead body." Though it did return to the Act, it came in with no teeth and if there is any question about that, one only needs to read the facts in the case of *CGU Ins. Co. v. Sabel Industries, Inc.*, 255 Ga. App. 236 (2002). It is difficult to prove that someone has been fully and completely compensated. Not impossible, but definitely an uphill battle. I was once told by a plaintiff's lawyer that my lien was akin to confederate money, worthless except to a collector. I am pretty sure he was from New York

We should either repeal O.C.G.A. § 34-9-11.1 or amend it so that it works as intended, which is to prevent a double recovery. Perhaps the best thing to do would be to limit the lien to medical expenses paid by an employer or insurer. Forget about the indemnity benefits, and focus on the medical payments since those are the lion's share of almost every workers' compensation claim. Give it the force of a hospital lien. Bottom line is that if you have a bicycle with a bent frame, you either fix the frame or get rid of the bike. Code section 34-9-11.1 has a bent frame.

Statutes of Limitation: The last time the legislature made a significant change to O.C.G.A. § 34-9-104(b) came in 1990 to address the problem that arose after the court of appeals issued its decision in *Holt's Bakery v. Hutchison*, 177 Ga. App. 154 (1985). This involved the issue of potentially

due, but unpaid, benefits which prevented the two year statute of limitations from running. The amendment to the Code section should have quieted things but over two decades later it rose from the dead and ended up before the Georgia Supreme Court. *MARTA v. Reid*, 295 Ga. 863 (2014). The court ruled that the question is not whether all benefits were paid, but when they were last paid. That is when the clock starts ticking.

In my opinion there are still problems with O.C.G.A. § 34-9-104(a) and (b). In the past it was fairly well accepted that that a condition was established only upon payment of lost time benefits or salary in lieu thereof. That went out the window with *Footstar v. Liberty Mutual Ins. Co.*, 281 Ga. 448 (2006). As the Georgia Supreme Court noted, according to the language in the statute it can be established by award "or otherwise." We all understand what an award is, but what is "otherwise?" Probably many interpretations, which is why I believe that Justice Carley's dissent in *Footstar* really makes sense. He and Justice Melton were of the opinion that payment of income benefits should be required to establish a condition. *Id.* At 452-455. It certainly would remove the guesswork because there would be no doubt as to when a "condition was established."

Subsection (b) only addresses the time periods in which one has to file for recommencement of "additional" indemnity benefits. It focusses solely on the date of last payment of either TTD or TPD and has a two/four year limitations period. If only PPD is paid, the statute of limitations does not begin to run on either TTD or TPD. In fact, if only permanency is paid, there is no period of limitation for additional benefits under O.C.G.A. § 34-9-263. While it could be argued that TTD/TPD and PPD are separate benefits, they are all indemnity, and the commencement of any one of them establishes a condition. If PPD is paid, it ought to bring into play a statute of limitations on future TTD, TPD and PPD – two years from last payment.

There are four things that I think could be done to the two statutes of limitation. Delete the language in O.C.G.A. § 34-9-82 which states that a claim needs to be filed within two years of last payment of weekly benefits. A claim for additional weekly benefits falls under O.C.G.A. § 34-9-104. The second would be to delete the language "award or otherwise" in subsection (a) of 34-9-104 and replace it with payment of any indemnity benefit or salary in lieu thereof. If the legislature opted not to go that narrow, it could delete the term "otherwise" and add "order" after "award," which would allow a condition to be established by "award, board order or payment of any indemnity benefit." In any of those scenarios there would be no debate about a "condition being established." The third would be to connect all of the indemnity benefits in subsection (b) of 34-9-104 so that a limitation period commences upon last payment of *any* of

them. Finally, if a condition has been established, require that there be a limitation period, say two years, from that date for payment of initial TTD, TPD or PPD.

O.C.G.A. S 34-9-100(d)(1)

Five years is far too long. Witnesses disappear, memories fade and evidence is lost. Make it two years – the same length of time a plaintiff has to file suit in a personal injury claim.

Cost of Living Allowance

For catastrophically injured workers this would be a great thing. These folks are stuck for the rest of their lives with the TTD rate in effect at the time of their accident. If they cannot qualify for Social Security disability income, or cannot pick the winning lottery ticket, they are in a real pickle since a TTD check is all they will ever receive. These are the people who need the help, so if you want to talk about fairness in the system, this is where the rubber meets the road.

Dependency

O.C.G.A. § 34-9-13(e) states that dependency of a spouse “shall terminate with remarriage or cohabitation in a meretricious relationship; and for this purpose cohabitation in a meretricious relationship shall be a relationship in which persons of the *opposite sex* live together continuously in and openly in a relationship similar or kin to a marriage, which relationship includes rather sexual intercourse or the sharing of living expenses.” Times have changed.

Denying Cases within 60/81 days

Get rid of *Cartersville Ready Mix Co. v. Hamby*, 224 Ga. App. 116 (1996). It is a trap for the unwary because the suspension of the benefits incorporates a *Holt's Bakery* inquiry and the misfiling of WC-2 or WC-3 may estop the employer from raising a defense. The law should avoid decisions based on procedure or technicalities and instead get to the merits, which is what the court of appeals did in *Reliance Electric Co. v. Brightwell*, 284 Ga. App. 235 (2007). If proper notice of the controvert and suspension of indemnity benefits is given to the employee, but some monies are still owed, make the employer pay the difference. On top of this, the time for paying or controverting is based on the employer's knowledge and runs quickly, especially when the employer sits on things. Three weeks is not long, and in many cases an injured worker hires a lawyer within that time period. An attempt to get a statement from the employee is almost always rebuffed. If so, the claims adjuster has to make a decision whether to deny the claim outright or pay while trying to investigate. Much easier to deny and take a chance on fees and costs but the employee would be better served by quick payment with employer's right to controvert at day 81 sans the technicalities. The *Hamby* case is an impediment.

O.C.G.A. § 34-9-23 – The Liberal Construction

Despite the fact that this Code section only applies for the purpose of “bringing employers and employees within the provisions of this chapter and to provide protection for both,” it is frequently invoked to justify a decision in favor of an employee for “humanitarian purposes.” Evidence cannot be liberally construed, nor can the burden of proof. The workers' compensation system is equal and a tie does not go to the runner. When I see this cited in a brief it tells me you did not prove your case.

Hearings

The real intent of the Act is to have a streamlined process so that claims are resolved in an expeditious manner. Unfortunately, we – us lawyers – have done our very best to make sure that does not happen. Many years ago I heard Neal Little, a former judge at the State Board (then a claimants' lawyer), tell John Sligh, another former ALJ (then a defense lawyer), that he could prove his case with seven questions. I had to think about that for a while and ultimately came to the conclusion that he was right. What he was saying was “less is more.” If the claim is going to be litigated, get it to a hearing, get to the point and get it over.

Discovery

How much discovery can we do in a workers' compensation claim? Thirty years ago there was one deposition, which was of the injured worker, and then the case tried. Files never went beyond one redwell but they now take up cabinets. We do not have to emulate Tecumseh Sherman and every once in a while should remind ourselves that our clients are better served if we keep our eyes on what should be litigated as opposed to what should not. That said, I admit that I have been guilty of this. We are, it is in our DNA.

Layers of Lawyers

If you are going to have a lawyer on the case, he or she really needs to be able to make decisions. There is nothing more demeaning than to be handed a file but be told that you cannot make a decision – on anything. Mistakes will be made, which is part of the learning process. You just try not to make the same mistake twice.

Willful Misconduct

Who knows what willful misconduct is at this point. In recent years the court of appeals has likened it to a violation of a criminal statute. That makes no sense, and if an employee is told in absolute terms not to do something, but does it anyway and ends up getting injured, benefits should not be awarded. I once told a client that stupidity was no defense to a workers' compensation claim, and I stand by that statement. However, total disregard and disobedience to someone who employs or supervises

that person should bar receipt of workers' compensation benefits if there is an accident. Intentional conduct can disqualify a person from receiving unemployment benefits. O.C.G.A. § 34-8-194. No reason not to have the same result in the workers' compensation system.

Mediations

A colossal waste of time unless you go in with sufficient authority and make a good faith effort to resolve the case. One of the biggest problems in settlements is a high demand that is made without any supporting facts and which usually leads the injured worker to believe he is going to get that amount or close to it. If you want to hear air going out of a tire, you will when that first offer is made in response to that type of demand. My other problem with mediations is using it to do discovery. That, in my opinion, is not good faith.

Drug and Alcohol Testing

OSHA has promulgated a new rule intended to punish employers who use drug and alcohol testing to deter the reporting of accidents. Apparently, OSHA believes drug and alcohol testing should be conducted only when the circumstances of the accident warrant it. This rule became effective August 16, 2016 and carries the potential of a significant fine. However, if the testing is conducted in order to comply with federal or state law, the new rule would not apply. This should include testing under Georgia's Drug Free Workplace law.

TV/Radio Advertisements

More emphasis on marketing, less focus on lawyering skills. Unfortunately, the genie is out of the bottle. John Sweet predicted years ago that at some point there would be one or two law firms in the state that represented the majority of the injured workers and that the solo folks or small firms would go by the wayside. I hope he was wrong. Frankly, I think advertising has been bad for the legal system.

Opting Out

The latest movement *du jour*. It apparently began in Texas where it is known as "non-subscribing" and spread to Oklahoma. I have heard Tennessee is considering it. To even think about adopting something like this we should study it – long and hard. And then study it again because the last thing we want is to be told that we needed to pass legislation so that we can find out what is in it. Might turn out to be a lump of coal and some switches. Anyone who has been involved in a bad injury where there was no insurance – like Marvin Price has – can tell you about the nightmares these folks have to endure. Going back to what that fellow in the Appellate Division courtroom said about fairness, which takes me full circle, I can only say that we have it pretty good. There are some things that could be changed, but that can be said about any system. As far as opting out, I will leave you with two observations: be careful what you wish for and if it sounds too good to be true, it usually is.



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Willful Misconduct Defense Under Attack From Many Fronts

By Ashik R. Jahan, Hall Booth Smith, P.C.

Willful misconduct has long been an affirmative defense that allows for the denial of workers' compensation claims in Georgia when certain conditions are met. Simply put, an employee is not covered under workers' compensation and no compensation will be allowed for any injury or death that is due to the employee's willful misconduct.

The burden of proof has generally rested with the party raising the defense. However, that burden has slowly become more difficult to meet. Now, the willful misconduct defense has come under attack from many fronts, as a recent case, *Burdette vs. Chandler Telecom, LLC*, 335 Ga. App. 190, 779 S.E.2d 75, 2015 Ga. App. LEXIS 619 (2015), has directly challenged past precedent on the meaning of what actions constitute willful misconduct. Likewise, the ramifications of new Occupational Safety and Health Administration (OSHA) rules have also limited an employer's ability to utilize the willful misconduct defense by limiting the nature and scope of post-incident drug/alcohol testing.

What is Willful Misconduct?

O.C.G.A. § 34-9-17(a) provides that "no compensation shall be allowed for an injury or death due to the employee's willful misconduct, including intentionally self-inflicted injury, or growing out of his or her attempt to injure another, or for the willful failure or refusal to use a safety appliance or perform a duty required by statute." To prevail on such a willful misconduct defense, it must be proven by a preponderance of the evidence that the willful misconduct of the employee is the proximate cause of the injury. *Commc'ns, Inc. v. Cannon*, 174 Ga. App. 820, 820 (331 S.E.2d 112) (1985).

Yet, the statute does not define what actually constitutes "willful misconduct." Instead, the meaning of willful misconduct has been left to the courts. A 1929 Supreme Court of Georgia decision, *Aetna Life Ins. Co. v. Carroll*, 169 Ga. 333, 150 SE 208 (1929), held:

"Misconduct is improper or wrong conduct. When improper or wrong conduct is intentionally or deliberately done, it becomes willful misconduct. It is true that willful misconduct means something different from and more than negligence. Willful misconduct by an employee, preventing recovery of compensation, involves an intentional, deliberate action, with a reckless disregard of consequences, either to himself or another, something less than self infliction of injury, but greater than gross negligence or wanton carelessness. Willful misconduct is much more than mere negligence,

or even than gross negligence. It involves conduct of a quasi-criminal nature, the intentional doing of something either with the knowledge that it is likely to result in serious injury, or with a wanton and reckless disregard of its probable consequences" *Aetna Life Ins. Co. v. Carroll*, 169 Ga. 333 (1929).

If a worker is acting within the scope of their employment, the mere disregard of a rule or order is not enough. Intent matters. In fact, the Court in *Carroll* went on to say that willful misconduct requires:

"...something more than thoughtlessness, heedlessness, or inadvertence in violating a rule or order of the employer, to constitute willful misconduct. There must be a willful breach of the rule or order. The mere violation of rules, when not willful or intentional, is not 'willful misconduct.' If the workman is acting within the scope of his employment, mere disregard of a rule or order does not become such misconduct, unless the disobedience be in fact willful or deliberate, and not a mere thoughtless act, done on the spur of the moment." *Aetna Life Ins. Co. v. Carroll*, 169 Ga. 333 (1929).

Likewise, O.C.G.A. §34-9-17(b), provides that "[n]o compensation shall be allowed for an injury or death due to intoxication by alcohol or being under the influence of marijuana or a controlled substance." The statute goes on to note that "[i]f any amount of marijuana or a controlled substance... is in the employee's blood within eight hours of the time of the alleged accident, as shown by chemical analysis of the employee's blood, urine, breath, or other bodily substance, there shall be a rebuttable presumption that the accident and injury or death were caused by the ingestion of marijuana or the controlled substance." (emphasis added). Similarly, the unjustifiable refusal to submit to a reliable, scientific test pursuant to §34-9-415 would also be a grounds to deny compensation.

The OSHA Front

On May 12, 2016, OSHA published a final rule regarding the reporting of injuries and illnesses, and protecting employees who make complaints. OSHA believes that evidence shows that blanket post-injury drug testing policies deter proper reporting. However, the final rule does not prohibit drug testing of employees. It only prohibits employers from using drug testing, or the threat of drug testing, as a form of retaliation against employees who report injuries or illnesses. The new OSHA rule also explains that drug tests would not be considered to be

“reasonable” where an employee suffers a repetitive strain injury, or an injury caused by a lack of machine guarding or a machine or tool malfunction.

While OSHA has concluded that “blanket” post-injury drug testing deters proper reporting, when the affected employee is “likely to have contributed to the incident,” a drug test can still accurately identify *impairment* caused by the drug use. As a result, such testing would be permissible. Given the focus on identifying impairment, timely blood screens, which can easily identify the presence of drugs, may now be necessary when a drug test is needed, as less-intrusive urine screens, which are commonly utilized today, may not adequately identify or show impairment.

For example, consider an employee who is injured at work on a Monday, and who subsequently tests positive for marijuana on a urine test provided timely after the accident. That urine tests has confirmed that marijuana was present in their system at the time of their injury. However, mere presence of marijuana in their system does not conclusively demonstrate that the injured employee was impaired at the time of his accident, especially when the Claimant alleges he had smoked marijuana the previous Saturday. Furthermore, the presence of a controlled substance in urine, which may be detectable long after usage, and long after the affects of impairment have subsided, creates a direct conflict with the OSHA rules requiring impairment. Therefore, statutes in many states regarding drug testing and Drug-Free Workplace (DFW) policies may need to be modified.

DFW policies and other state workers’ compensation laws designed to discourage drug use and which require post-accident testing offer employers a reduction in their insurance premiums if they voluntarily adopt such policies to receive a reduction in their insurance premiums. In Georgia, these policies include testing employees after accidents that result in lost work time, on reasonable suspicion of drug use (if documented), as a routine fitness for duty exam, upon return to work after rehabilitation for a positive test, as well as random drug testing. Fortunately, adherence to state DFW and state worker’s compensation laws will not change and OSHA will not find a violation when post-accident testing is performed in compliance with these laws and is not retaliatory in nature. However, it remains unclear how OSHA would treat a scenario where a state or company’s DFW policy is at all inconsistent with OSHA’s new rules.

Given OSHA’s position, reasonable suspicion testing will likely become the new standard for all employers. Blood testing may become the preferred method for all testing, and blanket testing will become a thing of the past, unless done in compliance with a state’s DFW policy. Consequently, a revision of post-accident testing policies will be needed for many companies to ensure compliance with OSHA and subsequent changes to state law, and to maintain the ability to deny benefits through a willful misconduct defense when a worker is injured while intoxicated or under the influence of a controlled substance.

The Burdette Front

Oral arguments were held at the Georgia Supreme Court on September 13, 2016 in *Burdette vs. Chandler Telecom, LLC*. In this claim, the worker was injured after rappelling down a cell-phone tower in violation of company policy. Evidence presented at the hearing demonstrated that Burdette had been specifically directed by his supervisor to descend from the tower in a certain manner, and he was not allowed to use a method called “controlled descent,” which is similar to rappelling. Despite that, towards the end of his shift, Burdette announced that he wanted to descend using the prohibited “controlled descent” method. The Claimant was repeatedly warned by his on-site lead several times not to do so, due to a lack of a safety rope and company policy, which he was further advised could result in his termination. Despite the warnings made by his on-site lead, Burdette began a controlled descent and ultimately fell, suffering serious injuries.

At his first hearing, the Administrative Law Judge (ALJ) denied Burdette’s claim on the basis that Burdette had engaged in “willful misconduct” by disregarding the supervisor’s instructions to climb down the tower. The Appellate Division confirmed the ALJ’s decision, and the Superior Court affirmed it by operation of law. However, the Georgia Court of Appeals granted Burdette’s discretionary appeal and subsequently reversed the lower court’s decision.



The Court of Appeals found that in order for an employer to assert a willful misconduct defense, an employer must show something more than intentional risky activity. While his actions were obviously dangerous, the Court of Appeals reasoned that the method he used was commonly used for descent. Therefore, they believed that there was not enough to constitute willful misconduct.

Burdette's attorneys argue that a fundamental tenet of workers' compensation is that if the employee was injured while in the course of his employment, even if it was his fault, he is entitled to compensation. They argue that Burdette's conduct did not rise to the level of "willful misconduct" because the law requires more than deliberate disregard of a rule for benefits to be denied. To disqualify an employee from receiving the benefits, they reason that an employer must show a reckless disregard for the consequences of his decision and a knowledge that his actions are likely to result in injury. Since the Claimant did not consider the controlled descent to be dangerous, he did not recklessly disregard the consequences of his actions. As a result, his attorneys contend that the Court of Appeals decision was proper.

Chandler's attorneys have argued that his conduct was expressly prohibited, but the Claimant proceeded anyways. He was warned that the equipment was insufficient to perform the prohibited action safely. He proceeded anyways. He was even warned that termination was possible if he went forward with the dangerous and prohibited action. He proceeded anyways. Chandler's attorney's argued that an employee's intentional disobedience should not be compensated. Moreover, they argued that this was not about an "absent-minded" employee or one who forgot a rule. Rather, it was about an employee who intentionally disobeyed his employer's policies and rules in the face of immediate and repeated warnings to not engage in such action.

It remains to be seen how the Georgia Supreme Court will address issues surrounding the employee's intent and the challenge of identifying negligence versus intentional disobedience in the context of a willful misconduct defense. As an exercise, consider a ban on texting while driving. Such action appears to be an intentional, deliberate action with a reckless disregard of consequences to the safety

of the person texting and to those around them. Yet, is it greater than gross negligence, wanton carelessness, thoughtlessness, heedlessness, or inadvertence? In Georgia, it is illegal in Georgia to engage in any action that distracts the driver from the safe operation of a motor vehicle, and this now includes a ban on texting while driving, punishable by fine. Does that make texting while driving a quasi-criminal conduct that may be enough to prevail on a willful misconduct defense? Brudette may, or may not, help clarify such issues moving forward.

Conclusion

The Employer and Insurer's affirmative defense of willful misconduct based upon a timely and proper, positive post-accident drug or alcohol screen, has been narrowed by OSHA. Blanket testing policies are no longer permitted unless in compliance with DFW policies, but those policies may themselves have to change. Moreover, it is likely that only blood testing can meet the heightened threshold under OSHA for finding impairment. Even still, such testing will only be allowed in scenarios where there is documented, reasonable suspicion that the injury was caused by the ingestion of alcohol or a controlled substance. In other words, the willful misconduct defense has survived OSHA, but its applicability has been greatly limited, and likely requires an overhaul of existing company policies and procedures on testing, as well as changes to state statutes.

Battered and bruised by OSHA, the willful misconduct defense now awaits the Georgia Supreme Court's decision on Brudette. If upheld, the willful misconduct defense will be further limited, as injured workers can still recover benefits if they successfully argue that they did not believe an action they undertook was dangerous. This would further diminish an already difficult willful misconduct defense, but may invite additional challenges in the future for issues like texting while driving. Either way, a willful misconduct defense under O.C.G.A. §34-9-17 has seen better days, but remains a worthwhile strategy in egregious circumstances, where the facts indicate that an accident was caused by the worker's intoxication or being under the influence of a controlled substance.



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Georgia Case Law Update

By Leesa A. Bohler, Moore, Clarke, DuVall, & Rodgers, P.C.

Willful Misconduct

Burdette v. Chandler Telecom, LLC., 335 Ga. App. 190 (2015)

Employee was initially employed by Chandler as a cell-tower technician on Sept. 1, 2012. Employee worked for three weeks before taking a five-week leave of absence. Employee was terminated during his leave of absence due to a miscommunication with his supervisor, but was rehired on Nov. 2, 2012. During Employee's leave of absence, Chandler required all cell-tower technicians to become "ComTrain" certified. Apparently, "ComTrain" is a training program that teaches safe tower climbing and rescue techniques. Employee was not ComTrain certified, but, upon his return, Employee told Chandler that he had this certification.

On Nov. 5, 2012, Employee's first day back at work, Employee was assigned to work on the top of a cell tower with Brian Prejean, the "lead tower hand" of the crew. Prejean and Employee worked together from around 8 a.m. until 3:30 or 4 p.m. When their work was almost complete, Prejean instructed Employee to climb down the tower, but Employee responded that he wanted to use controlled descent instead. Prior to Employee's shift that day, Employee's supervisor had specifically instructed Employee's crew to climb down the towers and not to use controlled descent. Accordingly, Prejean again instructed Employee several more times to climb down and not perform a controlled descent. Prejean also warned Employee that he did not have a safety rope and their supervisor would be upset if Employee attempted a controlled descent instead of climbing down as instructed.

Nevertheless, Employee prepared his equipment and used a controlled descent. As a result, Employee fell a great distance and sustained serious injuries to his ankle, leg, and hip. Employee has no memory of his fall or anything that happened immediately before or after it, including his conversation with Prejean. Prejean testified that Employee's fall was the result of user error rather than any equipment malfunction.

Employee subsequently filed a claim for WC benefits related to the injuries sustained as a result of his fall from the cell tower. After a hearing, the ALJ denied the claim on the grounds that Employee was barred from recovery because he engaged in "willful misconduct" within the meaning of O.C.G.A. § 34-9-17(a) when Employee defied his supervisor's instruction to climb down the tower instead of using controlled descent.

Employee appealed and the Board affirmed the ALJ. Employee filed a notice of appeal in superior court, but the court never scheduled a hearing or issued a ruling on the matter. As a result, the Board's decision denying benefits was affirmed by operation of law 60 days after

the appeal was docketed in the superior court. Thereafter, the Court of Appeals granted Employee's application for discretionary appeal.

The Court of Appeals reversed the Board, holding that Employee's injury did not result from his own willful misconduct such that his claim was barred under O.C.G.A. § 34-9-105(a). In reaching its decision, the Court applied the long-accepted interpretation of willful misconduct promulgated in *Aetna Life Ins. Co. v. Carroll*, 169 Ga. 333 (1929). The Court noted that mere violations of instructions, orders, rules, ordinances, and statutes, and the doing of hazardous acts where the danger is obvious, do not, without more constitute willful misconduct. There must be something more than thoughtlessness, heedlessness, or inadvertence in violating a rule or order of the employer, to constitute willful misconduct. Willful misconduct "involves conduct of a quasi-criminal nature the intentional doing of something either with the knowledge that it is likely to result in serious injury, or with a wanton and reckless disregard of its probable consequences."

The Court noted that, although Employee engaged in "a hazardous act in which the danger was obvious," his conduct was not of a "quasi criminal nature," involving "the intentional doing of something either with the knowledge that it is *likely* to result in serious injury, or with a wanton and reckless disregard of its *probable* consequences." The Court found Employee and other cell-tower technicians had successfully used controlled descents in the past to descend cell towers, and Chandler even required its technicians to learn controlled descent because it is necessary in certain circumstances for rescue purposes. Most certainly, Chandler would not require its technicians to train in and use controlled descent to rescue someone if serious injury would likely result from such conduct. In light of the foregoing, the Court reasoned that the Employer had not met its burden of proof for its affirmative defense that Employee's use of controlled descent was willful misconduct within the meaning of O.C.G.A. § 34-9-105(a).

The Supreme Court of Georgia has accepted Employer's petition for writ of certiorari.

Statutes of Limitations

Catastrophic

Roseburg Forest Products Company v. Barnes, 299 Ga. 167 (2016)

On Aug. 13, 1993, Employee suffered an amputation of his left leg below the knee in an industrial accident at the Georgia-Pacific (GP) wood processing plant. GP accepted the claim as catastrophic and commenced TTD benefits. In January 1994, Employee was fitted with a prosthetic leg



and returned to light duty work. Consequently, on Jan. 30, 1994, GP stopped paying TTD benefits to Employee and commenced payment of PPD benefits until May 1998.

In 2006, the GP plant was sold to Roseburg Forest Products Company (Roseburg). Employee continued working for Roseburg until Employee was laid off on Sept. 11, 2009. On Nov. 13, 2009, Employee sought medical treatment for chronic knee pain. Thereafter, Employee was fitted for a new prosthetic leg on Dec. 6, 2011. Both medical treatments were paid for by Roseburg's worker's compensation insurance carrier.

On Aug. 30, 2012, Employee filed a claim for change in condition from his Aug. 13, 1993 accident. Then, on Nov. 13, 2012, Employee filed a separate notice of claim for a fictional new injury based upon his Sept. 11, 2009, termination date. Employee claimed the work he performed since his return in 1994 exceeded light duty work restrictions placed upon him by his original injury resulting in a worsening of his condition which forced him to leave work. See *R.R. Donnelly v. Ogletree*, 312 Ga. App. 475 (2011) and *Scott v. Shaw Indus.*, 291 Ga. 313 (2012). The ALJ denied both claims as barred by the statutes of limitations set out in O.C.G.A. §§ 34-9-104 (b) and 34-9-82, respectively. The Board and the superior court affirmed the ALJ. However, the Court of Appeals reversed, finding that neither claim was barred by its respective statute of limitations. The Supreme Court of Georgia granted Roseburg's petition for writ of certiorari in both cases to address whether the Court of Appeal erred in determining the claims were not barred by the applicable statutes of limitations.

In a unanimous decision, the Supreme Court reversed the judgment of the Court of Appeals as to both claims. Regarding Employee's claim to resume TTD benefits due to a change in condition from his original injury, the Court held that, under the plain ordinary meaning of O.C.G.A. § 34-9-104 (b), an employee must file a claim for any additional TTD benefits within two years of his last

payment of TTD or the claim is time barred. The Court found that Employee stopped receiving TTD benefits on Jan. 30, 1994, and did not file a claim for reinstatement until more than 18 years later. The result is the same notwithstanding Employee's argument that he was entitled to reinstatement of TTD benefits because his injury remained designated as "catastrophic."

The Court further held Employee's fictional injury claim was barred under the plain, ordinary meaning of O.C.G.A. § 34-9-82 (a) because no weekly benefits were paid to Employee in connection with this alleged Sept. 11, 2009, fictional new injury and he did not file his claim within one year of the alleged injury or within one year of remedial treatment being provided. Employee received remedial treatment on Nov. 13, 2009, for chronic knee pain. He therefore had until Nov. 13, 2010, to file his claim. Because he did not file his claim until Nov. 30, 2012, it was already time barred. The fact that Employee received additional medical treatment in the form of a new prosthesis in Dec. 2011, did not revive his claim for TTD. *Poissonnier v. Better Business Bureau*, 180 Ga. App. 588 (1986); *Weir v. Skyline Messenger Serv.*, 203 Ga. App. 673 (1992).

PPD

Bell v. Glider Timber Co., 337 Ga. App. 47 (2016)

Employee sustained a compensable neck injury in January 1992 while working for Gilder Timber Company (Gilder). Employee subsequently underwent a cervical fusion in February 1992 as a result of his injury. Employee was paid TTD benefits until he was able to return to work for Gilder approximately four months later. After Employee returned to work in 1992, he was never assigned a PPD rating and continued working for Glider for 17 years until his retirement in 2009. During that time, Employee experienced continued neck pain and eventually elected to have a second surgery per the recommendation of his doctors after he retired.

The parties litigated the issue regarding whether Glider was required to pay the medical expenses related to Employee's second neck surgery. The ALJ issued an Order directing Glider to pay for the surgery because it, "resulted from an injury that arose during the course of Employee's employment." This decision is not on appeal and the surgery was performed in September 2013.

After his second surgery, Employee was assigned a 15 percent PPD rating. Thereafter, Employee sought payment of PPD benefits from Employer which was denied. Employee requested a hearing on the PPD issue. The ALJ denied Employee's request for PPD as barred by the statute of limitations set forth in O.C.G.A. § 34-9-104(b) because it had been more than four years since payment of TTD, although the surgery Employee underwent in 2013 was directly related to the original injury suffered in 1992. The Board and the superior court affirmed and Employee appealed to the Court of Appeals. Although it was undisputed that Employee's claim for PPD in 2014 was not filed within four years of the last payment of TTD income

benefits in 1992, Employee argued the Court should create a limited exception to the rule under the circumstances since Employee chose to return to work while another employee, who chose not to return to work and continued to receive TTD until a subsequent surgery was performed and a PPD rating assigned, would not be barred by the statute of limitations.

The Court of Appeals affirmed the Superior Court and denied Employee's request for PPD as barred by the statute. While recognizing that the application of the statute of limitations under the circumstances of this case leads to a harsh and inequitable result, the Court declined to create an exception. The court noted the statute of limitations is clear and unambiguous and Employee's arguments for an exception to the rule should be addressed to the General Assembly.

Change in Condition

McDuffie v. Ocmulgee EMC, 2016 WL 3884618 (Ga. App. July 15, 2016)

Employee suffered an injury to his right knee in 2002 when he was employed by Eastman Youth Detention Center (EYDC). By July 2003, Employee had undergone three right-knee surgeries. Employee settled his WC claim with EYDC and admitted in his settlement agreement that he was partially disabled, his condition would not improve, and there was no possibility of his being able to perform the same type employment on a regular basis in the future. Employee's doctor gave him a 20 percent permanent impairment rating for his right knee and placed him on permanent sedentary work restrictions. As a result, Employee was out of work from 2002 until 2006.

In March of 2007, Employee applied for a job at Ocmulgee EMC (EMC) and was hired to work as a meter reader/right-of-way laborer. On his EMC job application, Employee failed to disclose his former employment with EYDC, his 2002 injury, or his permanent sedentary work restrictions. Moreover, Employee indicated on his application that he was physically able to perform the job functions of a meter reader/right-of-way laborer, which required him to stand, walk, carry parts, and be able to get an injured person off a pole within a short period of time.

In September 2009, Employee stepped in a hole and re-injured his right knee while working for EMC. EMC commenced payment of TTD benefits shortly after Employee's injury. In March of 2010, EMC discovered Employee had provided false information on his application regarding his prior work restrictions. After learning this, EMC fired Employee and suspended his TTD.

Then, for reasons not disclosed in the opinion, EMC resumed payment of Employee's TTD benefits in February 2011 after Employee's treating physician Dr. Pope recommended an additional surgery. The surgery was performed in March 2011. After surgery, Dr. Pope released Employee to return to work with sedentary restrictions. In July 2011, Dr. Pope opined Employee had returned to his

pre-2009 baseline. Thereafter, another physician, Dr. Gupta, similarly opined that Employee's knee had been restored to its pre-2009 injury status. After receiving the opinions of Drs. Pope and Gupta, EMC suspended Employees' TTD benefits again.

Accordingly, Employee filed a WC-14 request for hearing seeking reinstatement of TTD. A hearing was held and the ALJ denied Employee's claim for reinstatement. Based on the opinions of Drs. Pope and Gupta, the ALJ found that Employee had improved to the extent that he had no work restrictions other than the permanent sedentary work restrictions imposed by his 2002 injury before Employee was hired by EMC. Thus, the ALJ found that EMC had met its burden in proving a change in condition for the better.

The Board's Appellate Division and the superior court affirmed the findings of the ALJ. Thereafter, the Court of Appeals granted Employee's application for discretionary review. On appeal, the Employee argued: 1) the superior court erred by affirming the full Board's decision regarding the Employee's pre-injury baseline condition because of the contradictory evidence of his actual physical condition before the 2009 injury, and; 2) EMC was required to show suitable employment was available.

The Court of appeals affirmed the decision that Employee had returned to his pre-2009 injury baseline condition resulting in a change in condition for the better. The Court noted the appropriate of review for this issue was the "any evidence" rule. The Court further noted it is within the province of the ALJ to determine the weight and credit to be given to physician opinion testimony and to resolve issues of fact arising from contrary opinions of the respective physicians. Moreover, the medical testimony only needs to be based upon a reasonable probability and does not have to be reasonably certain. The Court found there was evidence to support the finding that Employee's condition had improved for the better.

The Court, however, also held EMC could not suspend Employee's workers' compensation benefits based on a change in condition for the better without showing EMC had offered Employee suitable employment. The Court noted, although the ALJ recognized EMC had the burden of proving suitable work was available, the ALJ made no findings of fact on that issue. Thus, the Court of Appeals vacated the Superior Court judgment, in part, and remanded the case to the Superior Court to be remanded to the Board for further findings regarding the availability of suitable employment. The Court also noted that EMC remained responsible for providing and paying for reasonable and necessary medical treatment related to Employee's 2009 injury.

Dissent: Judge McFadden issued a dissenting opinion pointing out that the ALJ found that Employee was capable of more than sedentary work immediately before the 2009 date of injury. Judge McFadden concluded, therefore, that it was error for the ALJ to conclude, and for the appellate division and superior court to affirm, that

Employee's capability for sedentary work following the 2009 date of injury precluded him from further workers' compensation benefits.

Average Weekly Wage/Concurrent Similar Employment

Fulton County Board of Education v. Thomas, 299 Ga. 59 (2016)

Employee was employed as a school bus driver with the Fulton County Board of Education (Fulton County). Employee's employment required her to drive buses during the nine-month school year, but not during summer vacation. Employees' salary, however, was paid out over a 12-month period. During the 2011 summer vacation, Employee obtained a second job with Quality Drive Away (QDA) driving newly manufactured school buses from the Atlanta area to other parts of the country. Employee's QDA job ended on July 30, 2011 and she returned to her regular employment with Fulton County.

On Oct. 19, 2011, Employee was injured while driving for Fulton County and filed a claim for worker's comp benefits. Fulton County did not dispute the compensability of Employee's injury. The only contested issue was the correct calculation of Employee's average weekly wage. The dispute centered on whether O.C.G.A. § 34-9-260(1) was applicable and whether Employee's wages from her summer QDA job were to be included in the calculation of her average weekly wage.

Whether Employee's QDA wages were to be included in her average weekly wage calculation hinged upon whether Employee's employment with QDA fell within the "concurrent similar employment" doctrine adopted by the Court of Appeals in *St. Paul-Mercury Indemnity Co. v. Idov*, 88 Ga. App. 697 (1953). Under the concurrent similar employment doctrine, a Employee working multiple similar jobs at the time she sustains a compensable injury is entitled to have her wages earned from all such jobs included in calculating her average weekly wage.

The ALJ concluded that Employee's employment with QDA constituted concurrent similar employment because: 1) it involved the same "type and size" of school bus; 2) it involved the "same skill set" as required in her employment with Fulton County, and; 3) she was employed with QDA for some period within the 13 weeks prior to sustaining the compensable injury. Accordingly, the ALJ found O.C.G.A. § 34-9-260(1) should be applied and included Employee's QDA wages earned during the 13-week period into Employee's average weekly wage calculation.

The Board reversed the ALJ, finding that Employee's employment with QDA was "similar" but not "concurrent" with her Fulton County employment. The Board reasoned that, because Employee's employment with QDA ended prior to her Fulton County DOI, she "was not employed concurrently with another employer at the time of her work injury." Accordingly, the Board held that the QDA earnings should not be included in the average weekly wage calculation. The superior court affirmed the Board's decision.

On discretionary appeal, the Court of Appeals reversed the superior court's judgment. The Court found O.C.G.A. § 34-9-260(1) was applicable, but disagreed with the determination that QDA employment was not concurrent. The Court reasoned that, Employee was working as a bus driver for substantially the whole of the 13 weeks immediately preceding her injury on Oct. 19, 2011, because she worked as a bus driver for both QDA and Fulton County during the whole time. O.C.G.A. § 34-9-260(1) explicitly contemplates work "for the same or another employer" and thus, because Thomas worked those 13 weeks for the same or another employer in the type of employment during which she was injured, her average weekly wage should have been computed based on her "total amount of wages earned" for her work during the 13 weeks immediately preceding her injury.

In a unanimous decision, indicating this was a case of first impression as to the definition of concurrent, the Supreme Court affirmed the judgment of the Court of Appeals. The Court held that where a Employee sustains an employment-related injury, after having worked in that line of employment for substantially the whole of the 13-week period immediately preceding the injury, the "total amount of wages earned" under O.C.G.A. § 34-9-260(1) must include wages earned by the Employee for work performed for another employer in the same line of employment during the 13 weeks, regardless of the Employee's employment status with that other employer at the time of the injury. The Court further noted 'concurrent' means all jobs held within the 13-week period, even if not held on the date of injury. In a footnote, the Court of Appeals disapproved the definition of "concurrent" contained in *O'Kelley v. Hall County Bd. of Educ.*, 243 Ga. App. 522 (2000) as mere dicta.



Attorney's Fees

Cruz v. Paredes, 333 Ga. App. 857 (2015)

On Feb. 17, 2011, Paredes suffered a work-related back injury. On April 19, 2011, Paredes signed an attorney fee contract with former counsel. The fee agreement contained the following provision: "I understand that your hourly rate is \$200. It is agreed that you can also charge and be paid for services rendered, 25 percent ... of the gross weekly indemnity benefits, ... or in quantum meruit, whichever is greater, prior to termination of this contract by either party." (Language at issue). While represented by former counsel, Paredes was awarded ongoing TTD benefits.

On Dec. 19, 2013, Paredes terminated former counsel and retained new counsel. On Jan. 7, 2014, former counsel filed an attorney lien pursuant to Board Rule 108(e) seeking to recover fees in the amount of \$35,207. On Jan. 9, 2014, former counsel filed form WC-108 (b) attorney fee approval form pursuant to Board Rule 108(a). Paredes objected, maintaining that the request for attorneys' fee approval was untimely and, therefore, contractually barred.

The ALJ approved the fee contract, "finding that the record substantiates that the contingency provided for in the attorney's fee contract was met," and that, "during former counsel's representation and as a result of their efforts, income benefits were commenced." The ALJ awarded former counsel 25 percent of Paredes's weekly TTD income benefits beginning Jan. 9, 2014, for a period not to exceed 350 weeks. Paredes appealed.

The Board affirmed and adopted the ALJ's decision, finding that the ALJ's decision was supported by a preponderance of competent and credible evidence. The superior court reversed the Board's decision, concluding that former counsel was not entitled to collect fees because counsel was terminated prior to submitting their attorney fee approval form. The superior court also found that the language at issue in the fee contract was "plain and unambiguous" and that it precluded former counsel from collecting attorney's fees because Paredes dismissed them before a claim for fees was filed with the Board.

Former counsel filed an application for discretionary appeal, which the Court of Appeals granted. On appeal, former counsel argued that: 1) the trial court erred by applying a *de novo* standard of review rather than an "any evidence" standard, which resulted in the disregard of the Board's statutorily conferred authority to exercise discretion in approving attorney fee contracts, and; 2) regardless of whether the Superior Court applied the correct standard of review, the Superior Court erred by reversing the Board award of attorney fees.

The Court of Appeals affirmed on the first issue and found that the trial court was correct in applying a *de novo* standard of review. The Court pointed out that, although the "any evidence" standard is applied to findings of fact made by the Board, a *de novo* standard is applied when considering the Board's application of law to facts. The Court noted that the trial court had specifically found that

this case was one of straightforward contract interpretation and there was no factual dispute between the parties. Accordingly, the Court found that the case involved a review of the Board's application of law to facts and, thus, a *de novo* standard was appropriate.

The Court of Appeals reversed and remanded the case to address the language at issue in the fee contract. It found the ALJ erred by ruling the fee agreement was plain and unambiguous and that it precluded former counsel from collecting attorney's fees. In light of the ambiguity in the contract language with regard to the termination of the contract by either party, the judge should have applied the pertinent rules of contract construction.

Privileged Medical Evidence

Jasarevic v. Foster, 335 Ga. App. 528 (2016)

In 2008, Jasarevic (Plaintiff) suffered an on-the-job injury and filed a claim for worker's compensation benefits. Thereafter, the Board appointed Dr. Foster as Plaintiff's authorized treating physician. In 2010, Dr. Foster released Plaintiff to full duty, but continued to serve as Plaintiff's treating physician. At some point in 2012, Dr. Foster dictated a medical narrative that became a part of Plaintiff's worker's comp claim file. In the narrative, Dr. Foster indicated Plaintiff had made threatening statements during an appointment and that he considered Plaintiff a threat and refused to treat Plaintiff any longer.

Thereafter, Plaintiff brought a *pro se* libel suit alleging that Dr. Foster's statements had prevented him from obtaining needed medical care. Dr. Foster moved to dismiss Plaintiff's suit, contending, among other things, that statements made in workers' compensation proceedings are privileged and cannot serve as the basis for a libel claim. The trial court agreed and dismissed Plaintiff's complaint.

The Court of Appeals affirmed the trial court's decision, holding that, "statements made by a physician in his or her medical records that are pertinent and material to a workers' compensation claim, such as the statements at issue here, are privileged as a matter of law and cannot serve as a basis for a claim of libel."

Exclusive Remedy/Positional Risk Doctrine

Sturgess v. OA Logistics Servs., 336 Ga. App. 134 (2016)

OA Logistics Services (OA) contracted with StaffChex, a temporary staffing firm, to provide temporary workers to work at a warehouse owned and operate by OA. As part of their contract, OA required StaffChex to perform criminal background checks on applicant before they were employed. On Feb. 16, 2012, one Christopher Lema applied for a position with StaffChex using a false identity. Lema utilized an alias in his application to hide the fact that he had a felony criminal record. StaffChex initiated a background on the false identity Lema provided, but before Lema's background check was returned, he had already begun working at the OA warehouse.

On Feb. 24, 2012, while working at the OA warehouse, Lema entered an office area and attempted to forcibly kiss a female employee, who immediately pushed him away. During this encounter, another OA worker (decedent) was standing directly outside the office with his back turned, apparently unaware of what was occurring inside. After Lema was rebuffed by the female employee, Lema produced a handgun, stepped outside the office and shot decedent in the back of the head. Thereafter, Lema re-entered the office and sexually assaulted the female employee.

Following the incident, the decedent's mother brought a wrongful death action against multiple defendants, including StaffChex and OA. After the close of discovery, StaffChex and OA moved for summary judgment. The trial court granted summary judgment in favor of both Defendants on the grounds that decedent's death arose out of and in the course of his employment and, therefore, any tort claims against employers were barred by the exclusive remedy provisions of O.C.G.A. § 34-9-11(a).

The Court of Appeals affirmed, finding the claims against OA and StaffChex were barred by O.C.G.A. § 34-9-11(a) because decedent's death arose out of and in the course of his employment under the positional risk doctrine as defined in *Chaparral Boats, Inc. v. Health*, 269 Ga. App. 339 (2004). Specifically, the Court found that the facts at bar demonstrated that a causal connection to decedent's workplace did exist despite the seemingly random nature of the attack on decedent. The Court noted that it was undisputed that decedent's employment placed him in a locale that unfortunately exposed him to being shot by attacker. Thus, the Court further found that it was only because of his employment that decedent was at the Defendant's warehouse on the morning of his murder and only because of his employment that he had any contact or relationship with his attacker. Thus, the risk of being shot by his attacker, while not peculiar to defendant's workplace, was nevertheless connected to his workplace by virtue of where it occurred. Motion for Reconsideration was granted March 10, 2016.

Subrogation

Schechter v. Auto-Owners Ins. Co., 335 Ga. App. 30 (2015)

While acting within the scope of his employment, Plaintiff was injured in an automobile accident with a third-party Defendant Driver. Plaintiff's employer paid Plaintiff worker's compensation benefits for the injuries he sustained in the collision. On Feb. 4, 2013, Plaintiff filed a tort claim against Defendant Driver to recover damages for pain and suffering.

Plaintiff's complaint stated that he did not: 1) seek to recover workers' compensation/subrogation damages, or; 2) object to the workers' compensation carrier's right to join in the action to recover such damages. Nevertheless, Plaintiff's prayer for relief sought recovery for "special damages for past and future medical expenses and loss of income in the past and future in such an amount as shall be proven at trial."

On April 20, 2013, Employer's Insurer (Auto-Owners) filed a motion to intervene in Plaintiff's action and submitted a proposed order, providing that Auto-Owners not be named in the style of the case; that Plaintiff be required to "introduce evidence of all special damages at the trial of this action"; that the jury return a special verdict separating the various damages; and that there be a bifurcated trial for subrogation recovery.

Auto-Owners was ultimately permitted to intervene in Plaintiff's action. However, Plaintiff later moved to set aside and modify the order permitting Auto-Owners to intervene, objecting to "the request for bifurcated trials and Plaintiff to sue for intervenor's special damage because Plaintiff did "not intend to prove or offer specials in evidence at the trial and does not have any one to testify to same or the amounts." In response, Auto-Owners voluntarily dismissed its request to intervene. In doing so, Auto-Owners asserted that its withdrawal was "in no way a waiver or abandonment or should otherwise prejudice of the subrogation rights" of the company.

On Aug. 13, 2013, while Plaintiff's lawsuit remained pending, Auto-Owners filed suit against Defendant Driver seeking to recover \$22,535.98 for indemnity benefits and \$122,907.04 for medical bills. Defendant Driver answered, asserting that Auto-Owners's suit was barred by its failure to comply with O.C.G.A. § 34-9-11.1. Defendant Driver filed a motion to dismiss on those same grounds, but the trial court denied his motion and likewise denied a motion seeking a certificate of immediate review.

Defendant Driver then filed a motion for summary judgment against Auto-Owners, making the same argument from his earlier motion to dismiss. He also asserted he had settled the lawsuit brought by Plaintiff and that the settlement agreement barred a separate lawsuit by Auto-Owners. The trial court denied Defendant Driver's motion for summary judgment, but issued a certificate of immediate review. The Court of Appeals granted Defendant Driver's application for interlocutory appeal to determine whether Auto-Owners' failure to intervene in Plaintiff's action against Defendant Driver forfeited the company's right to enforce its subrogation lien.

The Court of Appeals reversed the trial court and found Defendant was entitled to summary judgment. The Court noted the express terms of O.C.G.A. § 34-9-11.1 allowed Auto-Owners two options: (1) intervene in Plaintiff's suit against Defendant Driver; or (2) file suit against Defendant Driver if Plaintiff had not filed suit within one year of the injury. Auto-Owners' right of action against Defendant Driver was derivative of Plaintiff's claims, and under the facts of this case, Auto-Owners had no right to pursue its own independent action against Defendant Driver when Plaintiff was already pursuing an action.

Certiorari Denied Apr. 4, 2016.

Best Buy Co., Inc. v. McKinney, 334 Ga. App. 42 (2015)

In January 2011, McKinney fell off a forklift during the course of his employment with Best Buy. As a result of the

fall, McKinney suffered several facial bone fractures and brain damage. McKinney underwent multiple surgeries and received facial implants. Nevertheless, McKinney's face was permanently disfigured and he continued to experience ongoing cognitive problems caused by his traumatic brain injury. It was noted that Best Buy had paid, and continued to pay, McKinney workers' compensation benefits.

In January 2013, McKinney filed a negligence and strict liability suit against several defendants involved in the manufacture and maintenance of the forklift from which he fell (tort defendants). Pursuant to O.C.G.A. § 34-9-11.1(b), Best Buy moved to intervene in the suit to protect its right to a WC subrogation lien against any recovery obtained from the tort defendants. The trial court ultimately granted Best Buy's motion to intervene.

In May 2014, McKinney and the tort defendants settled McKinney's case. Pursuant to the settlement agreement, McKinney dismissed with prejudice his suit against the tort defendants in June 2014. After McKinney dismissed his suit, Best Buy filed a motion to enforce its lien against the proceeds of the settlement and requested that the trial court conduct an evidentiary hearing regarding the motion. Best Buy argued that it was entitled to an evidentiary hearing so that it could present evidence that McKinney had been "fully and completely compensated" for all of his economic and noneconomic losses incurred as a result of his injuries, a statutory prerequisite for enforcement of a lien under O.C.G.A. § 34-9-11.1(b).

The trial court granted Best Buy's request for an evidentiary hearing. At the hearing, Best Buy presented the testimony of two witnesses. The first witness was the general manager (GM) of the Best Buy store where McKinney had worked. The GM testified that, as of Sept. 4, 2014, McKinney

had received \$173,679.49 in WC benefits, which included \$162,753.08 in medical benefits and \$10,926.41 in income benefits. The second witness was a partner in an Atlanta law firm who had experience in litigation and mediation. The lawyer sought to demonstrate that McKinney had been fully and completely compensated for his losses by comparing his case to that of other reported civil tort cases involving plaintiffs who suffered head injuries. After the testimony, Best Buy rested its case. McKinney did not present any evidence, other than the settlement agreement that he had reached with the tort defendants and a settlement statement prepared by his counsel.

The trial court heard argument from the parties and took the matter under advisement, but the court noted from the bench that it was not persuaded by the lawyer's testimony comparing McKinney's case to other cases. The court pointed out that the lawyer had not read McKinney's deposition and was unaware of the extent of McKinney's injuries or his long-term prognosis, making comparison of his case to the other four cases identified by the lawyer difficult "because cognitive issues can be very different among different plaintiffs."

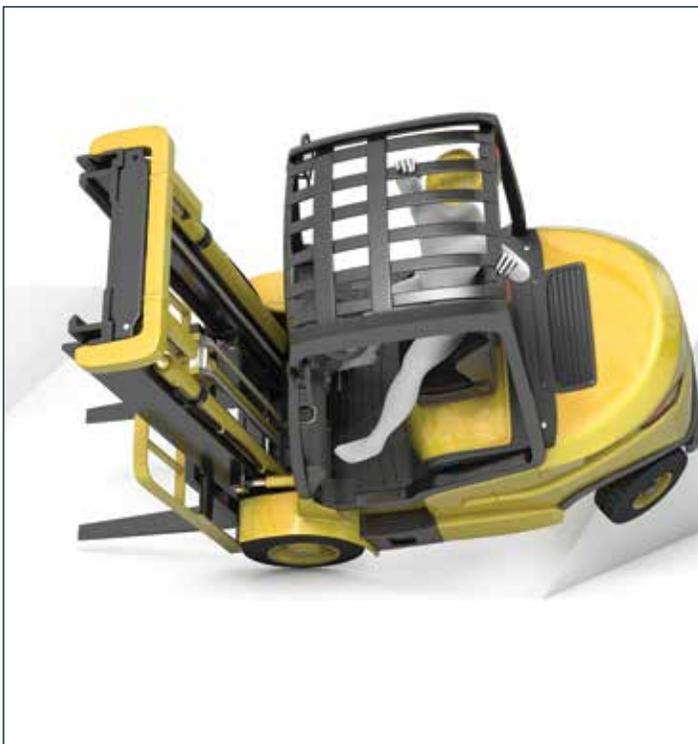
The trial court thereafter entered a written order denying Best Buy's motion to enforce its subrogation lien on the grounds that Best Buy had failed to carry its burden of proving full and complete compensation.

Best Buy subsequently appealed, arguing that: 1) the trial court erred in finding it failed to prove full and complete compensation because the evidence demanded a finding that McKinney had been fully and completely compensated, and; 2) the trial court erred in finding it failed to prove that McKinney had been fully and completely compensated because the court relied upon erroneous law.

The Court of Appeals affirmed the trial court's conclusion that Best Buy did not meet its burden of showing McKinney had been fully and completely compensated. The Court noted the appropriate standard of review was the deferential "clearly erroneous" standard. The Court further noted that, in light of the cross-examination of the lawyer-witness, the trial court was entitled to find that the lawyer had failed to gather all of the essential factual information necessary for a valid comparison between McKinney's case and the other four civil tort cases that he had identified, and thus was entitled to conclude that the lawyer's evaluation was too speculative to be credible. Consequently, the Court found that the trial court's judgment was not clearly erroneous and, therefore, could not be overturned.

The Court held that the trial court did not rely upon an erroneous interpretation of the law in determining that Best Buy had been unsuccessful in proving that McKinney had been fully and completely compensated for his losses. The Court provided three reasons to support its holding.

First, in *SunTrust Bank v. Travelers Prop. Cas. Co. of America*, 321 Ga. App. 538 (2013), upon which Best Buy



bases its argument, two of the three judges concurred in judgment only and, consequently, the opinion is not binding precedent of this Court under Court of Appeals Rule 33(a).

Second, the opinion in *SunTrust Bank* simply pointed out that cases quoting the language at issue do not prohibit a trial court—in the circumstance where the employee has reached a settlement with a third party without the input or consent of the employer—from conducting an evidentiary hearing where the employer is allowed an opportunity to prove that the employee was fully and completely compensated for his losses. The trial court in the present case clearly reached the same conclusion because it conducted an evidentiary hearing where Best Buy was afforded an opportunity to prove that McKinney was fully and completely compensated.

Third, Best Buy's argument is foreclosed by *Austell HealthCare v. Scott*, 308 Ga. App. 393 (2011), where the employer and its insurer similarly complained about the language at issue appearing in the trial court's order declining to enforce their subrogation lien.

Employer Immunity & Apportionment of Tort Liability

Walker v. Tensor Machinery Ltd., 298 Ga. 297 (2015)

Plaintiff was injured at work in August 2010 while operating a machine designed and manufactured by Tensor Machinery, Ltd. and Tensor Fiber Optic Technologies, Ltd. (collectively, Tensor). Plaintiff reached a settlement with his employer for Worker's Compensation benefits. Plaintiff subsequently brought a tort action against Tensor in federal court, alleging it negligently failed to warn him of safety-related defects in the machine. Tensor then gave notice under O.C.G.A. § 51-12-33 that it intended to ask the trier of fact in this case to assign some responsibility for Plaintiff's injuries to his employer. In response, Plaintiff filed a motion in limine to exclude all evidence concerning fault on the part of his employer on the grounds that O.C.G.A. § 51-12-33 does not allow a plaintiff to apportion fault to a nonparty employer that has immunity from liability in tort by virtue of the exclusive remedy provision of the Workers' Compensation Act, O.C.G.A. § 34-9-11.

The U.S. District Court for the Northern District of Georgia then certified the following question to the Supreme Court: Does O.C.G.A. § 51-12-33(c) allow the jury to assess a percentage of fault to the non-party employer of a plaintiff who sues a product manufacturer and seller for negligence in failing to warn about a product danger, even though the non-party employer has immunity under O.C.G.A. § 34-9-11?

The Supreme Court held that O.C.G.A. § 51-12-33(c) does allow a jury to assess a percentage of fault to a non-party employer of a plaintiff who sues a product manufacturer and seller for negligence in failing to warn about a product danger, even though the non-party employer has immunity under O.C.G.A. § 34-9-11.

Any Evidence Rule

J&R Schugel Trucking, Inc. v. Logan, 336 Ga. App. 899 (2016)

Employee, a North Carolina resident, was injured in August 2013 while working in Georgia for her employer, J & R Schugel Trucking, Inc. (J & R) of Minnesota. Employee received workers' compensation benefits under Minnesota law until benefits were suspended in September 2013 due to lack of evidence of disability. In October 2013, Employee filed a comp claim in Georgia seeking recommencement of income benefits and medical care under Georgia law. Employer/Insurer controverted the claim on the basis that there was no evidence of any continued disability and no need for ongoing medical treatment. The ALJ ruled that, although Employee had no continuing disability from the injury, she was still entitled to ongoing medical benefits. J & R appealed to the Appellate Division and the Board affirmed the ALJ's finding that there was no disability, but substituted alternative findings and ruled that Employee was not entitled to ongoing medical benefits.

Employee appealed to the Superior Court which reversed and entered an order setting aside the Board's decision as "contrary to law" under O.C.G.A. § 34-9-105(c)(5). In support of this conclusion, the superior court pointed out that the transcript of the hearing before the ALJ showed the ALJ ordered J & R to pay for another medical evaluation of Employee and to provide a copy of the evaluation report so that the ALJ can "make a decision about ongoing medical treatment." According to the superior court, the transcript showed that the ALJ intended to hold the hearing record open for the medical report to be filed and considered; that the ALJ subsequently refused to include the report in the record; and this prevented the filing of additional evidence necessary to complete the record. Based on this reasoning, the superior court ruled that the ALJ's decision to exclude the report was contrary to law and left the record incomplete which rendered the Appellate Division's decision finding that Employee was not entitled to medical benefits contrary to law under O.C.G.A. § 34-9-105(c)(5). J & R subsequently filed an appeal to the Court of Appeals.

The Court of Appeals reversed the Superior Court and agreed with the Board's decision. The Court found no evidence that Employee attempted to submit a medical report after the hearing or that the ALJ refused to open the record to receive a report. Consequently, the Court held that there was no basis for the Superior Court to find that the Board's decision was "contrary to law," and the Court erred by setting aside the decision. In regards to the medical benefits, the Court held that the Board was authorized to substitute its own alternative findings under O.C.G.A. § 34-9-103(a) and those findings could not be disturbed under the any evidence standard of review.

Jurisdictional Issues on the Waterfront:

Concurrent Claims under the Georgia & Longshore Workers' Compensation Acts vs. Jones Act Maritime Suits

By John David Blair, Partner, Litigation & Workers' Compensation

Intro to the "Concurrent Jurisdiction"

Dilemma...

Concurrent Jurisdiction is the legal term commonly used in the context of workers' compensation law to refer to a situation in which the same claim is subject to the jurisdiction/coverage of two or more federal and/or state workers' compensation systems. Most Georgia attorneys who routinely practice workers' compensation have run across a case where an argument could be made for jurisdiction in Georgia and another state. For example, an accident that occurs in Savannah to a worker who lives and is employed in Hilton Head could potentially invoke jurisdiction under both the Georgia and South Carolina Workers' Compensation Acts. Similarly, an accident occurring in Columbus to a worker who lives and is employed in Auburn could potentially invoke jurisdiction under both the Georgia and Alabama Workers' Compensation Acts.

Even the most experienced Georgia workers' compensation attorneys, however, can easily overlook concurrent jurisdiction under the federal Longshore and Harbor Workers' Compensation Act (*see* 33 U.S.C. §§ 901, *et seq.*, referred to commonly as the LHWCA or the Longshore Act) and the possibility of wholly **pre-emptive** jurisdiction under The (U.S.) Merchant Maritime Act of 1920 (*see* 46 U.S.C. § 30104 (formerly 46 U.S.C. § 688) most commonly referred to as the *Jones Act*). I recently spoke on this topic at length in a continuing education seminar in Savannah and barely had sufficient time to cover its many complexities. Given that experience, I am persuaded that it would be quite impossible to cover so broad a topic in-depth in a magazine article (at least not in an article anyone would care to publish, much less read).

Instead, this article has but one purpose: to equip its readers, as concisely as possible, with the minimum knowledge needed to recognize those Georgia work accidents that:

1. Are covered *concurrently* under *both* the Georgia and Longshore Acts;
2. Are covered *exclusively* under the Jones Act and federal maritime law; AND
3. Initially look as if they might be covered under the Longshore or Jones Act but that actually fall *exclusively* under the coverage of the Georgia Act.

To accomplish that goal, it is important that we briefly consider the background and purpose of the Longshore Act and the Jones Act, respectively.¹

The Longshore Act, Generally...

The Longshore and Harbor Workers' Compensation Act (hereinafter, "LHWCA" or the "Longshore Act") is codified at 33 U.S.C. §§ 901, *et seq.* and was first enacted in 1927 to protect dock workers, longshoremen, stevedores, and other maritime workers left out of the coverage and protection afforded to "seamen" (e.g., sailors, captains, and crewmembers) under the Jones Act. At its inception in 1927, the Longshore Act only covered injuries occurring over navigable waters of the United States. In 1972, it was amended to cover injuries occurring on areas "adjoining" such navigable waters that are used for maritime purposes (e.g., docks, piers, and dry docks) such that employees working over navigable waters would stop wandering in and out of longshore jurisdiction every time they stepped off a ship and onto/into such adjoining areas.

For the most part, the Longshore Act provides the same types of benefits to injured maritime workers as the Georgia Act provides to injured workers generally: (1) temporary total disability "TTD" benefits; (2) temporary partial disability "TPD" benefits; (3) permanent partial disability "PPD" benefits; and (4) permanent total disability "PTD" benefits, which are similar in concept and purpose to Georgia's "catastrophic" benefits under O.C.G.A. § 34-9-200.1. Accordingly, much of what an attorney knows about the Georgia Act will also apply to the Longshore Act.

However, there seemingly exists a distinction for every similarity between the Georgia and Longshore Acts. For example, while the Georgia and Longshore Acts both pay TTD benefits at two-thirds of the injured worker's pre-injury average weekly wage (AWW), the Longshore Act uses a 52-week standard AWW calculation as opposed to Georgia's 13-week calculation. Where the Georgia Act caps TTD benefits at 400 maximum weeks (O.C.G.A. § 34-9-261), the Longshore Act allows for TTD benefits to continue until such time as the injured worker reaches maximum medical improvement (MMI).

Perhaps the most important distinction between the two Acts, however, is the scope of coverage. Coverage under the Longshore Act is much narrower than under the Georgia Act. Certainly, there are exceptions, but the Georgia Act casts a "wide net" (no pun intended) when it comes to extending its benefits to accidents and injuries to workers having a reasonable connection to Georgia. By contrast, since the 1972 amendments, the Longshore Act covers only those injuries to workers who are: (1) employed as maritime workers (this is a grossly oversimplified description of the "status" test discussed below); (2) not "seamen" within the meaning of the Jones Act; and (3) who are actually injured

in a location that is over navigable waters of the U.S. or in an adjoining area that is used for maritime purposes. We will discuss these factors in greater detail later on when comparing the Longshore and Jones Acts.

In 1980, the U.S. Supreme Court ruled that the jurisdiction and coverage for a claim under the Longshore Act does **NOT** pre-empt jurisdiction/coverage under state workers' compensation laws², cementing the concept of what is known as "concurrent jurisdiction" discussed at the beginning of this article. Put more simply, it can be said that federal law allows a claimant to pursue his/her claim both under the Longshore Act and also under a state workers' compensation law – provided that the claimant can meet the criteria for coverage and jurisdiction under both acts.

However, there is no federal statute or precedent that prevents an individual state from withholding coverage under its workers' compensation act/system to employees who are otherwise covered under the Longshore Act. Florida, for example, has passed such a statute³ and is therefore regarded as an "exclusive" rather than "concurrent" jurisdiction. Georgia, however, has enacted no similar statute or precedent. Rather, in 1996, the Court of Appeals of Georgia expressly confirmed that concurrent jurisdiction for a work accident under the Georgia Act and the Longshore Act is permissible.⁴ This means that, in Georgia, a claimant may seek and obtain benefits contemporaneously under **both** the Georgia Act and the Longshore Act. However, no possibility exists for "double recovery" since benefits paid under the Longshore Act are credited against payments made under the Georgia Act, and vice versa.⁵ At the time of this article, Florida is currently the only "exclusive" jurisdiction in the 11th Circuit, though the recent trend among states, nationally, seems to be toward exclusivity and away from concurrent jurisdiction.

The Jones Act, Generally...

The Merchant Maritime Act of 1920 (46 U.S.C. § 30104 (formerly 46 U.S.C. § 688)) is known to most simply as the Jones Act and has significantly expanded personal injury suits under general federal maritime law. Prior to the enactment of the Jones Act, under general maritime law, a "seaman" injured in the course of his employment by/ service to a vessel/ship could sue only for maintenance and cure (i.e., minimal costs of living for a time plus reasonable costs of medical care), but the Jones Act provides a cause of action in negligence for any "seaman" so injured in the course of his employment.⁶ (Unfortunately, the Jones Act does not define the term "seaman,"⁷ and so one must look to case law for precedents that most closely fit the facts of the case sub judice before drawing any conclusions as to whether an injured worker meets this standard, and this is a common area of dispute in maritime cases.)

In other words, a Jones Act seaman can sue his employer for negligence and recover damages in tort (as well as maintenance and cure under general maritime law). However, the Jones Act represents the seaman's

exclusive remedy against his or her employer for work-related injuries in service to a qualifying ship/vessel.⁸ Moreover, the Jones Act **pre-empts** state **and** federal workers' compensation laws concerning injuries to seamen that arise out of and in the course of their maritime employment.⁹ In even stronger terms, "A seaman who suffers an injury on navigable waters of the United States cannot **constitutionally** be provided a remedy under a state workers' compensation statute."¹⁰

Therefore, work injuries to Jones Act seamen are outside the subject matter jurisdiction of both the Georgia State Board of Workers Compensation and the United States Department of Labor (which administers claims under the Longshore Act) in much the same manner as is the case with injuries to certain railroad workers under the Federal Employer's Liability Act (or "FELA," 45 U.S.C. §§ 51, et seq.). In fact, the Jones Act was modeled in large part on FELA, and so laws and case precedents of the United States regulating recovery for personal injury to, or death of, a railway employee also apply to an action under the Jones Act.¹¹

When do the Longshore Act and Jones Act Apply?

Now that we have discussed the nature and purpose of both Longshore Act and the Jones Act, we come to the primary purpose of this article: how does an attorney practicing in Georgia know which federal laws apply and when? This is, of course, a complex question that must be analyzed on the facts of each case; however, **it is fairly simple to recognize when a work-related injury that would ordinarily invoke the Georgia Act may be pre-empted by the Jones Act or may involve concurrent jurisdiction under the Longshore Act.** When reviewing the facts of a given case, consider the following factors or "flags" to recognize the potential implication of the Longshore Act or Jones Act:

- First, many of the same elements must be met in Longshore/Jones Act claims as with Georgia claims.
 - For example, neither the Jones Act nor the Longshore Act is designed to compensate an employee for intentional self-harm.
 - Also, there are legal definitions/parameters for who is an "employee" under maritime law just as with the Georgia Act.
- If the injury occurred on land, many miles from the nearest source or body of water, then there will be no coverage under the Longshore Act or the Jones Act.
- If the injury occurred near the water, then one must consider whether that water was "navigable" for purposes of interstate commerce *at the time of the injury*.
 - In case it is not obvious, oceans are **not** the only navigable bodies of water.
 - The Mississippi River has been deemed navigable.¹²

- The Chattahoochee River has been deemed navigable on at least one occasion, but only from Columbus, Georgia moving southward.¹³
- Lakes *can* be navigable bodies of water, given the right circumstances.¹⁴
- If the injury actually occurs near navigable waters, then further inquiry/investigation into the facts will be necessary to determine which acts apply.
- As a *very* general rule, injuries to workers that occur on, over, or adjoining¹⁵ navigable waters will fall under the Longshore Act provided that the worker is one who is primarily land-based (e.g., dock workers, longshoremen, etc.) as opposed to those who depart with a vessel (e.g., sailors/seamen, captains, crew, ship's cook, etc.) when it disembarks/leaves port; conversely, if the worker is one who departs with the vessel, then his/her claims will probably be covered only under the Jones Act.
- *Many exceptions apply to this most general of rules.*
- For example, a Jones Act seaman working in the service of his/her vessel does not cease to be a seaman and become a longshoreman simply because s/he engages in some work off the ship on the dock.
- Conversely, a longshoreman does not become a Jones Act seaman simply because s/he is working in a ship's cargo hold (which is quite common).
- The U.S. Supreme Court has created a test of sorts in the landmark case of *Chandris v. Latsis*: "A worker who spends **less than about 30 percent** of his time in the service of a vessel in navigation should not qualify as a seaman under the Jones Act..."¹⁶

Once one recognizes the potential for maritime jurisdiction/coverage in a particular case, it is time to "dig deeper" by analyzing the facts of that particular case and applying maritime law or, alternatively, by consulting an attorney who practices maritime law and can advise you. Only then can a final conclusion be reached as to which laws apply.

As alluded to above, the key to determining whether the Jones Act applies, instead of the Longshore Act (and/or Georgia Act), is in determining whether the employee is a "seaman" whose rights with respect to work-related injuries fall under the exclusive province and jurisdiction of the Jones Act (as supplemented by maritime law). As stated above, the simplest litmus test is that purely land-based workers are never Jones Act seamen (though they may be longshoremen). They have to be attached to a vessel capable of navigation.^{17,18} Further, an employee's duties must contribute to the function of such a vessel (or identifiable group of vessels) or to the accomplishment of its (their) mission - it is not sufficient to merely be a passenger on a vessel.

Once it has been determined that the injured worker is not a Jones Act seaman, one must consider whether s/

he is an employee covered by the Longshore Act. In 1984, the Longshore Act was again amended by Congress to add certain exclusions to coverage and to attempt to further clarify the meaning of "situs" and "status" - concepts (introduced originally in the 1972 Amendments) that are used to answer questions as to when and where there is coverage for claims under the Longshore Act. "Status" refers to whether the injured workers' employment is maritime in nature. "Situs" refers to whether the specific site/location of the injury is in an area covered by the Longshore Act (i.e., an area that is over navigable waters or adjoins navigable waters and is used for maritime purposes). The Longshore Act expressly excludes certain types of workers from coverage, and those workers thus fail the "status" test. One such category is the masters and members of the crew of a vessel (such workers would in all probability be Jones Act seamen anyway). A 2009 amendment excluded certain workers who are injured in the repair of "recreational vessels" **if** they are covered by a state workers' compensation act. An injury that occurred on a retaining wall, even though it adjoined navigable water, did not qualify as a "pier" or as an "adjoining area customarily used [in maritime/longshoring operations]" and thus failed the "situs" test.¹⁹ There are other such exclusions, and, again, each case must be analyzed on its own merits.

Remember, an injured worker can have: (1) a claim under the Georgia Act; (2) a Georgia claim and a concurrent claim under the Longshore Act; OR (3) a claim under the Jones Act. An injured worker **cannot** have: (a) claim under both the Jones Act and the Georgia Act; OR (b) a claim under both the Jones Act and the Longshore Act. The Jones Act stands alone. The Longshore Act and the Georgia Act can work in tandem (without violating Georgia's "exclusive remedy" provision under O.C.G.A. § 34-9-11).



Longshore & Jones Act Cases: more common than you might think...

Georgia's ports have made a lot of news in recent years, most notably including the Port of Savannah. Container traffic through the Port of Savannah has required improvements to the river. According to Wikipedia (reliable, I know), between 2000 and 2005, the Port of Savannah was the fastest-growing seaport in the United States. According to Bloomberg Business, Savannah "trails only New York City as an East Coast container port and ranks No. 4 nationally..."²⁰ Suffice it to say, coastal Georgia is a booming area for maritime commerce. Logically, with the rise and expansion of business at Georgia's ports comes an increase in the frequency of workplace injuries and claims. If you are dealing with an injury near navigable waters, then the best practice is always to either carefully examine potential coverage under the Longshore Act and Jones Act or to consult with another attorney who practices in that area.

Parting Words...

There are many perils and pitfalls for the unwary and uninitiated when dealing with concurrent jurisdiction cases, and there are exceptions to the general rules discussed in this article that are beyond its limited scope and purpose. Taking on a client's Georgia workers' compensation claim in isolation, with no thought or care to a potential and concurrent claim/exposure under the Longshore Act (particularly in light of collateral estoppel issues) could potentially be regarded as legal malpractice. However, for anyone interested in learning more about this subject, Loyola University's Institute for Continuing Legal Education in New Orleans presents the Annual Longshore Conference ("ALC"), which provides a more advanced level, two-day course attended by attorneys nationwide who regularly practice in the area of maritime injury law. I attend almost every year, and every time that I attend, I learn something new.

(Endnotes)

- 1 By design, this article presumes a certain degree of familiarity on the part of the reader with the basic requirements for jurisdiction and under the Georgia Act.
- 2 Sun Ship, Inc. v. Pennsylvania, 447 U.S. 715 (1980).
- 3 See Fl. Stat. § 440.09(2) ("Benefits are **not** payable in respect of the disability or death of any employee covered by the Federal Employer's Liability Act, the **Longshoremen's and Harbor Worker's Compensation Act**, the Defense Base Act, or the Jones Act.").
- 4 Atlantic Contains Svcs. V. Godbee, 218 Ga.App. 594, 462 S.E.2d 465 (1995); see also, Allsouth Stevedoring Co. v. Wilson, 220 Ga.App. 205 (1996) (cert. denied).
- 5 Id.
- 6 Chandris, Inc. v. Latsis, 515 U.S. 347, 354 (1995).
- 7 Id.
- 8 See Smith v. McAllister Towing of New York, LLC, 361 F.Supp.2d 348 (S.D.N.Y. 2005); see also, Tucker v. Fearn, 333 F.3d 1216, 1220 (11th Cir. 2003).
- 9 Id.
- 10 82 Am.Jur.2d Workers' Compensation, § 36 (West 2013) (emphasis supplied).
- 11 See 46 U.S.C. § 30104.
- 12 Ivy v. Sec. Barge Lines, Inc., 606 F.2d 524, 1980 A.M.C. 356 (5th Cir. 1979).
- 13 In re Stephens, 341 F.Supp. 1404, 1405 (N.D. Ga. 1965) ("The Chattahoochee River is not in fact 'a continuously navigable waterway' except at a point many miles south of Lake Lanier. It is not navigable at all north of Lake Lanier, nor south of Lake Lanier until it reaches Columbus, Georgia." (cit. omitted)).
- 14 See In re Stephens, generally, for pertinent discussion.
- 15 Adjoining" was not specifically defined by the 1972 Amendments to the Longshore Act, and so how far inland coverage under the Longshore Act goes has been the subject of much litigation and a current split among the federal circuits; as such, discussion of this point is outside the scope of an article such as this.
- 16 Chandris v. Latsis, 515 U.S. 347, 371 (cit. omitted).
- 17 Martin J. Norris, *The Law of Seamen*, 4th Ed., Vol 2 § 30:12, p. 360.
- 18 Generally, a vessel is only a vessel for maritime purposes if it is at least *capable* of being used/navigated for purposes of interstate commerce at the time of injury, though this requirement is so broad as to preclude only stationary platforms and similar structures.
- 19 Brooker v. Durocher Dock & Dredge, 133 F.3d 1390, 1392, A.M.C. 1314, 11 Fla. L. Weekly Fed. C 1018, 1998 WL 24951 (11th Cir. 1998).
- 20 <http://www.bloomberg.com/news/articles/2014-10-28/savannah-surges-as-major-port-for-imports-on-u-s-growth>

The opinions expressed within the newsletter are those of the authors and do not necessarily reflect the opinions of the State Bar of Georgia, the Workers' Compensation Law Section or the Section's executive committee

Transportation in Workers' Comp Claims

What Happens in the New Ride-Share Economy?

By J. Hunter Chandler, Speed, Seta, Martin, Trivett & Stubley, LLC

An emerging “hot button” issue in the administration of Georgia workers’ compensation claims is the provision by employers/insurers of transportation to and from medical appointments. Oftentimes, attorneys representing claimants request employer/insurer-furnished transportation due either to the absence of a working automobile in their client’s household or their client’s lack of a driver’s license. In our experience, the latter scenario arises frequently in claims in which the injured worker is an undocumented worker.

There is no provision of the Georgia Workers’ Compensation Act or the Rules promulgated thereunder which, in the absence of medical necessity, requires an employer/insurer to provide transportation to and from medical appointments. Board Rule 203(e) provides that medical expenses under the Act “shall include ... the reasonable cost of travel between the employee’s home and the place of examination or treatment or physical therapy, or the pharmacy. When travel is by private vehicle the rate of mileage shall be 40 cents per mile.”

If an authorized treating physician assigns driving restrictions to an injured worker on account of the at-work injury (for example, if the injured worker is on pain medications which make driving dangerous), a viable argument can be made that the injured worker’s inability to attend a medical appointment is directly attributable to the at-work injury and that the employer/insurer should furnish transportation.

Practically, what happens when an injured worker requests transportation to and from medical appointments in the absence of driving restrictions attributable to the at-work injury?

In Board Claim No. 2013-001264, the Claimant sustained compensable injuries following an accepted, at-work injury. He was not under driving restrictions imposed by any of his treating physicians; had two working cars in his household; and drove himself to his deposition. His wife drove him to the hearing. He drove himself to work prior to the injury.

In support of his request for employer/insurer-furnished transportation to and from medical appointments, the Claimant alleged that his being “forced” to drive himself to medical appointments would be against public policy as “potentially encouraging wrongdoing of driving without a license.” The administrative law judge found that Board Rule 203(e) was not specifically limited to mileage reimbursement and may “contemplate an insurer’s provision of expenses other than mileage.”

On appeal, the employer/insurer argued that since

there was no workers’ compensation at common law, the “recoverability of workers’ compensation benefits is strictly a matter of statutory construction.” *Abernathy v. City of Albany*, 269 Ga. 88, 89 (1998). We contended that an ALJ is constrained by the explicit terms of the Act and the Board’s Rules promulgated thereunder. Accordingly, a new right (transportation to and from medical appointments) cannot be found in the Act or the Board’s Rules without explicit statutory authority. We interpreted the word “cost” in Board Rule 203(e) as simply reimbursement after the fact – not an affirmative duty to furnish transportation prior to treatment.

The Appellate Division overturned the ALJ’s ruling and found that the employer/insurer’s declination of transportation for authorized medical appointments did not require the Claimant to drive without a driver’s license, require any other family member to drive the Claimant to appointments, or encourage action different than the Claimant faced for “any existing transportation need.” The Appellate Division suggested that the Claimant use “public transportation, as suggested by the ALJ, or otherwise arrange for transportation to his medical appointments as necessary.”

The Appellate Division specifically held that the “Employer/Insurer are not required to provide the [Claimant] transportation to and from authorized medical appointments, except for reasonable mileage reimbursement at 40 cents per mile,” citing O.C.G.A. § 34-9-200 and Board Rule 203(e).

The Claimant in Board Claim No. 2013-001264 lived in an urban area, had access to several automobiles, and admitted to driving himself at the same time he requested transportation to and from medical appointments.

The Appellate Division’s ruling, however, leaves unanswered several questions: if a claimant does not live in an area served by public transportation, will the phrase “reasonable cost of travel” be interpreted to include ride-sharing applications such as Uber and Lyft? If a claimant’s community is not serviced by Uber or Lyft, what options are left for injured workers who are without transportation and facing a possible suspension of indemnity benefits for failure to cooperate with medical treatment? Will the Advisory Council’s Legislative Committee recommend amendment of Board Rule 203(e) to specifically address these issues?

One fact is for certain: the provision of transportation can prove costly throughout the pendency of a workers’ compensation claim in Georgia. Without a definitive clarification of Board Rule 203(e), the Appellate Division’s ruling in Board Claim No. 2013-001264 will remain persuasive authority and both claimants and employers/insurers will continue to use the current form of the Rule to suit their purposes.

Odyssey From *Sturgess I* to *Sturgess II*

By Andrew J. Hamiton and Holly J. Portier, Hamilton, Westby, Antonowich, & Anderson, L.L.C.

Introduction

On Feb. 15, 2016, the Court of Appeals held in *Sturgess v. OA Logistics Services, Inc. (OA)*, et. al., 2016 Ga. App. LEXIS 67 that the provisions of the Georgia Workers' Compensation Act (WCA) [O.C.G.A. §34-9-11(a)] did not provide a defense to OA for the wrongful death of its employee (*Sturgess I*). Almost a month later, on March 10, 2016, the same panel issued a new opinion in *Sturgess*, 336 Ga. App. 134 (2016) (*Sturgess II*), holding that OA was indeed protected by the exclusive remedy provisions of the WCA. The facts were the same; the law cited by the court in *Sturgess I* and *Sturgess II* was the same; only the application of the law to the facts was different. This presents an opportunity to revisit again the sometimes elusive doctrine of positional risk.

The Positional Risk Doctrine and Work Place Assault Cases

In work place assault cases, the case law provides that if the felonious injury is personal in nature, the injury or death is not covered under the Workers' Compensation Act (WCA). There are certainly examples where a third party assault peg fits squarely into the "personal" hole or not. In *Johnson v. Holiday Food Stores*, 238 Ga. App. 822 (1999), the injured worker was killed by a jealous fiancée. Contrarily, in *Dekalb Collision Center, Inc. v. Foster*, 254 Ga. App. 477 (2002), the deceased employee was killed in a scuffle surrounding some construction work performed to the building where employee worked.

What about cases where the work place violence is simply random and there does not appear to be any unique risk of violence at the work place? That is what the Georgia Court of Appeals was confronted with in *Sturgess v. OA Logistics Services, Inc., et. al.*, 336 Ga. App. 134 (2016). The *Sturgess* case involves temporary employees working at a plant in Chatham County. The employees were directly hired by a staffing agency. The perpetrator, Christopher Lema, shot and killed a co-employee, Mr. Zephyrine. Both Christopher Lema's police interrogation transcript and another employee's testimony confirm that Christopher Lema did not know Mr. Zephyrine, never spoke to Mr. Zephyrine, and had no ill will toward Mr. Zephyrine. Mr. Zephyrine's family brought a civil lawsuit for, inter alia, negligent hiring against the plant, the temporary employment agency, and the PEO. The defendants moved for summary judgment asserting the exclusive defense. O.C.G.A. § 34-9-11(a) provides that the rights and remedies granted to an employee in this chapter (WCA) shall be in place of all other rights and remedies. Thus, the defendants argued that Mr. Zephyrine's death was work related. Plaintiff argued that it was not.

The Court of Appeals ultimately found that Mr. Zephyrine's death was covered under the WCA and did so by citing the positional risk doctrine. Before this opinion was published, the Court of Appeals originally concluded that Mr. Zephyrine's death was not covered under the WCA. The Court held that the positional risk doctrine applied to Acts of God. Both opinions cite the same case, *Dawson v. Wal-Mart Stores, Inc.*, 324 Ga. App. 604 (2013) for the proposition that, "the definition of arising out of excludes an injury which cannot fairly be traced to the employment as a contributing proximate cause, and which comes from a hazard to which the workmen would have been equally exposed apart from the employment." *Sturgess I* and *Sturgess II*.

In initially finding that Mr. Zephyrine's death was not covered under the WCA, the Court compared the case to *Helton v. Interstate Brands Corporation*, 155 Ga. App. 607 (1980), where an employee was assaulted by a co-employee in the parking lot before her shift began. In the *Helton* case, the Court of Appeals held that the injury arose out of the employment because the employee had to arrive early and known criminal activity occurred in the vicinity. The Court of Appeals then cited the *Kennedy v. Pineland State Bank*, 211 Ga. App. 375 (1993) case where an employee was sexually harassed by her supervisor and the Court of Appeals found that the case was not covered by the WCA. In deciding that Mr. Zephyrine's case was not covered under the WCA, the Court of Appeals contended that there had to be a discernible connection between the injury and the employee's work or workplace. The Court cited the peculiar risk doctrine and found that there must be a causative danger peculiar to the work in a way that causally connects the employment to the injury and that there cannot be equal exposure to the risk outside of employment if the claim falls under the WCA. The Court went on to explain that if employees are injured while "traversing dark parking lots or high crime areas because of their employment, injuries by third party criminal acts are compensable".

Approximately one month later, after the defendants filed a motion for reconsideration, the Court of Appeals reversed its opinion but used much of the same reasoning. The Court cited *Chapparral Boats, Inc. v. Heath*, 269 Ga. App. 339 (2004) in discussing the positional risk doctrine "the risk does not have to be peculiar to the employment where a causal connection between the employment and the injury is otherwise established by evidence that a condition of the employment required the employee's presence at a location and a time where the employee confronted the risk." *Sturgess II*, 334 Ga. App. 134 at 137. The positional risk doctrine provides that, "an accidental injury arises out of the employment when the employee proves that his work brought him

within the range of the danger by requiring his presence in the locale when the peril struck, even though any other person would have also been injured irrespective of employment." *Sturgess II*, 334 Ga. App. 134 at 137.

Can a third party assault without a specific work related motive ever really fall under the positional risk doctrine? "Where the injury would have occurred regardless of where the employee was required to be located, and results from a risk to which the employee would have been equally exposed apart from any condition of employment, there is no basis for finding a causal connection between the employment and the injury, and no basis for compensation under the positional risk doctrine." *Chaparral Boats, Inc. v. Heath*, 269 Ga. App. 339, 341 (2004).

The likelihood of being a victim of criminal activity is always unknown (what a criminal would do, where he would do it and when). In *Chaparral Boats*, could the employee have been equally exposed to hurting her knee while walking outside of work? The answer is "yes". Pose the same question for criminal assault. Could the employee have been equally exposed to getting shot outside of work? The answer is still "yes". The reason is that we never know what a criminal will do when we are discussing a random act of violence. In the original *Sturgess I* opinion the Court discussed positional risk as a doctrine used for Acts of God. Could an employee be equally exposed to a hurricane at work or at home? "Yes". What about more common workplace injuries? Could an employee be equally exposed to carpal tunnel syndrome at home as she would at the plant where she slices widgets? Perhaps, but this is not as likely. She's not likely to slice widgets at home or if she does, she's not likely to slice them at the rate or speed that she uses at work. What about heavy lifting? An employee can lift heavy objects at home but the heavy objects the same employee is lifting for work may only be found at work. Contrarily, a criminal or the criminal who caused the assault could be at your home or at your office.

In *Sturgess II*, while the workplace brought Mr. Zephyrine within the range of danger, the risk could have also occurred to the general public. No one could know at what point Christopher Lema would snap and shoot a stranger. While there certainly was a connection between Mr. Zephyrine's workplace and the work injury, we cannot know whether conditions that are not unique to the workplace could have brought Mr. Zephyrine into the same danger. For example, Mr. Zephyrine could have been at a movie theater, car wash or any number of locations at the same time Christopher Lema pulled out his gun.

In other random violence cases, the Court uses a standard of whether the conditions of employment are essentially ripe for criminal activity. In *Macy's v. Clark*, 215 Ga. App. 661 (1994), an employee was sexually assaulted when she was leaving work. The Court of Appeals found that her civil case was barred by the

exclusive remedy because her injury fell under the WCA. The Court opined that her work brought her within the range of danger because she was working late at night. This case is similar to *Sturgess* in that there is no clear motive. The assailant did not know the employee. Any victim of a sexual assault will likely say that the assault certainly feels very personal; however, the Court did not find that the injury was personal in the same way as the victim in the *Johnson* case where the employee was murdered by a jealous boyfriend. The employee in the *Macy's* case was going to a garage used by both customers and employees. However, if we apply the positional risk doctrine, a female customer would have the same risk as the employee. The locale exposed the employee to the risk but would the injury have occurred regardless of where the employee was required to be located? What if the injured work in the *Macy's* case were shopping instead of working?

In the *Burns Int'l Sec. Servs. Corp. v. Johnson*, 284 Ga. App. 289 (2007) case, a security guard was strangled at the hotel where she was performing security duties. The opinion does not tell us why the security guard was in one of the hotel rooms. It was presumed that she was acting in furtherance of her job duties. Again, applying the positional risk doctrine, would she be at equal risk of exposure as a hotel guest? The absence of any personal motive against the security guard will lead us to answer "yes". In both *Burns* and *Macy's*, the Courts looked at conditions ripe for criminal activity, the time of day when the injury occurred, the location of the crime and in *Burns*, the fact that vagrants inhabited the hotel. The Court in *Sturgess* opined that an injury arises out of employment under the positional risk doctrine if it would not have occurred but for the fact that the conditions and obligations of the employment placed the claimant in the position where he was injured. Women are victims of criminal assaults in places other than parking garages. Crimes occur in safe neighborhoods as well as ones inhabited by vagrants. When we are discussing a criminal assault, is one any more likely to be a victim outside of work than at work?

In the *Sturgess* cases as in other workplace violent cases, the courts are tasked with the difficult duty of determining whether the case should be compensable under the WCA or tort. Given the two differing opinions in *Sturgess I* and *Sturgess II*, this is no easy task. It will be interesting to see how the positional risk doctrine is used in future cases involving workplace violence cases and other workers' compensation cases.

Writ of certiorari denied *Sturgess v. OA Logistics Services, Inc.*, 2016 Ga. LEXIS 513 (Ga., Sept. 6, 2016)

Medicare Set-Asides in 2016:

Refresher Course, Revisiting Liability MSAs and Current Trends

By Nicholas Formisano, Beverly Manley & Associates

PART I. MSA Refresher Course

When settling a workers compensation claim for an injured worker (*or a liability claim*) who is or will soon be eligible for Medicare benefits, Medicare's interest as a secondary payer for future injury-related care must be reasonably considered to preserve the worker's future Medicare eligibility.

42 C.F.R § 411.46, the Medicare Secondary Payer Act (MSP) states Medicare cannot pay for a claimant's medical services when that individual received a WC settlement award that includes funds for future medical expenses. Through publication of policy memos, the Centers for Medicare and Medicaid Services (CMS) has clarified CMS policy regarding Medicare and WC settlements.

Other issues for consideration related to WC cases:

1. **Compromise** – When a settlement includes compensation for medical expenses incurred prior to the settlement date.
2. **Commutation** – When a settlement includes compensation for future medical expenses, it is a commutation, regardless of whether the Insurer admits or denies liability.

The MSP regulations provide that if a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments. 42 C.F.R § 411.47(a)(1). After the set aside funds are depleted, there must be a complete accounting to the Medicare lead contractor to ensure that the funds were used for medical services that would have been reimbursable by Medicare. Based on the acceptance by the Medicare contractor of documentation that justifies the depletion of the set aside funds, then Medicare can be billed for future medical services.

Although 42 C.F.R. § 411.46 requires that all WC settlements must adequately consider Medicare's interests, the regulation must be used to set aside funds for Medicare. In accord with 20 C.F.R. § 404.408(d), the funds allocated to a set aside arrangement must be consonant with the applicable law and reflect either the actual amount of expenses already incurred (based on a fee schedule) or a reasonable estimate of future expenses. Thus, the amounts to be set-aside for future medical expenses may be based on the applicable WC fee schedule amounts, rather than on actual dollar amounts. However, the WC settlement must clarify that the amount allocated to future medical expenses was calculated based upon applicable WC medical fee schedule amounts. Note the medical providers

must be reimbursed out of the set aside arrangement at the WC rate for medical services rather than the physician's regular full rate or the Medicare rate for covered services.

Submission of MSA to CMS for its Review

A second step in the MSA process – after completing the MSA - is whether CMS review of the MSA is warranted. For CMS to review an MSA, the threshold for review must be met. The threshold for CMS review of a proposed MSA is a settlement that: 1) involves a Medicare beneficiary, if the total settlement is over \$25,000; or 2) involves a client not yet entitled to Medicare but is expected to be within 30 months and the overall settlement is in excess of \$250,000.

The objective of the MSP is to ensure that workers' compensation primary payers do not shift the responsibility for payment of medical services to Medicare. Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of the WC carrier or Self-Insured. Because an MSA arrangement's purpose is to pay for all Medicare covered services and drugs related to the worker's on the job injury or disease, Medicare will not make any payments for any services related to the work-related injury or disease until all funds in the set-aside arrangement have been depleted.

It is incumbent on the attorneys on both sides of the claim to properly inform their respective clients, prior to the settlement of the claim, of the possible consequences the settlement can have on the claimant's Medicare entitlement for future medical care. Be mindful that there are consequences to the attorneys as well that are written into the MSP for failure to comply.

Conditional Payments

Note also that it is a best practice to complete a *Conditional Payment "sweep"* prior to settlement of a Medicare-eligible claimant's claim so as to avoid any surprise expenses post-settlement.

MSA Administration

Professional administration of the MSA for the benefit of the claimant is a very valuable tool that should not be overlooked. It protects the parties down the road so that the claims remains "closed." The cost of administration has come down in recent years.

PART II Revisiting Liability MSAs

The topic of whether or not to fund Liability Medicare Set Asides (LMSAs) provokes more debate and confusion

than any other area within the MSP. A close examination of the MSP provisions is necessary to understand why the topic is as controversial as it is. A conservative position that many have adopted is that allocating a portion of a liability settlement for future Medicare covered medical needs should be considered to mitigate the risk of Plaintiff billing Medicare for costs of future injury related treatment. Such an approach requires a thorough review of the circumstances involved in each case, based upon the limited guidance CMS has provided.

Background

In 1965, Medicare was created as part of the Social Security Act. Medicare was considered a primary payer, except in Workers' Compensation claims, where it was a secondary payer. In 1980, the Omnibus Budget Reconciliation Act added general liability policies as primary payers. At the heart of any MSP discussion lies 42 U.S.C § 1395y (b) (2) (A). It establishes Medicare's status as a secondary payer when "payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." Many interpret this broad language to mean that Medicare's secondary payer status exists with regard to both past and future medical expenses.

The Code of Federal Regulations also addresses Medicare's secondary payer status. Medicare's secondary payer status in Workers' Compensation claims is established in 42 C.F.R § 411.40(b)(1) and in § 411.50(b) for liability and no-fault claims.

The picture becomes muddier when 42 C.F.R § 411.46 is reviewed. This regulation addresses Workers' Compensation settlements. The fact that there is not similar language to address liability settlements has fueled some opinions that there is no need for LMSAs. John Campbell, elder law attorney, states, "These provisions in the MSP

WC regulations arguably provide the only authority for CMS to review the 'reasonableness' of an allocation for future medical expenses or to disregard a settlement if it appears to be an attempt to shift responsibility for future medical expenses to Medicare. Thus, CMS may not legally be able to make this determination in any settlement other than a WC settlement. However, he goes on to say that until CMS publishes policy regarding future medical in liability settlements, it is advisable to include funding for future medical needs in liability settlements.

As one reviews the codes and regulations, it is interesting to note that the term, Medicare Set Aside, is conspicuously absent. Given that Medicare has made it clear that it is a secondary payer and Workers' Compensation, liability, or no-fault insurance are primary, the MSA was born of case parties' efforts to consider Medicare's interests in claim settlements. Since MSAs are not named within the codes and regulations, settling parties have relied heavily on a body of policy memoranda, published by CMS. The vast majority deal with WCMSAs. The lack of policy concerning LMSAs has encouraged those who believe there is no need to fund LMSAs.

The exception is the CMS policy Memo published on Sept. 30, 2011, specifically addressing LMSAs. The underlying premise on which this memo is based is that settling parties have the obligation to consider Medicare's interest when settling liability cases. The so-called Stalcup memo, attached hereto, offers insight into CMS interpretation of the intent of the codes and regulations.

Sally Stalcup, MSP Regional Coordinator, CMS Dallas Regional Office, states unequivocally, "The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law." She goes even further to state, "Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary."

When LMSA Funding is Highly Recommended

A risk analysis should be done for each liability settlement when determining whether or not to allocate a portion of the settlement for future medical costs. Funding a LMSA is an appropriate, conservative approach when **the plaintiff will need future medical care** related to the injury.

1. A careful evaluation of the risk factors in each case will help determine whether or not future medical allocation should be a part of a liability settlement. These risk factors include the following:
2. How severe is the injury? The more severe the injury, the higher the future medical costs will be and the longer the duration of treatment. Therefore, there is a higher risk that Medicare will eventually be billed for injury related treatment, thus, exposing the settling parties to a higher risk of Medicare claiming it remains a secondary payer.
3. How high is the settlement? The higher the



settlement, the more difficult it may be to support no allocation for future medical.

4. What is your client's risk tolerance? Doing as much as possible to document efforts to consider Medicare's interest will reduce the risk of having to deal with Medicare in the future.

What is the treatment plan? The more costly the treatment needs and prescription medications, the more risk is involved if no future medical allocation is made. For example, a plaintiff may be doing well at the time of settlement, but if a joint replacement was performed as a result of the injury, revision surgery will likely be required in the future.

It is clear that Medicare is a secondary payer in WC, liability, and no-fault claims. Beyond that, complying with the MSP provisions is fraught with ambiguity, when dealing with liability cases, which involve future medical needs. It is wise to acknowledge that preservation of diminishing Medicare funds remains of paramount importance to CMS. At the end of the day, funding a LMSA for future medical in liability settlements is the most logical way to avoid butting heads with 42 U.S.C. § 1395y(b)(2)(A).

PART III Current Trends

How to Keep Up with CMS Changes:

- CMS website (www.cms.gov): By clicking Medicare, and then, Workers Compensation Medicare Set Aside Arrangements, you can locate the link for subscription (under Related Links) to CMS alerts regarding published changes in this arena.
- Our website (www.bmanleymsa.com): We provide copies of many pertinent CMS policy memos and resources at our own website.
- CMS decisions: When you receive decisions for MSAs submitted for review, be sure to analyze the attached "WCMSA Review" document for details on services/meds, pricing, etc.

WCMSA Medical Payments:

- **Self-Administration Toolkit (January 5, 2015):** Previous version directed claimants to inform medical providers whether MSA based on full actual charges or fee scheduled prices "so they can bill you for your WC injury treatments using the correct pricing method." This language has been deleted from the current Toolkit.
- **CMS Decision Letters:** Before January, 2015, CMS decisions stated MSA should be spent *using the same pricing methodology* as used in MSA. This language has been deleted from CMS decision letters.
- **WCMSA Reference Guide (January 5, 2015):** Section 17.3 of previous version of the Guide stated, "If you set up for WCMSA based on a fee schedule, pay providers based on the fee schedule. If you set up your WCMSA based on full actual charges, pay

based on full actual charges." This has been deleted from the new Guide.

- **Caution: CMS has NOT issued a new Policy Memo to affirmatively state WCMSA spending is not required to conform to the pricing methodology used in the approved WCMSA.** WCMSA Reference Guide states, "For comprehensive explanations, please refer to the WCMSA RO Memorandums." The Oct. 15, 2004, CMS Policy Memo states payments from the MSA should use same basis as the pricing methodology used in approved WCMSA.

Generic Drugs:

- Generics for Abilify, Nexium, Celebrex and Lunesta recently became available.
- Generally, costs for generics go down over time as more manufacturers begin to produce.

ICD 10 Codes:

- ICD 10 Diagnosis Codes are now in use.

Hydrocodone Reclassification:

- Section 9.4.6.2 of the WCMSA Reference Guide notes when a Hydrocodone combination is prescribed, the WCMSA must now include costs for *at least* four physician visits per year. This is due to the October, 2014, reclassification of Hydrocodone combination products from C-III to C-II controlled substances, requiring prescriptions to be written thirty days at a time, with up to three consecutive prescriptions being written in one doctor visit. Patients can get a maximum ninety day supply, prior to returning to the doctor.

CMS Decisions:

- CMS is including more drugs for gastrointestinal issues than they have in the past; off label interpretation seems broader now.
- CMS is more open to leaving out invasive procedures (for example, joint replacement revisions) for older claimants.

Development Letter Response Time:

- Section 9.4.1 of the new Guide changes the deadline for response to CMS development letters from ten business days to 20.

400 Week Cap for Medical in GA - non-CAT

Beverly Manley & Associates is actively engaged with CMS representatives as to the interaction of this GA WC law with CMS "allocate for life" rules. Our firm presently has a test case before CMS. STAY TUNED.

Be sure to contact us with any questions – we are always availed to assist. Thank you.

Bringing Problems Home

Solving Problems Through Home Assessments

By Peggy Freedman, Occupational Therapist

Most of us are healthy, active people moving from place to place in our daily battle with life's stresses. Running about the house is just a part of our fast paced activities.

Just think with me for a moment what your life would be like if, suddenly, you were in a wheelchair and had to maneuver around the couches and tables in your home? Or you were faced with the obstacle of climbing steps after the amputation of one leg. How about taking a bath, or cooking, or doing the laundry? Could you do it? Yes, but with adjustments both physically and mentally.

For many people, even a minor injury can interrupt their life, whether it is for a short period of time or long term. Consider how an injury may impact basic concerns of how to bathe and dress. How do you cook if you are maneuvering around the house with crutches and trying to adhere to weight bearing precautions? How do you bring firewood into the home or take the garbage out? How do you perform cleaning tasks around the house? Or how do you wash clothes? What about driving? There are so many questions the injured client will have about their injury as it relates to how it will impact their home life, work life, and their family – short term and long term.

One thing that can be assured is that no matter how major or minor the injury or illness, there will be changes in the family dynamics and the self-perception of the injured individual. Their role and self-identity within the family, at work and in their community will be changed. They may be concerned about how to accomplish simple self-care activities or chores, or will question who will perform the homemaking activities they might be unable to perform.

The question is how we, as health care professionals, will help these individuals to safely function in their home environment and encourage independent functioning. A **Home Assessment** is the skillful identification of barriers and the art of solving problems with Activities of Daily Living, Homemaking Tasks, Movement about the Home, Medication Management, etc. The Home Assessment Evaluator's job is to remove obstacles and provide alternative solutions to allow the individual to be successful in their own environment.

Nuts And Bolts Of A Home Assessment

What is in a Home Assessment? A good Home Assessment includes four basic subject matters: (1) the evaluation should be specific to the individual; (2) it should include an objective evaluation of the person functioning in the home; (3) the purpose of the Home Assessment should be identified; and (4) the report must include specific

recommendations. If you get a home assessment without any of these topics covered, call the provider for more clarity.

Who performs the Home Assessment? Generally, an Occupational Therapist is the most qualified and trained professional to perform these assessments because their entire educational background and training is focused on returning an individual to functionality.

How long does it take to perform the Home Assessment? The time required for the assessment to be performed within the home varies between 2 ½ and 4 hours. The report generation and research time can vary widely depending on the scope of the assessment but can require between 4 and 6 hours.

What Is Included In The Home Assessment?

All Home Assessments should cover many, if not all of the activities described below.

Activities of Daily Living Assessment: Assess and determine if the individual is having difficulty or is unable to perform self care tasks, including: feeding, dressing, bathing, toileting, grooming, or hygiene activities. Transfers are evaluated which includes the client's ability to safely move from the bed, chair, sofa, commode, tub, etc. Once all self-care activities and transfers are addressed, the evaluator (when appropriate) provides education regarding energy conservation techniques and the use of proper body mechanics when performing specific tasks. This instruction may also invite the participation of a family member or caregiver. The need for equipment or modifications within the home, if any, to facilitate safety and independence in Activities of Daily Living, is determined and outlined in the report.

Homemaking Activities: Assess and determine how the individual is performing homemaking activities. What activities were they participating in prior to their injury or illness and what activities are they currently performing? Is there an easier or safer way to execute the activity? Or perhaps there is a technique that will allow the individual to return to the ability to perform a specific task. Tasks evaluated should include vacuuming, sweeping, mopping, washing clothing, cooking, dish washing, grocery shopping, and performing lawn maintenance to name a few. Once the Homemaking Activities are assessed, the evaluator (when appropriate) provides instructions to the client and perhaps a family member for energy conservation techniques and the use of proper body mechanics. The need for equipment or home modifications, if any, is determined and outlined in the report.

Architectural Assessment: Identify the barriers and structures within the home and take measurements of doors, hallways, stairs, bathrooms, bedrooms, kitchen, laundry area, etc. If indicated, recommendations providing specific information for architectural changes are outlined in the report. These recommendations can vary widely and are dependent on the injury or illness of the individual and their specific home environment.

Avocational/Hobbies: Determine the hobbies or interests the individual participated in prior to the injury/accident as well as leisure activities in which they are currently involved. The evaluator can then provide suggestions on ways the client can adapt and resume these activities. Equipment, if necessary, is outlined in the report.

Safety and Cognitive Abilities: Safety in the home and decreased cognitive abilities are taken into consideration when determine if any modifications may be appropriate to facilitate independence in functioning within the home. Recommendations are provided.

What Is Included In The Report?

The report should outline in detail the areas of concern with performance of Activities of Daily Living, Homemaking Tasks, Architectural Barriers, Avocational/Hobbies, Cognitive Abilities and Safety in the home. When requested the determination for Attendant Care/Housekeeping Services can also be addressed. Concise and accurate reporting substantiates the recommendations which are based on medical necessity. At times, the client may have requests for products or architectural modifications which are also outlined in the report and are commented on by the evaluator including if they are deemed medically necessary or not.

Pictures of the home and the individual functioning within the home are also included in the report and all parties involved in the client's care are copied with the findings of the Home Assessment.

What Is Included in the Recommendations?

The recommendations provided at the conclusion of the report give a detailed view of what can assist the individual with functioning independently in their own environment. These recommendations may include modified techniques such as energy conservation, education of family members, modifications to the home or recommendations for durable medical equipment. When products are suggested, resources are provided including the specific product name, catalog number and where to purchase the equipment. Recommendations for architectural modifications to the home are provided (when appropriate) with specific and detailed information regarding the suggested modifications. The names of a few construction specialists can be provided if requested. All recommendations provided are based on medical necessity.

At times, the request for the Home Assessment will include questions regarding Care Attendance or Housekeeping Services and if these are medically necessary. After the evaluation has been performed, an opinion is provided regarding the specific services recommended and the number of days/hours the services should be provided based on the client's medical necessity.

The recommendations and final Home Assessment report as described above encompasses a comprehensive approach to Home Assessments as provided by The Freedman Group, though this approach may not be utilized by all evaluators who perform Home Assessments.

Though the same activities may be evaluated from one client to the next, the outcome of the assessment varies among individuals. Everything is based on the specific needs of the client and the medical necessity for the recommendations provided.

The Home Assessment can be a powerful tool because it helps teach the client *that they may have hurdles to overcome, but that is all they are – hurdles, not roadblocks.*

Please call with any questions or a referral.

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Motions Practice at the Board

By Hon. Nicole Tifverman, Administrative Law Judge, Savannah, & Hon. David Imahara, Administrative Law Judge, Gainesville

Motions are an important aspect of any litigation practice. In the workers' compensation arena, this is no different. Motions place issues before an administrative law judge for an expedited ruling prior to or in lieu of a full evidentiary hearing. We want to take this opportunity to address some good practices regarding motions.

Filing the motion or objection

When filing a motion or objection, use Form WC-102D, unless you are filing a request for approval of an attorney fee, request for a change of physician, or a motion for reconsideration which have their own forms or ICMS 2 doc types. Motions and objections, including briefs and exhibits, are limited to 50 pages, unless otherwise permitted by the judge. Board Rule 102(D)(1)(a). Prior to filing a motion, the moving party is required to confer with the opposing counsel or unrepresented party in a good faith effort to resolve the matter. Board Rule 102(D)(2). The opposing party has 15 days from the date on the motion's certificate of service to file an objection with the Board. Board Rule 102(D)(3).

Be sure to attach a certificate of service to the motion or objection. Board Rule 102(D)(1)(a). Also, serve a copy on the opposing side. A common complaint among attorneys is

that parties are not serving the other side with documents. If all parties are represented, service should be by electronic mail. Board Rule 102.1(h). Service also is required on all unrepresented parties. Board Rule 102(D)(1)(a).

If you require an extension of time to file a response, first ask opposing counsel. If all parties are in agreement to the extension, immediately request the extension from the ALJ. If there is no agreement among the parties, request a conference call with the judge.

Supplemental responses are permitted and perhaps underutilized. If an important fact or argument is raised in an objection that was not addressed in the motion, a response may be warranted. If you want to file a supplemental response, notify the judge of your intent in order to prevent the issuance of a ruling before you have the opportunity to file the response.

Briefs and evidence

Judges want to see both briefs and evidence. We occasionally receive motions/objections filed with briefs but no evidence or no briefs and only evidence. In each scenario it is difficult for the judge to rule. Remember that facts stated in briefs are not evidence and cannot be the basis for a decision. *See Rheem Mfg. Co. v. Jackson*, 254 Ga. App. 454, 562 S.E.2d 524 (2002). When the motion form is filed with exhibits attached but no brief, the judge may not be able to determine what relief is sought or why.

In the brief, provide a short statement of the facts and the issue in dispute to provide us some context before focusing on the issue to be decided. For example, tell us whether the claim has been accepted as compensable or is controverted. Clearly identify and state the relief you are requesting, with specificity. If you are requesting the commencement of income benefits, you must provide the compensation rate. If you are requesting medical treatment, name the doctor with whom treatment is requested. If you seek assessed attorney fees, specify the amount and include the evidence necessary to support an award of fees.

Evidence submitted with a motion/objection may include medical records, affidavits, deposition excerpts, or other records relevant to the issues. Judicial notice and stipulations are also valid forms of evidence. We don't recommend the "shot gun" approach to evidence — throwing everything into the record with no organization. Organize and label the records to make them easy to read and cite. Medical records are easier to read when separated by medical provider and organized chronologically.

Pre-trial motions

GEORGIA STATE BOARD OF WORKERS' COMPENSATION					
MOTION / OBJECTION TO MOTION					
<input type="checkbox"/> Motion <input type="checkbox"/> Objection to Motion					
When you receive this completed form, you may file a response with the Board within fifteen (15) days of the date of the certificate of service (O.C.G.A. §9-11-6 (e)); All responses must be filed on Form WC-102D.					
Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
A. IDENTIFYING INFORMATION					
EMPLOYEE		County of Injury			
Address		Address			
E-mail Address		City		State	Zip Code
EMPLOYER		INSURER / SELF-INSURER		Name	
Address		CLAIMS OFFICE		Name	
City		State	Zip Code	Address	
Employer E-mail		City		State	Zip Code
Name		Name		Claims E-mail	
ATTORNEY FOR EMPLOYEE / CLAIMANT		ATTORNEY FOR EMPLOYER / INSURER			
Address		Address			
City		State	Zip Code	City	
GA Bar Number		GA Bar Number		State	
Attorney E-mail		Attorney E-mail			
B. ACTION REQUESTED					
<input type="checkbox"/> 1. This MOTION is being requested by <input type="checkbox"/> Employee <input type="checkbox"/> Employer/insurer <input type="checkbox"/> Other Party The purpose of this motion is to request:					
(Arguments and documentation in support of this motion are attached.)					
<input type="checkbox"/> 2. This OBJECTION is being submitted by <input type="checkbox"/> Employee <input type="checkbox"/> Employer/insurer <input type="checkbox"/> Other Party The purpose of this objection is to request:					
(Arguments and documentation in support of this objection are attached.)					
C. ENTRY OF APPEARANCE					
<input type="checkbox"/> I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or Form WC 102B filed in compliance of Board Rule 102. (A fee contract or Form WC 102B has been filed previously or is attached.)					
D. CERTIFICATE OF SERVICE					
<input type="checkbox"/> I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, GA 30303-1299 and to all parties and counsel in this claim.					
Print Name Here		Signature			
Phone Number		E-mail Address			
IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbcwv.georgia.gov WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-11 AND §34-9-15).					
WC-102D	REVISION 07/2014	102D	MOTION / OBJECTION TO MOTION		

Prior to a hearing, motions should be used to resolve discovery disputes. Motions in limine also can be useful to address evidentiary issues. Try to avoid appearing at a hearing without such issues resolved, since that may result in a hearing postponement and a waste of time for everyone.

A party may file a motion for an interlocutory order suspending or reinstating payment of weekly income benefits to an employee pending an evidentiary hearing. Board Rule 102(D)(5). In an "all issues" case in which the compensability of the claim has been controverted, motions for an interlocutory order commencing benefits will not be granted. Such motions only will be considered in claims previously accepted or found to be compensable.

Where the issue is an offer of suitable employment and income benefits have been suspended under Board Rule 240, a motion for reinstatement of weekly benefits pending the hearing may be filed simultaneously with the hearing request or while the hearing is pending. The motion must be accompanied by the affidavit of the employee as well as current medical records when applicable. Board Rule 240(f).

Likewise, a motion to suspend payment of weekly benefits based on an employee's unjustifiable refusal to accept suitable employment may be filed simultaneously with the filing of a hearing request or subsequent to that filing. The motion must be accompanied by an affidavit from the employer stating that suitable employment was offered to the employee, the offer is continuing, and the job analysis is attached. The employer/insurer also must have the employee examined by the authorized treating physician within 60 days of the request for suspension of benefits. *See* Board Rule 240(b)(1). The request for suspension of income benefits will not be granted unless the authorized treating physician has approved the job offered by the employer/insurer. Board Rule 240(e).

Where the issue is which of two or more employers and/or insurers is responsible for payment of benefits, the ALJ may issue an interlocutory order directing an employer/insurer to pay income and medical benefits until the determination of which party is liable has been made. Reimbursement may be ordered if, following the evidentiary hearing, a different employer or insurer is found responsible for payment of benefits. Board Rule 102(D)(6).

A motion to dismiss a workers' compensation claim may be filed, for example, based on a statute of limitations defense pursuant to O.C.G.A. § 34-9-82(a) or O.C.G.A. § 34-9-104(b) or based on lack of jurisdiction over an accident that occurred outside the state pursuant to O.C.G.A. § 34-9-242.

Motions with no hearing pending

At any time during the pendency of a claim, even when the case is not in litigation, motions may be used to address a variety of issues, such as approval or assessment of attorney fees, change of physician requests, and authorization of medical care.

Use Form WC-108a to request approval of a payment pursuant to an attorney fee contract, approval of an assessed attorney fee by agreement of the parties, or agreement of the resolution of a fee lien dispute. Any other motions regarding attorney fees should be filed with Form WC-102D. If you are seeking approval of an attorney fee of 25 percent of the employee's benefits, you must attach proof that benefits have been paid (such as Form WC-2, a copy of the benefits check, or the insurer's payment records). You also must include proof that the payment of weekly benefits was the result of your efforts. Board Rule 108(b)(9).

When requesting or objecting to a change of physician, file Form WC-200b and attach supporting documents. The request for or objection to the change of physician should specify why the change will or will not provide the employee with medical care reasonably required to effect a cure, give relief, or restore the employee to suitable employment, as required by O.C.G.A. §34-9-200. Board Rule 200(b)(2) lists factors which may be considered in support of the request or objection. Such factors include the location of the physician's office, the physician's accessibility, whether excessive or redundant medical procedures have been performed, the necessity for specialized medical care, language barrier, a referral by the authorized physician, a physician's noncompliance with Board rules and procedures, whether a valid panel of physicians was posted, the duration of treatment without appreciable improvement, the number of prior treating physicians, prior requests for a change of physician or treatment, whether the employee has been released to normal duty work by the authorized treating physician, and if the current physician indicates there is nothing more to offer. The factors a judge will consider in making this decision vary depending on the facts of the case and are not limited to this list.

Communication with the ALJ

After a motion is filed, communication with the judge's office regarding that motion may be required or appropriate under certain circumstances. The parties or attorneys are required to notify the ALJ immediately if the issues are resolved in whole or in part while the motion is pending or if a ruling on the motion is no longer necessary or desired. Board Rule 102(D)(4).

If the timing of a ruling is important to keep the case moving (for example, the motion involves discovery issues), let the judge's office know to prevent, to the extent possible, a delay of the hearing.

When a motion is filed but the opposing party takes the position that the issue is not appropriate for resolution by motion, a timely objection still should be filed and should include that argument. Additionally, the respondent may contact the judge's office to communicate the request that the matter not be resolved by motion.

All written communications with the judge's office, whether by letter or email, must be copied to the opposing

counsel or unrepresented party. Any communications by phone should be made with the permission of the opposing counsel or party or by conference call.

Why do judges defer rulings to a hearing?

Whether the judge can resolve a dispute by motion or an evidentiary hearing is required depends on the issue. If the compensability of a condition is at issue, most likely a hearing is needed. Where the facts are disputed, a hearing is necessary. For example, if an employee seeks a change of physician to a doctor of the employee's choice on the basis that the panel of physicians was never explained and submits an affidavit in support of that request, but the employer files an affidavit of the HR manager asserting she properly explained the panel, a hearing would be required because a clear dispute of fact exists.

Additionally, we try to avoid bifurcating issues, which would result in part of the claim pending before the judge and part of the claim on appeal. For example, when an employer/insurer controverts further medical care on the basis that the treatment is no longer related to the employee's compensable injury, the employee's request for a change of physician most likely will be deferred until the hearing and a determination is made regarding the compensability of the injury.

If, however, the parties prefer a ruling on the record without a hearing and can stipulate to the facts, just let the judge know and that can be accomplished.

Orders and appeals

Judges generally will rule on motions within 30 to 60 days of filing. The order will become final if not appealed to the Appellate Division within 20 days of the date the order is issued.

If a motion for reconsideration is filed, the judge has 20 days from the date of the order to "reconsider." The judge may reconsider the decision only to correct apparent errors or omissions. O.C.G.A. §34-9-102(f). Because time is of the essence for both the attorneys and the judge, the moving party must notify the judge that the motion has been filed. Use the ICMS doc-type labeled motion for reconsideration and limit the motion to 20 pages including briefs and exhibits, unless otherwise permitted by the judge. Board Rule 102(D)(1)(b).

If the order issued by the judge is "interlocutory," and you would like to appeal immediately, you must receive a certificate of immediate review from the judge for the appeal to be accepted by the Appellate Division. The judge has the discretion to grant or deny the request for a certificate of review, depending on whether the judge finds that the decision is of such importance to the case that an immediate review should be conducted by the appellate judges. Board Rule 103(d). If the request for a certificate of immediate review is denied by the ALJ, you may appeal the ruling after the judge issues an award following the hearing.

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An Examination of *Roseburg v. Barnes* and the Overarching Legal Implications on Catastrophic Cases

By Dustin K. Peters, S. Gregory Wagner, and Michael D. Thorpe, Cuzdey, Ehrmann, Wagner, Stine & Sansalone, LLC

*I. Summary of Case Facts and Legal Posture*¹

On Aug. 13, 1993, claimant, Willie Barnes sustained a compensable injury while employed by Georgia Pacific Corporation (Georgia Pacific) resulting in the immediate amputation of his left leg below the knee. Mr. Barnes' claim was accepted as catastrophic, and he received temporary total disability benefits until Jan. 30, 1994, when he returned to work in a light-duty capacity. Thereafter, permanent partial disability benefits were initiated attendant to an 88 percent lower extremity impairment rating. Eventually, permanent partial disability benefits were suspended on May 23, 1998, upon full payment.

Barnes continued to work for Georgia Pacific until Sept. 15, 2006, when the Georgia Pacific plant where he was employed was purchased by Roseburg Forest Products Company (Roseburg). As a part of this purchase, Roseburg agreed to assume all liabilities related to prior workers' compensation claims for employees at this facility.

Barnes remained employed by Roseburg until approximately three years later, when during the course of a general layoff, Barnes' employment was terminated on Sept. 11, 2009. At this point in time, it had been over 15 years since he had received any temporary total disability benefits. On Nov. 13, 2009, Barnes reported to an authorized physician requesting treatment for chronic knee pain. Other than this visit, he did not receive any authorized medical treatment following his termination until Dec. 6, 2011, when he was fitted with a new prosthetic leg.

On Aug. 30, 2012, through counsel, Barnes filed a WC-14 seeking reinstatement of income benefits stemming from his Aug. 13, 1993, claim based on an alleged change in condition. On Nov. 30, 2012, he filed a WC-14 alleging a fictional accident occurring upon his termination in September of 2009. Both claims were timely controverted by the employer/insurer as time barred by the applicable statutes of limitation outlined in O.C.G.A. § 34-9-104(b) and O.C.G.A. § 34-9-82(a).

The Administrative Law Judge, the Appellate Division of the State Board and the Superior Court denied the claims, holding that the statutes of limitation on both claims had passed. Conversely, the Court of Appeals reversed those decisions holding that neither statute of limitation barred Barnes' claims. The Supreme Court of

Georgia granted Certiorari in October of 2016, and in July of 2016 issued a unanimous decision delivered by Justice Melton which reversed the Court of Appeals and held that, despite the original acceptance of Barnes' claim as catastrophic, the two year statute of limitations contained in O.C.G.A. § 34-9-104(b) barred his claim to resume temporary total disability benefits under his 1993 claim, and the one year statute of limitation contained in O.C.G.A. § 34-9-82(a) likewise barred Barnes' claim to receive benefits in connection with an alleged fictional new injury sustained when he was terminated in September of 2009.

It should be noted that Michael Thorpe of Cuzdey, Ehrmann, Wagner, Stine & Sansalone represented Georgia Pacific during the early stages of this case. Due to the purchase agreement executed by Roseburg, wherein Roseburg agreed to assume all liabilities for prior workers' compensation claims, Georgia Pacific was successfully dismissed from the case, but our firm continued to follow the outcome in what turned out to be a landmark decision for catastrophic cases.

II. Understanding Statutes of Limitation in Workers' Compensation Cases as Applied in Roseburg

In the *Roseburg* case, the claimant asserted two claims for which he alleged he was entitled to income benefits. First, the claimant alleged he was entitled to reinstatement of his income benefits in his 1993 accepted catastrophic claim based on change in condition, relying on the fact that catastrophic claims carry no cap on entitlement to indemnity benefits under O.C.G.A. § 34-9-261.² Second, the claimant alleged entitlement to income benefits based upon an alleged fictional date of accident occurring in September of 2009, due to an alleged gradual worsening of his condition that resulted in a change in his earning capacity when he was terminated. Both claims were determined by the Georgia Supreme Court to be time barred by the applicable statutes of limitation.

A. The claimant's claim for reinstatement of benefits under the 1993 date of accident was time barred by O.C.G.A. § 34-9-104(b), requiring that a claim for reinstatement of income benefits be filed within two years of the last payment of income benefits.

It was undisputed that Barnes had not received income benefits since he made an actual return to work on Jan. 30, 1994. Approximately 15 years later, Barnes

filed a WC-14 seeking reinstatement of income benefits under his 1993 claim, alleging a change in condition. Simple arithmetic reveals that 15 years is greater than two years and Barnes' claim for reinstatement of income benefits was time barred by the provisions of O.C.G.A. § 34-9-104(b).³

B. Barnes' alleged fictional date of accident claim from September 2009 was time barred by O.C.G.A. § 34-9-82(a), because he had not received remedial treatment within one year of the filing of his claim for benefits.

The timing issues for Barnes' second claim are slightly more complex than his first claim for reinstatement of benefits under the 1993 injury. Barnes was terminated on Sept. 11, 2009, which was when he alleged he sustained a gradual worsening of condition that led to a change in his earning capacity, or fictional new accident.

Following his termination, Barnes sought treatment for chronic knee pain on Nov. 13, 2009, approximately two months later. Since he was not paid indemnity benefits for this alleged accident and, assuming that the treatment received on Nov. 13, 2009, was for his Sept. 11, 2009, alleged fictional injury, this would effectively toll the statute of limitations until Nov. 13, 2010, one year following the last remedial treatment for the alleged Sept. 11, 2009, fictional accident.

Once Nov. 13, 2010, had passed (which was one year after the receipt of remedial medical treatment) the statute of limitations for Barnes' alleged Sept. 11, 2009, fictional date of accident expired, and any claim arising out of that injury was time barred by O.C.G.A. § 34-9-82(a).⁴

An argument was made that the Dec. 6, 2011, treatment received by Barnes, wherein he was fitted with a new prosthetic leg, tolled the statute of limitations on his September 2009 fictional injury claim, because the Employer/Insurer furnished remedial medical treatment. However, as pointed out by Justice Melton, once one year had passed since the last remedial medical treatment was provided, the statute of limitations expired and the care subsequently provided by the employer/insurer did not legally revive the claim.⁵ Accordingly, the Supreme Court of Georgia found that Barnes' 2009 claim for an alleged fictional date of accident was time barred by the applicable statute of limitations.

III. If the Case Was So Simple, Why Did it Make it to the Supreme Court?

Obviously, this article is not intended to make light of any argument presented by either party, nor is it intended to downplay the complexity of the statute of limitations issues surrounding this case. However, sympathetic claimants, especially claimants whose injuries have been deemed catastrophic, are oftentimes provided the greatest extent of leeway in the system to be provided with medical benefits and compensation if a viable argument exists as to the right to compensation and/or benefits in their case.

In this particularly bizarre set of facts, a catastrophically injured worker was provided with light-duty work for over 15 years, and an argument was asserted that such a situation was not contemplated by the Legislator when drafting the statute of limitations on workers' compensation cases. Further, an unsettled area of law concerning provision of remedial medical treatment and tolling of the statute of limitations was fleshed out by the Court to precisely hold that there is no revival of claim once the statute of limitations has expired, despite the somewhat ambiguous wording of O.C.G.A. § 34-9-82(a).⁶

IV. Catastrophic Cases Are Not Different for Statute of Limitations Purposes

The Supreme Court of Georgia overturned the Court of Appeals' decision, which erroneously stated in dicta that it was "clear that the Legislature intended to treat workers who received catastrophic injuries differently from workers who are less severely injured"⁷ and recited the notion that "[t]he Workers' Compensation Act is a humanitarian measure that should be liberally construed to effectuate its purpose."⁸ In doing so the Court confirmed that catastrophic claims are subject to the same requirements as non-catastrophic claims.

Based on same, we can conclude there is no free pass for catastrophic claims, and those claimants must comply with the provisions outlined in the Workers' Compensation Act concerning statutes of limitation, as well as other provisions concerning form filing and compliance with Board rules.

V. Broader Implications on Other Catastrophic Claim Issues

The Supreme Court's ruling in *Roseburg* has broader implications beyond Barnes' claim for income benefits. At first glance, the Court held that statutes of limitation are to be equally applied to catastrophic cases, just as they would be applied to non-catastrophic cases; however, the underlying theme of this ruling and the legal precedent set by this ruling, could reach far beyond the narrow set of facts presented in the *Roseburg* case.

Examine, for instance, the process of a claimant seeking catastrophic designation. When a claimant files a WC-R1CATEE seeking catastrophic designation from the Rehabilitation Division of the Board, under the *Roseburg* ruling, does the filing of a WC-R1CATEE within two years of the last payment of income benefits toll the statute of limitations outlined in O.C.G.A. § 34-9-104(b)?

This issue was previously addressed in *Georgia Institute of Technology, et al. vs. Hunnicutt*, 303 Ga.App. 536. In the *Hunnicutt* case, the only issue presented upon appeal was whether the filing of the WC-R1CATEE constituted an application for additional income benefits under O.C.G.A. § 34-9-104(b).⁹ It was undisputed that the claimant had filed a WC-R1CATEE within two years of the last receipt of income benefits, which ceased upon the expiration of the 400 week cap. However, the WC-

R1CATEE did not include any request for income benefits, and no WC-14 was filed with the Administrative Law Division of the Board, seeking reinstatement of income benefits due to catastrophic designation.

Despite the fact that no formal request for income benefits was filed, the Court of Appeals held that the filing of the WC-R1CATEE was sufficient for statute of limitations purposes, and the claimant's pursuit of catastrophic designation constituted an application for income benefits.¹⁰ The Court of Appeals relied on the language in O.C.G.A. § 34-9-261 placing no cap on income benefits for catastrophic cases, and the claimant argued that while the request for catastrophic designation did not expressly request resumption of income benefits, it either "implicitly incorporated a request for TTD income benefits, or alternatively, tolled the statute of limitation" in O.C.G.A. § 34-9-104(b).¹¹

Arguably, the *Roseburg* case implies that this decision should be overturned, as the Rehabilitation Division of the Board has no authority to compel the Employer/Insurer to reinstate benefits or issue an award for income benefits. Further, the same reliance on O.C.G.A. § 34-9-261 regarding catastrophic claims, and there being no cap on benefits, to attempt to circumvent the statute of limitations in O.C.G.A. § 34-9-104(b) was defeated by the Georgia Supreme Court in *Roseburg*.¹² Accordingly, filing of a WC-R1CATEE, alone, conceivably does not amount to an "application" for income benefits as anticipated under O.C.G.A. § 34-9-104(b) and would not toll the statute of limitations.

VI. Conclusion

In light of the *Roseburg* decision, one can only derive that catastrophic cases are treated no differently than non-catastrophic cases for statute of limitations purposes. The broader implications of this decision have yet to unfold, and it is unclear how the Trial Division will apply this case to future workers' compensation jurisprudence. In order to safeguard against an argument that a filing of a WC-R1CATEE is insufficient to toll the statute of limitations listed in O.C.G.A. § 34-9-104(b), we would advise that a party seeking catastrophic designation both file a WC-R1CATEE and simultaneously file a WC-14 Request for Hearing seeking reinstatement of income benefits.

Following same, the parties could agree to "TOC" the hearing for income benefits until a decision is rendered by the Rehabilitation Division, but the filing of a WC-14 Request for Hearing would satisfy the requirements of O.C.G.A. § 34-9-104(b) that an application for income benefits be made within 2 years of the last receipt of income benefits.

The full effect of the monumental decision in *Roseburg* has yet to have been realized by the Georgia workers' compensation system. However, regardless of the future application of this case, it should also serve as a reminder that we all must carefully examine the key elements for statute of limitations purposes when conducting an evaluation of a new case. Oftentimes, the underlying

merits of a claim can act as a distraction from the statutory requirements laid out by the Legislature, and this case shows that even prior acceptance of a claim as catastrophic will not prevent a dismissal for the lapse of the applicable statute of limitation.

(Endnotes)

- 1 In order to avoid numerous citations and maintain the appearance of a reader friendly article, we would like to inform the reader that the facts contained in this section were derived from several sources surrounding *Barnes v. Roseburg Forest Products Company et al.*, 299 Ga. 167 (2016). These sources included the Amicus Curiae Brief of the Georgia Defense Lawyers Association; the Amicus Curiae Brief of the Georgia Workers' Compensation Association, Georgia Manufacturer's Association, and Georgia Poultry Federation; the Appellants' Brief to the Georgia Supreme Court; the Appellee's Brief to the Georgia Supreme Court; the facts as presented in both the Georgia Supreme Court's decision and the underlying Court of Appeals decision; as well as our firm's firsthand experience with the case.
- 2 The pertinent portion of this statute states "that in the event of a catastrophic injury as defined in subsection (g) of Code Section 34-9-200.1, the weekly benefit under this Code section shall be paid until such time as the employee undergoes a change in condition for the better as provided in paragraph (1) of subsection (a) of Code Section 34-9-104."
- 3 O.C.G.A. § 34-9-104(b) requires that if a party is alleging a change in condition, "that at the time of application not more than two years have elapsed since the date the last payment of income benefits pursuant to Code Section 34-9-261 or 34-9-262."
- 4 O.C.G.A. § 34-9-82(a) provides that "the right to compensation shall be barred unless a claim therefore is filed within one year after injury, except that if payment of weekly benefits has been made or remedial treatment has been furnished by the employer on account of the injury the claim may be filed within one year after the date of the last remedial treatment furnished by the employer or within two years after the date of the last payment of weekly benefits."
- 5 See *Roseburg*, 299 Ga. 167, 171 (2016); this issue is also addressed at length in the Amicus Brief prepared on behalf of the Georgia Workers' Compensation Association, Georgia Manufacturer's Association, and Georgia Poultry Federation.
- 6 Particularly, the language of O.C.G.A. § 34-9-82(a) that has been subject to interpretation "the claim may be filed within one year after the date of the last remedial treatment furnished by the employer" does not expressly indicate that the claim cannot be revived by the subsequent provision of remedial treatment. However, the underlying principle that revival of stale claims is to be discouraged, and the public policy implications of an interpretation that essentially calls for no statute of limitations at all, ultimately proved to be most persuasive for the Court. The public policy implications were discussed in detail in the Amicus brief prepared on behalf of the Georgia Workers' Compensation Association, Georgia Manufacturer's Association, and Georgia Poultry Federation.
- 7 *Barnes v. Roseburg Forest Products Co.*, 333 Ga.App. 273, 277 (2015).
- 8 Id. (citing *City of Waycross v. Holmes*, 272 Ga. 488, 489, 532 S.E.2d 90 (2000); see *Ray Bell Constr. Co. v. King*, 281 Ga. 853, 854, 642 S.E.2d 841 (2007); *DeKalb Collision Center v. Foster*, 254 Ga.App. 477, 482, 562 S.E.2d 740 (2002)).
- 9 Id. at 538
- 10 Id. at 539
- 11 See Id.
- 12 See *Roseburg*, 299 Ga. 167, 169-170.

Timing Is Everything in Applying the Continuous Employment Doctrine

By Timothy A. (TJ) Raimsey Jr., and Matthew Pittman, Bovis, Kyle, Burch, & Medlin, LLC

By the end of the 2016 calendar year, we should see at least one opinion from the Court of Appeals that may or may not provide some limitation to the ever-expanding scope of the continuous employment doctrine following a closely-decided 4-3 opinion by the Georgia Supreme Court in 2007. *See Ray Bell Cons. Co. v. King*, 281 Ga. 853, 642 S.E. 2d 841 (2007). Whether the Georgia Supreme Court will review the doctrine again in 2017 to provide further clarification to the already fact-specific, and sometimes puzzling, doctrine of continuous employment is yet to be determined. However, where *Ray Bell* and much of the previous case law has focused on the general proximity requirement and whether the actions of a claimant deviated from such to determine whether or not the employee falls within the scope of the doctrine, a 2012 Court of Appeals decision, *Medical Center, Inc. v. Hernandez*, should provide some guidance for the Courts and State Board to focus their attention when determining whether an employee falls within the doctrine. The scope of this doctrine is something employees, employers, and insurers should keep an eye on as the traditional 40-hour work weeks and typical office jobs continue to evolve along with technological advances and socio-economic values and principles. Providing a more specific standard as to when the continuous or “traveling” employee is covered by the doctrine would resolve some of confusion following the 2007 *Ray Bell* decision.

Ray Bell involved a Florida resident hired to work as a superintendent for a construction project in Jackson, Georgia and was provided housing in Fayetteville, Georgia by the employer. Death benefits were sought after he was killed in a motor vehicle accident on a Sunday while driving a vehicle provided by the employer. As the dissent points out, but the majority makes no reference to, it was undisputed that the decedent was also on sick leave for a knee injury at the time of the accident and was returning home from helping his mother move furniture to storage in Alamo, Georgia when the accident occurred. Conversely, the majority relies on the factual findings from the State Board which determined the decedent had concluded a personal mission in an employer-provided vehicle and was returning to either the job site or his employer-provided home when the accident occurred. *Ray Bell*, 281 Ga. at 854-55. The majority opinion does not discuss whether the claimant was on-call, worked weekends, or traveled home on weekends. *Id.*

The particular findings from the State Board that the claimant was either returning to work or returning to his employer-provided home are the limited factual findings the Supreme Court relied on when concluding the accident arose out of and in the course of his employment under

the continuous employment doctrine. *Id.* at 855. Arising out of refers to causation and in the course of refers to the time, date, and circumstances of the employment. *Id.* In addressing the “in the course of employment” requirement, the Court provides that the rule to apply is whether “the period of employment is at a place where the employee may reasonably be in the performance of his duties and while he is fulfilling those duties or engaged in something incidental thereto.” *Id.*

Despite this rule, neither the majority or dissent identify specific facts as to whether the employee was required to work on Sundays by his employment contract, required to stay in Georgia on the weekends, whether he was an on-call employee, or whether the work week had begun or ended when the accident occurred. While the dissent identifies facts that establish the claimant was on sick leave and performing a personal mission at all times on a Sunday, its legal analysis does not discuss the timing of the accident but instead focuses on the general proximity case law and whether the accident arose out of his employment. Alternatively, the facts used by the majority in *Ray Bell* place the claimant in the course of employment as he was in an employer-provided vehicle traveling to either employer-provided housing or the job site when the accident occurred. Perhaps the majority and dissent may have found more common ground had they analyzed the timing element in the continuous employment doctrine, such as the Court of Appeals did in *Medical Center, Inc. v. Hernandez*, 319 Ga. App. 335 (2012).

In *Hernandez*, two employees died in an auto accident on their way to work in Columbus, Georgia on a Monday morning. The two employees would stay in Columbus, Georgia during the work week and then return home to Savannah, Georgia on the weekends. There was no dispute that the two decedents fell within the doctrine during the actual work week and likely this accident would have been found compensable had they arrived at the job site and started the work week. Further, the Court of Appeals decided that the two decedents were likely within the general proximity of the job site when the accident occurred. The distinguishing fact that the Court of Appeals applied in its decision, which held that the doctrine did not apply to the decedents, was that the work week had not yet started for them when the accident took place as the employees had not yet reached the job site on a Monday morning on their way from Savannah to Columbus. *Hernandez*, 319 Ga. App. at 337. As such, the accident did not arise out of and in the course of their employment under the continuous employment doctrine, as required under *Ray Bell*.

The two-part rule we can take away from *Hernandez* after *Ray Bell* to determine whether an employee should fall within the continuous employment doctrine is as follows: (1) the injury must occur in the general proximity of employment; and (2) at a time when the employee was employed to be in that proximity. *Id.* The takeaway from *Hernandez* is that continuous employment only extends to employees during periods of time when the job offered by the employer requires the injured worker to be away from home. In *Ray Bell*, the decedent lived in Florida but was required to stay and live in metro Atlanta. In effect, his work week did not end as the continuous-employment doctrine is concerned because he was required to live in employer provided housing and was possibly traveling back to his job site.

The decision in *Hernandez* is also consistent with prior rulings from the appellate courts in Georgia. See, e.g. *United States Fidelity, etc. Co. v. Navarre*, 147 Ga. App. 302 (1978); *McDonald v. State Highway Department*, 127 Ga. App. 171 (1972); *Mayor, etc. of Savannah v. Stevens*, 278 Ga. 166 (2004). In *Navarre* and *McDonald*, both employees were injured after the work week had started and held to fall within the doctrine. *Id.* Alternatively, in *Stevens* an off-duty police officer was held not to fall within the doctrine in an accident on her way to work because she was not an on-call 24-7 employee despite the opinion acknowledging that a police officer is responsible for enforcing the law while in city limits at all time. 278 Ga. at 167. The distinguishing facts among all these cases, including *Ray Bell* and *Hernandez*, as to whether someone falls under the continuous employment doctrine is whether or not that employee's employment contract requires them to be in the general proximity of where the accident occurred.

Going forward, expects trial and appellate courts to examine closely not only whether the claimant was in the general proximity of his or her employment when an accident takes place, but the requirements of the employment contracts as to when the employee is expected to be away from his permanent residence for work-related reasons. Practitioners should not limit their focus their discovery and application of the facts to where the accident took place and whether or not the claimant had deviated from the general proximity of where he or she was expected to be as part of his or her employment. Additionally, practitioners should focus on what were the terms of the contract of employment, details of compensation, and the hours of service a particular employee was expected to work, including whether they were on-call 24/7, whether they worked after hours, whether they worked weekends, and whether they were expected to remain in the general proximity on weekends. Taking all of these facts together, the trier of fact should then find whether or not the employee was in a place *and time* at the employer's benefit when the accident took place to determine whether the employee falls within the continuous employment doctrine.

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Why does Carpal Tunnel Surgery in Workers' Comp Frequently Fail?

By Waldo E. Floyd III, MD, OrthoGeorgia

Over the past quarter-century, I have seen many workers' compensation patients develop worsening symptoms of pain and increased impairment following carpal tunnel decompression surgery. One wonders why a relatively simple procedure that in many cases is predictably successful can be a therapeutic failure in many workers. A frequent scenario is a patient employed at a single industry in a rural region with limited employment options. Healthcare for workers may be limited and obesity, diabetes, and hypothyroidism are endemic. Many patients are single parents with significant stress and untreated or unrecognized depression. In this setting, a worker develops hand symptoms. The hand symptoms may be pain and occasional numbness. Nerve conduction tests and EMGs are obtained demonstrating mild or borderline carpal tunnel syndrome and the patient ultimately undergoes a carpal tunnel decompression that results in worsening hand symptoms that may include complaints of forearm and upper arm pain.

The reason that these patients may not improve is that their symptoms were not caused by carpal tunnel syndrome. Patients with carpal tunnel syndrome rarely have pain and proximal forearm and upper arm symptoms of pain are not caused by carpal tunnel syndrome. Patients

with carpal tunnel syndrome characteristically develop hand numbness and tingling at night that may respond favorably to wrist splinting. As the condition progresses, the nocturnal numbness and tingling occurs during the day with activity, and when the condition becomes severe, there is constant numbness of the thumb, index, middle, and part of the ring finger day and night.

Unfortunately, the public and many doctors believe that most hand pain is carpal tunnel syndrome. This perception has increased over the past 25 years since the repetitive strain, cumulative trauma epidemic of the 1980s and 1990s. For instance, *The New York Times* in nineteen-ninety would report that carpal tunnel syndrome causes pain in the wrist and forearm and results from repeating the same motion on the assembly line and at a computer. During the period of the dissemination of this concept, the U.S. Department of Labor reported that work place injuries increased from 18 percent in 1981 to 38 percent in 1987.

There is significant disparity between popular and scientific illness concepts of carpal tunnel syndrome causation. Current accepted medical risks factors for carpal tunnel syndrome include heredity, hormonal changes related to pregnancy, hand use over time, age, and medical conditions including diabetes, rheumatoid arthritis, and hypothyroidism. Usually there is no single factor that can be determined to be the cause for carpal tunnel syndrome. An exception is the patient that develops carpal tunnel syndrome following injuries such as a wrist fracture. There is extreme difficulty in establishing a causal relationship in a scientifically reliable and valid manner. Speculative causation can precipitate or exacerbate illness and foster workers' compensation claims. The popular conception is that computer use causes carpal tunnel syndrome and many patients believe computer use led to their carpal tunnel syndrome. In fact, the incidence of carpal tunnel syndrome is the same in the computer users and the general population. There is another group of patients who mistakenly believe that they could not have carpal tunnel syndrome because they have never used a computer!

The worker with hand pain does not have symptom relief after uncomplicated release of the carpal tunnel because a carpal tunnel release does not relieve hand pain and hand pain is likely due to alternate and unrecognized diagnoses. The nerve conduction tests and EMGs that the doctor orders for the patient with hand pain may lead the treating doctor towards an erroneous carpal tunnel syndrome diagnosis. Research has shown that patients with border line electro-diagnostic findings have less successful outcomes than workers with more severe electro-diagnostic findings. The surgeon should be



extremely cautious when considering carpal tunnel surgery in workers with normal or near normal nerve conduction results.

Hand and upper extremity pain in the worker is rarely due to carpal tunnel syndrome but maybe be related to musculoskeletal disorders and/or depression. The depressed worker may have increased pain and disability that is influenced by pain catastrophizing, a tendency to magnify pain, and feel helpless and to ruminate on pain. The surgeon may feel pressured to act and patient distress can be contagious. Carpal tunnel decompression may falsely validate symptoms and worsen a pain cycle that may be related to untreated depressive symptoms.

The workers' compensation system often results in ineffective treatment for the worker with hand symptoms. Addressing depressive symptoms that may or may not be caused by the work place, is challenging in the workers' compensation arena. However, addressing depressive symptoms instead of surgery or before an elective procedure may hinder transition from acute to chronic pain. Frequently, surgery is not the answer. The decision to release the carpal tunnel syndrome requires experience and judgment. Carpal tunnel syndrome is characterized by hand numbness and tingling that awakens the worker at night and may progress to being present during the day. Hand pain is unlikely to be due to carpal tunnel syndrome and in fact, carpal tunnel surgery in the absence

of specific carpal tunnel syndrome symptoms may magnify the pain cycle. Psychological issues may be manifested unconsciously as hand pain. Workers with hand pain may have electro-diagnostic signs for carpal tunnel syndrome when their symptoms are not carpal tunnel syndrome. Comorbidities such as diabetes, obesity, and hypothyroidism may make abnormal electro-diagnostic studies more likely in the absence of the proper diagnosis leading treatment down the wrong path. The decision to release the carpal tunnel requires experience and judgment in order to avoid failed carpal tunnel surgery in patients whose problem is not carpal tunnel syndrome.

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